FORM INSTRUCTIONS CMS-R-0282

Medicare Advantage organizations are expected to disclose grievance and appeals data, upon request, to individuals eligible to elect a Medicare Advantage organization. For purposes of this section, by appeals data we mean all appeals filed with the Medicare Advantage organization that are accepted for review, or withdrawn upon the enrollee's request, but excludes appeals that the organization forwards to CMS' Independent Review Entity (IRE) for dismissal. Medicare Advantage organizations should not send out a subset or partial list of the data, even if only a subset of the data is requested. For example, if a beneficiary requests data on the number of appeals received by the Medicare Advantage organization, then the Medicare Advantage organization must send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

Medicare Advantage organizations must report to beneficiaries the number of appeal and grievance requests per 1000 enrollees. The purpose of this calculation is to normalize reporting among larger and smaller Medicare Advantage organizations for comparison purposes. Since larger organizations would reasonably be expected to receive more appeals and grievances relative to smaller organizations, simply reporting raw data could be misleading.

The rate is calculated by multiplying the total number of requests for [an appeal or grievance] by 1,000, and dividing that number by the average number of members enrolled during the data collection period. The calculation does not require that the Medicare Advantage organization have a minimal enrollment of 1000 members. The following are examples of how the rates get normalized across small and large organizations:

EXAMPLE 1

Medicare Advantage organization average membership = 500
# of appeals received during the data collection period = 4
4 x 1000/500 = 8
# of Appeals per 1000 members = 8

EXAMPLE 2

Medicare Advantage organization average membership = 5000
# of appeals received during the data collection period = 40
40 x 1000/5000 = 8
# of Appeals per 1000 members = 8

Reporting Unit for Appeal and Grievance Data Collection Requirements

The reporting unit for appeal and grievance data sent to beneficiaries is to be consistent with (generally the same as) the reporting unit for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study

(CAHPS), and the Medicare Health Outcomes Survey (HOS). Therefore, Medicare Advantage organizations must make changes to the reporting unit for appeals and grievances concurrently. However, CMS retains the flexibility to grant special exceptions to the general reporting unit to allow for case-by-case exceptions for good cause.

Data Collection and Reporting Periods

In order for Medicare Advantage organizations to report appeal and grievance data consistently, data collection and reporting periods have been established.

- The data collection period is the timeframe in which the data were collected. Data collection periods will be based on an ongoing 12-month period. By ongoing, we mean that the prior 6 months of data are added to the next 6 months of data in order to come up with a 12-month data collection period;
- The reporting period refers to the timeframe during which organizations will be expected to report the data. The reporting period begins 3 months after the data collection period ends. Reporting periods are 6 months in duration; and
- Organizations are expected to report out appeal and grievance data to MA eligible individuals, upon request, beginning 3 months after the end of each data collection period. For example, if the data collection period ended 9/30/05, the organization would begin reporting data to the beneficiary 1/1/2006. The 3-month lag between the end of the data collection period and the beginning of the report period allows the Medicare Advantage organization to resolve appeals received during the data collection period and ensure quality control over the data reported.

Below is a chart detailing the sample yearly collection and reporting cycles.

Sample Yearly Collection and Reporting Cycles

6-month Data Collection	3-month Reconciliation	What kind of data?
4/1/06 - 9/30/06	10/1/06 - 12/31/06	last 6 months
10/1/06 - 3/31/07	4/1/07 - 6/30/07	last 12 months
4/1/07 - 9/30/07	10/1/07 - 12/31/07	last 12 months, etc.

New Reporting Periods Start Every Six Months

Medicare Advantage organizations are expected to report out new data every 6 months. The new data to be reported will include the two most recent data collection periods. For example, the data collection period would begin each year starting on April 1 and ending on September 30, thus the reporting period would run from January 1 through June 30. The next reporting period begins July 1 and runs through December 31. This sample report includes appeal and grievance data collected beginning April 1 through March 31 (or the two latest 6 month data collection periods). As an example, beneficiary requests for appeal and grievance data beginning January 1, 2007, through June 30, 2007, would be based on appeals received by the organization from October 1, 2005, through September 30, 2006, and so on.

Maintaining Data

CMS expects Medicare Advantage organizations to maintain a health information system that collects, analyzes and integrates the data necessary to implement disclosure requirements.

Appeal and Grievance Data Collection Requirements

The following describes the appeal and grievance data Medicare Advantage organizations are expected to record and report. This format should be used by the organization in recording the data internally and is the required format for reporting the information to beneficiaries. Reports should be readable and understandable to the recipient of the information. The material also should be typed in at least a 12-point font. Organizations should provide informational copies to the appropriate Regional Office. If the Medicare Advantage organization intends to provide any of its own materials or discussion to supplement CMS' standardized format, as with all member materials, prior approval by the Regional Office is required.

Appeal Data

Line 1 Time Period(s) Covered: **[Sample Reporting Period lasts from 1/1/07 through 6/30/07, which includes data collected from 10/1/05 through 9/30/06, and 7/1/07 through 12/31/07 which includes data collected from 4/1/06 through 3/31/07.]**

Line 2. Total Number of Requests for an Appeal Received by **[Organization Name]*:* [insert # here].**

Instructions: This line includes all requests for reconsideration, including Pre-Service {standard & expedited} and Claims (Payment) Appeals, but excludes appeals that the organization forwards to CMS' independent review entity for dismissal.

