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


**CENTER FOR DRUG AND HEALTH PLAN CHOICE**

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

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

SUBJECT: Complaint Tracking Module (CTM) and Casework Reminders

DATE: December 28, 2009

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. Your efforts have helped reduce the aggregate volume of CTM complaints and improved turn-around times in resolving issues. Still with the upcoming new benefit year, now is a good opportunity for your organization to review the following casework reminders to ensure beneficiaries continue to receive high quality customer service and access to services. The suggestions that follow are intended to supplement the December 9, 2008 HPMS memo on these same topics.

## Customer Service and CTM Reminders

- Medicare plans are already aware of the long-standing requirement to resolve 95% of cases designated as Immediate Need within 2 calendar days of receipt. Plans also should be aware that it is expected that they resolve at least 95% of CTM complaints designated as "urgent" within 7 days, and 95% of CTM complaints designated without an issue level within 30 days. CMS will closely monitor these metrics next year.
- CMS has observed that most plans routinely contact beneficiaries after their complaints have been resolved. However, CMS also encourages plans to make interim contact with their members if their complaints will take more than seven days to resolve. Doing so, even when a complaint has been referred to CMS as a "CMS Issue," will reduce the likelihood of a repeat complaint by the beneficiary.
- Recent enhancements to the CTM give plans the ability to view multiple complaints from the same complainant within their organization *(See March 3, 2009 HPMS Memo – Upcoming Complaints Tracking Module Enhancements).* Plans are encouraged to identify these complainants, proactively outreach to them, and offer specialized assistance in an effort to reduce the likelihood of additional repeat complaints.

- Upon accepting a new enrollment from a beneficiary in premium withhold, plans should advise their member that it could take up to 90 days for their Social Security deductions for their new plan premiums to begin and they could see premiums for their former plan continue for that period of time. For more information, please see the HPMS Memo dated October 23, 2009 entitled, "Customer Service Representative Scripting Concerning Premium Withhold."
- Some plans have requested that CMS downgrade the issue level for complaints after the access portion of the complaint has been addressed. CMS staff will not approve these requests unless the issue level was originally incorrect.
- Similarly, some plans have requested that CMS re-categorize complaints in the "Enrollment Exception – Alleged Marketing Misrepresentation" categories when a complaint is subsequently determined to be unfounded. CMS also will not approve these requests.
- In an effort to improve the turn-around time for CTM complaints, plans are encouraged to carefully review submissions to the Retro Processing Contractor (RPC), send submissions timely, and resubmit any rejects quickly. If the complaint is in CTM and flagged as "Immediate Need," plans should request CMS assistance in expediting the case. All other issue level cases should be sent directly to the RPC. Similarly, plans should close the CTM complaint once they receive an indication from the RPC that the requested change has been successfully made. For CTM cases that are referred to the RPC for handling, plans are required to make their members active on their enrollment system to ensure access to health services and prescription drugs and when necessary, include a CTM screen-shot indicating Regional Office approval.
- CMS records provider and pharmacy complaints in the CTM and reminds plans of their obligations to educate these complainants and resolve their issues.
- Beginning in 2010, nearly all plans must accept enrollment elections made through CMS' Online Enrollment Center (OEC) and are required to download pending enrollments every business day. Doing so will expedite the enrollment process and assist in the reduction of untimely enrollment complaints in the CTM.
- Over the last two years, CMS has seen a significant rise in the volume of Late Enrollment Penalty (LEP) complaints. CMS encourages plans to accept telephonic attestations from members in order to assist in the timely and effective completion of the attestation process. Having timely and complete attestations will help reduce the number of LEP appeals that are referred to CMS' Independent Review Entity (IRE) and ultimately result in a favorable decision. In addition, some drug plans have reportedly been "blaming the imposition of LEPs on CMS." This is inappropriate and plans should cease this practice.
- Plans are encouraged to provide refresher training to improve staff understanding of the Best Available Evidence (BAE) process in order to provide better customer service to beneficiaries. Customer Service Representatives should know what forms of evidence are considered acceptable proof of Low Income Subsidy (LIS) and how to use the BAE assistance process to verify that an individual has LIS because of their Medicaid status. The BAE process is for beneficiaries who believe they are full or partial Medicare/Medicaid dual-eligible. Once eligibility has been verified, the drug plan should provide access to drugs at

the correct LIS cost-sharing level even when CMS systems do not yet reflect this eligibility. The August 4, 2008 HPMS Memo, entitled “Best Available Evidence Policy-UPDATE,” summarizes the overall process.

- If the plans are contacted by beneficiaries who have received an indication that they qualify for Extra Help/LIS through SSA, the plan should assist the beneficiaries in obtaining a letter from SSA to be used as BAE (*See the October 16, 2008 Identifying Key Information in Social Security Administration Letters to Low-Income Subsidy Applicants Memo*) and work to get that information updated as needed.
- 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.

Thank you again for your contribution to making the Medicare program a success. If you have any questions or comments regarding this memorandum, we encourage you discuss them with your Account Manager.