

Medicare Part C Plan Reporting Requirements
Technical Specifications Document
Contract Year 2016

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BACKGROUND AND INTRODUCTION

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled “Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program” (CMS 4131-F).

This document provides a description of the reporting sections,¹ reporting timeframes and deadlines, and specific data elements for each reporting section.

The technical specifications contained in this document should be used to develop a common understanding of the data, to assist organizations in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for organizations to correct and resubmit data.

Each Part C Reporting Requirement reporting section of this document has the following information presented in a standardized way for ease of use:

- A. Data element definitions - details for each data element reported to CMS.
- B. Notes - additional clarifications to a reporting section derived from the responses to comments received under the OMB clearance process.
- C. **Reminder: Underlined passages indicate updates and/or new information from the last version including draft versions.**

GENERAL INFORMATION

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type and reporting section. Most reporting sections will be reported annually.

Reporting Part C Data: The information here should be used (unless otherwise indicated, or instructed by CMS) for reporting from this point forward.

The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA):*

- Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Sponsors), Agent/Broker Name, and Beneficiary Name.

*Under FOIA, Plans may need to provide independently justification for protecting these data if a FOIA request is submitted.

¹ The term “measure” has been replaced with the term “reporting section” effective 2013.

In order to provide guidance to Part C sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.

Exclusions from Reporting

National PACE plans and 1833 cost plans are excluded from reporting all Part C Reporting Requirements reporting sections.

Suspended from Reporting:

Reporting section # 1 *Benefit Utilization*;
Reporting section # 2 *Procedure Frequency*;
Reporting section # 3 *Serious Reportable Adverse Events*;
Reporting section # 4 *Provider Network Adequacy*;
Reporting section #10 *Agent Compensation Structure*;
Reporting section #11 *Agent Training and Testing*;

Major Changes from CY 2015 Technical Specifications

Two reporting sections Reporting Section # 6 (*Organization Determinations/Reconsiderations*), and Reporting Section #14 (*Enrollments/Disenrollments*) were updated to include additional data elements. In addition, three new reporting sections were added: *Rewards and Incentives Program*, *Mid-Year Network Changes*, and *Payments to Providers*. Reporting Section # 12 *Plan Oversight of Agents* was changed to *Sponsor Oversight of Agents* and the data due date was changed to the first Monday in February of the following year. The dues dates for *Grievances and Employer Group Plan Sponsors* were also changed to the first Monday in February. The due dates for *Enrollment/Disenrollment* were changed to last Monday of August and February.

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline. CMS expects that data are accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late and may not be incorporated within CMS data analyses and reporting. Only data reflecting a good faith effort by an organization to provide accurate responses to Part C reporting requirements will be counted as data submitted in a timely manner.

If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY.

Organizations failing to submit data, or submitting data late and/or inaccurately, will receive compliance notices from CMS.

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, Part C Sponsors should request the opportunity to correct and resubmit data. Corrections of previously submitted data are appropriate if they are due to an error made at the date of the original submission, or as otherwise indicated by CMS. Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit data via the HPMS Plan Reporting Module. Resubmission requests may only be submitted after the original reporting deadline has expired. In order to accommodate data validation activities, data corrections may only be submitted until March 31st following the last quarter or end of year reporting deadline. CMS reserves the right to establish deadlines after which no further corrections may be submitted. Detailed instructions on resubmissions may be found on the starter page of the HPMS Plan Reporting Module User Guide.

Due Date Extension Requests

Generally speaking, CMS does not grant extensions to reporting deadlines, as these have been established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current version of the Technical Specifications to prepare the data to be submitted in a timely fashion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit. CMS will consider appropriate “Resubmission Requests” through the Plan Reporting Module (PRM).

Periodic Updates to the Technical Specifications

If CMS, through questions raised by plans, clarifies the prior technical specifications for a data element, CMS requires that plans incorporate this change for the entire reporting period. CMS has established the following email address for collecting all questions regarding the Part C Technical Specifications: PartCplanreporting@cms.hhs.gov. Plans should be aware that immediate responses to individual questions may not always be possible given the volume of email this box receives. CMS recommends that plans first refer to the current Medicare Part C Reporting Requirements Technical Specifications for answers or, when appropriate, contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov.

Reporting Requirement Reporting Sections List

The following summary table provides an overview of the parameters around each of the current Part C reporting requirements reporting sections.

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization	Suspended			
2. Procedure Frequency	Suspended			
3. Serious Reportable Adverse Events	Suspended			
4. Provider Network Adequacy	Suspended			
5. Grievances (Revised)	CCP, PFFS, 1876 Cost, MMP, MSA, Employer/Union Direct Contract (includes all 800 series plans)	<u>1/Year Contract</u>	<u>1/1-3/31</u> <u>4/1-6/30</u> <u>7/1-9/30</u> <u>10/1-12/31</u> <u>(2/28 reporting will include each quarter)</u>	<u>First Monday of February in following year</u>
6. Organization Determinations/ Reconsiderations (Revised)	CCP, PFFS, 1876 Cost, MMP, , Employer/Union Direct Contract MSA (includes all 800 series plans)	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 <u>(2/28 reporting will include each quarter)</u>	<u>Last Monday of February in following year</u>
7. Employer Group Plan Sponsors	1/year PBP	1/1 - 12/31		<u>First Monday of February in following year</u>
8. PFFS Plan Enrollment Verification Calls	PFFS (800-series plans should NOT report)	1/year PBP	1/1-12/31	<u>Last Monday of February in following year</u> Validation unnecessary— using for monitoring only

Reporting Section	Organization Types Required to Report	Report Freq./	Reporting Section	Organization Types Required to Report
9. PFFS Provider Payment Dispute Resolution Process	PFFS, Employer/Union Direct Contract (includes all 800 series plans)	1/year PBP	1/1-12/31	<u>Last Monday of February in following year</u> Validation unnecessary— using for monitoring only
10. Agent Compensation Structure		Suspended		
11. Agent Training and Testing		Suspended		
12. Plan Oversight of Agents	1876 cost plans, local Coordinated Care Plans (Local CCP), Medicare Savings Accounts (MSA), Provider Fee-For-Service plans (PFFS), and Regional Coordinated Care Plans (Regional CCP).	<u>Revised</u>	1/1-12/31	<u>First Monday of February in following year</u>
13. Special Need Plans (SNP) Care Management	Local, CCP, Regional CCP, RFB Local CCP with SNPs. Includes 800 series plans.	1/Year PBP	1/1-12/31	<u>Last Monday of February in following year</u>
14. Enrollment/Disenrollment	Only 1876 cost plans with no Part D.*	<u>2/Year Contract</u>	<u>1/1-6/30</u> <u>7/112/31</u>	<u>Last Monday of August and February</u> Validation unnecessary— using for monitoring only

