

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

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

**FROM:** Amy K. Larrick, Acting Director, Medicare Drug Benefit and C & D Data Group

**SUBJECT:** Complaints Tracking Module (CTM) Enhancements, Casework Reminders, Updated Standard Operating Procedures (SOP), and Other Helpful Information

**DATE:** December 30, 2015

CMS is providing this update to the Standard Operating Procedures (SOP) for the handling of Complaints Tracking Module (CTM) Complaints. It is effective January 1, 2016 and replaces Section 2 of the previous HPMS memorandum released on February 6, 2015. Other portions of that HPMS memorandum remain in force.

Plans are encouraged to use the CTM not only to resolve individual complaints but also to continuously examine the root causes that drive the complaint volumes and address broader, systemic issues in a timely manner. Throughout this document, the term “plans” is frequently used. Please note, unless otherwise stated, the term “plans” applies to: Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), PACE organizations, and Medicare-Medicaid Plans (MMPs). Also, the terms “case” and “complaint” are used throughout the document synonymously.

Proper use of the CTM is critical to ensuring the accuracy of complaint information. Plans are encouraged to communicate regularly and work with CMS staff not only to appropriately resolve individual complaints but also to continuously examine the root causes that drive complaint volumes. To assist plans with providing complete resolution notes when responding to and closing CTM complaints, examples of satisfactory resolution notes are included in Section 5.

MMPs are encouraged to work closely with the CMS, State Contract Management Teams, and State Ombudsman Programs to resolve complaints. State staff have access to the CTM to review and assist with resolving complaints in coordination with CMS. Although CMS receives comparatively few complaints from PACE enrollees, PACE organizations are expected to monitor CTM and adhere to the procedures outlined in this document.

For general questions about complaint handling and casework procedures, contact your plan’s casework lead or Account Manager. For technical assistance with HPMS or CTM, please contact the HPMS Help Desk at either 1-800-220-2028 or [HPMS@cms.hhs.gov](mailto:HPMS@cms.hhs.gov). Technical data questions related to your plan’s CTM performance should be sent to [ctm@cms.hhs.gov](mailto:ctm@cms.hhs.gov), with a copy to your Account Manager.

**Plans are required to follow the procedures outlined in the CTM Plan SOP. The CTM User Guide contained in HPMS is available as a technical reference.**

**Scenarios/Issues:**

- A.** Plan receives a complaint that should have gone to a subsidiary or another organization.
- B.** Plan cannot do further work with the complaint and requires assistance.
- C.** Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.
- D.** Plan receives a complaint related to a Retroactive Enrollment.
- E.** Plan receives a complaint related to a Retroactive Disenrollment.
- F.** Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS' enrollment guidance.
- G.** Plan receives an incorrectly categorized complaint or a complaint with no assigned category and subcategory.
- H.** Plan receives a complaint but disagrees with the issue level.
- I.** Plan receives a complaint with one or more of the following indicators flagged in CTM: SWIFT, Congressional, and/or, Press or Hill Interest.
- J.** Plan receives a premium withhold complaint.
- K.** Plan receives a provider/pharmacy complaint in CTM.
- L.** Plan receives a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed)."
- M.** Plan receives a second CTM complaint from the same complainant.
- N.** Plan needs CMS assistance to secure BAE (Best Available Evidence).
- O.** Plan has supporting documentation that relates to a complaint.
- P.** Plan receives a complaint related to a Good Cause (GC) reinstatement request.
- Q.** Plan is approaching a resolution for a complaint.
- R.** Plan user needs HPMS Access but does not have it.
- S.** Plan has a general CTM related question or issue.
- T.** Assignment/Reassignment date is reset.

