EXHIBIT A

Medicare Advantage Appeals and Grievance Data Disclosure Requirements
(CMS-R-282; OMB 0938-0778)

CHANGE CROSSWALK

FORM	CHANGES TO FORM	EXPLANATION
Title: **Sample Report (Appendix 2)** **Medicare Appeals and Quality of Care Grievances** **April 1, 2016 to March 31, 2017** On all pages throughout the form: • Use of the term "Organization X" • Sample dates and numbers. • Footers that included language for what pages specific information can be found (e.g., "Appeals information beginning on page 2")	Title: ***{Medicare Advantage Plan Name}* Appeals and Grievances Data Report** **January 1, {*Insert year of report data*} to December 31 {*insert year of report data*}** On all pages throughout the form: • Updated the term "Organization X" to "*{plan name}*". • Replaced sample information with curly brackets "{ }" and italicized instructions. • Footers were removed.	To reduce plan burden, the form was changed from a sample report to a template with parts in curly brackets "{ }" with italicized instructions for plans to enter plan specific information, such as "plan name" or "year of data report". The title and various places throughout the form has been revised to reflect this change. References to "Appendix 2" of Chapter 13 of the Medicare Managed Care Manual have been removed, as this guidance is no longer applicable. Footers were removed because information is easier to find due to the form being reduced from seven to three pages.
On all pages throughout the form: "Medicare member"	"Medicare member" changed to "member".	To more clearly distinguish the members being referenced in the form are members of the plan and not original Medicare beneficiaries.
On all pages throughout the form:	Removed references to the term "quality of care	Grievances data in the report will reflect both

FORM	CHANGES TO FORM	EXPLANATION
Quality of care grievances	grievances" and changed to "grievances".	grievances and quality of care grievances.
On page 1, under heading "What kind of information is this?" When asked, the government requires **Organization X** to provide reports that describe **what happened** to formal complaints that **Organization X** received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances.** Medicare members have the right to file an appeal or grievance with their Medicare Advantage organization. The next few pages contain information about the appeals and quality of care grievances that Organization X received between April 1, 2016, and March 31, 2017. Each organization will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, an organization might have a small number of appeals and quality of care grievances because the organization talks with members about	On page 1, under heading "What kind of information is this?" Medicare Advantage plan members have the right to file an appeal or grievance with their plan. Individuals eligible to enroll in a Medicare Advantage plan have the right to request information about the number of appeals and grievances a plan receives. The next few pages contain information about the appeals and grievances that {*plan name*} received in {*insert year of report data*}.	First paragraph removed to reduce the unnecessary and repetitive language within the form. Added language in second paragraph to explain why this report may be requested and updated with curly brackets "{ }" and italicized instructions for plans to insert plan name and the year the data in the report is from. Last paragraph is removed so individuals do not misinterpret why some plan's data may be different than others.

FORM	CHANGES TO FORM	EXPLANATION
their concerns and agrees to solutions. Alternatively, an organization might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.		
Section titled: "How big is **Organization X**?"	Section titled: "How many members does {*plan name*} have?"	Heading changed to be more specific and clarify the information being provided is the number of enrollees.
Throughout the form, there is use of the term "appeal" when referring to a plan level reconsideration.	Updated the term "appeal" to "level 1 appeal" (when related to a plan level reconsideration).	To ensure universal language throughout various appeals related guidance and notices/forms issued by CMS.
Under section titled: "What is an appeal?" An appeal is a formal complaint about **Organization X**'s decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes she/he needs. If a member cannot get an item or service that the member feels she/he needs, or if the organization has denied payment of a claim for a service the member has already received, the member can appeal.	Under section titled: "What is a level 1 appeal?" A level 1 appeal is a formal request for {*plan name*} to review {*plan name*}'s decision not to pay for, not to provide, or to stop an item or service that a member believes they need. If a member cannot get an item or service that the member feels they need, or if the organization has denied payment of a claim for a service the member has already received, the member can	Added "level 1" and "to the plan" to clarify this is a level 1 plan appeal. Removed the term "complaint" and replaced with "request" to clarify an appeal is a request for a review and not a complaint/grievance. Removed gender specific pronouns. Added "appeal to the plan" to clarify level 1 appeals are plan level appeals and requests should be made to the plan. Added a sentence

