Complaint Tracking Module (CTM)

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Complaint Tracking Module What is it?

- The Complaint Tracking Module (CTM) is a CMS system to directly enter in complaints for Medicare part D and Medicare Advantage plans
- Plans respond within a designated timeframe, reducing the need to make multiple calls to plans, regional CMS office or 1-800 MEDICARE
- Plan complaints generally should not be recorded if the beneficiary has not already contacted the plan
- Every SHIP will have a SHIP CTM point of contact for questions about the CTM

Complaints Resolved using CTM

Typical complaints resolved using CTM:

- Premium withholding issues
- Enrollment/marketing issues
- Access to medications/medical services
- Customer service issues
- Incorrect billing issues
- Network issues

Issues not to be entered into the CTM

- Medicare part A and B issues
- Medigap Issues
- IRMAA issues
- Good cause can only be entered in certain circumstances
- Repeat complaints regarding the same issue

Complaint Sub Categories

- Enrollment/Disenrollment
- Enrollment Exceptions
- Benefits, Access, Quality of Care
- Marketing
- Premiums and Costs

CTM Levels

All required fields need to be filled in Issue levels:

- **Immediate need**: (typically resolved in 2 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.
- **Urgent need**: (typically resolved in 7 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.
- **No issue level** for non urgent issues (typically resolved in 30 days)

Immediate Need – Retroactive Coverage Examples

- Beneficiary had open heart surgery January 10 and thought he had Medicare part D drug coverage. He tried to fill his prescriptions at the pharmacy and was told he did not have any coverage. He had enrolled in a part D plan during open enrollment, but there was some sort of error and it did not go into effect in January. He called the plan and they said they would re-enroll him for a 2/1 effective date. This was entered into CTM. It was resolved the same day and made retroactive with a January 1 effective date.
- Beneficiary moved to WV in February 2018. She got a 90 day supply of her medicine prior to moving. She was in a HMO Dual plan that would not work in West Virginia. She had prescriptions that she was in need of getting at the pharmacy but could not be filled because her insurance was not working and she could not afford to buy them. She enrolled into a WV PDP but it would not start until the following month. A CTM was filed asking that the PDP enrollment be made retroactive so that the beneficiary could get her medications and she could use her Medicare and WV Medicaid for medical services. This was approved

Immediate Need – Retroactive Coverage Examples

- An agent came to the beneficiary's senior living housing complex and talked about extra dental and vision benefits people with Medicare and Medicaid could get at no extra premium. The beneficiary stated there was never any mention that it would change how the beneficiary would get medical and prescription coverage. The agent did not check her doctors or medications to see if they were covered by the plan. The beneficiary did not know that he was enrolled into a Special Needs Plan until he got a letter from the Advantage plan telling him they were his new health coverage. When he called about cancelling the coverage he was told he would have to wait until July 1st. The beneficiary is diabetic and his doctor was not in the network, he needed diabetic supplies that required prior approval but since his doctor was not in the network he would first need to get a new doctor. • A CTM was filed asking CMS to grant a disenrollment/enrollment exception to cancel the Advantage SNP plan and to retroactively reinstate his PDP. This was approved.

Enrollment issue - Urgent

- Beneficiary was turning 65 but had Medicare prior to turning 65 due to disability. When he turned 65 he decided to change from an Advantage plan to a Medicare Supplement and Part D. He contacted a PDP to enroll in Part D. They told him the plan would start January 1, 2018. He was under the impression the enrollment was complete and that it would automatically cancel his Advantage plan. However, he then started getting bills stating that Medicare was not the primary insurance and that claims should be billed to his Advantage plan as that was his main coverage for Health and Drugs. He contacted his advantage plan and was told that they sent him paperwork about cancelling the policy and because he did not complete it, they didn't cancel the plan. He stated he never received paperwork from the Advantage plan about cancelling. He then contacted the PDP as to why the PDP did not start in January. The representative could see where an enrollment was completed but for some reason it was not processed. His enrollment was processed in February 2018 during the MA disenrollment SEP timeframe to start March 2018. However, he had a lot of outstanding bills and has paid for Supplement insurance for January and February. He wanted his enrollment into the PDP plan to be retroactively effective to January 1, 2018 as he did try to enroll into coverage during both an SEP for turning 65 and during OEP. A CTM was filed asking for a retroactive enrollment change. This was granted

No issue level

- A beneficiary enrolled with an agent into part D during open enrollment and also had VA coverage. In error, the plan was charging him 32 months worth of penalties. He contacted the plan and they said they would take care of it, however, the penalties were not removed. They were able to get them to remove penalties after supplying the VA information in the CTM.

No Issue Level

- Due to a system error, a beneficiary was dis-enrolled from Medicare part B for a period of a few months. He had been enrolled in a Medicare Advantage plan, so they took back all their payments since he did not have part B. He was then told he owed payments of over $30,000 for his services. After filing the CTM, the plan worked with SSA to have his effective dates corrected and they will go back and re-bill for the claims.

CTM not resolved – CMS Referral

- A beneficiary was having their premium deducted from a Social Security check. They received notice from the plan after a few months that they still owed premium, even though the premiums had been deducted. The beneficiary called the plan and they said to contact Social Security. Then they contacted Social Security and they said to contact the plan. When they contacted SHIP, we filed a CTM for them. The plan responded to the CTM that it was a Social Security issue and closed it. We contacted CMS and they reopened the CTM and had the plan follow up and work with Social Security to resolve the issue.

Complaint Tracking Form

File Code 6.101 (Name of document) _____

COMPLAINT INTAKE FORM

COMPLAINANT INFORMATION

NAME WILMA SCHMITZ
ORGANIZATION CLAIM/ MISSOURI STATE HEALTH INSURANCE ASSISTANCE PROGRAM
RELATIONSHIP TO BENEFICIARY SHIP STAFF
PHONE NUMBER(S) 314-594-7834

BENEFICIARY INFORMATION

NAME		DUAL ELIGIBLE ☐
MEDICARE	SSN	MEDICAID #
PHONE NUMBER		DATE OF BIRTH
ADDRESS		
CITY	STATE MO	ZIP
PLAN NAME		MEMBER #
PHARMACY	CONTACT	PHONE NUMBER
NATURE OF COMPLAINT		
		OUT OF MEDS? X WHEN?
TO BE COMPLETED BY CMS STAFF ONLY		
INTAKE NAME		DATE AND TIME

RECEIPT DATE: _____
ASSIGNED TO: _____
DATE ASSIGNED: _____
CLOSED DATE: _____
CTM: _____

IMMEDIATE NEED (LIFE THREATENING) ..... ☐
URGENT ..... ☐
CONGRESSIONAL ..... ☐
LIS LEVEL 1 2 3 4

NOTE: HICN/ SOCIAL SECURITY NUMBERS AND OTHER BENEFICIARY PROTECTED HEALTH INFORMATION MUST NOT BE TRANSMITTED VIA E-MAIL

Complaint Steps and Tips

STEPS

- Plan must be contacted **first** to work with the beneficiary's issue
- If plan does not resolve the issue, then it could be considered as a potential complaint for the CTM
- Please, contact your RL!
- Beneficiary's issue should be discuss with **your Regional Liaison** to decide proper action. RL will be refer the issue to Regional Liaisons that have CTM access. The RL's will refer issues to other organizations when CTM does not apply (CMS, DCI , SMP, etc.)

TIPS

- Gather as much information as possible to enter into the CTM
- Attachments can be included
- Be very clear in the complaint summary and let the plan know the outcome the beneficiary would like, especially if it involves switching plans
- File the complaint against the plan that the person has issues with


QUESTIONS
ANSWERS