Technical Specifications

Public Use File (PUF) of

CY 2014 Part C and D Reporting Requirements Data

Last Revision: September 2016

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I. Introduction

Reporting Requirements

With the implementation of the Medicare Drug Benefit Program in 2006, the Centers for Medicare and Medicaid Services (CMS) established Part D Reporting Requirements for all Part D prescription drug plan sponsors in 2006. Shortly thereafter, CMS initiated new Part C Reporting Requirements for Medicare Advantage organizations in December 2008. Both sets of reporting requirements undergo Office of Management and Budget (OMB) approval of the "Information Collection Request" (ICR) under the Paperwork Reduction Act of 1995 (PRA). CMS has made efforts to refine or remove reporting sections each year.

Appendices A and B outline the Part C and Part D Reporting Requirements since CY2010.

Data Validation

CMS uses plan-reported data as sources of information for data analyses, compliance and monitoring actions, oversight, and performance measurement. Most recently, CMS is using the reported data to release annual summary data reports and public use files (PUFs). In order to support these uses, CMS implemented Data Validation (DV) requirements in 2011. DV has been imperative in ensuring that these data are audited for accuracy and consistency prior to relying on these data for expanded uses. Since DV's implementation in 2011, CMS has made policy decisions and revisions to improve DV guidance and standards/sub-standards to ensure reported data are accurate, reliable, and valid. It is important to note that reporting sections that are used for monitoring only are excluded from DV.

Appendix C outlines the Part C and Part D reporting sections included in DV since 2011.

II. Public Use File (PUF)

Increasingly, there is encouragement to make providers and plans more accountable by making the appropriate, performance-related data available to the public. In 2012, CMS developed three display measures using plan-reported and validated data. CMS recently introduced the Special Needs Plans (SNPs) Care Management measure and Medication Therapy Management (MTM) Comprehensive Medication Review (CMR) Completion Rate measure into the Star Ratings system and anticipates doing so for the Grievance Rate measure in the future. PUFs containing other plan and provider data have been made available via the CMS website for some time. To increase accountability of the Medicare Program, the Office of the Inspector General (OIG) has recommended that CMS release PUFs containing plan reported data collected via the Part C and D Reporting Requirements. In order to make these PUFs available to the general public, researchers and academic institutions, health care organizations, and government agencies, CMS has developed PUFs of plan-reported reporting requirements data that would be downloaded from the CMS website. CMS released its first PUF of Part C and Part D Reporting Requirements data on July 31, 2014.

Datasets

Each contract year's PUF contains individual datasets for each reporting section, listing the raw data as reported by contracts. Additionally, both validated and non-validated data will be included in the PUF. With a few exceptions, CMS will release all data elements collected within a reporting section. Beneficiary information, proprietary, confidential, or otherwise sensitive data are not included. Technical specifications such as reporting frequency and schedule, inclusions/exclusions, and any other information that is important for accurate interpretation of the data elements are provided.

For reporting sections that undergo data validation, CMS only releases data for contracts receiving at least the minimal DV score to pass. Contracts which did not pass DV would be listed to indicate that "CMS identified issues with plan's data". Also, contracts that passed DV but were later found to have significant data issues may be excluded from the PUF. More information about the data validation standards can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html.

Reporting Sections Included in the PUF

The table below outlines the Part C and D reporting sections that are included in the CY 2014 PUF and whether they were included in the 2015 DV cycle.

Table 1: CY 2014 PUF Reporting Sections

Reporting Section	CY	2015 DV Cycle
Organization Determinations and Reconsiderations – Part C	CY2014	✓
Special Needs Plan (SNP) Care Management – Part C	CY2014	✓
Coverage Determinations & Redeterminations – Part D	CY2014	✓
Grievances – Part C	CY2014	✓
Grievances – Part D	CY2014	✓
Medication Therapy Management (MTM) Programs – Part D	CY2014	✓
Enrollment and Disenrollment – Part C and Part D	CY2014	

Data elements included in the PUF are listed below as they appear in the CY2014 Part C and D Reporting Requirements documents. The Reporting Requirements documents can be found at the below locations:

Part C reporting sections - http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html

Part D reporting sections - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html

Organization Determinations and Reconsiderations – Part C

Contract Level

6.1 Total Number of Organization Determinations Made in Reporting Time Period
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
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

Special Needs Plans (SNPs) Care Management – Part C

Plan Level

13.1 Number of new enrollees
13.2 Number of enrollees eligible for an annual health risk reassessment (HRA)
13.3 Number of initial HRAs performed on new enrollees
13.4 Number of annual reassessments performed

Coverage Determinations and Redeterminations – Part D

Contract Level

Coverage Determinations and Exceptions:

A. The total number of pharmacy transactions in the time period
B. Of the total reported in A, the number of pharmacy transactions rejected due to non-formulary status
C. Of the total reported in A, the number of pharmacy transactions rejected due to prior authorization (PA) requirements
D. Of the total reported in A, the number of pharmacy transactions rejected due to step therapy requirements
E. Of the total reported in A, the number of pharmacy transactions rejected due to quantity limits (QL) requirements based on CMS approved formulary
F. Did the plan have high cost edits for compounds in place?
G. If yes to element F, the cost threshold used
H. Did the plan have high cost edits for non-compounds in place?
I. If yes to element H, the cost threshold used
J. Of the total reported in A, the total number of claims rejected due to high cost edits for compounds
K. Of the total reported in A, the total number of claims rejected due to high cost edits for non-compounds
L. The total number of coverage determinations decisions made
M. Of the number reported in element L, the total number of exception decisions made
O. Of the number reported in element L, the number that were fully favorable

