Medicare Part C Plan: Technical Specifications Document
Contract Year 2019

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INTRODUCTION

Beginning for CY 2019 CMS has separated the Medicare Part C Technical Specifications (this document) and the Medicare Part C Reporting Requirements into two (2) separate documents. Having two separate documents aligns with what Medicare Part D has published for Part D reporters, and provides business operations with better flexibility when making changes prompted by internal or industry suggestions.

The Part C Plan Reporting Requirements' document provides a description of the reporting sections, reporting timeframes and deadlines, and specific data elements for each reporting section. The document has completed OMB review and approval in compliance with the Paper Reduction Act of 1995, and its OMB control number is https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements. This document and the Part C Reporting requirements are located on the CMS website https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html

These technical specifications supplement the Part C Plan Reporting Requirements, and do not change, alter, or add to the data collection described above. They serve to further define data elements and alert plans to how CMS will review and analyze these data.

The purposes of these technical specifications are to help assure a common understanding of the data to be reported by Organizations, 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.

This document lists reporting timeframes and required levels of reporting. Plans will report data elements at the Plan Benefit Package (PBP) level, or the individual Contract level. These requirements are subject to change at the discretion of CMS.

General Information

Level of Data to be Reported

Contract-level reporting indicates data should be entered at the H#, Plan-level reporting indicates data should be entered at the PBP level, (e.g. Plan 001 for contract H#, R#, S#, or E). Plan-level reporting is necessary to conduct appropriate oversight and monitoring of some areas A summary of the reporting level required for each reporting section is below.

Reporting Section #	Reporting Sections	Report level	Data submission method
I.	Grievances	Contract	Upload
II.	Organization/Determinations and Reconsiderations	Contract	Upload
III.	Employer Group Plans	Contract (each plan within a contract.)	Upload
IV.	Special Needs Plans (SNPs) Care Management	Plan	Data entry
V.	Enrollment/Disenrollment	Contract	Data entry
VI.	Rewards and Incentives Programs	Contract	Upload
VII.	Payments to Providers	Contract	Upload

Timely submission of data

Compliance with these reporting requirements is a contractual obligation of all Part C Organizations. Compliance requires that the data not only be submitted in a timely manner, but that they also are accurate. Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline.

Please note the quarterly reports are now due annually and will be available in HPMS on or after 12/30/2019. Organizations should generate these reports at the end of each quarter of the contract year and hold them for the annual submission.

Only data that reflect a good faith effort by an Organization to provide accurate responses to Part C reporting requirements will count as data submitted in a timely manner. Organizations must not submit “placeholder” data (e.g., submitting the value “0” in reporting fields in HPMS). Organizations can expect CMS to rely more on compliance notices and enforcement actions in response to reporting requirement failures. Therefore, CMS may issue warning notices or requests for corrective action plans to non-compliant Organizations. Should the non-compliance persist, CMS may impose intermediate sanctions (e.g., suspension of marketing and enrollment activities) or civil monetary penalties pursuant to Subpart O of 42 C.F.R. Part 422 or contract termination pursuant to Subpart K of 42 C.F.R. Part 422.

If previously submitted data are incorrect, Part C Organizations should request the opportunity to correct and resubmit data. Part C Organizations are, responsible for correcting previously submitted data if it is determined the data were erroneous. If CMS changes the technical specifications during the contract year, which requires a change in reporting methodology, CMS is requiring that reports be regenerated for the prior reporting periods for Part C reporting. 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.

Once a reporting deadline has passed, CMS requires the Part C Organizations to submit a formal request to resubmit any data. HPMS designates this request as a Request Resubmission. Requests for resubmissions will only be approved for 7 days from the date the request is reviewed and approved by CMS. Organizations should not submit requests to resubmit data until they have data available to submit. Data submitted after the given reporting period deadline shall be considered late, and may not be incorporated within CMS data analyses and reporting. HPMS will not allow the resubmission of data that are identical to the original data submission.

CMS tracks resubmissions, including the number of resubmissions after the deadline. Failure to resubmit after requesting a resubmission is considered as overdue. CMS expects that data are accurate on the date they are submitted. Data resubmissions may only be submitted until March 31st following the last quarter or end of year reporting deadline. CMS urges Plans to store revised data for CMS auditors and data validation reviewers. Plans should retain documentation supporting their reported data.

The following steps must be followed by Part C Organizations to request resubmission:

1. On the HPMS Part C Plan Reporting Start Page, click the Resubmission Request link.
2. Select/complete the following: a. Reporting section (e.g. Reconsiderations);
    a. Reporting section (e.g. Reconsiderations);
    b. Time period (e.g., 1st quarter 2019);
    c. Select contracts or plans, depending on reporting level; and
    d. The reason for the resubmission request.

