

**60 Day Comments and Responses
(Part C Reporting Requirements CMS-10261; OMB 0938-1054)**

There were 10 commenters: CMS, UCare, HealthPartners, Inc., Essence Healthcare, Independent Health, PrimeWest Health, Health First Health Plans, Inc., United HealthCare, HDC Data, and MMM Healthcare. There was a total of 57 comments. Most of the comments were concerned with clarifications of the technical specifications. There were few comments directly concerned with increased resource needs. Only 7 comments required action to be taken by CMS. These included revisions to the Mid-Year Network Changes, Payments to Providers, and Enrollment/Disenrollment reporting sections. Most CMS responses were informational only, requiring no changes to the reporting sections.

Commenter: CMS

Comment 1: Please find revisions to the Mid-Year Network Changes section (16) of the CY 2017 Part C reporting requirements tech specs (see pages 6 & 33-35 for edits/comments).

CMS Response 1: We will make those changes.

CMS Action 1: Changes will be made to the Part C Reporting Requirements Technical Specifications for the Mid-Year Network Changes Reporting Section. These changes did not involve additional data elements or additional resource requirements.

Comment 2: Revised data elements for Section 17-payments to providers.

CMS Response 2: We will make those revisions. These revisions involved 4 new data elements increasing the number of data elements from 10 to 14.

CMS Action 2: Changes will be made to the Part C Reporting Requirements Technical Specifications for the Mid-Year Network Changes Reporting Section. The increase in the number of data elements from 10 to 14 increased the resource utilization for this reporting section from 8,080 hours per year to 11,312 hours per year ($14/10 \times 8,080$). It increased the cost per year from \$678,397 to \$949,756 ($14/10 \times \$678,397$), a net increase of \$271,359.

Comment 3: Technical specifications and the initial supporting statement list 5 new data elements for Organization Determinations and Reconsiderations reporting section for 2017 measurement year. There are only 4 new data elements. “Case Level (Organization Determination/Reconsideration)” is not a new data element.

CMS Response 3: This has been changed in the draft technical specifications and the revised reporting statement.

CMS Action 3: The impact of this revision is to reduce the estimate of the total burden hours across all contracts by 2,380 or by an average of 4.3 hours per contract. Total cost decrease is

estimated at \$199,792 across all contracts or by an average of \$367 per contract from the previous version of this ICR.

Comment 4: Data elements 1-M and 1-N need to be removed from the enrollment/disenrollment reporting section.

CMS Response 4: CMS agrees.

CMS Action: CMS will remove these data elements for CY 2017.

Commenter: UCare

Comment 1: We support suspending the Sponsor Oversight of Agents reporting section.

CMS Response 1: Thank you for your comment.

CMS Action 1: None.

Comment 2: It would be helpful to sponsors if CMS would provide additional guidance for plans that have dual eligible beneficiaries.

CMS Response 2: This is a general comment.

CMS Action 2: CMS will share your comment with subject matter experts (SMEs) involved in developing the reporting sections.

Comment 3: If guidance is released and there are issues identified, please communicate corrections immediately.

CMS Response 3: Thank you for your comment.

CMS Action 3: CMS will share your comment with SMEs involved in developing and releasing guidance.

Comment 4: It would be helpful to sponsors if CMS would explain in detail how they intend to use the reported data.

CMS Response 4: This is a general comment. CMS analyzes and reports the data in annual reports.

CMS Action 4: CMS will review data current release procedures to see that plans and other stakeholders have access to annual Part C reports.

Commenter: HealthPartners, Inc.

Comment 1: #15 Rewards and Incentives Programs. We received guidance from CMS that 1876 Cost plans are not required to report data for this reporting section. We request that CMS include this guidance in the technical specifications.

CMS Response 1: Thank you for your comment. A chart entitled, Reporting Requirement Reporting Sections List, begins on page 4 of the technical specifications and contains a column that lists each organization type required to report on each section.

CMS Action 1: None.

