Complaints Tracking Module (CTM)
Plan Standard Operational Procedures (SOP)

(Effective – May 30, 2019)

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[A] – CTM Access

1. Plan users first need access to the Health Plans Management System (HPMS). To obtain access, complete the standard "Application for Access to CMS Computer Systems" form found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess.html. The completed, signed, original form (with original signature and date) is to be mailed (traceable carrier recommended) to the following address:

    ATTENTION: HPMS User Access
    Centers for Medicare & Medicaid Services
    7500 Security Boulevard
    Mail Stop: C4-18-13
    Baltimore, MD 21244

    The processing time for new user access may take up to two weeks.

2. After a new user is notified of their HPMS access, an e-mail must be sent to: HPMS_Access@cms.hhs.gov to request CTM access. The e-mail's subject line should read "CTM Access Request" and the message should contain the individual's four character user ID. The user will be informed when complete.

3. To maintain access, users must change their CMS password a minimum of every 60 days, and complete their Computer Based (Security) Training and recertification annually or risk having their user ID revoked. CMS will send users a notification when training and recertification are due. Users can check the status of their existing account by going to https://eua.cms.gov, and checking the "Modify My Profile" section.

[B] – General Complaint Handling

- **Review All Complaints:** Plans are encouraged to review all complaints at intake, even those that are not Immediate Need or Urgent, to verify that the contract number and issue level are correct. CMS reserves the right to classify any complaint that does not fit the definitions for Immediate Need or Urgent.

- **Supporting Documents:** Plans are encouraged to view attachments and add additional supporting documents to the complaint in CTM by going to the "Intake Information" screen (see "CTM Plan User Manual" on HPMS for more details).

- **Periodic Casework Notes:** CMS strongly suggests plans enter periodic casework notes, provide acknowledgment, detail research, note interim contacts, etc. Furthermore, plans are encouraged to make interim contact with their members if a complaint takes more than seven calendar days to resolve.

- **Multiple CTMs:** When plans have multiple CTMs from the same beneficiary:

    - If the prior complaint(s) have already been resolved, the plan should verify the beneficiary was informed of the initial resolution. If the beneficiary acknowledges the previous resolution was communicated to them, the plan should close the open complaint and note it was a repeat complaint in the resolution notes.

  - If the prior complaint(s) are still open, but the plan is working to resolve the issue or the plan has not yet begun to investigate the issue, the plan should close the older complaint, and reference the CTM number of the new complaint in the resolution notes.
  - If the first complaint is a sufficiently distinct issue than the second complaint, the plan is to keep both complaints open until they are resolved.

- **Immediate Need Complaints:** For MA/MMP/PACE/Cost Plans, an Immediate Need complaint is defined as a complaint where a beneficiary has no access to care and an immediate need for care exists. For Part D, an Immediate Need complaint is defined as a complaint that is related to the beneficiary's need for medication where the beneficiary has two or less days of medication remaining.

- **Urgent Complaints:** For MA/MMP/PACE/Cost Plans, an Urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For Part D, 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.

- **Timeframes:** Calculated mathematically, i.e., "2 calendar days" would be calculated as follows: Complaint received on 8/22 at 8:00 AM must be resolved by 8/24 at 11:59 PM to be in compliance (24 less 22 = 2 days). Assignment/Reassignment dates are reset when a complaint is re-opened, when the Issue Level is upgraded, the CMS Issue flag is set or removed (the Plan Requests must be accepted for the date to reset), and when the contract is changed. The Assignment/Reassignment date is not changed when a Plan Request to have a complaint designated as a CMS Issue is denied.

[C] – Retroactive Enrollment

1. The plan is to investigate the complaint to determine if it is a valid retroactive enrollment request.

   a. **Valid Requests:** If the request is valid, the plan needs to update its system to verify that the beneficiary has access to drugs and/or health services and initiate actions to update MARx with enrollment/disenrollment change(s).

      - Plans must make sure that enrollees have access to benefits as of the enrollment effective date and may not delay the availability of benefits while waiting for confirmation of enrollment from CMS systems. In other words, plan systems should reflect enrollment as of the effective date, even if the enrollment is pending a transmittal to the Retro Processing Contractor (RPC) and submission to CMS systems.

