CMS Manual System

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Department of Health & Human Services (DHHS)
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SUBJECT: Surveys, Contracting Strategy, Grievances and Appeals

I. SUMMARY OF CHANGES: This revision provides the following changes:

Surveys: Chapter 5 is updated to reflect 2005 requirements for PACE plan and health outcomes surveys, and to correct the organizational component for technical questions about the Health Outcomes Survey.

Contract Requirements: Chapter 11 is updated to remove the 6th bullet (about the contract acknowledging M+C organization responsibility for performance of services) to conform to current contracting strategy.

Grievances and Appeals: Chapter 13 is updated to address services before the M+C organization completes the pre-service reconsideration, and to clarify language about amount in controversy requirements

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/40/40.1/Background
R	5/40/40.2/Specifics Applicable to CAHPS and HEDIS
R	5/40/40.4/The Medicare Health Outcomes Survey (HOS) Requirements
R	5/40/40.6/Minimum Performance Levels and Performance Goals
R	11/100/100.5/Administrative Contracting Requirements
N	13/70/70.7.5/Converting from Standard Pre-Service Appeal to Post-Service Activity
R	13/90/ Reconsiderations by the Independent Review Entity
R	13/100/Administrative Law Judge (ALJ) Hearings
R	13/100/100.2/Determination of Amount in Controversy

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/120 - Judicial Review

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

40.1 - Background

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

This section provides information regarding the annual Medicare HEDIS submission and provides clarification for Medicare contracting organizations under applicable law, regulations and contract requirements governing Medicare+Choice (M+C) organizations, the §1876 of the Act cost contracting organizations, and demonstration projects. This section also explains reporting requirements for HOS and CAHPS and addresses specific CMS implementation requirements. Throughout this section of Chapter 5, the general term, Managed Care Organization (MCO), will be used to refer to all contracting organizations, unless otherwise specified. Effective January 1, 1997, CMS began requiring MCOs to report on performance measures from the HEDIS® reporting set relevant to the Medicare managed care population, and to participate both in CAHPS® and the Health Outcomes Survey (HOS). These requirements are consistent with the law and with the requirements of other large purchasers. It is critical to CMS' mission that it collect and disseminate information that will help beneficiaries choose among MCOs and contribute to better health care through identification of quality improvement opportunities. For M+C organizations, HEDIS represents a performance measurement system that is acceptable to CMS since it uses standard measures adopted by CMS and it meets the provision at 42 CFR 422.152(c)(1).

The CMS makes summary, plan-level performance measures available to the public through media that are beneficiary-oriented, such as the Medicare Personal Plan Finder and Medicare Health Plan Compare tools on (www.medicare.gov). A subset of HEDIS and CAHPS data is also available in printed form through a toll free line (1-800-MEDICARE). Disenrollment rates and reasons also are available in printed form through the same toll free line. HEDIS summary-level data files are available through CMS' Internet Web site as a Public Use File (http://www.hcfa.gov/hedisdwn.htm). Complete HEDIS and CAHPS (including the annual M+C CAHPS survey and the Disenrollment Reasons Surveys) patient-level files are available at cost to requesters authorized to receive such information. Requesters, for confidentiality reasons, must sign a Data Use Agreement with CMS and must meet CMS' data policies and procedures that include, but are not limited to, submitting a research protocol and study purpose. For information about Data Use Agreements, contact the Division of Data Liaison and Distribution, Enterprise Database Group, within CMS' Office of Information Services. For more information about Medicare data for research purposes, go to http://www.cms.hhs.gov and then select the area for Researchers.

The following is a chart describing HEDIS, HOS, and CAHPS program requirements.

