Medicare Part C Plan Reporting Requirements
Technical Specifications Document
Contract Year 2015

Effective Date: January 1, 2015

Version Date: December 14, 2015

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Table of Contents

BACKGROUND AND INTRODUCTION 1

GENERAL INFORMATION 1

REPORTING REQUIREMENT REPORTING SECTIONS LIST 3

REPORTING SECTIONS 7

1. BENEFIT UTILIZATION (SUSPENDED).....7

2. PROCEDURE FREQUENCY (SUSPENDED).....7

3. SERIOUS REPORTABLE ADVERSE EVENTS (SUSPENDED) 7

4. PROVIDER NETWORK ADEQUACY (SUSPENDED).....7

5. GRIEVANCES 7

6. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS 11

7. EMPLOYER GROUP PLAN SPONSORS 17

8. PROVIDER FEE-FOR-SERVICE ((PFFS) PLAN ENROLLMENT VERIFICATION CALLS; MONITORING PURPOSES ONLY.....19

9. PFFS PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS; MONITORING PURPOSES ONLY 20

10. AGENT COMPENSATION STRUCTURE – SUSPENDED 21

11. AGENT TRAINING AND TESTING – SUSPENDED 21

12. PLAN OVERSIGHT OF AGENTS –.....21

13. SPECIAL NEEDS PLANS (SNPS) CARE MANAGEMENT 23

14. ENROLLMENT AND DISENROLLMENT.....27

APPENDIX 1: FAQS: REPORTING SECTIONS 5 & 6:.....30

BACKGROUND AND INTRODUCTION

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-F).

This document provides a description of the reporting sections,[1] reporting timeframes and deadlines, and specific data elements for each reporting section.

The technical specifications contained in this document should be used to develop a common understanding of the data, 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.

Each Part C Reporting Requirement reporting section of this document has the following information presented in a standardized way for ease of use:

A. Data element definitions - details for each data element reported to CMS.

B. Notes - additional clarifications to a reporting section derived from the responses to comments received under the OMB clearance process.

C. **Reminder: Underlined passages indicate updates and/or new information from the last version including draft versions.**

GENERAL INFORMATION

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type and reporting section. Most reporting sections will be reported annually.

Reporting Part C Data: The information here should be used (unless otherwise indicated, or instructed by CMS) for reporting from this point forward.

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 Sponsors), Agent/Broker Name, and Beneficiary Name.

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

[1] The term "measure" has been replaced with the term "reporting section" effective 2013.

In order to provide guidance to Part C Sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.

Exclusions from Reporting

National PACE Plans and 1833 Cost Plans are excluded from reporting all Part C Reporting Requirements reporting sections.

Suspended from Reporting:

Reporting section # 1 *Benefit Utilization*;
Reporting section # 2 *Procedure Frequency;*
Reporting section # 3 *Serious Reportable Adverse Events*;
Reporting section # 4 *Provider Network Adequacy;*
Reporting section #10 *Agent Compensation Structure*;
Reporting section #11 *Agent Training and Testing*; and

Major Changes from CY 2013 Technical Specifications

Reporting Section # 5 (*Grievances*), Reporting Section # 6 (*Organization Determinations/Reconsiderations*), and Reporting Section #12 (*Plan Oversight of Agents*) are significantly upgraded to accommodate user needs for data trending, policy development, auditing, and compliance monitoring. Reporting Section #3 (*Serious Reportable Adverse Events*) is suspended for 2014.

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline. CMS expects that data are accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late and may not be incorporated within CMS data analyses and reporting. Only data reflecting a good faith effort by an organization to provide accurate responses to Part C reporting requirements will be counted as data submitted in a timely manner.

If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY.

Organizations failing to submit data, or submitting data late and/or inaccurately, will receive compliance notices from CMS.

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, Part C Sponsors 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 speaking, CMS does not grant extensions to 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 version of the 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).

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. Plans 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 Technical Specifications for answers or, when appropriate, contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov .

REPORTING REQUIREMENT REPORTING SECTIONS LIST

The following summary table provides an overview of the parameters around each of the current Part C Reporting Requirements reporting sections.