      - CMS encourages plans to counsel beneficiaries on the impact of retroactivity on claims processing and premium payments, and document the counseling that took place in the CTM notes.

   b. **Invalid Requests:** If the request is not valid, the plan should advise the beneficiary accordingly and close the complaint.

2. Once the retroactive enrollment request is deemed valid, if the plan is unable to update MARx directly with the change(s), then a request must be prepared and sent to the RPC with required documentation for review and processing as described in the latest retroactive processing guidance.

a. **Could not be Processed as Submitted:** If the plan receives notification from the RPC that the request could not be processed, the plan should research the problem immediately to resubmit for processing and resolution.

b. **CMS Approval Needed:**

(1) If CMS approval is needed prior to submission to the RPC, such as complaints that require a retroactive effective date of more than 3 months (see HPMS Memorandum dated February 24, 2009, "Instructions for Submitting Retroactive Enrollment and Disenrollment Activity"), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a CMS Issue Plan Request to CMS for approval to refer the issue to the RPC.

- Plans should refer to the Special Note regarding Regional Office Casework Actions in Chapter 3, Section 60.3 of the Medicare Prescription Drug Benefit Manual and Chapter 2, Section 60.4 of the Medicare Managed Care Manual for instructions on how to submit caseworker actions/approvals to the RPC.

(2) If CMS agrees that the complaint can be forwarded to the RPC, CMS will provide written authorization in the "Comments" field. The plan will use this as documentation to send their request to the RPC requesting an update to CMS' systems. If CMS does not agree that a complaint should be forwarded to the RPC, CMS will provide the plan with instructions on next steps in CTM.

3. Plans may close cases once they have been referred to the RPC. However, plans are encouraged to inform beneficiaries of any delays associated with having enrollment changes reflected in CMS' systems, including mymedicare.gov. The plan should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems.

NOTE:

- For retroactive enrollment complaints received directly by plans (i.e., not via CTM) requiring an effective date of more than three months of retroactivity, plans should update its system to verify that the beneficiary has access to drugs and/or health services and contact their Account Manager to request approval if needed. Beneficiaries should not be referred to 1-800 MEDICARE in this circumstance.

- Individuals who become entitled to Medicare Part A or enrolled in Medicare Part B with a retroactive effective date are Part D eligible as of the month in which a notice of entitlement to Part A or enrollment in Part B is provided to the individual. If the entitlement to Medicare Part A and/or B has been updated in CMS systems, the plan should submit an enrollment or reinstatement to the RPC, and update internal systems.

- Requests for reinstatements for Good Cause do not apply to this section.

[D] – Retroactive Disenrollment

1. The plan investigates the complaint to determine if it is a valid retroactive disenrollment request.

    a. **Valid Request:** If the request is valid, the plan can initiate actions to update MARx to resolve the complaint. This should be done without CMS assistance by updating plan systems, closing the complaint, and notifying the beneficiary accordingly.

    b. **Invalid Request:** If the request is not valid, the plan should advise the beneficiary accordingly and close the complaint.

2. If the request is valid, but the plan is unable to make the appropriate MARx action, the plan will determine if the complaint is Critical or Non-Critical. Complaints labeled Immediate Need and complaints concerning opt-out due to employer group coverage are considered Critical.

    a. **Critical Complaint:** If the complaint is Critical, a CMS Issue Plan Request is to be made to CMS for MARx action. "Critical Retroactive Disenrollment" should be notated in the complaint by the plan and the plan should indicate any internal systems changes it has already made. CMS will either take the necessary MARx action and close the complaint, or disagree with the Plan Request, describing next steps in the CTM.

        - For a Critical retroactive disenrollment issue received directly that is not in the CTM, plans should contact their CMS Lead Caseworker for assistance.

    b. **Non-Critical Complaint:** If the complaint is Non-Critical, with the appropriate documentation, the plan should submit a request to the RPC asking them to update CMS' systems with their change(s). Upon the submission to the RPC, the plan can close the complaint. See Scenario C (steps 2-3) if CMS assistance is needed with the RPC submission request.

        - For a Non-Critical retroactive disenrollment issue received directly that is not in the CTM, plans should make a request to the RPC for correction if the plan is unable to make the change themselves.

[E] – Best Available Evidence Assistance

1. The plan will record a CTM entry. Absent unusual circumstances, cases are to be entered by plans within one business day of being notified that the beneficiary claims to be subsidy eligible but cannot provide the plan with acceptable Best Available Evidence (BAE).