**A. Scenario/Issue: Plan receives a complaint that should have gone to a subsidiary or another organization.**

**Procedure:**

1. From the Plan Request tab, select the option to indicate the complaint belongs to another contract and, if known, enter the name and/or contract number of the appropriate plan, along with any pertinent information in Casework Notes.
2. Plans are encouraged to notify the beneficiary that their complaint has been reassigned to the appropriate plan.
3. While the reassignment of the complaint to a different plan is pending, plans should still seek to resolve the complaint if it relates to one of its subsidiaries.
4. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system after it is reassigned to a different contract. If the plan has access to the other contract number, then it will be able to view the complaint under the new contract number.

**Please Note:**

- Complaints with pending Plan Requests cannot be closed.

**B. Scenario/Issue: Plan cannot do further work with the complaint and requires assistance.**

**Procedure:**

1. From the Plan Request tab, select the option to indicate that this complaint is a CMS Issue and explain in Casework Notes:
  - a. The reason CMS intervention is needed.
  - b. Whether access to services has been provided to the beneficiary.
  - c. Whether the beneficiary was contacted.
2. CMS will agree or disagree with the Plan Request.
  - a. If CMS agrees with the request, the plan will no longer be able to see the complaint.
  - b. If CMS disagrees with the request, instructions for next steps will be provided to the plan in CTM.

**Examples of CMS Issues include, but are not limited to:**

- Instances where a beneficiary seeks an enrollment or disenrollment change for which a Special Enrollment Period (SEP) is not explicitly outlined in CMS' enrollment guidance.
- Beneficiary needs a critical retroactive disenrollment action taken in MARx (see Scenario E).
- Beneficiary has lost coverage due to possible erroneous loss of Part Medicare A/B entitlement that spans multiple plans. If the temporary loss of entitlement has resulted in a loss of Medicare Part C and/or Part D coverage, but only affects enrollment in one parent organization, the plan should submit a reinstatement request to CMS' Retro-Processing Center (RPC). No referral to the MA-PD help desk is necessary.

**Please Note:**

- To reduce the likelihood of repeat complaints, plans are encouraged to make interim contact with their members if a complaint takes more than seven calendar days to resolve, even when a complaint has been referred back to CMS. Plan Requests should not be submitted when a beneficiary or provider cannot be contacted unless directed by CMS. Please follow the recommendations in scenario Q for appropriate handling.
- 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.

**C. Scenario/Issue: Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.**

**Procedure:**

1. The plan should troubleshoot the issue by:
  - a. Confirming that the complaint category is properly assigned. If no category is assigned, refer to Scenario G.
  - b. Verifying that the following restricted characters were not entered in the Casework Note and/or the Resolution Date fields: < > & ;
  - c. Verifying that there is no pending Plan Request.
  - d. When attempting to close the complaint, confirm that a date was entered into the Resolution Date field and that it is not earlier than the Received Date. A CTM cannot be closed unless this entry is made.
2. If no obvious problem is found, the plan should contact the HPMS Help Desk at 1-800-220-2028 or [HPMS@cms.hhs.gov](mailto:HPMS@cms.hhs.gov).

**D. Scenario/Issue: Plan receives a complaint related to a Retroactive Enrollment.**

**Procedure:**

1. The plan investigates the complaint to determine if it is a valid retroactive enrollment request.
  - a. If the request is not valid and the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario Q).
  - b. 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 update MARx with enrollment/disenrollment change(s).
2. 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. As soon as the plan has submitted the retroactive enrollment request to the RPC, the plan must:
  - a. Document the development of the complaint in Casework Notes on the Complaint Resolution tab and close the CTM case.
  - b. 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.

The RPC cannot process complaints that fall outside CMS enrollment or retroactive processing guidance without approval from a CMS caseworker. If the retroactive request falls outside CMS enrollment guidance due to timeliness, plan error, or because it lacks required documentation, the plan should refer to Step 3 below to request CMS approval to resolve.

3. 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 the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.
  - a. 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. After submitting the request, the plan should follow steps 2 a-b above.
  - b. 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.