Comment 2: #16 Mid-Year Network Changes. We received guidance from CMS that 1876 Cost plans are not required to report data for this reporting section. We request that CMS include this guidance in the technical specifications.

CMS Response 2: Thank you for your comment. A chart entitled, Reporting Requirement Reporting Sections List, begins on page 4 of the technical specifications and contains a column that lists each organization type required to report on each section.

CMS Action 2: None.

Comment 3: #17 Payments to Providers. We received guidance from CMS that 1876 Cost plans are not required to report data for this reporting section. We request that CMS include this guidance in the technical specifications.

CMS Response 3: Thank you for your comment. A chart entitled, Reporting Requirement Reporting Sections List, begins on page 4 of the technical specifications and contains a column that lists each organization type required to report on each section.

CMS Action 3: None.

Commenter: Essence Healthcare

Comment 1: Part C Section 5: Grievances New report inclusion: Dismissals-- Examples given refer to Dismissals based on no AOR, It would be helpful if additional examples to explain what CMS considers a Dismissed grievance to better distinguish from member withdrawn grievances.

CMS Comment 1: We believe we have provided enough guidance. A withdrawn grievance is one that is upon request from the enrollee or appointed representative is removed from the grievance process. A dismissal occurs when the procedure requirements for a valid grievance are not met and the plan is unable to cure the defect.

CMS Action Taken 1: None.

Comment 2: Part C Section 6: ODR Clarification: 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, service authorizations which include prior authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered) and postauthorization (authorization that is issued after the services has already been provided), and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and noncontract providers.

CMS Response 2: Report: Completed Organization determinations... Do not report: Concurrent reviews...

CMS Action Taken: None.

Comment 3: It would be helpful if more clarification was provided demonstrating the differences between what CMS considers "Concurrent Authorization & requests to continue previously authorized ongoing courses of treatment" vs. "Concurrent Reviews."

CMS Response 3: Concurrent authorizations are delivered at the time of service outside of a hospital, SNF, HHA or CORF, such as authorizations done for services provided in an office setting such as physical therapy. Concurrent reviews in hospitals, SNF, HHA and CORF are done as services are occurring while a beneficiary is in one of the settings listed. Part C Section 6: ODR Report Inclusion: All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.

CMS Action Taken 3: None.

Comment 4: CMS specifically states Paid (favorable/partially favorable) claims. Should denied (rejected/unpaid) claims be excluded from this report?

CMS Response 4: No. Additional clarification will be provided in the reporting requirements.

CMS Action Taken 4: None.

Commenter: Independent Health

Comment 1: 2017 Draft Medicare Part C Reporting Requirements/Technical Specifications Regarding section 6 of the reporting requirements, Organization determinations/Reconsiderations, we noticed that there is a new data element, 6.33, 'Additional Information (Optional)' and we were wondering what is expected for this data element/field. Please provide clarification and/or examples of what type of information would be input for data element 6.33, 'Additional Information (Optional).'

CMS Response 1: This new data element is an optional field. This field can be populated by plans if they wanted to provide more information such as a subcategory or notes.

CMS Action 1: None.

Commenter PrimeWest Health

Comment 1: SNP Care Management. In data element 13.1, it says that after the 90day period following the effective date of enrollment enrollees are no longer reported as eligible for an initial HRA but are eligible for a reassessment. Does this mean that if they didn't have an HRA in the time frame they are now not reported in the denominator for "initial assessments"?

CMS Response 1: No, they are still counted in 13.3 (denominator)

CMS Action 1: None.

Comment 2: If yes, would data elements 13.4 and 13.5 both be zero, since they are a subset of new enrollees (defined by 13.1) and members enrolled for more than 90 days without an assessment are no longer eligible for 13.1?

CMS Response 2: N/A

CMS Action 2: N/A

Comment 3: If no, are these members double counted in the year since they will then qualify for bullet 3 in 13.2?

CMS Response 3: If an enrollee has multiple reassessments within the 90 day or the 365 day time periods, just report one HRA for the period in order to meet the reporting requirement. The count for the 365 day cycle period for the HRA begins with the day after the date the previous HRA was completed for the enrollee.