P. Of the number reported in element L, the number that were partially favorable
Q. Of the number reported in element L, the number that were adverse
R. The total number of requests for coverage determinations that were withdrawn
S. The total number of requests for coverage determinations that were dismissed

Redeterminations:
A. The total number of redeterminations made in the reporting time period
C. Of the number reported in element A, the number that were fully favorable
D. Of the number reported in element A, the number that were partially favorable
E. Of the number reported in element A, the number that were adverse
F. The total number of requests for redeterminations that were withdrawn
G. The total number of requests for redeterminations that were dismissed

Reopenings:
A. The total number of reopened (revised) decisions

Grievances – Part C

Contract Level

5.1 Total number of grievances – Total
5.2 Total number of grievances – Expedited
5.3 Total number of grievances – Enrollment/Disenrollment
5.4 Total number of grievances – Benefit Package
5.5 Total number of grievances – Access
5.6 Total number of grievances – Marketing
5.7 Total number of grievances – Customer Service
5.8 Total number of grievances – Organization Determination and Reconsideration Process
5.9 Total number of grievances – Quality of Care
5.10 Total number of grievances – CMS Issues
5.11 Total Number of grievances – Other
5.12 Number of grievances in which timely notification was given – Total
5.13 Number of grievances in which timely notification was given – Expedited
5.14 Number of grievances in which timely notification was given – Enrollment/Disenrollment
5.15 Number of grievances in which timely notification was given – Benefit Package
5.16 Number of grievances in which timely notification was given – Access
5.17 Number of grievances in which timely notification was given – Marketing
5.18 Number of grievances in which timely notification was given – Customer Service
5.19 Number of grievances in which timely notification was given – Organization Determination and Reconsideration Process
5.20 Number of grievances in which timely notification was given – Quality of Care
5.21 Number of grievances in which timely notification was given – CMS Issues
5.22 Number of grievances in which timely notification was given – Other

Grievances – Part D

Contract Level

A. Contract Number
B. Total number of grievances – Total
C. Number of grievances in which timely notification was given – Total
D. Total number of grievances – Expedited
E. Number of grievances in which timely notification was given – Expedited
F. Total number of grievances – Enrollment/Disenrollment
G. Number of grievances in which timely notification was given – Enrollment/Disenrollment
H. Total number of grievances – Plan Benefit
I. Number of grievances in which timely notification was given – Plan Benefit
J. Total number of grievances – Pharmacy Access
K. Number of grievances in which timely notification was given – Pharmacy Access
L. Total number of grievances – Marketing
M. Number of grievances in which timely notification was given – Marketing
N. Total number of grievances – Customer Service
O. Number of grievances in which timely notification was given – Customer Service
P. Total number of grievances – Coverage Determination and Redetermination Process
Q. Number of grievances in which timely notification was given – Coverage Determination and Redetermination Process
R. Total number of grievances – Quality of Care
S. Number of grievances in which timely notification was given – Quality of Care
T. Total number of grievances – CMS Issues
U. Number of grievances in which timely notification was given – CMS Issues
V. Total number of grievances – Other
W. Number of grievances in which timely notification was given – Other

Medication Therapy Management (MTM) Programs – Part D

Contract Level

A. Contract Number
F. Beneficiary date of birth (excluded; however, age band will be provided in lieu of Beneficiary date of birth – under 65, 66-74, 75-84, and 85 and above; age calculated as of the last day of the reporting period)
G. Met the specified targeting criteria per CMS – Part D requirements
H. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR
I. Date of MTM program enrollment
J. Date met the specified targeting criteria per CMS – Part D requirements
K. Date of MTM program opt-out, if applicable
L. Reason participant opted-out of MTM program
M. Offered annual CMR
N. If offered a CMR, date of (initial) offer
O. Received annual CMR with written summary in CMS standardized format

P. Number of CMRs received with written summary in CMS standardized format
Q. Date(s) of CMR(s) with written summary in CMS standardized format (up to five)
R. Method of delivery for the annual CMR
S. Qualified provider who performed the initial CMR
T. Recipient of CMR
U. Number of targeted medication reviews
V. Number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services
W. Number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations

Enrollment and Disenrollment – Part C and Part D

Contract Level

Enrollment:

A. The total number of enrollment requests received in the specified time period
B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative)
C. Of the total reported in A, the number of enrollment requests for which the Sponsor was required to request additional information from the applicant (or his/her representative)
D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not eligible for an election period)
E. Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes
F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes
G. Of the total reported in A, the number of paper enrollment requests received
H. Of the total reported in A, the number of telephonic enrollment requests received (if Sponsor offers this mechanism)
I. Of the total reported in A, the number of internet enrollment requests received via plan website (if Sponsor offers this mechanism)
J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received
K. 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)
L. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage
M. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP

N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the total number of enrollment transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period
O. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period Code “S” for individuals affected by a contract nonrenewal, plan termination or service area reduction

Disenrollment:
A. The total number of voluntary disenrollment requests received
B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative)
C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason

