DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

DATE: December 14, 2006

Memorandum to: All Part D Plan Sponsors

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

Subject: November 3rd HPMS Complaints Tracking Module Release (CTM) and Update to CTM Plan Standard Operating Procedure (SOP)

On November 3, 2006, CMS implemented several enhancements to the HPMS Complaints Tracking Module (CTM). Your organization will find the following enhancements in the HPMS CTM:

- A new option to the "Plan Requests for CMS" page to allow plans to request a change of "Issue Level". The Part D sponsor will have the ability to propose the appropriate issue level. As with other reassignment requests, the CMS regional office must agree or disagree with the request. Please refer to Attachment A for further information on various issue levels in the CTM.
- Plans will have the ability to include 31 days instead of just 30 days on the Plan Resolution Entry Selection Criteria page.
- A new view complaints link called "My Open Complaints", where the plan user has the capability to view **all** open complaints in the CTM. Plans will be required to select a contract (one, more or all) before the list of complaints is shown. If the user selects "All" and more than 300 complaints are returned, the user will receive a message saying they have exceeded the limit; however, if they select only one contract and more than 300 complaints are returned, the user will be able to view all complaints. The user will also be able to sort by columns.
- Two new columns where plans can view the contract name and complaint status will be added to the Plans' Search Results page and the Plans' My Open Complaints page.
- The Contract Assignment date (also known as the Contract Entry Date), the date when the plan is assigned the complaint, will be used to pull complaints in the CTM instead of the Complaints Received date.

- Upload error messages will be more detailed so that plans will be able to troubleshoot upload issues more efficiently.

Some of the above improvements to the CTM warranted updates to the CTM Plan Standard Operating Procedure (SOP). **Attachment A** provides guidance to all Part D organizations for various issues related to the CTM. For general questions about complaints tracking, please contact CMS via the CTM mailbox at ctm@cms.hhs.gov. For technical assistance with the HPMS CTM, please contact the HPMS Help Desk at either 1-800-220-2028 or hpms@cms.hhs.gov. Thank you for your continued work and support in complaints resolution.

ATTACHMENT A

Complaints Tracking Module (CTM)
Standard Operational Procedure
Medicare Part D Plan Sponsor User
October 31, 2006

*** Procedure has been revised or added since last iteration.**

#	Scenario/ Issue	Procedure
Complaint-specific Issues		
A	Plan A receives a complaint that should have gone to Plan B	1. Plan A indicates in the Current Entry (Plan Response) field a. if known, the name and/or contract number of the Plan to where the complaint must be reassigned and b. any additional pertinent notes related to the complaint. 2. Plan A checks the indicator to request for a case reassignment because it belongs to another plan. 3. Plan A should NOT close case in CTM. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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.
B	Plan A received a complaint that involves one of it's subsidiaries	1. Plan A indicates in the Current Entry (Plan Response) field a. if known, the name and/or contract number of the Plan to where the complaint must be reassigned and , b. any additional pertinent notes related to the complaint, 2. Plan A checks the indicator to request for a case reassignment because it belongs to another plan. 3. Plan A should NOT close case in CTM. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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 unless Plan A has access to the subsidiary's CTM. 5. Plan A shares the PHI (which was provided by CMS) related to the complaint to the involved subsidiary by a secure means of data transfer.

C*	Plan A can not do further casework with complaint and requires RO assistance to resolve (CMS issue)	1. Plan A indicates in the Current Entry (Plan Response) field any additional pertinent notes related to the complaint. 2. Plan A checks the indicator to request for a case reassignment because it is a CMS issue. 3. Plan A should NOT close case in CTM. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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 "CMS".
D*	Plan A receives a complaint that is not related to Part D	Most likely, the complaint is related to Part C. The complaint needs to be moved to the MA Only CTM and, subsequently, requires a complaint category reassignment. Part D Sponsors are not responsible to resolve Part C complaints in the CTM. Please do the following: 1. Plan A indicates in the Current Entry (Plan Response) field the following: a. "CTM Case Not Part D", b. plan's recommendation of appropriate complaint category, and c. any additional pertinent notes related to the complaint. 2. Plan A checks the indicator to request for a case reassignment because it requires category reassignment. 3. Plan A clicks "Selects Complaint Category" under "Requested Complaint Category", selects the most appropriate category, and then clicks "Select Category" button at the bottom of the page to save. Plan A's category recommendation should appear in the blue box if saved correctly. Submit the request when complete. 4. Plan A should NOT close case in CTM. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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 MA only complaint. **Note: Complaints related to premium withholds, RD, FE, or EE do not fall into this scenario and are considered related to Part D.**
E	Plan A has reached resolution of complaint but has not yet notified the beneficiary	1. Plan A closes complaint in CTM and reports disposition as resolved. 2. Plan A notifies the beneficiary according to the Plan A's business practices and customer service policies.