**Please Note:**

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

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- 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.
- Plans should refer to the Special Note regarding Regional Office Casework Actions in Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Managed Care Manual for instructions on how to submit caseworker actions/approvals to the RPC.
- Organizations 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, the plan's systems should reflect enrollment as of the effective date, even if the enrollment is pending a transmittal to the RPC and submission to CMS systems.
- For retroactive enrollment complaints received directly by plans (e.g. not via CTM) requiring an effective date of more than 3 months of retroactivity, the plan should update its system to verify that the beneficiary has access to drugs and/or health services and contact their Account Manager (AM) to request approval.
- Requests for reinstatements for Good Cause are noted in Scenario P. Reinstatements, and are NOT retroactive enrollments.
- Reinstatements into a previous plan subsequent to enrollment in a new plan are contingent upon the individual's successful cancellation of the new enrollment. See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Managed Care Manual for more information on enrollment cancellation requirements and the process for reinstatement following automatic disenrollment due to enrollment in a new plan.
- Congressional cases dealing with enrollment changes should not be sent to the RPC.
- MMPs should investigate retroactive enrollment/disenrollment cases with the respective state enrollment broker. When possible, MMPs should make full use of the RPC to resolve retroactive enrollment/disenrollment issues.
- 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, update internal systems, and close the CTM.

**E. Scenario/Issue: Plan receives a complaint related to a Retroactive Disenrollment.**

**Procedure:**

1. The plan investigates the complaint to determine if it is a valid retroactive disenrollment request.
  - a. If the request is not valid and/or the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario Q).
2. If the request is valid and the plan can take the appropriate MARx actions themselves to resolve the complaint, they should do so without CMS assistance by updating their systems, closing the complaint, and notifying the beneficiary accordingly.
3. 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. If the complaint is Critical, a Plan Request is to be made to CMS for MARx action. “Critical Retroactive Disenrollment” should be notated in the Casework Notes, and the plan should indicate any internal systems changes it has made.
    - i. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system as the complaint is flagged as “CMS Issue”, and CMS will be responsible for resolving the complaint.
    - ii. If CMS disagrees with the Plan Request, CMS will describe next steps in CTM.
  - b. If the complaint is Non-Critical, the plan should submit a request to the RPC with the appropriate documentation asking them to update CMS’ systems with their change(s). As soon as the request is made, the plan should follow the steps in Scenario D.2.a-b.
    - i. 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 the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC’s requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.
      1. 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 its request to the RPC requesting an update to CMS’ systems. After submitting the request, the plan should follow steps in Scenario D.2 a-b.
      2. 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.

**Please Note:**

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



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- 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.

See the “Please Note” section of the previous scenario for more details relating to retroactive changes.

- F. Scenario/Issue: Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS’ enrollment guidance (often referred to as an ‘Enrollment Exception’).**

**Procedure:**

1. The plan should submit a Plan Request to indicate the complaint is a “CMS Issue” and describe in Casework Notes why the beneficiary is seeking an exception to make an enrollment or disenrollment change outside of a valid enrollment period.
  - a. If CMS agrees with the request, the plan will no longer be able to see the complaint and CMS will be responsible for resolving the complaint.
  - b. If CMS disagrees with the request, instructions for next steps will be provided to the plan in CTM.

**Please Note:**

- Valid Enrollment Exceptions are excluded from plan performance metrics.
- For prospective MMP enrollment requests, beneficiaries should be referred to the respective state enrollment broker.

**G. Scenario/Issue: Plan receives an incorrectly categorized complaint or a complaint with no assigned category and subcategory.**

**Procedure:**

1. The plan needs to explain the reason for their request in the Casework Notes field of the Complaint Resolution tab.
2. From the Plan Request tab:
  - a. Select the option to request a change to the complaint's category/subcategory.
  - b. Select the appropriate category/subcategory from the drop-down list.
  - c. Submit the request when done.