Reporting Section	Organization Types Required to Report	Report Freq./	Reporting Section	Organization Types Required to Report
15. Rewards and Incentives	Local Coordinated Care Plans (Local CCP), Medicare Savings Accounts (MSA), Provider Fee-For-Service plans (PFFS), and Regional Coordinated Care Plans (Regional CCP)	1/Year	1/1-12/31	<u>Last Monday of February in following year</u>
16. Mid-Year Network Changes	Regional CCP, Local CCP, and <u>RFB</u>	1/Year	1/1-12/31	<u>Last Monday of February in following year</u>
17. Payments to Providers	Regional CCP, Local CCP, RFB, and PFFS	1/Year	<u>04 – PFFS</u>	<u>Last Monday of February in following year</u>

* MA-only. MA-PDs and PDPs report under Part D. MSA and chronic care excluded.

Reporting Sections

1. BENEFIT UTILIZATION (SUSPENDED)

2. PROCEDURE FREQUENCY (SUSPENDED)

3. SERIOUS REPORTABLE ADVERSE EVENTS (SUSPENDED)

4. PROVIDER NETWORK ADEQUACY (SUSPENDED)

5. GRIEVANCES

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/28 reporting will include each quarter)	<u>First Monday of February in following year</u>

The data elements to be reported under this reporting section are:

Grievance Category	Total number of Grievances	Number of grievances in which timely notification* was given
Total Grievances	(5.1)	(5.2)
Number of Expedited Grievances	(5.3)	(5.4)
Enrollment/Disenrollment	(5.5)	(5.6)
Benefit Package Grievances	(5.7)	(5.8)
Access Grievances	(5.9)	(5.10)
Marketing Grievances	(5.11)	(5.12)
Customer Service Grievances	(5.13)	(5.14)
Organization determination and reconsideration process grievances	(5.15)	(5.16)
Quality Of Care Grievances	(5.17)	(5.18)
Grievances related to “CMS Issues”	(5.19)	(5.20)
Other Grievances	(5.21)	(5.22)

* Timely notification of grievances means the member was notified according to the following timelines:

- For standard grievances: no later than 30 calendar days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

This reporting section requires upload into HPMS.

In cases where a purported representative files a grievance on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation (“clock”) starts upon receipt of the AOR form. This is a contrast to grievances filed by a beneficiary, in which cases the clock starts upon receipt of the grievance.

For an explanation of Medicare Part C grievance procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: <http://www.cms.gov/MMCAG/>. For an explanation of grievance procedures for MMPs, refer to the State-specific Memorandum of Understanding.

CMS requires plans to use one of 22 categories described in this section to report grievances to CMS (Elements 5.1 – 5.22). For purposes of Reporting Section 5:

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual as “Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their

representative may make the complaint or dispute, orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.”

- For Part C reporting, grievances are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

The category, “Grievances Related to CMS Issues” involves grievances that primarily involve complaints concerning CMS’ policies, processes, or operations; the grievance is not directed against the health plan or providers. The new grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan’s direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan’s direct control, from the total number of grievances filed against the contract

Reporting Inclusions:

Report:

- Only those grievances processed in accordance with the grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances).
- Report grievances involving multiple issues under each applicable category.
- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

Reporting Exclusions:

Do not report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). CTM complaints are addressed through a process that is separate and distinct from the plan’s procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.
- Withdrawn grievances.

- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- See CY2014 Part C Plan Reporting Module for specific guidance concerning reporting grievances.
- **Plans should validate that the total number of grievances is equal to the sum of the total number of grievances for each category excluding expedited grievances.**
- **Plans should validate that the total number of timely notifications is equal to the sum of the total number of timely notifications for each category excluding expedited grievances.**
- In cases where an extension is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example, Plan receives grievance on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes investigation and provides notification on 2/5/2014 04:00pm (35 calendar days after receipt). This grievance is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue *prior to* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.
- *For MA-PD contracts:* Include only grievances that apply to the Part C benefit. (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.)

For additional details concerning Reporting Section 5 reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

**6. ORGANIZATION
DETERMINATIONS/RECONSIDERATIONS**

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	01 – Local CCP 02 –MSA 03 – RFB PFFS 04 –PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/28 reporting will include each quarter)	<u>Last Monday of February in following year</u>

Data elements for this reporting section are contained in Table 1. Two new data elements would be added: data element 6.10, Number of Requests for Organization Determinations—Dismissals, and data element 6.20, Number of Requests for Reconsiderations—Dismissals. These additions will fill user needs for data on dismissals and make this reporting section more consistent with a similar reporting section in Part D, Coverage Determinations and Redeterminations.

Table 1: Data Elements for Organization Determinations/Reconsiderations Reporting Section

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Total Number of Organization Determinations Made in Reporting Time Period Above
6.2	Of the Total Number of Organization Determinations in 6.1, Number Processed Timely
6.3	Number of Organization Determinations – Fully Favorable (Services)
6.4	Number of Organization Determinations – Fully Favorable (Claims)
6.5	Number of Organization Determinations – Partially Favorable (Services)
6.6	Number of Organization Determinations – Partially Favorable (Claims)
6.7	Number of Organization Determinations – Adverse (Services)
6.8	Number of Organization Determinations – Adverse (Claims)
6.9	Number of Requests for Organization Determinations - Withdrawn
6.10*	<u>Number of Requests for Organization Determinations - Dismissals</u>
6.11	Total number of Reconsiderations Made in Reporting Time Period Above
6.12	Of the Total Number of Reconsiderations in 6.10, Number Processed Timely
6.13	Number of Reconsiderations – Fully Favorable (Services)
6.14	Number of Reconsiderations – Fully Favorable (Claims)
6.15	Number of Reconsiderations – Partially Favorable (Services)
6.16	Number of Reconsiderations – Partially Favorable (Claims)
6.17	Number of Reconsiderations – Adverse (Services)
6.18	Number of Reconsiderations – Adverse (Claims)
6.19	Number of Requests for Reconsiderations - Withdrawn
6.20*	<u>Number of Requests for Reconsiderations - Dismissals</u>
6.21	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
6.22	Contract Number
6.23	Plan ID
6.24	Case ID

6.25	Date of original disposition
6.26	Original disposition (Fully Favorable; Partially Favorable or Adverse)
6.27	Case level (Organization Determination or Reconsideration)
6.28	Date case was reopened
6.29	Reason(s) for reopening (Clerical Error, New and Material Evidence, or Other)
6.30	Date of reopening disposition (revised decision)
6.31	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

*** Indicates new data element.**

Notes

This reporting section requires both data entry and a file upload.

