Centers for Medicare & Medicaid Services 
Center for Medicare Component Logo

**Technical Specifications**

**Public Use File (PUF) of**

**CY 2017 Part C and D Reporting Requirements Data**

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# Introduction

*Reporting Requirements*

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

Appendices A and B outline the Part C and Part D Reporting Requirements since CY 2014.

*Data Validation*

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

Appendix C outlines the Part C and Part D reporting sections included in DV since CY 2014.

# Public Use File (PUF)

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

*Datasets*

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

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

*Reporting Sections Included in the PUF*

The table below outlines the Part C and D reporting sections that are included in the CY 2017 PUF and whether they were included in the 2018 DV cycle.

**Table 1: CY 2017 PUF Reporting Sections**

|  |  |  |
| --- | --- | --- |
| Reporting Section | Calendar Year | 2018 DV Cycle |
| Grievances – Part C | CY 2017 | ✓ |
| Organization Determinations and Reconsiderations – Part C | CY 2017 | ✓ |
| Payments to Providers – Part C | CY 2017 |  |
| Rewards and Incentives – Part C | CY 2017 |  |
| Special Needs Plan (SNP) Care Management – Part C | CY 2017 | ✓ |
| Coverage Determinations & Redeterminations – Part D | CY 2017 | ✓ |
| Grievances – Part D | CY 2017 | ✓ |
| Improving Drug Utilization Review Controls – Part D | CY 2017 | ✓ |
| Medication Therapy Management (MTM) Programs – Part D | CY 2017 | ✓ |
| Enrollment and Disenrollment – Part C and Part D | CY 2017 |  |

Data elements included in the PUF are listed below as they appear in the CY 2017 Part C and D Reporting Requirements documents. The Reporting Requirements documents can be found at the below locations:

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

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

**Grievances – Part C**

*Contract Level*

1. Total number of grievances – Total
2. Number of grievances in which timely notification was given – Total
3. Total number of grievances – Expedited
4. Number of grievances in which timely notification was given – Expedited
5. Number of grievances – Dismissed
6. Total number of grievances – Enrollment/Disenrollment
7. Number of grievances in which timely notification was given – Enrollment/Disenrollment
8. Total number of grievances – Plan Benefit
9. Number of grievances in which timely notification was given – Plan Benefit
10. Total number of grievances – Access
11. Number of grievances in which timely notification was given – Access
12. Total number of grievances – Marketing
13. Number of grievances in which timely notification was given – Marketing
14. Total number of grievances – Customer Service
15. Number of grievances in which timely notification was given – Customer Service
16. Total number of grievances – Organization Determination and Reconsideration Process
17. Number of grievances in which timely notification was given – Organization Determination and Reconsideration Process
18. Total number of grievances – Quality of Care
19. Number of grievances in which timely notification was given – Quality of Care
20. Total number of grievances – CMS Issues
21. Number of grievances in which timely notification was given – CMS Issues
22. Total number of grievances – Other
23. Number of grievances in which timely notification was given – Other

**Organization Determinations and Reconsiderations – Part C**

*Contract Level*

6.1. Total Number of Organization Determinations Made in Reporting Time Period

6.2. Of the Total Number of Organization Determinations in 6.1, Number Processed Timely

6.3. Number of Organization Determinations – Fully Favorable (Services)

6.4. Number of Organization Determinations – Fully Favorable (Claims)

6.5. Number of Organization Determinations – Partially Favorable (Services)

6.6. Number of Organization Determinations – Partially Favorable (Claims)

6.7. Number of Organization Determinations – Adverse (Services)

6.8. Number of Organization Determinations – Adverse (Claims)

6.9. Number of Requests for Organization Determinations – Withdrawn

6.10. Number of Requests for Organization Determinations - Dismissals

6.11. Total Number of Reconsiderations Made in Reporting Time Period

6.12. Of the Total Number of Reconsiderations in 6.11, Number Processed Timely

6.13. Number of Reconsiderations – Fully Favorable (Services)

6.14. Number of Reconsiderations – Fully Favorable (Claims)

6.15. Number of Reconsiderations – Partially Favorable (Services)

6.16. Number of Reconsiderations – Partially Favorable (Claims)

6.17. Number of Reconsiderations – Adverse (Services)

6.18. Number of Reconsiderations – Adverse (Claims)

6.19. Number of Requests for Reconsiderations – Withdrawn

6.20. Number of Requests for Reconsiderations - Dismissals

6.21. Total Number of Reopened (Revised) Decisions, for any Reason, in Time Period

**Payments to Providers – Part C**

*Contract Level*

17.1. Total Medicare Advantage payment made to contracted providers.

17.2. Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (Category 1)

