

**Medicare Part C and Part D Measure
Data Validation Standards**

**For Industry Comment:
September 9, 2009 – September 23, 2009**

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1.0 PART C DATA VALIDATION STANDARDS

1.1 BENEFIT UTILIZATION

Contract #:

To determine compliance with the standards for Benefit Utilization, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in</p>

	enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED) Note: Columns referenced below correspond to the HPMS Upload Table provided in Appendix 1 of the Medicare Part C Plan Reporting Requirements Technical Specifications Document.	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadline for reporting annual data to CMS by 8/31.
4	Organization accurately maps Plan Benefit Package (PBP) Service Category services to the Corresponding MA Medical Utilization and Expenditure Experience Category per the chart provided in Appendix 3 of the Medicare Part C Plan Reporting Requirements Technical Specifications Document.
5	Organization accurately calculates the number of members with access to services, including the following criteria: <ul style="list-style-type: none"> Includes members who were enrolled for at least one month during the reporting period. Includes members who had access to each of the following services: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); Other (Non-Covered); and Medical. [Column C]
6	Organization accurately calculates member utilization of benefits, including the following criteria: <ul style="list-style-type: none"> Includes unique members who used each of the following services during the reporting period: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); Other (Non-Covered); and Medical. Correctly selects the appropriate code to identify how the organization captures utilization data for each service listed above. Correctly sums the total utilization of each service listed above by calculating the total number of services used by members during the reporting period. [Columns D – F]
7	For Plan Experience, organization accurately calculates the amounts of all plan benefits provided for all members, including the following criteria: <ul style="list-style-type: none"> Includes all benefits paid for with federal funding, state funding, group sponsor funding, and member premiums. Includes all benefits furnished during the reporting period, regardless of their representation in the approved bid. Includes benefits regardless of a member's ESRD status. Excludes optional supplemental benefits. [Columns G – H]
8	Organization accurately calculates the amounts of plan reimbursement, including the following criteria: <ul style="list-style-type: none"> Correctly sums the total amount reimbursed from the plan to providers during the reporting period for each of the following services: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); Other (Non-Covered); and Medical. [Column G]

9	<p>Organization accurately calculates the amounts of member cost sharing, including the following criteria:</p> <ul style="list-style-type: none"> Correctly sums the total cost-sharing amount that members paid directly to providers during the reporting period for each of the following services: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); Other (Non-Covered); and Medical. <p><i>Note to reviewer:</i> The organization should provide the reviewer and CMS with a brief narrative explaining how the cost-sharing amounts are derived. [Column H]</p>
10	<p>Organization accurately calculates the amounts of total payments to providers for Medicare covered services, including the following criteria:</p> <ul style="list-style-type: none"> Correctly sums the total payments made to providers during the reporting period for services covered under original Medicare for each of the following services: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; and Medical. Number calculated for total payments for each of the following <u>non-covered</u> services must be \$0: Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); and Other (Non-Covered). <p><i>Note to reviewer:</i> The organization should provide the reviewer and CMS with a brief narrative explaining how the payment amounts for Medicare-covered services are derived. [Column J]</p>
11	<p>Organization accurately calculates the amounts of Medicare actuarial equivalent (cost-sharing), including the following criteria:</p> <ul style="list-style-type: none"> Uses appropriate actuarial equivalent factors to calculate the cost sharing that would be required for covered services using original Medicare requirements for each of the following services: Inpatient Facility; Skilled Nursing Facility; Home Health; Ambulance; DME/Prosthetics/Supplies; OP Facility-Emergency; OP Facility-Surgery; OP Facility-Other; Professional; Part B Rx; Other Medicare Part B; and Medical. Number calculated for actuarial equivalent (cost-sharing) for each of the following <u>non-covered</u> services must be \$0: Transportation (Non-Covered); Dental (Non-Covered); Vision (Non-Covered); Hearing (Non-Covered); Health & Education (Non-Covered); and Other (Non-Covered). <p><i>Note to reviewer:</i> The organization should provide the reviewer and CMS with a brief narrative explaining how the Medicare actuarial equivalent amounts are derived. [Column L]</p>
12	<p>Organization accurately calculates the total number of members, including the following criteria:</p> <ul style="list-style-type: none"> Includes all members who were enrolled for at least one month during the reporting period. <p>[Data Element 133]</p>
13	<p>Organization accurately calculates the number of member months during the reporting period. [Data Element 134]</p>
14	<p>Organization accurately calculates the amount of premiums collected, including the following criteria:</p> <ul style="list-style-type: none"> Includes all premium payments during the reporting period from members, employer/union groups, State Medicaid agencies, and other third parties. <p>[Data Element 135]</p>
15	<p>Organization accurately calculates the amount of CMS revenue collected, including the following criteria:</p> <ul style="list-style-type: none"> Includes all revenue received from CMS under the contract during the reporting period. Includes rebates applied to Part A and Part B services. <p>[Data Element 136]</p>
16	<p>Organization accurately calculates the amount of CMS rebates for Part A and Part B services, including the following criteria:</p> <ul style="list-style-type: none"> Includes all CMS rebates for Part A and Part B services and additional non-prescription drug benefits collected under the contract during the reporting period. Excludes rebates designated to reduce Part B and Part D premiums. <p>[Data Element 137]</p>
17	<p>Organization accurately calculates the amount of reserves for outstanding claims, including the following criteria:</p> <ul style="list-style-type: none"> Includes all reserves for outstanding claims from the reporting period. Includes claims that have not been submitted to the organization and claims that have been received but not yet

	processed. [Data Element 138]
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1.2 PROCEDURE FREQUENCY

Contract #:

To determine compliance with the standards for Procedure Frequency, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 5/31.
4	<p>Organization accurately calculates the number of members receiving the specified procedures, including the following criteria:</p> <ul style="list-style-type: none"> Includes all members that received the specified procedures with dates of service that occur during the reporting period. Accurately maps non-standard codes to the standard codes provided by CMS in Appendix 4 of the Part C Reporting Requirements Technical Specifications Document. Properly sorts by each of the following procedures: Cardiac Catheterization; Open Coronary Angioplasty; PTCA or Coronary Atherectomy with CABG; PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent(s); PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent(s); PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent; Total Hip Replacement; Total Knee Replacement; Bone Marrow Transplant; Heart Transplant; Heart/Lung Transplant; Kidney Transplant; Liver Transplant; Lung Transplant; Pancreas Transplant; Pancreas/Kidney Transplant; CABG; Gastric Bypass; Excision or Destruction of Lesion or Tissue of Lung; Excision of Large Intestine; Mastectomy; Lumpectomy; and Prostatectomy. For Data Elements 2.20 through 2.23, includes only members with the specified cancer diagnosis that received the following procedures: Excision or Destruction of Lesion or Tissue of Lung; Excision of Large Intestine; Mastectomy; Lumpectomy; and Prostatectomy. <p>[Data Elements 2.1 – 2.23]</p>
5	<p>Organization provides evidence of having reported the associated HEDIS measure for each of the following procedures: Cardiac Catheterization; Total Hip Replacement; Total Knee Replacement; CABG; Excision or Destruction of Large Intestine; Mastectomy; Lumpectomy; and Prostatectomy.</p> <p><i>Note:</i> These criteria are only applicable to organizations that reported the associated HEDIS measure.</p> <p>[Data Elements 2.1, 2.7, 2.8, 2.17, 2.20 – 2.23]</p>

1.3 SERIOUS REPORTABLE ADVERSE EVENTS (SRAEs)

Contract #:

To determine compliance with the standards for Serious Reportable Adverse Events (SRAEs), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans) • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 5/31.
4	Organization accurately calculates the total number of surgeries, including the following criteria: <ul style="list-style-type: none"> Includes all surgeries with dates of service that occur during the reporting period. [Data Element 3.1]
5	Organization accurately calculates the number of surgical SRAEs, including the following criteria <ul style="list-style-type: none"> Accurately maps SRAEs to the codes provided by CMS in Appendix 5 of the Part C Reporting Requirements Technical Specifications Document, Table 2. Includes all specified SRAEs that are confirmed to have occurred during the reporting period. Properly sorts by each of the following events: Surgeries on wrong body part; Surgeries on wrong patient; Wrong surgical procedures on a patient; and Surgeries with post-operative death in normal health patient. Each number calculated for Data Elements 3.2 through 3.5 is a subset of the total number of surgeries calculated for Data Element 3.1. [Data Elements 3.2 – 3.5]
6	Organization accurately calculates the number of hospital acquired conditions (HACs), including the following criteria: <ul style="list-style-type: none"> Accurately maps HACs to the codes provided by CMS in Appendix 5 of the Part C Reporting Requirements Technical Specifications Document, Table 3. Includes all specified HACs that are confirmed to have occurred during the reporting period. Properly sorts by each of the following HACs: Foreign object retained after surgery; Air embolism events; Blood incompatibility events; Stage III & IV pressure ulcers; Fractures; Dislocations; Intracranial injuries; Crushing injuries; Burns; Vascular catheter-associated infections; and Catheter-associated UTIs. [Data Elements 3.6 – 3.16]
7	Organization accurately calculates the number of HACs, including the following criteria: <ul style="list-style-type: none"> Accurately maps HACs to the codes provided by CMS in Appendix 5 of the Part C Reporting Requirements Technical Specifications Document, Table 4. Includes all specified HACs that are confirmed to have occurred during the reporting period. Properly sorts by each of the following HACs: Manifestations of poor glycemic control; SSI (mediastinitis) after CABG; SSI after certain orthopedic procedures; SSI following bariatric surgery for obesity; and DVT and pulmonary embolism following certain orthopedic procedures. [Data Elements 3.17 – 3.21]

1.4 PROVIDER NETWORK ADEQUACY

Contract #:

To determine compliance with the standards for Provider Network Adequacy, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	<p>Organization accurately calculates the number of primary care physicians (PCPs) in the network on the first day of the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes only physicians that are contracted in the network as of the first day of the reporting period. Includes only physicians that are identified as able to serve as a member's primary care physician. Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.1 – 4.6]</p>
5	<p>Organization accurately calculates the number of PCPs in the network continuously through the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes only physicians that are contracted in the network as of the first and last day of the reporting period. Includes only physicians that are identified as able to serve as a member's primary care physician. Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.7 – 4.12]</p>
6	<p>Organization accurately calculates the number of PCPs added to the network during the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes only physicians whose effective date of contracted network participation occurs within the reporting period. Includes only physicians that are identified as able to serve as a member's primary care physician. Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.13 – 4.18]</p>
7	<p>Organization accurately calculates the number of PCPs accepting new patients at the beginning of the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes only physicians who are contracted in the network and identified as accepting new patients as of the first day of the reporting period. Includes only physicians that are identified as able to serve as a member's primary care physician. Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.19 – 4.24]</p>
8	<p>Organization accurately calculates the number of PCPs accepting new patients at the end of the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes only physicians who are contracted in the network and identified as accepting new patients as of the last day of the reporting period. Includes only physicians that are identified as able to serve as a member's primary care physician. Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.25 – 4.30]</p>
9	Organization accurately calculates the number of PCPs in the network on the last day of the reporting period, including the