For an explanation of Part C organization determination, reconsideration, and reopenings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: <http://www.cms.gov/MMCAG/>. For an explanation of reconsideration procedures for MMPs, refer to the State-specific Memorandum of Understanding.

All plan types listed in the table at the beginning of this section are required to report: organization determinations, reconsiderations and reopenings, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee’s representative, a physician or a non-contract provider who signed a Waiver of Liability.

In cases where a purported representative files an appeal on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation (“clock”) starts upon receipt of the AOR form. This is a contrast to appeals filed by a beneficiary, in which case the clock starts upon receipt of the appeal.

For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

Plans are to report encounter data, whereby an encounter took place under a capitation arrangement, as an organization determination. That is, we want plans to report capitated providers’ encounters in lieu of actual claims data. All encounter data should be reported as timely submissions.

Requests for Organization Determinations – Withdrawn (Element 6.9) should not be included in the Total Number of Organization Determinations (Element 6.1).

Requests for Reconsiderations – Withdrawn (Element 6.19) should not be included in the Total Number of Reconsiderations (Element 6.11).

If the Reopening Disposition (Element 6.31) is resolved (Fully Favorable, Partially Favorable, or Adverse), the Date of Reopening Disposition (Element 6.30) is expected to fall in the quarter for which the data is being reported.

CMS requires plans to report organization determinations and reconsiderations requests submitted to the plan. For purposes of Reporting Section 6:

- An **organization determination** is a plan’s response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.
- Reconsideration is a plan’s review of an adverse or partially favorable organization determination.
- A **Fully Favorable** decision means an item or service was covered in whole.
- A **Partially Favorable** decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services were processed, but only 5 were authorized, this would be considered partially favorable.
- An **Adverse** decision means an item or service was denied in whole.
- In contrast to claims (payment decisions), **service authorizations** include all service-related decisions, including pre-authorizations, concurrent authorizations and post-authorizations.
- A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.
- A **withdrawn** organization determination or reconsideration is one that is, upon request, removed from the plan’s review process. This category excludes appeals that are dismissed.
- A **dismissal** is an action taken by a Medicare health plan when an organization determination request or reconsideration request lacks required information or otherwise does not meet CMS requirements to be considered a valid request. For example, an individual requests reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to

show that the individual is legally authorized to act on the enrollee's behalf per the guidance set forth in section 10.4.1 of Chapter 13. The plan must follow Chapter guidance prior to issuing the dismissal

If a provider (e.g., a physician) declines to provide a service an enrollee has requested or offers alternative service, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusion

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.
- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.
- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.
- All partially favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.
- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Reopenings:

- All Fully Favorable, Partially Favorable, Adverse or Pending Reopenings of Organization Determinations and Reconsiderations, as described in the preceding sections.

Report:

- **Completed organization determinations and reconsiderations** (i.e., plan has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are to report organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M and Chapter 13 of the Medicare Managed Care Manual.
- All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.
- **Reopenings** that are in a reopening status across multiple reporting periods are to be reported in each applicable reporting period. For example, if a plan reopened an organization determination on 3/15/2014 and sent the notice of the revised decision on 4/22/2014, that case should be reported as "pending" in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse).
- **Claims with multiple line items** at the "summary level."
- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.
- A denial of **Medicare payment** for item or service as either partially favorable or adverse, regardless of whether Medicaid payment ultimately is provided, in whole or in part, for that item or service.
- Report denials based on exhaustion of Medicare benefits.
- In cases where an **extension** is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example, Plan receives standard pre-service reconsideration request on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes reconsideration and provides notification on 2/5/2014 04:00pm (35 calendar days after receipt). This reconsideration is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.
- Dismissals

Do not report:

- Independent Review Entity (IRE) decisions.

- Reopenings requested or completed by the IRE, ALJ, and MAC.
- Concurrent reviews during hospitalization.
- Concurrent review of SNF, HHA or CORF care.
- Duplicate payment requests concerning the same service or item.
- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made— e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).
- A Quality Improvement Organization (QIO) review of an individual’s request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

For additional details concerning the Reporting Section 6 reporting requirements, see Appendix 1: FAQs: Reporting Sections 5 & 6.

7. EMPLOYER GROUP PLAN SPONSORS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	01 – Local CCP 02 – MSA 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/year PBP	1/1 - 12/31	<u>First Monday of February in following year</u>

Data elements reported under this reporting section are:

Element Number	Data Elements for Employer Group Plan Sponsors
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Is this a calendar year plan? (Y (yes) or N (no))
7.9	If data element 7.8 is no, provide non-calendar year start date.
7.10	Current/Anticipated Enrollment

Notes

All employer groups who have an arrangement in place with the Part C Organization for any portion of the reporting period should be included in the file upload, regardless of enrollment. In this case, plans **should use** the date they have an arrangement in place with the employer group to identify the reporting year. For employer groups maintaining multiple addresses with your organization, please report the address from which the employer manages the human resources/health benefits.

Federal Tax ID is a required field in the file upload. Organizations should work with their employer groups to collect this information directly. Alternatively, several commercially available lookup services may be used to locate this number.

Data Element 7.7 refers to the type of contract the organization holds with the employer group that binds you to offer benefits to their retirees.

For Data Element 7.10, the enrollment to be reported should be as of the last day of the reporting period and should include all enrollments from the particular employer group into the specific plan benefit package (PBP) noted. (If an employer group canceled mid-way through the reporting period, they would still appear on the listing but would show zero enrollments.)

The employer organization type is based on *how* plan sponsors file their taxes.

For organizations that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data, CMS permits these organizations to use the employer address and tax ID information submitted via the MIR to also satisfy CMS' Part C reporting and validation requirements. However, this does not imply that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us again for the purposes of the Part C reporting requirements.

