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

(Effective – April 16, 2018)

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1. <u>Background & Purpose</u>

CMS has made its Complaints Tracking Module (CTM) available to State Health Insurance Assistance Programs (SHIPs) so they can assist Medicare Advantage and/or Part D program enrollees with their issues, without having to contact 1-800 MEDICARE or a local CMS Regional Office. The CTM allows SHIP users to directly enter complaints for routing to CMS and/or its plans real-time, promptly initiating the complaint resolution process. The CTM was never intended to be a replacement for the communication between the Medicare beneficiary and their plan. In fact, it is expected that under most circumstances, prior to making a CTM entry, the enrollee has first sought resolution with their plan. Entries made in CTM can impact the performance metrics for plans operating in the Medicare Advantage and Prescription Drug Program. As such, SHIP users must use the system appropriately at all times.

Access to the CTM is granted solely on a "need to have" basis and is not necessarily needed by SHIPs. SHIPs are not required to have CTM access. SHIP Directors should independently assess if system access is necessary and efficient to best support their activities. Access is not to be requested for SHIP volunteers.

CMS adheres to strict internal controls, which are carefully maintained and all users are obliged to fully adhere to. This includes requirements relating to security awareness training, annual re-certification, and agreeing that under no circumstances will access to the system be shared amongst users and SHIPs are not to share any output from the CTM or MARx, with a beneficiary or their representative. SHIP users are required to timely review and address CMS system email notifications regarding training, changing passwords every 60 days, and certification. SHIPs can only view complaints that were entered by SHIPs in their state.

Each state SHIP is assigned a SHIP CTM Point of Contact (POC) who is intimately familiar with CMS' casework and CTM operations, located in their CMS Regional Office. This individual is different than the Regional Office SHIP Liaison. The POC serves as the first level resource for questions and access. The POC performs quality assurance of SHIP case entries and assists with training as needed. The POC should be informed of any requests for new access, as well as access removals. Contact your SHIP Director if you need to identify your CTM POC.

In addition to this document, the SHIP CTM User Guide (located in the Documentation section of CTM) is to be used as a resource to guide users in the appropriate entry and steps needed to record a complaint in the CTM. SHIP users need to fully understand the content of these two documents prior to using the CTM. This document replaces and supersedes all previous versions of the SHIP CTM SOP. Lastly, throughout this document, the terms case and complaint are used synonymously.

CMS appreciates the partnership of the SHIPs with their activities in support of Medicare beneficiaries.

2. <u>CTM Access</u>

a) **Acquiring Access (New Users)**

1. Prior to starting this process, please add the following email addresses to your email address book and/or "safe senders list" to ensure delivery: EUA@cms.hhs.gov, ESS@cms.hhs.gov.
2. Enter the EUA Front-End Interface (EFI) URL https://eua.cms.gov/efi making sure you are not in compatibility mode and are using IE 9+ or Firefox 35.0+. Please do not use Google Chrome.
3. Click the "Register" button.
4. Enter your personal details in the respective boxes. Create your own "username" and "password". Note – Both the user name and password are case sensitive. The password must be eight to twenty-four characters long, and contain at least one uppercase letter, contain at least one special character (i.e.!, @, % etc.), and contain at least one number. The email address you use in EFI must be the same email address you will use in HPMS, under your User ID profile. Email addresses need to reflect the SHIP. Personal email addresses are not to be used.
5. Click on the "Sign Up" tab and log out.
6. Check your email for an automated email from EUA to activate your account.
7. Click the "Activate EFI Account" link in the email you receive from eua@cms.hhs.gov.
8. Enter the "username" and "password" that you created when you registered and then click on the "Login" tab.
9. At the "Warning" screen click on the "Agree" tab to continue.
10. Click on word "Access" and "view access" from the drop down menu, it will take you to the screen to enter User Details.
11. Under "User Category" select "Business Partner."
12. Under "type" select "State Agency."
13. Under "State Agency."
    a. If you are a SHIP State user select "State Govt – HPMS SHIP"
14. In the "Request Justification" box, type what type of user you are, and what access you need in the system.
15. Select "Personal Details" and enter the required information in the boxes. Note – Enter your Social Security number with dashes (xxx-xx-xxxx).
16. Select "Contact Details" and enter the required information in the boxes.
17. Select "Additional Details" and enter the following information. For "CMS Region/Facility" select the CMS Region/Facility where your office/state is located. Do <u>not</u> select any "Central Office" location.
18. Select "Access Details" and select "No" for ALL questions.
19. The "745a Details" section is Optional. You do not have to complete this section.
20. Select "Save" or "Submit". If you choose to "save" your request, you can log back into EFI and modify the request details at a later time. Once you select "Submit," you will receive notice on the screen that the submission was successful and an automated confirmation email from the system.
    a. You will receive several system generated emails throughout the approval and connection process.