	<p>following criteria:</p> <ul style="list-style-type: none"> • Includes only physicians that are contracted in the network as of the last day of the reporting period. • Includes only physicians that are identified as able to serve as a member's primary care physician. • Properly sorts by each of the following PCP types: General Medicine; Family Medicine; Internal Medicine; Obstetricians; Pediatricians; and State Licensed Nurse Practitioners. <p>[Data Elements 4.31 – 4.36]</p>
10	<p>Organization accurately calculates the number of specialists/facilities in the network on the first day of the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only specialists/facilities defined as having been in network on the first day of the reporting period. • Properly sorts by each of the following specialty/facility types: Hospitals; Home Health Agencies; Cardiologist; Oncologist; Pulmonologist; Endocrinologist; Skilled Nursing Facilities; Rheumatologist; Ophthalmologist; and Urologist. <p>[Data Elements 4.37 – 4.46]</p>
11	<p>Organization accurately calculates the number of specialists/facilities continuously in the network through the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only specialists/facilities defined as having been continuously in the network through the reporting period. • Properly sorts by each of the following specialty/facility types: Hospitals; Home Health Agencies; Cardiologist; Oncologist; Pulmonologist; Endocrinologist; Skilled Nursing Facilities; Rheumatologist; Ophthalmologist; and Urologist. <p>[Data Elements 4.47 – 4.56]</p>
12	<p>Organization accurately calculates the number of specialists/facilities added to the network during the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only specialists/facilities whose effective date of network participation occurs within the reporting period. • Properly sorts by each of the following specialty/facility types: Hospitals; Home Health Agencies; Cardiologist; Oncologist; Pulmonologist; Endocrinologist; Skilled Nursing Facilities; Rheumatologist; Ophthalmologist; and Urologist. <p>[Data Elements 4.57 – 4.66]</p>
13	<p>Organization accurately calculates the number of specialists/facilities in the network on the last day of the reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only specialists/facilities that are contracted in the network as of the last day of the reporting period. • Properly sorts by each of the following specialty/facility types: Hospitals; Home Health Agencies; Cardiologist; Oncologist; Pulmonologist; Endocrinologist; Skilled Nursing Facilities; Rheumatologist; Ophthalmologist; and Urologist. <p>[Data Elements 4.67 – 4.76]</p>

1.5 GRIEVANCES (PART C)

Contract #:

To determine compliance with the standards for Grievances (Part C), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	Organization properly defines the term "Grievance" in accordance with the Medicare Managed Care Manual Chapter 13, Sections 10.1 and 20.2. Requests for organization determinations or appeals are not categorized as grievances.
5	<p>Organization accurately calculates the total number of grievances, including the following criteria:</p> <ul style="list-style-type: none"> Includes all grievances that were completed (i.e., organization has notified member of its decision) during the reporting period, regardless of when the grievance was received. Includes grievances regardless of whether the event or incidence of the grievance was filed late (i.e., more than 60 calendar days after the event). If a grievance contains multiple issues filed by a single complainant, each issue is calculated as a separate grievance. If a single complainant contacts the organization multiple times regarding the same issue, each time the complainant contacts the organization is calculated as a separate grievance. Includes all methods of grievance receipt (e.g., telephone, letter, fax, in-person). Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative). Includes only grievances that are filed directly with the organization (e.g., excludes all complaints that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization). Includes grievances regarding services covered under plan benefits, even if they are not services that would be covered under Fee For Service Medicare. <i>For MA-PD contracts:</i> Includes 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). <p>[Data Elements 5.1 – 5.7]</p>
6	<p>Organization accurately calculates the number of grievances by category, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts the total number of grievances by grievance category: Fraud and Abuse; Enrollment/Disenrollment Access/Benefit Package; Marketing; Confidentiality and Privacy; Quality of Care; and Expedited Grievances. Assigns all additional categories tracked by the organization that are not listed above as Other. <p>[Data Elements 5.1 – 5.7]</p>
7	<p>Organization accurately categorizes all expedited grievances based on the following criteria:</p> <ul style="list-style-type: none"> Complaints involving an MAO's decision to invoke an extension in an organization determination or reconsideration. Complaints involving an MAO's refusal to grant a request for an expedited organization determination or reconsideration. <p>[Data Element 5.6]</p>

1.6 ORGANIZATION DETERMINATIONS / RECONSIDERATIONS

Contract #:

To determine compliance with the standards for Organization Determinations/ Reconsiderations, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/31, 8/31, 11/30, and 2/28.
4	Organization properly defines the term "Organization Determination" in accordance with 42 CFR §422.566(b) and the Medicare Managed Care Manual Chapter 13, Sections 10.1 and 20.2.
5	<p>Organization accurately calculates the total number of organization determinations, including the following criteria:</p> <ul style="list-style-type: none"> Includes all organization determinations with a date of final decision that occurs during the reporting period, regardless of when the request for organization determination was received. Includes all types of organization determinations (e.g., pre-service, post-service, concurrent, UM, and claims). Includes all pre-service network and non-network data. Includes all payment data from non-network providers. Includes organization determinations from delegated entities. Includes only organization determinations that are filed directly with the organization or its delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity). Includes all methods of organization determination request receipt (e.g., telephone, letter, fax, in-person). Includes all organization determinations regardless of who filed the request (e.g., member or appointed representative). Excludes dismissals or withdrawals. Excludes organization determinations where there is no member liability. Excludes Quality Improvement Organization reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay). <p>[Data Elements 6.1 – 6.3]</p>
6	<p>Organization accurately calculates the number of organization determinations by final decision, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts the total number of organization determinations by final decision: Fully Favorable (e.g., approval of entire request), Partially Favorable (e.g., denial with a "part" that has been approved), or Adverse (e.g., denial of entire request). Each number calculated for Data Element 6.1, 6.2, and 6.3 is a subset of the total number of organization determinations. <p>[Data Elements 6.1 – 6.3]</p>
7	Organization properly defines the term "Reconsideration" in accordance with the Medicare Managed Care Manual Chapter 13, Section 70.
8	<p>Organization accurately calculates the total number of reconsiderations, including the following criteria:</p> <ul style="list-style-type: none"> Includes all reconsiderations with a date of final decision that occurs during the reporting period, regardless of when the request for reconsideration was received. Includes all reviews of partially favorable and adverse organization determinations. Includes reconsiderations made by or forwarded from delegated entities. Includes all reviews of a member's request to continue Medicare-covered services (e.g., if a member misses the Quality Improvement Organization's deadline). Excludes reconsiderations where there is no member liability. Excludes dismissals or withdrawals.

	<ul style="list-style-type: none"> Excludes Quality Improvement Organization reviews. Includes reconsideration cases forwarded to the Independent Review Entity. Includes all methods of reconsideration request receipt (e.g., telephone, letter, fax, in-person). Includes all reconsiderations regardless of who filed the request (e.g., member, appointed representative, provider). Includes only reconsiderations that are filed directly with the organization or its delegated entities (e.g., excludes all reconsiderations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity). <p>[Data Elements 6.4 – 6.6]</p>
9	<p>Organization accurately calculates the number of reconsiderations by final decision, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts the total number of reconsiderations by final decision: Fully Favorable (e.g., approval of entire request); Partially Favorable (e.g., denial with a “part” that has been approved); or Adverse (e.g., denial of entire request). Each number calculated for Data Elements 6.4, 6.5, and 6.6 is a subset of the total number of reconsiderations. <p>[Data Elements 6.4 – 6.6]</p>

1.7 EMPLOYER GROUP PLAN SPONSORS (PART C)

Contract #:

Note: If the contract does not have any employer group plans for any portion of the reporting period, then it is exempt from reporting this data measure. If the contract indicates that this is the case (in Section 3.3 of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Employer Group Plan Sponsors, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission.

	<ul style="list-style-type: none"> Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 7/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
5	<p>Organization accurately identifies data on each employer group plan and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> Includes the following information for each plan benefit package reported: Employer Legal Name; Employer DBA Name; Employer Federal Tax ID; Employer Address; Type of Group Sponsor (employer, union, trustees of a fund); Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other); Type of Contract (insured, ASO, other); Employer Plan Year Start Date; and Current Enrollment. Follows the specified file format provided by CMS in the Part C Reporting Requirements Technical Specifications Document (Appendix 6). <p>[Data Elements 7.1 – 7.9]</p>
5	<p>The organization's "Employer Address" data field accurately reflects the address at which the employer manages the human resources/health benefits.</p> <p>[Data Element 7.4]</p>
6	<p>The organization's "Type of Contract" data field accurately captures the type of contract that the organization holds with the employer group that binds it to offer benefits to group retirees.</p> <p>[Data Element 7.7]</p>
7	<p>The organization's "Employer Plan Year Start Date" data field accurately reflects the month and year in which the employer's benefit year begins.</p> <p>[Data Element 7.8]</p>
8	<p>The organization accurately calculates the number of currently enrolled members, including the following criteria:</p> <ul style="list-style-type: none"> Includes all enrollments from a particular employer group into the specific PBP. Includes all members that are enrolled in the employer group plan as of the last day of the reporting period. Enrollment number for contracts that were cancelled during the reporting period is reported as zero. <p>[Data Element 7.9]</p>

1.8 PFFS PLAN ENROLLMENT VERIFICATION CALLS

Contract #:

To determine compliance with the standards for PFFS Plan Enrollment Verification Calls, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	Organization properly reports only individual enrollment data for this measure, not PFFS group coverage. [Data Elements 8.1 – 8.3]
5	Organization accurately calculates the number of times a prospective member was reached with the first call attempt, including the following criteria: <ul style="list-style-type: none"> • Date of phone call attempt occurs within the reporting period. • Includes only first call attempts that resulted in reaching the prospective member. [Data Element 8.1]
6	Organization accurately calculates the number of educational letters mailed in a reporting period, including the following criteria: <ul style="list-style-type: none"> • Includes all "Letters to Beneficiaries Who Could Not be Reached for Verification by Phone" with a mailing date that occurs within the reporting period. [Data Element 8.2]
7	Organization accurately calculates the number of enrollments, including the following criteria: <ul style="list-style-type: none"> • Includes all enrollment requests with a date of receipt that occurs during the reporting period. [Data Element 8.3]