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization	Suspended			
2. Procedure Frequency	Suspended			
3. Serious Reportable Adverse Events	Suspended			
4. Provider Network	Suspended			

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
Adequacy				
5. Grievances (Revised)	Coordinated Care Plans (CCPs), Provider Fee-For-Service Plans (PFFS), 1876 Cost Plans, Medicare-Medicaid Plans (MMPs), Medicare Savings Accounts (MSAs) (includes all 800 series plans), Employer/Union Direct Contract	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/29 reporting will include each quarter)	2/29/2016
6. Organization Determinations/ Reconsiderations (Revised)	CCP, PFFS, 1876 Cost, MMP,MSA (includes all 800 series plans), Employer/Union Direct Contract	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/29 reporting will include each quarter)	2/29/2016
7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contract	1/year PBP	1/1 - 12/31	2/29/2016 Validation unnecessary —using for monitoring only
8. PFFS Plan Enrollment Verification Calls	PFFS (800-series plans should NOT report)	1/year PBP	1/1-12/31	2/29/2016 Validation unnecessary —using for

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
				monitoring only
9. PFFS Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1-12/31	2/29/2016 Validation unnecessary —using for monitoring only
10. Agent Compensation Structure		Suspended		
11. Agent Training and Testing		Suspended		
12. Plan Oversight of Agents	1876 Cost Plans, Local Coordinated Care Plans (Local CCPs), Medicare Savings Accounts (MSAs), Provider Fee-For-Service Plans (PFFS), and Regional Coordinated Care Plans (Regional CCPs)	Revised	1/1-12/31	2/29/2016
13. Special Need Plans (SNPs) Care Management	Local CCP, Regional CCP, RFB Local CCP with SNPs. Includes 800 series plans.	1/Year PBP	1/1-12/31	2/29/2016
14. Enrollment/Disenrollment	Only 1876 Cost Plans with no Part D.*	2/Year Contract	1/1-6/30 7/1-12/31	8/31/2015 2/29/2016 Validation unnecessary

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
				—using for monitoring only

* MA-only. MA-PDs and PDPs report under Part D. MSA and chronic care excluded.

REPORTING SECTIONS

1. BENEFIT UTILIZATION (SUSPENDED)

2. PROCEDURE FREQUENCY (SUSPENDED)

3. SERIOUS REPORTABLE ADVERSE EVENTS (SUSPENDED)

4. PROVIDER NETWORK ADEQUACY (SUSPENDED)

5. GRIEVANCES

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 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 (2/29 reporting will include each quarter)	2/29/2016

The data elements to be reported under this reporting section are:

Grievance Category	Total number of Grievances	Number of grievances in which timely notification* was given
Total Grievances	**(5.1)**	**(5.2)**
Number of Expedited Grievances	**(5.3)**	**(5.4)**
Enrollment/Disenrollment	**(5.5)**	**(5.6)**
Benefit Package Grievances	**(5.7)**	**(5.8)**
Access Grievances	**(5.9)**	**(5.10)**
Marketing Grievances	**(5.11)**	**(5.12)**
Customer Service Grievances	**(5.13)**	**(5.14)**
Organization determination and reconsideration process grievances	**(5.15)**	**(5.16)**
Quality Of Care Grievances	**(5.17)**	**(5.18)**
Grievances related to "CMS Issues"	**(5.19)**	**(5.20)**
Other Grievances	**(5.21)**	**(5.22)**

* Timely notification of grievances means the member was notified according to the following timelines:

- For standard grievances: no later than 30 calendar days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

This reporting section requires upload into HPMS.

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.

For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of grievance procedures for MMPs, refer to the State-specific Memorandum of Understanding.

CMS requires plans to use one of 22 categories described in this section to report grievances to CMS (Elements 5.1 – 5.22). For purposes of Reporting Section 5:

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual 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.

The category, "Grievances Related to CMS Issues" involves grievances that primarily involve complaints concerning CMS' policies, processes, or operations; the grievance is not directed against the health plan or providers. The new grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control, from the total number of grievances filed against the contract

Reporting Inclusions:

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 involving multiple issues under each applicable category.

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

Reporting Exclusions:

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.

- Withdrawn grievances.