b) Maintaining Access

- CMS will send users a notification when security training and recertification are due. Make sure to complete both if both are requested.
- Users can check the status of their existing account by going to https://eua.cms.gov and checking the "Modify My Profile" section.
- Change your password at least once every 60 days.
- If you are locked out of the system, need to reset your password, or would like to check the status of your CMS account, contact CMS' IT help desk at 1-800-562-1963. (Have your four character CMS ID available.)
- If there is a change in the user's email, please contact Paul Collura (paul.collura@cms.hhs.gov) with a copy to your SHIP CTM POC.
- More information can be found here: https://vpnext.cms.hhs.gov/EUADOCS

c) Removing Access

- The user or SHIP Director is to email their SHIP CTM POC, with a copy to Paul Collura (paul.collura@cms.hhs.gov), requesting access to be removed.

3. <u>Complaint Entry</u>

Several fields in the complaint are auto-populated. This includes the intake source, complaint received/performance dates fields, and caseworker. Each case that is assigned a unique case ID, beginning with "C" and the first two digits will correspond to the calendar year the complaint was recorded. When entering complaints, ensure all your data entry fields are complete. While not all fields are mandatory, the more information you can provide at intake, especially in the "Complaint Summary" field, the more helpful your CTM referral will be.

a) Reminders

- Identical complaints relating to a husband and wife should be entered separately.
- Repeat complaints relating to the same issue should not be entered.
- Complaints are not to be recorded if they relate to Original Medicare.
- Plan complaints generally should not be recorded unless the beneficiary has first sought assistance through their plan.
- If you have questions about recording a complaint or if a complaint has been entered in error, contact your SHIP CTM POC.
- If a CTM complaint was resolved, but the SHIP believes it was not handled correctly or has a concern, contact your CTM SHIP POC

b) General Information Section

1. Leave the "Issue Level" dropdown selection unchanged, unless the beneficiary meets the following criteria for Urgent or Immediate Need complaints:
    a. **Immediate Need (typically resolved within 2 calendar days):** For Medical/Hospital Services, the beneficiary has no access to care and an immediate need exists. For

prescription drug coverage, the beneficiary needs medication and has 2 days or less of medication left.

    b. Urgent (typically resolved within 7 calendar days): For Medical/Hospital Services, the beneficiary has no access to care, but no immediate need exists. For prescription drug coverage, the beneficiary needs medication and has 3 to 14 days of medication left.

2. Select "Yes" if the complaint is related to pain medication.

c) Category Information Section

Be sure to review Attachment A and Attachment B for key category/subcategory usage guidance beforehand.

1. For "Lead," select CMS or Plan, depending on who will need to resolve the complaint. Most typically, it will be "Plan."
For "Category" and "Subcategory," pick the choice that is most applicable to the beneficiary's issue, recognizing that more than one category or subcategory may be apply.
   a. If prompted, select "Yes" if the complainant has contacted their plan first to try and resolve the complaint.
   b. If prompted, select "Yes" if the complaint relates to alleged inappropriate activity on the part of an agent/broker. If "Yes" is selected, you will be prompted to provide additional information relating to the agent/broker. Please provide it if known.

d) Contact Information Section

1. Provide contact and complainant information as requested. While only the name, state, and telephone number are required, please provide as much information as possible to help expedite the resolution of the complaint. While the Medicare Beneficiary Identifier (MBI) can be used, CMS prefers SHIPs use the Health Insurance Claim Number (HICN) until such time that all New Medicare Cards have been mailed.
2. If it is not known if the beneficiary receives a Low Income Subsidy (LIS) or is a Qualified Medicare Beneficiary (QMB), leave the fields untouched. The default is "Unknown"
3. If the beneficiary has a different preferred language than English or Spanish, select "Other" in the "Preferred Language" drop down and note that language in the Complaint Summary.
4. Note the preferred call back time for the complaint, changing the default from "Any," when appropriate.