Table - Program Requirements

Contract Year	Sampling Frame/ Period	Dates for Participation Eligibility	Minimum Sample Size	Financial Responsibility	Demon-strations	Mergers and Acquisitions	Cost Contract Report-ing	Due Dates
HEDIS and HEDIS audit	Services delivered in measurement (previous) year (and earlier for some measures)	First Medicare Enrollment on Jan. 1 of prev. year or earlier. Minimum Medicare enrollment of 1,000 as of July 1 in previous year	Measure specific (MCOs must report all CMS-required Medicare measures according to instructions)	MCO pays for external HEDIS Audit	Required in some cases as specified in this manual	Reporting by surviving MCO only	Report Cost Contract Measures Only	MCO must submit Audited Summary and Patient-Level Data by the last business day in June.
Health Outcomes Survey	Members continuously enrolled 6 months prior to survey sampling*; for PACE, Mass Health SCO, M-SHO & WPP, members enrolled one month prior to survey sampling*	Medicare contract in place no later than Jan. 1 of previous year	1000 (If less than 1000 enrollees, all members must be surveyed.)	MCO pays for NCQA certified vendor to administer survey	Yes (See section on demon-strations)	Reporting of surviving MCO's membership only	Yes	MCO*, including Program of All Inclusive Care for the Elderly (PACE) plans,* must contract with NCQA certified vendor before Feb. 1 of reporting (current) year
Annual CAHPS: Assessment Survey Current (Enrollees and Disenrollees)	Members continuously enrolled 6 mo. prior to July 1 of measurement year	Medicare contract in place no later than July 1 of previous year	600 enrollees (If less than 600, all members will be surveyed.) Disenrollee sampling proportionate to disenrollment rate	CMS pays for survey administration	Yes (See section on demon-strations)	Reporting of surviving MCO's membership only only	Yes	CMS will conduct survey in the Fall.
Quarterly CAHPS Disenrollment Reasons Survey	Members who have disenrolled during previous quarter	Medicare contract in place no later than Jan. 1 of previous year	Approximately 388, (If less than 388, all disenrolled members will be surveyed except those for CAHPS Assessment)	CMS pays for survey administration	Yes (See section on demonstra-tions)	Reporting of surviving MCO's membership only	Yes	CMS will conduct survey quarterly.

40.2 - Specifics Applicable to CAHPS and HEDIS

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

A - Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the Medicare+Choice program, which replaced the §1876 program of risk and cost contracting starting with contracts effective January 1, 2000. The reporting requirements contained in this section of Chapter 5 apply to organizations that hold an M+C contract, a §1876 cost contract, or a demonstration contract, in accordance with applicable law, regulations, and contract requirements. HEDIS submission requirements also apply to deemed M+C organizations. Please see section C below for exceptions to this requirement, such as organizations that have terminated their M+C contract or §1876 contract with CMS.

B - Requirements for MCOs

1. Reporting Requirements

    a. HEDIS - A MCO must report HEDIS measures for its Medicare managed care contract(s), as detailed in the "HEDIS Volume 2: Technical Specifications" if all of the following criteria are met:

        - The contract was in effect on 1/1 of the measurement (previous) year or earlier;
        - The contract had initial enrollment on 1/1 of the measurement year or earlier;
        - Contract had an enrollment of 1,000 or more on 7/1 of the measurement year;
        - The contract was not terminated on or before 1/1 of the reporting (current) year.

    The HEDIS technical specifications are updated annually. For example, MCOs preparing HEDIS 2003 data submissions must follow instructions in HEDIS 2003, Volume 2, and the HEDIS 2003, Volume 2 Update (to be released in October 2002). Please note that where there are differences between this manual chapter and HEDIS Volume 2, this chapter takes precedence for reporting data. The final HEDIS Volume 2: Technical Specifications is available from NCQA. Please call NCQA Customer Support at 1-888-275-7585 to obtain a copy. When the HEDIS 2003 Volume 2 Update is released HEDIS specifications are frozen. MCOs are

required to take into account the update. You may wish to check periodically the HEDIS Data Submission section of NCQA's Web site to review Frequently Asked Questions (FAQs).

The Medicare relevant HEDIS measures that M+COs must report are listed in Exhibit I, and the Medicare relevant measures that continuing cost contractors must report are listed in Exhibit IA. M+C PPO and PFFS plan reporting requirements are shown in Exhibit IB. Note that two measures in the Health Plan Descriptive Information Domain (that are listed in NCQA's Technical Specifications as appropriate for Medicare) are not required to be submitted to CMS - Practitioner Compensation and Arrangements with Public Health, Educational and Social Service Organizations.

b. Health Outcomes Survey (HOS) - All MCOs*, including the Program of All Inclusive Care for the Elderly (PACE) plans,* that had a Medicare contract in effect on or before January 1st, of the previous year must comply with the HOS requirements for current year reporting. See the chart in section C below for specific requirements for demonstration projects.

c. Medicare+Choice CAHPS Survey - All Organizations that had a Medicare contract in effect on or before July 1, of the previous year, must comply with the M+C CAHPS survey of current enrollees and disenrollees.

d. Medicare CAHPS Disenrollment Reasons Survey - All organizations that had a Medicare contract in effect on or before January 1 of the previous year must comply with the Medicare CAHPS disenrollment Reasons Survey (hereinafter "The Reasons" Survey. The Reasons Survey does not apply to organizations that began a contract effective after January 1 of the previous year. However, such MCOs may be required to undertake an enrollee satisfaction survey to comply with the CMS regulations on physician incentive plans (Volume 61, "Federal Register," 13430, March 27, 1996). The Medicare CAHPs can be used for this purpose.