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

Additional Guidance

- See CY2014 Part C Plan Reporting Module for specific guidance concerning reporting grievances.

- 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 grievance on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes investigation and provides notification on 2/5/2014 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.

- *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 Reporting Section 5 reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

6. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 – MMP 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 (2/29 reporting will include each quarter)	2/29/2016

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Total Number of Organization Determinations Made in Reporting Time Period Above
6.2	Of the Total Number of Organization Determinations in 6.1, Number Processed Timely
6.3	Number of Organization Determinations – Fully Favorable (Services)
6.4	Number of Organization Determinations – Fully Favorable (Claims)
6.5	Number of Organization Determinations – Partially Favorable (Services)
6.6	Number of Organization Determinations – Partially Favorable (Claims)
6.7	Number of Organization Determinations – Adverse (Services)
6.8	Number of Organization Determinations – Adverse (Claims)
6.9	Number of Requests for Organization Determinations - Withdrawn
6.10	Total number of Reconsiderations Made in Reporting Time Period Above
6.11	Of the Total Number of Reconsiderations in 6.10, Number Processed Timely
6.12	Number of Reconsiderations – Fully Favorable (Services)
6.13	Number of Reconsiderations – Fully Favorable (Claims)
6.14	Number of Reconsiderations – Partially Favorable (Services)
6.15	Number of Reconsiderations – Partially Favorable (Claims)
6.16	Number of Reconsiderations – Adverse (Services)
6.17	Number of Reconsiderations – Adverse (Claims)
6.18	Number of Requests for Reconsiderations - Withdrawn
6.19	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
6.20	Contract Number
6.21	Plan ID
6.22	Case ID
6.23	Date of original disposition
6.24	Original disposition (Fully Favorable; Partially Favorable or Adverse)
6.25	Case level (Organization Determination or Reconsideration)
6.26	Date case was reopened
6.27	Reason(s) for reopening (Clerical Error, New and Material Evidence, or Other)
6.28	Date of reopening disposition (revised decision)
6.29	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

Notes

This reporting section requires direct data entry into HPMS.

For an explanation of Part C organization determination, reconsideration, and reopenings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of reconsideration procedures for MMPs, refer to the State-specific Memorandum of Understanding.

All plan types listed in the table at the beginning of this section are required to report: organization determinations, reconsiderations and reopenings, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician 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.

Plans are to report encounter data, whereby an encounter took place under a capitation arrangement, as an organization determination. That is, we want plans to report capitated providers' encounters in lieu of actual claims data. All encounter data should be reported as timely submissions.

CMS requires plans to report organization determinations and reconsiderations requests submitted to the plan. For purposes of Reporting Section 6:

- An **organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

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

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

- A **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.

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

- In contrast to claims (payment decisions), **service authorizations** include all service-related decisions, including pre-authorizations, concurrent authorizations and post-authorizations.

- A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

- A **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.

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.

Reporting Inclusion

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Reopenings:

- All Fully Favorable, Partially Favorable, Adverse or Pending Reopenings of Organization Determinations and Reconsiderations, as described in the preceding sections.

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 Chapter 13 of the Medicare Managed Care Manual.

- All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.

- **Reopenings** that are in a reopening status across multiple reporting periods are to be reported in each applicable reporting period. For example, if a plan reopened an organization determination on 3/15/2014 and sent the notice of the revised decision on 4/22/2014, 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).

- **Claims with multiple line items** at the "summary level."

- A **request for payment** 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 **Medicare payment** for item or service as either partially favorable or adverse, regardless of whether Medicaid payment ultimately is provided, in whole or in part, for that item or service.

- Report 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. <u>For example</u>: Plan receives standard pre-service reconsideration request on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes reconsideration and provides notification on 2/5/2014 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.

Do not report:

- Dismissals.
- Independent Review Entity (IRE) decisions.
- Reopenings requested or completed by the IRE, ALJ, and MAC.
- Concurrent reviews during hospitalization.
- Concurrent review of SNF, HHA or 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.
- 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.