**8. PROVIDER FEE-FOR-SERVICE ((PFFS)
PLAN ENROLLMENT VERIFICATION CALLS;
MONITORING PURPOSES ONLY**

– Validation of this reporting section is not required because these data will be initially used only for monitoring.

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
8. PFFS Plan Enrollment Verification Calls	03 – RFB PFFS 04 – PFFS 800-series plans should NOT report	1/year PBP	1/1- 12/31	<u>Last Monday of February in following year</u>

Data elements to be reported under this reporting section are:

Element Number	Data Elements for PFFS Plan Enrollment Verification Calls
8.1	Number of times the plan reached the prospective enrollee with the first call of up to three required attempts in reporting period
8.2	Number of follow-up educational letters sent in reporting period
8.3	Number of enrollments in reporting period

Notes

This reporting section requires direct data entry into HPMS.

Note that this does not apply to group PFFS coverage. Also, this reporting section only pertains to calls made to individual enrollees.

Plans should tie the reported elements to enrollment effective dates. For example, report for 2016 all those calls and follow-up letters linked to 2016 effective enrollments—including those done in late 2015 for 2016 enrollments. Any enrollment requests received in 2015 (for 2016 effective dates) and calls/letters associated with them would be reported in the 2016 reporting period--not in the 2015 reporting period. Otherwise, the reported elements for this reporting section would not connect for “Annual Coordinated Election Period” (AEP) enrollments.

**9. PFFS PROVIDER PAYMENT DISPUTE
RESOLUTION PROCESS; MONITORING
PURPOSES ONLY**

–Validation of this reporting section is not required because these data will initially be used only for monitoring.

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
9. PFFS Provider Payment Dispute Resolution Process	03 – RFB PFFS 04 – PFFS 14 – ED-PFFS	1/year PBP	1/1- 12/31	<u>Last Monday of February in following year</u>

Data elements reported under this reporting section are:

Element Number	Data Elements for PFFS Provider Payment Dispute Resolution Process
9.1	Number of provider payment denials overturned in favor of provider upon appeal
9.2	Number of provider payment appeals
9.3	Number of provider payment appeals resolved in greater than 60 days

Notes

This reporting section requires direct data entry into HPMS.

This reporting section must be reported by all PFFS plans, regardless of whether or not they have a network attached.

This reporting requirement seeks to capture only provider payment disputes which include any decisions where there is a dispute that the payment amount made by the MA PFFS Plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan’s terms and conditions, or the amount paid to non-contracted providers is less than would have been paid under original Medicare (including balance billing).

**10. AGENT COMPENSATION STRUCTURE –
SUSPENDED**

**11. AGENT TRAINING AND TESTING –
SUSPENDED**

12. SPONSOR OVERSIGHT OF AGENTS –

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
<u>12. SPONSOR OVERSIGHT OF AGENTS</u>	1876 cost plans, local Coordinated Care Plans (Local CCP), Medicare Savings Accounts (MSA), Provider Fee-For-Service plans (PFFS), and Regional Coordinated Care Plans (Regional CCP).*	1/year Contract	1/1-12/31	<u>First Monday of February in following year</u>

Sponsors are 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. However, CMS needs to monitor agent complaints to determine if Organizations are investigating identified complaints and imposing disciplinary actions as well as reporting poor conduct to the state. Therefore, Organizations must continue to monitor the conduct of their agents.

Complaints include both complaints from the Complaint Tracking Module (CTM) and other complaints or grievances made directly to the Organization. Complaints may result in various disciplinary actions, ranging from verbal warning to termination of employment or contract.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 28

Data elements to be uploaded in two data files at the Contract level:

1. Agent/Broker:

For each agent/broker who earned compensation during the reporting period (initial enrollments and renewal payments received) for members with an effective date of 1/1/2015-12/31/2015, provide the information requested below. Enrollment applications received in 2014 for CY2015 effective dates are considered earned for CY2015 since the enrollment effective date is in CY2015. For purposes of these reporting requirements compensation is defined as any payment made to an agent/broker for purposes of enrolling beneficiaries into health plans for purposes of the reporting requirement based on effective date, (e.g. commission, salary, bonuses, and

referrals) earned during in the reporting period (initial enrollments and renewal payments received), indicate:

- A. Contract Number.
- B. Agent/Broker Type (Captive², Employed, Independent).³
- C. Agent/Broker Last Name.
- D. Agent/Broker First Name.
- E. Agent/Broker Middle Initial.
- F. Agent/Broker State Licensed. For agents licensed in multiple states, complete a row for each state in which the agent is licensed if they also earned compensation in that state.
- G. Agent/Broker National Producer Number (NPN).
- H. Organization Assigned Agent/Broker Identification Number.
- I. Agent/Broker Current License Effective/Renewal Date (if applicable). For “evergreen” licenses, this would be the original license date. For other licenses, this would be the most recent renewal date.
- J. Agent/Broker Appointment Date (if applicable). This date should be the most recent date the agent becomes affiliated with the sponsor.
- K. Agent/Broker Training Completion Date for the previous contract year products.
- L. Agent/Broker Testing Completion Date for the previous contract year products.
- M. In aggregate, the number of Agent/Broker marketing complaints from any source for reported during the reporting period. If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has four complaints and is licensed in Florida and Georgia, all four complaints should be listed under the Florida line. For complaints that cannot be tied to a contract number, please put the aggregate number of complaints into the first contract number.
- N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc. If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has received two disciplinary actions and is licensed in Florida and Georgia, both actions should be listed under the Florida line.
- O. Agent/Broker Termination Date (if applicable).
- P. Termination for Cause? (Y (yes) or N (no)).
- Q. Third-party Marketing Organization (TMO)/Field Marketing Organization Name (FMO), if applicable.
- R. The number of new enrollments in the reporting period. If more than one line is filled out because of agent being licensed in multiple states, please put enrollments in by state.

² A captive agent sells for one organization only but is not an employee of the organization.

³ *When a single agent/broker has multiple types (e.g., captive and employed) or has a gap in appointment, please provide the type of “employment” that was most prevalent during the reporting period.

