MEDICARE PART C
REPORTING REQUIRMENTS
Contract Year 2009

~~June 2008~~
September 2008

Attachment II: Part C Reporting Requirements Detail

Measure Category	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
1. Benefit Utilization	~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ CCP, PFFS, 1876 Cost, Demo, MSA, SNPs (includes all 800 series plans), Employer/Union Direct Contract	For each service category: • ~~# enrollees with benefit~~ • # member months of enrollees covered by benefit • # enrollees utilizing benefit • utilization type (e.g., visits, days) • total plan reimbursement • total member cost sharing • total Medicare covered allowed cost • ~~supplemental benefits~~ • Total utilization • Medicare actuarial equivalent cost sharing (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. ~~CMS will define the procedure codes. Collection frequency is once on annual basis.~~ ~~We will collect 2007 and 2008~~	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.

		~~data in contract year 2009. After 2009, we will collect data for previous contract year only.~~ Collection frequency is once on an annual basis.		
2. Procedures	~~All PFFS and 800 series plans~~ ~~All CCP, 1876 cost, demo, MSA, and Nation-al PACE plans~~ CCP, PFFS, Demo, MSA, SNPs (includes all 800 series plans), Employer/ Union Direct Contract-	• ~~# total enrollees in plan~~ • ~~# enrollees receiving each of following procedures:~~ • ~~total hip replacement~~ • ~~total knee replacement~~ • ~~organ transplants by organ (categories: bone marrow, heart, heart/lung, kidney, liver, lung, pancreas, kidney/pancreas, intestinal)~~ • ~~cardiac catheterization,~~ • ~~coronary artery bypass graft (CABG)~~ • ~~gastric bypass~~ • ~~cancer surgeries (lung, breast, prostate, colon)~~ ~~Collection frequency is once on annual basis. Attachment aa contains the ICD-9 CM codes for all the measures.~~ • ~~# total enrollees~~ • ~~# enrollees receiving each of following procedures:~~	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." ~~Procedure rate= (# enrollees receiving procedure / total # enrollees) x 1000~~ 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

		~~• gastric bypass~~ ~~• organ transplants by organ (as listed above)~~ ~~• cancer surgeries (lung, breast, prostate, colon)~~ ~~Collection frequency is once on annual basis.~~ # 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 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	~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~	~~• # 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~~ ~~• Catheter-Associated Urinary Tract Infection (UTI)~~ ~~• Vascular Catheter-Associated Infection~~ ~~• Surgical Site Infection-Mediastinitis after CABG~~ • # surgeries on wrong body part • # surgeries on wrong patient • # wrong surgical procedures on a patient • # surgeries with foreign	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. ~~Rates will be calculated as follows: adverse surgical event rate= (# surgeries with specified adverse event / total # surgeries) x 1,000,000 adverse medical event rate= (# specified adverse events / total medical admissions) x 1,000,000~~	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 .

		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-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	~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ CCP, 1876 Cost, Demo (includes all 800 series plans)	~~Number of:~~ • ~~primary care physicians (PCPs) in network on first day of reporting period (RP)~~ • ~~PCPs in network continuously through RP~~ • ~~PCPs added to network during RP~~ • ~~PCPs accepting new patients at start of RP~~ • ~~PCPs accepting new patients at end of RP~~ • ~~PCPs in network on last day of RP~~ • ~~Specialists in network on first day of RP~~ • ~~Specialists in network continuously through RP~~ • ~~Specialists added during RP~~ • ~~Specialists accepting new patients at start of RP~~ • ~~Specialists accepting new patients at end of RP~~ • ~~Specialists in network on last day of RP~~ • All MAOs that coordinate care will be required to report this	~~CMS does not have mechanism for assuring continued network adequacy. The following rates will be calculated:~~ ~~PCP adequacy rate = # PCPs in network last day of RP / # PCPs in network first day RP~~ ~~Specialist Adequacy Rate = # specialists in network last day of RP/ # specialists in network first day of RP~~ ~~PCP stability rate = # PCPs in network last day of RP who were in network first day of RP / # PCPs in network first day RP~~ ~~PCP open practice rate at start of RP = # PCPs accepting new patients on first day of RP / # PCPs in network on first day of RP~~ ~~PCP open practice rate at end of RP = # PCPs accepting new patients on last day of RP / # PCPs in network on last day of RP~~ ~~Specialist stability rate =# specialists in network on last day of RP who were in network on first day of RP / # specialists in network on first day of RP~~ ~~Specialist open practice rate at start of RP = # specialists accepting new patients on first day of RP / # specialists in network on first day of RP~~ ~~Specialist open practice rate at end of RP = # specialists accepting new patients on last day of RP / # specialists in network on last day of RP~~ CMS permits MAOs to count as	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.