CMS Action 3: None.

Comment 4: Also, does 13.2 have no enrollment criteria other than the 90 days from the initial period?

CMS Response 4: Report all enrollees in the same health plan: 1. Who were enrolled for up to 365 days continuously after their last HRA. 2. For whom no initial HRA was completed within 90 days before or after the effective date of enrollment.

CMS Action 4: None required.

Comment 5: In data element 13.2, bullets 1 and 2 have the criteria of eligibility as being enrolled up to 365 days after initial or most recent HRA. Does this mean that members who did not receive a reassessment (or initial) in the last year are not accounted for, since it will have been over 365 days since their most recent HRA? Or will the "anniversary date" idea be used?

CMS Response 5: No, if they didn't receive an initial HRA and were enrolled at least 90 days continuously, they should appear in 13.1 but not in 13.3.

CMS Action 5: None.

Comment 6: What, if any, is the time frame for the attempts to contact and the refusal?

CMS Response 6: It is up the health plan to determine the time frame for attempts to contact the member.

CMS Action 6: None.

Comment 7: Do the attempts/refusals have to be renewed yearly to keep them in a bucket? Or members in the 13.4/5 buckets that would then by bullet 3 fall into 13.2 need to have attempts/refusals documented again? Or would the member not even fall into the reassessment eligibility in the next year if they were in 13.4/5/7/8 in the previous year?

CMS Response 7: All SNPs must follow regulations at 42 CFR §422.101(f)(i) that stipulate a Health Risk Assessment must be conducted annually. All annual reassessment HRAs should occur within 365 days of the last HRA. Accordingly, the SNP must provide outreach attempts annually, and follow the requirements set forth in the Part C Reporting Requirements.

CMS Action 7: None.

Comment 8a: What counts as a phone attempt?

CMS Response 8a: A phone attempt is a non-automated call by a designed SNP representative.

CMS Action Taken: None,

Comment 8b: Do they all have to be calls to the member?

CMS Response 8b: Yes, the phone call is an attempt to the SNP enrollee.

CMS Action Taken 8b: None.

Comment 8c: What if there isn't a known phone number for the member or the phone number is incorrect, as is often the case with dual eligible members?

CMS Response 8c: The SNP should note in its internal records that the health plan attempted to reach the enrollee, that there is an unknown phone number for the member, and/or indicate the phone number is incorrect. A follow up letter is still required to meet the Part C Reporting requirements. One suggestion is that a SNP can reach out to the PCP to inquire about a possible known phone number, since enrollees sign consent forms at the PCP office that permits the PCP to share information with the SNP regarding payment and treatment.

CMS Action 8: None:

Comment 9: How do we handle members that have been retroenrolled? They could potentially fall off enrollment in the month prior to their reassessment due date but then after being off the plan for a month, retroenroll back to their disenrollment date. Our enrollment at the end of the year wouldn't show them as having fallen off, it'd show them as having continuous enrollment even though during the month they should have had their reassessment they didn't appear to be enrolled.

CMS Response 9: If the example in this question refers to a beneficiary that is enrolled in a D-SNP and loses Medicaid eligibility, the beneficiary would be considered "deemed eligible" and the reassessment would still be conducted within 365 days of the last enrollment.

CMS Action 9: None.

Commenter: Health First Health Plans, Inc.

Comment 1: Reporting Measure: Payments to Providers. Our provider directory is constantly changing. For purposes of this measure, what would the "as of date" be? For instance, for 17.6, would the total number of Medicare Advantage contracted providers be the number of contracted providers as of the first day of the reporting period (1/1/16) or the last day of the reporting period (12/31/16)?

CMS Response 1: This applies to any contracted provider in 2016, regardless of length of contract in 2016.

CMS Action 1: None.