2. Minimum Size Requirements - There is a minimum size requirement for MCOs to report HEDIS measures; MCO enrollment must be 1,000 or more on July 1st of the measurement year. In reviewing previous HEDIS submissions, CMS noted that this is the enrollment level at which most MCOs could submit valid data on the Effectiveness of Care measures. There is no minimum size requirement to participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size requirements (see table above for specific program requirements) or the HOS sample size of 1,000, at the time the sample is drawn, the entire membership must be surveyed. An MCO must report all the CMS-required Medicare HEDIS measures, even if the MCO has

small numbers for the denominator of a measure. For specific instructions on how to handle small numbers, review the Specific Guidelines in the "HEDIS Volume 2, Technical Specifications." For information regarding the audit designation for these measures review "HEDIS Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures."

Sampling and Reporting Unit - In 2004 MCOs will have one reporting unit for HEDIS, HOS, and Disenrollment Reasons and Rates, for each contract. This aligns HEDIS and HOS reporting with the level at which MCO performance is monitored and quality assessment and performance improvement projects are performed, i.e. at the contract level. Note that HEDIS reporting will be based on the membership in the service area in place during the measurement (previous) year while the reporting entity will reflect the contract or entity structure under the reporting (current) year configuration.

Medicare CAHPS instituted a local sampling and reporting unit for the traditional CAHPS survey of enrollees and disenrollees that accommodates comparison with Medicare CAHPS fee-for-service (FFS) and Private Fee-For-Service (PFFS) plans and retains the collection of beneficiary satisfaction and experience data at a local level. The sampling unit is a collection of counties combined into a Health Service Area (HSA), which is a standard unit of measure of health services utilization as determined by the Department of Health and Human Services. Currently, the CAHPS data on Medicare managed care plans is compared to CAHPS data on Original Medicare at the State level in the Medicare Personal Plan Finder and Medicare Health Plan Compare on www.medicare.gov and in the annual CAHPS health plan reports. The comparisons between managed care, private fee-for-service, and Original Medicare are displayed. Please send questions to CAHPS@cms.hhs.gov..

C - MCOs With Special Circumstances

1. MCOs with Multiple Contract Types - A MCO cannot combine small contracts of different types, e.g., risk and cost, into a larger reporting unit.

2. MCOs Carrying Cost or former HCPP Members - HEDIS performance measures will be calculated using only the Medicare enrollment in the M+C contract or the §1876 of the Act contract in effect at the end of the measurement year. Therefore, any residual cost based enrollees within an M+C contract should not be included in HEDIS calculations.

3. For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

4. MCOs with New Members "Aging-in" from their Commercial Product Line - These MCOs must consider "aging in" members eligible for performance measure

calculations assuming that they meet any continuous enrollment requirements. That is, plan members who switch from a MCO's commercial product line to the MCO's Medicare product line are considered continuously enrolled. Please read the General Guidelines of HEDIS Volume 2: Technical Specifications for a discussion of "age-ins" (see *Members who switch product lines*) and continuous enrollment requirements.

5. MCOs with Changes in Service Areas - MCOs that received approval for a service area expansion during the previous year and those that will be reducing their service area effective January 1st of the next contract and reporting year must include information regarding those beneficiaries in the expanded or reduced areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

6. HMOs with Home and Host Plans - The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with CMS. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled in the plan.

7. New Contractors and Contractors Below the Minimum Enrollment Threshold - MCOs that did not have enrollment on January 1st of the measurement year or later will not report HEDIS performance measures for the corresponding reporting year. In addition, MCOs with enrollment below 1,000 on July 1st of the measurement year will not be required to submit a HEDIS report and they will not need to request a DST from NCQA. However, these plans must have systems in place to collect performance measurement information so that they can provide reliable and valid HEDIS data in the next reporting year.

