Appendix C: Crosswalk for Supporting Statement for Paperwork Reduction Act Submission: Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a)
CMS-10261, OCN 0938-1054—
30-Day Comment Period

Please note that a detailed discussion of the associated burden changes is set out in section 15 of Supporting Statement A.

The proposed changes in this ICR are as follows: Three reporting sections, Organization Determinations/Reconsiderations, Special Needs Plans Care Management, and Enrollments/Disenrollments, were updated to include additional data elements. For most reporting sections with a data due date of February 28, the data due date was changed to the last Monday in February, For Part C Grievances, Sponsor Oversight of Agents, and Employer Group Plan Sponsors, the data due dates were changed to the first Monday in February. The due date for Enrollment/Disenrollment was changed to the last Monday of August and February. This "staggering" of data due dates is proposed so that the reporting load would be more manageable in 2016 than it was in 2015 for CMS/HPMS. Also, having the data due date fall on February 28, as it was in the past, introduced problems when February 28 was on a weekend or when it occurred in a leap year. By listing the last Monday in February, this problem is eliminated. This changing of due dates is not expected to impact burden in terms of hours or costs. The final set of proposed changes is the addition of three reporting sections: Rewards and Incentives Program, Mid-Year Network Changes, and Payments to Providers.

#6 Organization Determinations and Reconsiderations (see below for added data elements)

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	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*	Number of Requests for Organization Determinations - Dismissals
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*	Number of Requests for Reconsiderations - Dismissals
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.**

#13: Special Needs Plans (SNPs) Care Management

SNPs will now also report the enrollee initial health risk assessment (HRA), and the annual reassessment refusals that must be documented in their internal records. SNPs will also report when the plans 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 3 phone calls and a follow up letter, all soliciting participation in the HRA. The data elements are listed below:

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 Organizations should exclude 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	2/28 of following year

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 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	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. 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 entity during the member's continuous enrollment, where the consolidated SNP is still

		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.	under the same MOC as the enrollee's previous SNP.
13.2	Number of enrollees eligible for an annual health risk reassessment (HRA)	Report all members in the same health plan who: 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.	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.
13.3	Number of initial HRAs performed on new enrollees.	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 1/1and 12/31 of the measurement year.	
13.4	Number of initial HRA refusals*	Initial HRAs not performed on new enrollees within 90 days (before or after) effective date of enrollment due to enrollee refusal.	Excludes reporting on number of completed initial HRAs if there is no documentation on enrollee refusal.
13.5	Number of initial HRAs where SNP is unable to reach new enrollees*	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	Excludes reporting on number of completed initial HRAs where the SNP has less than 3 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
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	Number of annual reassessments refusals*	Annual reassessments not performed on an enrollee due to enrollee refusal.	Excludes reporting on number of completed reassessments if there is no documentation on enrollee refusal.

13.8	Number of annual reassessments where SNP is unable to reach enrollee*	Annual reassessments not performed on an enrollee where SNP is unable to reach enrollees.	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.

*Indicates new data element.

#14: Enrollment/Disenrollment (see below for added data elements)

CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests. For Part C reporting, this involves only 1876 cost contracts with no Part D. (For other organization types, reporting is under the appropriate section in the Part D reporting requirements.) Under enrollment, only data elements A-I are reported under Part C. In 2014, there were only 10 contracts reporting enrollment/disenrollment for this reporting section under Part C.

Four new data elements would be added under disenrollment—data elements D-G. These data elements would 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 Reporting Section: Rewards and Incentives Program (new reporting section)

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. Based on 60-day comments, this reporting section no longer requires 1876 cost plans to report.

The data elements remain as follows:

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 Reporting Section: Mid-Year Network Changes (new reporting section)

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. Collecting these data will help to inform CMS in determining 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 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."

Based on 60-day comments, there are now 53 data elements instead of 13. The proposed data elements, all reported at the contract level, are now:

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)

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 3rd 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 is pay 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.