



The Beneficiary Comes First Casework and Complaints

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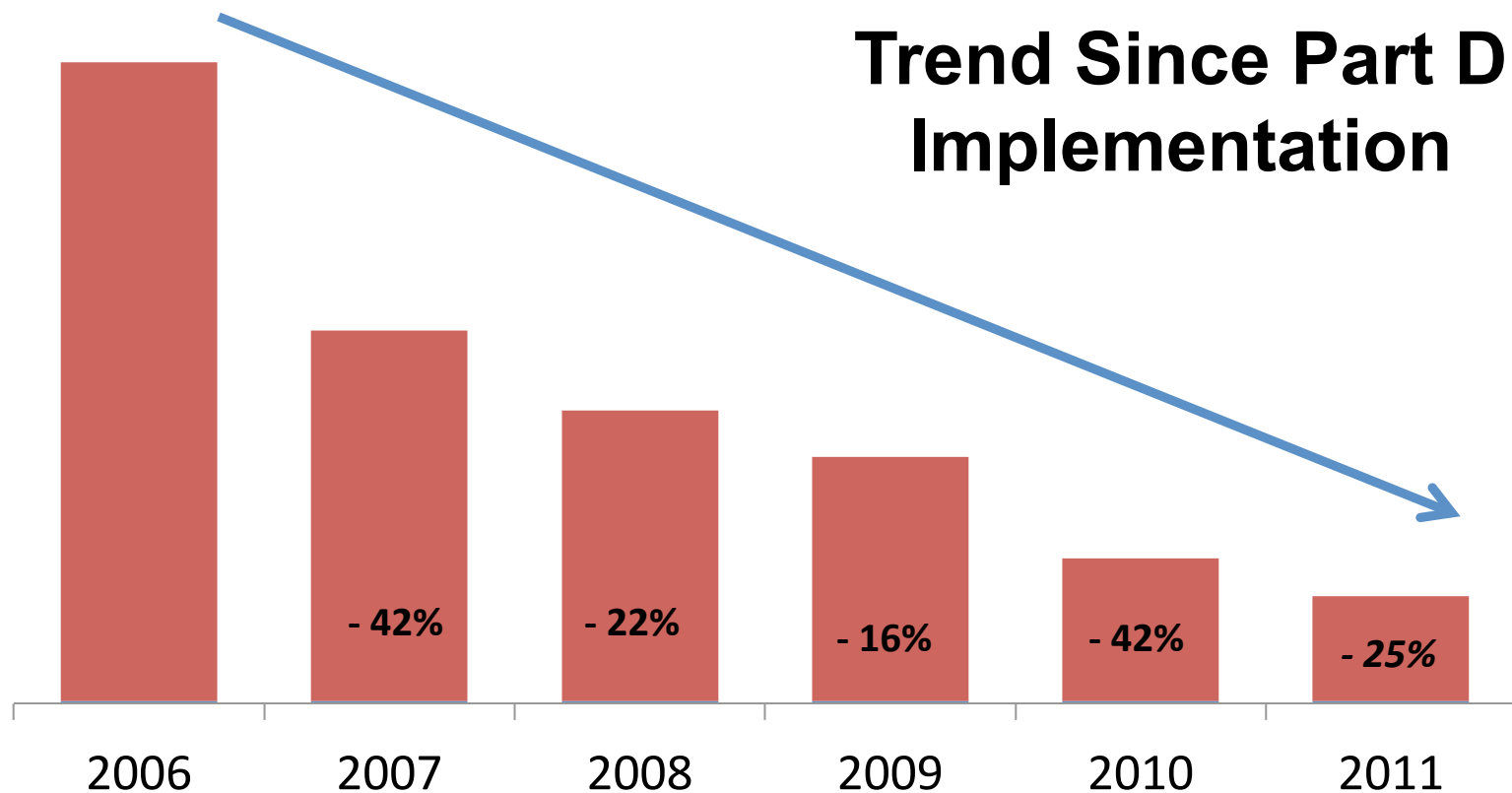
Consortium for Medicare Health Plans Operations