    Lead: CMS
    Category: Premiums and Costs
    Subcategory: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)

    When entering, include all of the following information in the "Complaint Summary:"

    - Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
    - Beneficiary's First and Last Name
    - Beneficiary's Address

- Beneficiary's Date of Birth
- Issue Level. If the beneficiary has less than 3 days of medication remaining, select "Immediate Need." If the beneficiary has 3-14 days of medication remaining, select "Urgent." For all other situations, select "No Issue Level"
- Any additional information germane to the beneficiary's matter.

These cases will be reflected as "1.50" in the plan data extract.

2. After receiving the CTM case, CMS will:

a. Attempt to confirm with the appropriate state Medicaid agency whether the beneficiary is eligible for LIS.

b. CMS will make the case a "Plan Lead" matter and re-categorize as "Premiums and Costs - Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)" category/subcategory for plan review/action. These cases will be reflected as "2.50" in the plan data extract. Additional information will be placed in the "Comments" section of the case and will include as applicable:

- Resolution
- Start of Medicaid/ Medicaid Institutional Status (MM/CCYY)
- Dual Eligible Status (Full/Partial)
- Institutional Status (Yes/No/ Unknown)
- LIS Co-Pay Level
- Any additional information germane to the beneficiary's matter.

3. The plan will update its internal systems to reflect LIS status if appropriate and submit a request for correction to CMS' contractor in accordance with the procedures outlined in Chapter 13, Section 70.5.4 of the CMS Prescription Drug Benefit Manual. If CMS determines the beneficiary ineligible for LIS, no system updates are to be initiated.

4. As soon as the plan receives confirmation from CMS that a beneficiary is subsidy eligible (consistent with the direction in Chapter 13, Section 70.5.3 of the CMS Prescription Drug Benefit Manual), plans are to:

a. Provide Drug Coverage at Correct Cost-Share: Must immediately provide the beneficiary access to covered Part D drugs at a reduced cost-sharing level no greater than the higher of the LIS cost-sharing levels for full subsidy eligibles, or at zero cost-sharing if CMS also verifies the beneficiary's institutional status.

b. Contact Beneficiary: Attempt to notify the beneficiary of the results of the CMS review within one business day of receiving those results. If a plan is unable to reach the beneficiary as a result of this initial attempt, it must attempt to notify the beneficiary until it succeeds or until it has attempted to do so a total of four times. The fourth attempt, if necessary, shall be in writing, using one of two CMS Model Notices listed in Chapter 13 of the CMS Prescription Drug Benefit Manual.

- If a request for a subsidy was made on the beneficiary's behalf by an advocate or authorized representative, it shall be sufficient for the plan to contact that advocate or representative. If, however, the only request made on the beneficiary's behalf

was by a pharmacist, the plan must also contact the beneficiary directly. After informing the beneficiary, or their representative of the outcome, the plan is to close the case. After informing the beneficiary, or their representative of the outcome, the plan is to close the case.

c. **Notice of Eligibility:** If CMS determines that the beneficiary is LIS eligible, plans are to send the "Determination of LIS Eligibility" Model Notice provided as Attachment A. If CMS determines that the beneficiary is not LIS eligible, or is unable to confirm the beneficiary's LIS status, plans are to use the "Determination of LIS Ineligibility" Model Notice provided as Attachment B. See February 2017 HPMS Memo, "Best Available Evidence Process Update" for attachments.

d. **Disagreement with Decision:** Should the beneficiary disagree with the outcome, the plan is to submit a Plan Request to refer the matter back to CMS with appropriate CTM notes. A CMS caseworker will attempt to contact the beneficiary, affirm the outcome, and close the case.

NOTE:

- This process is not intended to serve as a general alternative to the subsidy eligibility confirmation process. Thus, it does not permit pharmacies or any other parties to send beneficiary records directly to the plan for research in the absence of a request for assistance from the beneficiary (or other individual on the beneficiary's behalf) or in lieu of making reasonable efforts to acquire the documentation from, or on behalf of, the beneficiary.

- In rare circumstances, a beneficiary's record may be incorrect in CMS systems after they have applied for and been awarded the Part D extra help through the Social Security Administration. In these instances, make certain the beneficiary is able to access their Part D plan benefit. You may use this process to advise CMS when our systems need to be updated since corrections cannot be submitted to the RPC for processing.