General Data Entry Rules

HPMS will not allow the entry of greater than sign (>); less than sign (<); or semi-colon (;) in any data entry field or uploaded file.

Unless otherwise noted:

- the entry of a zero is allowed,
- the entry of a negative is not allowed, and
- decimals are not allowed.

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 Plans), and Beneficiary Name.

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

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, Part C Organization 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, CMS does not grant extensions of 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 versions of the business requirements and 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).

General questions about Part C Reporting Requirements, or Technical Specifications can be emailed to Partcplanreporting@cms.hhs.gov

Note: Contracts and/or Plan Benefit Packages (PBPs) that terminate prior to July 1st of the following Contract Year are to be excluded from these reporting requirements.

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 the purpose of collecting all questions regarding the Part C Technical Specifications: **Partcplanreporting@cms.hhs.gov** 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, or Technical Specifications for answers and, when appropriate, contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov .

Exclusions from Reporting

National PACE Plans and 1833 Cost Plans are excluded from reporting all Part C Reporting Requirements reporting sections. Additionally, Medicare/Medicaid Plans (MMPs) are now excluded from reporting for Grievances, Organization/Determinations and Reconsiderations, and continue to be excluded from the following reporting sections: Employer Group Sponsors,

Special Needs Plans and Enrollment/Disenrollment. Please report MMPs as instructed for other reporting sections.

Based on the information in the Reporting Requirements document and these Technical Specifications, Organizations should report data based on interpretation of these documents and be able to support their reporting decisions. For questions about Part C reporting please contact Partcplanreporting@cms.hhs.gov

REPORTING SECTIONS

Grievances

According to MMA statute, all Part C organizations must provide meaningful procedures for hearing and resolving grievances between an enrollee and the Plan, including an entity or individual through which the Organization provides benefits. A grievance is any complaint or dispute, other than an organization determination, or appeal about any aspect of the operations, activities, or behavior of a Part C organization, regardless of whether remedial action is requested. Part C organizations are required to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the Part C Organization needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a Part C organization to process an enrollee's request for an expedited organization determination or redetermination requires a response from the Part C organization within 24 hours.
Note: Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS

I. GRIEVANCES - should be uploaded into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Data Element ID	Description
A.	Number of Total Grievances
B.	Number of Total Grievances in which timely notification was given
C.	Number of Expedited Grievances
D.	Number of Expedited Grievances in which timely notification was given
E.	Number of Dismissed Grievances

A. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS' outlier notifications serve only to give Part C organizations the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
- The percent of beneficiaries filing grievances will be examined for outlier data.

After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.

- The percent of grievances for which the plan provided timely notification of its decision will be examined for outlier data. All plans with values below the 5th percentile for their plan will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Plans.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- Contracts should validate Number of Total Grievances is not less than all other date elements combined.

C. Analysis- how CMS will evaluate reported data, as well as how other data sources may be monitored.

- The total grievance rate per 1,000 enrollees is equal to the sum of the total number of grievances divided by average enrollments, multiplied by 1,000.
- [Total Grievance Rate per 1,000 enrollees] = Total # Grievances / Avg. Enrollment x 1,000
- The grievance rate by category per 1,000 enrollees is equal to the sum of the grievance element divided by average enrollment, multiplied by 1,000.
- [Grievance Rate by Category per 1,000 enrollees] = Grievance Element / Avg. Enrollment x 1,000
- CMS will order contracts based on rates of grievances per 1,000 enrollees and determine percentile rankings
- CMS will correlate grievances with complaints in the CMS complaints tracking module (CTM)

Notes – additional clarifications to the Grievance Reporting section.

- A grievance is defined 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, either 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 time frame. 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.

- For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website: Medicare Managed Care Appeals & Grievances.

- 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.

- The total number of expedited grievances **should be** counted in the overall total number of grievances.

- The total number of dismissed grievances should **not** be reported in the total number of grievances.

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 if the member is ineligible on the date of the call to the plan but was eligible previously.

- Dismissals: CMS expects that dismissed grievances represent a very small percentage of total Part C grievances a plan receives. This element provides plans with a means to report grievances that are received but not processed by the plan because they do not meet the requirements for a valid grievance. Generally, a dismissal would occur when the procedure requirements for a valid grievance are not met and the plan is unable to cure the defect. For example, a grievance is received from a purported representative of the 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 and the plan is unable to obtain the required documentation in a reasonable amount of time and therefore, dismisses the grievance. See 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website:

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.

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

- Medicare/Medicaid Program (MMPs) organizations grievances.

- Grievances filed by non-enrollees, including prospective enrollees.