e) Contract Information Section

1. An appropriate contract number must be completed to record a CTM complaint. This assures a plan can concurrently review the CTM case and take action. If there is no plan involved in a complaint, "Other" or "Unknown" should be selected, as appropriate. The "Parent Organization" field does not need to be completed. It is provided to help reduce the number options in the "Contract" field. The contract number can often be found on the beneficiary's plan materials (e.g. membership card, enrollment confirmation notice).
2. Provide the plan ID number (if known). Plans can only view complaints assigned to them.

f) Complaint Summary

- Provide a clear, concise description of the beneficiary's issue. Provide steps (if any) to describe actions already taken to address the matter. Only describe facts relating to the complaint. Do not use pejorative language.
- Do not use any of these four characters < & ; >
- If the SHIP should be contacted to discuss the complaint, indicate so in the Complaint Summary.
- When applicable, state the following, "No need to contact SHIP when matter is resolved – will review the CTM. Please inform the beneficiary though when the issue has been addressed."

The CTM will log the user out after 15 minutes of inactivity. Users should enter their complaints within this timeframe to prevent the loss of data. As a best practice, users may want to draft their complaint summary contents separately and cutting/pasting it into the CTM when ready.

g) Re-Review and Save

1. Prior to saving the complaint, carefully review the entry. Once saved it cannot be removed and the Complaint Summary cannot be edited. CTM entries are official government records and may be provided to a beneficiary under a Freedom of Information Act (FOIA) request.
2. Advise your client that it can take up to 30 days to achieve a resolution to a complaint, unless it is classified as Immediate Need or Urgent.
3. After a complaint is saved, you will receive a confirmation and the CTM case ID will display. You'll also have the ability to upload an attachment to the complaint, using the upload feature in this section. Example attachments can include enrollment welcome letters, membership cards, invoices, etc. You may also download a copy of the complaint as a PDF file for your records.

h) Monitoring Resolution

By using the "Search Complaints" feature, users can retrieve CTM cases entered by SHIPs in their state. Filters are available to allow users to select open or closed complaints, date ranges of interest, and a variety of other filters. Users can also search for cases by HICN or CTM ID. Additional ways to view complaints can be done using the "My Open Complaints" feature and the "SHIP Entry Monitoring Report." For more instructions for reviewing the status of entered cases, consult with the CTM SHIP User Guide, located in the Documentation section of CTM.

4. <u>Scenario Specific CTM Entry Guidance</u>

a) Inappropriate Marketing Allegations

Marketing complaints should be entered as "Plan Lead" in an appropriate subcategory under Marketing, except if the beneficiary seeks disenrollment from the plan due to the alleged misrepresentation. Should that be the case, enter a CMS Lead complaint, in the Marketing category, with details of the contract/plan the beneficiary would like to enroll with instead if applicable. CMS will carefully review the matter and make a decision. All marketing complaints are shared with state insurance regulators, who are responsible for overseeing the activities of agents/brokers in their state. As such, allegations of inappropriate marketing need to be carefully considered prior to entry as licensure actions may be taken

on the agent/broker involved. Beneficiaries may be contacted by their state insurance department to gain additional details about alleged inappropriate marketing contact.

b) Good Cause Reinstatements for Failure to Pay Premiums

The SHIP user should explain to the beneficiary that when they do not pay their premiums, they may be disenrolled. Unless beneficiaries qualify for a Special Enrollment Period (e.g. they receive the Low Income Subsidy), they will need to wait until the next Annual Enrollment Period (AEP). As a beneficiary protection, should they encounter an unusual and unforeseen event, such as a prolonged hospitalization that impaired their ability to pay premiums, plans consider reinstatement requests if: 1) it has been less than 60 days since the beneficiary was disenrolled, and 2) they can pay owed payments. Financial hardship is not considered an unusual and unforeseen event. If the beneficiary would like to be considered for reinstatement and meets these conditions, refer the beneficiary to the plan. CMS does not review/evaluate these requests and beneficiaries should be directed to contact their plan to discuss good cause. If necessary, a CTM entry can be made by going to "Plan Lead," and selecting the "Good Cause" category. However, entries should only be made when 1) the beneficiary has had difficulty receiving a good cause determination from their plan, and 2) the beneficiary has not received a denial of good cause reinstatement.

c) Part D Income Related Monthly Adjustment Amount (IRMAA)

Generally, Part D IRMAA complaints should NOT be entered into the CTM. SHIP users should explain to the complainant that if a beneficiary is enrolled in a plan that offers Part D coverage, even if it is an employer/union sponsored plan, they have to pay IRMAA Part D if they meet certain income parameters. If they disagree that they have to pay IRMAA or disagree with the IRMAA amount and would like to appeal, refer the individual to Social Security Administration (SSA).