17.3. Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (Category 2)

17.4a. Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (Category 3)

17.4b. Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework)

17.5a. Total Medicare Advantage payment made using population-based payment (Category 4)

17.5b. Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)

17.6. Total number of Medicare Advantage contracted providers

17.7. Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (Category 1)

17.8. Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (Category 2)

17.9a. Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3)

17.9b. Total Medicare Advantage contracted providers paid based on risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)

17.10a. Total Medicare Advantage contracted providers paid based on population based payment (Category 4)

17.10b. Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

**Rewards and Incentives – Part C**

*Contract Level*

* 1. Do you have a Rewards and Incentives Program(s)? If yes, please list each individual Rewards and Incentives Program you offer and provide information on the following:
  2. What health related services and/or activities are included in the program?
  3. What reward(s) may enrollees earn for participation?
  4. How do you calculate the value of the reward?
  5. How do you track enrollee participation in the program?
  6. How many enrollees are currently enrolled in the program?
  7. How many rewards have been awarded so far?

**Special Needs Plans (SNPs) Care Management – Part C**

*Plan Level*

13.1. Number of new enrollees due for an Initial Health Risk Assessment (HRA)

13.2. Number of enrollees eligible for an annual reassessment HRA

13.3. Number of initial HRAs performed on new enrollees

13.4. Number of initial HRA refusals

13.5. Number of initial HRAs not performed because SNP is unable to reach new enrollees

13.6. Number of annual reassessments performed on enrollees eligible for reassessment

13.7. Number of annual reassessment refusals

13.8. Number of annual reassessments where SNP is unable to reach enrollee

**Coverage Determinations and Redeterminations – Part D**

*Contract Level*

Rejected Pharmacy Transactions:

1.A. The total number pharmacy transactions.

1.B. The number of pharmacy transactions rejected due to non-formulary status.

1.C. The number of pharmacy transactions rejected due to prior authorization (PA) requirements.

1.D. The number of pharmacy transactions rejected due step therapy requirements.

1.E. The number of pharmacy transactions rejected due to quantity limits based on CMS approved formulary. Safety edits and rejections due to early refills should be excluded.

1.F. Did the plan have high cost edits for non-compounds? If yes, what is the cost threshold used? N/A, if no.

1.G. The number of pharmacy transaction claims rejected due to high cost edits for

non-compounds.

Coverage Determinations

2.A. Total number of coverage determinations

2.E. The total number of fully favorable decisions.

2.F. The total number of partially favorable decisions.

2.G. The total number of adverse decisions.

2.H. The total number withdrawn.

2.I. The total number dismissed.

*Utilization Management Exceptions*

2.J. The number of utilization management exceptions.

2.K. The number of fully favorable decisions.

2.L. The number of partially favorable decisions.

2.M. The number of adverse decisions.

2.N. The number withdrawn.

2.O. The number dismissed.

*Formulary Exceptions*

2.P. The number of formulary exceptions.

2.Q. The number of fully favorable decisions.

2.R. The number of partially favorable decisions.

2.S. The number of adverse decisions.

2.T. The number withdrawn.

2.U. The number dismissed.

*Tiering Exceptions*

2.V. The number of tiering exceptions.

2.W. The number of fully favorable decisions.

2.X. The number of partially favorable decisions.

2.Y. The number of adverse decisions.

2.Z. The number withdrawn.

2.AA. The number dismissed.

Redeterminations:

3.A. Total number of redeterminations

3.E. The number of fully favorable decisions.

3.F. The number of partially favorable decisions.

3.G. The number of adverse decisions.

3.H. The number withdrawn.

3.I. The number dismissed.

Reopenings:

4.A. The total number of reopened (revised) decisions.