7. EMPLOYER GROUP PLAN SPONSORS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	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	2/29/2016

Data elements reported under this reporting section are:

Element Number	Data Elements for Employer Group Plan Sponsors
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Is this a calendar year plan? (Y (yes) or N (no))
7.9	If data element 7.8 is no, provide non-calendar year start date.
7.10	Current/Anticipated Enrollment

Notes

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 7.7 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 7.10, 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. However, this does not imply that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us again for the purposes of the Part C reporting requirements.

8. PROVIDER FEE-FOR-SERVICE ((PFFS) PLAN ENROLLMENT VERIFICATION CALLS; MONITORING PURPOSES ONLY

– Validation of this reporting section is not required because these data will be initially used only for monitoring.

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
8. PFFS Plan Enrollment Verification Calls	03 – RFB PFFS 04 – PFFS 800-series plans should **NOT** report	1/year PBP	1/1-12/31	2/29/2016

Data elements to be reported under this reporting section are:

Element Number	Data Elements for PFFS Plan Enrollment Verification Calls
8.1	Number of times the plan reached the prospective enrollee with the first call of up to three required attempts in reporting period
8.2	Number of follow-up educational letters sent in reporting period
8.3	Number of enrollments in reporting period

Notes

This reporting section requires direct data entry into HPMS.

Note that this does not apply to group PFFS coverage. Also, this reporting section only pertains to calls made to individual enrollees.

Plans should tie the reported elements to enrollment effective dates. For example, report for 2013 all those calls and follow-up letters linked to 2013 effective enrollments—including those done in late 2012 for 2013 enrollments. Any enrollment requests received in 2012 (for 2013 effective dates) and calls/letters associated with them would be reported in the 2013 reporting period--not in the 2012 reporting period. Otherwise, the reported elements for this reporting section would not connect for "Annual Coordinated Election Period" (AEP) enrollments.

9. PFFS PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS; MONITORING PURPOSES ONLY

–Validation of this reporting section is not required because these data will initially be used only for monitoring.

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
9. PFFS Provider Payment Dispute Resolution Process	03 – RFB PFFS 04 – PFFS 14 – ED-PFFS	1/year PBP	1/1- 12/31	2/29/2016

Data elements reported under this reporting section are:

Element Number	Data Elements for PFFS Provider Payment Dispute Resolution Process
9.1	Number of provider payment denials overturned in favor of provider upon appeal
9.2	Number of provider payment appeals
9.3	Number of provider payment appeals resolved in greater than 60 days

Notes

This reporting section requires direct data entry into HPMS.

This reporting section must be reported by all PFFS plans, regardless of whether or not they have a network attached.

This reporting requirement seeks to capture only provider payment disputes which include any decisions where there is a dispute that the payment amount made by the MA PFFS Plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to non-contracted providers is less than would have been paid under original Medicare (including balance billing).

10. AGENT COMPENSATION STRUCTURE – SUSPENDED

11. AGENT TRAINING AND TESTING – SUSPENDED

12. PLAN OVERSIGHT OF AGENTS –

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
12. Plan Oversight of Agents	1876 Cost Plans, Local Coordinated Care Plans (Local CCPs), Medicare Savings Accounts (MSAs), Provider Fee-For-Service Plans (PFFS), and Regional Coordinated Care Plans (Regional CCPs).*	1/year Contract	1/1-12/31	2/29/2016

NOTE: Sponsors of stand-alone prescription drug plans, which do not also have MA-PD plans, already report these data as part of the Part D reporting requirements and are, therefore, exempt from this Part C reporting section. Employer/union group plans are exempt from this reporting section.

Sponsors are required to comply with State requests for information about the performance of licensed agents or brokers as part of a state investigation into the individual's conduct. Plans are responsible for monitoring the conduct of their agents. While the states oversee agent licensing, CMS will monitor agent complaints to determine if Sponsors are investigating identified complaints and imposing disciplinary actions as well as reporting poor conduct to the state.