Denver Plan Compliance Conference – October 26, 2011

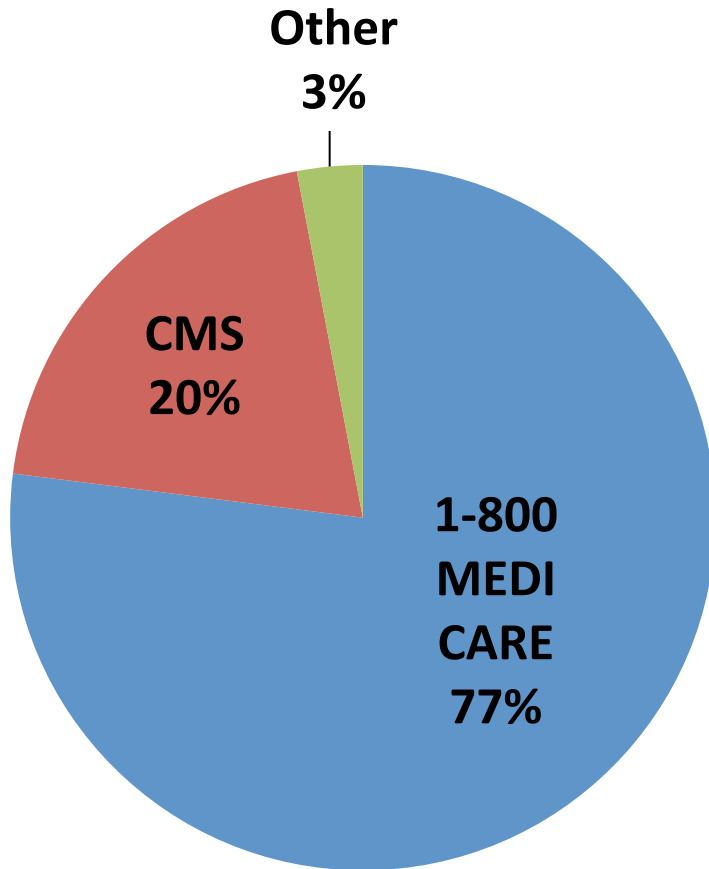
What is a Complaint?

- Definition
- CMS Perspective and the Plan Perspective
- Distinguishing from Grievances
- Increasing Importance

CTM Complaint Statistics



Complaint Sources - All



- **1-800 MEDICARE Primary Means**
- **Regional Office Complaint Mailboxes, Hotlines, Letters, Faxes, from Partners and Elected Officials**
- **“Other” – SHIPs, MEDIC, and Web-Complaint Forms**

Complaint Source: 1-800 MEDICARE

- Six Call Centers across the United States
 - Staffing Varies Based on Time of Year
 - 26 Million Calls Received in 2010
 - Peak Times
 - Peak Days
- Automated IVR
 - Part C and D enrollment status
 - LIS status
- What “Can” and “Can’t” our CSRs Do?

1-800 Capabilities

- CSRs can:
 - Provide Current Enrollment/LIS information
 - Send Extra Help Applications
 - Help with Selecting Plans
 - Record Part C and D Complaints
 - Order Replacement Medicare Card
- CSRs can't:
 - Conduct Retro-Disenrollments
 - Make Appeal/Reconsideration Requests
 - Handle RDS Issues
 - Help Complete Extra Help Applications

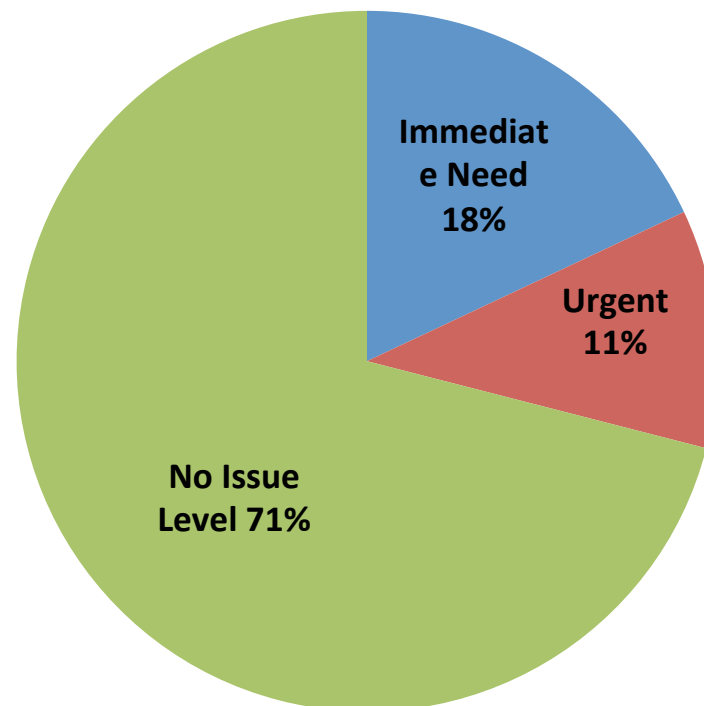
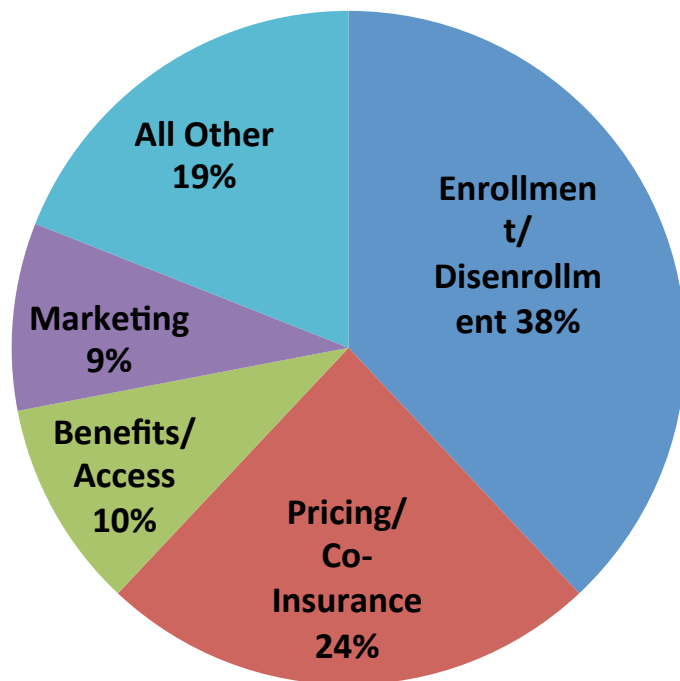
Complaint Source: SHIPs