Additional Guidance

- 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, an MA Plan receives grievance on 1/1/2019 at 04:00pm, and an extension is requested at 1/31/2019 04:05pm. The plan completes investigation and provides notification on 2/5/2019 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.

- If the enrollee files a grievance with a previous contract, but enrolls in a new contract before the grievance is resolved, the previous contract is still responsible for investigating, resolving and reporting the 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 the Grievances Reporting Section I reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs.

II. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS:

Requires File Upload. Please refer to HPMS layouts and templates for more information.

Note: New data elements have been added to this reporting section beginning in CY 2019. Please refer to the below chart and the HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
01 – Local CCP 02 –MSA 03- RFB PFFS 04–PFFS 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 (reporting will include each quarter)	Last Monday of February in the following year

Elements	Data Elements
Subsection #1:	**Organization Determinations**
A.	Total Number of Organization Determinations Made in the Reporting Period Above
B.	Number of Organization Determinations - Withdrawn
C.	Number of Organization Determinations - Dismissals
D.	Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E.	Number of Organization Determinations submitted by Enrollee/Representative (Claims)
F.	Number of Organization Determinations requested by Non-Contract Provider (Services)
G.	Number of Organization Determinations submitted by Non-Contract Provider (Claims)

Elements	Data Elements
Subsection #2:	**Disposition – All Organization Determinations**
A.	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider
C.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by enrollee/representative
D.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by Non-contract Provider
E.	Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider
G.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by enrollee/representative
H.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by Non-contract Provider
I.	Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Organization Determinations – Adverse (Services) Requested by Non-contract Provider
K.	Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative
L.	Number of Organization Determinations – Adverse (Claims) Submitted by Non-contract Provider
Subsection #3:	**Reconsiderations**
A.	Total number of Reconsiderations Made in Reporting Time Period Above
B.	Number of Reconsiderations - Withdrawn
C.	Number of Reconsiderations - Dismissals
D.	Number of Reconsiderations requested by or on behalf of the enrollee (Services)
E.	Number of Reconsiderations submitted by Enrollee/Representative (Claims)
F.	Number of Reconsiderations requested by Non-Contract Provider (Services)
G.	Number of Reconsiderations submitted by Non-Contract Provider (Claims)
Subsection #4:	**Disposition – All Reconsiderations**
A.	Number of Reconsiderations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Reconsiderations – Fully Favorable (Services) Requested by Non-contract Provider
C.	Number of Reconsiderations – Fully Favorable (Claims) Submitted by enrollee/representative
D.	Number of Reconsiderations – Fully Favorable (Claims) Submitted by Non-contract Provider

Elements	Data Elements
E.	Number of Reconsiderations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Reconsiderations – Partially Favorable (Services) Requested by Non-contract Provider
G.	Number of Reconsiderations – Partially Favorable (Claims) Submitted by enrollee/representative
H.	Number of Reconsiderations – Partially Favorable (Claims) Submitted by Non-contract Provider
I.	Number of Reconsiderations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Reconsiderations – Adverse (Services) Requested by Non-contract Provider
K.	Number of Reconsiderations – Adverse (Claims) submitted by enrollee/respresentative
L.	Number of Reconsiderations – Adverse (Claims) Submitted by Non-contract Provider
Subsection #5:	**Reopenings**
A.	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:
B.	Contract Number
C.	Plan ID
D.	Case ID
E.	Case level (Organization Determination or Reconsideration)
F.	Date of original disposition
G.	Original disposition (Fully Favorable; Partially Favorable or Adverse)
H.	Was the case processed under the expedited timeframe? (Y/N)
I.	Case type (Service or Claim)
J.	Status of treating provider (Contract, Non-contract)
K.	Date case was reopened
L.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
M.	Additional Information (Optional)
N.	Date of reopening disposition (revised decision)*
O.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

A. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS' outlier notifications serve only to give Part C organizations the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

- The rate of exception requests per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, plans with values above the 95th percentile for their plan type or below the 5th percentile for their plan type will be flagged as outliers.

- The percent of organization determinations requests approved by the contract will be examined for outlier data. Contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C organizations.

- The rate of reconsiderations per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The percent of reconsiderations resulting in a full or partial reversal of the original decision will be examined for outlier data. After accounting for the number of reconsiderations filed, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The percent of reconsiderations resulting in upholding the original decision will be examined for analysis purposes.

- The rate of reopenings per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers. CMS will also identify outliers in the percent of organization determinations and reconsiderations that are reopened.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- Contracts should validate that the Case_Reopened_Date field is later than or equal to the Original_Disposition_Date field and that Reopening_Disposition_Date field is later than or equal to Case_Reopened_Date field.

- All data elements should be positive values.

C. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will evaluate exception rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous years.

- Rates of appeals will be calculated per 1,000 enrollees. This means the total appeal rate per 1,000 enrollees is equal to the sum of the total number of appeals divided by average enrollment, times 1,000.

- Total # of appeals/average enrollment x 1,000 = Total appeals rate per 1,000 enrollees

Notes

- For an explanation of Part C organization determinations, reconsiderations, and reopenings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website:
- **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 an 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 the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/MMCAG/
- Organization determinations, reconsiderations, and reopenings should be included, if requested by an enrollee, the enrollee's representative, a physician/provider (as applicable) making the request on behalf of an enrollee 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.

- If the plan receives an Organization Determination or Reconsideration Request and issues a timely decision, however, the request is withdrawn, the plan would report the timely decision as well as the withdrawn request.

- If the plan receives an Organization Determination or Reconsideration Request and the request is withdrawn prior to a decision being issued, the plan would report the withdrawal only.

- The total number of dismissals are ***not*** included in the total number of organization determinations.

- **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 requests to continue previously authorized ongoing courses of treatment. It includes organization determination and reconsideration requests submitted by contract providers on behalf of the enrollee and requests from non-contract providers. It does not include claims for payment or appeals from contract providers that are governed by the contractual arrangement between the MAO and its contract providers.

- **Reconsideration** is a plan's review of an adverse or partially favorable organization determination.

- **Fully Favorable** decision means an item or service was covered in whole.

- **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 was processed, but only 5 were authorized, this would be considered partially favorable.

- **Adverse** decision means an item or service was denied in whole.

- **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.

- **Dismissal** is a decision not to review an organization determination or reconsideration request because it is considered invalid or does not otherwise meet Medicare Advantage requirements. For example, an individual requests a 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 the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' chapter of the Medicare Managed

Care Manual via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/MMCAG/

- 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.

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 see and see 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' chapter of the Medicare Managed Care Manual via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/MMCAG/

- All Part B drug claims submitted by the enrollee or non-contract provider should be reported as organization determinations or reconsiderations.
- All Part B drug claims processed and paid by the plan's Prescription Benefits Manager (PBM) are reported as organization determinations or reconsiderations.
- Part B drugs rendered at the point of sale without Prior Authorization are to be included in OD/R reporting, and should be reported under data element "E" subsection #1.
- **Claims with multiple line items** at the "summary level."
- **A request for payment**, other than contract provider, 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 a Medicare request** for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service provision ultimately is provided, in whole or in part, for that item or service.

- 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 1/1/2019 at 04:00pm. An extension is requested at 1/31/2019 04:05pm. Plan completes reconsideration and provides notification on 2/5/2019 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

- Withdrawals

Do not report:

- Data from Medicare/Medicaid Programs (MMPs) organizations.

- Independent Review Entity (IRE) decisions.

- Claims payment or appeals from contract providers that are governed under the contractual arrangement between the MAO and its contract providers.

- Reopenings requested or completed by the IRE, Administrative Law Judge (ALJ), and Appeals Council.

- Concurrent reviews during hospitalization.

- Concurrent review of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (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.

- If a service is only covered under the plan's Medicaid benefits and **never** covered by Medicare **and not** covered by the MA plan as a supplemental Medicare benefit (such as Medicaid home- and community-based long term services and supports)

- 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.

Reopenings (Organization Determinations and Reconsiderations)

- A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

- Refer to 42 CFR §422.616 and described under Subpart M and the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/MMCAG/

- All reopened organization determinations and reconsiderations should be included.

- For cases that are in a reopening status across multiple reporting periods, contracts should report those cases in each applicable reporting period. For example, if a plan reopened an organization determination in the first quarter of a given calendar year, and sent the notice of the revised decision in the second quarter of the same calendar year 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).

- If the IRE fully or partially overturns the plan's determination, *the case is not and must not be reported as a reopening.*

III. EMPLOYER GROUP PLAN SPONSORS - should be uploaded into HPMS at the Plan (PBP) and Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
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	First Monday of February in the following year

Element Number	Data Elements
A.	Employer Legal Name
B.	Employer DBA Name
C.	Employer Federal Tax ID
D	Employer Address
E.	Type of Group Sponsor (employer, union, trustees of a fund)
F.	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
G.	Type of Contract (insured, ASO, other)
H.	Is this a calendar year plan? (Y (yes) or N (no))
I.	If data element H is "N", provide non-calendar year start date.
J.	Current/Anticipated Enrollment

A. Checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS' outlier notifications serve only to give Part C Organizations the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Organizations.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- N/A.

C. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

- TBD

Additional clarifications:

- HPMS displays one module for reporting both Part C and Part D Employer/Union-Sponsored Group Health Plan Sponsors data.

