MEDICARE PART C
REPORTING REQUIRMENTS
Contract Year 2009

September 2008

Attachment II: Part C Reporting Requirements Detail

Measure Category	**Type Plan**	**Data Elements**	**Objective/Justification**	**Requirements that Support Measure**
1. Benefit Utilization	CCP, PFFS, Demo, MSA, (includes all 800 series plans), Employer/Union Direct Contract-	For each service category: • # member months of enrollees covered by benefit • # enrollees utilizing benefit • utilization type • total plan reimbursement • total member cost sharing • total Medicare covered allowed cost • Total utilization • Medicare actuarial equivalent cost sharing Note: Service cost data will be considered as proprietary. (See attached chart entitled "Medicare Advantage Medical Utilization and Expenditure Experience" for more detail) Only rebates applied to A/B services are to be included in reporting of rebates. Collection frequency is once on annual basis.	CMS needs to determine if Part A & B rebates are being used to increase access to care and/or to improve care. Congress has requested data regarding the utilization of MA benefits by plan enrollees. To date, CMS has not collected utilization and expenditure data to enable it to accommodate Congress' request nor to analyze the use of MA rebate dollars. Under a proposed rule entitled "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009" (CMS-1390-P), CMS would have the authority to require MA organizations to submit encounter data for each item and service provided to the MA enrollee. However, there is no schedule of collection of encounter data contained in the proposed rule. We expect that there will be one year of overlap in the collection of encounter data and Part C reporting of benefit utilization.	42 CFR, Subpart K 422.516 (a) each MA must have an effective procedure to develop, compile, evaluate, and report to CMS statistics and other information on (2) Patterns of utilization of its services.

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2. Procedures	CCP, PFFS, Demo, MSA, SNPs (includes all 800 series plans), Employer/ Union Direct Contract	# enrollees receiving each of following procedures: • Cardiac Catheterization • Open coronary angioplasty • PTCA or Coronary Atherectomy with CABG • PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent (s) • PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent (s) • PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent • Joint Replacements (Hip/Knee) • Transplants (Heart/Heart/Lung ,Kidney Liver, Lung, Pancreas, Kidney) • Gastric Bypass • Cancer Surgeries (Lung, Large Intestine, Breast, Prostate) CMS has defined the codes in Attachment V. Collection frequency is once on annual	Plans with lower than expected rates of these procedures may have barriers to care. CMS will look for outliers in rates of "semi-elective procedures." PFFS set includes current HEDIS measures. Non-PFFS set includes only those measures not currently collected.	42 CFR Subpart K 422.516 (a) each MA must have an effective procedure to develop, compile, evaluate, and report to CMS statistics and other information on (3) availability, accessibility, and acceptability of its services

		basis. Plans already submitting any of these measures via HEDIS can continue to report these measures through HEDIS and are exempt from reporting separately on those measures.		

Measure Category	**Type Plan**	**Data Elements**	**Objective/Justification**	**Requirements that Support Measure**
3. Serious Reportable Adverse Events	CCP, PFFS, Demo, MSA, SNPs (includes all 800 series plans), Employer/ Union Direct Contract	• # surgeries on wrong body part • # surgeries on wrong patient • # wrong surgical procedures on a patient • # surgeries with foreign object left in patient after surgery • # surgeries with post-operative death in normal health patient • # total surgeries • Air Embolism • Blood Incompatibility • Stage III & IV Pressure Ulcers • Falls and Trauma, (Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns) • Catheter-Associated UTI • Vascular Catheter-	These events are either on the list of the most serious of the current National Quality Forum (NQF) serious reportable adverse events (http://www.ahrq.gov/downloads/pub/advances/vol4/Kizer2.doc.) or on the list of hospital acquired conditions that have payment implications per final rule "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates", 42 CFR Parts 411, 412, 413, and 489 [CMS–1533–FC] RIN 0938–AO70. Plans with any of these events should take steps to get at root causes and implement procedures to guard against the events from happening again. CMS will compare MA organizations on these measures in order to identify outliers. CMS will then attempt to determine the reasons for unusually high or low rates on these measures.	42 CFR Subpart E 422.516 (a) each MA must have an effective procedure to develop, compile, evaluate, and report to CMS statistics and other information on (4) To the extent practical, developments in the health status of its enrollees.

		Associated Infection • SSI (Mediastinitis) after CABG • SSI after certain Orthopedic Procedures • SSI following Bariatric Surgery for Obesity • DVT and pulmonary embolism following certain orthopedic procedures • Manifestations of Poor Glycemic Control CMS has defined the codes in Attachment V Collection frequency is once on annual basis.		