Reporting Sections Excluded from the PUF

- Data that are validated:
  - LTC Utilization (Part D)
  - Plan Oversight of Agents (Part C and Part D)

- Data that are non-validated and are used for CMS monitoring only:
  - PFFS Plan Enrollment Verification Calls (Part C)
  - PFFS Provider Payment Dispute Resolution Process (Part C)
  - Serious Reportable Adverse Events (Part C)
  - Retail, Home Infusion, and Long-Term Care Pharmacy Access (Part D)
  - Employer Group Plan Sponsors (Part C and Part D)

- Reporting sections that have been suspended by CMS:
  - Agent Compensation Structure (Part C)
  - Agent Training and Testing (Part C)
  - Benefit Utilization (Part C)
  - Provider Network Adequacy (Part C)
  - Procedure Frequency (Part C)
  - Fraud, Waste, and Abuse Compliance Programs (Part D)
  - Prompt Payment by Part D Sponsors (Part D)

Additional Exclusions from PUF

- Due to the limited number of Medicare-Medicaid Plans (MMPs) that were active for the full reporting year, data submitted to CMS by MMPs are excluded from the CY 2014 PUF.

III. CMS Disclaimer – User Agreement for Public Use Data

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare Parts C and D Programs. Our agency resources, including staff and computing resources, are primarily dedicated to agency operations. The agency is committed to providing program information and data to the public to the fullest extent possible. This disclaimer details the restrictions on CMS services in supporting data requests so that requestors can plan their projects accordingly. It also outlines the responsibility of CMS and the data user in regard to the delivery, processing, and understanding of the data files.

- Timeframes for data delivery: CMS expects to post plan-reported data on an annual basis, following the data validation process and other CMS reviews. CMS cannot guarantee the release of these data to meet any timeframe.
- Data validation: CMS is providing plan-reported data available to the public; most of these data have undergone the data validation process and are used by CMS for operational purposes. CMS requires that organizations contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly review to validate data reported to CMS per the *Medicare Part C and Part D Reporting Requirements and Technical Specifications (Technical Specifications)*.[1] The purpose of the independent data validation (DV) is to ensure that Part C and Part D Sponsors are reporting health and drug plan data that are reliable, valid, complete, comparable, and timely.
- Data accuracy: CMS does not ensure 100% accuracy of all records and all fields. Some data fields that are not used for core agency functions may contain incorrect and/or incomplete data. Data contained in the public use file are necessarily limited to data that was reported to CMS in any given year. Data reporting requirements and technical specifications may change from year to year. Therefore, users must familiarize themselves with any modifications to the reporting requirements or technical specifications when considering these data across plan years.
- Data integrity: It is the responsibility of each user to identify the information needed to satisfy the need for the data contained in the public use file. Any alteration of the original data, including conversion to other media or other data formats, is the responsibility of the user. Data that has been manipulated or reprocessed by the user is the responsibility of the user. The user may not present data that has been altered in any way as CMS data. CMS has no responsibility for the data file after it has been converted, processed or otherwise altered. CMS has no responsibility for assisting users with converting the data to another format.

[1] See 42 CFR §422.516(g) and §423.514(g)

- Privacy protection: CMS is obligated by the federal Privacy Act, 5 U.S.C. Section. 552a and the HIPAA Privacy Rule, 45 C.F.R Parts 160 and 164, to protect the privacy of individual beneficiaries and other persons. Public files consist of aggregated data that do not permit direct identification of individuals. Attempting to determine individual identities from public data is a violation of the federal Privacy Act, 5 U.S.C and the HIPAA Privacy Rule.

IV. Technical Assistance

Questions about the PUFs should be sent to the below mailboxes:

Part C reporting sections - Partcplanreporting@cms.hhs.gov

Part D reporting sections - partd-planreporting@cms.hhs.gov

V. PUF Specifications by Reporting Section

The following subsections provide specifications of each individual dataset of the PUF including, for each reporting section:

- Reporting section details, such as the year of data included and level and frequency at which the data are reported by sponsors
- PUF dataset details, such as any minimum size and/or data validation criteria applied to exclude or suppress data from the PUF
- File layout, including variable names and definitions

All datasets are provided as tab delimited files in .txt format.

Organization Determinations and Reconsiderations – Part C

Reporting Section Details

Year: CY2014

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at CONTRACT_ID-YEAR-QUARTER level.

Exclusion Criteria: Contracts that were not required to submit Organization Determinations and Reconsiderations data, that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2014-December 2014) according to the Health Plan Management System (HPMS) are excluded. Data reported by MMP contracts are excluded as well.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Organization Determinations and Reconsiderations section will be included but will have all variables other than CONTRACT_ID, CONTRACT_NAME, YEAR, and QUARTER listed as *X*. This *X* indicates that CMS found issues with the contract's data. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X*. Data elements which were compliant with DV standards/sub-standards will be included as reported by the contract.