Comment 2: Reporting Measure: Payments to Provider. Are the data elements 17.7 through 17.9 subsets of data elements 17.2 through 17.4, or are they exclusive? For instance, would the amount declared in 17.2 (Total Medicare Advantage payment made on a feeforservice basis with no link to quality) include payments made to contracted providers paid on a feefor service with no link to quality? Or would payments to providers paid on a feefor service basis with no link to quality be excluded from 17.2 and only reported under 17.7?

CMS Response 2: Data elements 17.1 through 17.5 refer to payment based on the categories of value based payment (fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); population-based payment (category 4)). Data element 17.6 through 17.10 refer to the number of contracted providers paid based on these categories. For example, data element 17.2 refers to the total amount of payment made based on fee-for-service basis with no link to quality. Data element 17.7 refers to the number of contracted providers paid through this type of payment arrangement (fee-for-service basis with no link to quality).

CMS Action 2: None.

Comment 3: Reporting Measure: Sponsor Oversight of Agents. We agree with the decision to suspend the Sponsor Oversight of Agents measure.

CMS Response 3: Thank you for your comment.

CMS Action 3: None.

Commenter: United HealthCare

Comment 1: Organization Determinations/Reconsiderations. United seeks clarity regarding the Data Elements for the Organization Determinations/ Reconsiderations Reporting Section, which are found in Table 1. Data element 6.32, "Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)" has added "Other Error" and "Other" as potential data elements to be reported. We respectfully request that CMS provide further explanation as to the difference between "Other Error" and "Other", as well as examples of each. We also request that CMS provide examples of what should be included for data element 6.33, "Additional Information (Optional)."

CMS Response 1: "Other" refers to cases that would not be considered a "clerical error" or "other error." Examples of "other" may include policy/procedure change, business configuration change, provider update, other adjustment etc.

Data element 6.33 is an optional field. This field can be populated by plans if they wanted to provide more information such as a subcategory or notes.

CMS Action 1: None:

Comment 2: Rewards and Incentives Programs. United has concerns regarding a discrepancy in data element 15.1 regarding the technical specifications and data file layout for this reporting section. The technical specifications indicate the need to answer "Yes" or "No." While the data file layout asks for the Rewards and Incentives Program to be entered, it does not ask for a "Yes" or "No" answer for Element 15.1. We are concerned that this may lead to problems with indicating whether or not a Rewards and Incentives Program is offered for a specific contract, as the file layout is inconsistent with the expected content requested. Based on the technical specifications, we believe that the Health Plan Management System (HPMS) needs to accept "Yes" or "No" responses in the data file layout (upload), as compared to the name of a Rewards and Incentives Program.

CMS Response 2: The data collection method for Rewards and Incentives Program reporting section is partially a data entry and an upload. A plan user needs to select "Yes" or "No" for data

element 15.1 on the edit page. If the plan user selected "No", no upload is necessary. If the plan user select "Yes", then the user will be required to upload additional information in accordance with the file record layout.

CMS Action 2: None.

Comment 3: Mid-Year Network Changes. Per technical specifications, this section states that "This reporting section requires data entry into HPMS." We respectfully request that CMS update the technical specifications to note that the submission file can be uploaded into HPMS. United understands that CMS expects Medicare Advantage organizations (MAOs) to do their best to prepare Part C Reporting data for submission based on the information provided in the most current version of the Technical Specifications. While MAOs make a good faith effort to provide accurate Mid-Year Network Changes data, organizations may not have their termination data currently separated by terminations with cause and no cause, or MAO-initiated versus provider-initiated, as those limitations are defined in this context. Therefore, we recommend that CMS require MAOs to report all terminations for the proposed providers types (PCPs, 7 types of specialties and 2 types of facilities) without regard to whether the terminations are MAO-initiated, provider-initiated, or mutually agreed to by the MAO and provider and without regard to whether the terminations are with or without cause. Expanding the reporting to include all mid-year terminations furthers CMS' purpose for the reporting, which is to ensure adequate access to care for enrollees and to better understand how many enrollees are impacted by mid-year network changes. Impact to enrollees and to access to care is the same regardless of whether a provider termination is initiated by an MAO or by a provider, or is without cause versus with cause. In addition, reporting all terminations will be less burdensome from an MAO administrative perspective. Since this is a new reporting requirement, MAO operational areas that process terminations and have responsibility for reporting this information may not currently have a mechanism to systematically distinguish MAO-initiated terminations from provider-initiated or mutual terminations, or no-cause terminations from with-cause terminations. Finally, this change would ensure greater consistency and would level the playing field among all MAOs since it does not permit different interpretations on what "initiated by the MAO" and "no cause" means. In the event that CMS does not make changes to the current Mid-Year Network Changes Part C reporting requirements, we ask that CMS confirm that its expectation for the first year of reporting is that MAOs make a reasonable, good-faith effort to provide the data at the level of detail requested by CMS, as MAOs continue to work towards building this new reporting capability.