**Grievances – Part D**

*Contract Level*

1. Total number of grievances – Total
2. Number of grievances in which timely notification was given – Total
3. Total number of grievances – Expedited
4. Number of grievances in which timely notification was given – Expedited
5. Number of grievances – Dismissed
6. Total number of grievances – Enrollment/Disenrollment
7. Number of grievances in which timely notification was given – Enrollment/Disenrollment
8. Total number of grievances – Plan Benefit
9. Number of grievances in which timely notification was given – Plan Benefit
10. Total number of grievances – Pharmacy Access
11. Number of grievances in which timely notification was given – Pharmacy Access
12. Total number of grievances – Marketing
13. Number of grievances in which timely notification was given – Marketing
14. Total number of grievances – Customer Service
15. Number of grievances in which timely notification was given – Customer Service
16. Total number of grievances – Coverage Determination and Redetermination Process
17. Number of grievances in which timely notification was given – Coverage Determination and Redetermination Process
18. Total number of grievances – Quality of Care
19. Number of grievances in which timely notification was given – Quality of Care
20. Total number of grievances – CMS Issues
21. Number of grievances in which timely notification was given – CMS Issues
22. Total number of grievances – Other
23. Number of grievances in which timely notification was given – Other

**Improving Drug Utilization Review Controls – Part D**

*Plan Level*

1. Did the plan have a soft formulary-level cumulative opioid morphine equivalent dose (MED) edit at point-of-sale (POS) in place during the time period above? (Y (yes) or N (no)).
2. If yes to element A, the cumulative MED threshold used.
3. If yes to element A, the provider count criterion used, if applicable.
4. If yes to element A, the pharmacy count criterion used, if applicable.
5. If yes to element A, the number of claims rejected due to the soft formulary-level cumulative opioid MED edit at POS.
6. If yes to element A, the number of unique beneficiaries with at least one claim rejected due to the soft formulary-level cumulative opioid MED edit at POS.
7. Of the total reported in element E, the number of soft edit claim rejections overridden by the pharmacist at the pharmacy.
8. Of the total reported in element F, the number of beneficiaries with at least one soft edit claim rejection overridden by the pharmacist at the pharmacy.
9. Did the plan have a hard formulary-level cumulative opioid MED edit at POS in place during the time period above? (Y (yes) or N (no)).
10. If yes to element I, the cumulative MED threshold used.
11. If yes to element I, the provider count criterion used, if applicable.
12. If yes to element I, the pharmacy count criterion used, if applicable.
13. If yes to element I, the number of claims rejected due to the hard formulary-level cumulative opioid MED edit at POS.
14. If yes to element I, the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS.
15. Of the total reported in element N, the number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request for an opioid drug subject to the hard opioid MED edit.
16. Of the total reported in element N, the number of unique beneficiaries with at least one rejected claim that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit such as, but not limited to, through a favorable coverage determination or process.

**Medication Therapy Management (MTM) Programs – Part D**

*Contract Level*

1. Contract Number
2. Beneficiary date of birth (excluded; however, age band will be provided in lieu of Beneficiary date of birth – under 65, 66-74, 75-84, and 85 and above; age calculated as of the last day of the reporting period)
3. Met the specified targeting criteria per CMS – Part D requirements
4. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR
5. Date of MTM program enrollment
6. Date met the specified targeting criteria per CMS – Part D requirements
7. Date of MTM program opt-out, if applicable
8. Reason participant opted-out of MTM program
9. Offered annual CMR
10. If offered a CMR, date of (initial) offer
11. Received annual CMR with written summary in CMS standardized format
12. Number of CMRs received with written summary in CMS standardized format
13. Date(s) of CMR(s) with written summary in CMS standardized format (up to two)
14. Method of delivery for the annual CMR
15. Qualified provider who performed the initial CMR
16. Recipient of CMR
17. Number of targeted medication reviews
18. Number of drug therapy problem recommendations made to beneficiary’s prescriber(s) as a result of MTM services
19. Number of drug therapy problem resolutions resulting from recommendations made to beneficiary’s prescriber(s) as a result of MTM recommendations

**Enrollment and Disenrollment – Part C and Part D**

*Contract Level*

Enrollment:

1. The total number of enrollment requests received in the specified time period
2. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative)
3. Of the total reported in A, the number of enrollment requests for which the Sponsor was required to request additional information from the applicant (or his/her representative)
4. Of the total reported in A, the number of enrollment requests denied due to the Sponsor’s determination of the applicant’s ineligibility to elect the plan (e.g. individual not eligible for an election period)
5. Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes
6. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes
7. Of the total reported in A, the number of paper enrollment requests received
8. Of the total reported in A, the number of telephonic enrollment requests received (if Sponsor offers this mechanism)
9. Of the total reported in A, the number of internet enrollment requests received via plan website or affiliated third party website (if Sponsor offers this mechanism)
10. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received
11. For stand-alone prescription drug plans (PDPs) only: Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual)
12. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage
13. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP
14. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the total number of enrollment transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period
15. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period Code “S” for individuals affected by a contract nonrenewal, plan termination, or service area reduction
16. The total number of individuals included in the advance notification for seamless conversion enrollment for effective dates occurring within the reporting period. (Approved MA Plans Only)
17. Of the total reported in 1P, the number of individuals whose Medicare eligibility is based on age (Approved MA Plans Only)
18. Of the total reported in 1P, the number of individuals whose Medicare eligibility is based on disability (Approved MA Plans Only)
19. Of the total reported in 1P, the number of enrollments submitted to CMS (Approved MA Plans Only)

Disenrollment:

1. The total number of voluntary disenrollment requests received in the specified time period.
2. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative)
3. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason
4. The total number of involuntary disenrollments for failure to pay plan premium in the specified time period
5. Of the total reported in 2D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause
6. Of the total reported in 2E, the number of favorable Good Cause determinations.
7. Of the total reported in 2F, the number of individuals reinstated.

*Reporting Sections Excluded from the PUF*

* Data that are non-validated and are used for CMS monitoring only:
* PFFS Provider Payment Dispute Resolution Process (Part C)
* Mid-Year Network Changes (Part C)
* Retail, Home Infusion, and Long-Term Care Pharmacy Access (Part D)
* Employer Group Plan Sponsors (Part C and Part D)
* Reporting sections that have been suspended by CMS:
* Agent Compensation Structure (Part C)
* Agent Training and Testing (Part C)
* Benefit Utilization (Part C)
* Provider Network Adequacy (Part C)
* Procedure Frequency (Part C)
* Serious Reportable Adverse Events (Part C)
* PFFS Plan Enrollment Verification Calls (Part C)
* Fraud, Waste, and Abuse Compliance Programs (Part D)
* Prompt Payment by Part D Sponsors (Part D)
* LTC Utilization (Part D)
* Sponsor Oversight of Agents (Part C and Part D)

# CMS Disclaimer – User Agreement for Public Use Data

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

* Timeframes for data delivery: CMS expects to post plan-reported data on an annual basis, following the data validation process and other CMS reviews. CMS cannot guarantee the release of these data to meet any timeframe.
* Data validation: CMS is providing plan-reported data available to the public; most of these data have undergone the data validation process and are used by CMS for operational purposes. CMS requires that organizations contracted to offer Medicare Part C and/or Part D benefits be subject to an independent yearly review to validate data reported to CMS per the *Medicare Part C and Part D Reporting Requirements and Technical Specifications (Technical Specifications)*.[[1]](#footnote-2) The purpose of the independent data validation (DV) is to ensure that Part C and Part D Sponsors are reporting health and drug plan data that are reliable, valid, complete, comparable, and timely.
* Data accuracy: CMS does not ensure 100% accuracy of all records and all fields. Some data fields that are not used for core agency functions may contain incorrect and/or incomplete data. Data contained in the public use file are necessarily limited to data that was reported to CMS in any given year. Data reporting requirements and technical specifications may change from year to year. Therefore, users must familiarize themselves with any modifications to the reporting requirements or technical specifications when considering these data across plan years.
* Data integrity: It is the responsibility of each user to identify the information needed to satisfy the need for the data contained in the public use file. Any alteration of the original data, including conversion to other media or other data formats, is the responsibility of the user. Data that has been manipulated or reprocessed by the user is the responsibility of the user. The user may not present data that has been altered in any way as CMS data. CMS has no responsibility for the data file after it has been converted, processed or otherwise altered. CMS has no responsibility for assisting users with converting the data to another format.
* Privacy protection: CMS is obligated by the federal Privacy Act, 5 U.S.C. Section. 552a and the HIPAA Privacy Rule, 45 C.F.R Parts 160 and 164, to protect the privacy of individual beneficiaries and other persons. Public files consist of aggregated data that do not permit direct identification of individuals. Attempting to determine individual identities from public data is a violation of the federal Privacy Act, 5 U.S.C and the HIPAA Privacy Rule.

# Technical Assistance

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

Part C reporting sections - [partcplanreporting@cms.hhs.gov](mailto:partcplanreporting@cms.hhs.gov)

Part D reporting sections - [partd-planreporting@cms.hhs.gov](mailto:partd-planreporting@cms.hhs.gov)

# PUF Specifications by Reporting Section

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

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

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

## Grievances – Part C

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-QUARTER level.