2. New Enrollments:

Important: Sponsors should not upload the POA New Enrollments level data file if they have no new enrollees to report. CMS is defining “new enrollments” for reporting purposes as new to the organization. A change from one Plan Beneficiary Benefit Package (PBP) to another PBP, within the same organization, is not considered a “new enrollment” for purposes of these reporting requirements. Also, a change from one contract to another contract within the same organization) is not a new enrollment. New enrollments are only considered changes from no organization or changes from one organization to an entirely new organization. Organizations should report on all agents/brokers, not just independent agents/brokers. For all new enrollments (initial or renewal) during the reporting period for which an Agent/Broker is associated⁴, indicate:

- A. Contract Number.
- B. Plan Beneficiary Benefit Package (PBP) Number.
- C. Beneficiary Last Name.
- D. Beneficiary First Name.
- E. Beneficiary Middle Initial.
- F. Beneficiary HICN or RRB Number.
- G. Agent/Broker Last Name.
- H. Agent/Broker First Name.
- I. Agent/Broker Middle Initial.
- J. Agent/Broker National Producer Number (NPN).
- K. Organization Assigned Agent/Broker Identification Number.
- L. Enrollment Mechanism.
 - 1=Organization Representative Online
 - 2=CMS Online Enrollment Center
 - 3=Organization Call Center
 - 4=1-800-MEDICARE
 - 5=Paper Application
 - 6=Auto-Assigned/Facilitated
 - 7=Other(Note: This should be the media type by which a member is enrolled.)
- M. Enrollment Application Date.
- N. Enrollment Effective Date.
- O. The number of Agent/Broker complaints filed by the beneficiary in the reporting period. This should be all complaints related to agent/brokers by the beneficiary, not just confirmed allegations. Examples would include: Agent did not show up, Agent stated premium was \$0 when it was \$20, Agent did not return phone call.
- P. Of the number reported in O, the number of Marketing related complaints. This should be a subset of Element O. Marketing related complaints are complaints dealing with the information provided by the agent. For example, the premium complaint would be marketing

⁴ Assistance is defined by an agent providing information/answering questions to a potential beneficiary. This would include face to face, interactive, and telephonic. Mailing a packet of information to a member with no further contact would not be considered “assistance.”

complaint, whereas an agent not returning a phone call or not showing up would not be a marketing related complaint. It is up the Sponsor to make a determination which complaints are reported for both Elements O and P.

13. SPECIAL NEEDS PLANS (SNPs) CARE MANAGEMENT

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
13. SNPs Care Management	SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP <u>Organizations should exclude 800 series plans if they are SNPs.</u>	1/Year PBP	1/1-12/31	<u>Last Monday of February in following year</u>

Data elements reported under this reporting section are:

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
13.1	Number of new enrollees.	New enrollees are defined with respect to the "90-day rule." The initial health risk assessment is expected to be completed within 90 days (before or after) the effective date of enrollment which must be continuous for that period. The member could have initially enrolled as early as 90 days prior to the measurement year (enrolled as early as 10/3 of the previous year) and would still be eligible in the current measurement year as of 1/1 if no initial HRA had been performed prior to 1/1. For the purposes of this reporting, members enrolled continuously for more than 90 days in the same plan without completing an initial HRA are reported as being eligible for an initial HRA (data element 13.1=1) but not having received an initial HRA (data	Members with a documented initial HRA under that plan prior to the measurement year. Excludes new members who disenrolled from the plan within 90 days before or after the effective date of enrollment, if they did not complete an initial HRA prior to disenrolling. <u>Excludes members who receive an initial HRA and remain continuously enrolled under a MAO whose contract was part of a consolidation or merger under the same legal</u>

		<p>element 13.3=0—refer to data element 13.3 below). After that 90-day period, members are no longer reported as eligible for an initial HRA in the same plan but are reported as eligible for a “reassessment HRA” in that same plan. If a member disenrolls from one plan and enrolls in another plan, that member is reported as eligible for an initial HRA anytime during the initial period of 90 days before or after the effective enrollment date.</p>	<p><u>entity during the member’s continuous enrollment, where the consolidated SNP is still under the same MOC as the enrollee’s previous SNP.</u></p>
13.2	<p>Number of enrollees eligible for an annual health risk reassessment (HRA)</p>	<p>Report all members in the same health plan who:</p> <ol style="list-style-type: none"> 1. Completed a reassessment HRA within 365 days of their last HRA (initial or reassessment). 2. Were enrolled for 365 days continuously after their initial HRA or their last reassessment HRA and did not complete a reassessment HRA within 365 days 3. Did not complete an initial HRA within 90 days before or after the effective date of enrollment and reached the threshold of 365 days of continuous enrollment after initial enrollment without completing a reassessment HRA. 	<p>Enrollees who did not reach a threshold of continuous enrollment in the same health plan for at least 365 days after their last HRA and did not complete a reassessment HRA in that plan within the 365 day timeframe as required.</p>
13.3	<p>Number of initial HRAs performed on new enrollees.</p>	<p>Initial HRAs performed on new enrollees (as defined above in data element 13.1) within 90 days before or after effective date of enrollment. The HRA must be completed between 1/1 and 12/31 of the measurement year.</p>	
13.4	<p><u>Number of initial HRA refusals</u></p>	<p><u>Initial HRAs not performed on new enrollees within 90 days (before or after) effective date of enrollment due to enrollee refusal.</u></p>	<p><u>Excludes reporting on number of completed initial HRAs if there is no documentation on enrollee refusal.</u></p>
13.5	<p><u>Number of initial HRAs where SNP is unable to reach new</u></p>	<p><u>Initial HRAs not performed on new enrollees within 90 days before or after the effective date of refusal due to SNP unable to reach new enrollees</u></p>	<p><u>Excludes reporting on number of completed initial HRAs where the SNP has less than 3</u></p>

	<u>enrollees</u>		<u>phone calls and a follow up letter – during the 90 day period (before or after) the initial assessment. Excludes reporting on initial HRAs if there is no documentation that the enrollee did not respond to SNP solicitation to participate in the initial HRA</u>
13.6	Number of annual reassessments performed.	Number of annual reassessments performed on enrollees eligible for a reassessment (during the measurement year as defined in element 13.2 above). This includes: Reassessments performed within 365 days of last HRA (initial or reassessment HRA) on eligible enrollees. It also includes “first time” assessments occurring within 365 days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA.	
13.7	<u>Number of annual reassessments refusals</u>	<u>Annual reassessments not performed on an enrollee due to enrollee refusal.</u>	<u>Excludes reporting on number of completed reassessments if there is no documentation on enrollee refusal.</u>
13.8	<u>Number of annual reassessments where SNP is unable to reach enrollee</u>	<u>Annual reassessments not performed on an enrollee where SNP is unable to reach enrollees.</u>	<u>Excludes reporting on number of completed reassessments where the SNP documents that it has less than 3 phone calls, and a follow up letter. Excludes reporting on enrollees if there is no documentation that the enrollee did not respond to SNP solicitation to participate in the initial HRA.</u>

Notes:

This reporting section requires direct data entry into HPMS.