[F] – Marketing

1. The plan investigates the complaint and then corrects any underlying issues identified that may have led to the beneficiary complaint, including any agent/broker corrective actions deemed necessary.

2. The plan is to provide details in its CTM notes. Prior to closing the complaint, plan should include the name of any agents/brokers involved if it was not provided in the original complaint. If the plan determines the allegation is unfounded, that should be indicated in its CTM notes.

NOTE:

- Most Marketing complaints will be assigned to the plans to review and close. However, some complaints will be designated as "CMS Lead" and can be found in the "Marketing – Allegation of inappropriate marketing by plan, plan representative, or agent/broker" category/subcategory. While these "CMS Lead" complaints cannot be closed by plans, plans are encouraged to review these complaints as they would any other marketing complaint and record notes in the CTM.

- Plans should not submit Plan Requests seeking re-categorization of marketing complaints when a plan determines a complaint was unfounded. However, if a marketing complaint has been misclassified, and the narrative reflects that the alleged misrepresentation occurred by a Call Center representative, SHIP, etc., then a Plan Request to make the complaint a "CMS Issue" is appropriate.

- CMS makes its alleged marketing misrepresentation complaints available with state insurance regulators.

[G] – Premium Withhold

1. The plan reviews the complaint, checks that their system reflects the same premium amount and payment option specified in the complaint, and corrects if necessary. The plan should inform the beneficiary that it may take up to 90 days to fully correct their premium withhold issue or for Social Security (SSA)/Railroad Retirement Board (RRB) to issue a refund. The plan should recommend that the complainant call the plan back if there is no resolution after 90 days and close the complaint.

    a. If the plan's system and MARx correctly reflects premium amounts and payment option, but the beneficiary still complains that the premium deductions are incorrect, the plan should review the date of the last transaction to see if it has been 90 days since the last submittal. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint.

    b. If the complaint relates to SSA/RRB premium deductions that extend past the expected period, the SSA/RRB withholding issue relates to a non-current year, or actions by the plan will not correct the issue, submit a Plan Request to have the issue treated as a CMS Issue.

NOTE:

- CTM complaints that include both a complaint that the beneficiary is getting billed while in premium withhold status and include a plan premium payment problem should remain open until the beneficiary issue is resolved and the beneficiary is made whole. Complaints that include only plan premium payment issues can be closed upon resolution. If further assistance is needed the plan should contact the MAPD Help Desk (MAPDHelp@cms.hhs.gov or 1-800-927-8069).

[H] – Good Cause

1. The plan is to follow the same processes for reviewing Good Cause (GC) cases as if the plan received the request directly (i.e., outside the CTM). See HPMS Memo dated August 18, 2015, "Revisions to Good Cause Processes for Contract Year 2016."

2. The plan is to close the case with the plan's decision (approved or denied), indicating in the CTM notes what communication has occurred with the beneficiary. For approved GC requests, the CTM may be closed at that time. Plans do not need to wait for the beneficiary to complete their repayment or be reinstated to close the case.

NOTE:

- Plans should not grant access to care in cases where an individual was disenrolled by CMS for failure to pay Part D Income Related Monthly Adjustment Amount (IRMAA) and still owes Part D–IRMAA. These cases will be accompanied by CMS notes in CTM case. If, however, the individual was disenrolled by the plan for failure to pay plan premium, receives a favorable GC determination and makes full payment of the plan premium amounts owed within 3 months of disenrollment, the plan should reinstate the individual's coverage, regardless of whether there are Part D-IRMAA amounts owed.

[I] – Congressional

1. Casework should be completed within two or seven calendar days, depending on the issue level (either immediate need or urgent). If the complaint cannot be resolved timely, interim CTM notes should be entered by the plan, with an explanation of the delay.
2. After resolving the complaint, the plan should submit a CMS Issue Plan Request. If CMS agrees, the plan will no longer be able to view the complaint typically until it is closed. If CMS disagrees, instructions as to next steps will be provided to the plan. Plans should not refer any of these cases to the RPC. Instead, indicate in the CTM notes what enrollment updates are needed in MARx in order for CMS to make those changes directly.
3. CMS is responsible for final complaint closure. While plans are expected to notify the beneficiary of the outcome, plans are not to notify the congressional office of the resolution.