F	Plan A can not close and/ or save complaint after entering resolution notes and resolution date	1. Plan A verifies a resolution date is entered in the resolution date field. Note: Resolution date must be entered in order for complaint to be recorded as closed/resolved in the CTM. a. If there is no resolution date, enter and save the date the case was resolved. The complaint should close. If the case still does not save, move to item 2. b. If there is a resolution date, move to item 2. 2. Plan A verifies that the complaint category is assigned properly. a. If no category is assigned, refer to Scenario I. b. If a category is assigned, move to item 3. 3. Plan A indicates in the Current Entry (Plan Response) field that a. the complaint requires further assistance from the lead RO, b. the complaint disposition is resolved, and c. any additional pertinent notes related to the complaint, the name of the caseworker as shown on the complaint in CTM. 4. Plan A notifies its lead RO of the status by sending an email to the RO's mailbox. The email subject line should state, "CTM Case Resolved But Will Not Close." The email includes: a. the CTM complaint ID for the case(s) that need(s) further evaluation by CMS, b. the caseworker(s) shown on the complaint(s) in CTM and c. the name and contract number of Plan A.
G*	Plan A receives cases related to retroactive disenrollments (RDs)	1. Plan A develops case to determine if it is a valid RD request 2. If RD request is not valid and case is resolved, plan notifies the beneficiary and closes the case in the CTM 3. If a case is incorrectly coded as an RD and requires referral to another Plan, see Scenario #A in this SOP. 4. If RD request is valid, Plan A determines if case is Critical or Non-Critical. **Cases labeled Immediate Need by 1-800 MEDICARE are ALWAYS considered Critical**. Other cases that shall be considered Critical include: a. For MA-PD: case concerns immediate need to access to care. b. For MA-PD and PDP: case concerns opt-out due to employer group coverage 5. Critical Retro-Disenrollment: Plan A refers case to **home** RO a. Plan A checks the indicator that the case requires reassignment because it is a CMS issue and indicates in the Current Entry (Plan Response) field "CRITICAL RD". b. Plan notifies home region by sending an email to the Home Region's Part D complaint box (see Addendum A and B). The email subject line should state, "CRITICAL RD, in CTM". The email includes:

		i. the CTM complaint ID for case(s), ii. the name and contract number of Plan A, iii. the caseworker listed on the complaint in the CTM iv. any other relevant information c. Plan leaves the case **OPEN** and indicates in the Current Entry (Plan Response) field that the case and all development have been referred to home RO for processing. d. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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 an "other" contract. 6. Non-Critical Retro-Disenrollment: Plan A refers case to IntegriGuard a. Plan leaves the case open, documents all case development, and indicates in the Current Entry field that case has been referred to IntegriGuard. b. Plan sends all relevant information to IntegriGuard c. Plans are strongly encouraged to give the beneficiary a status update of the RD complaint d. When a RD case is resolved by IntegriGuard, they will notify Plan of the resolution. Subsequently, Plan A will close case in CTM.
H*	Plan A receives cases related to enrollment exceptions (EE)	1. After validating the case is truly an enrollment exception request, Plan A indicates in the Current Entry (Plan Response) field a. "EE Complaint" and b. any additional pertinent notes related to the complaint. 2. Plan A checks the indicator that the case requires reassignment because it is a CMS issue. 3. Plan A should NOT close case in CTM. The case 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 timestamp 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 on the system generated "Note to Plan" section on the Plan Resolution 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 "CMS".
I	Plan A receives miscategorized case	1. Plan A indicates in the Current Entry (Plan Response) field any additional pertinent notes related to the complaint. 2. Plan A checks the indicator that the case requires

		reassignment to another complaint category. 3. Plan A clicks “Select Complaint Category” under “Requested Complaint Category”, selects the most appropriate category, and then clicks “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. Plan A should NOT close case in CTM. The case is flagged in the CTM for the RO to recategorize the complaint. The time clock for Plan A will stop once the indicator is checked and will commence once the complaint is recategorized. 5. For updates on the request, Plan A will be able to view the RO action/decision on the system generated "Note to Plan" section on the Plan Resolution page.
J*	Plan A receives case with issue level of “Immediate Need” but Plan A does not believe it should be	1. Plan A indicates in the Current Entry (Plan Response) field any additional pertinent notes related to the complaint. 2. Plan A checks the indicator that the case requires reassignment to another issue level. 3. Plan A clicks “Select Issue Level” under “Requested Issue Level”, selects the most appropriate level, and then clicks “Select Issue Level” button at the bottom of the pop-up page to save (refer to the Issue Level Definitions below to determine appropriate issue level for complaint). Plan A’s category recommendation should appear in the blue box if saved correctly. Submit the request when complete. 4. Plan A should NOT close case in CTM. The case 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. 5. For updates on the request, Plan A will be able to view the RO action/decision on the system generated "Note to Plan" section on the Plan Resolution page. NOTE: Issue Level Definitions • 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. • 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. • 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.
Gentran (GT) or Connect:Direct (C:D) Related Issues		
K	Plan A is having trouble accessing file(s) via GT or C:D	1. Plan contacts MMA Help Desk at 1-800-927-8069 or mmahelp@cms.hhs.gov.
L	Plan A does not see file(s) via GT or C:D for a particular day or time period and want to verify if they should have received file(s)	1. Plan contacts MMA Help Desk at 1-800-927-8069 or mmahelp@cms.hhs.gov.