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
4. Provider Network Adequacy and Stability	CCP, 1876 Cost, Demo (includes all 800 series plans)	Data elements are: A) Number of primary care physicians (PCPs) in network on first day of reporting period by type of PCP B) Number of PCPs in network continuously through reporting period by type of PCP C) Number of PCPs added to network during reporting period by type of PCP D) Number of PCPs accepting new patients at start of reporting period by type of PCP E) Number of PCPs accepting new patients at end of reporting period by type of PCP F) Number of PCPs in network on last day of reporting period by type of PCP G) Number of specialists in network on first day of reporting period by type of specialist/facility H) Number of specialists in network continuously through reporting period by type of specialist/facility I) Number of specialists added during reporting period by type of specialist/facility L) Number of specialists in	CMS does not have mechanism for assuring continued network adequacy. CMS permits MAOs to count as Primary Care Providers (PCPs) as physicians that practice general medicine, family medicine, internal medicine, obstetricians, pediatricians, and state licensed nurse practitioners. This is consistent CMS' longstanding policy for determining network adequacy for new applicants. The ten other provider and facility types are: (1) Hospitals, (2) Home Health Agencies (Medicare Certified), (3) Cardiologist, (4) Oncologist, (5) Pulmonologist, (6) Endocrinologist , (7) Skilled Nursing Facilities, (8) Rheumatologist, (9) Ophthalmologist, and 10 (Urologist). This will not increase reporting burden since the provider/facility grouping are now consistent with HSD definitions.	42 CFR Subpart E 422.204 (a) An MA organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform to the credential and recredentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in 422.205.

		network on last day of reporting period by type of specialist/facility Reporting frequency is on an annual basis.		

<table>
<tr><th>Measure category</th><th>Type Plan</th><th>Data Elements</th><th>Objective/Justification</th><th>Requirements that Support Measure</th></tr>
<tr>
<td>5. Grievances</td>
<td>CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract</td>
<td>Data elements are to be entered into HPMS, at the MA Plan level.

Number of grievances in following categories:

<table>
<tr><th>Category of Grievance</th></tr>
<tr><td>fraud/abuse</td></tr>
<tr><td>enrollment/disenrollment access/benefit package</td></tr>
<tr><td>marketing</td></tr>
<tr><td>confidentiality/privacy</td></tr>
<tr><td>quality of care</td></tr>
<tr><td>Grievances related to expedited requests</td></tr>
<tr><td>other grievances</td></tr>
</table>

Data will be collected quarterly.</td>
<td>A grievance is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of an MA organization, regardless of whether remedial action is requested.

A quality of care grievance is one in which the plan must determine whether the quality of services (including both inpatient and outpatient services) provided by the plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings. A grievance must be expedited if (1) the complaint involves an MAO’s decision to invoke an extension in an organization determination or reconsideration or (2) if the complaint involves An MAO’s refusal to grant a request for an expedited organization determination or reconsideration. MAOs are required to track and maintain records on all grievances received both orally and in writing.
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<td>42 CFR Subpart M 422.564 (g) The MA organization must have an established process to track and maintain records on all grievances received both orally and in writing

42 CFR Subpart K 422.516 (a) (6) each MAO must have an effective procedure to develop, compile, evaluate and report to CMS statistics and other information on other matters that CMS may require</td>
</tr>
</table>

<table>
<tr><th>Measure category</th><th>Type Plan</th><th>Data Elements</th><th>Objective/Justification</th><th>Requirements that Support Measure</th></tr>
<tr>
<td>6. Organization Determina-tions/ Reconsidera-tions</td>
<td>CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract</td>
<td>Data elements are to be entered into HPMS, at the MA Plan level shown below:

Determinations
<table>
<tr><td>Type</td></tr>
<tr><td>Fully favorable</td></tr>
<tr><td>Partially favorable</td></tr>
<tr><td>Adverse</td></tr>
</table>
Reconsiderations:
<table>
<tr><td>Type</td></tr>
<tr><td>Fully favorable</td></tr>
<tr><td>Partially favorable</td></tr>
<tr><td>Adverse</td></tr>
</table>
Data reported quarterly.</td>
<td>42 CFR Subpart M includes regulations regarding organization determinations under Part C. Organization determinations are defined in §422.566 and include determinations made by an MA organization with respect to coverage or payment of services.