[J] – Plan Request

1. To submit a Plan Request, go to the "Plan Requests" tab in CTM case after entering a "Casework" note. Provide any additional information relating to the complaint to aid in the review of the request (e.g., reason why CMS intervention is needed, which contract the complaint should be assigned to instead when known, why the issue level is incorrect, etc.). Do not check the "Include in Resolution Summary" box in the plan notes. Plans are encouraged to notify the beneficiary that their complaint has been referred to CMS or to a different plan, when applicable.

2. Upon acceptance of a Plan Request by CMS, plans may no longer be able to see the complaint. Plan Requests should not be submitted when a beneficiary or provider cannot be contacted, unless directed by CMS.

Types of Plan Requests:

- **Incorrect Contract Assignment:** If the complaint that should have gone to a subsidiary or another organization, the plan should submit a Contract Change Plan Request. The plan should continue to work the case to resolution if possible when the contract is within the parent organization. Upon acceptance of these Plan Requests by CMS, plans will no longer be able to see the complaint if assigned to a different parent organization. Plan Requests should not be made for the purpose of assigning a Late Enrollment Penalty (LEP) issue to a beneficiary's former plan. Per Chapter 4, Section 30.5 of the Medicare Prescription Drug Benefit Manual, the beneficiary's current plan should be able to resolve this type of complaint.

- **Issue Level Change:** Fully recognizing that the Issue Level corresponds to self-reported information from the beneficiary at intake, the plan may submit an Issue Level Change Plan request if they

substantially disagree with the urgency of the complaint. Plans requesting that CMS downgrade an issue level after the access portion of the complaint has been addressed will not be approved unless the Issue Level was originally incorrect.

- **Issue Change Requests:** For matters that are delegated to CMS for handling and/or final resolution, plans are to submit a CMS Issue Change Request. These situations include, but are not limited to:
  - Part D Income Related Monthly Adjustment Amount (IRMAA) Good Cause Requests
  - Cases flagged as "Congressional" in CTM.
  - Low Income Subsidy (LIS) correction requests involving Social Security Administration (SSA) extra help determinations.
  - Instances where a beneficiary seeks a Special Enrollment Period (SEP) that is not explicitly outlined in CMS' enrollment guidance.
  - Beneficiary needs a Critical retroactive disenrollment action or retroactive enrollment action requiring CMS authorization (see Scenarios C and D).
  - Beneficiary has lost coverage due to possible erroneous loss of Part A/B entitlement that spans multiple plans. Note, if the temporary loss of entitlement has resulted in a loss of Part C and/or Part D coverage, but only affects enrollment in one parent organization, the plan should submit a reinstatement request to CMS' RPC.

- **Category/Subcategory Change:** In very infrequent circumstances, plans may request a category/subcategory change by making a CMS Issue Plan Request if it is abundantly evident in the Complaint Summary that it was incorrectly categorized at intake. Such requests should be infrequent and should not be used for the sole purpose of improving a plan's performance metrics.

[K] – Complaint Resolution

- **Contact Complainant:** The plan will notify the beneficiary or complainant according to the plan's business practice and customer service policy. If the plan is having difficulty contacting the beneficiary, CMS strongly recommends that the plan attempt to contact the complainant at least four times times at different times on different days. Details, including the dates and times of contact attempts and actions taken, should be documented in the CTM. For the fourth attempt, plans are encouraged to send a letter when they are unable to reach a beneficiary to notify a beneficiary of the resolution.

  For State Health Insurance Program (SHIP) entered complaints, SHIP counselors may request in the "Complaint Summary" that the plan contact the counselor with the resolution rather than the beneficiary. MMP State Reviewers may request the same. It is acceptable for the plan to contact either of these entities with the resolution.

- **Case Narrative:** The plan records a clear and concise narrative (up to 4,000 characters) in the "Casework" note of the Complaint Resolution tab. All entities that review CTM complaint records should be able to easily understand the notes clarifying the issue, action taken, and decisions made to investigate and resolve the complaint. See Appendix A for guidance on documenting resolution notes.

  Please note that HPMS will log users out of the system after 15 minutes of inactivity. Users should frequently save or draft their notes in a separate document for cutting and pasting when drafting notes.