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
QUARTER	Reporting quarter (e.g., Q1)
DET_ISSUED	Number of organization determinations (Element 6.1)

Variable Name	Definition
DET_ISSUED_TIME	Number of organization determinations processed timely (Element 6.2)
DET_FULLY_FAVORABLE_SERV	Number of fully favorable organization determinations for services (Element 6.3)
DET_FULLY_FAVORABLE_CLAIM	Number of fully favorable organization determinations for claims (Element 6.4)
DET_PARTIALLY_FAVORABLE_SERV	Number of partially favorable organization determinations for services (Element 6.5)
DET_PARTIALLY_FAVORABLE_CLAIM	Number of partially favorable organization determinations for claims (Element 6.6)
DET_ADVERSE_SERV	Number of adverse organization determinations for services (Element 6.7)
DET_ADVERSE_CLAIM	Number of adverse organization determinations for claims (Element 6.8)
DET_WITHDRAWN	Number of organization determination requests withdrawn (Element 6.9)
TOTAL_REC_MADE	Number of reconsiderations (Element 6.10)
TOTAL_REC_MADE_TIME	Number of reconsiderations processed timely (Element 6.11)
REC_FULLY_FAVORABLE_SERV	Number of fully favorable reconsiderations for services (Element 6.12)
REC_FULLY_FAVORABLE_CLAIM	Number of fully favorable reconsiderations for claims (Element 6.13)
REC_PARTIALLY_FAVORABLE_SERV	Number of partially favorable reconsiderations for services (Element 6.14)
REC_PARTIALLY_FAVORABLE_CLAIM	Number of partially favorable reconsiderations for claims (Element 6.15)
REC_ADVERSE_SERV	Number of adverse reconsiderations for services (Element 6.16)
REC_ADVERSE_CLAIM	Number of adverse reconsiderations for claims (Element 6.17)
REC_WITHDRAWN	Number of reconsiderations requests withdrawn (Element 6.18)
TOTAL_REOPENED	Number of reopened/revised decisions (Element 6.19)

Special Needs Plans (SNPs) Care Management – Part C

Reporting Section Details

Year: CY2014

Level: Plan

Frequency: 1/Year

PUF Details

File Level: Unique at CONTRACT_ID-PLAN_ID-YEAR level.

Exclusion Criteria: Plans that were not required to submit SNP Care Management data or that did not undergo DV are excluded. Additionally, plans whose sum of new enrollees (Element 13.1) and enrollees eligible for an annual reassessment (Element 13.2) is less than 11 are excluded.

Data Validation: Plans scoring less than 95% in DV for their reporting of the SNP Care Management section will be included but will have all variables other than CONTRACT_ID, CONTRACT_NAME, PLAN_ID, and YEAR listed as *X.* This *X* indicates that CMS found issues with the plan's data. Plans that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X.* Data elements which were compliant with DV standards/sub-standards will be included as reported by the plan. Note: There may be a number of reasons for less than 100% completion of the HRA, including refusals on the part of beneficiaries despite proactive efforts by plans

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID
CONTRACT_NAME	Contract name associated with Contract ID
PLAN_ID	Plan ID
YEAR	Reporting year (e.g., 2014)
NEW_ENROLLEES	Number of new enrollees (Element 13.1)
ELIGIBLE_ENROLLEES	Number of enrollees eligible for an annual reassessment (Element 13.2)
INITIAL_ASSESSMENTS	Number of initial assessments performed on new enrollees during reporting period (Element 13.3)

Variable Name	Definition
ANNUAL_REASSESSMENTS	Number of annual reassessments performed on enrollees eligible for a reassessment (Element 13.4)

Coverage Determinations and Redeterminations – Part D

Reporting Section Details

Year: CY2014

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at CONTRACT_ID-YEAR-QUARTER level.

Exclusion Criteria: Contracts that were not required to submit Coverage Determinations and Redeterminations data, that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2014-December 2014) according to HPMS are excluded. Data reported by MMP contracts are excluded as well.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Coverage Determinations and Redeterminations section will be included but will have all variables other than CONTRACT_ID, CONTRACT_NAME, YEAR, and QUARTER listed as *X.* This *X* indicates that CMS found issues with the contract's data. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X.* Data elements which were compliant with DV standards/sub-standards will be included as reported by the contract.

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
QUARTER	Reporting quarter (e.g., Q1)
PHARM_TRANS	Number of pharmacy transactions (Element 1.A)
PHARM_TRANS_REJ_NONFORM	Number of pharmacy transactions rejected due non-formulary status (Element 1.B)

Variable Name	Definition
PHARM_TRANS_REJ_PA	Number of pharmacy transactions rejected due to PA requirements (Element 1.C)
PHARM_TRANS_REJ_STEP	Number of pharmacy transactions rejected due to step therapy requirements (Element 1.D)
PHARM_TRANS_REJ_QL	Number of pharmacy transactions rejected due to QL requirements based on CMS approved formulary (Element 1.E)
COMP_EDITS	Did the plan have high cost edits for compounds in place? (Element 1.F)
COMP_EDITS_COST	If Yes to Element 1.F, the cost threshold used (Element 1.G) Blank if Element 1.F is No
NONCOMP_EDITS	Did the plan have high cost edits for non-compounds in place? (Element H)
NONCOMP_EDITS_COST	If Yes to Element 1.H, the cost threshold used (Element 1.I) Blank if Element 1.H is No
PHARM_TRANS_REJ_COMP_EDITS	Of the total reported in 1.A, the total number of claims rejected by the plan due to high cost edits for compounds (Element 1.J)
PHARM_TRANS_REJ_NONCOMP_EDITS	Of the total reported in 1.A, the total number of claims rejected by the plan due to high cost edits for non-compounds (Element 1.K)
TOTAL_DET	Number of coverage determinations decisions (Element 1.L)
TOTAL_EXCEPTIONS	Number of exception decisions (Element 1.M)
FULLY_FAVORABLE_DET	Number of coverage determinations decisions that were fully favorable (Element 1.O)
PARTIALLY_FAVORABLE_DET	Number of coverage determinations decisions that were partially favorable (Element 1.P)
ADVERSE_DET	Number of coverage determinations decisions that were adverse (Element 1.Q)