1.9 PFFS PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS

Contract #:

To determine compliance with the standards for PFFS Provider Payment Dispute Resolution Process, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	Organization properly defines a provider payment dispute including the following criteria: <ul style="list-style-type: none"> Includes all disputes that the payment amount made by the MA PFFS Plan to a deemed provider is less than what the provider would have been paid under the MA PFFS Plan's terms and conditions. Includes all disputes that the payment received by a non-contracted provider was less than the provider would have been paid under original Medicare (including balance billing).
5	Organization accurately calculates the number of provider payment denials that were overturned in favor of the provider upon appeal, including the following criteria: <ul style="list-style-type: none"> Includes only provider payment appeals for which the final disposition is favorable. The number calculated for Data Element 9.1 is a subset of the number of provider payment appeals calculated for Data Element 9.2. [Data Element 9.1]
6	Organization accurately calculates the number of provider payment appeals, including the following criteria: <ul style="list-style-type: none"> Includes all provider payment appeals with a date of receipt that occurs during the reporting period. Includes all methods of provider payment appeal receipt (e.g., telephone, letter, fax, in-person). [Data Element 9.2]
7	Organization accurately calculates the number of provider payment appeals resolved in greater than 60 days, including the following criteria: <ul style="list-style-type: none"> Includes only provider payment appeals for which the date of decision is more than 60 days after the date of receipt. The number calculated for Data Element 9.3 is equal to or less than the number of provider payment appeals calculated for Data Element 9.2. [Data Element 9.3]

1.10 AGENT COMPENSATION STRUCTURE

Contract #:

Note: If a contract does not use any licensed independent agents or brokers (i.e., not directly employed by the organization) to conduct marketing for its Medicare products, then it is appropriate to report zeros for each data element in this reporting requirement. If the organization indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Agent Compensation Structure, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.

	<ul style="list-style-type: none"> ○ Indicated edits and validation checks are performed prior to data submission. ● Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	<p>Organization accurately calculates the number of licensed independent agents who made a Part C, Part D, or Cost plan sale, including the following criteria:</p> <ul style="list-style-type: none"> ● Includes all licensed independent agents or brokers with contracts that are effective within the reporting period and with at least one enrollment request attributed that agent or broker that was received during the reporting period. ● Excludes any individuals who are directly employed by the organization. <p>[Data Element 10.2]</p>
5	<p>Organization accurately calculates the number of members with enrollment changes and retained members where a licensed independent agent or broker was involved, including the following criteria:</p> <ul style="list-style-type: none"> ● Properly identifies members with initial or renewal enrollment effective dates that are within the reporting period. ● Matches each relevant enrollment to the applicable licensed independent agent or broker. ● Categorizes each enrollment as "initial" or "renewal" as reflected in the monthly CMS compensation report that identifies beneficiary enrollment changes and the corresponding compensation cycle status. ● Includes only members who are in the 6-year compensation cycle. <p>[Data Elements 10.3 and 10.4]</p>
6	<p>Organization accurately calculates compensation totals paid to licensed independent agents or brokers for members with initial or renewal enrollments, including the following criteria:</p> <ul style="list-style-type: none"> ● Uses the CMS-compliant definition of "compensation" in its calculation of compensation (i.e., all pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy, including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finders fees). Compensation must be compliant with definition in the Medicare Marketing Guidelines, Section 120.5.1. ● Includes all applicable payments to licensed independent agents or brokers. <p>[Data Elements 10.5 and 10.7]</p>
7	<p>Organization accurately calculates the number of licensed independent agents or brokers who received compensation for retained members, including the following criteria:</p> <ul style="list-style-type: none"> ● Includes all licensed independent agents or brokers with compensation for retained members that was paid during the reporting period. ● Excludes any individuals who are directly employed by the organization. <p>[Data Element 10.6]</p>

1.11 AGENT TRAINING AND TESTING (PART C)

Contract #:

Note: If a contract does not have agents who are licensed to sell on behalf of the Part C organization, either by being a direct employee or by contractual arrangement, then it is appropriate to report zeros for each data element in this reporting requirement. If the Part C organization indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Agent Training and Testing (Part C), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.

	<ul style="list-style-type: none"> ○ Indicated edits and validation checks are performed prior to data submission. ● Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	<p>Organization accurately calculates the total number of agents affiliated with the contract within a contract year, including the following criteria:</p> <ul style="list-style-type: none"> ● Includes only agents who are licensed to sell on behalf of the contract, either by being a direct employee or by contractual arrangement. ● Includes all agents that are contracted/employed for any portion of the reporting period. <p>[Data Element 11.1]</p>
5	<p>Organization accurately calculates the number of agents who successfully completed the required training during the contract year, including the following criteria:</p> <ul style="list-style-type: none"> ● Includes only agents who received a passing test score of 85% or above on a date that occurs within the reporting period. <p>[Data Element 11.2]</p>
6	<p>Organization accurately calculates the number of agents with a passing test score of 85% or above, including the following criteria:</p> <ul style="list-style-type: none"> ● Properly sorts by number of times an agent took a test: first testing, second testing. ● For Data Element 11.3: Includes only agents with ≥85% test score for first testing. ● For Data Element 11.6: Includes only agents with ≥85% test score for second testing. <p>[Data Elements 11.3 and 11.6]</p>
7	<p>Organization accurately calculates the average scores of agents with a test score of 85% or above, including the following criteria:</p> <ul style="list-style-type: none"> ● Properly sorts scores by the number of test attempts: first testing, second testing. ● For Data Element 11.4: Sums and averages the ≥85% test scores for first testing. ● For Data Element 11.7: Sums and averages the ≥85% test scores for second testing. <p>[Data Elements 11.4 and 11.7]</p>
8	<p>Organization accurately calculates the number of agents taking test multiple times, including the following criteria:</p> <ul style="list-style-type: none"> ● Properly sorts by number of times an agent took a test: first testing, second testing, third or more testing. ● For Data Element 11.5: Includes only agents that took the test at least twice. ● For Data Element 11.8: Includes only agents that took the test at least three times. ● The number calculated for Data Element 11.8 will be a subset of the number of agents who took the test at least twice calculated for Data Element 11.5. <p>[Data Elements 11.5 and 11.8]</p>

1.12 PLAN OVERSIGHT OF AGENTS (PART C)

Contract #:

Note: If a contract does not have agents who are licensed to sell on behalf of the contract, either by being a direct employee or by contractual arrangement, then it is appropriate to report zeros for each data element in this reporting requirement. If the Part C organization indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Plan Oversight of Agents (Part C), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.

4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/31, 8/31, 11/30, and 2/28.
4	<p>Organization accurately calculates the total number of agents who are licensed to sell on behalf of the contract during the applicable reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes all direct employees of the organization who are licensed to sell on behalf of the contract. Includes all licensed agents who are under a contractual agreement to sell on behalf of the contract, regardless of whether or not the agent was actively selling during the reporting period. <p>[Data Element 12.1]</p>
5	<p>Organization accurately calculates the number of agents investigated based on complaints, including the following criteria:</p> <ul style="list-style-type: none"> Includes all investigations that were completed during the applicable reporting period, regardless of when the complaint was received. Includes investigations based on complaints filed directly with the organization as well as those from the HPMS Complaint Tracking Module (CTM). Includes all investigations based on complaints against an agent under the applicable plan contract. If a complaint cannot be tied to a specific contract, then the agent is included under all contracts that the agent is licensed to sell. The number calculated for Data Element 12.2 is a subset of the total number of agents calculated for Data Element 12.1. <p>[Data Element 12.2]</p>
6	<p>Organization accurately calculates the number of agents receiving disciplinary action resulting from a complaint filed against an agent, including the following criteria:</p> <ul style="list-style-type: none"> Includes all disciplinary actions that were taken during the applicable reporting period, regardless of when the complaint was received. Includes any disciplinary action taken by the organization, including manager-coaching, documented verbal warning, re-training, documented corrective action plan, suspension, termination of employment/contract, and short-term revocation. Includes disciplinary actions based on complaints filed directly with the organization as well as those from the HPMS Complaint Tracking Module (CTM). Includes all disciplinary actions based on complaints against an agent under the applicable plan contract. If a complaint cannot be tied to a specific contract, then the disciplinary action is included under all contracts that the agent is licensed to sell. The number calculated for Data Element 12.3 is a subset of the total number of agents calculated for Data Element 12.1. <p>[Data Element 12.3]</p>
7	<p>Organization accurately calculates the number of complaints filed against an agent that the organization reported to the governing State, including the following criteria:</p> <ul style="list-style-type: none"> Includes all complaints reported to the State during the applicable reporting period, regardless of when the complaint was received. Includes only complaints that are filed directly with the organization (e.g., excludes all complaints that are only

	<p>forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization).</p> <ul style="list-style-type: none"> Includes all complaints against an agent and reported to the governing State under the applicable plan contract. If a complaint that is reported to the governing State cannot be tied to a specific contract, then the complaint is included under all contracts that the agent is licensed to sell. <p>[Data Element 12.4]</p>
8	<p>Organization accurately calculates the number of agents whose selling privileges were revoked by the organization based on conduct or discipline, including the following criteria:</p> <ul style="list-style-type: none"> Includes all revocations initiated during the applicable reporting period, regardless of when the conduct causing the revocation occurred. The number calculated for Data Element 12.5 is a subset of the total number of agents calculated for Data Element 12.1. <p>[Data Element 12.5]</p>
9	<p>Organization accurately calculates the number of “agent assisted enrollments” during the applicable reporting period, including the following criteria:</p> <ul style="list-style-type: none"> Includes all agent assisted enrollments that became effective during the reporting period. Defines “agent assisted enrollments” as enrollments where the member used a licensed agent to complete the enrollment process (e.g., includes enrollments completed through a call center staffed by licensed agents, in person sales appointments, and public sales meetings where a licensed agent collects enrollment forms). Includes agent assisted enrollments from both the individual and group enrollment process. Includes enrollments that are as a direct result of the participation of the group of agents reported in Data Element 12.1. <p>[Data Element 12.6]</p>