*Exclusion Criteria:* Contracts that were not required to submit Grievances data[[2]](#footnote-3), that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| QUARTER | Reporting quarter (e.g., Q1) |
| TOTAL\_GRIEVE | Total number of grievances (Element A) |
| TIMELY\_GRIEVE | Number of grievances in which the sponsor provided timely notification of its decision (Element B) |
| TOTAL\_EXP | Total number of expedited grievances (Element C) |
| TIMELY\_EXP | Number of expedited grievances in which the sponsor provided timely notification of its decision (Element D) |
| DISMISSED\_GREIVE | Total number of dismissed grievances (Element E) |
| TOTAL\_ENROLLMENT | Total number of enrollment/disenrollment grievances (Element F) |
| TIMELY\_ENROLLMENT | Number of enrollment/disenrollment grievances in which the sponsor provided timely notification of its decision (Element G) |
| TOTAL\_BENEFIT | Total number of plan benefit grievances (Element H) |
| TIMELY\_BENEFIT | Number of plan benefit grievances in which the sponsor provided timely notification of its decision (Element I) |
| TOTAL\_ACCESS | Total number of access grievances (Element J) |
| TIMELY\_ACCESS | Number of access grievances in which the sponsor provided timely notification of its decision (Element K) |
| TOTAL\_MARKETING | Total number of marketing grievances (Element L) |
| TIMELY\_MARKETING | Number of marketing grievances in which the sponsor provided timely notification of its decision (Element M) |
| TOTAL\_CUSTSERV | Total number of customer service grievances (Element N) |
| TIMELY\_CUSTSERV | Number of customer service grievances in which the sponsor provided timely notification of its decision (Element O) |
| TOTAL\_DETRECON | Total number of organization determination and reconsideration process grievances (Element P) |
| TIMELY\_DETRECON | Number of organization determination and reconsideration grievances in which the sponsor provided timely notification of its decision (Element Q) |
| TOTAL\_QUALITY | Total number of quality of care grievances (Element R) |
| TIMELY\_QUALITY | Number of quality of care grievances in which the sponsor provided timely notification of its decision (Element S) |
| TOTAL\_CMS | Total number of grievances related to “CMS Issues” (Element T) |
| TIMELY\_CMS | Number of grievances related to “CMS Issues” in which the sponsor provided timely notification of its decision (Element U) |
| TOTAL\_OTHER | Total number of other grievances (Element V) |
| TIMELY\_OTHER | Number of other grievances in which the sponsor provided timely notification of its decision (Element W) |

## Organization Determinations and Reconsiderations – Part C

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-QUARTER level.

*Exclusion Criteria:* Contracts that were not required to submit Organization Determinations and Reconsiderations data[[3]](#footnote-4), that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to the Health Plan Management System (HPMS) are excluded.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| QUARTER | Reporting quarter (e.g., Q1) |
| DET\_ISSUED | Number of organization determinations (Element 6.1) |
| DET\_ISSUED\_TIME | Number of organization determinations processed timely (Element 6.2) |
| DET\_FULLY\_FAVORABLE\_SERV | Number of fully favorable organization determinations for services (Element 6.3) |
| DET\_FULLY\_FAVORABLE\_CLAIM | Number of fully favorable organization determinations for claims (Element 6.4) |
| DET\_PARTIALLY\_FAVORABLE\_SERV | Number of partially favorable organization determinations for services (Element 6.5) |
| DET\_PARTIALLY\_FAVORABLE\_CLAIM | Number of partially favorable organization determinations for claims (Element 6.6) |
| DET\_ADVERSE\_SERV | Number of adverse organization determinations for services (Element 6.7) |
| DET\_ADVERSE\_CLAIM | Number of adverse organization determinations for claims (Element 6.8) |
| DET\_WITHDRAWN | Number of organization determination requests withdrawn (Element 6.9) |
| DET\_DISMISSED | Number of organization determination requests dismissed (Element 6.10) |
| TOTAL\_REC\_MADE | Number of reconsiderations (Element 6.11) |
| TOTAL\_REC\_MADE\_TIME | Number of reconsiderations processed timely (Element 6.12) |
| REC\_FULLY\_FAVORABLE\_SERV | Number of fully favorable reconsiderations for services (Element 6.13) |
| REC\_FULLY\_FAVORABLE\_CLAIM | Number of fully favorable reconsiderations for claims (Element 6.14) |
| REC\_PARTIALLY\_FAVORABLE\_SERV | Number of partially favorable reconsiderations for services (Element 6.15) |
| REC\_PARTIALLY\_FAVORABLE\_CLAIM | Number of partially favorable reconsiderations for claims (Element 6.16) |
| REC\_ADVERSE\_SERV | Number of adverse reconsiderations for services (Element 6.17) |
| REC\_ADVERSE\_CLAIM | Number of adverse reconsiderations for claims (Element 6.18) |
| REC\_WITHDRAWN | Number of reconsiderations requests withdrawn (Element 6.19) |
| REC\_DISMISSED | Number of reconsiderations requests dismissed (Element 6.20) |
| TOTAL\_REOPENED | Number of reopened/revised decisions (Element 6.21) |