8. Non-renewing/Terminating MCOs - Entities that meet the HEDIS reporting requirements stated above but which have terminated contracts effective January 1st of the reporting year will not be required to submit a HEDIS report or participate in the HOS survey. These contracts are required to participate in the CAHPS surveys in the fall prior to their contract termination date.

9. MCOs with Continuing §1876 Cost Contracts - For cost contracts, CMS has modified the list of HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Exhibit I.A. CMS does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from

the MCO. Thus, CMS and the public would not know to what degree the data for these measures are complete.

10. Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Exhibit I.A.)

11. M+C preferred provider organizations and private fee for service plans due to the structure of their organizations are not able to report all measures of M+C coordinated care plans. Consequently, a separate reporting matrix for these organizations is included as Exhibit I.B.

12. Mergers and Acquisitions - The entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the enrollment of the surviving company. The CMS recognizes that a separate set of beneficiaries and affiliated providers may be associated with the surviving entity's contract. However, HEDIS measures based on the combined membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract. The surviving contract(s) must comply with all aspects of this section for all members it had in the measurement year.

    NOTE: An entity that acquires and novates an existing Medicare contract must file a HEDIS report since the membership, benefits and medical delivery system are essentially unchanged. Therefore, during negotiations for the acquisition it is essential that parties agree on a method of data exchange that will permit the acquiring organization to file a HEDIS report covering the measurement year in which the transaction occurred.

13. Demonstration Projects - CMS also requires demonstration projects to meet the HEDIS, CAHPS, and HOS reporting requirements, in accordance with applicable law, regulations, and contract requirements for similar type plans. However, specific waivers contained in the demonstration contracts that have been or will be negotiated with CMS take precedence over any requirements specified in this manual section. The chart below summarizes reporting requirements by type of demonstration. For further information on the requirements for specific demonstrations, contact the CMS project officer in the Division of Demonstration Programs.

Demonstration	HEDIS	HEDIS Audit	M+C CAHPS	Disenrollee Reasons Survey	HOS
Social HMOs	YES	YES	YES	YES	YES
Minnesota Senior Health Options	NO	NO	NO	NO	*YES*
Massachusetts Health Senior Care Options	*NO*	*NO*	*NO*	*NO*	*YES*
Wisconsin Partnership Program	NO	NO	NO	NO	*YES*
Evercare	NO	NO	NO	NO	NO
Medicare Alternative Payment Demo I	*	*	YES	YES	*
PPO	*	*	YES	NO	*

***Contact the CMS project officer in the Division of Demonstration Programs with additional questions and for advice on whether a report should be filed.**

D - Implications for Failure to Comply

The CMS expects full compliance with the requirements of this section. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate and audited. In addition, many of the HEDIS requirements described herein will be reviewed as part of CMS' contractor performance oversight process using the M+C Monitoring Review Guide, Version I.

E - Use of Data

Data reported to CMS under this requirement will be used in a variety of ways. The HEDIS, CAHPS, and Disenrollment summary data is available to assist the Medicare beneficiary to make informed choices. This data will provide comparative information on contracts to beneficiaries to assist them in choosing among MMC plans and FFS. In addition, CMS expects MCOs to use the data, including HOS data, for internal quality improvement. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted and may be used as the baseline data for Quality Assessment and Performance Improvement (QAPI) projects. Additionally, all four data sets may be used for research purposes by public or private entities. Further, the data will provide CMS with information useful for monitoring the quality of, and access to, care provided by MCOs. CMS may target areas that warrant further review based on the data.

For example, CMS has developed a Performance Assessment System that will array information from the HEDIS, HOS, CAHPS, and disenrollment data sets in a manner that will permit performance evaluation by CMS. The MCOs can also view their own PAS information online via secured access to the Health Plan Management System. *For organizations that are subject to frailty adjusted payment, the data will also be used to determine an organization-level frailty adjuster.*

40.4 - The Medicare Health Outcomes Survey (HOS) Requirements

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

A - Survey Process

The Short Form (SF) 36, supplemented with additional case-mix adjustment variables, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS functional status measure, Medicare Health Outcomes Survey (HOS). This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that MCOs are currently using for clinical quality improvement. Each year a baseline cohort will be drawn and 1,000 beneficiaries per reporting unit will be surveyed. The survey is designed to achieve a 70 percent response rate. If the contract-market has fewer than 1,000 eligible members, all will be surveyed.

Additionally, each year a cohort drawn two years previously will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well being of each respondent. Depending on the amount of expected change the respondent's physical and mental health status will be categorized as better, the same or worse than expected over the two-year period. Members who are deceased at follow-up are included in the "worse" physical outcome category.