1.13 SPECIAL NEEDS PLANS (SNPs) CARE MANAGEMENT

Contract #:

To determine compliance with the standards for Special Needs Plans (SNPs) Care Management, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadline for reporting annual data to CMS by 5/31.
4	Organization accurately calculates the number of new members, including the following criteria: <ul style="list-style-type: none"> Includes all members whose effective date of enrollment occurred during the reporting period. [Data Element 13.1]
5	Organization accurately calculates the number of existing members who were eligible for a reassessment during the reporting period. [Data Element 13.2]
6	Organization accurately calculates the number of initial assessments performed on new members, including the following criteria: <ul style="list-style-type: none"> Includes all initial assessments with a date of service that occurs within the reporting period. The number of initial assessments calculated for Data Element 13.3 is a subset of number of new members calculated for Data Element 13.1. [Data Element 13.3]
7	Organization accurately calculates the number of annual reassessments performed on members eligible for a reassessment, including the following criteria: <ul style="list-style-type: none"> Includes all annual reassessments with a date of service that occurs within the reporting period. The number of annual reassessments calculated for Data Element 13.4 is a subset of number of eligible members calculated for Data Element 13.2. [Data Element 13.4]

2.0 PART D DATA VALIDATION STANDARDS

2.1 ENROLLMENT	
Contract #:	
To determine compliance with the standards for Enrollment, the reviewer will assess the following information:	
<ul style="list-style-type: none"> Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual) Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements Results of interviews with organization staff <i>If sampling is done:</i> Samples of [insert relevant source data] Sample of data files Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure Other relevant information provided by organization 	
VALIDATION STANDARDS	
1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> Source documents and output are protected against overwriting. Source documents create all required data fields for reporting requirements. Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). All data fields have meaningful, consistent labels. Data file locations are referenced correctly. If used, macros are properly documented. Source documents are clearly and adequately documented. Titles and footnotes on reports and tables are accurate. Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> The appropriate date range for the reporting period is captured. Data is assigned at the applicable level (e.g., plan benefit package or contract level). Appropriate deadlines are met for reporting data (e.g., quarterly). Terms used are properly defined per CMS requirements. The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. Ranges of data fields are verified. All calculations (e.g., derived data fields) are verified. Missing data has been properly addressed. Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Indicated edits and validation checks are performed prior to data submission. Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in</p>

	enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	<p>Organization accurately calculates the total number of enrollment requests received, including each of the following criteria:</p> <ul style="list-style-type: none"> Includes all enrollment requests with a date of receipt that occurs during the reporting period, regardless of whether the enrollment was completed or became effective. Includes all methods of enrollment request receipt (e.g., mail, agent/broker, telephone, on-line, fax, in-person). <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of enrollment requests that were denied, including the following criteria:</p> <ul style="list-style-type: none"> Includes all denials made by the organization (i.e., not CMS denials) of enrollment requests with a date of receipt that occurs during the reporting period. Properly sorts by reason for denial, including: <ul style="list-style-type: none"> Denials due to the organization's determination of the ineligibility of the individual to elect the plan (e.g., individual not having a valid enrollment period to elect a plan). Denials due to the individual not providing information to complete the enrollment request within established timeframes. Each number calculated for Data Elements B-C is a subset of the total number of enrollment requests received calculated for Data Element A. <p>[Data Elements B and C]</p>
6	<p>Organization accurately calculates the number of incomplete enrollment requests that were successfully completed within established timeframes, including the following criteria:</p> <ul style="list-style-type: none"> Includes all enrollment requests that are both 1) identified as incomplete when received and 2) eventually transmitted to CMS as an enrollment transaction. The number calculated for Data Element D is a subset of the total number of enrollment requests received calculated for Data Element A. <p>[Data Element D]</p>
7	Organization properly identifies the reason for granting a Special Enrollment Period in accordance with the Prescription Drug Benefit Manual Chapter 3, Section 20.3 or (for MA-PDs) in accordance with the Medicare Managed Care Manual, Chapter 2, Section 30.4.
8	<p>Organization accurately calculates the number of enrollment transactions submitted to CMS using the "Special Enrollment Period" (SEP) Election Period code "S" for Other SEP, including the following criteria:</p> <ul style="list-style-type: none"> Includes all enrollments that are transmitted to CMS using code "S" during the reporting period. Properly sorts by each of the following reasons for Special Enrollment Period: <ul style="list-style-type: none"> Contract Changes (Contract Non-Renewal or Termination, CMS Sanction, Cost Plan Non-Renewal). Change in the member's eligibility or status (Part B General Enrollment Period, MA SEP65, Medigap Trial Period, Change in Special Needs Status, Chronic Care SNP Eligibility). Creditable Coverage (Loss of Creditable Coverage, Not Adequately Informed About Creditable Coverage, Enroll or Maintain Other Creditable Coverage). Special Plan types and situations (Special Needs Plans, PACE Plans, Institutionalized Individuals, SPAP, OEPI, Cost Plan).

	<ul style="list-style-type: none">○ MA OEP Coordination (MA OEP, MA OEPNEW).○ Other (any other reason not covered above). <p>[Data Elements E – J]</p>
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2.2 RETAIL, HOME INFUSION, AND LONG TERM CARE PHARMACY ACCESS

Contract #:

Note: Only contracts that have received a CMS waiver of the any willing pharmacy requirement for the reporting period are required to report Data Element C, and only contracts that have received a CMS waiver of the retail pharmacy convenient access standards for the reporting period are required to report Data Element D. Unless the Part D sponsor indicates that either of these waivers have been granted (in the applicable measure section of the OAI), the reviewer should score Data Elements C and D as "N/A."

To determine compliance with the standards for Retail, Home Infusion and Long Term Care Pharmacy Access, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including:

	<ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31 (Data Elements A and B) and 1/1 through 12/31 (Data Elements C and D).
2	Organization properly assigns data to the applicable CMS contract number (Data Elements A and B) and plan benefit package (Data Elements C and D).
3	Organization meets deadlines for reporting data to CMS by 5/31 (Data Elements A and B) and by 2/28 (Data Elements C and D).
4	Organization maintains appropriate documentation to support submitted pharmacy access data elements (e.g., Geo-Access reports).
5	<p>Organization accurately calculates retail pharmacy access percentages, including the following criteria:</p> <ul style="list-style-type: none"> • Uses either the Quest Analytics Suite™ or GeoNetworks® software or another alternative method that has been approved by CMS to calculate the ratios. • Uses the CMS reference file that provides counts of Medicare beneficiaries by State, region, and zip code for the appropriate year. • Bases the calculated ratios on the “total Medicare beneficiary count” and not plan member counts. • Bases the calculated ratios on pharmacies that are contracted in the network as of the last day of the reporting period. • Calculates the ratios by state for PDPs and RPPOs. • Calculates the ratios by service area for local MA-PDs, Employer Group “800 Series Only” contracts, Employer/Union Direct contracts, and Part D sponsors that offer both individual plans and “800 series” plans. • Percentages reported for Data Elements A1-A3 sum to less than or equal to 100 percent. <p>[Data Element A1 – A3]</p>
6	<p>Organization accurately calculates the number of contracted retail pharmacies in Contract's service area, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only retail pharmacies. • Includes the number of contracted retail pharmacies by state for PDPs and RPPOs, and by service area for local MA-PDs. <p>[Data Element A4]</p>
7	<p>Organization accurately calculates data for each home infusion network pharmacy and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only home infusion pharmacies. <p>[Data Element B1]</p>
8	<p>Organization accurately calculates data for each long-term care (LTC) pharmacy and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only long-term care pharmacies. <p>[Data Element B2]</p>

9	<p>Organization accurately calculates the number of prescriptions provided, including the following criteria:</p> <ul style="list-style-type: none"> • For Data Element C1: Includes only pharmacy claims with dates of service within the reporting period that are identified as provided by a pharmacy that is owned and operated by the plan. • For Data Element C2: Includes all pharmacy claims with dates of service within the reporting period. • Number calculated for Data Element C1 is a subset of the number of prescriptions provided at all pharmacies calculated for Data Element C2. <p>[Data Element C]</p>
10	<p>Organization accurately calculates the number of prescriptions provided by <u>retail</u> pharmacies, including the following criteria:</p> <ul style="list-style-type: none"> • For Data Element D1: Includes only pharmacy claims with dates of service within the reporting period that are identified as provided by a retail pharmacy that is owned and operated by the plan. • For Data Element D2: Includes all retail pharmacy claims with dates of service within the reporting period. • Number calculated for Data Element D1 is a subset of the number of prescriptions provided at all retail pharmacies calculated for Data Element D2. <p>[Data Element D]</p>

2.3 ACCESS TO EXTENDED DAY SUPPLIES AT RETAIL PHARMACIES

Contract #:

Note: If the contract's Part D pharmacy network does not include mail-order pharmacies that offer an extended day supply (e.g., greater than one month/>34 days) of covered Part D drugs, then the contract is exempt from reporting this data measure and the reviewer should score this measure as "N/A." If the contract's Part D network retail pharmacies do not offer an extended day supply (e.g., greater than one month/>34 days) of covered Part D drugs, then the contract should report a zero value for this data measure and the reviewer should score this measure as "Pass."

To determine compliance with the standards for Access to Extended Day Supplies at Retail Pharmacies, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including:

	<ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 3/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting data to CMS by 5/31.
4	<p>Organization accurately calculates the requested number of pharmacies, including the following criteria:</p> <ul style="list-style-type: none"> • Includes the number of contracted retail pharmacies by state for PDPs and RPPOs, and by service area for local MA-PDs. • Includes only pharmacies that are contracted to dispense an extended day supply as of the last day of the reporting period. • Includes only retail pharmacies. <p>[Data Element A]</p>
5	Organization's data element value is a subset of the retail pharmacies value calculated for the Retail, Home Infusion, and Long-Term Care Pharmacy Access measure's Data Element A.4.