- **Supplemental Information:** Prior to closing the complaint, answer two questions:
    - **Was the complainant satisfied with the outcome of the resolution?** As appropriate, select "Yes," "No," or "Unknown/Unable to Reach" (default).
    - **HPI Related?** Answer "Yes" if the reported complaint is in relation to either the services or benefits associated with the Part D Enhanced Medication Therapy Management (MTM) model or the MA Value-Based Insurance Design (VBID) Model. If the complaint is not in relation to these models, leave the default response, "No." If unknown, select "Unsure/Unrelated."

- **Case Completion:** Plans have the ability to upload documents and enter additional CTM notes, even if a complaint is already resolved. Plans are encouraged to make use of this approach when additional, relevant information is presented relating to a complaint, for the purposes of creating a more complete record of the beneficiary's matter.

- **Difficulty with Complaint Closure:** Troubleshoot any one of the following issues.
    - There are no restricted characters in plan entered fields: < >& ;
    - There are no open Plan Requests for the complaint.
    - The complaint is not already closed (by CMS).
    - The Congressional indicator is selected.

- **Beneficiary Refund:** If the resolution involves a refund from the plan to the beneficiary (e.g., any overpayment of co-payments, premiums, late enrollment penalties, etc.), the complaint can be closed once that refund is issued. Similarly, if the complaint involves educating the beneficiary about the appeals process, the complaint can be closed when the communication is complete (i.e., the plan does not need to wait for the appeal to adjudicate).

- **Provider/Pharmacy Complaints:** CMS expects plans to provide the same level of research and quality service as they would for a Medicare beneficiary or other program stakeholder.

APPENDIX A - Category and Subcategory Listing

Below is a list of categories and subcategories in the CTM that are viewable by plans. Subcategories that end with (EX) are automatically excluded from plan performance metrics. CMS Lead cases begin with the number "1" and are also excluded from plan performance metrics. There have been no changes since the listing was last published by CMS.

Enrollment/Disenrollment
- 2.10: Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change
- 2.11: Beneficiary has not received enrollment card or other membership materials
- 2.19: Other

Marketing
- 1.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker
- 2.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker
- 2.39: Other

Benefits, Access, Quality of Care
- 2.40: Beneficiary has difficulty securing Part D prescriptions
- 2.41: Beneficiary has difficulty finding a network provider/pharmacy
- 2.42: Beneficiary has concerns about the quality of care they have received
- 2.43: Beneficiary has concerns about a denied claim
- 2.49: Other

Premium and Costs
- 1.50: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)
- 2.50: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)
- 2.51: Beneficiary has a coordination of benefits issue
- 2.52: Beneficiary has a premium issue, direct bill or withhold related
- 2.53: Beneficiary has an issue with Late Enrollment Penalty (LEP) being charged
- 2.54: Beneficiary has a cost-sharing/co-insurance issue, including coverage gap or balance billing
- 2.55: Beneficiary's Best Available Evidence (BAE) not honored by the plan
- 2.59: Other

Plan Lead Legal and Administrative
- 2.60: Allegation or concern relating to HIPAA, Confidentiality, Security Breach, or Privacy Violation
- 2.61: Plan has provided poor customer service
- 2.62: Difficulties acquiring materials in alternative formats
- 2.69: Other

Provider Specific
- 2.70: Improper, insufficient, or delayed claims payment
- 2.71: Network contracting issue
- 2.79: Other

Good Cause
- 2.80: Plan Premium Good Cause Request (EX)
- 2.89: Other (EX)

Other Matter Requiring Plan Review
- 2.90: Other Matter Requiring Plan Review

There are additional categories and subcategories in CTM that plans are not able to view. They are not included in performance metrics.

APPENDIX B - Suggested Examples of Plan CTM Resolution Notes

Complete and accurate plan resolution notes assist CMS staff, SHIP users, and the 1-800 MEDICARE Call Center when following up on inquiries. Moreover, quality resolution notes help prevent the recording of repeat complaints. For these reasons, CMS is providing general guidance for plans to follow, as appropriate, for the recording of plan resolutions in the CTM.