Variable Name	Definition
WITHDRAWN_DET	Number of requests for coverage determinations that were withdrawn (Element 1.R)
DISMISSED_DET	Number of requests for coverage determinations that were dismissed (Element 1.S)
TOTAL_REDET	Number of redeterminations (Element 2.A)
FULLY_FAVORABLE_REDET	Number of fully favorable redeterminations (Element 2.C)
PARTIALLY_FAVORABLE_REDET	Number of partially favorable redeterminations (Element 2.D)
ADVERSE_REDET	Number of adverse redeterminations (Element 2.E)
WITHDRAWN_REDET	Number of requests for redeterminations that were withdrawn (Element 2.F)
DISMISSED_REDET	Number of requests for redeterminations that were dismissed (Element 2.G)
TOTAL_REOPENINGS	Number of reopened/revised decisions (Element 3.A)

Grievances – Part C

Reporting Section Details

Year: CY2014

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at CONTRACT_ID-YEAR-QUARTER level.

Exclusion Criteria: Contracts that were not required to submit Grievances data, that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2014-December 2014) according to HPMS are excluded. Data reported by MMP contracts are excluded as well.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Grievances section will be included but will have all variables other than CONTRACT_ID, CONTRACT_NAME, YEAR, and QUARTER listed as *X*. This *X* indicates that CMS found issues with the contract's data. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X*. Data elements which were compliant with DV standards/sub-standards will be included as reported by the contract.

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
QUARTER	Reporting quarter (e.g., Q1)
TOTAL_GRIEVE	Total number of grievances (Element 5.1)
TIMELY_GRIEVE	Number of grievances in which the sponsor provided timely notification of its decision (Element 5.12)
TOTAL_EXP	Total number of expedited grievances (Element 5.2)
TIMELY_EXP	Number of expedited grievances in which the sponsor provided timely notification of its decision (Element 5.13)

Variable Name	Definition
TOTAL_ENROLLMENT	Total number of enrollment/disenrollment grievances (Element 5.3)
TIMELY_ENROLLMENT	Number of enrollment/disenrollment grievances in which the sponsor provided timely notification of its decision (Element 5.14)
TOTAL_BENEFIT	Total number of benefit package grievances (Element 5.4)
TIMELY_BENEFIT	Number of benefit package grievances in which the sponsor provided timely notification of its decision (Element 5.15)
TOTAL_ACCESS	Total number of access grievances (Element 5.5)
TIMELY_ACCESS	Number of access grievances in which the sponsor provided timely notification of its decision (Element 5.16)
TOTAL_MARKETING	Total number of marketing grievances (Element 5.6)
TIMELY_MARKETING	Number of marketing grievances in which the sponsor provided timely notification of its decision (Element 5.17)
TOTAL_CUSTSERV	Total number of customer service grievances (Element 5.7)
TIMELY_CUSTSERV	Number of customer service grievances in which the sponsor provided timely notification of its decision (Element 5.18)
TOTAL_DETRECON	Total number of organization determination and reconsideration process grievances (Element 5.8)
TIMELY_DETRECON	Number of organization determination and reconsideration grievances in which the sponsor provided timely notification of its decision (Element 5.19)
TOTAL_QUALITY	Total number of quality of care grievances (Element 5.9)
TIMELY_QUALITY	Number of quality of care grievances in which the sponsor provided timely notification of its decision (Element 5.20)
TOTAL_CMS	Total number of grievances related to “CMS Issues” (Element 5.10)
TIMELY_CMS	Number of grievances related to “CMS Issues” in which the sponsor provided timely notification of its decision (Element 5.21)
TOTAL_OTHER	Total number of other grievances (Element 5.11)
TIMELY_OTHER	Number of other grievances in which the sponsor provided timely notification of its decision (Element 5.22)

Grievances – Part D

Reporting Section Details

Year: CY2014

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at CONTRACT_ID-YEAR-QUARTER level.

Exclusion Criteria: Contracts that were not required to submit Grievances data, that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2014-December 2014) according to HPMS are excluded. Data reported by MMP contracts are excluded as well.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Grievances section will be included but will have all variables other than CONTRACT_ID, CONTRACT_NAME, YEAR, and QUARTER listed as *X*. This *X* indicates that CMS found issues with the contract's data. Contracts that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X*. Data elements which were compliant with DV standards/sub-standards will be included as reported by the contract.