2.4 VACCINES

Contract #:

To determine compliance with the standards for Vaccines, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications. • Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. • Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
4	<p>Organization accurately calculates the total number of Part D vaccines, including the following criteria:</p> <ul style="list-style-type: none"> Includes all vaccines with dates of dispensing/immunization that occur during the reporting period. Includes all methods used to process the claim. <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of Part D vaccines according to the method used to adjudicate the claim, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts by method used to adjudicate the claim: In-Network; Out-of-Network Member Retrospective Claim; Out-of-Network Paper Enhanced; Out-of-Network Internet-Based Web Tool; and Other. The numbers calculated for Data Elements B through F will each be a subset of the total number of Part D vaccines calculated for Data Element A. The sum of the numbers calculated for Data Elements B through F is equal to the total number of Part D vaccines calculated for Data Element A. <p>[Data Elements B – F]</p>

2.5 MEDICATION THERAPY MANAGEMENT PROGRAMS

Contract #:

To determine compliance with the standards for Medication Therapy Management Programs (MTMP), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
4	<p>Organization accurately calculates the number of members identified to be eligible and auto-enrolled in the MTMP, including the following criteria:</p> <ul style="list-style-type: none"> Properly identifies members who met the eligibility criteria during the reporting period, as described in the organization's policy and procedure/training manual. Includes continuing MTMP members as well as members who were newly identified and auto-enrolled in the MTMP at any time during the reporting period. <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of members who opted-out of enrollment in the MTMP, including:</p> <ul style="list-style-type: none"> Properly identifies members with a date of MTM opt-out that occurs within the reporting period. The number calculated for Data Element B is a longitudinally cumulative total (i.e., number calculated for the second reporting period (1/1 through 12/31) is larger than the number calculated for the first reporting period (1/1 through 6/30). The number calculated for Data Element B is a subset of the number of members identified as eligible for and auto-enrolled in MTMP calculated for Data Element A. <p>[Data Element B]</p>
6	<p>Organization accurately calculates the number of members who opted-out of MTMP enrollment by reason for opt-out, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts the total number of members who opted-out of MTMP by each of the following opt-out reasons: death, disenrollment, request by member, other reason. The sum of the numbers calculated for Data Elements C through F is equal to the total number of members who opted-out of MTMP enrollment calculated for Data Element B. <p>[Data Elements C – F]</p>
7	<p>Organization accurately calculates the total prescription cost of all covered Part D medications on a per MTMP member per month basis, including the following criteria:</p> <ul style="list-style-type: none"> Rounding the currency value to the nearest dollar. The numerator is the sum of gross drug cost, which equals Ingredient Cost Paid + Dispensing Fee + Sales Tax (Illinois only). The numerator includes the costs of covered Part D prescriptions dispensed in the reporting period. The numerator includes both MTMP member cost sharing and Part D paid costs. The denominator equals the total number of member months for the enrolled MTMP members. The denominator includes all months the member was enrolled in the Part D contract during the reporting period, not only the months the member was enrolled in the MTMP. <p>[Data Element G]</p>
8	<p>Organization accurately calculates the number of covered Part D prescriptions on a per MTMP member per month basis to a 30-day equivalent, including the following criteria:</p> <ul style="list-style-type: none"> The numerator is the sum of the days supply of all covered part D prescriptions filled by all members enrolled in MTMP as of the last day of the reporting period divided by 30. The denominator is the total number of months the member was enrolled in the Part D contract during the reporting period specified, not only the months the member was enrolled in MTMP.

	[Data Element H]
9	<p>Organization accurately calculates the number of MTMP members offered a comprehensive medication review, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all MTMP members with a date of offer of a comprehensive medication review that occurs within the reporting period. • The number calculated for Data Element I should be equal to or less than the number of members identified to be eligible and auto-enrolled in the MTMP calculated for Data Element A. <p>[Data Element I]</p>
10	<p>Organization correctly calculates the number of MTMP members who received a comprehensive medication review, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all MTMP members with a comprehensive medication review with date of service that occurs within the reporting period. • The number calculated for Data Element J should be equal to or less than the number of members offered a comprehensive medication review calculated for Data Element I. <p>[Data Element J]</p>
11	<p>Organization accurately identifies data on MTMP participation for each member identified as being eligible for the MTMP and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> • Each of the data elements requested in Section II is based on the same members counted for Data Element A. • For Section II (g): Properly identifies whether each member was a resident in a long-term care facility for the entire time s/he was enrolled in the MTMP or on the date the member opted-out of MTMP enrollment. • For Section II (i): The date of MTMP opt-out, if applicable, is completed for the same members counted for Data Element B. • For Section II (j): The reason participant opted-out of the MTMP is completed for every member with a date of opt-out completed, and is completed for the same members counted for Data Elements C through F.
12	<p>Organization accurately calculates data on MTM interventions for each member identified as being eligible for the MTMP and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> • For Section II (k): Properly identifies whether each member received a comprehensive medication review during the reporting period, and completes this field for the same members counted for Data Element J. • For Section II (l): The date of comprehensive medication review, if applicable, occurs within the reporting period, is completed for every member with a "Y" entered for Section II (k). • For Section II (m): Includes all targeted medication reviews within the reporting period for each applicable member. • For Section II (n): Includes all prescriber interventions within the reporting period for each applicable member. • For Section II (o): Includes all changes to drug therapy made as a result of MTM interventions within the reporting period for each applicable member (includes dosage changes, therapeutic or generic substitutions, and discontinuation of therapy).

2.6 PROMPT PAYMENT BY PART D SPONSORS

Contract #:

To determine compliance with the standards for Prompt Payment by Part D Sponsors, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 7/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
4	Organization properly defines "clean claims" as claims where the Part D sponsor that receives the claim does not issue notice to the submitting network pharmacy of any deficiency in the claim within 10 calendar days after an electronic claim is received and within 15 calendar days after a non-electronically submitted claim is received.
5	<p>Organization accurately calculates the total number of paid claims, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all claims submitted by retail and home infusion network pharmacies. • Excludes claims from mail-order and long-term care (LTC) pharmacies. • Includes only claims that are identified as Part D covered drugs. • Includes clean claims only. • Includes all claims with date paid that occurs within the reporting period. • For Data Element A, includes all methods of receipt (e.g., electronic, non-electronic, other). • For Data Element B, includes only claims that are received electronically. • For Data Element C, includes only claims that are received non-electronically (e.g., paper). • The number reported for Data Element B is a subset of the number of paid claims calculated for Data Element A. • The number reported for Data Element C is a subset of the number of paid claims calculated for Data Element A. <p>[Data Element A – C]</p>
6	<p>Organization accurately calculates the total number of paid electronic claims that were not paid timely, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only electronic claims that are paid <u>after</u> 14 calendar days of the date the claim is received. • Assigns receipt date of an electronic claim as the date on which the claim is transferred. • The number reported for Data Element D is a subset of the number of paid electronic claims calculated for Data Element B. <p>[Data Element D]</p>
7	<p>Organization accurately calculates the total number of non-electronic (e.g., paper) claims that were not paid timely, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only non-electronically submitted claims that are paid <u>after</u> 30 calendar days of the day on which the claim is received. • Assigns receipt date of a non-electronically submitted claim as the 5th calendar day after the postmark day of the claim or the date specified in the time stamp of the transmission, whichever is sooner. • The number reported for Data Element E is a subset of the number of paid non-electronic claims calculated for Data Element C. <p>[Data Element E]</p>
8	<p>Organization accurately calculates the interest dollar amount paid on electronic and non-electronic claims that were not paid timely, including the following criteria:</p> <ul style="list-style-type: none"> • Calculates the interest at a rate equal to the weighted average of interest on 3-month marketable Treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment was made. <p>[Data Elements F and G]</p>

2.7 PHARMACY SUPPORT OF ELECTRONIC PRESCRIBING

Contract #:

To determine compliance with the standards for Pharmacy Support of Electronic Prescribing, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 3/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting data to CMS by 5/31.
4	<p>Organization accurately calculates the number of contracted retail pharmacies in Contract's service area that are enabled to received electronic prescriptions, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only retail pharmacies. • Includes only pharmacies enabled to receive electronic prescriptions. • Includes the number of pharmacies by state for PDPs and RPPOs, and by service area for local MA-PDs. • The number calculated for Data Element A is a subset of the number of contracted retail pharmacies calculated for Data Element A4 of the Retail, Home Infusion, and LTC Pharmacy Access data measure. <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of contracted long-term care pharmacies in Contract's service area that are enabled to received electronic prescriptions, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only long-term care pharmacies. • Includes only pharmacies enabled to receive electronic prescriptions. • Includes the number of pharmacies by state for PDPs and RPPOs, and by service area for local MA-PDs. • The number calculated for Data Element B is a subset of the list of contracted LTC pharmacies compiled for Data Element B2 of the Retail, Home Infusion, and LTC Pharmacy Access data measure. <p>[Data Element B]</p>
6	<p>Organization accurately calculates the number of contracted home infusion pharmacies in Contract's service area that are enabled to received electronic prescriptions, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only pharmacies that are contracted in the network as of the last day of the reporting period. • Includes only home infusion pharmacies. • Includes only pharmacies enabled to receive electronic prescriptions. • Includes the number of pharmacies by state for PDPs and RPPOs, and by service area for local MA-PDs. • The number calculated for Data Element C is a subset of the list of contracted home infusion pharmacies compiled for Data Element B1 of the Retail, Home Infusion, and LTC Pharmacy Access data measure. <p>[Data Element C]</p>

2.8 GENERIC DRUG UTILIZATION

Contract #:

To determine compliance with the standards for Generic Drug Utilization, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	Organization correctly identifies generic drugs, including the following criteria: <ul style="list-style-type: none"> • Uses drug databases First DataBank or Medispan or another alternative resource; or • Uses an alternative resource and ensures that its generic drugs meet the definition set forth in Title I, Part 423, Sub-Part A, § 423.4.
5	Organization accurately calculates the total number of paid claims for Part D generic drugs, including the following criteria: <ul style="list-style-type: none"> • Properly sorts the total number of paid claims for all Part D drugs to include only claims that are identified as Part D covered generic drugs. • The number calculated for Data Element A is a subset of the number of Part D paid claims calculated for Data Element B. [Data Element A]
6	Organization accurately calculates the total number of paid claims for all Part D drugs, including the following criteria: <ul style="list-style-type: none"> • Includes all claims with dates of service within the reporting period and with a status of "paid". • Includes all applicable claims without regard to days supply. • Includes all methods of receipt (e.g., electronic, non-electronic, other). [Data Element B]

2.9 GRIEVANCES (PART D)

Contract #:

To determine compliance with the standards for Grievances (Part D), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	Organization properly defines the term "Grievance" in accordance with the Prescription Drug Benefit Manual Chapter 18, Sections 10.1 and 20.2. Requests for coverage determinations, exceptions, or redeterminations are not categorized as grievances.
5	Organization accurately calculates the number of members who filed a grievance, including the following criteria: <ul style="list-style-type: none"> Includes all members who filed a grievance with a date of receipt that occurs during the reporting period. Properly sorts by member's low-income subsidy (LIS) eligibility status on the date the grievance was received. [Data Elements A and B]
6	Organization accurately calculates the total number of grievances, including the following criteria: <ul style="list-style-type: none"> Includes all grievances that were received during the reporting period, regardless of when the grievance was completed (i.e., organization notified member of its decision). If a grievance contains multiple issues filed by a single complainant, each issue is calculated as a separate grievance. If a single complainant contacts the organization multiple times regarding the same issue, each time the complainant contacts the organization is calculated as a separate grievance. Includes all methods of grievance receipt (e.g., telephone, letter, fax, in-person). Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative). Includes only grievances that are filed directly with the organization (e.g., excludes all complaints that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization). <i>For MA-PD contracts:</i> Includes only grievances that apply to the Part D benefit. If a clear distinction cannot be made for an MA-PD, cases are calculated as Part C grievances. [Data Elements C and D]
7	Organization accurately sorts all grievances received during the reporting period according to the member's LIS eligibility status on the date the grievance was received. [Data Element C]
8	Organization accurately calculates the number of grievances which the Part D sponsor provided timely notification of the decision, including the following criteria: <ul style="list-style-type: none"> Includes only grievances for which the member is notified of decision according to the following timelines: <ul style="list-style-type: none"> For standard grievances: no later than 30 days after receipt of grievance. For standard grievances with an extension taken: no later than 44 days after receipt of grievance. For expedited grievances: no later than 24 hours after receipt of grievance. Each number calculated is equal to or less than the total number of grievances received for the applicable beneficiary status and category. [Data Elements C and D]
9	Organization accurately calculates the number of grievances by category, including the following criteria: <ul style="list-style-type: none"> Properly sorts the total number of grievances by grievance category: Enrollment/Plan Benefits/Pharmacy Access; Customer Service; and Coverage determinations/Exceptions/Appeals Process (which includes expedited grievances (e.g., untimely decisions) and any grievance about the exceptions and appeals process). Assigns all additional categories tracked by organization that are not listed above as Other.

	[Data Element D]
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2.10 COVERAGE DETERMINATIONS AND EXCEPTIONS

Contract #:

To determine compliance with the standards for Coverage Determinations and Exceptions, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	Organization properly determines whether a request is subject to the coverage determinations or the exceptions process in accordance with the Prescription Drug Benefit Manual Chapter 18, Section 30.1.
5	Organization accurately calculates the number of pharmacy transactions, including the following criteria: <ul style="list-style-type: none"> Includes pharmacy transactions with dates of service within the reporting period. Includes in-network and out-of-network transactions. [Data Element A]
6	Organization accurately calculates the number of pharmacy transactions rejected due to formulary restrictions, including the following criteria: <ul style="list-style-type: none"> Includes non-formulary status, prior authorization (PA) requirements, step therapy and quantity limits. Excludes rejections due to early refill requests. Number calculated for Data Element B is a subset of the number of pharmacy transactions calculated for Data Element A. [Data Element B]
7	Organization accurately calculates the number of coverage determinations and exceptions, including the following criteria: <ul style="list-style-type: none"> Includes all coverage determinations/exceptions with a date of final decision that occurs during the reporting period, regardless of when the request for coverage determination/exception was received. Includes all methods of receipt (e.g., telephone, letter, fax, in-person). Includes all coverage determinations/exceptions regardless of who filed the request (e.g., beneficiary, appointed representative, or prescribing physician). Includes coverage determinations/exceptions from delegated entities. Includes both standard and expedited coverage determinations/exceptions. Excludes coverage determinations/exceptions that were forwarded to the IRE because the organization failed to make a timely decision on a standard or expedited request. [Data Elements C – J]
8	Organization accurately calculates the total number of PAs requested and approved, including the following criteria: <ul style="list-style-type: none"> Data Element C: Includes all decisions on whether a member has, or has not, satisfied a PA requirement. Data Element D: Includes all fully favorable decisions on requests for PAs. Number calculated for approved requests (Data Element D) is less than or equal to the number of decisions calculated for Data Element C. [Data Elements C and D]
9	Organization accurately calculates the number of exceptions to the organization's utilization management (UM) tools (PAs, quantity limits, step therapy requirements) requested and approved, including the following criteria: <ul style="list-style-type: none"> Data Element E: Includes all decisions where a member/prescribing physician is seeking an exception to a PA or other UM requirement (e.g., a physician indicates that the member would suffer adverse effects if he or she were required to satisfy the PA requirement). Data Element F: Includes all fully favorable decisions on requests for exceptions to the organization's UM tools. Number calculated for approved requests (Data Element F) is less than or equal to the number of decisions calculated for Data Element E. [Data Elements E and F]

10	<p>Organization accurately calculates the number of tier exceptions requested and approved, including the following criteria:</p> <ul style="list-style-type: none">• Data Element G: Includes all decisions on whether to permit a member to obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier.• Data Element H: Includes all fully favorable decisions on requests for tier exceptions.• Number calculated for approved requests (Data Element H) is less than or equal to the number of decisions calculated for Data Element G. <p>[Data Elements G and H]</p>
11	<p>Organization accurately calculates the number of exceptions for non-formulary medications requested and approved, including the following criteria:</p> <ul style="list-style-type: none">• Data Element I: Includes all decisions on whether to permit a member to obtain a Part D drug that is not included on the formulary.• Data Element J: Includes all fully favorable decisions on requests for non-formulary medications.• Number calculated for approved requests (Data Element J) is less than or equal to the number of decisions calculated for Data Element I. <p>[Data Elements I and J]</p>

2.11 APPEALS

Contract #:

To determine compliance with the standards for Appeals, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	Organization properly defines the term "Appeal" in accordance with Title 1, Part 423, Subpart M §423.560 and the Prescription Drug Benefit Manual Chapter 18, Section 10.1.
5	<p>Organization accurately calculates the total number of redeterminations, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all redeterminations with a date of final decision that occurs during the reporting period, regardless of when the request for redetermination was received. • Includes all reviews of partially favorable and adverse coverage determinations. • Includes both standard and expedited redeterminations. • Includes all methods of receipt (e.g., telephone, letter, fax, in-person). • Includes all redeterminations regardless of who filed the request (e.g., member, appointed representative, or prescribing physician). • Excludes dismissals or withdrawals. • Excludes IRE decisions, as they are considered to be the second level of appeal. <p>[Data Element A]</p>
6	<p>Organization accurately calculates the number of redeterminations by final decision, including the following criteria:</p> <ul style="list-style-type: none"> • Properly sorts the total number of redeterminations by final decision: Full Reversal (e.g., fully favorable decision reversing the original coverage determination) and Partial Reversal (e.g., denial with a "part" that has been approved). • Each number calculated for Data Elements B and C is a subset of the total number of redeterminations calculated for Data Element A. <p>[Data Elements B and C]</p>

2.12 PHARMACEUTICAL MANUFACTURER REBATES, DISCOUNTS, AND OTHER PRICE CONCESSIONS

Contract #:

To determine compliance with the standards for Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.

4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract or sponsor identifier and reports at the proper level, including the following criteria: <ul style="list-style-type: none"> • Reporting at the level of the national Part D sponsor, or • Reporting at the Part D sponsor-specific level if a regional or local Part D sponsor, or • Reporting at the level of the PBM if the PBM is the Part D sponsor.
3	Organization meets deadline for reporting annual data to CMS by 6/30.
4	Organization accurately calculates data on rebates and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> • Data is based on actual amounts, not estimates. • Data is based on paid valid claims. • Summarizes rebate information for each drug, rolled up to include multiple strengths, multiple package sizes, multiple dosage formulations, or combinations of the above. • Includes late payment fees received from pharmaceutical manufacturers. • May include Pharma Admin Fees (at the discretion of the Part D sponsor). • For Data Element A3: Includes only rebates received with a date of receipt that occurs within the reporting period. • For Data Element A4: Includes only pending rebates that are identified as pending during the reporting period (i.e., does not include pending rebates that have previously been reported to CMS as pending). • For Data Element A5: Includes prior rebates with a date of receipt that occurs within the reporting period. [Data Element A]
5	Organization accurately calculates data on discounts and other price concessions and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> • Includes all non-rebate discounts, price concessions, and value adds such as a gifts-in-kind, coupons, and disease management programs specific to a Part D sponsor. • Includes any grant monies related to Part D business regardless of the recipient within the Organization. • Includes Part D Sponsor's Pharma Rebate Performance Guarantee with a PBM. • Includes the manufacturer/company name, description, value, and justification for each discount/price concession reported. [Data Element B]

2.13 LONG-TERM CARE UTILIZATION

Contract #:

To determine compliance with the standards for Long-Term Care (LTC) Utilization, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting data to CMS by 12/31 and 6/30.
4	Organization accurately calculates the number of network LTC pharmacies in the service area and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> Includes the number of contracted LTC pharmacies by state for PDPs and RPPOs, and by service area for MA-PDs. Includes only LTC pharmacies that are contracted as of the last day of the reporting period. [Data Element A]
5	Organization accurately calculates the number of network retail pharmacies in the service area and uploads it into the HPMS submission tool, including: <ul style="list-style-type: none"> Includes the number of contracted retail pharmacies by state for PDPs and regional for PPOs, and by service area for local MA-PDs. Includes only retail pharmacies that are contracted as of the last day of the reporting period. [Data Element B]
6	Organization accurately calculates the total number of members in LTC facilities for whom Part D drugs have been provided and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> Counts each member only once in each reporting period. Includes only members with covered Part D drug claims with dates of service within the reporting period. Includes only members who resided in a long-term care facility on the date of service for that Part D drug at the time the Part D claim for that member was processed. [Data Element C]
7	Organization accurately identifies data on LTC network pharmacies and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> For a-d: Each of these data elements is based on same LTC pharmacies counted for Data Element A (LTC pharmacy name, LTC pharmacy NPI, contract entity name of LTC pharmacy, chain code of LTC pharmacy). [Data Element D: a-d]
8	Organization accurately calculates the number of 31-day equivalent prescriptions dispensed for each network LTC pharmacy in the service area and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> Summing days supply of all covered Part D prescriptions and dividing this by 31 days. Performs the calculations separately for formulary prescriptions and non-formulary prescriptions. Includes only covered Part D drug claims with dates of service within the reporting period. [Data Element D: e-f]
9	Organization accurately calculates prescription costs for each LTC and retail pharmacy in the service area and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> Prescription cost is the sum of the ingredient cost, dispensing fee, and sales tax (Illinois only). Ingredient cost reflects Sponsor's negotiated price. [Data Elements D: g-h and E: c-d]
10	Organization accurately calculates the number of 30-day equivalent prescriptions dispensed for each network retail pharmacy in the service area and uploads it into the HPMS submission tool, including the following criteria: <ul style="list-style-type: none"> Summing days supply of all covered Part D prescriptions and dividing this by 30 days. Performs the calculations separately for formulary prescriptions and non-formulary prescriptions.