CTM plan notes should be clear, concise and easy to understand. Entries should show that the plan has researched the complaint, taken appropriate steps towards resolution, addressed all beneficiary issues, and informed the beneficiary of the resolution. In cases where CMS intervention is needed, complete and accurate notes accompanying Plan Requests will assist CMS caseworkers to quickly assess and take the necessary action to resolve the complaint. Overall, plan notes should:

- Report contacts with the beneficiary or complainant with contact dates. This may include contacts that precede the date the complaint was first recorded.
- Clarify the beneficiary or complainant’s issue(s).
- Explain the root cause(s) for the issue(s) if known at the time of complaint resolution.
- Describe decisions made and actions taken by the plan.
- Use only widely accepted CMS abbreviations (e.g., LEP, SEP, BAE, LIS, PBP, etc.).
- Include dates of system updates and enrollment/disenrollment effective dates.

Below are examples of plan resolution notes. Recognizing the unique nature of individual beneficiary complaints, the guidance provided here is only intended to serve as examples of satisfactory resolution notes and do not constitute plan requirements.

Access to Benefits: “Plan system shows the member is enrolled in <contract-PBP> effective <date> which <matches or does not match> MARx. Review of the plan’s benefits show <reason it was not covered and research into the issue>. The member was <called or sent a letter> on <date> to notify them of our <findings, explain denial or action taken to correct the issue> in resolving their complaint. The member has also been advised to contact us directly should they have any access issues or concerns about their plan benefits.”

Alleged Marketing Complaint: “The plan contacted the member on <date> and he/she stated <details of marketing allegation>. Member’s record shows enrollment in <contract-PBP> from <date> to <date>. Application was submitted by <agent or member> via <telephone, paper application or online> on <date>. Our research revealed that <allegation is founded or not, describe findings and any corrective action>. The plan has called the member on <date> to inform them of <findings and corrective actions>.” If the member states that they want a retroactive start date for their new plan, a Plan Request should be submitted, requesting the following in their notes: “The member is requesting CMS take a MARx action to retroactively <enroll/disenroll> them in/from <contract-PBP> to <date>. We have advised the member that their case is being sent to Medicare for review.”

Belongs to Different Plan: “After contacting the member on <date>, we learned that their issue is with their previous plan, <contract-PBP>, and not our plan. We are requesting a reassignment of this complaint to that contract. We informed the member that the matter will be referred back to Medicare and/or the other plan for review.”

Best Available Evidence (BAE): “The plan’s system does not show that the member has LIS but he/she has provided valid BAE. We have updated our system and notified the member that he/she can now access their medication at the correct LIS copay.”

Best Available Evidence (BAE) Assistance: If CMS confirms an LIS change: "CMS confirmed with Medicaid that member has LIS <level>. The plan has updated the member's record to <show LIS or change the LIS level> and contacted the member on <date> to notify them of this change." If CMS confirms there is NO change to LIS: "CMS confirmed that the member <does not have or there is no change to their> LIS since <additional details>. Member's record shows <LIS level or no LIS> which matches MARx. The plan contacted the member on <date> to notify them that CMS confirmed with Medicaid that <they have no LIS or there is no change to their LIS level>. We advised the member that they can <re-apply for Medicaid or apply for the Extra Help>."

Claims: "The plan has contacted the member for additional information, reviewed the claim <describing the service that was denied or not covered in full> in question and determined that the plan's decision was <correct or incorrect> because <what was learned that led to their decision, making reference to any plan materials that describe the benefit in question>. We have <called or sent a letter> to the member to notify them of the <resolution> to their complaint. The member has also been informed of their appeal rights (when applicable). The member has also been advised to contact us directly should they have any access issues or concerns about their plan benefits."

CMS Issue: "The plan is requesting a change to CMS Issue for assistance in resolving this complaint. A <correction or exception> is being requested because <reason>."If the case is immediate, the plan should also note when applicable. "Plan systems have been opened to allow the member access to plan benefits. We have called to notify the member on <date> of their access to the plan and to advise them that their case has been sent to Medicare for review."

Enrollment Exception: "The beneficiary does not qualify for an SEP that the plan is able to process. As such, the beneficiary request CMS approval for an exception to <enroll into or disenroll from> <contract-PBP> for <effective date> due to <reason>. We informed the beneficiary that the matter will be referred back to Medicare for review."

Good Cause (Approved): "The member has been informed they must pay <$> by < date> to be eligible for reinstatement by CMS. The plan has sent the member a Notice of Favorable Decision letter on <date>."

Good Cause (Denied): "The member's request for a good cause reinstatement was carefully reviewed and denied. The beneficiary has been advised of the next available enrollment period and received a plan decision letter. The member is no longer eligible for a Good Cause reinstatement because the time period for making a request has lapsed."