Complete HRAs are those that comply with guidance in Chapter 5 of the Medicare Managed Care Manual, Quality Improvement program. For Part C reporting, there should never be more than 365 days between Health Risk Assessment (HRAs) for special needs plans. The initial HRA should occur within 90 days before or after the effective date of enrollment in a special needs plan. Initial HRAs completed and received prior to the date of eligibility for benefits are excluded from this reporting section. A SNP should not perform or report on a completed HRA for the Part C reporting requirements if the beneficiary is not yet determined to be eligible to enroll in the SNP. If there is no HRA occurring within 90 days (before or after) the effective enrollment date, there should be an HRA as soon as possible but no more than 365 days from initial enrollment. (Note that, if the initial HRA is not completed within 90 days before or after the effective enrollment date, the SNP will be deemed non-compliant with this requirement. For example, if a SNP enrollee's effective date of enrollment is January 1, 2016, the SNP may conduct the HRA 90 days before January 1, 2016 and no later than 90 days after January 1, 2016.) All reassessment HRAs should occur within 365 days of the last HRA.

SNPs will report enrollee initial HRA, and annual reassessment refusals that must be documented in their internal records. SNPs will also report when they are unable to reach an enrollee to perform an initial HRA or an annual reassessment. The SNP must document in its internal records that the enrollee did not respond to at least three phone calls and a follow up letter, all soliciting participation in the HRA. CMS can request SNP HRA refusal and/or unable to reach documentation at any time to determine health plan compliance with Part C reporting requirements.

Complete HRAs are those that comply with guidance in Chapter 5 of the Medicare Managed Care Manual, titled "Quality Improvement Program." Specifically, only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. This means, for example, that HRAs completed only using claims and/or other administrative data, would not be acceptable. For Data Elements 13.3 and 13.6, CMS requires only completed assessments. This reporting section excludes cancelled enrollments.⁵

For Dual Eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed within 90 days before, or no more than 90 days after the effective date of Medicare enrollment as compliant with Part C reporting requirements.

If an enrollee has multiple reassessments within the 90-day or the 365 day time periods, just report one HRA for the 90-day period or one reassessment within the 365 day time period. The

⁵A cancelled enrollment is one that never becomes effective as in the following example:

An individual submits an enrollment request to enroll in Plan A on March 25th for an effective date of April 1st. Then, on March 30th, the individual contacts Plan A and submits a request to cancel the enrollment. Plan A cancels the enrollment request per our instructions in Chapter 2, and the enrollment never becomes effective."

365-day recycle period for the HRA begins after the last reassessment HRA for that measurement year. Therefore, for example, if reassessment HRAs was completed for the same member on 4/1/2016, 6/1/2016, 8/1/ 2016, and 11/1/2016, the plan should report only one reassessment HRA in 2016. In this case, the 365 day recycle period would start on 11/2/2016, and the next HRA would be due by 11/1/2017.

If eligibility records received after completion of the health assessment retroactively indicate the member was never enrolled in the plan (even when doing the HRA), do not count this beneficiary as a new enrollee or count the HRA.

The date the HRA is completed by the sponsoring organization is the completed date of the HRA.

If a beneficiary enrolls and is mailed an HRA in December 2014, and the HRA is completed in 2015 (within 90 days before or after the effective date of enrollment), count this beneficiary as a new enrollee in 2015 with an HRA completed in calendar 2015.

Questions have arisen regarding how to report data elements in this reporting section when members disenroll and then re-enroll, either in the same plan or a different plan (different organization or sponsor). When a member disenrolls from one plan and re-enrolls into another plan (a different sponsor or organization), the member should be counted as a “new enrollee” for the purposes of Part C reporting. Enrollees who received an initial HRA, and remain continuously enrolled under a MAO that was part of a consolidation or merger within the same MAO or parent organization will not need to participate in a second initial HRA.

A health risk assessment can be reported before an individualized care plan (ICP) is completed.

Please note that these technical specifications pertain to Part C reporting only and are not a statement of policy relating to special needs plan care management.

14. ENROLLMENT AND DISENROLLMENT

Reporting section	Organization Types Required to Report*	Report Freq./ Level	Report Period (s)	Data Due date (s)
14. Enrollment and Disenrollment	All stand-alone MAOs (MA, no Part D) 1876 Cost Plans with no Part D	<u>2/Year Contract</u>	<u>1/1-6/30</u> <u>7/1 – 12/31</u>	<u>Last Monday of August and February</u>

* For other organization types, please report this reporting section under the appropriate section in the Part D reporting requirements. For example, MA-PDs should report in Part D for this reporting section, listed as a “section” in Part D.

This reporting section requires data entry into HPMS

For Part C Reporting:

For Part C reporting, all stand-alone MAOs (MA, no Part D) are to report this reporting section as well as 1876 cost plans with no Part D. For other organization types, please report this reporting section under the appropriate section in the Part D reporting requirements. For example, MA-PDs should report in Part D for this reporting section, listed as a “section” in Part D.

CMS provides guidance for MAOs and Part D sponsors’ processing of enrollment and disenrollment requests.

Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans.

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor’s processing of enrollment and disenrollment requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual’s eligibility for a Special Enrollment Period (SEP), sponsors is currently unable to specify each of these factors when submitting enrollment transactions. Sponsor’s reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring sponsors are providing support to beneficiaries, while complying with CMS policies.

Data elements 1.A-1.O must include all enrollments (code 61 transactions). Disenrollments must not be included in Section 1 Enrollment.

Section 2: Disenrollment must include all voluntary disenrollment transactions.

Reporting Timeline:

<u>Reporting Period</u>	<u>January 1 – June 30</u>	<u>July 1-December 31</u>
<u>Data Due to CMS</u>	<u>August 31</u>	<u>Last Monday of August and February</u>

Data elements to be entered into the HPMS at the Contract level:

Four new data elements are added under disenrollment—data elements D-G. These data elements report the number of involuntary disenrollments for failure to pay plan premium in the specified time period, of these, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause, of these, the number of favorable Good Cause determinations, and, of these, the number of individuals reinstated.