	<ul style="list-style-type: none">• Includes only covered Part D drug claims with dates of service within the reporting period. <p>[Data Element E: a-b]</p>
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2.14 DRUG BENEFIT ANALYSES

Contract #:

To determine compliance with the standards for Drug Benefit Analyses, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	<p>Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).</p>

5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/15, 8/15, 11/15, and 2/15.
4	<p>Organization accurately calculates number of members within each benefit phase, including the following criteria:</p> <ul style="list-style-type: none"> • Properly identifies members who are LIS eligible and non-LIS eligible according to the member's LIS eligibility status on the last day of the quarter. • For counts of all LIS members, includes all subsidy levels. • Matches each relevant member to the applicable benefit phase. • Counts each member only once in each reporting period. • Uses a prescription's fill date to determine where a member falls in the benefit as of the last day of the quarter. • The sum of the number of members calculated for Data Elements B through I should be within 10% of CMS enrollment records on the last day of the reporting period. <p>[Data Elements B – I]</p>
5	<p>Organization's systems for tracking records in the benefit phases contain the appropriate parameters for the standard benefit for the applicable plan year (parameters listed below apply to plan year 2010), including the following criteria:</p> <ul style="list-style-type: none"> • Deductible Limit \$310. • Initial Coverage Limit \$2,830 (Total Drug Costs). • Coverage Gap \$2,831 - Out-of-Pocket Threshold \$4,550 / Total Drug Costs \$6,440. • Catastrophic Coverage greater than Out-of-Pocket Threshold \$4,550 / Total Drug Costs \$6,440.00. <p><i>Note to reviewer:</i> These criteria are applicable for standard plan benefit packages only.</p> <p>[Data Elements B – I]</p>
6	<p>Organization's systems for tracking records in the benefit phases contain the appropriate parameters for the structure of the plan benefit for the applicable plan year.</p> <p><i>Note to reviewer:</i> These criteria are applicable for all plan benefit designs other than the standard benefit.</p> <p>[Data Elements B – I]</p>
7	<p><i>For plan benefit packages that have a deductible:</i> Organization accurately calculates the number of members who are in the deductible phase, including the following criteria:</p> <ul style="list-style-type: none"> • Includes members with a deductible amount equal to \$0. • Includes members who have not filed claims as of the last date of the reporting period. <p><i>Note to reviewer:</i> These criteria are not applicable for plan benefit packages that have no deductible.</p> <p>[Data Elements B and C]</p>
8	<p><i>For plan benefit packages that do not have a coverage gap:</i> Organization accurately calculates the number of members who are in the pre-catastrophic and coverage gap phases, including the following criteria:</p> <ul style="list-style-type: none"> • Data Elements D and E: Includes members who are pre-catastrophic in the numbers calculated for members in the pre-initial coverage limit phase. • Data Elements F and G: Calculates "0" value for members in the coverage gap. <p><i>Note to reviewer:</i> These criteria are not applicable for plan benefit packages that have a coverage gap.</p>
9	<p><i>For plan benefit packages that offer partial coverage during the coverage gap (e.g., generics only):</i> Organization accurately calculates the number of members who are in the coverage gap phase, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all members in the coverage gap phase, regardless of the fact that the plan benefit offers partial coverage during this phase. <p>[Data Elements F and G]</p>

	<i>Note to reviewer:</i> These criteria are not applicable for plan benefit packages that do not offer partial coverage during the coverage gap.
10	<p><i>For plan benefit packages that offer deductibles for only some types of drugs (e.g., deductibles for brand name drugs only and no deductible for generic drugs):</i> Organization accurately calculates the number of members in the applicable phase, including the following criteria:</p> <ul style="list-style-type: none"> Includes members in the furthest phase of the benefit when calculating number of members in the applicable phase (e.g., member who is the initial coverage limit phase due to generic drug utilization, but in the deductible phase due to brand drug utilization is reported in the initial coverage limit phase). <p><i>Note to reviewer:</i> These criteria are not applicable for plan benefit packages that do not vary deductibles based on type of drug.</p>

2.15 FRAUD, WASTE, AND ABUSE COMPLIANCE PROGRAMS

Contract #:

Note: Part D sponsors may choose not to voluntarily report aggregate data for Fraud, Waste, and Abuse Compliance Programs. If the Part D sponsor indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Fraud, Waste, and Abuse Compliance Programs, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission.

	<ul style="list-style-type: none"> Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
4	<p>Organization properly defines fraud and abuse incidents, including the following criteria:</p> <ul style="list-style-type: none"> A fraud incident/complaint is defined as a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, plan, plan agent or broker, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. An abuse incident/complaint is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, plan, plan agent or broker or beneficiary engaged in behavior that the individual should have known to be false, and the individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person.
5	<p>Organization accurately calculates the number of potential fraud and abuse incidents, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts by each specified category: <ul style="list-style-type: none"> Inappropriate billing (including inappropriate billing by pharmacies). Providing false information. Doctor shopping/drug seeking member. Attempting to steal identity/money. Other (e.g., OIG exclusion list, broker agent complaints, and incidents that gave rise to grievances). Each number calculated for Data Elements A through E is a subset of the total number of potential fraud and abuse incidents calculated for Data Element F. The sum of the numbers calculated for Data Elements A through E is equal to the total number of potential fraud and abuse incidents calculated for Data Element F. <p>[Data Elements A – E]</p>
6	<p>Organization accurately calculates the total number of potential fraud and abuse incidents identified, including the following criteria:</p> <ul style="list-style-type: none"> Includes all potential fraud and abuse incidents that were identified during the reporting period. If identical potential fraud and abuse incidents are reported multiple times and/or to multiple departments, each incident is tracked and reported as a separate incident. Includes all potential fraud and abuse incidents identified regardless of the source (e.g., reported through internal sources, the CMS Complaint Tracking Module (CTM), and filed directly with the organization). <i>For MA-PD contracts:</i> Includes only potential fraud and abuse incidents that apply to the Part D benefit. If a clear distinction cannot be made for an MA-PD, cases are considered as Part C incidents and are not included in the calculation. <p>[Data Element F]</p>
7	<p>Organization accurately calculates the total number of potential fraud and abuse incidents identified by source, including the following criteria:</p> <ul style="list-style-type: none"> Properly sorts by source of incident identification: <ul style="list-style-type: none"> Incidents identified through internal efforts.

	<ul style="list-style-type: none"> ○ Received from external sources (e.g., CTM and member grievances). ● Each number reported for Data Elements G through H is a subset of the total number of potential fraud and abuse incidents calculated for Data Element F. ● The sum of the numbers calculated for Data Elements G through H is equal to the total number of potential fraud and abuse incidents calculated for Data Element F. <p>[Data Elements G and H]</p>
8	<p>Organization accurately calculates the number of actions taken as a result of potential fraud and abuse incidents, including the following criteria:</p> <ul style="list-style-type: none"> ● Includes all actions taken as a result of potential fraud and abuse incidents that occurred within the reporting period. ● Properly sorts by action taken, including: <ul style="list-style-type: none"> ○ Inquiries initiated by the sponsor. ○ Corrective actions initiated by the sponsor. ○ Incidents referred to CMS for action (includes referrals to CMS staff, MEDICS and other CMS designated program safeguard contractor). ○ Incidents referred to federal law enforcement for action (includes referrals to the FBI, OIG, DEA, and FDA). ○ Incidents referred to local law enforcement for action (includes, but not limited to, referrals to state, county, township, or province police). ○ Incidents referred to State Insurance Commissioners (SICs) or state licensing authorities. <p>[Data Elements I – N]</p>

2.16 EMPLOYER/UNION-SPONSORED GROUP HEALTH PLAN SPONSORS

Contract #:

Note: If a contract does not have any employer/union-sponsored group health plans for any portion of the reporting period, then it is exempt from reporting this data measure. If the Part D sponsor indicates that this is the case (in Section 3.3 of the OAI), the reviewer should score this data measure as "N/A."

Also, MA-PDs that report data for the Part C Employer Group Plan Sponsors data measure are exempt from reporting this Part D data measure unless there is a significant difference in their data systems for their Part D-only contracts. If the Part D sponsor indicates that this is the case (in Section 3.3 of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Employer/Union-Sponsored Group Health Plan Sponsors, the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p> <ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents.

	<ul style="list-style-type: none"> Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Indicated edits and validation checks are performed prior to data submission. Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 6/30 and 7/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract and plan benefit package.
3	Organization meets deadlines for reporting data to CMS by 8/31 and 2/28.
4	<p>Organization accurately identifies data on each employer/union-sponsored group health plan and uploads it into the HPMS submission tool, including the following criteria:</p> <ul style="list-style-type: none"> Includes the following information for each plan benefit package reported: Employer Legal Name; Employer DBA Name; Employer Federal Tax ID; Employer Address; Type of Group Sponsor (employer, union, trustees of a fund); Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other); Type of Contract (insured, ASO, other); Employer Plan Year Start Date; and Current/Anticipated Enrollment. Follows the specified file format provided by CMS in the Part D Reporting Requirements Technical Specifications Document (TBD). <p>[Data Elements A – I]</p>
5	<p>The organization's "Employer Address" data field accurately reflects the address at which the employer manages the human resources/health benefits.</p> <p>[Data Element D]</p>
6	<p>The organization's "Type of Contract" data field accurately captures the type of contract that the organization holds with the employer group that binds it to offer benefits to group retirees.</p> <p>[Data Element G]</p>
7	<p>The organization's "Employer Plan Year Start Date" data field accurately reflects the month and year in which the employer's benefit year begins.</p> <p>[Data Element H]</p>
8	<p>The organization accurately calculates the number of currently enrolled members, including the following criteria:</p> <ul style="list-style-type: none"> Includes all enrollments from a particular employer group into the specific PBP. Includes all members that are enrolled in the employer group plan as of the last day of the reporting period. Enrollment number for contracts that were cancelled during the reporting period is reported as zero. <p>[Data Element I]</p>

2.17 AGENT TRAINING AND TESTING (PART D)

Contract #:

Note: If a contract does not have agents who are licensed to sell on behalf of the Part D organization, either by being a direct employee or by contractual arrangement, then it is appropriate to report zeros for each data element in this reporting requirement. If the Part C organization indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

Also, MA-PDs that report data for the Part C Agent Training and Testing data measure are exempt from reporting this Part D data measure unless there is a significant difference in their data systems for their Part D-only contracts. If the Part D sponsor indicates that this is the case (in Section 3.3 of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Agent Training and Testing (Part D), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p>

	<ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting period of 1/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadline for reporting annual data to CMS by 2/28.
4	<p>Organization accurately calculates the total number of agents affiliated with the contract within a contract year, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only agents who are licensed to sell on behalf of the contract, either by being a direct employee or by contractual arrangement. • Includes all agents that are contracted/employed for any portion of the reporting period. <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of agents who successfully completed the required training during the contract year, including the following criteria:</p> <ul style="list-style-type: none"> • Includes only agents who received a passing test score of 85% or above on a date that occurs within the reporting period. <p>[Data Element B]</p>
6	<p>Organization accurately calculates the number of agents with a passing test score of 85% or above, including the following criteria:</p> <ul style="list-style-type: none"> • Properly sorts by number of times an agent took a test: first testing, second testing. • For Data Element C: Includes only agents with ≥85% test score for first testing. • For Data Element F: Includes only agents with ≥85% test score for second testing. <p>[Data Elements C and F]</p>
7	<p>Organization accurately calculates the average scores of agents with a test score of 85% or above, including the following criteria:</p> <ul style="list-style-type: none"> • Properly sorts scores by the number of test attempts: first testing, second testing. • For Data Element D: Sums and averages the ≥85% test scores for first testing. • For Data Element G: Sums and averages the ≥85% test scores for second testing. <p>[Data Elements D and G]</p>
8	<p>Organization accurately calculates the number of agents taking test multiple times, including the following criteria:</p> <ul style="list-style-type: none"> • Properly sorts by number of times an agent took a test: first testing, second testing, third or more testing. • For Data Element E: Includes only agents that took the test at least twice. • For Data Element H: Includes only agents that took the test at least three times. • The number calculated for Data Element H will be a subset of the number of agents who took the test at least twice calculated for Data Element E. <p>[Data Elements E and H]</p>

2.18 PLAN OVERSIGHT OF AGENTS (PART D)

Contract #:

Note: If a contract does not have agents who are licensed to sell on behalf of the contract, either by being a direct employee or by contractual arrangement, then it is appropriate to report zeros for each data element in this reporting requirement. If the Part D sponsor indicates that this is the case (in the applicable measure section of the OAI), the reviewer should score this data measure as "N/A."

Also, MA-PDs that report data for the Part C Plan Oversight of Agents data measure are exempt from reporting this Part D data measure unless there is a significant difference in their data systems for their Part D-only contracts. If the Part D sponsor indicates that this is the case (in Section 3.3 of the OAI), the reviewer should score this data measure as "N/A."

To determine compliance with the standards for Plan Oversight of Agents (Part D), the reviewer will assess the following information:

- Written response to OAI's Section 3 and applicable measure section, and attachments (e.g., policies and procedures manual)
- Programming code, spreadsheet formulas, analysis plans, record layouts, saved data queries, and process flows used for generating the reporting requirements
- Results of interviews with organization staff
- *If sampling is done:* Samples of [insert relevant source data]
- Sample of data files
- Data file created for submission to CMS and copy of HPMS print-out of data entered for this data measure
- Other relevant information provided by organization

VALIDATION STANDARDS

1	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.</p> <p><u>Criteria for Validating Source Documents:</u></p> <ul style="list-style-type: none"> • Source documents and output are protected against overwriting. • Source documents create all required data fields for reporting requirements. • Source documents are error-free (e.g., programs and spreadsheet formulas have no messages or warnings indicating errors). • All data fields have meaningful, consistent labels. • Data file locations are referenced correctly. • If used, macros are properly documented. • Source documents are clearly and adequately documented. • Titles and footnotes on reports and tables are accurate. • Version control of source documents is appropriately applied.
2	<p>A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, record layouts, process flows) and potential samples indicates that data elements for each measure are accurately identified, processed, and calculated.</p> <p><u>Criteria for Validating Measure-Specific Criteria (Refer to measure-specific criteria section below):</u></p> <ul style="list-style-type: none"> • The appropriate date range for the reporting period is captured. • Data is assigned at the applicable level (e.g., plan benefit package or contract level). • Appropriate deadlines are met for reporting data (e.g., quarterly). • Terms used are properly defined per CMS requirements. • The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified. • Ranges of data fields are verified. • All calculations (e.g., derived data fields) are verified. • Missing data has been properly addressed. • Reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans). • Version control of reported data elements is appropriately applied.
3	<p>Organization implements appropriate policies and procedures for data submission, including the following:</p>

	<ul style="list-style-type: none"> • Data elements are accurately entered into the HPMS tool and entries match corresponding source documents. • Data elements are validated as specified in the Reporting Requirements Technical Specifications, including: <ul style="list-style-type: none"> ○ Indicated QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. ○ Indicated edits and validation checks are performed prior to data submission. • Data files are properly uploaded into HPMS according to any HPMS templates provided.
4	Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5	Organization implements appropriate policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
6	<i>If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):</i> Organization provided documentation on the data system changes and, upon review, there were no issues that significantly impacted data reported.
7	<i>If data collection, validation, and/or reporting for this data measure is delegated to another entity:</i> Organization regularly monitors the quality and timeliness of the data collected, validated, and/or reported by the delegated entity or first tier/downstream contractor.
MEASURE-SPECIFIC CRITERIA (NOT SCORED)	
1	Organization reports data based on the required reporting periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.
2	Organization properly assigns data to the applicable CMS contract.
3	Organization meets deadlines for reporting quarterly data to CMS by 5/31, 8/31, 11/30, and 2/28.
4	<p>Organization accurately calculates the total number of agents who are licensed to sell on behalf of the contract during the applicable reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all direct employees of the Part D sponsor who are licensed to sell on behalf of the contract. • Includes all licensed agents who are under a contractual agreement to sell on behalf of the contract, regardless of whether or not the agent was actively selling during the reporting period. <p>[Data Element A]</p>
5	<p>Organization accurately calculates the number of agents investigated based on complaints, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all investigations that were completed during the applicable reporting period, regardless of when the complaint was received. • Includes investigations based on complaints filed directly with the organization as well as those from the HPMS Complaint Tracking Module (CTM). • Includes all investigations based on complaints against an agent under the applicable contract. If a complaint cannot be tied to a specific contract, then the agent is included under all contracts that the agent is licensed to sell. • The number calculated for Data Element B is a subset of the total number of agents calculated for Data Element A. <p>[Data Element B]</p>
6	<p>Organization accurately calculates the number of agents receiving disciplinary action resulting from a complaint filed against an agent, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all disciplinary actions that were taken during the applicable reporting period, regardless of when the complaint was received. • Includes any disciplinary action taken by the Part D sponsor, including manager-coaching, documented verbal warning, re-training, documented corrective action plan, suspension, termination of employment/contract, and short-term revocation. • Includes disciplinary actions based on complaints filed directly with the organization as well as those from the HPMS Complaint Tracking Module (CTM). • Includes all disciplinary actions based on complaints against an agent under the applicable contract. If a complaint cannot be tied to a specific contract, then the disciplinary action is included under all contracts that the agent is licensed to sell. • The number calculated for Data Element C is a subset of the total number of agents calculated for Data Element A.

	[Data Element C]
7	<p>Organization accurately calculates the number of complaints filed against an agent that the Part D sponsor reported to the governing State, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all complaints reported to the State during the applicable reporting period, regardless of when the complaint was received. • Includes only complaints that are filed directly with the organization (e.g., excludes all complaints that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization). • Includes all complaints against an agent and reported to the governing State under the applicable plan contract. If a complaint that is reported to the governing State cannot be tied to a specific contract, then the complaint is included under all contracts that the agent is licensed to sell. <p>[Data Element D]</p>
8	<p>Organization accurately calculates the number of agents whose selling privileges were revoked by the organization based on conduct or discipline, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all revocations initiated during the applicable reporting period, regardless of when the conduct causing the revocation occurred. • The number calculated for Data Element E is a subset of the total number of agents calculated for Data Element A. <p>[Data Element E]</p>
9	<p>Organization accurately calculates the number of “agent assisted enrollments” during the applicable reporting period, including the following criteria:</p> <ul style="list-style-type: none"> • Includes all agent assisted enrollments that became effective during the reporting period. • Defines “agent assisted enrollments” as enrollments where the member used a licensed agent to complete the enrollment process (e.g., includes enrollments completed through a call center staffed by licensed agents, in person sales appointments, and public sales meetings where a licensed agent collects enrollment forms). • Includes agent assisted enrollments from both the individual and group enrollment process. • Includes enrollments that are as a direct result of the participation of the group of agents reported in Data Element A. <p>[Data Element F]</p>

APPENDIX: ACRONYMS

Acronym	Description
ASO	Administrative Services Only
CABG	Coronary Artery Bypass Surgery
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CTM	Complaint Tracking Module
DBA	Doing Business As
DEA	Drug Enforcement Agency
DME	Durable Medical Equipment
ESRD	End Stage Renal Disease
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
HAC	Hospital Acquired Condition
HEDIS	Healthcare Effectiveness Data and Information Set
HPMS	Health Plan Management System
ID	Identification
IRE	Independent Review Entity
LIS	Low Income Subsidy
LTC	Long-Term Care
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	Medicare Advantage Prescription Drug Plan
MTMP	Medication Therapy Management Program
N/A	Not Applicable
OAI	Organizational Assessment Instrument
OEP	Open Enrollment Period
OEPI	Open Enrollment Period for Institutionalized Individuals
OIG	Office of Inspector General
OP	Outpatient
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Management
PBP	Plan Benefit Package
PCP	Primary Care Physician
PDP	Prescription Drug Plan
PFFS	Private Fee for Service
PTCA	Percutaneous Transluminal Coronary Angioplasty
QA	Quality Assurance
QIO	Quality Improvement Organization
RPPO	Regional Preferred Provider Organization
Rx	Prescription
SEP	Special Enrollment Period
SIC	State Insurance Commissioners
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program

Acronym	Description
SRAE	Serious Reportable Adverse Event
TBD	To Be Determined
UM	Utilization Management
UTI	Urinary Tract Infection