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID (Element A)
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
QUARTER	Reporting quarter (e.g., Q1)
GRIEVE_TOTAL	Total number of grievances (Element B)
GRIEVE_TIMELY	Number of grievances in which timely notification was given (Element C)
EXP_TOTAL	Total number of expedited grievances (Element D)
EXP_TIMELY	Number of expedited grievances in which timely notification was given (Element E)

Variable Name	Definition
ENROLL_TOTAL	Total number of enrollment/disenrollment grievances (Element F)
ENROLL_TIMELY	Number of enrollment/disenrollment grievances in which timely notification was given (Element G)
BENEFIT_TOTAL	Total number of plan benefit grievances (Element H)
BENEFIT_TIMELY	Number of plan benefit grievances in which timely notification was given (Element I)
ACCESS_TOTAL	Total number of pharmacy access grievances (Element J)
ACCESS_TIMELY	Number of pharmacy access grievances in which timely notification was given (Element K)
MARKETING_TOTAL	Total number of marketing grievances (Element L)
MARKETING_TIMELY	Number of marketing grievances in which timely notification was given (Element M)
CUSTSERV_TOTAL	Total number of customer service grievances (Element N)
CUSTSERV_TIMELY	Number of customer service grievances in which timely notification was given (Element O)
COVDET_TOTAL	Total number of coverage determinations and redeterminations process grievances (Element P)
COVDET_TIMELY	Number of coverage determinations and redeterminations process grievances in which timely notification was given (Element Q)
QUALITY_TOTAL	Total number of quality of care grievances (Element R)
QUALITY_TIMELY	Number of quality of care grievances in which timely notification was given (Element S)
CMS_TOTAL	Total number of grievances related to “CMS Issues” (Element T)
CMS_TIMELY	Number of grievances related to “CMS Issues” in which timely notification was given (Element U)
OTHER_TOTAL	Total number of other grievances (Element V)
OTHER_TIMELY	Number of other grievances in which timely notification was given (Element W)

Medication Therapy Management (MTM) Programs – Part D

Reporting Section Details

Year: CY2014

Level: Contract

Frequency: 1/Year

PUF Details

File Level: Unique at FILE_REC_NUM level

Exclusion Criteria: Contracts that were not required to submit Medication Therapy Management data or that did not undergo data validation (DV) are excluded. Data reported by MMP contracts are excluded as well.

Data Validation: Contracts scoring less than 95% in DV for their reporting of the Medication Therapy Management section are listed a single time in the PUF with all variables other than FILE_REC_NUM, CONTRACT_ID, CONTRACT_NAME, YEAR, and CONTRACT_REC_NUM listed as *F.* This *F* indicates that CMS found issues with the contract's data.

Contracts scoring 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will have only the specific data element(s) for which they were non-compliant listed as *X.* This *X* indicates that CMS found issues with the contract's data. Data elements which were compliant with DV standards/sub-standards will be included as reported by the contract.

Minimum Size: Contracts reporting fewer than 11 total records in their MTM data are listed a single time in the PUF with all variables other than FILE_REC_NUM, CONTRACT_ID, CONTRACT_NAME, YEAR, and CONTRACT_REC_NUM listed as *S.* This *S* indicates the contract's data are suppressed from the PUF.

Contracts reporting more than 11 total records in their MTM data but fewer than 11 records in a single AGE_BRACKET will have that specific AGE_BRACKET listed a single time in the PUF with all variables other than FILE_REC_NUM, CONTRACT_ID, CONTRACT_NAME, YEAR, CONTRACT_REC_NUM, and AGE_BRACKET listed as *S*. This *S* indicates the contract's data are suppressed from the PUF.

Other: Records that cannot be mapped to a valid beneficiary or that contain dates of MTM program enrollment (Element I) outside of the reporting year are excluded. Additionally, if multiple conflicting

records are reported for the same beneficiary by the same contract, those records are excluded.

File Layout

Variable Name	Definition
FILE_REC_NUM	Incremental count of number of records across all Contract IDs in PUF
CONTRACT_ID	Contract ID
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
CONTRACT_REC_NUM	Incremental count of number of records within Contract ID in PUF
AGE_BRACKET	Beneficiary age, categorized into an age bracket, as of December 31, 2014 according to date of birth reported by contract in Element F A: Under 65 B: 65-74 C: 75-84 D: 85+ F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
MET_CRITERIA	Indicates if beneficiary met the specified targeting criteria per CMS – Part D requirements (Element G) Y: Yes N: No F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
COGNITIVELY_IMPAIRED	Indicates if the beneficiary was identified as being cognitively impaired. (Element H) Y: Yes N: No U: Unknown F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
ENROLLMENT_DATE	Date of MTM program enrollment (Element I). CCYYMMDD format.

Variable Name	Definition
DATE_MET_CRITERIA	Date the beneficiary met the specified targeting criteria per CMS – Part D requirements, if applicable (Element J). CCYYMMDD format. N if beneficiary did not meet the specified targeting criteria per CMS – Part D requirements.
OPT_OUT_DATE	Date of MTM program opt out, if applicable (Element K). CCYYMMDD format. N if beneficiary did not opt out. 99999999 if opt-out reason is death.
OPT_OUT_REASON	Reason participant opted out of MTM program, if applicable (Element L). Listed as 'NA' if beneficiary did not opt out. 01: Death 02: Disenrollment from plan 03: Request by beneficiary 04: Other NA: Beneficiary did not opt out F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
CMR_OFFERED	Indicates if beneficiary was offered a comprehensive medication review (Element M) Y: Yes N: No F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
CMR_OFFER_DATE	If beneficiary was offered a comprehensive medication review, date of (initial) offer (Element N). CCYYMMDD format. N if beneficiary was not offered a CMR.
CMR_RECEIVED	Indicates if beneficiary received a comprehensive medication review (Element O) Y: Yes N: No F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
NUMBER_CMRS	The number of CMRs received (Element P). 0 if beneficiary did not receive a CMR.