**Please Note:**

- A plan should not delay steps to resolve the complaint while the plan's request to change the category/subcategory is pending.
- CMS will only consider a category/subcategory re-assignment request if it is abundantly evident in the Complaint Summary that it was incorrectly categorized at intake. Requests should be infrequent and should not be used for the sole purpose of improving a plan's performance metrics.
- If a beneficiary requests a Good Cause determination while the plan is responding to a CTM related to disenrollment for failure to pay premiums (or Part D-IRMAA), the plan should evaluate the case as a Good Cause request and not submit a Plan Request.
- Please note, a complaint cannot be closed without assigning valid category and subcategory.

**H. Scenario/Issue: Plan receives a complaint but disagrees with the issue level.**

**Procedure:**

1. Explain the reason for the request in Casework Notes.
2. From the Plan Request tab, select the option to change the complaint's issue level, and then submit to CMS for review.
3. Once this option has been selected, the time clock for the plan will stop. If CMS approves the plan's request, the clock will start over once the issue level has changed. If CMS disapproves the request, an explanation will be provided.
4. If the complaint remains the responsibility of the plan to resolve, casework should continue as CMS evaluates the plan's request to change the issue level.

**Please Note:**

- For MAO/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 PDPs, 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 fewer days of medication left.
- For MAO/MMP/PACE/Cost Plans, an Urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For PDPs, 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.
- Immediate Need or Urgent issues can only be downgraded if they never were Immediate Need or Urgent. 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.
- 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 above definitions for "Immediate Need" or "Urgent."
- Timeframes are 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).

**I. Scenario/Issue: Plan receives a complaint with one or more of the following indicators flagged in CTM: SWIFT, Congressional, and/or, Press or Hill Interest**

**Procedure:**

1. Contact the beneficiary/provider to obtain details of their case and begin the investigation, as needed. The plan should inform the complainant of planned actions and anticipated timeframes.
2. Casework should be completed within 2 to 7 calendar days, depending on the issue level. If the complaint cannot be resolved within 7 calendar days, interim casework notes should be entered by the plan, with an explanation of the delay.
3. Record clear and concise Casework Notes of the research and actions taken. Entries should include all actions taken including contact dates and instructions to the beneficiary, complainant and contacts. Include systems updates and the dates the actions were taken.
4. After resolving the complaint, the plan should submit a Plan Request to change the complaint to a CMS Issue. CMS is responsible for final closure of such cases, for notifying congressional offices of final resolution, and will make any needed enrollment changes in MARx. As a best practice, plans should request this within 2 to 7 calendar days to allow time for proper closure of the case by the Regional Office (RO).
5. CMS will agree or disagree with the Plan Request. If CMS agrees, the plan will no longer be able to view the complaint. If CMS disagrees, instructions as to next steps will be provided to the plan.

**Please Note:**

- SWIFT, Congressional, Press, or Hill interest complaints are classified as immediate need or urgent in the CTM.
- For Congressional cases, the plan should NOT notify the congressional office of the resolution as this is CMS' responsibility.
- Plans are unable to close SWIFT cases in CTM. A Plan Request for a change to CMS Issue must be made so CMS can review and close the complaint.
- Plans should not refer any of these cases to the RPC, indicating in the casework notes what enrollment updates are need in MARx.

**J. Scenario/Issue: Plan receives a premium withhold complaint.**

**Procedure:**

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.
  - a. 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.
  - b. The plan should recommend that the complainant call the plan back if there is no resolution after 90 days and close the complaint.
2. 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.
  - a. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint.
3. 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.

**Please Note:**

- Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding."
- 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 is advised to contact their CM/MPPG/DPO representative.

**K. Scenario/Issue: Plan receives a provider/pharmacy complaint in CTM.**

**Procedure:**

1. The plan reviews the complaint, contacting the provider/pharmacy for more information if needed.
2. The plan takes any necessary steps to address the complaint, acknowledges the complaint in the complaint resolution summary (noting any steps toward resolution), and closes the complaint in the CTM.
3. The same best practice that CMS recommends for notifying beneficiaries of resolutions (Scenario Q) is also recommended for provider/pharmacy complaints.