42 CFR Subpart K provides CMS with the authority to collect data on matters that CMS may require.

42 CFR Subpart M includes regulations regarding reconsiderations under Part C. As defined in §422.580, a reconsideration consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or the MA organization or CMS obtains.

Plans will be responsible for reporting several data elements related to these activities.</td>
<td>42 CFR Subpart M 422.566 – 422.576 Each MAO must have a procedure for making timely organization determinations regarding the benefits an enrollee is entitled to receive under the MA plan, including basic benefits and mandatory and optional supplemental benefits, and the amount, if any, that the enrollee is required to pay for a health service.

42 CFR Subpart K 422.516 (a) (6) each MAO must have an effective procedure to develop, compile, evaluate and report to CMS statistics and other information on other matters that CMS may require</td>
</tr>
</table>

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, Demo, MSA (includes sponsors of individual plans and 800 series plans)	• Employer Legal Name • Employer DBA Name • Employer Federal Tax ID • Employer Address • Type of Group Sponsor (employer, union, trustees of a fund) • Organization Type • Type of Contract (insured, ASO, other) • Employer Plan Year Start Date • Current/Anticipated enrollment First 4 bullets are proprietary data. Reporting frequency is twice annually.	CMS does not collect any information on the employer and union group plan sponsors that contract with MAOs to offer benefits. This information is needed to monitor these plans effectively and to ensure that our statutory waiver authority (which requires there to be employer or union group plan coverage) is being used in accordance with our statutory mandates.	42 CFR, Subpart K 422.516 (a) each MA must have an effective procedure to develop, compile, evaluate, and report to CMS statistics and other information on (6) other matters that CMS may require. Statutory employer group waiver authority in Sections 1857(i) (MAOs) and Section 1860D-22(b) (PDPs) of the Social Security Act

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
8. Enrollment Verification Calls	PFFS	• The number of times the PFFS reaches the prospective enrollee with the first call of up to three required attempts in reporting period • Number of follow-up educational letters sent in reporting period • Number of enrollments in reporting period Reporting frequency is once on annual basis. Enrollments though self enrollment via the Medicare web site or though 1-800-medicare are excluded from this measure.	Will measure whether PFFS plan is completing required enrollment verification activities for its new members; Will identify which PFFSs are 'losing' the highest proportion of prospective members during the enrollment verification process—suggesting PFFSs most likely to have poor marketing practices. PFFS plans can be analyzed by cohorts of like plans (i.e., by geography or enrollment size) and low-end outliers identified by running a frequency distribution for each cohort.	42 CFR Subpart B 422.50 Eligibility to elect an MA Plan.

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
9. Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans) , Employer/ Union Direct Contract	• # Provider Payment Denials Overturned in Favor of Provider upon Appeal • # Provider Payment Appeals • # Provider Payment Appeals Resolved in greater than 60 days Reporting frequency is once per year.	PFFS plans must a have a provider payment dispute resolution in place to consider provider allegations of improper payment in timely and reasonable manner; CMS presently has no data on these processes and these measures will identify poor performers for audit and referral to CMS's in-coming PFFS Payment Adjudication. All measures can be analyzed by cohorts of like plans (i.e., by product type, geography, or enrollment size) and low-end outliers identified by running a frequency distribution for each cohort.	The prompt pay requirement that requires PFFS plans to pay clean claims within 30 days is located at §422.520(a). PFFS MAOs must have a provider dispute resolution process in place per CFR 42, Subpart M 422.608 Medicare Appeals Council Review; CMS Model PFFS Terms and Conditions

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
10. Commission Structure	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)	In 2009, only new enrollee data are involved. In 2010, the data pertain to both new enrollees and retained enrollees. For the CY 2009 reporting period, MAOs will report the following data elements: A) Number of licensed marketing representatives who are employees of the MAO for reporting period who made a Part C or Part D sale. B) Number of licensed independent agents for reporting period who made a Part C or Part D sale and who received compensation related to the volume of sales. C) Number of beneficiaries making an enrollment change in 2009 for which an agent was involved as defined above in (A) or (B) by agent type. D) Initial total agent compensation (related to volume of sales) for enrolling beneficiaries making an enrollment change in 2009 for which an agent was involved as defined above in (A) or (B) by agent type.	The relevant proposed MIPPA revision is as follows: The first year commission or other first year compensation can be no more than 200 percent of the commission or other compensation paid for selling or servicing the enrollee in the second year and subsequent years. If commission or other compensation is paid in the first year, renewal commission or other compensation must be paid for no fewer than 5 renewal years. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing plan on renewal policies if an existing policy is replaced with a like plan type during the first year and 5 renewal years. Note: Agent compensation data will be considered to be proprietary.	42 CFR, Subpart K 422.516 (a) each MA must have an effective procedure to develop, compile, evaluate, and report to CMS statistics and other information on (6) other matters that CMS may require. Requirements under CMS-4131-IFC support measure. .