		measure, which will include the following data elements: 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	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 with 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. The reporting frequency will be once on an annual basis.	

		of specialist/facility J) Number of specialists in network on last day of reporting period by type of specialist/facility The reporting frequency will be once 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>~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ 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>
<tr><td>total 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 related to expedited requests occurs when an enrollee requests an expedited grievance but it is not granted. The enrollee has 72 hours to file that grievance.~~

~~MAOs are required to track and maintain records on all grievances received both orally and in writing.~~

~~Grievance rate (for each category and overall) = (# grievances = / # enrollees) x 1000~~</td>
<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>

			. 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.	

<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 Determinations / Reconsiderations</td>
<td>~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ 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>
<tr><td>~~Total substantive determinations issued~~</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>
<tr><td>~~Total substantive reconsiderations issued~~</td></tr>
</table>
Data will be 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 payment or 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.

These procedures include reconsideration by the Plan

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	~~PFFS~~ 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 ~~All individual MA plans and "800 series" MA Plans sponsored by employer groups will report.~~ Collection 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 using either individual or "800 series" Medicare plans. 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	~~• Number of initial enrollee taken enrollment verification calls completed in reporting period~~ • the number of times the MAO 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 Collection 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 MAOs are 'losing' the highest proportion of prospective members during the enrollment verification process—suggesting MAOs 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. ~~Calculated rate is as follows:~~ ~~Rate of enrollment verification completion=# of verification calls completed + number of follow-up letters sent / # enrollments in reporting period; canceled enrollments is the remaining difference~~	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~~ PFFS (includes all 800 series plans) , Employer/ Union Direct Contract	• ~~# Claims Rejected on First Submission (i.e., not clean)~~ • ~~# of Clean Claims processed~~ • ~~# of Clean Claims paid in 30 days or less~~ • # Provider Payment ~~Appeals~~ 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.	~~Claims payment accuracy and timeliness are among the most common complaints against PFFS. CMS is presently without a mechanism for measuring PFFS MAO performance in this area. 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.~~ ~~# Claims Rejected on First Submission (i.e., not clean) / Total # submitted Claims processed.~~ ~~# of Clean Claims paid in 30 days or less / Total # of Claims processed~~ ~~# Provider Payment Appeals Overturned in Favor of Provider / # of Provider Payment Appeals~~ ~~# Provider Payment Appeals Resolved in greater than 60 days / # of Provider~~	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

			~~Payment Appeals~~ 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.	

<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>10. Commission Structure</td>
<td>All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)</td>
<td>Number of captive agents, number of contract agents for reporting period. Also, for captive agents:

<table>
<tr><th>Meas.</th><th colspan="3">Year</th></tr>
<tr><th></th><th>2009</th><th>2008</th><th>2007</th></tr>
<tr><td>Average Salary</td><td></td><td></td><td></td></tr>
<tr><td>Average Total Com-mission</td><td></td><td></td><td></td></tr>
</table>

For contract Agents:

<table>
<tr><th>Meas.</th><th colspan="3">Year</th></tr>
<tr><th></th><th>2009</th><th>2008</th><th>2007</th></tr>
<tr><td>Average Total Com-mission</td><td></td><td></td><td></td></tr>
</table>

For the CY 2009 reporting period, MAOs will report the following data elements:

A) Number of licensed</td>
<td>Variance in commission structure by organization and product type can lead to steering beneficiaries to plans that are the most profitable for the agent. CMS will use these data to compare commission structures by organization, captive and contracted agents, product type, and rapid disenrollment rates to identify outliers. Rates will be as follows:
Captive agent rate=(# of Captive agents / # enrollees) x 1000
Contracted agent rate=(# of Contracted agents / # enrollees) x 1000
Total agent rate =(total # agents/ # enrollees) x 1000
Total compensation increase rates of all agents
across all 3 years (current vs. previous as an example) = (average total compensation current year/average total compensation previous year) – 1.