**L. Scenario/Issue: Plan receives a complaint categorized as “Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed).”**

**Procedure:**

1. The plan carefully reviews the allegation of marketing misrepresentation, conducts an investigation, and contacts the beneficiary if additional information is needed.
2. After investigating the complaint, the plan corrects any underlying issues identified that may have led to the beneficiary complaint, including agent/broker termination or retraining, or any further corrective action deemed necessary.
3. The plan enters any action taken to correct the situation as a Casework Note on the Complaint Resolution tab and closes the complaint in CTM by entering a Resolution Date.
4. Details in the Casework Notes should include the name of any agents/brokers involved if it was not provided in the original complaint.
5. If the plan determines the allegation is unfounded, that should be indicated in Casework Notes on the Complaint Resolution tab, along with any documents supporting the plans’ findings.

**Please Note:**

- Plans should carefully review the October 3, 2008 HPMS memorandum, “Enhancement to Complaints Tracking Module (CTM) to Review and Investigate Marketing Misrepresentation Complaints,” prior to handling any marketing misrepresentation complaint.
- Plans are expected to similarly handle complaints categorized as “Enrollment Exception – alleged Marketing Misrepresentation (RO Action Needed),” which are viewable through the “Marketing Misrepresentation Report” link on the CTM Start Page. For complaints viewable only in this report, plans should follow the steps 1-2 above and are encouraged to upload a response to complaints in this subcategory.
- Plans should not submit Plan Requests seeking re-categorization of marketing complaints when a plan determines a complaint was unfounded.
- CMS shares its alleged marketing misrepresentation complaints regularly with State Departments of Insurance.



**M. Scenario/Issue: Plan receives a second CTM complaint from the same complainant.**

**Procedure:**

1. If the prior complaint has 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 complaint and note it was a repeat complaint in the resolution notes.
2. If the first complaint is 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.
3. If the first complaint is sufficiently distinct issue than the second complaint, the plan is to keep both complaints open until they are resolved.

**Please Note:**

- CTM gives plans the ability to view multiple complaints from the same complainant within their organization. Plans are encouraged to utilize this capability to identify repeat complainants for the purposes of educating beneficiaries about ways to contact their plan directly for assistance.

**N. Scenario/Issue: Plan needs CMS assistance to secure Best Available Evidence (BAE) on behalf of a low-income subsidy (LIS) beneficiary who qualified with Medicaid or the Social Security Administration (SSA).**

**Procedure:**

1. The plan completes the plan’s portion of the BAE Assistance Worksheet. See Attachment B of the August 4, 2008 HPMS memo.
2. The plan sends the completed worksheet via an encrypted e-mail to the Home Regional Office (RO), noting in the subject line: “Immediate BAE Assistance Needed” for an immediate case or “Non-Immediate BAE Assistance Needed” for all others. See Section 7 for a list of Home ROs.
3. CMS RO staff will enter a new complaint in CTM with the information provided by the plan in the worksheet. The RO:
  - a. Contacts the state Medicaid or SSA office to verify the beneficiary’s Medicaid or SSA LIS status.
  - b. Enters the beneficiary’s Medicaid or SSA LIS status in the CMS Only section of the BAE Assistance Worksheet.
  - c. Worksheets that do not require SSA verification for LIS status will have verification results documented within the “For CMS Only” Comments Section of the worksheet.
  - d. Sends the worksheet back to the plan securely or uploads the worksheet to the CTM complaint.
4. Upon receiving the completed BAE Assistance Worksheet back, the plan updates their internal systems. Within one business day of receiving the BAE worksheet from the RO, the plan will attempt to notify the beneficiary of the LIS update to plan systems and inform them that it can take up to 30 days for their LIS to reflect in CMS’ systems. After notifying the beneficiary, the plan can close the case in CTM.
5. If in 30-60 days, the beneficiary’s CMS record does not automatically update with the LIS, the plan is to submit the change to the RPC along with the worksheet as proof.