		For the CY 2010 and subsequent reporting periods, MAOs will report the following data elements: A) Number of licensed marketing representatives who are employees of the MAO for reporting period and who made a Part C or Part D sale and who received compensation related to the volume of sales. B) Number of licensed independent agents for reporting period and who made a Part C or Part D sale. C) Number of beneficiaries making an enrollment change in reporting period for which an agent was involved as defined above in (A) or (B) by agent type. D) Number of beneficiaries retained in reporting period for which an agent was involved as defined above in (A) or (B) by agent type. E) Total agent compensation (related to volume of sales) for enrolling beneficiaries making a plan change in reporting period for which an agent was involved as defined above in (A) or (B) by agent type. F) Number of agents who received compensation for		

		retained enrollees. G) Total agent compensation (related to volume of sales) for beneficiaries retained from previous reporting period for which an agent was involved as defined above in (A) or (B) by agent type. Reporting frequency is once per year.		

Measure	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
11. Training and Testing	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)	• Total # agents in contract year • # agents in contract year who completed training successfully • # agents in contract year with a passing score of 85% or above on first testing • Average scores of agents in contract year with a passing score of 85% or above on first testing • # agents taking second test • # agents in contract year with a passing score of 85% or above on second testing • Average scores of agents in contract year with a passing score of 85% or above on second testing • # agents in contract year taking test 3 + times CMS is requesting data on licensed marketing representatives who are employees of the MAO and licensed independent agents. Collection frequency is once on annual basis. The passing score is 85% in 2009.	Agents must be trained in order to accurately represent plan benefits and the MA program to prospective enrollees. Testing is an accepted indicator of training success.	In CMS 4131-IFC, MA organizations would be required to train all agents selling Medicare products on Medicare rules, regulations and compliance-related information. Also, in 422.2274(c) and 423.2274(c), agents selling Medicare products would be required to pass written or electronic tests on Medicare rules, regulations and information on the plan products they intend to sell. A requirement for PDPs the same as this one will be in the 2010 Part D reporting revisions.

Measure	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
12. Plan oversight of agents	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) -	A) Number of agents B) Number of agents investigated based on complaints C) Number of agents receiving disciplinary actions based on complaints D) Number of complaints reported to State by MAO E) Number of agents whose selling privileges were revoked by the plan based on conduct or discipline F) Number of agent-assisted enrollments Reportable revocations of selling privileges are those that stem specifically from marketing conduct. Disciplinary action is defined as "all forms of corrective and disciplinary action ((i.e., agents who were alerted to a compliance infraction, directed to retake training certifications)." CMS is requesting data on licensed marketing representatives who are employees of the MAO and licensed independent agents. Reporting is quarterly.	Plans are responsible for monitoring the conduct of their agents. The states oversee the agent's license so plans should be working closely with states on agent conduct issues. CMS will monitor agent complaints to determine if organizations are investigating identified complaints and imposing disciplinary actions as well reporting poor conduct to the state.	42 CFR, Subpart K 422.516 (a) In 422.2274(e) and 423.2274(e), of "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-IF), MA organizations would be required to comply with State requests for information about the performance of licensed agents or brokers as part of a state investigation into the individual's conduct. A requirement for PDPs the same as this one will be in the 2010 Part D reporting revisions.

Measure	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
13. SNPs Care Management	SNPs	• # new enrollees • # enrollees eligible for an annual reassessment • # initial assessments performed on new enrollees during reporting period • # annual reassessments performed on enrollees eligible for a reassessment Data to be reported annually	Special needs individuals" (SNP) were identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions. The initial assessment of enrollees' physical, psychological, and functional needs as well as an annual reassessment of these needs is a crucial element to effective care management.	Section 164 of MIPPA requires all SNPs to have an evidenced-based model of care with appropriate networks of providers and specialists. The plans would be required to: Conduct an initial assessment and annual reassessment of each enrollee's physical, psychological, and functional needs. Develop a plan that identifies goals and objectives, measurable outcomes, and specific services and benefits to be provided. Use an interdisciplinary team in the care management.