- State Health Insurance Programs (SHIP)
Complaints
 - Pilot Program – 9 states in 2008
 - Currently 35 States/Territories
 - 300 Users
 - Seeking to Increase Use with Existing Users
 - Possible Expansion in 2012 to Remaining States

Complaint Source: Internet

- Section 3311 of the Affordable Care Act
 - Implementation of an Electronic Complaint Form
 - Accessible from www.medicare.gov homepage and Medicare Ombudsman homepage by 1/1/2011
- Triage by 1-800 MEDICARE Staff
 - Entry into CTM when appropriate
- New Plan Requirements

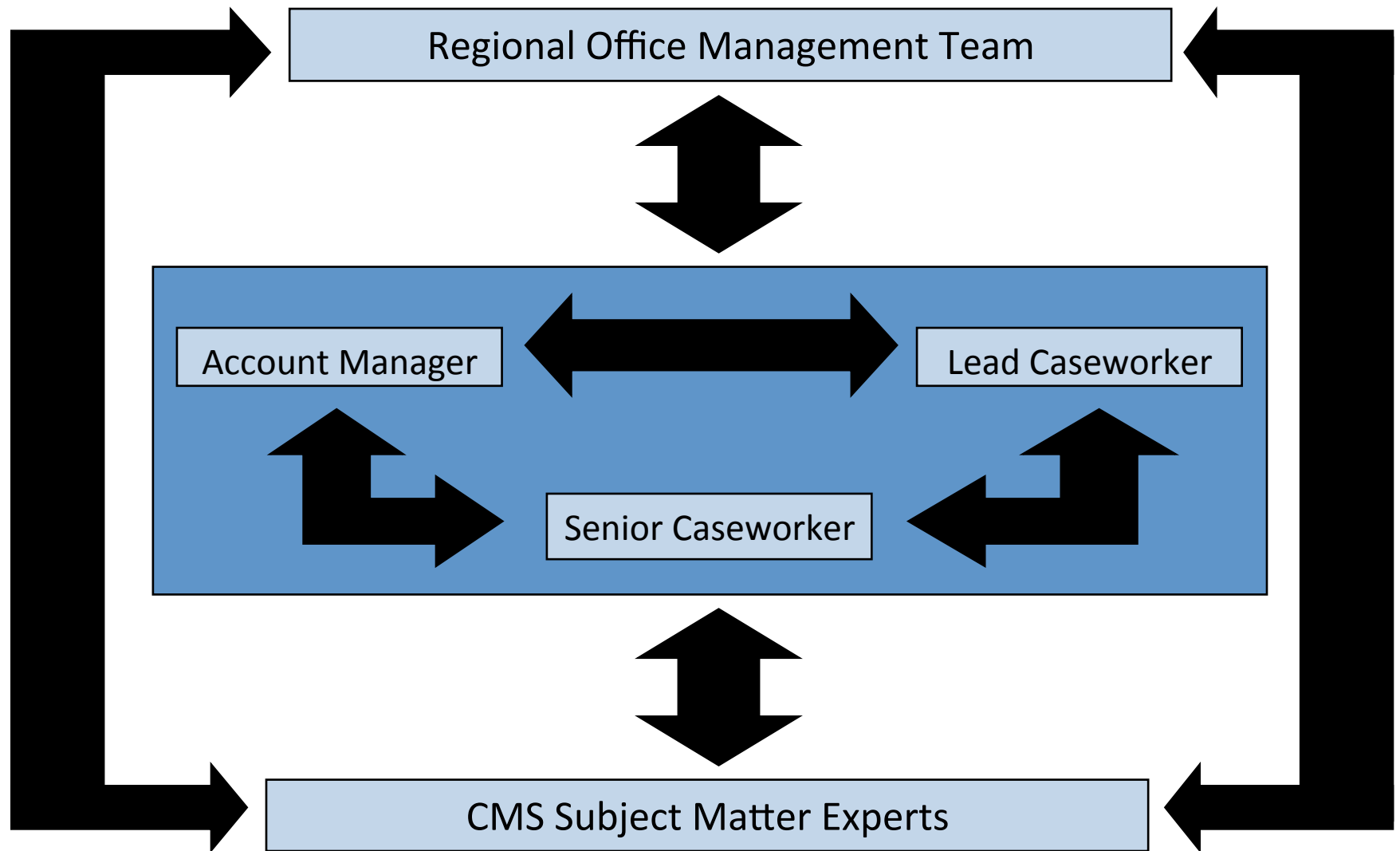
Most Common Issues and Severity



Issue Level and CMS Standards

Issue Level	Definition	CMS Requirement
Immediate Need	Part C - Beneficiary has no access to care and needs care Part D – Beneficiary has 0-2 days of medication left	Resolve at least 95% within 2 calendar days
Urgent	Part C - Beneficiary has no access to care but doesn't need care immediately Part D – Beneficiary has 3-14 days of medication left	Resolve at least 95% within 7 calendar days
No Issue Level	Everything else	Resolve at least 95% within 30 days

CMS Communication



CMS Approach to CTM Data

- Use CTM Data to Identify Plan Compliance Issues
 - Compare statistics to other similarly sized contracts
 - Understand complaint drivers and root causes
 - Monitor fixes
 - Provide Technical Assistance
- Look Out for Access Issues
- Audit and Enforcement referrals

CMS Approach to Casework

- Two Key Guiding Principles for CMS
 - Resolve Complaints Expeditiously
 - Satisfy the Medicare Beneficiary
- Have the Plans Resolve Most Complaints
 - Push Back Issues within Plan Control
 - Provide Technical Assistance As Needed