FORM	CHANGES TO FORM	EXPLANATION
	appeal to the plan. The number of level 1 appeals {*plan name*} had in {*insert year of report data*} can be found on **line 1** of the attached report. The number of level 1 appeals received per 1,000 members can be found on **line 2**.	notifying individuals where they can find specific information regarding number of appeals and number of appeals per 1,000 enrollees in the attached report.
All of pages 3 through 5, related to "Expedited or "fast" appeals" and "Information on independent review" and sections titled: • "How many appeals did **Organization X** receive?" • "How many appeals did **Organization X** review?" • "How many quality of care grievances did **Organization X** receive?"	Sections were removed.	Pages 3 through 5 regarding "fast appeals" and "appeals the IRE considered" were removed because these data elements are not necessarily based on plan performance. The decision to expedite an appeal request is based on medical necessity and the enrollee's health condition, which is specific to the enrollee making the request. Further, expedited appeals are already included in number of total appeals received. For independent review, IRE (level 2) appeals data was removed because overturn data is not indicative of plan performance (i.e., the decision was overturned because the IRE received different information, not because the plan's decision was incorrect). The additional sections removed contained

FORM	CHANGES TO FORM	EXPLANATION
		specific plan data, and a simple, easy to read chart was added at the end of the report so individuals could quickly and easily find data and to reduce plan burden (adding data in one place in the form versus two places).
Section titled: "What happened?" From the 174 appeals it received from its members: Organization X decided to pay for or to provide all services that the member asked for 41% of the time. Organization X decided not to pay for or to provide the services that the member asked for 49% of the time. Medicare members withdrew their request before Organization X issued a decision 10% of the time.	Changed to "What can happen with level 1 appeals?" Plans may decide to pay for or to provide all services that the member asked for. These are called favorable decisions. Sometimes, plans decide not to pay for or to provide the services that the member asked for. These are called unfavorable decisions. Sometimes a member may decide to withdraw their appeal. Because the plan doesn't do anything with a withdrawn appeal, they are not included in this report. The number of favorable level 1 appeal decisions {*plan name*} made can be found on **line 3** of the attached report. Unfavorable decisions	Section title changed to provide clarification on which type of appeals. Information regarding plan specific appeal data is removed to reduce plan burden and enrollee confusion (entering and looking for data in two different places). All data is found in a table on one page of the report. Language is added to define and easily understand the difference between favorable and unfavorable decisions. Language added to define a withdrawal and explain why withdrawals are not included in the report. A sentence was added to help enrollees easily identify where this information can be found on the report.

FORM	CHANGES TO FORM	EXPLANATION
	can be found on **line 4**.	
Section titled: "What is a quality of care grievance"?	Replaced with: "What is a grievance?" A grievance is a complaint that a member makes about {*plan name*}. For example, a member can file a grievance when they are unhappy because they believe their plan gives them too much or too little information, there are long wait times when calling the plan, a doctor's office waiting room is too cold, or they have to travel long distances to get to their doctor. The number of grievances {*plan name*} had in {*insert year of report data*} can be found on **line 5** of the attached report. The number of grievances received per 1,000 members can be found on **line 6**.	Data for "grievances" was added so individuals have data for all grievances. Quality of care grievances have been included in the total number of grievances. A section has been created to provide the individual with a definition of a grievance.
Section titled: "Where can I get more information?" You can contact Organization X at (insert phone number) to resolve a concern you may have or to get more information	Section titled: "Where can I get more information about appeals and grievances?" You can contact {*plan name*} at {*insert plan phone number*} to resolve a concern you may have or to get more information	Changed title to specify contact information is for information on appeals and grievances. Added sentence with instructions in curly brackets "{ }" to add TTY number. Changed "Quality

FORM	CHANGES TO FORM	EXPLANATION
on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights. You also can contact a group of independent doctors in STATE, called a Quality Improvement Organization, at (insert QIO's phone number) for more information about quality of care grievances or to file a quality of care grievance.	on how to file an appeal or grievance. TTY users can call {*insert TTY phone number*}. You may also refer to your Evidence of Coverage for a complete explanation of your rights. You also can contact the Beneficiary and Family Centered Care-Quality Improvement Organization (QIO) at {*insert QIO's phone number*} for more information about quality of care grievances or to file a quality of care grievance.	Improvement Organization" to "Beneficiary and Family Centered Care-Quality Improvement Organization (QIO)" to reflect recent change in name of QIO.
Current form has no report/table to insert data.	New page titled: **{*Plan Name*} Appeals and Grievances Data Report** **January 1, {*insert year of report data*} to December 31, {*insert year of report data*}** Page includes a place for plans to insert average number of enrollees in the plan and italicized instructions in curly brackets, "{ }"for plans to insert applicable data in the table titled "Level 1 Appeals". Table includes cells to enter quarterly and yearly data for:	Specific template for a data table template was added so individuals requesting reports from multiple plans have reports in the same format and all data can be found in one place in the report. This also eliminates the need for plans to create their own report.