M	Plan A received file(s) via GT or C:D but file(s) has incomplete information (e.g., missing contract number)	1. Plan A refers to CTM using CTM complaint ID or beneficiary's name to locate complaint. 2. If Plan A cannot locate complaint in CTM, they contact the corresponding lead RO to locate.
N	Plan A sees complaint(s) on GT or C:D files which can not be found in CTM	1. Plan A receives a complaint(s) which involves multiple contracts. 2. After looking in the case notes, RO reassigned complaint(s) to Plan B for casework resolution after it was already uploaded to Plan A's GT or C:D file. 3. Complaint(s) now appear in the CTM for Plan B and no longer appear in the CTM for Plan A. 4. Due to the manual process, complaint(s) which have been reassigned will appear on the GT or C:D files for Plan A.
O	Plan A sees complaint(s) in CTM but not on the GT or C:D files	There could be one of three reasons: <u>REASON I</u> Complaint(s) considered "direct receive" complaint, where it was first reported directly to the RO and was directly input into CTM by RO. 1. Plan A works complaint. 2. Plan A sends an email to the home RO's mailbox if further beneficiary specific information is needed and cannot be located in the CTM to reach resolution. The email subject line should state "Need PHI". The email includes: a. the complaint ID for the case in question, b. the caseworker listed on the complaint in the CTM. and c. the specific PHI requested. 3. Note: Complaints on file received via GT or C:D originate from 1-800-Medicare only <u>REASON II</u> Plan A receives a complaint(s) which was originally considered "unknown" or "other - 99999".Complaint(s) considered "unknown" or "other" because contract number could not be identified and assigned during data upload. After looking in the case notes, RO reassigned complaint(s) to Plan A for casework resolution. Complaint(s) now appear in the CTM for Plan A. Due to the manual process, reassigned complaint(s) will not appear on the GT or C:D files. 1. Plan A works complaint. 2. Plan A sends an email to the RO's mailbox if further beneficiary specific information is needed and cannot be located in the CTM to reach resolution. The email subject line should state "Need PHI". The email includes: a. the complaint ID for the case in question, the caseworker listed on the complaint in the CTM, and b. the specific PHI requested. REASON III Plan A receives complaint(s) which originally was assigned to Plan B.

		After looking in the case notes, RO reassigned complaint(s) to Plan A for casework resolution because complaint is actually attributed to Plan A. Complaint(s) now appear in the CTM for Plan A. Due to the manual process, reassigned complaint(s) will not appear on the GT or C:D files. 1. Plan A works complaint. 2. Plan A sends an email to the RO's mailbox if further beneficiary specific information is needed and cannot be located in the CTM to reach resolution. The email subject line should state "Need PHI". The email includes: c. the complaint ID for the case in question, the caseworker listed on the complaint in the CTM, and d. the specific PHI requested.
Access		
P	Plan A user does not have CTM access	1. Plan A's Medicare Compliance Officer (listed in HPMS) submits request to ctm@cms.hhs.gov. 2. Request must include specific information, as described in the April 26th memo posted in HPMS. 3. Note: Requests submitted which do not exactly follow instructions posted in April 26th HPMS memo will delay processing of access.
Q	Plan A user does not have CTM access and has submitted request already	1. Plan A sends notification to CMS at ctm@cms.hhs.gov. 2. The email includes: a. the name and contract number of Plan A and b. the name and HPMS ID of requested user.
R	Plan A user needs HPMS but does not have it	1. Plan A submits request to CMS per standard procedures 2. Note: HPMS user set up will take 2 weeks or longer
General		
S	Plan A has general CTM related question or issue	1. Plan A sends inquiry to CMS at ctm@cms.hhs.gov. 2. The email includes: a. the name and contract number of Plan A, b. the question or issue, and c. pertinent information related to concern at hand

Key & Definitions

1. "CMS" contract assignment = a complaint contract assigned to "CMS" when the complaint is a CMS issue and is not attributed to the Part D sponsor
2. CTM = Complaint Tracking Module
3. C:D = Connect:Direct
4. EE = Enrollment exception
5. FE = Facilitated enrollments
6. GT = Gentran
7. HPMS = Health Plan Management System
8. Immediate Need complaint = aka "immediate action"; type of issue level; complaint that is related to the beneficiary's need for medication where the beneficiary has 2 or less days of medication left; Part D Sponsors are required to resolve these complaints within 2 calendar days from the time it is assigned to the Part D sponsor. 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
9. "Other" contract assignment = a complaint contract assigned to "other" when beneficiary complains about a Part D sponsor but the contract number was not identified or found at the time of intake
10. PHI = Protected Health Information

11. Plan A, B, etc. = Any Medicare Part D sponsor/plan
12. RD = Retroactive disenrollments
13. RO = Regional Office
14. “Unknown” contract assignment – a complaint contract assigned to “unknown” when beneficiary complains about a Part D sponsor that is not known or when beneficiary complaint is not directed toward a Part D sponsor
15. Urgent complaint = type of issue level; complaint that is related to the beneficiary’s need for medication where the beneficiary has 3 to 14 days of medication left