Below is a list of CMS Home Region Mailboxes and States/Territories:

**PartDComplaints\_RO1@cms.hhs.gov – CT, MA, ME, NH, RI, VT**  
**PartDComplaints\_RO2@cms.hhs.gov – NJ, NY, PR, VI**  
**PartDComplaints\_RO3@cms.hhs.gov – DE, DC, MD, PA, VA, WV**  
**PartDComplaints\_RO4@cms.hhs.gov – AL, FL, GA, KY, MS, NC, SC, TN**  
**PartDComplaints\_RO5@cms.hhs.gov – IL, IN, MI, MN, OH, WI**  
**PartDComplaints\_RO6@cms.hhs.gov – AR, LA, NM, OK, TX**  
**PartDComplaints\_RO7@cms.hhs.gov – IA, KS, MO, NE**  
**PartDComplaints\_RO8@cms.hhs.gov – CO, MT, ND, SD, UT, WY**  
**PartDComplaints\_RO9@cms.hhs.gov – AS, AR, CA, GU, HI, MP, NV**  
**PartDComplaints\_RO10@cms.hhs.gov – AK, ID, OR, WA**

**O. Scenario/Issue: Plan has supporting documentation that relates to a complaint.**

**Procedure:**

1. From the Complaint Attachment tab, browse to locate the document to upload. The name of the file cannot contain any special characters. Examples of appropriate documents are beneficiary communications (except email), system screen prints, and notifications received from third parties such as the RPC (.pdf, .jpg, .txt, .docx, .xlsx, .zip).
2. Select the type of document being uploaded from the drop-down list that describes the file. If “Other” is selected, the “Other” field text box must also be completed. This becomes a mandatory entry.
3. Click on the Upload File button and the attachment will appear listed. Close the window.
4. Save the CTM record. The attachment will now display on the Complaint Data Entry page.

**Please Note:**

- Plans can also download documents attached by CMS, SHIP, or MMP State Reviewers.
- If a document was uploaded by a plan and subsequently reassigned to another plan, the second plan will not be able to view uploaded documentation. If that documentation is believed to be necessary to resolve the complaint, the plan should submit a Plan Request seeking CMS assistance.

**P. Scenario/Issue: Plan receives a complaint related to a Good Cause (GC) reinstatement request complaint.**

**Procedure:**

1. On a limited basis, CMS will send GC requests for failure to pay plan premiums to plans for review.
2. Plans are to follow the same processes for reviewing GC cases as if the plan received the request directly. See HPMS Memo dated August 18, 2015, “Revisions to Good Cause Processes for Contract Year 2016.” The plan will be responsible for intake, triage, determinations, management, and closure of all GC requests with a disenrollment effective date of January 1, 2016.
3. 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. In other words, plans do not need to wait for the beneficiary to complete their repayment or be reinstated to close the case.

**Please Note:**

- Please refer to the procedure in the February 8, 2015 version of the CTM SOP for GC cases that involve disenrollments that occurred in 2015.
- For purposes of this SOP, requests for GC reinstatement are called “complaints” because CMS is using the CTM system to communicate with plans for these requests for reinstatement. “Complaints” entered into CTM for GC reinstatement requests are not included in plan performance metrics.
- Plans still need to collect premiums owed to them for the 3 months following disenrollment when the individual has requested GC reinstatement after having been disenrolled for failure to pay Part D IRMAA.
- Plans should not grant access to care in cases where an individual still owes Part D–IRMAA. These cases will be notated in CTM by special casework notes by CMS.
- See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information, including model notices and sample GC scenarios.