FORM	CHANGES TO FORM	EXPLANATION
	• Level 1 appeals received • Level 1 appeals per 1,000 members • Favorable level 1 appeal decisions • Unfavorable level 1 appeal decisions A second table titled "Grievances" is included and provides titled cells to enter quarterly and yearly data for: • Grievances received • Grievances per 1,000 members This page also explains which months each quarter in the tables represent: **Quarter 1:** January 1 – March 31 **Quarter 2:** April 1 – June 30 **Quarter 3:** July 1 – September 30 **Quarter 4:** October 1 – December 31 **Year Total:** January 1 – December 31	

FORM	CHANGES TO FORM	EXPLANATION
Current form has No PRA disclosure statement.	Added PRA disclosure statement: **PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0778. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.	Per PRA requirements.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
On all pages, the following terms are used: • "Medicare Advantage Organization" • "Member"	• Updated the term "Medicare Advantage Organization" to "Plans". • Changed "member" to "enrollee"	Change made to simplify and reduce text within instructions. Changed to ensure universal language throughout various appeals related guidance and notices/forms issued by CMS.
On page 1: Medicare Advantage organizations are expected to disclose grievance and appeals data, upon request, to individuals eligible to elect a Medicare Advantage organization. For purposes of this section, by appeals data we mean all appeals filed with the Medicare Advantage organization that are accepted for review, or withdrawn upon the enrollee's request, but excluding appeals that the organization forwards to CMS' Independent Review Entity (IRE) for dismissal.	On page 1: Medicare Advantage plans are expected to disclose grievance and appeals data, upon request, to individuals eligible to elect a Medicare Advantage plan (i.e., beneficiaries).	Added "i.e., beneficiaries" to identify the types of individuals that may request a data report. Sentence regarding what data is included, was removed. Plans no longer forward cases to the IRE for dismissal.
On Page 1: No heading identifying how to calculate the number of appeals and grievances.	On Page 1, added a heading between the first and second paragraph that states: "Calculating Number of Appeals and Grievances"	To clearly identify where to find information on how to calculate number of appeals and grievances.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
On page 1: The following are examples of how the rates get normalized across small and large organizations:	On page 1: See examples below:	Change made to simplify and reduce text within instructions.
On page 1: Section titled: **Reporting Unit for Appeal and Grievance Data Collection Requirements** The reporting unit for appeal and grievance data sent to beneficiaries is to be consistent with (generally the same as) the reporting unit for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study, and the Medicare Health Outcomes Survey. Therefore, plans must make changes to the reporting unit for appeals and grievances concurrently. However, CMS retains the flexibility to grant special exceptions to the general reporting unit to allow for case-by-case exceptions for good cause.	Section titled, “Reporting Unit for Appeal and Grievance Data Collection Requirements” has been removed.	Ensuring data is consistent with HEDIS, CAHPS and HOS is no longer pertinent.
On page 2:	On page 2:	Added language to indicate the data used in