## Payments to Providers – Part C

**Reporting Section/Measure Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR level.

*Exclusion Criteria:* Contracts that were not required to submit Payments to Providers data[[4]](#footnote-5) are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

*Data Validation:* The CY 2017 Payments to Providers data did not undergo DV.

**File Layout**

|  |  |
| --- | --- |
| **Variable Name** | **Definition** |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Contract name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| TOTAL\_PAY | Total Medicare Advantage payment made to contracted providers (Element 17.1) |
| TOTAL\_PAY\_FFS\_NO\_LINK | Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (Category 1) (Element 17.2) |
| TOTAL\_PAY\_FFS\_LINK | Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (Category 2) (Element 17.3) |
| TOTAL\_PAY\_ALT\_MODEL | Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (Category 3) (Element 17.4a) |
| TOTAL\_PAY\_RISK | Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework) (Element 17.4b) |
| TOTAL\_PAY\_POP\_BASED | Total Medicare Advantage payment made using population-based payment (Category 4) (Element 17.5a) |
| TOTAL\_PAY\_CAP | Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework) (Element 17.5b) |
| TOTAL\_PROV | Total number of Medicare Advantage contracted providers (Element 17.6) |
| TOTAL\_PROV\_FFS\_NO\_LINK | Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (Category 1) (Element 17.7) |
| TOTAL\_PROV\_FFS\_LINK | Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (Category 2) (Element 17.8) |
| TOTAL\_PROV\_ALT\_MODEL | Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (Category 3) (Element 17.9a) |
| TOTAL\_PROV\_RISK | Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework) (Element 17.9b) |
| TOTAL\_PROV\_POP\_BASED | Total Medicare Advantage contracted providers paid based on population based payment (Category 4) (Element 17.10a) |
| TOTAL\_PROV\_CAP | Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework) (Element 17.10b) |

## Rewards and Incentives – Part C

**Reporting Section/Measure Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-CONTRACT\_REC\_NUM level.

*Exclusion Criteria:* Contracts that were not required to submit Rewards and Incentives[[5]](#footnote-6) are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

*Data Validation:* The CY 2017 Rewards and Incentives data did not undergo DV.

**File Layout**

|  |  |
| --- | --- |
| **Variable Name** | **Definition** |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Contract name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| CONTRACT\_REC\_NUM | Incremental count of number of records within Contract ID in PUF |
| REWARDS\_NAME | Do you have a Rewards and Incentives Program(s)? If yes, please list each individual Rewards and Incentives Program you offer and provide information on the following (Element 15.1) |
| ACTIVITY\_DESCRIPTION | What health related services and/or activities are included in the program? (Element 15.2) |
| EARN\_DESCRIPTION | What reward(s) may enrollees earn for participation? (Element 15.3) |
| REWARD\_VALUE | How do you calculate the value of the reward? (Element 15.4) |
| TRACK\_PARTICIPATION | How do you track enrollee participation in the program? (Element 15.5) |
| TOTAL\_ENROLLED | How many enrollees are currently enrolled in the program? (Element 15.6) |
| TOTAL\_REWARDS | How many rewards have been awarded so far? (Element 15.7) |

## Special Needs Plans (SNPs) Care Management – Part C

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Plan

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-PLAN\_ID-YEAR level.