If due to unforeseen and extenuating circumstances (as described in the last part), a beneficiary was disenrolled for failure to pay Part D IRMAA, they can be evaluated for Good Cause. The SHIP user may enter a CTM complaint by going to "CMS Lead," and selecting the "Good Cause" category.

[Attachment A] – Category and Subcategories (CMS Lead)

Category/Subcategory	Sample Situations
Enrollment/Disenrollment - Beneficiary was disenrolled from their plan due to loss of Medicare entitlement (EX)	Beneficiary has lost their Medicare entitlement and needs it restored to regain access to MA or Part D coverage/access. This could include "erroneous death" or other situations where an update is needed to a beneficiary's record.
Enrollment/Disenrollment - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Enrollment Exceptions (EE) - Beneficiary seeks to enroll/change plans outside available enrollment period (EX)	Beneficiary alleges he/she was unable to enroll or disenroll from a plan due to exceptional circumstances (e.g. prolonged hospitalization).
Enrollment Exceptions (EE) - Beneficiary seeks to enroll/change plans outside available enrollment period, due to a provider network change (EX)	Beneficiary seeks to change plans due to a provider network change that is significant and impairs their ability to successfully acquire needed services. This should be used infrequently as provider networks change regularly and beneficiaries are expected to find alternative providers and/or work with their plan.
Enrollment Exceptions (EE) - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Marketing Allegation of inappropriate marketing by plan, plan representative, or agent/broker	Beneficiary alleges s/he was enrolled in a plan fraudulently or misleadingly on the part of the plan or their representative, and as a result, they are seeking an enrollment change.
Marketing – Other (EX)	Beneficiary alleges s/he was enrolled in a plan fraudulently or misleadingly on the part of the SHIP, 1-800 MEDICARE, or CMS, and as a result, they are seeking an enrollment change.
Premiums and Costs- Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)	Beneficiary needs assistance securing evidence of Medicaid coverage or Low Income Subsidy (LIS) status. This subcategory should not be used for beneficiaries who already show as having LIS on CMS systems.
Premiums and Costs - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Legal and Administrative- Program Integrity Issues - Potential Fraud, Waste and Abuse (EX)	FWA complaints should be referred to the Medicare Drug Integrity Contractor (MEDIC) who can be contacted at 1-877-7SAFERX (preferred). However a complaint can be entered in the CTM and placed in this subcategory.

Legal and Administrative - CMS contractor or partner performance (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Legal and Administrative - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Good Cause - Part D IRMAA Good Cause Request (EX)	This is to be used when a beneficiary was disenrolled for failure to pay Part D IRMAA and seeks a good cause reinstatement. Please note if the beneficiary is a Railroad Retiree Board enrollee. IMPORTANT - This is only to be used in matters involving Part D IRMAA.
Good Cause - Part D IRMAA Equitable Relief Request (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Good Cause - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Other Matter Requiring CMS Review (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.

[Attachment B] – Category and Subcategories (Plan Lead)

Category/Subcategory	Sample Situations
Enrollment/Disenrollment - Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change	Beneficiary believes the following may have occurred with his/her enrollment or disenrollment: • Request was not processed or was made effective with an improper date. • Action was taken without their consent (i.e., the beneficiary states they did not request the change). • Medicare entitlement was lost but has been corrected requiring reinstatement. • Auto-assignment by CMS.
Enrollment/Disenrollment- Beneficiary has not received enrollment card or other membership materials	Beneficiary is enrolled with a plan, per CMS systems, but the plan has no record of the enrollment and/or has not sent materials, such as a membership card.
Enrollment/Disenrollment - Other	Intended to be infrequently used, this subcategory is intended to capture enrollment issues that don't fit elsewhere and require plan review.
Marketing - Allegation of inappropriate marketing by plan, plan representative, or agent/broker	Beneficiary reports a soliciting through door-to-door marketing, telemarketing, or unsolicited e-mail, or other illegal practice or false advertising of Part C and/or Part D products. This includes the production of misleading materials. IMPORTANT - Allegations of misconduct that require enrollment change, go in the CMS Lead Marketing category.
Marketing - Other (no enrollment change requested)	Any other marketing issue that is to be reviewed by a plan, but does not involve enrollment changes.
Benefits, Access, Quality of Care - Beneficiary has difficulty securing Part D prescriptions	Beneficiary is having trouble getting their Part D prescriptions filled, including transition fill issues.
Benefits, Access, Quality of Care - Beneficiary has difficulty finding a network provider/pharmacy	Beneficiary is having difficulty finding a network provider or network/preferred pharmacy.
Benefits, Access, Quality of Care - Beneficiary has concerns about the quality of care they have received	Beneficiary believes they received inadequate or poor care or that inferior services were rendered.
Benefits, Access, Quality of Care - Beneficiary has concerns about a denied claim	Beneficiary does not understand why payment of a particular claim was denied or may need further help understanding the next steps in the next level review/appeal process.