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
Data Collection and Reporting Periods In order for Medicare Advantage organizations to report appeal and grievance data consistently, data collection and reporting periods have been established. • The data collection period is the timeframe in which the data was collected. Data collection periods will be based on an ongoing 12 month period. By ongoing, we mean that the prior 6 months of data are added to the next 6 months of data in order to come up with a 12 month data collection period; • The reporting period refers to the timeframe during which organizations will be expected to report the data. The reporting period begins 3 months after the data collection period ends. Reporting periods are 6 months in duration; and • Organizations are expected to report appeal and grievance data to Medicare Advantage	Data Collection and Reporting Periods In order for plans to report appeal and grievance data consistently, data collection and reporting periods are aligned with CMS Part C reporting requirements. Plans may use the data reported to CMS for data reports requested by individuals. • The **data collection period** is the timeframe in which the data was collected. Data collection periods will be quarterly and the same as CMS Part C reporting requirements report period(s). Data collection periods are as follows: January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31 • The **reporting period** refers to the timeframe during which plans report the data to beneficiaries. The reporting period is from April 1 through March 31 of the following year. For example,	the report is the same as data submitted to CMS for the Part C reporting requirements. Also, the data collection and reporting periods align with Part C reporting requirements. Data collection periods are outlined in the instructions. A chart in the form with Sample Yearly Collection and Reporting Cycles, has been removed because collection and reporting periods have changed.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
eligible individuals, upon request, beginning 3 months after the end of each data collection period. For example, if the data collection period ended 9/30/15, the organization would begin reporting data to the beneficiary 1/1/2016. The 3 month lag between the end of the data collection period and the beginning of the report period allows the Medicare Advantage organization to resolve appeals received during the data collection period and ensure quality control over the data reported. Below is a chart detailing the sample yearly collection and reporting cycles.	plan reported grievance and appeals data for 2018 submitted to CMS in February 2019, would be used April 1, 2019 through March 31, 2020 in reports requested by individuals.	
On pages 2 and 3, sections with the heading: "New Reporting Periods Start Every Six Months" And "Maintaining Data"	These sections have been removed.	Sections removed because collection and reporting periods have changed.
On page 3: **Appeal and Grievance Data Collection Requirements**	On page 3: **Appeal and Grievance Data Report Instructions**	Title changed to more appropriately describe what is found in the section (i.e., report instructions).

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
The following describes the appeal and grievance data Medicare Advantage organizations are expected to record and report. This format should be used by the organization in recording the data internally and is the required format for reporting the information to beneficiaries.	The following are instructions for each section and line item of the appeals and grievances data reports for Form CMS-R-0282. Plans will meet the disclosure requirements set forth in the regulations at 42 CFR 422.111(c)(3) using this form. This format should be used by the plan in recording the data internally and is the required format for reporting the information to beneficiaries.	
No section in current form instructions describing the first section of the form.	On page 2: **Explanation of Data Report** In addition to reporting raw data to beneficiaries, this form provides an explanation to beneficiaries of what the numbers mean. This explanation of the data report includes information about the report itself and defines level 1 appeals and grievances. Throughout the form, text should be inserted into the curly brackets "{ }", as explained.	Added paragraph to provide a brief description of the beginning of the form, as well as provide instruction to plans for inserting information into curly brackets, "{ }" throughout the form.
On pages 6 and 7, sections titled (and	Number of data elements was reduced from	

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
instructions for each section): Appeal Data **Line 1** Time Period(s) Covered: **Line 2.** Total Number of Requests for an Appeal Received by [Organization Name]: [insert number here]. **Line 3.** Average Number of Enrollees in [Organization Name]: [insert number here]. **Line 4**. Total Number of Appeal Requests per 1,000 enrollees: [insert number here] **Line 5.** Of the Appeal Requests Received by [Organization Name] between [sample 12 month period: 04/01/16 through 03/31/17], [Organization Name] completed [insert number here]. **Line 6.**	nineteen to six. All elements in form were removed and replaced with the following: Data Form Average Number of Enrollees Insert the average number of enrollees. To calculate the number of enrollees, count the number of enrollees at the end of each month of the data report period. Divide that total by 12 (the total number of months in the data report period). **Line 1:** Total Number of Level 1 Appeals Received Insert the number of level 1 appeals received in each quarter. This would be organization determinations and reconsiderations data element subsection #3A in reporting requirements. Add the number of level 1 appeals for each quarter and put the total in the "Year Total" column.	New instructions for how to insert information into the last page of the form with the data report and table. Instructions include how to calculate average number of enrollees, total appeals and grievances per 1,000 enrollees, and where the information in this report can be found in CMS Part C reporting requirements.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
[Insert number here] or [insert percent here] of the appeals were decided fully in favor of the enrollee. **Line 7.** [Insert number here] or [insert percent here] of the appeals were not decided fully in favor of the enrollee. **Line 8.** [Insert number here] or [insert percent here] of the appeals were withdrawn by the enrollee. **Line 9.** For all appeals received by [Organization Name] between [sample 12 month period: 04/01/16 through 03/31/17], [insert number here] cases were sent to the IRE for review. **Line 10.** [Insert number here] or [insert percent here] of [Organization's Name] cases reviewed by the IRE were decided fully in favor of the enrollee. **Line 11.** [Insert number here] or [insert percent here] of	This line includes all requests for reconsideration, including pre- service (standard and expedited) and claims (payment) appeals. **Line 2:** Total Number of Level 1 Appeal Received per 1,000 Enrollees Insert the number of level 1 appeals received per 1,000 enrollees each quarter. This number is calculated by multiplying the total number of requests for a level 1 appeal (line 1) by 1,000 and dividing by the average number of enrollees for each quarterly column. Add the number of level 1 appeals per enrollee for each quarter and put the total in the “Year Total” column. **Line 3:** Favorable Level 1 Appeal Decisions Insert the number of level 1 appeals that were decided as fully favorable to the enrollee each quarter. This would be the total number of	

