Complaint Drivers and How to Avoid Them

This bulletin is designed to provide you with some helpful insights and best practices to help you avoid some of the more common drivers of Complaints to Medicare (CTMs).

- **Presentation of Benefits**
  - It is important to cover the core elements of the products you offer:
    - Know the plan details
    - Communicate them clearly
    - Disclose all plan benefits
    - Confirm you are speaking with the decision-maker before beginning your presentation of benefits
    - Review any benefits that tend to drive customer allegations, such as:
      - Spending account cards
      - Dental, vision and hearing benefits
      - Transportation benefits
- **Enrollment with a Decision Maker**
  - It is important to directly ask the beneficiary if they make their own healthcare decisions

    - If the beneficiary has a Power of Attorney (POA) or Legal Guardian present during the enrollment process, ask the POA or Legal Guardian if they are legally authorized to act on behalf of the beneficiary and if they can provide proof, if requested by CMS later
- **Late Enrollment Penalty (LEP)**
    - Medicare beneficiaries who do not have creditable drug coverage may incur a late enrollment penalty (LEP) if there is a continuous period of 63 days or more, at any time, after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage
    - It is important to inform enrollees about the potential for this penalty so the member will not be surprised if CMS imposes an assessment for the LEP
- **Chronic Care SNP**
    - Explain the eligibility requirements to the beneficiary to enroll in or remain enrolled in a C-SNP
    - Make sure applicants/members clearly understand their role in providing their physician with the Verification of Chronic Condition (VCC) form to be completed and returned to the plan/insurer
    - If a completed VCC is not returned to the plan/insurer by the end of the second month of enrollment, the member will be disenrolled from the C-SNP
- **Part B Giveback**
    - Explain to the beneficiary what the Medicare Part B Giveback is
    - When first joining in a new Part B Giveback plan, it can take up to 3 months for the Part B Giveback reimbursement to start. The member will be reimbursed for each month they weren't compensated since joining the new plan
    - Make sure the beneficiary understands how the Part B Giveback reimbursement occurs:
        - Credited to a member's monthly Social Security check, if the Part B premium is paid through Social Security
        - If the Part B premium is not paid through Social Security, the member will pay a reduced monthly amount directly to Medicare
        - If receiving Railroad Retirement Benefits, the Part B Giveback will be applied to the monthly railroad benefit

- **Veteran Healthcare and Engagement**
    - Do a NEEDS analysis of each veteran's needs, lifestyle, and budget to determine which plan is right for them and their unique situation
    - If a TRICARE for Life or CHAMPVA beneficiary wishes to enroll in a Medicare Advantage Plan, inform them of two things:
        - They must use providers in the Plan's network
        - Beneficiaries will need to coordinate with their providers to ensure that TRICARE for Life or CHAMPVA pays as secondary coverage OR they may need to fill out reimbursement forms to be reimbursed for their copays
- **Honors Plans and Tricare for Life/VA/ChampVA**
    - Explain to a beneficiary how a Medicare Advantage Honors plan may impact TRICARE for Life, VA, or ChampVA coverage
    - Be sure the beneficiary understands the **VA/ChampVA Healthcare and Medicare are two separate programs, they do not overlap or coordinate**
    - VA Healthcare typically only pays for services rendered by VA physicians or VA pharmacies
    - Medications prescribed by non-VA providers cannot be filled at the VA pharmacy unless a VA physician agrees