Complaints include both complaints from the Complaint Tracking Module (CTM) and other complaints or grievances made directly to the Sponsor. Complaints may result in various disciplinary actions, ranging from verbal warning to termination of employment or contract.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 29, 2016

Data elements to be uploaded in two data files at the Contract level:

1. **Agent/Broker:**

   For each agent/broker who earned and received compensation during the reporting period (initial enrollments and renewal payments received) for members with an effective date of 1/1/2015-12/31/2015, provide the information requested below. For purposes of these

reporting requirements compensation is defined as any payment made to an agent/broker for purposes of enrolling beneficiaries into health plans for purposes of the reporting requirement based on effective date, (including commission and salary) earned during in the reporting period (initial enrollments and renewal payments received), indicate:

A. Contract Number.
B. Agent/Broker Type (Captive, Employed, Independent, None).
C. Agent/Broker Last Name.
D. Agent/Broker First Name.
E. Agent/Broker Middle Initial.
F. Agent/Broker State Licensed. For agents licensed in multiple states, complete a row for each state in which the agent is licensed.
G. Agent/Broker National Producer Number (NPN).
H. Plan Assigned Agent/Broker Identification Number.
I. Agent/Broker Current License Effective Date.
J. Agent/Broker Appointment Date.
K. Agent/Broker Training Completion Date.
L. Agent/Broker Testing Completion Date.
M. In aggregate, the number of Agent/Broker marketing complaints from any source for reported during the reporting period. If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has four complaints and is licensed in Florida and Georgia, all four complaints should be listed under the Florida line. For complaints that cannot be tied to a contract number, please put the aggregate number of complaints into the first contract number.
N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc. If multiple lines are needed for an agent (licensed in more than one state), only fill out this data element for the first line. For example, if an agent has received two disciplinary actions and is licensed in Florida and Georgia, both actions should be listed under the Florida line.
O. Agent/Broker Termination Date (if applicable).
P. Termination for Cause? (Y (yes) or N (no)).
Q. Third-party Marketing Organization (TMO)/Field Marketing Organization Name (FMO), if applicable.
R. The number of new enrollments in the reporting period. If more than one line is filled out because of agent being licensed in multiple states, please put enrollments in by state.

2. New Enrollments:

Important: Sponsors should not upload the POA New Enrollments level data file if they have no new enrollees to report. CMS is defining “new enrollments” for reporting purposes as new to the organization. A change from one Plan Beneficiary Benefit Package (PBP) to another PBP, within the same organization, is not considered a “new enrollment” for purposes of these reporting requirements. Also, a change from one contract to another contract within the same parent organization/sponsor) is not a new enrollment. Plans should report on all agents/brokers, not just independent

agents/brokers. For all new enrollments (initial or renewal) during the reporting period for which an Agent/Broker is associated (includes instances where the agent/broker was assigned after the enrollment was initiated), indicate:

A. Contract Number.
B. Plan Beneficiary Benefit Package (PBP) Number.
C. Beneficiary Last Name.
D. Beneficiary First Name.
E. Beneficiary Middle Initial.
F. Beneficiary HICN or RRB Number.
G. Agent/Broker Last Name.
H. Agent/Broker First Name.
I. Agent/Broker Middle Initial.
J. Agent/Broker National Producer Number (NPN).
K. Plan Assigned Agent/Broker Identification Number.
L. Enrollment Mechanism. (Plan/Plan Representative Online; CMS Online Enrollment Center; Plan Call Center; 1-800-MEDICARE; Paper Application; Auto-Assigned/Facilitated; Other).
M. Enrollment Application Date.
N. Enrollment Effective Date.
O. The number of Agent/Broker complaints filed by the beneficiary in the reporting period.
P. Of the number reported in O, the number of Marketing related complaints.
Q. "No Data to Report." Enter "Y" if no data to report; otherwise leave blank.

13. SPECIAL NEEDS PLANS (SNPS) CARE MANAGEMENT

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
13. SNPS Care Management	SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP <u>Organizations should exclude 800 series plans if they are SNPs.</u>	1/Year PBP	1/1-12/31	<u>2/29/2016</u>

Data elements reported under this reporting section are:

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
13.1	Number of new enrollees.	New enrollees are defined with respect to the "90-day rule." The initial health risk assessment is expected to be completed within 90 days of enrollment, which must be continuous for that period. The member could have initially enrolled as early as 90 days prior to the measurement year (enrolled as early as 10/3 of the previous year) and would still be eligible in the current measurement year as of 1/1 if no initial HRA had been performed prior to 1/1. For the purposes of this reporting, members enrolled continuously for more than 90 days in the same plan without receiving an initial HRA **are reported as being eligible for an initial HRA (data element 13.1=1) but not having received an initial HRA (data element 13.3=0—refer to data element 13.3 below). After that 90-day period, members** are no longer reported as eligible for an initial HRA in the same plan but are reported as eligible for a "reassessment HRA" in that same plan. If a member disenrolls from one plan and enrolls in another plan, that member is reported as eligible for an initial HRA anytime during the initial period of 90 days from enrollment date.	Members with a documented initial HRA under that plan prior to the measurement year. Excludes new members who disenrolled from the plan within 90 days of enrollment, if they did not complete an initial HRA prior to disenrolling.
13.2	Number of enrollees eligible for an annual health risk reassessment (HRA)	Report all members in the same health plan who: **1. Completed a reassessment HRA within 365 days of their last HRA (initial or reassessment).** **2. Were enrolled for 365 days continuously after their initial HRA or their last reassessment HRA and did not complete a reassessment HRA within 365 days**	Enrollees who did not reach a threshold of continuous enrollment in the same health plan for at least 365 days after their last HRA and did not complete a reassessment HRA in that plan within the 365 day timeframe as required.

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		3. **Did not complete an initial HRA within 90 days of enrollment and reached the threshold of 365 days of continuous enrollment after initial enrollment without completing a reassessment HRA.**	
13.3	Number of initial HRAs performed on new enrollees.	Initial HRAs performed on new enrollees (as defined above in data element 13.1) within 90 days of enrollment. The HRA must have been completed between 1/1and 12/31 of the measurement year.	
13.4	Number of annual reassessments performed.	Number of annual reassessments performed on enrollees eligible for a reassessment (during the measurement year as defined in element 13.2 above). This includes: **Reassessments performed within 365 days of last HRA (initial or reassessment HRA) on eligible enrollees. It also includes "first time" assessments occurring within 365 days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA.**	

Notes:

This reporting section requires direct data entry into HPMS.

Complete HRAs are those that comply with guidance in Chapter 5 of the Medicare Managed Care Manual, Quality Improvement program. For Part C reporting, there should never be more than 365 days between Health Risk Assessment (HRAs) for special needs plans. The initial HRA after enrollment should occur within 90 days **of the effective date of** enrollment in a special needs plan. Initial HRAs administered and received prior to the date of eligibility for benefits are excluded from this reporting section. If there is no HRA occurring within 90 days of **the effective** enrollment **date**, there should be an HRA as soon as possible but no more than 365 days from initial enrollment. (Note that, if the initial HRA is not completed within 90 days of **the effective** enrollment **date**, the SNP will be deemed non-compliant with this requirement.) All reassessment HRAs should occur within 365 days of the last HRA.

Complete HRAs are those that comply with guidance in Chapter 5 of the Medicare Managed Care Manual, titled "Quality Improvement Program." Specifically, 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 13.3 and 13.4, CMS requires only **completed** assessments. This reporting section excludes cancelled enrollments.[2]

If an enrollee has multiple reassessments within the 90-day or the 365 day time periods, just report one HRA for the 90-day period and/or one reassessment within the 365 day time period. The 365-day recycle period for the HRA begins after the last reassessment HRA for that measurement year. Therefore, for example, if reassessment HRAs was completed for the same member on 4/1/2015, 6/1/2015, 8/1/ 2015, and 11/1/2015, the plan should report only one reassessment HRA in 2015. In this case, the 365 day recycle period would start on 11/2/2015, and the next HRA would be due by 11/1/2016.

If eligibility records received after completion of the health assessment retroactively indicate the member was never enrolled in the plan (even when doing the HRA), do not count this beneficiary as a new enrollee or count the HRA.

The 90-day rule applies to initial health risk assessments (HRAs) for new enrollees and current enrollees who do not have a documented health risk assessment within 90 days of enrollment. Current enrollees with documented health risk assessments must have an annual reassessment no later than one year (365 days) after their last documented health risk assessment.

The date the HRA is completed by the sponsoring organization is the completed date of the HRA.