It is assumed that we will collect 3 years of data if the “minibus reg” is not final. Otherwise, we will collect one year of data (2009), because the commission structure is set.

The relevant proposed MIPPA revision is</td>
<td>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

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.

.</td>
</tr>
</table>

		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. 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. 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. B) Number of licensed independent agents for reporting	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.	

		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. F) 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	~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ 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. CMS will use these data to determine if all agents completed training and testing, if minimum passing score should be raised, and if captive agents score better than contracted agents. The rates will be calculated as follows for both captive and contracted agents:~~ ~~Training completion rate= # of agents who completed training / # agents~~ ~~First test training completion rate= # of agents with passing score of 80% or above on first test/ # agents~~ ~~Second Test training Completion Rate= # of agents with passing score of 80% or above on second testing / # agents taking second test~~ ~~Rate of agents taking test 3+ times= # of agents that repeated tests 3 or more times / # agents~~ ~~Average score of agents with passing score~~	~~In 422.2274(b) and 423.2274(b) of proposed rule, published in FR on 5/16/08, and entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-P), 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~~

		• Reporting frequency is once per year. ~~Total # agents in current year~~ • ~~# agents in index year who completed training successfully~~ • ~~# agents in index year with a passing score of 80% or above on first testing~~ • ~~Sum of scores of agents in index year with a passing score of 80% or above on first testing~~ • ~~# agents taking second test~~ • ~~# agents in index year with a passing score of 80% or above on second testing~~ • ~~Sum of scores of agents in index year with a passing score of 80% or above on second testing~~ • ~~# agents in index year taking test 3 + times~~ • • ~~Collection frequency is once on annual basis.~~ ~~The passing score is 80% in 2009. CMS has the option of setting another score (likely higher) in~~	~~= Sum of individual passing scores / # agents with passing score~~ 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.	~~requirement for PDPs the same as this one will be in the 2010 Part D reporting revisions.~~ 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.

		2010.		

Measure	Type Plan	Data Elements	Objective/Justification	Requirements that Support Measure
12. Plan oversight of agents	~~All CCP, PFFS, 800 series, 1876 cost, demo, MSA, and Nation-al PACE plans~~ CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans)	~~For both captive and contractual agents~~ ~~• # agents~~ ~~• # agents investigated based on complaints (subset of 1 above)~~ ~~• # agents receiving disciplinary actions based on complaints (subset of 2 above)~~ ~~• # of complaints reported to State by MAO~~ ~~• # of agents whose selling privileges were revoked by the plan based on conduct or discipline~~ 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	~~Plans are responsible for monitoring the conduct of captive and contracted 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.~~ ~~For both captive and contracted agents, the following rates will be calculated:~~ ~~Agent investigation rate=# of agents investigated based on complaints / # agents~~ ~~Disciplinary action rate= # of agents receiving disciplinary actions based on complaints / # complaints~~ ~~Complaints reported to state rate= # of complaints reported to State by the organization / # enrollees~~ ~~Agent revocation of selling rights rate=# of agents whose selling privileges were revoked by the plan based on conduct/discipline / # agents~~ Plans are responsible for monitoring the	~~42 CFR, Subpart K 422.516 (a)~~ ~~In 422.2274(e) and 423.2274(e), of proposed rule "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-P), 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.~~ ~~42 CFR, Subpart K 422.516 (a)~~ In 422.2274(e) and 423.2274(e), of

		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 frequency is once per year.	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.	"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.