Benefits, Access, Quality of Care - Other	Any other Benefits/Access complaint that does not fit into another subcategory, including, but not limited to, issues concerning: • Authorization/referral. • Explanation of Benefits (EOBs). • Medication Therapy Management. • Part B vs. Part D coverage. • Pharmacy does not offer generic alternatives. • Pharmacy incorrectly listed in Part D tool.
Premiums and Costs - Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)	Never to be used by SHIPs.
Premiums and Costs - Beneficiary has a coordination of benefits issue	Issues are arising because Medicare claim payments must be coordinated with another payer and it is not happening or not happening correctly. Other payers may include State Pharmaceutical Assistance Programs (SPAPs) or employer/union groups.
Premiums and Costs - Beneficiary has a premium issue, direct bill or withhold related	Premiums billed/withheld/paid to plan incorrectly, including: • Beneficiary double-billed (both withhold and direct pay). • SSA is withholding the incorrect amount or not withholding as requested. • Plan is billing the incorrect amount or continues to automatically deduct from a member's bank account in error. • Sponsor charges the beneficiary more than the premium listed in the Plan Finder Tool. • Part B Premium Reduction issues.
Premiums and Costs - Beneficiary has an issue with Late Enrollment Penalty (LEP) being charged	Examples include, but are not limited to: • Beneficiary attests to having creditable coverage but is still being charged an LEP. • Beneficiary receives a favorable appeal, but has not received a refund after an appropriate period of time. • Plan needs to update the number of uncovered months for CMS' systems.
Premiums and Costs - Beneficiary has a cost-sharing/co-insurance issue, including coverage gap or balance billing	Beneficiary charged improper co-insurance based on formulary tier or as listed on the Part D Tool or in their description of benefits. The beneficiary was charged an improper amount for their medications.
Premiums and Costs - Beneficiary's Best Available Evidence (BAE) is not honored by the plan	Plan will not honor BAE when sufficient documentation is supplied.

Premiums and Costs - Other	Any other complaint that does not fit into another subcategory. These may include complaints about: • Pharmacy charging more than lowest available price. • True Out-of-Pocket (TrOOP) balance unavailable.
Legal and Administrative - Allegation or concern relating to HIPAA, Confidentiality, Security Breach or Privacy Violation	Beneficiary believes their privacy rights regarding their personal information and medical information have been compromised or that personal information has been requested or shared inappropriately by their plan or provider.
Legal and Administrative - Plan has provided poor customer service	Any other customer service complaint that does not fit into another subcategory, including complaints about a plan's website or their communications with providers.
Legal and Administrative - Difficulties Acquiring Materials in Alternate Formats	Beneficiary indicated difficulty receiving plan materials in alternative formats (e.g. braille, large print, etc.).
Legal and Administrative - Other	Any other "legal" or "administrative" issue that doesn't fit elsewhere.
Provider Specific - Improper, insufficient, or delayed claims payment	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Provider Specific - Network contracting issue	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Provider Specific - Other	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Good Cause - Plan Premium Good Cause Request (EX)	Although Good Cause requests are to be directed to the plan (not using CTM), CTM can be used if a beneficiary is having difficulty contacting their plan about their Good Cause request.
Good Cause - Other (EX)	Not to be used by SHIPs, except when directed by CMS' CTM POC.
Other Matter Requiring Plan Review	Any plan matter that does not fit elsewhere. Should be infrequently used.