If a beneficiary enrolls and is mailed an HRA in December 2013, and the HRA is completed in 2014 (within 90 days of enrollment), count this beneficiary as a new enrollee in 2014 with an HRA completed in calendar 2014.

Questions have arisen regarding how to report data elements in this reporting section when members disenroll and then re-enroll, either in the same plan or a different plan (different organization or sponsor). When a member disenrolls from one plan and re-enrolls into another plan (a different sponsor or organization), the member should be counted as a "new enrollee" for the purposes of Part C reporting.

A health risk assessment can be reported before an individualized care plan (ICP) is completed.

Please note that these technical specifications pertain to Part C reporting only and are not a statement of policy relating to special needs plan care management.

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[2] 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."

14. ENROLLMENT AND DISENROLLMENT

Reporting section	Organization Types Required to Report*	Report Freq./ Level	Report Period (s)	Data Due date (s)
14. Enrollment and Disenrollment	All stand-alone MAOs (MA, no Part D) 1876 Cost Plans with no Part D	2/Year Contract	1/1-6/30 7/1 – 12/31	8/31/2015 2/29/2016

* 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.

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.

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor's processing of enrollment and disenrollment requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual's eligibility for a Special Enrollment Period (SEP), sponsors is currently unable to specify each of these factors when submitting enrollment transactions. Sponsor's reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring sponsors are providing support to beneficiaries, while complying with CMS policies.

Data elements 1.A-1.O must include all enrollments (code 61 transactions). Disenrollments must not be included in Section 1 Enrollment.

Section 2: Disenrollment must include all voluntary disenrollment transactions.
Reporting Timeline:

Reporting Period	January 1 – June 30	July 1-December 31
Data Due to CMS	August 31, 2015	February 29, 2016

Data elements to be entered into the HPMS at the Contract level:

1. **Enrollment:**
   A. The total number of enrollment requests received in the specified time period. (data element 14.1).
   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). (data element 14.2)
   C. Of the total reported in A, the number of enrollment requests that required requests for additional information. (data element 14.3)

D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not having a valid enrollment period). (data element 14.4)
E. Of the total reported in C, the number of incomplete enrollment requests received that are completed within established timeframes. (data element 14.5)
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. (data element 14.6)
G. Of the total reported in A, the number of paper enrollment requests received. (data element 14.7)
H. Of the total reported in A, the number of telephonic enrollment requests received (if offered). (data element 14.8)
I. Of the total reported in A, the number of internet enrollment requests received via plan website (if offered). (data element 14.9)
J. Of the total reported in A, the number of Online Enrollment Center (OEC) enrollment requests received. (data element 14.10)
K. For stand-alone prescription drug plans (PDPs) only: Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual). (This does not apply to Part C or 1876 Cost Plans.)
L. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.
M. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP. (This does not apply to Part C or 1876 Cost Plans.)
N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP (This does not apply to Part C or 1876 Cost Plans.)
O. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period Code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction. (data element 14.11)

2. Disenrollment:

A. The total number of voluntary disenrollment requests received in the specified time period. (data element 14.12)
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). (data element 14.13)
C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason. (data element 14.14)

APPENDIX 1: FAQS: REPORTING SECTIONS 5 & 6:

Grievances, Organization Determinations, & Reconsiderations

	PLAN INQUIRIES	CMS RESPONSES
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.	Should plans report all Dual Eligible member grievances to CMS?	No. Plans are only to report Dual Eligible member grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, plans will not report grievances filed under the state Medicaid process, but not filed with the plan and addressed under the plan's Subpart M grievance process.
3.	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.

4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as "organization determinations." For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations), as described in this guidance
6.	If we have a prior authorization request and a claim 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 claim for the same service; this is not considered a duplicate.
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, 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 (claim) is a reportable organization determination.
11.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. Is this an organization determination?	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). *Written* notice is required for Partially Favorable, and Adverse determinations.
12.	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 further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.
13.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage 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.

14.	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.
15.	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."
16.	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.
17.	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. <u>Exceptions</u>: Plans are not to report: 1.) Dismissed cases, or 2.) QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.

18.	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.