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
[Organization's Name] cases reviewed by the IRE were not decided fully in favor of the enrollee. **Line 12.** [Insert number here] or [insert percent here] were withdrawn by the enrollee. **Line 13.** [Insert number here] or [insert percent here] are still awaiting a decision by the IRE. **Line 14**. Between [sample 12-month period: 04/01/16 through 03/31/17] [Organization Name] received [insert number here] requests for expedited processing for appeals. **Line 15.** [Insert number here] or [insert percentage here] of the requests for expedited processing of the appeal were granted.	organization determinations and reconsiderations data element subsections #4A through #4D in reporting requirements. Add the number of favorable level 1 appeals for each quarter and put the total in the "Year Total" column. NOTE: Partially favorable decisions should be recorded as unfavorable decisions in line 4. **Line 4:** Unfavorable Level 1 Appeal Decisions Insert the number of level 1 appeals that were unfavorable to the enrollee each quarter. This would be the total number of organization determinations and reconsiderations data element subsections #4E through #4L in reporting requirements. Add the number of unfavorable level 1 appeals for each quarter and put the total in the "Year Total" column. **Line 5:** Number of Grievances	

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
	Received Insert the total number of grievances received each quarter. This would be grievances data element A in reporting requirements. Add the number of favorable level 1 appeals for each quarter and put the total in the "Year Total" column. **Line 6:** Grievances Received per 1,000 Enrollees Insert the number of grievances received per 1,000 enrollees for each quarter. This number is calculated by multiplying the total number of grievances (line 5) by 1,000 and dividing by the average number of enrollees in each quarterly column. Add the number of grievances per enrollee for each quarter and put the total in the "Year Total" column.	
On page 6, Sections titled: Quality of Care Grievance Data	All language in this section related to "quality of care grievances" was removed.	Data for "grievances" was added and quality of care grievances have been included in the total number of grievances; these line items are no

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
Line 1. Time Period Covered: [Sample Reporting Period lasts from 1/1/17 through 6/30/17, which includes data collected from 10/1/15 through 9/30/16, and 7/1/17 through 12/31/17 which includes data collected from 4/1/16 through 3/31/17]. **Line 2.** Total number of Quality of Care Grievances Received by [Organization's name: insert number here]. Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period. **Line 3.** Average Number of Enrollees in [Organization's name]: [insert number here]. Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).		longer needed.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
Line 4. Total Number of Quality of Care Grievances received per 1,000 enrollees [insert number here]. Instructions: This number is calculated by multiplying the total number of grievances (line 2) by 1,000 and dividing by the total number of enrollees as of the last date of the reporting period (line 3). Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.		
On page 7: In addition to reporting raw data to beneficiaries, Medicare Advantage organizations also must explain what the numbers mean in a separate report. See the Sample Report (Appendix 2) for standardized language. **Explaining Appeal and Quality of Care Grievance Data Reports** The standardized language included in Appendix 2 provides both	All language removed.	Information is no longer relevant due to sample report changing to a template format.

INSTRUCTIONS	CHANGES TO INSTRUCTIONS	EXPLANATION
contextual information and, where possible, offers an explanation about what the data provided by a Medicare Advantage organization might suggest to a beneficiary. By doing so, Medicare Advantage organizations will help beneficiaries make a connection between the processing and disposition of appeals. On page 4 of Appendix 2, the report provides background regarding independent reviews. For example, one sentence states that an independent review provides an opportunity for a new, fresh look at the appeal outside of the plan. Also, in an effort to explain why the IRE might disagree with the Medicare Advantage organization, the report offers that the IRE may have had more information about the appeal. Medicare Advantage organizations will meet the disclosure requirements set forth in the regulations at 42 CFR 422.111(c)(3) by utilizing the report found at Appendix 2.		