CMS Response 3: Thank you for your comments. CMS recognizes that this section requires a file upload into HPMS, and the technical specifications will be revised to reflect that.

In addition, CMS is removing the "no-cause" and "MAO-initiated" restrictions from this section due to many organizations' questions and concerns about these restrictions. We recognize that the restrictions may skew the data elements, and we understand your concerns regarding the purpose of this reporting section as well as MAO administrative burden. The technical specifications will be revised. MAOs are to report on both for-cause and no-cause terminations, as well as both MAO-initiated and provider-initiated terminations.

CMS Action 3: Revise technical specifications to reflect that this section requires a file upload into HPMS.

Revise technical specifications to remove the “no-cause” and “MAO-initiated” restrictions.

Comment 4: Appendix 1: FAQs: Reporting Sections 5 & 6. United believes that additional clarity is needed regarding the timeframe for the reporting of payments. The February 2017 deadline does not allow enough time for the reporting of all payments to providers for the Calendar Year 2016 period. As a result, we recommend, in cases when the actual payment is issued after the submission due date, that CMS allow for allocated spending to be reported in its place.

CMS Response 4: CMS will consider your comment.

CMS Action 4: None at this time:

Commenter: HDC Data

Comment 1: Report Section: ORGANIZATION DETERMINATIONS/RECONSIDERATIONS. Due to the common practice of assigning a new number to a new determination, we recommend the following text change: Current data element definition: 6.24 Case ID. Recommended data element definition: 6.24 Original Case ID, prior to reopening.

CMS Response 1: Thank you for your comment.

CMS Action 1: CMS will take your suggestion under consideration.

Commenter: MMM Healthcare

Comment 1: Reporting: Rewards and Incentives. In the past, CMS has expressed itself about the consideration of Rewards and Incentives for part D activities, however at present time plans are not authorized to provide incentives for activities related to part D. CMS also establishes the requirement to concede rewards or incentives based upon processes completed by the patient, rather than outcomes. From this perspective, there are certain processes or activities that the member needs to comply with in order to attain or maintain the optimum health status that are related to part D but have an impact on the utilization and behavior on part C. One simple example is granting rewards for getting refills on time from their pharmacy. This simple process activity impacts directly part C related measures such as Antidepressant Management, Diabetes Blood Sugar Control, and Rheumatoid Arthritis Management, among others. Based on the above, CMS should allow plans to reward members on part D related activities.

CMS Response 1: CMS understands that Part C and Part D activities often coincide and will take your comment under consideration during the next rule making cycle.

CMS Action 1: CMS will consider extending RI Program regulations to Part D.

Comment 2: Reporting: Organization Determinations/Reconsiderations. What is expected to be included under element 6.33 "Additional information" for Reopenings? Can you please provide an example?

CMS Response 2: This new data element is an optional field. This field can be populated by plans if they wanted to provide more information such as a subcategory or notes.

CMS Action 2: None.

Comment 3: Reporting: Organization Determinations/Reconsiderations. Does CMS expect Plans to include only those reopened cases in which a change of the initial decision is performed? If after proper evaluation of the reopening the decision remains upheld, do we have to report?

CMS Response 3: Yes, you report the reopening decision even when the original decision is upheld.