- 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, there are several commercially available lookup services that may be used to locate this number.

- Data Element G.: Type of contract (insured, ASO, other) 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 J.: Current/Anticipated Enrollment 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. This does not imply, however, that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us for the purposes of the Part C reporting requirements.

SPECIAL NEEDS PLANS (SNPs) CARE MANAGEMENT: requires direct data entry into HPMS at the Plan (PBP) level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
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	Last Monday of February in following year

Note: Some of the language below has been revised for clarification purposes. The data elements remain the same.

Data Element ID	Data Element	Inclusions	Exclusions
A.	Number of new enrollees due for an Initial Health Risk Assessment (HRA)	An enrollee should be reported under this element when: • The enrollee has an effective enrollment date that falls within the measurement year, and is continuously enrolled for at least 90 days during the measurement year. • The enrollee has an effective enrollment date that falls within the measurement year, is continuously enrolled for fewer than 90 days, and completes an initial HRA. • The enrollee has an effective enrollment date that falls in the previous measurement year, but a 90-day deadline for initial HRA completion that falls in this measurement year, if no initial HRA was	• Enrollees who are continuously enrolled in a plan with a documented initial or reassessment HRA in the previous measurement year. • New enrollees who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date if they did not complete an initial HRA prior to disenrolling. • Enrollees who receive an initial or reassessment HRA and remain continuously enrolled

Data Element ID	Data Element	Inclusions	Exclusions
		completed in the previous measurement year. The initial HRA is expected to be completed within 90 days (before or after) the effective date of enrollment.	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 under the same Model of Care (MOC) as the enrollee's previous SNP.
B.	Number of enrollees eligible for an annual reassessment HRA	An enrollee should be reported under this element when: • The enrollee has been continuously enrolled for 365 days or more. • The enrollee is a new enrollee who missed the deadline to complete an initial HRA, but completed a reassessment HRA by the 365-day deadline (even if the enrollee was covered for fewer than 365 days). • The enrollee is a new enrollee who missed both the deadline to complete an initial HRA and the deadline to complete a reassessment HRA, and is enrolled for all 365 days of the measurement year. • The enrollee is a new enrollee whose initial HRA was performed in the 90 days prior to the start of the calendar year, and the enrollee remained enrolled until their 365-day reassessment deadline.	New enrollees for whom the initial HRA was completed within the current measurement year. New enrollees who miss the deadline to complete an initial HRA and have not yet completed their reassessment HRA, but whose 365-day reassessment deadline is not until the following calendar year.

Data Element ID	Data Element	Inclusions	Exclusions
C.	Number of initial HRAs performed on new enrollees	Initial HRAs performed on new enrollees (as defined above in data element A) within 90 days before or after the effective date of enrollment. If the initial HRA is performed in the 90 days prior to the effective enrollment date, it is reported as an initial HRA in the reporting year in which the effective enrollment date falls.	An HRA that is performed after the first 90 days of enrollment.
D.	Number of initial HRA refusals	Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to enrollee refusal and for which the SNP has documentation of enrollee refusal.	Initial HRAs not performed for which there is no documentation of enrollee refusal.
E.	Number of initial HRAs not performed because SNP is unable to reach new enrollees	Initial HRAs not performed on new enrollees within 90 days (before or after) the effective date of enrollment due to the SNP being unable to reach new enrollees and for which the SNP has documentation showing that the enrollee did not respond to the SNP's attempts to reach him/her. Documentation must show that a SNP representative made at least 3 "non-automated" phone calls and sent a follow-up letter in its attempts to reach the enrollee.	Initial HRAs not performed where the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempts to reach him/her.
F.	Number of annual reassessments performed on enrollees eligible for a reassessment	Number of annual reassessments performed on enrollees eligible for a reassessment (during the measurement year as defined in element B 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	A reassessment HRA that is completed past the 365-day reassessment deadline.

Data Element ID	Data Element	Inclusions	Exclusions
		days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA. When an initial assessment is performed in the 90 days prior to the effective enrollment date, the first annual reassessment must completed no more than 365 days after the initial HRA.	
G.	Number of annual reassessment refusals	Annual reassessments not performed due to enrollee refusal and for which the SNP has documentation of enrollee refusal.	Annual reassessments not performed for which there is no documentation of enrollee refusal.
H.	Number of annual reassessments where SNP is unable to reach enrollee	Annual reassessments not performed due to the SNP's inability to reach enrollees and for which the SNP has documentation showing that the enrollee did not respond to the plan's attempts to reach him/her. Documentation must show that a SNP representative made at least 3 non-automated phone calls and sent a follow-up letter in its attempts to reach the enrollee.	Annual reassessments not performed for which the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempts to reach him/her. Required documentation of SNP's attempts to contact the enrollee show that the SNP made at least 3 phone calls and sent a follow-up letter in its attempts to reach the enrollee.