Line 3. Average Number of Enrollees in **[Organization Name]**: **[insert # here]**.

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Appeal Requests per 1,000 enrollees: **[insert # here]**

Instructions: This number is calculated by multiplying the total number of requests for an appeal (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the data collection period (line #3).

Line 5. Of the Appeal Requests Received by **[Organization Name]** between **[sample 12-month period: 04/01/06** through **03/31/07]**, **[Organization Name]** completed **[insert # here]**.

Instructions: This number should be equal to or less than the number in line #2. Organizations are reporting cases received in the period indicated in line #1, but completed at the Medicare Advantage organization level within 60 days following the last date in line #1. For example, a withdrawal would be reflected in line #2 as a case received; but since a decision is not rendered for a withdrawn case, a withdrawal would not be reflected in this line item.

A "completed" appeal means one that has been resolved by the Medicare Advantage organization or has left the Medicare Advantage organization level. If there were no withdrawals, we anticipate that the number of completed appeals will be the same as the number of requests for reconsideration, provided the Medicare Advantage organization has met its deadlines.

Therefore, the organization is accounting for all appeals that it has completed within 60 days after the last date in line #1.

The 60-day timeframe is based on the maximum timeframe in 422.590(b), which allows a Medicare Advantage organization 60 days to resolve a dispute involving a claim or request for payment either by deciding an enrollee should receive payment or by forwarding the case to the IRE. Cases involving requests for services have a shorter timeframe.

Of those cases:

NOTE: partial denials should be recorded as not decided fully in favor of the enrollee.

Line 6. **[Insert # here]** or **[insert % here]** of the appeals were decided fully in favor of the enrollee.

Line 7. **[Insert # here]** or **[insert % here]** of the appeals were not decided fully in favor of the enrollee.

Line 8. **[Insert # here]** or **[insert % here]** of the appeals were withdrawn by the enrollee.

[**NOTE**: When the decision is not fully in favor of the enrollee, or when the decision is not completed within the required time, as specified in 42 CFR 422.590, the case is automatically sent to the IRE.]

Line 9. For all appeals received by **[Organization Name]** between **[sample 12-month period: 04/01/06** through **03/31/07]**, **[insert # here]** cases were sent to the IRE for review.

Instructions: This number should be the same as the number in line #7, provided that organizations forwarded all case files to CMS' IRE in a timely manner.

Of those cases:

[**NOTE**: Partial denials should be recorded as not decided fully in favor of the enrollee.]

Line 10. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the IRE were decided fully in favor of the enrollee.

Line 11. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the IRE were not decided fully in favor of the enrollee.

Line 12. **[Insert # here]** or **[insert % here]** were withdrawn by the enrollee.

Line 13. **[Insert # here]** or **[insert % here]** are still awaiting a decision by the IRE.

In certain situations, the Medicare Advantage organization is required to process an appeal faster because delay in making a decision could cause serious harm to enrollees. This is called an expedited appeal. In many cases, it is the Medicare Advantage organization that decides whether or not to expedite the appeal.

Instructions: The following measurements are meant to reveal how often the Medicare Advantage organization granted requests for the expedited processing of an appeal. (Expedited organization determinations are not covered by this measure.)

Line 14. Between **[sample 12-month period: 04/01/06** through **03/31/07]** **[Organization Name]** received **[insert # here]** requests for expedited processing for appeals.

Of those cases:

Line 15. **[Insert # here]** or **[insert % here]** of the requests for expedited processing of the appeal were granted.

Instructions: This line includes cases where the decision was to expedite.

Quality of Care Grievance Data

Line 1. Time Period Covered: **[Sample Reporting Period lasts from 1/1/07 through 6/30/07, which includes data collected from 10/1/05 through 9/30/06, and 7/1/07 through 12/31/07 which includes data collected from 4/1/06 through 3/31/07].**

Line 2. Total number of Quality of Care Grievances Received by **[Organization's name: insert # here].**

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

Line 3. Average Number of Enrollees in **[Organization's name]: [insert # here].**

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Quality of Care Grievances received per 1,000 enrollees **[insert # here].**

Instructions: This number is calculated by multiplying the total number of grievances (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the reporting period (line #3).

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

In addition to reporting raw data to beneficiaries, Medicare Advantage organizations also must explain what the numbers mean in a separate report. See Appendix 2 for standardized language.

Explaining Appeal and Quality of Care Grievance Data Reports

The standardized language included in **Appendix 2** provides both contextual information and, where possible, offers an explanation about what the data provided by a Medicare Advantage organization might suggest to a beneficiary. By doing so, Medicare Advantage organizations will help beneficiaries make a connection between the processing and disposition of appeals.

On page 4 of **Appendix 2**, the report provides background regarding independent reviews. For example, one sentence states that an independent review provides an opportunity for a new, fresh look at the appeal outside of the plan. Also, in an effort to explain why the IRE might disagree with XYZ organization, the report offers that the IRE may have had more information about the appeal.

Medicare Advantage organizations will meet the disclosure requirements set forth in the regulations at **42 CFR 422.111(c)(3)** by utilizing the report found at Appendix 2.