



2019 SMP/SHIP NATIONAL CONFERENCE

Using the Complaint Tracking Module (CTM) to Resolve Casework

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July 22–25, 2019 • San Diego, CA

SHIP Introductions

- Louisiana SHIP – administered through the Louisiana Department of Insurance
- Ohio SHIP – administered through the Ohio Department of Insurance
- West Virginia SHIP – administered through the West Virginia Bureau of Senior Services

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Introduction to the Complaint Tracking Module

- 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
- A CTM SHIP SOP manual is available for reference, there is also a CMS/CTM contact at the regional office

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Introduction to the Complaint Tracking Module

- Complaints are only to be entered for Medicare part D or Medicare Advantage plans
- 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

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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

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Issues not to be entered into the CTM

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

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Entering in a CTM

HPMS : CTM

https://hpms.cms.gov/app/CTM/CtmAddComplaint.aspx?PI=052101000000

File Edit View Favorites Tools Help

Congressional No

Is this complaint related to pain medication? Unknown

Category Information

*Lead (Select One)

*Category (Select Category Lead First)

*Subcategory (Select Category Lead and Category First)

Contact Information

*First Name Last Name

*State (Select One)

*Phone

Alt. Phone

Please check if the complainant is the same as the contact above.

Is the complainant a beneficiary or provider? Beneficiary

First Name Last Name

Address 1 Address 2

City

State (Select One) ZIP Code

Phone

Alt. Phone

Email

Organization

Beneficiary Identifier

DOB

Would you like to store your password for cms.gov? [More info](#) Yes Not for this site

Entering in a CTM

- 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)

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Immediate Need – Retroactive Coverage

- 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. He contacted OSHIP and we filed a CTM. It was resolved the same day and made retroactive with a January 1 effective date.

Immediate Need – Retroactive Coverage

- 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

- 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.

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Enrollment issue - Urgent

- Beneficiary met with local SHIP counselor in early December and applied for LIS/Extra Help. When beneficiary was approved she contacted SHIP counselor back about changing her Part D plan since she had to still pay a monthly premium for her current Part D plan. The SHIP counselor assisted the beneficiary in enrolling into a new Part D plan on 12/31/2018. The beneficiary called the SHIP counselor in January because she had not gotten her new card. The SHIP counselor called the plan and was told by a representative that the beneficiary's enrollment was denied because the beneficiary's old Medicare number was entered on the enrollment form instead of her new Medicare number. A CTM was filed asking for a retroactive enrollment change. This was granted.

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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.

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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. We 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.

Reimbursement – No Issue

- Beneficiary was a resident in a WV nursing home on nursing home Medicaid. Her niece and POA contacted WV SHIP during OEP because the beneficiary's plan was terminating and she needed a new prescription drug plan. The SHIP checked MARx and it did not show Medicaid. They then contacted WV Medicaid and they had the wrong social security number listed for the beneficiary which caused her to not have her Medicaid status updated with Medicare. The beneficiary's niece had been paying full premium, Late Enrollment Penalty, and medicine costs since December 2013 when she should not have been because she has Nursing Home Medicaid which entitles her to LIS level 3. SHIP Counselor contacted WV Medicaid to have her social security number corrected. When this was completed her Medicaid status was updated with Medicare but her LIS level 3 was only effective as of 11/1/2014. She had been receiving Nursing Home Medicaid since October 2013. SHIP Counselor contacted beneficiary's drug plan to submit BAE to update her LIS and help her niece get reimbursed for out of pocket costs she should not have owed. When SHIP counselor spoke with a representative at the plan she was told that the plan could not update their LIS records - they get LIS information from Medicare only. They do not accept BAE and only go based on what Medicare has in their system and only accept BAE that comes from Medicare. The representative said this was per their enrollment department.
- A CTM was filed with BAE documents showing the beneficiary has had Nursing Home Medicaid since October 2013. Beneficiary's niece was reimbursed over \$1,000.

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CTM not resolved – CMS Referral

- The beneficiary had partial Extra Help with his medicines. What he was being charged at the pharmacy for a 30 day supply of a medicine was higher than what the Medicare.gov plan finder and the plan's website showed as the cost of the medicine. His initial copay level should have been \$35 because 15% was more than the co-pay level 3 price on the plan. The SHIP counselor verified the beneficiary was in the initial coverage level, however he was being charged 15% percent of the cost of the drug. When SHIP counselor contacted the plan, the representative stated that this is the correct amount. A CTM was filed as the beneficiary should not have been charged 15% until post-initial coverage (coverage gap) due to the co-pay level being less than 15%. The representative who contacted SHIP counselor as a result of CTM said no, the Medicare.gov plan finder was incorrect, that beneficiaries with partial Extra Help do not pay co-pay levels even if less than 15%.
- SHIP Director reached out to regional CMS office who worked with the plan on correcting this issue. The beneficiary is now being charged correct co-pays.

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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.

Tips and Tricks

- 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 issue with
- Do not make CMS the lead on the plan unless directed by your CMS CTM point of contact
- Put your contact information in the complaint summary if you would like to be contacted about the complaint
- You can contact CMS if the complaint was not resolved correctly

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Questions?



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