- For reporting purposes, the "measurement year" is the same as the calendar year.

- If a new enrollee does not receive an initial HRA within 90 days of enrollment that enrollee's annual HRA is due to be completed within 365 days of enrollment. A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.

IMPORTANT: A member cannot be counted more than once in the same data element for the same plan.

A. QA checks/Thresholds - procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS' outlier notifications serve only to give Part C the opportunity to correct submitted data if needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.

- The percent of HRAs by the contract will be examined for outlier data. Contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part C Organizations.

- The rate of HRAs per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers.

- The rate of HRAs per 1,000 enrollees will be examined for outlier data. After accounting for enrollment, contracts with values above the 95th percentile or below the 5th percentile will be flagged as outliers. CMS will also identify outliers in the percent of coverage determinations and redeterminations that are reopened.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- All data elements should be positive values.

C. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

- CMS will evaluate HRAs rates per 1,000 enrollees and will trend rates from previous years.
- Rates of HRAs will be calculated per 1,000 enrollees. This means the total HRA rate per 1,000 enrollees is equal to the sum of the total number of HRAs divided by average enrollment, times 1,000.
- Total # of HRAs average enrollment x 1,000 = Total HRAs rate per 1,000 enrollees

Notes

- Under data element 'G.' (Number of annual reassessment refusals) a plan's reporting should be based off of the enrollee's most recent HRA activity. If the enrollee completes more than one (1) reassessment HRA during the reporting period, then the plan should base their reporting off of the most recent reassessment HRA completed. An enrollee can only be counted once in F., even if the enrollee completes more than one (1) reassessment during the reporting period.

- For Part C reporting, there are never to be more than 365 days between Health Risk Assessments (HRAs) for enrollees in special needs plans. SNPs are required to conduct an initial HRA within 90 days before or after a beneficiary's effective enrollment date. Initial HRAs conducted prior to the effective enrollment date are counted as initial HRAs in the year in which the effective enrollment date falls. For example, an initial HRA performed on November 23, 2016 for an enrollee with an effective date of enrollment of January 1, 2017 would be counted as an initial HRA in 2017. A SNP should not perform, or report on, a HRA 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) of the effective enrollment date, the SNP is to complete a HRA as soon as possible. In this case, the HRA would be considered a reassessment.

- 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.

- All annual reassessment HRAs are due to occur within 365 days of the last HRA. Thus, when an initial HRA is performed in the 90 days prior to an effective enrollment date that falls in the beginning of a calendar year, in order to comply with the requirement to perform the annual reassessment within 365 days of the last assessment, the first annual reassessment will be due within the same measurement year as the initial HRA. Note that is such cases, a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA, will be counted in both data elements A. and B. because he/she is a new enrollee (A.) and an enrollee eligible for an annual reassessment (B.). (Example: The effective enrollment date is 1-1-2017 and the initial HRA was completed in November 2016. The annual reassessment will be due in November 2017. The initial HRA and the annual reassessment HRA will both be reported for 2017 and the enrollee will be counted as both a new enrollee and as an enrollee eligible for annual reassessment.)

Note: The plan must have documentation of any HRAs not performed based on enrollee refusal or the SNP's inability to reach the enrollee. The SNP must document in its internal records that the enrollee did not respond to at least 3 "non-automated" phone calls and a follow up letter, all soliciting participation in the HRA. Automated calls ("robo" or "blast" calls) as a means of soliciting enrollees' participation in completing an HRA are inappropriate and do not count toward the three phone call attempts. Further, phone call attempts must be made by a SNP representative so that when an enrollee is reached, it is possible to perform the HRA at that time, by phone. 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.

- 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 C. and F.., CMS requires only completed assessments. This reporting section excludes cancelled enrollments.[1]

- 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 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.

- If eligibility records received after completion of the HRA indicate the member was never enrolled in the plan, 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.

- Questions have arisen regarding how to report data elements in this reporting section when enrollees disenroll and then re-enroll, either in the same SNP or a different one (different organization or sponsor) within the measurement year. When a member disenrolls from one SNP and enrolls into another SNP (a different sponsor or organization), the member should be counted as a "new enrollee" for the receiving plan. 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 HRA may be reported before an individualized care plan (ICP) is completed.

- Please note that these reporting requirements specifications pertain to Part C reporting only and are not a statement of policy relating to SNP care management.

[1] A 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."