CMS Action 3: None:

Comment 4: SNP MC Report. Our Organization has SNP and Non-SNP plans within the same contract number. We have only one contract number. When the requirements state that the enrollee must be enrolled continuously in the same health plan (90 or 365 days), does that mean in the same Organization or within any SNP that is within the same organization? For example, our enrollee is enrolled continuously in a SNP plan for less than 90 days, but moved to a non-SNP Plan within our same Parent Organization and continued his enrollment for more than 90 days (same organization, non-SNP plan). Should we consider this enrollee as continuously enrolled in the same Plan for more than 90 days?

CMS Response 4: No.

CMS Action 4: None.

Comment 5: In relation the Question #1, let's say a beneficiary was initially enrolled in a NON-SNP Plan within our organization. That same beneficiary changed to a SNP Plan within

the same organization. Should the initial HRA be conducted within the first 90 days of the enrollment date into the SNP Plan?

CMS Response 5: Yes

CMS Action 5: None.

Comment 6: Element 13.1 exclusion states the following: “Enrollees with a documented initial HRA under that plan in the previous measurement year.” However, the Inclusions section states the contrary “The initial HRA is expected to be completed within 90 days (before or after) of the effective date of enrollment.” The example provided states that if an initial HRA is performed on 11/23/15 for an enrollee with an effective date of 1/1/16, that enrollee would be counted as an initial HRA in 2016. Clearly, the HRA was completed in 2015 and not 2016. Therefore, should that HRA be excluded as stated in the Exclusions column? Or is that an error?

CMS Response 6:

CMS Action 6: None required.

Comment 7. Element 13.2 exclusion states the following: “Enrollees for whom the last HRA was completed less than 365 days prior.” Does this mean that the reassessment must be completed on day 365?

CMS Response 7: No. This exclusion was eliminated in the new version of the technical specifications.

CMS Action 7: None.

Comment 8: Organization Determination and Reconsideration Report. Element 6.28 – ‘Was the case processed under the expedited timeframe’, does this refer to the original determination or the reopened case?

CMS Response 8: This refers to the original determination.

CMS Action 9: None.

Comment 10 Element 6.32 – What does ‘Fraud or Similar Fault’ and ‘Other’ mean?

CMS Response 10: Fraud or Similar fault means to obtain, retain, convert, seek or receive Medicare funds to which a person knows or should reasonably be expected to know that he or

she or another for whose benefit Medicare funds are obtained, retained, converted, sought or received is not legally entitled. “Other” refers to cases that would not be considered a “clerical error” or “other error.” Examples of “other” may include policy/procedure change, business configuration change, provider update, other adjustment etc.

CMS Action 10: None required.

Comment 11: Element 6.33 – What is expected to be included under ‘Additional Information’?

CMS Response 11: This is an optional free text field. “Additional information” was added so plans that could provide more information, such as a subcategory or notes.

CMS Action: None.

Comment12: Element 6.10 and 6.20 – When should an organization determination and reconsideration be dismissed for lack of AOR? Are Waiver of Liability forms required for organization determinations? If an organization or reconsideration determination is made untimely, should the case automatically be reported as adverse?

CMS Response 12: For organization determination requests, if the Medicare health plan does not receive the appropriate appointment documentation by the conclusion of the determination timeframe, plus any applicable extension, the Medicare health plan shall dismiss the organization determination request. For reconsideration requests, if the Medicare health plan does not receive the appropriate appointment documentation by the conclusion of the appeal time frame, plus any applicable extension, the Medicare health plan is responsible for issuing a dismissal notice. Please refer to Chapter 13 of the Medicare Managed Care Manual for decision timeframes.

CMS Action 12: None.

Comment 13: CMS Grievances Part C. My concern regarding the inclusion of the grievance dismissals in the Reporting Requirements is that CMS may publish it as part of the Display Measures and the publication of these data may be misleading to beneficiaries since they are not aware of the processes behind the dismissal (the behind the scene). For example, if CMS were to publish our dismissal data or any other plan’s data, beneficiaries may think that plans are dismissing their arguments and that they are not being addressed as supposed.