All M+C organizations and continuing cost contracts that held §1876 risk and cost contracts, *all Program of All-Inclusive Care for the Elderly (PACE) plans,* as well as Social HMOs (SHMOs), with Medicare contracts in effect on or before January 1 of the previous year must comply with this survey requirement. *In addition, all Massachusetts Health Senior Care Options, Minnesota Senior Health Options, and Wisconsin Partnership Program plans, regardless of contract effective date, must comply with this survey requirement.*

To expedite the survey process, MCOs may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means. MCOs, at their expense, are expected to contract with any of the NCQA certified vendors for administration of the survey to do both the new baseline cohort and the re-measurement cohort (if the MCO participated when an earlier cohort was drawn for

baseline measurement). Contracts with vendors are expected to be in place by February 1st to ensure survey implementation by mid-March of the reporting year. Further details will be provided by NCQA, CMS' contractor, regarding administration of the survey. MCOs must ensure the integrity of the data files they provide to the vendors by checking for, among other things, shifted data fields or out of range values. MCOs will be financially liable for the cost of any re-work (including but not limited to re-administration of the survey) and subsequent delay by the vendor resulting from corrupt data files transmitted to the vendor by the MCO.

B - Data Feedback

Please remember that individual member level data will not be provided to plans after baseline data collection. However, you will receive the following from CMS:

HOS Baseline Profile Report

This profile will be mailed to all plans participating in the previous year's baseline cohort. This quality improvement tool, which presents an aggregate overview of the baseline health status of your MCO's Medicare enrollees, was developed and extensively tested to ensure that MCOs would find the data useful and actionable. Your state Peer Review Organization/Quality Improvement Organization will also receive copies of the baseline profiles and stands ready to collaborate with you on interpreting the data, identifying opportunities to improve care, assisting you in planning effective, measurable interventions, and evaluating and monitoring the results of your interventions. Using data from the Health Outcomes Survey to plan and conduct a quality improvement project may fulfill one of the Quality Assessment and Performance Improvement (QAPI) program requirements. Baseline profile reports should be available by late June or early July. Effective Fall 2003, plan report distribution will no longer occur in hard copy format. Instead all report distribution will occur electronically through HPMS. Please contact your plan’s CMS Quality Point of Contact to gain access to your HOS reports.

HOS Performance Measurement Report and Data

After the administration of each follow up cohort, a cohort specific performance measurement report is produced. Survey responses from baseline and follow up are merged to create a performance measurement data set. The HOS performance measurement results are computed using a rigorous case mix/risk adjustment model. The resulting aggregation of these scores across beneficiaries within a plan yields the HOS plan level performance measurement results. The performance measurement reports and corresponding data results are designed to support MCO quality improvement activities.

Vendor Reports

The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number of surveys issued during the first and second survey mailings, the number of surveys

returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

Please DO NOT ask your vendor for additional analyses or member specific data. They are prohibited from providing this type of information. Requests for interpretation of the data or more detailed analyses of the data should be directed to your State PRO/QIO.

40.6 - Minimum Performance Levels and Performance Goals

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

While provisions at 42 CFR 422.152(c) permit CMS to establish minimum performance levels which must be met by contracting organizations, CMS has not yet established these levels. To establish minimum performance levels CMS must assure that organizations have had sufficient experience reporting specific measures on which levels would be set. When the accuracy and validity of submissions over time can be determined, CMS will be able to establish not only minimum performance levels but also set benchmarks for MCOs to achieve as specific goals.

Contacts

1	HEDIS Technical Specifications and Reporting and HEDIS Compliance Audit	MCOs should address all questions or requests for clarifications about the HEDIS technical specifications and audit to NCQA through its new Policy Clarification Support (PCS) Web page. The PCS page is accessible from the main NCQA Web site (http://www.ncqa.org). To access PCS, click on Support on the bottom of the gray bar along the left side of the NCQA home page and then click on Policy Clarification Support. The direct link for the PCS Web page is: http://www.ncqa.org/programs/faq/PCS.asp. From here, users can view Frequently Asked Questions (FAQ) and Policy Updates or submit a question to PCS staff. You can also reach NCQA through its Customer Support Line at (888) 275-7585. Questions about Medicare HEDIS not resolved through NCQA can be directed to the *Division of Managed Care Policy, (410) 786 1093, Medicare Plan Policy Group)* in CMS' Center for Beneficiary Choices. When contacting CMS, MCOs should be prepared to tell CMS both the advice that they received from NCQA and the individual at NCQA with whom they spoke.
2	HOS	For technical questions regarding the Medicare Health Outcomes Survey programs, please contact Chris Haffer in CMS' *Office of Research, Development and Information* at (410) 786-8764. Questions relating to the vendors or survey protocol should be addressed to Oanh Vuong at NCQA at (202)