Immediate Need (Disenrollment) "The plan is requesting CMS to cancel the member from <contract-PBP> and reinstate them with their prior plan because <source of issue and reason for the plan's request>. We have called the member on <date> to advise them that their case has been sent to Medicare for review."

Immediate Need (Enrollment): "On <date>, the plan contacted the member for clarification of their issue. We reviewed the member's record which shows <describe findings>. The plan will reinstate the member into <contract-PBP> due to <reason> and the member's immediate need for services. We have contacted the member on <date> to inform them that they now have access to their plan. We have submitted a request for <reinstatement or enrollment> <in MARx or to the RPC> on <date>."

Retroactive Disenrollment (Critical): "Member's record shows enrollment in <contract-PBP> effective <date> which <matches or does not match> MARx. The plan contacted the member on <date> and the

member explained the <circumstances leading to their request>. Plan is requesting CMS approval to cancel them from <contract-PBP> due to the member's immediate need and <reason for the request>."

Retroactive Enrollment: "Member's record shows enrollment in <contract-PBP> from <date> to <date>. The plan contacted the member on <date> and learned <circumstances leading to member's request>. Review of the member's record shows that the disenrollment was due to <cause> and the plan has decided < decision, reason for decision and action by the plan>." If the plan has approved reinstatement, add: "We have submitted a disenrollment cancellation to CMS <in MARx or to the RPC> and updated our system with the member's reinstatement. On <date>, we called to inform the member of the resolution to their complaint, their current access to the plan and the reimbursement procedure for claims or medications they paid before the reinstatement."

Congressional: "The plan spoke with the member on <date> and the member stated <key information about the member's issue>. The member's record and plan <claim/enrollment> systems were reviewed to show <additional findings>. The plan decided to <describe decision made and actions taken to resolve their issue>. We contacted the member on <date> to provide <details of our investigation, actions that were taken and recommendations to the member>. The member understood the resolution to their complaint. The case is now being submitted to CMS for final CTM closure and contact with the congressional office."

Out of Area Disenrollment: "The member's record shows enrollment in <contract-PBP> from <date> to <date>. Upon further review, it was determined that this was incorrect due to <reason>. The plan has submitted a reinstatement for the member <in MARx or to the RPC> on <date> and updated our system to open services for the member. We called to inform the member on <date> of their access to services and sent a letter confirming their reinstatement on <date>." If the plan disenrolled the member correctly: "The member's record shows enrollment in <contract-PBP> from <date> to <date>. We received <TRC, returned mail or other> on <date> and began tracking for "out of service area" for this member on <date>. Correspondence was sent to <the member's address> that <matches or does not match> MARx. <Successful or unsuccessful> calls were made on <dates> and member was disenrolled on <date>. A termination letter was sent to the member on <date> using <address>. The plan believes this was a valid disenrollment action and informed the member on <date>."

Provider/Pharmacy: "The plan has contacted the provider/pharmacy on <date> for additional information, reviewed the claims in question and found <root cause of the issue>. We have taken <corrective action> notified the provider/pharmacy on <date> to inform them of <the corrective action taken and any operational improvements that will prevent a reoccurrence>." Also, "We have educated the provider about the details relating to their claims issue. Specifically, the provider was <describe the explanation given>. The matter has been resolved and the provider has been encouraged to work directly with our Provider Services Dept. with any future issues they may encounter."

Premium Withholding: "The plan submitted a cancellation of the member's plan to CMS on <date>. The member has been advised that it may take up to 90 days for Social Security (or Railroad Retirement Board) to reflect this and refund premiums that were inappropriately deducted. We instructed the member to call us back if the deductions have not stopped at that time."

"The member's record shows that they selected to have premiums deducted from their Social Security benefits but the plan has not received these payments. We have requested our billing department to stop sending bills to the member and we have reported the plan payment issue to the MA PD Help Desk. We have notified the member that as we work to address the matter with Medicare, they will remain enrolled in their plan and can disregard any billing notices they have received."

Unable to Contact: "The plan has made unsuccessful calls to the member on <dates and times>. We have left messages including our contact number asking them to call us, but the member has still not returned our calls. A letter was sent to the member on <date> to <address> <requesting additional information or notifying them of the resolution to their complaint>."