Variable Name	Definition
FIRST_CMR_DATE	If beneficiary received a comprehensive medication review, first date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a comprehensive medication review.
SECOND_CMR_DATE	If beneficiary received a comprehensive medication review, second date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a second comprehensive medication review.
THIRD_CMR_DATE	If beneficiary received a comprehensive medication review, third date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a third comprehensive medication review.
FOURTH_CMR_DATE	If beneficiary received a comprehensive medication review, fourth date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a fourth comprehensive medication review
FIFTH_CMR_DATE	If beneficiary received a comprehensive medication review, fifth date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a fifth comprehensive medication review
CMR_METHOD	Method of delivery for the annual CMR (Element R) 01: Face to face 02: Telephone 03: Telehealth consultation 04: Other NA: Beneficiary did not receive a CMR F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV

Variable Name	Definition
CMR_PROVIDER	The qualified provider who performed the CMR (Element S). 01: Physician 02: Registered Nurse 03: Licensed Practical Nurse 04: Nurse Practitioner 05: Physician's Assistant 06: Local Pharmacist 07: LTC Consultant Pharmacist 08: Plan Sponsor Pharmacist 09: PBM Pharmacist 10: MTM Vendor Local Pharmacist 11: MTM Vendor In-House Pharmacist 12: Hospital Pharmacist 13: Pharmacist – Other 14: Other NA: Beneficiary did not receive a CMR F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
CMR_RECIPIENT	The recipient of the annual CMR (Element T). 01: Beneficiary 02: Beneficiary's prescriber 03: Caregiver 04: Other authorized individual NA: Beneficiary did not receive a CMR F: Issues with section-level DV S: Data suppressed due to minimum size criteria X: Issues with element-level DV
TMR	Number of targeted medication reviews (Element U)
THERAPY_RECOMMENDATIONS	The number of drug therapy problem recommendations made to prescriber(s) as a result of MTM services (Element V).
THERAPY_RESOLUTIONS	Number of drug therapy problem resolutions made as a result of MTM interventions (Element W)

Enrollment and Disenrollment – Part C and Part D

Reporting Section/Measure Details

Year: CY2014

Level: Contract

Frequency: 2/Year

PUF Details

File Level: Unique at CONTRACT_ID-YEAR-PERIOD level.

Exclusion Criteria: Contracts that were not required to submit Enrollment and Disenrollment data or that did not have at least one enrollee in both periods of the year are excluded. Required submissions that were missing are listed with missing values ('.'). Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2014-December 2014) according to HPMS are excluded.

Data Validation: The CY 2014 Enrollment and Disenrollment data did not undergo DV.

File Layout

Variable Name	Definition
CONTRACT_ID	Contract ID
CONTRACT_NAME	Name associated with Contract ID
YEAR	Reporting year (e.g., 2014)
PERIOD	Reporting period (e.g., P1)
E_TOTAL_REQUESTS	Total number of enrollment requests received (Enrollment Element A)
E_INITIAL_COMPLETE	Total number of enrollment requests complete at the time of initial receipt (Enrollment Element B)
E_INITIAL_INCOMPLETE	Total number of enrollment requests that required requests for additional information (Enrollment Element C)
E_DENIED_INELIGIBLE	Total number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (Enrollment Element D)
E_INCOMPLETE_TIMELY	Number of incomplete enrollment requests received that are completed within established timeframes (Enrollment Element E)

Variable Name	Definition
E_DENIED_INCOMPLETE	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 (Enrollment Element F)
E_REQUESTS_PAPER	Number of paper enrollment requests received (Enrollment Element G)
E_REQUESTS_PHONE	Number of telephonic enrollment requests received (Enrollment Element H)
E_REQUESTS_PLAN_WEB	Number of internet enrollment requests received via plan website (Enrollment Element I)
E_REQUESTS_OEC	Number of Online Enrollment Center (OEC) enrollment requests received (Enrollment Element J)
E_REQUESTS_SALES	Number of enrollment requests effectuated by sales persons (Enrollment Element K).
E_SEP_CREDITABLE	Number of enrollment transactions submitted using the SEP Election Period code “S” related to creditable coverage (Enrollment Element L)
E_SEP_SPAP	Number of enrollment transactions submitted using the SEP Election Period code “S” related to SPAP (Enrollment Element M)
E_SEP_MA_DISENROLLMT	Number of enrollment transactions submitted using the SEP Election Period code “S” that coordinates with the Medicare Advantage Disenrollment Period (Enrollment Element N)
E_SEP_NONRENEWALS	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 (Enrollment Element O)
D_TOTAL_REQUESTS	Total number of voluntary disenrollment requests received in the specified time period (Disenrollment Element A)
D_INITIAL_COMPLETE	Total number of disenrollment requests complete at the time of initial receipt (Disenrollment Element B)
D_DENIED_ANY	Total number of disenrollment requests denied by the sponsor for any reason (Disenrollment Element C)