Complaints – CMS Responsibility

- Key Areas
 - General Enrollment Exceptions
 - Marketing Misrepresentation Possibly Requiring Retro-active Enrollment Change
 - Help Acquiring Best Available Evidence
 - Critical Retro-Disenrollments
 - Congressional and SSA Dire Need
 - Premium Withhold (PETS)
 - **2012:** Part D IRMAA and Good Cause for Failure to Pay Premiums

Complaints – CMS Regional Office Activities

- Internal Coordination
 - Home and Lead Regions
 - Ombudsman's Office
 - Office of Legislation
 - Center for Medicare (CPC)
 - MEDIC
- Quality Assurance Projects
- Housekeeping
 - Assignments/Reassignments
 - Plan Requests

Complaints – CMS Internal Standards

- Disclosure Requirements
- Timeliness Standards
- Documentation Requirements
 - Casework Notes
 - Status Updates
- Upload Pertinent Documents
- Inform Beneficiary of Resolution
- Translation Services

Top Complaint Issues *Enrollment*

- Downward Trend
 - MARx Modernization
- Reconcile and Submit Transactions Timely
- Download Online Enrollment Center (OEC) Transactions
- Accurate Retro Processing Contractor (RPC) Submissions
- Retroactive Enrollment and Disenrollment Complaints

Top Complaint Issues

Alleged Marketing Misrepresentation

- Beneficiary-Friendly Policy
- RO Action and No RO Action Needed
 - Re-Categorization Requests
- Allegations Requiring your Review
- Agent/Broker Names and Details
- Partnerships
 - Senior Medicare Patrols (SMPs)
 - State Department of Insurance Departments (DOIs)

Top Complaint Issues

Premium Withhold

- Statutory Right
- A CMS/SSA “Success Story”
 - Overcoming an Implementation Challenge
- Railroad Retiree Board (RRB)
- Harm Utility
- Libby Beneficiaries