CMS Response 13: No, waiver of liability forms are required when a non-contract provider is appealing a denied claim. Please refer to Chapter 13, Section 60.1.1 of the Medicare Managed Care Manual, for additional guidance.

CMS Action Taken 13: None.

Comment 14: If an organization or reconsideration determination is made untimely, should the case automatically be reported as adverse?

CMS Response 14: Yes, please refer to Chapter 13, Sections 40.2.2 and 70.7.4 of the Medicare Managed Care Manual, for additional guidance.

CMS Action Taken 14: None

Comment 15: Grievances Part C—My concern regarding the inclusion of the grievance dismissals in the Reporting Requirements is that CMS may publish it as part of the Display Measures and the publication of these data may be misleading to beneficiaries since they are not aware of the processes behind the dismissal (the behind the scene). For example, if CMS were to publish our dismissal data or any other plan’s data, beneficiaries may think that plans are dismissing their arguments and that they are not being addressed as supposed. ??

CMS Response 15: Your concern is noted.

CMS Action Taken 15: None at this time.

Comment 16: Reporting due date states 2/6/17, shouldn’t it be 2018?

CMS Response 16: We agree.

CMS Action Taken 16: This will be corrected.

Comment 17: Are dismissed grievances counted in the Total Grievances (Element 5.1)?

CMS Response 17: No.

CMS Action 18: None.

Comment 19: The Part D Technical Specifications state the following: If a grievance is resolved within the reporting period for a member that has disenrolled from a plan and enrolled in a new plan, then the member’s new plan should report the grievance regardless of where the grievance originated if they actually resolve the grievance.

Our interpretation of this that for Part D the grievance will be reported under the plan in which the beneficiary is enrolled when the grievance was closed. This specification is not included in the Part C Reporting Requirements and we are requesting clarification. We would like specifications as to the definition of plan change. Is it a change in PBP within the same organization (ex. Contract S4477, PBP 002 to Contract S4477, PBP 001) or a change between different organizations? If it’s a change between organizations, if a grievance originated in Organization A and during the investigation the beneficiary moved to Organization B. Should Organization A transfer the Grievance to Organization B and not report the grievance, therefore Organization B would report it. Or, should Organization A continue to resolve the grievance and report it. Or do both Organizations (A and B) report it.

CMS Response 19: If a beneficiary was enrolled in Plan A and filed a grievance with Plan A, but then moved to Plan B during the investigation period, Plan A is responsible for reviewing and

resolving the grievance. The grievance should be reported by Plan A. Plan A should not transfer the grievance to Plan B.

CMS Action Taken 19: None.

Comment 20: Are dismissed grievances counted in the Total Grievances (Element 5.1)?

CMS Response 20: No

CMS Action Taken 20: None.

Comment 21: What is the timeframe to dismiss a grievance for lack of an Appointment of Representative (AOR) form? Chapter 13 is not specific.

CMS Response 21: For grievances, if the Medicare health plan does not receive the appropriate appointment documentation (AOR) by the conclusion of the grievance timeframe (30 days), plus any applicable extension (up to 14 days), the Medicare health plan shall dismiss the grievance.

CMS Action Taken 21: None.

Comment 22: The proposed CY2017 Part C Reporting Requirements Technical Specifications states the following:

- 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.

It does not specify that Plans must report expedited grievances in 2 elements: First, in the total number of expedited grievances. Second, in the appropriate grievance category. For example, if an enrollee files an expedited grievance because the plan denied their request for an expedited organization determination, that grievance should be reported both as an “Expedited Grievance” and also as an “Organization Determination and Reconsideration process” grievance.

CMS Response 22: The number of expedited grievances should not be reported in the total number of grievances. Expedited grievance should be reported in the appropriate category. As you say, “if an enrollee files an expedited grievance because the plan denied their request for an expedited organization determination, that grievance should be reported both as an “Expedited Grievance” and also as an “Organization Determination and Reconsideration process” grievance.

CMS Action Taken 22: None: