DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**CENTER FOR BENEFICIARY CHOICES**

MEMORANDUM

**DATE:** **August 14, 2006**

**Memorandum to:** **All Part D Plan Sponsors**

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

**Subject:** **Closing Repeat Complaints in the Complaint Tracking Module**

CMS appreciates the actions Part D plan sponsors are taking to reduce casework associated with beneficiary complaints. An issue that has been identified by sponsors as hindering this effort has been the inability to identify all complaints by the same person for the same issue. As a result, CMS is proposing some short term solutions that may help Part D sponsors identify and address this problem.

CMS recognizes that beneficiaries will call 1-800-Medicare call centers repeatedly when their complaint is not resolved as quickly as they anticipated. CMS call center customer service representatives (CSR) have been instructed to ask beneficiaries if they have previously filed a complaint on the same issue. If they answer yes, but it is within a specified timeframe (less than 48 hours for an urgent complaint and less than 5 business days for non-urgent complaints) then the CSR does not enter another complaint into the system. However, in some cases it is legitimate to have duplicate/repeat complaints. For example, it would be acceptable for a beneficiary who only has four days of medication remaining to call back after two days if they were still unable to get their medication refilled.

Although these processes are in place to reduce the number of duplicate complaints reflected in the Complaint Tracking Module (CTM), CMS realizes that plan sponsors need a better way to manage these issues. CMS has identified a short term solution to assist plans and is working to identify longer term solutions. One short term solution is outlined in Attachment A. This solution requires that plans construct a dataset using the CTM extract linked to the person's identifiers to identify duplicates. In the longer term, sponsors will be able to search the CTM using the beneficiary's Health Insurance Claim Number (HICN). In addition, CMS is looking at ways to improve a sponsor's ability to group and obtain a report of duplicate complaints.

The combined effort of these changes will make the casework process more efficient and assist plans in reducing the number of caseworkers who are working on a duplicate issue for the same beneficiary. At the same time, it provides a more efficient process to close out multiple complaints at once without having to open each one separately within the CTM. However, CMS recommends that a plan caseworker ensure that the case is indeed a true duplicate complaint and resolved before entering a closed disposition.

We appreciate your time and dedication to resolving beneficiary complaints. We are continuing to work with you to improve the performance and functionality of the CTM. As always, if you have any questions or comments about this process, please contact CMS via email to ctm@cms.hhs.gov with "Repeat Complaints' in the subject line.

Attachment A

Short Solution for Plans to Manage Duplicate Complaints in the CTM

Steps:

1. Plans should download all of their complaints (open and closed) from the CTM into a spreadsheet or database, such as Microsoft Excel, Microsoft Access, or SAS. The CTM system allows the download of only ten days of complaint data at a time so several downloads would need to be appended into one file.
2. Using the Gentran or Connect:Direct files, merge in the HIC number associated with a given complaint id, if available.
3. Group the file by beneficiary HICN, name, and category and possibly other common identifiers (e.g., phone number, zip code, etc.). Verify that a series of complaints for the same beneficiary is about the same issue. Then the plan can work the multiple complaints as one.
4. When resolution is reached on one, in effect that resolves all the other associated repeat complaints. The plan should then mark each of those linked complaints as closed and upload the resolutions into the CTM.
5. CMS recommends that the plan contact the beneficiary to notify that the complaints have been resolved and to reduce further inquiry from the beneficiary for the same issue.
6. The plan may append new data to the existing file and repeat the above steps, if necessary.