V. ENROLLMENT AND DISENROLLMENT: requires data entry into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report*	Report Frequency Level	Report Period (s)	Data Due date (s)
MAOs offering MA-only (no Part D) plans 1876 Cost Plans (enrollments that do not include a Part D optional supplemental benefit)	2/Year Contract	1/1-6/30 7/1 – 12/31	Last Monday of August and February

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.

Subsection #1 Enrollment Data elements **Note: Disenrollments must not be included in Subsection #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 for which the sponsor was required to request additional information from the applicant (or his/her representative).
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 (i.e. individual not eligible for an election period).
E.	Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and 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 sponsor offers this mechanism).
I.	Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism).
J.	Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.
K.	Of the total 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.
Subsection #2 Disenrollment: Data elements A. - F.	
A.	The total number of voluntary disenrollment requests received in the specified time period. Do not include disenrollments resulting from an individual's enrollment in another plan.
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 G, the number of individuals reinstated.

A. QA checks/thresholds – procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS's outlier notifications serve only to give Part D sponsors the opportunity to correct submitted data of needed, and does not indicate that submitted data are incorrect, or that resubmissions are required.
- The percent of enrollment requests denied by the contract will be examined for outlier data. After accounting for the number of enrollment requests filed, contracts with values above the 95th percentile for the contract type will be flagged as outliers.
- The percent of disenrollment request denied by the contract will be examined for outlier data. After accounting for the number of disenrollment request files, contracts with values above the 95th percentile for their contract type will be flagged as outliers.
- CMS may apply new or adjust existing quality assurance checks and threshold validations based upon data received from Part Organizations.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- N/A

C. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

- TBD

VI. REWARDS AND INCENTIVES PROGRAMS: is a partial data entry and upload into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

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

Data Elements	Descriptions
A.	Do you have a Rewards and Incentives Program(s)? ("Yes" or "No" only;)
B.	What health related services and/or activities are included in the program? [Text]
C.	What reward(s) may enrollees earn for participation? [Text]
D.	How do you calculate the value of the reward? [Text]
E.	How do you track enrollee participation in the program? [Text]
F.	How many enrollees are currently enrolled in the program? Enter _____
G.	How many rewards have been awarded so far? Enter_____

A. QA checks/thresholds – procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

B. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- Must be positive values.

C. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

- TBD

Notes

- Plan's utilizing Part B drug step therapy must report on their associated drug management care coordination Rewards and Incentives Program. Plans should use data element 'D.' (*How do you calculate the value of the reward?)* to describe the value of the reward or incentive offered on a per member basis as compared to the average per participant savings of the particular Part B step therapy utilized. These requirements were included in the August 7, 2018 HPMS memo, *"Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage."*

- Currently Enrolled (Element F) means as of December 31st of the current reporting period, and the number of awards made "so far" (Element G) means awards made at any time up until December 31st of the current reporting period.

VII. PAYMENTS TO PROVIDERS: should be uploaded into HPMS at the Contract level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency/ Level	Report Period (s)	Data Due date (s)
01 – Local CCP 04 – PFFS 05 – MMP* 11 – Regional CCP 15 – RFB Local CCP	1/Year Contract	1/1-12/31	Last Monday of February in following year

* MMPs should report for all APMs, not just Medicare APMs.

Note: For additional information refer to Appendix 1. : FAQs.

HHS developed the four 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); and population-based payment (category 4). CMS will collect data from MA organizations about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry. Descriptions of the four categories are as follows:

- Category one includes 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.

- Category two includes 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 including hospital value-based purchasing and physician value-based modifiers.

- Category three includes 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.

- Category four includes 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).

For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework https://hcp-lan.org/workproducts/apm-whitepaper.pdf

PAYMENTS TO PROVIDERS (cont.) Data Elements (contract level):

Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements.

Data Elements	Payments to Providers
A.	Total Medicare Advantage payment made to contracted providers.
B.	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1).
C.	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2).
D.	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3)
E.	Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework)
F.	Total Medicare Advantage payment made using population-based payment (category 4).
G.	Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)
H.	Total number of Medicare Advantage contracted providers.
I.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1).
J.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2).
K.	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3).
L.	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
M.	Total Medicare Advantage contracted providers paid based on population based payment (category 4).
N.	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

D. QA checks/thresholds – procedures used by CMS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

E. Edits and Validation Checks - validation checks that should be performed by each Part C Organization prior to data submission.

- All data elements should be positive values.

F. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

APPENDIX 1. FAQS: REPORTING SECTIONS: (I) Grievances, (II) Organization Determinations, & Reconsiderations and (VII) Payments to Providers

	PLAN INQUIRIES	CMS RESPONSES
Grievances, and Organization Determinations & Reconsiderations		
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.	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.
3.	Are plans to report the total number of organization determinations or reconsiderations that were processed timely?	The plans are no longer required to report timeliness data.
4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	Yes, plans report organization determinations as defined at 42 CFR §422.566(b) and as described in the Part C Technical Specifications, Reporting section VI.
5.	We are seeking information on how we should report pre-service requests and payment requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and payment requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and payment requests (organization determinations and reconsiderations), as described in this guidance

6.	If we have a prior authorization request and a payment request 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 payment request for the same service if the payment request is submitted by the enrollee or a non-contract provider. Payment requests from contract providers should not be reported.
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 on behalf of the enrollee, 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 didn't 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 from a non-contract provider is a reportable organization determination.
11.	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	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.

	further. Is this an organization determination?	
12.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests an organization determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-auth and claim not counted as two events)?	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.
13.	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.
14.	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."
15.	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.

16.	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 *and* reconsideration. Exceptions: Plans are not to report QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.
17.	Should supplemental benefit data be excluded from the Part C Reporting?	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.
18.	Can you please clarify in the below how these counts should be included for organization determinations? **Example scenario**: A pharmacy claim is processed at point-of-sale for test strips; the claim rejects. The pharm tech. resubmits the claim and it rejects again. The pharmacy tech then adjusts the quantity and day supply and the claim eventually pays. Would this be counted as one paid claim (fully favorable) or should it be counted as two adverse claims and one paid claim?	Report only the final outcome of the submission.
Payments to Providers		
	PLAN INQUIRIES	**CMS RESPONSES**
1.	What are the four categories of value-based payment? Can you provide examples of each category?	MAOs will report on the proportion of payments made to contracted providers based on the HHS-developed four categories of value based payment: 1. Fee-for-service with no link to quality (category 1);

		2. Fee-for-service with a link to quality (category 2); 3. Alternative payment models built on fee- for-service architecture (category 3); 4. Population-based payment (category 4) For additional guidance regarding the four (4) categories of payment, we ask that you refer to the Learning Action Network Definitional Framework white paper, which describes in detail each category and which types of payments fall into each category.
2.	How are contracted providers defined?	For the purposes of the Payments to Providers Part C reporting requirements, contracted providers include both physicians and clinicians. Payments for administrative services and payments to hospitals, facilities, pharmacies, or labs are not to be reported.
3.	For data elements F – J, how do we report if a provider is paid using multiple payment arrangements that fit under multiple categories?	If a provider is paid under multiple payment arrangements that do not fit in one category, we ask that the MAO report that provider under the category for the dominant payment arrangement.
4.	For data elements F. and J. are we to report by individual providers or by contracts (which include groups with one or more providers)?	Please report by contracts. If a plan is in a contract with a provider group, the provider group counts as one contracted provider. If the plan is in a contract with an individual provider, the individual provider counts as one contracted provider.
5.	For data elements A. – E., are we to report payments made to providers in 2018 based on services rendered in 2017?	Please report based on the year payment was made, regardless of when services were furnished.
6.	For data elements A. – E., do payments refer to the total calculated allowed amount or actual payments to providers?	This refers to the total actual payments made to contracted providers based on the aforementioned categories of value-based payment.
7.	Should plans report the incentive portion of the alternative payment method or all of the dollars going to the provider under that arrangement?	Plans should report the total dollars (actual payment), which includes the base payment plus any incentive, such as a bonus for performance (P4P), savings that were shared with providers, etc.
8.	Should plans report shared savings or capitation without links to quality?	Yes. Risk-based payment with no link to quality (classified as 3N in the Learning Action Network

		Definitional Framework white paper) should be reported under element number 17.4b. Capitation with no link to quality (classified as 4N in the Learning Action Network Definitional Framework white paper) should be reported under element 17.5b.
9.	Are elements B, C, D and F subsets of elements "A?"	Yes. It is possible, however, that there are some forms of payments that would not fit into elements B, C, and F, and therefore the sum of B, C, D and F can be less than A.
10.	Is element E a subset of element D?	No. They are both different categories of payment as noted in the referenced alternate payment model (APM) definitional framework.
11.	Is element G and subset of element F?	No. They are both different categories of payment as noted in the referenced alternate payment model (APM) definitional framework.
12.	Are elements I, J, K, and M subsets of element H?	Yes. However, it is possible that there are some forms of payments that would not fit into I, J, K, or M. Hence, the sum of I,J, K, and M can be less than H.
13.	Is element L a subset of element K?	No. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework: https://hcp-lan.org/workproducts/apm-whitepaper.pdf
14.	Is element N a subset of element M?	No. They are both different categories of payment as noted in the referenced APM definitional network. For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework: https://hcp-lan.org/workproducts/apm-whitepaper.pdf