Top Complaint Issues

Premium Withhold

- Opportunities – Promote Premium Withhold
 - Reliable Predictable Plan Payments
 - Fewer Disenrollments for Failure to Pay Premium
 - “Green” Option
- Resubmission of Beneficiary Requests
 - TRC 144
 - Communication to the Beneficiary
 - Key Dates:
 - 12/7 – December Plan Data Due
 - 1/13 – January Plan Data Due

Top Complaint Issues

Good Cause for Failure to Pay Premiums

- Beneficiary Right in 2012
 - Plans to refer requests to 1-800 MEDICARE
 - Can grieve an aspect of the disenrollment
 - A very, very, very, good reason
 - Housed in the CTM
 - Approval Decisions only
 - Made by CMS Casework Staff
 - CMS/Plan Coordination
- Flexibility

Top Complaint Issues

Part D IRMAA

- “Income-Related Adjustment Amount”
- Provision in the Affordable Care Act
- Unrelated to Plan Drug Premium
 - Direct Government Collection
 - Communication to Beneficiaries
- Disenrollments to Occur Starting Next Year for Failure to Pay
- Employer Group Plans
- CMS Outreach Initiatives
- Flexibility

Top Complaint Issues

\$250 Coverage Gap Rebate

- Provision in the Affordable Care Act
- Another Success Story
 - Lots of Checks and Few Complaints
 - Effective Communication to Beneficiaries
 - Management of Expectations
- Timely Submissions of PDEs by Part D Plans

Complaint Exclusions

- April 27, 2011 HPMS Memorandum
 - CTM Cases not Counted in Performance Metrics
- Sub-Categories
 - Facilitated/Auto Enrollment Issues
 - Enrollment Exceptions
 - Beneficiary has Lost Status/Eligibility
 - Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information
 - Part D IRMAA
 - Other Contractor Performance
 - Program Integrity
 - Good Cause for Failure to Pay (December 2012)

New CTM Plan SOP Highlights

- September 30, 2011 HPMS Memorandum
 - Inform Beneficiaries when Complaint is Reassigned
 - Tell Beneficiaries
 - Leave Informing the Congressional Office of the Resolution to CMS
 - Do not Send Congressional Cases to RPC
 - Refer Critical Retro-Enrollment Cases are to RPC (or Fix in MARx)
 - Instructions for Uploading Attachments to Marketing Misrepresentation (RO Action Needed) Complaints

Keeping the Beneficiary FIRST!

- Send Essential Plan Materials Timely and Accurately
- Prepare for Increased, Seasonal Call Volume
- Don't Refer Callers to 1-800-MEDICARE
- Notify beneficiaries of complaint resolution
- Interim Responses to CTM Complaints
- Repeat Complainants
- LIS Grace Period
- SHIP Unique ID Program

Keeping the Beneficiary FIRST!

- Use the CTM to Proactively Identify Issues
 - Perform trend analysis
 - Examine commonalities
 - Conduct root cause analysis
 - Identify problems before CMS
 - Deploy corrective actions
- Sync with Other Information Sources
 - Call Center Volume
 - Grievance Data

Keeping the Beneficiary FIRST!

- Frequent communication with your Account Manager
 - Anticipating call volume – “no surprises”
- Being better prepared for complaints at the start of the Plan year
 - Formulary changes, premium increases, large number of new reassignments
 - Reporting issues to CMS early, especially at the start of the new benefit year

Looking Ahead – The National Horizon

- General

- Annual Disenrollment Period
- 5 Star SEP

- Positives:

- Far Fewer Reassignments
- Less Beneficiaries Impacted by Non-Renewals/Service Area Expansions

- Negatives:

- Increased Number of Enrollment Exceptions
- Good Cause for Failure to Pay Premiums
- Part D IRMAA Disenrollments

Coming Soon.....

- CTM Mini-Release
 - New Categories
 - Minor Fixes
- “Outreach through Casework”
 - Leveraging Opportunities
- SHIP/CTM Expansion
- Casework Reminders Memo
 - Third Consecutive Year
- Beyond Part C and D

Additional Resources

HPMS Memoranda

- October 3, 2008 – Marketing Misrepresentation and CTM
- December 9, 2008 - SHIP Unique ID Database
- December 29, 2010 - Casework Reminders
- January 7, 2011 - Premium Withhold for January 1, 2011 Enrollment
- April 27, 2011 - CTM Exclusions
- May 27, 2011- Part D IRMAA Updates

CMS Partner Tip Sheet on Complaints

- <http://www.cms.gov/partnerships/downloads/11259-P.pdf>

Final Thoughts

- Significant progress has been made
- Much more can be achieved
- Preparing for changes
- We all have a valuable role to play
- Beneficiaries FIRST!