1. Enrollment:

- A. The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time period. Do not include auto/facilitated or passive enrollments, rollover transactions or other enrollments effectuated by CMS.
- B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).
- C. Of the total reported in A, the number of enrollment requests that required requests for additional information.
- D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not having a valid enrollment period).
- E. Of the total reported in C, the number of incomplete enrollment requests received that are completed within established timeframes.
- F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
- G. Of the total reported in A, the number of paper enrollment requests received.
- H. Of the total reported in A, the number of telephonic enrollment requests received (if offered).
- I. Of the total reported in A, the number of internet enrollment requests received via plan or third-party affiliated website.
- J. Of the total reported in A, the number of Online Enrollment Center (OEC) enrollment requests received. For stand-alone prescription drug plans (PDPs) only:*
- K. Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual). (This does not apply to Part C or 1876 cost plans.)*
- L. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.*
- M. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP. (This does not apply to Part C or 1876 cost plans.)*
- N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP (This does not apply to Part C or 1876 cost plans.)*
- O. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period Code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction.*

*Indicates not reported under Part C.

2. Disenrollment:

- A. The total number of voluntary disenrollment requests received in the specified time period.
- B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).
- C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.
- D. The total number of involuntary disenrollments for failure to pay plan premium in the specified time period.**
- E. Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.**
- F. Of the total reported in E, the number of favorable Good Cause determinations.**
- G. Of the total reported in F, the number of individuals reinstated.**

** Indicates new data element.

15. Rewards and Incentives Programs

<u>Reporting section</u>	<u>Organization Types Required to Report</u>	<u>Report Freq./ Level</u>	<u>Report Period (s)</u>	<u>Data Due date (s)</u>
<u>15. Reports and Incentives Programs</u>	<u>01 – Local CCP</u> <u>02 – MSA</u> <u>03 – RFB PFFS</u> <u>04 – PFFS</u> <u>05 – MMP</u> <u>11 – Regional CCP</u> <u>14 – ED-PFFS</u> <u>15 – RFB Local CCP</u> <u>Organizations should include all 800 series plans.</u> <u>Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.</u>	<u>1/Year Contract</u>	<u>1/Yr.</u>	<u>Last Monday of February in following year</u>

This is a new reporting section. This reporting section requires data entry into HPMS.

CMS has added a new regulation at 42 CFR §422.134 that permits MA organizations to offer one or more Rewards and Incentives Program to currently enrolled members. Plans have a

choice in whether or not they offer a Rewards and Incentives Program(s), but if they do, they must comply with the regulatory requirements set forth at §422.134. CMS needs to collect Rewards and Incentives Program data in order to track which MA organizations are offering such programs and how those programs are structured. This will inform future policy development and allow CMS to determine whether programs being offered adhere to CMS standards and have proper beneficiary protections in place.

Data Elements:

15.1 Do you have a Rewards and Incentives Program(s)? (“0” = “No”; “1” = “Yes”)

If yes, please list each individual Rewards and Incentives Program you offer and provide information on the following:

15.2 What health related services and/or activities are included in the program? Text

15.3 What reward(s) may enrollees earn for participation? Text

15.4 How do you calculate the value of the reward? Text

15.5 How do you track enrollee participation in the program? Text

15.6 How many enrollees are currently enrolled in the program? Enter _____

15.7 How many rewards have been awarded so far? Enter _____

16. Mid-Year Network Changes

<u>Reporting section</u>	<u>Organization Types Required to Report</u>	<u>Report Freq./ Level</u>	<u>Report Period (s)</u>	<u>Data Due date (s)</u>
<u>16. Mid-Year Network Changes</u>	<u>01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP</u>	<u>1/Year Contract</u>	<u>1/Yr.</u>	<u>Last Monday of February</u>

This is a new reporting section. This reporting section requires data entry into HPMS.

CMS is increasing its oversight and management of MAOs’ network changes in order to ensure that changes made during the plan year do not result in inadequate access to care for enrolled beneficiaries and that MAOs are provided timely and appropriate notification to providers and enrollees. The data collected in this new measure will provide CMS with a better understanding of how often Medicare Advantage Organizations (MAOs) undergo mid-year network changes and how many enrollees are affected. CMS considers a mid-year network change to be any change in network that is not effective January 1 of a given year (the first day of the reporting period). In the following we are asking MAOs to report on no cause mid-year terminations of PCPs, certain specialists (cardiologists, endocrinologists, oncologists, ophthalmologists, pulmonologists, rheumatologists, urologists), and facilities (acute inpatient hospitals and skilled nursing facilities) initiated by the MAO during the reporting period.

Affected enrollees are those enrollees who were assigned to a terminated PCP or who were treated by a terminated specialist or received care in a terminated facility within 90 days prior to the specialist/ facility contract termination date. To maintain consistency in reporting, we are using the definition of PCP used in the CMS network adequacy criteria guidance, found on our website at <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>. In addition to PCP data, we are seeking data on the mid-year network changes for the provider and facility specialties that MAOs are required to include on their Health Service Delivery (HSD) tables submitted with a Medicare Advantage (MA) application.

Collecting these data will help to inform us as we determine how broadly to use the new Network Management Module (NMM) in the Health Plan Management System (HPMS) to verify that plans’ networks meet CMS network adequacy standards. In addition, responses from MAOs will enhance CMS’ ability to improve our network change protocol.

Legal Basis:

In accordance with 42 CFR § 422.112 (a)(1)(i), each MA organization under Part C Medicare that offers a coordinated care plan is required to “maintain and monitor a network of appropriate providers that is...sufficient to provide adequate access to covered services to meet the needs of the population served.”