VI. Appendix A: Part C Reporting Requirements Summary

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
Enrollment and Disenrollment			✓	✓	✓	✓
Grievances	✓	✓	✓	✓	✓	✓
Employer Group Plan Sponsors	✓	✓	✓	✓	✓	✓
Plan Oversight of Agents[2]	✓	✓	✓		✓	✓
Organization Determinations and Reconsiderations	✓	✓	✓	✓	✓	✓
Special Needs Plans (SNPs) Care Management	✓	✓	✓	✓	✓	✓
Serious Reportable Adverse Events	✓	✓	✓	✓		
Provider Network Adequacy	✓	✓	✓			
Benefit Utilization	✓					
Procedure Frequency	✓	✓	✓			
PFFS Plan Enrollment Verification Calls	✓	✓	✓	✓	✓	✓
PFFS Provider Payment Dispute Resolution Process	✓	✓	✓	✓	✓	✓

[2] The Plan Oversight of Agents reporting section was suspended in CY2013; however, a revised data collection was introduced in CY2014.

VII. Appendix B: Part D Reporting Requirements Summary

Reporting Section	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
Enrollment and Disenrollment[3]	✓	✓	✓	✓	✓	✓
Retail, HI, LTC Pharmacy Access	✓	✓	✓	✓	✓	✓
Access to Extended Day Supplies at Retail Pharmacies	✓	✓	✓			
Medication Therapy Management (MTM) Programs	✓	✓	✓	✓	✓	✓
Prompt Payment by Part D Sponsors	✓	✓	✓	✓		
Pharmacy Support for Electronic Prescribing	✓	✓	✓			
Grievances	✓	✓	✓	✓	✓	✓
P&T Committees/Provision of Part D Functions[4]	✓	✓	✓			
Coverage Determinations/Exceptions	✓	✓	✓	✓		
Appeals/Redeterminations[5]	✓	✓	✓	✓		
Coverage Determinations and Redeterminations[6]					✓	✓
Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions	✓					
Long-Term Care (LTC) Utilization	✓	✓	✓	✓	✓	
Licensure and Solvency, Business Transactions and Financial Requirements[7]	✓					
Fraud, Waste and Abuse Compliance Programs	✓	✓	✓	✓		
Employer/Union-Sponsored Group Health Plan Sponsors	✓	✓	✓	✓	✓	✓
Plan Oversight of Agents[8]	✓	✓	✓		✓	✓

[3] The Enrollment reporting section was renamed Enrollment and Disenrollment in CY2012.
[4] The P&T Committee/Provision of Part D Functions reporting section was suspended in CY2013.
[5] The Appeals reporting section was renamed Redeterminations in CY2012.
[6] The Coverage Determinations/Exceptions and Redeterminations sections were combined into a single section for CY2014.
[7] Effective March 2009, the Licensure and Solvency, Business Transactions and Financial Requirements data were submitted into the HPMS Fiscal Soundness Module.
[8] The Plan Oversight of Agents reporting section was suspended in CY2013; however, a revised data collection was introduced in CY2014.

VIII. Appendix C: Part C and Part D Data Validation Summary

Reporting Section	DV2011	DV2012	DV2013	DV2014	DV2015
Procedure Frequency[9]		CY2010			
Serious Reportable Adverse Events (SRAEs)[10]		CY2010	CY2011	CY2012, CY2013	
Provider Network Adequacy[11]	CY2010	CY2011			
Organization Determinations/ Reconsiderations	CY2010	CY2011	CY2012	CY2013	CY2014
Special Needs Plans (SNPs) Care Management		CY2010	CY2011	CY2012, CY2013	CY2014
Retail, HI, LTC Pharmacy Access[12]	CY2010	CY2011			
Medication Therapy Management (MTM) Programs	CY2010	CY2011	CY2012	CY2013	CY2014
Grievances - Part C	CY2010	CY2011	CY2012	CY2013	CY2014
Grievances - Part D	CY2010	CY2011	CY2012	CY2013	CY2014
Coverage Determinations and Exceptions	CY2010	CY2011	CY2012	CY2013	
Appeals/Redeterminations[13]	CY2010	CY2011	CY2012	CY2013	
Coverage Determinations and Redeterminations[14]					CY2014
Long-Term Care (LTC) Utilization		CY2010	CY2011, CY2012	CY2013	CY2014
Employer Group Plan Sponsors (Part C and Part D)[15]	CY2010	CY2011			
Plan Oversight of Agents (Part C and Part D)[16]	CY2010	CY2011	CY2012		CY2014

[9] The Procedure Frequency reporting section was collected for monitoring purposes only for CY2011 and CY 2012 and suspended for CY2013.
[10] The SRAEs reporting section was suspended for CY2014.
[11] The Provider Network Adequacy reporting section was collected for monitoring purposes only for CY2012 and suspended for CY2013.
[12] The Retail, Home Infusion, and LTC Pharmacy Access reporting section is collected for monitoring purposes only starting for CY2012.
[13] The Appeals reporting section was renamed Redeterminations in CY2012.
[14] The Coverage Determinations/Exceptions and Redeterminations sections were combined into a single section for CY2014
[15] The Employer Group Plan Sponsors reporting section is collected for monitoring purposes only starting for CY2012.
[16] The Plan Oversight of Agents reporting section was suspended from data validation for CY2013; but was reintroduced for CY2014.