		Contacts
		955-1777 or vuong@ncqa.org. For technical questions regarding the use of technical data or reports, please contact the HOS Information and Technical Support Telephone Line at HSAG at 1-888-880-0077 or via email at hos@azqio.sdps.org.
3	CAHPS	For technical questions regarding the MMC CAHPS Survey, please contact Amy Heller at (410) 786-9234 of CMS' Center for Beneficiary Choices or email CAHPS@cms.hhs.gov. For the Disenrollment Reasons Survey, please contact Chris Smith-Ritter at (410) 786-4636 or email CAHPS@cms.hhs.gov.
4	Demonstrations	For questions regarding policy and technical questions on the demonstration projects contact the assigned CMS project officer.

100.5 - Administrative Contracting Requirements

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

The M+C administrative contracting requirements apply both to first tier contracts and to downstream contracts in the manner specified for provider contracts, as described above. At the same time, the responsibility of the M+C organization is to assure that its contractor and any downstream contractors have the information necessary to know how to comply with the requirements under the M+C program.

These requirements do not apply to administrative contracts that do not directly relate to the M+C organization's core functions under its contract with CMS. For example, a contract between the M+C organization and a clerical support firm would not need to contain these provisions. Similarly, a contract between the M+C organization and a real estate broker to identify rental properties for office space would not be required to address these areas. CMS would, however, view contracts for administration and management, marketing, utilization management, quality assurance, applications processing, enrollment and disenrollment functions, claims processing, adjudicating Medicare organization determinations, appeals and grievances, and credentialing to be administrative contracts subject to M+C requirements as articulated in the M+C regulation and this OPL.

The following provisions must be addressed in the administrative service contracts:

- The person or entity must agree to comply with all applicable Medicare laws, regulations, and CMS instructions;

- The person or entity must agree to comply with all State and Federal confidentiality requirements, including the requirements established by the M+C organization and the M+C program;

- The person or entity must agree to grant DHHS, the Comptroller General, or their designees the right to inspect any pertinent information related to the contract during the contract term, for up to six years from the final date of the contract period, and in certain instances described in the M+C regulation, periods in excess of six years, as appropriate.

- The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements.

- The contract must provide that the M+C organization and any first tier and downstream entities has/have the right to revoke the contract if M+C organizations do not perform the services satisfactorily, and if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner;

- If the written arrangement provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable M+C credentialing requirements;

- If the written arrangement provides for the selection of providers by a first-tier or downstream entity, written arrangements must State that the M+C organization retains the right to approve, suspend, or terminate any such arrangement;

    - Contracts between M+C organizations and first tier entities, and first tier entities and downstream entities must contain provisions specifying M+C delegation requirements specified at §422.502(i)(3)(iii) and §422.502(i)(4). A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance. Contracts must indicate what functions have been delegated and must require the entity to comply with the requirements of these standards and of applicable law and regulations. When a function is only partially delegated, contract provisions must clearly delineate which responsibilities have been delegated and which remain with the organization. In the QAPI area, for example, the organization might develop topics for projects in consultation with an affiliated medical group, but delegate the actual conduct of a specific project to the group. The agreement must specify how the delegate is to conduct QAPI activities, at what points in the process decisions by the delegate (for example, on data collection methodologies) are subject to the organization's review, and how the delegate's activities will be integrated into the organization's overall QAPI program (for example, through participation in an organization-wide committee);

70.7.5 - Converting from Standard Pre-Service Appeal to Post-Service Activity

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

If an enrollee has requested a standard pre-service reconsideration, but the M+C organization becomes aware that the enrollee has obtained the service before the M+C organization completes its reconsideration determination, the M+C organization should dismiss the pre-service appeal since the provision of the service is now moot. The pre-service reconsideration processing stops, and the organization forwards the appeal case to the IRE for dismissal. When the provider submits the bill for payment to the M+C organization, the organization should make a determination on whether to pay for the service. If the M+C organization decides to deny payment, it will then issue either an NDP or electronic EOB and appeal rights will then be available.