**Q. Scenario/Issue: Plan is approaching a resolution for a complaint.**

**Procedure:**

1. The plan will notify the beneficiary or complainant according to the plan’s business practice and customer service policy.
  - a. If the plan is having difficulty contacting the beneficiary, CMS strongly recommends that the plan attempt to contact the complainant at least three 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.
  - b. For 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.
2. The plan records a clear and concise narrative (up to 4,000 characters) in the Casework Note field of the Complaint Resolution tab. All entities that review CTM complaint records should be able to easily understand the notes clarifying the issue, action(s) taken, and decisions made to investigate and resolve the complaint.
  - a. See Section 5 for guidance on documenting resolution notes.
3. To close a resolved complaint in the CTM:
  - a. Make a selection from the “Contact Made” dropdown list and select “System Update Action Taken” if appropriate. At least one of these must be selected to close the complaint.
  - b. Select “Yes” to indicate that the complaint has been resolved and enter a Resolution Date. The final Casework Note entered will automatically populate into the Resolution Summary. Other notes may be added to the Summary by simply checking the box under the Casework Note.

**Please Note:**

- To reduce the likelihood of CMS contacting the plan for a status update on a particular complaint, plans are encouraged to provide ongoing, interim documentation and notes as they work toward the ultimate resolution of the complaint
- Plans are encouraged to send a letter when they are unable to contact a beneficiary to inform them of a resolution. The “Template Resolution Letter” is available in the Documentation section of the CTM. The date the letter was sent should be documented in Casework Notes.
- Plans can work directly with SHIP CTM users as needed for SHIP entered complaints without requiring additional beneficiary disclosure agreements from the SHIP. MMPs can work similarly with MMP State Users.
- If the resolution involves a refund from the plan to the beneficiary (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

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complaint can be closed when the communication is complete (i.e., the plan does not need to wait for the appeal to adjudicate).

- Plan Requests should not be submitted when a beneficiary or provider cannot be contacted unless directed by CMS. Please follow the recommendations in Scenario Q for appropriate handling.
- CMS encourages plans to counsel beneficiaries on the impact of retroactivity on claims processing and premium payments, document that counseling in the CTM notes.

**R. Scenario/Issue: Plan user needs HPMS Access but does not have it.**

**Procedure:**

1. Plan user completes the standard “Application for Access to CMS Computer Systems” form found at <http://www.cms.hhs.gov/AccessstoDataApplication>.
2. Plan user sends the completed, signed, original form (with wet signature/date) to the following address:

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

The use of a traceable mail carrier is encouraged for timely delivery. HPMS user access may take 2 weeks or longer.

3. Once the plan user is notified of their HPMS access, the plan user sends an e-mail to [HPMS\\_Access@cms.hhs.gov](mailto:HPMS_Access@cms.hhs.gov) to request CTM access. The e-mail’s subject should read “CTM Access Request” and the message should contain the user’s HPMS ID.

**Please Note:**

- A plan user with HPMS access that needs CTM access should send an e-mail that includes their four character HPMS ID to [HPMS\\_Access@cms.hhs.gov](mailto:HPMS_Access@cms.hhs.gov). The e-mail’s subject should read “CTM Access Request.” and the message should contain the user’s HPMS ID.

**S. Scenario/Issue: Plan has a general CTM-related question or issue.**

**Procedure:**

1. The plan should seek resolution with their Lead Caseworker or Account Manager for casework/CTM process questions.
2. The plan can seek answers to technical questions by emailing: [CTM@cms.hhs.gov](mailto:CTM@cms.hhs.gov), with a copy to their Account Manager. Be sure to include the plan's contract number and complaint ID(s).



**T. Scenario/Issue: Assignment/Reassignment date is reset.**

**Procedure:**

1. The following are instances when the automatic resetting of Assignment/Reassignment dates is appropriate, other than those noted in specific scenarios above:
  - a. Complaint is re-opened.
  - b. Issue Level is changed from non-Issue/Urgent to Urgent/Immediate Need (Issue Level is upgraded).
  - c. CMS Issue flag is set or removed. Plan Request must be accepted for the clock to be reset.
  - d. Contract is changed.

**Please Note:**

- The Assignment/Reassignment date is not changed if Plan Request to have a complaint designated as a CMS Issue is denied.