Data Elements (at the contract level):

Element Number	Data Elements for Provider Network Adequacy Measure
16.1	Total number of PCPs in network on first day of reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care- Physician Assistants, Primary Care-Nurse Practitioners
16.2	Total number of PCPs in network terminated during the reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care- Physician Assistants, Primary Care-Nurse Practitioners
16.3	Total number of PCPs added to network during reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care- Physician Assistants, Primary Care-Nurse Practitioners
16.4	Total number of PCPs in network on last day of reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care- Physician Assistants, Primary Care-Nurse Practitioners
16.5-16.13	Number of specialists/facilities in network on first day of reporting period by specialist/facility type –Cardiologist (16.5), Endocrinologist (16.6), Oncologist (16.7), Ophthalmologist (16.8), Pulmonologist (16.9), Rheumatologist (16.10), Urologist (16.11), Acute Inpatient Hospitals (16.12), Skilled Nursing Facilities (16.13)
16.14-16.22	Number of specialists/facilities in network terminated during the reporting period by specialist/facility type– Cardiologist (16.14), Endocrinologist (16.15), Oncologist (16.16), Ophthalmologist (16.17), Pulmonologist (16.18), Rheumatologist (16.19), Urologist (16.20), Acute Inpatient Hospitals (16.21), Skilled Nursing Facilities (16.22)
16.23-16.31	Number of specialists/facilities added during reporting period by specialist/facility type - Cardiologist (16.23), Endocrinologist (16.24), Oncologist (16.25), Ophthalmologist (16.26), Pulmonologist (16.27), Rheumatologist (16.28), Urologist (16.29), Acute Inpatient Hospitals (16.30), Skilled Nursing Facilities (16.31)
16.32-16.40	Number of specialists in network on last day of reporting period by specialist/facility type- Cardiologist (16.32), Endocrinologist (16.33), Oncologist (16.34), Ophthalmologist (16.35), Pulmonologist (16.36), Rheumatologist (16.37), Urologist (16.38), Acute Inpatient Hospitals (16.39), Skilled Nursing Facilities (16.40)
16.41	Total number of enrollees on first day of reporting period
16.42	Total number of enrollees affected by termination of PCPs during reporting period
16.43-16.51	Total number of enrollees affected by termination of specialists/facilities by specialist/facility type during reporting period- Cardiologist (16.43), Endocrinologist (16.44), Oncologist (16.45),

	Ophthalmologist (16.46), Pulmonologist (16.47), Rheumatologist (16.48), Urologist (16.49), Acute Inpatient Hospitals (16.50), Skilled Nursing Facilities (16.51)
16.52	Total number of enrollees on last day of reporting period

17. Payments to Providers (new reporting section)

<u>Reporting section</u>	<u>Organization Types Required to Report</u>	<u>Report Freq./ Level</u>	<u>Report Period (s)</u>	<u>Data Due date (s)</u>
<u>17. Payments to Providers</u>	<u>01 – Local CCP</u> <u>11 – Regional CCP</u> <u>15 – RFB Local CCP</u> <u>04 – PFFS</u>	<u>1/Year Contract</u>	<u>1/Yr.</u>	<u>Last Monday of February</u>

This is a new reporting section. This reporting section requires data entry into HPMS. We are adding this new requirement based on internal review. In order to maintain consistency with HHS goals of increasing the proportion of payment made based on quality and value, HHS developed four categories of value-based payment: fee-for-service with no link to quality; fee-for-service with a link to quality; alternative payment models built on fee-for-service architecture; and population-based payment. CMS is seeking to collect data from MA organizations about the proportion of their payments to providers made based on these four categories in order to help us understand the extent and use of alternate payment models in the MA industry. This does not include MAO payments for administrative services or payments to hospitals, facilities, and labs. As we are interested in the direct contractual arrangements between MAOs and providers, we are also interested in the contracts between MAOs and third party administrators who contract with providers on behalf of MAOs.

CMS considers a fee-for-service with no link to quality arrangement to include all arrangements where payments are based on volume of services and not linked to quality of efficiency.

CMS considers a fee-for-service with a link to quality to include all arrangements where at least a portion of payments vary based on the quality or efficiency of health care delivery, such as physician value-based modifiers. Included in this category are for performance (P4P) payment structures.

CMS considers alternative payment models built on fee-for-service architecture to include all arrangements where some payment is linked to the effective management of a population or an

episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or 2-sided risk. Included in this category are bundled payments, Accountable Care Organizations, patient Centered Medical Homes, and other payments with upside and downside risk.

CMS considers population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year). Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements. Included in this category are partial capitation, full capitation, and risk-based models.

Data Elements (at the contract level):

Element Number	Data Elements for Payments to Provider
17.1	Total Medicare Advantage payment made to contracted providers. This includes payments to groups of providers and third party administrators through which the MAO pays providers.
17.2	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality.
17.3	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality.
17.4	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture
17.5	Total Medicare Advantage payment made using population-based payment.
17.6	Total number of Medicare Advantage contracted providers. Please note: Third party administrators should be counted as a single contracted provider.
17.7	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality.
17.8	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality.
17.9	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture.
17.10	Total Medicare Advantage contracted providers paid based on population based payment.

**Appendix 1: FAQs: Reporting Sections 5 & 6:
Grievances, Organization Determinations, & Reconsiderations**

	PLAN INQUIRIES	CMS RESPONSES
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example, During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.
2.	Should plans report all Dual Eligible member grievances to CMS?	No. Plans are only to report Dual Eligible member grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, plans will not report grievances filed under the state Medicaid process, but not filed with the plan and addressed under the plan's Subpart M grievance process.
3.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.

4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as “organization determinations.” For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations), as described in this guidance
6.	If we have a prior authorization request and a claim for the same service -- is that considered a duplicate or should we report both?	Plans are to report both a prior authorization request and a claim for the same service; this is not considered a duplicate.
7.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service (“predetermination”) decision submitted to the plan, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report partially favorable, adverse and fully favorable pre-service organization determinations, as described in this guidance.
8.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.

9.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider did not submit the claim with the required modifier, should that be excluded from the count?	Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
10.	Do we have to include lab claims for this reporting section? Do we need to report the ones, which involve no pre-service, as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.
11.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. <u>Is this an organization determination?</u>	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). <i>Written notice is required for Partially Favorable, and Adverse determinations.</i>
12.	<u>Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ non-covered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?</u>	<u>The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.</u>
13.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. <u>Is this counted as one event (i.e., pre-auth and claim not counted as two events)?</u>	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.

14.	When an organization determination is extended into the future, does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans generally are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
15.	Our interpretation is that the term “contracted provider” means “contracted with the health plan” not “contracted with Medicare”.	Yes. For purposes of Part C Reporting Section 6 reporting requirements, “contracted provider” means “contracted with the health plan” not “contracted” (or participating) with Medicare.”
16.	When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.
17.	Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination <i>and</i> reconsideration. <u>Exceptions</u> : Plans are not to report: 1.) Dismissed cases, or 2.) QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.

18.	<u>Should supplemental benefit data be excluded from the Part C Reporting?</u>	<u>As described in this guidance, a plan's response to a request for coverage (payment or provision) of an item or service is a reportable organization determination. Thus, requests for coverage of a supplemental benefit (e.g., a non-Medicare covered item/service) are reportable under this effort.</u>
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