If the M+C organization does not become aware that the enrollee has already received the service (after the enrollee submitted the pre-service appeal) and the organization continues to deny the reconsideration, if the IRE receives information indicating that the service has already been obtained, the IRE will process the appeal as a post-service, i.e., payment, appeal, and will apply the appropriate processing time frame.

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90 - Reconsiderations by the Independent Review Entity

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

The independent review entity must conduct the reconsideration as expeditiously as the enrollee's health condition requires and should observe the same time frames as required for M+C organizations. When the independent review entity conducts its reconsideration, the parties to the reconsideration are the parties listed in §60.1 of this chapter as well as the M+C organization.

When the independent review entity completes its reconsidered determination, it is responsible for notifying all the parties of the reconsidered determination, and for sending a copy of the reconsidered determination to the appropriate CMS Regional Office.

The determination notice of the independent review entity must be stated in understandable language and in a culturally competent manner taking into account the enrollees presenting medical condition, disabilities, and special language requirements, if any, and:

1. Include specific reasons for the entity's decisions;

2. Inform parties, other than M+C organization of their right to an ALJ hearing if the amount in controversy *meets the appropriate threshold requirement*, and if the

decision is adverse (i.e., does not completely reverse the organization's adverse determination); and

3. Describe procedures that the parties must follow to obtain an ALJ hearing.

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100 - Administrative Law Judge (ALJ) Hearings

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

If the amount remaining in controversy meets *the appropriate threshold requirement*, any party to the reconsideration (with the exception of the M+C organization) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ.

The amount remaining in controversy can include any combination of Part A and B services. Other services for which an enrollee is entitled under a plan's benefit package may be used to reach the threshold amount. See 42 CFR 422.100 for a description of the types of services covered by M+C organizations.

If the basis for the appeal is the M+C organization's refusal to provide services, the projected value of those services is used to compute the amount remaining in controversy. If the basis for the appeal is the M+C organization's refusal to cover optional or supplemental benefits, the projected value of those benefits is used to compute the amount remaining in controversy.

100.2 - Determination of Amount in Controversy

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

Beginning in January 2005, the amount in controversy requirement for an ALJ hearing will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

The ALJ determines whether the amount remaining in controversy (for both Part A and Part B services) *meets the appropriate threshold.* For cases involving denied services, the projected value of the services is used to determine whether the amount in controversy is *met*. For cases involving optional or supplemental benefits, but not employer-sponsored benefits limited to employer group members, the projected value of those benefits is used to determine whether the amount in controversy is *met*. The M+C organization is expected to cooperate with the ALJ and assist in the computation of the amount in controversy. The hearing may be conducted on more than one claim at a time;

i.e., the enrollee may have several claims involving several issues. The enrollee may combine claims to meet the threshold requirement, if the following *elements* are met:

1. The claims must belong to the same beneficiary;

2. The claims must each have received a determination through the independent review entity reconsideration process;

3. The 60-day filing time limit must be met for all claims involved; and

4. The hearing request must identify all claims.

The ALJ dismisses cases *where the appropriate amount in controversy is not met*. If, after a hearing is initiated, the ALJ finds that the amount in controversy is *not met*, he/she discontinues the hearing and does not rule on the substantive issues raised in the appeal. Any party may request review of the dismissal of a hearing through the Departmental Appeals Board (DAB) review.

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120 - Judicial Review

(Rev. 64, Issued: 12/03/04 Effective Date: 01/01/05)

Any party, including the M+C organization (upon notifying all the other parties), may request judicial review of an ALJ's decision if:

1. The DAB denied the parties request for review; and

2. The amount in controversy *meets the appropriate threshold*.

In addition, any party, including the M+C organization (upon notifying all the other parties), may request judicial review of a DAB decision if:

1. The DAB denied the parties request for review; or

2. It is the final decision of CMS; and

3. The amount in controversy is *met*.

Beginning in January 2005, the amount in controversy required for judicial review will be $1,050.

The enrollee may combine claims to meet the amount in controversy requirement. To meet the requirement:

1. All claims must belong to the same enrollee;

2. The DAB must have acted on all the claims;

3. The enrollee must meet the 60-day filing time limit for all claims; and

4. The requests must identify all claims.

A party may not obtain judicial review unless the DAB has acted on the case - either in response to a request for review or on its own motion.