*Exclusion Criteria:* Plans that were not required to submit SNP Care Management data[[6]](#footnote-7) or that did not undergo DV are excluded. Additionally, plans whose sum of new enrollees (Element 13.1) and enrollees eligible for an annual reassessment (Element 13.2) is less than 11 are excluded.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Contract name associated with Contract ID |
| PLAN\_ID | Plan ID |
| YEAR | Reporting year (e.g., 2017) |
| NEW\_ENROLLEES | Number of new enrollees due for initial Health Risk Assessment (HRA) (Element 13.1) |
| ELIGIBLE\_ENROLLEES | Number of enrollees eligible for an annual HRA reassessment (Element 13.2) |
| INITIAL\_ASSESSMENTS | Number of initial HRA assessments performed on new enrollees during reporting period (Element 13.3) |
| INITIAL\_REFUSALS | Number of initial assessments not performed on new enrollees due to enrollee refusal with documentation of enrollee refusal (13.4) |
| INITIAL\_UNREACHABLE | Number of initial assessments not performed because SNP is unable to reach new enrollees with documentation of inability to reach enrollee. Documentation must show that a SNP representative made at least 3 “non-automated” phone calls and sent a follow-up letter in its attempts to reach the enrollee (13.5) |
| ANNUAL\_REASSESSMENTS | Number of annual reassessments performed on enrollees eligible for a reassessment (Element 13.6) |
| ANNUAL\_REFUSALS | Number of annual assessments not performed on eligible enrollees due to enrollee refusal with documentation of enrollee refusal (13.7) |
| ANNUAL\_UNREACHABLE | Number of annual reassessments not performed because SNP is unable to reach enrollee with documentation of inability to reach enrollee. Documentation must show that a SNP representative made at least 3 non-automated phone calls and sent a follow-up letter in its attempts to reach the enrollee (13.8) |

## Coverage Determinations and Redeterminations – Part D

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-QUARTER level.

*Exclusion Criteria:* Contracts that were not required to submit Coverage Determinations and Redeterminations data[[7]](#footnote-8), that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| QUARTER | Reporting quarter (e.g., Q1) |
| PHARM\_TRANS | Number of pharmacy transactions (Element 1.A) |
| PHARM\_TRANS\_REJ\_NONFORM | Number of pharmacy transactions rejected due to non-formulary status (Element 1.B) |
| PHARM\_TRANS\_REJ\_PA | Number of pharmacy transactions rejected due to PA requirements (Element 1.C) |
| PHARM\_TRANS\_REJ\_STEP | Number of pharmacy transactions rejected due to step therapy requirements (Element 1.D) |
| PHARM\_TRANS\_REJ\_QL | Number of pharmacy transactions rejected due to QL requirements based on CMS approved formulary (Element 1.E) |
| NONCOMP\_EDITS\_COST | Did the plan have high cost edits for non-compounds? If yes, what is the cost threshold used? N/A, if no. (Element 1.F) |
| PHARM\_TRANS\_REJ\_NONCOMP\_EDITS | Number of pharmacy transaction claims rejected due to high cost edits for non-compounds (Element 1.G) |
| TOTAL\_DET | Number of coverage determinations decisions (Element 2.A) |
| FULLY\_FAVORABLE\_DET | Number of coverage determinations decisions that were fully favorable (Element 2.E) |
| PARTIALLY\_FAVORABLE\_DET | Number of coverage determinations decisions that were partially favorable (Element 2.F) |
| ADVERSE\_DET | Number of coverage determinations decisions that were adverse (Element 2.G) |
| WITHDRAWN\_DET | Number of requests for coverage determinations that were withdrawn (Element 2.H) |
| DISMISSED\_DET | Number of requests for coverage determinations that were dismissed (Element 2.I) |
| TOTAL\_UM | Number of utilization management exceptions (Element 2.J) |
| FULLY\_FAVORABLE\_UM | Number of fully favorable utilization management exception decisions (Element 2.K) |
| PARTIALLY\_FAVORABLE\_UM | Number of partially favorable utilization management exception decisions (Element 2.L) |
| ADVERSE\_UM | Number of adverse utilization management exception decisions (Element 2.M) |
| WITHDRAWN\_UM | Number of withdrawn utilization management exceptions (Element 2.N) |
| DISMISSED\_UM | Number of dismissed utilization management exceptions (Element 2.O) |
| TOTAL\_FORM | Number of formulary exceptions (Element 2.P) |
| FULLY\_FAVORABLE\_FORM | Number of fully favorable formulary exception decisions (Element 2.Q) |
| PARTIALLY\_FAVORABLE\_FORM | Number of partially favorable formulary exception decisions (Element 2.R) |
| ADVERSE\_FORM | Number of adverse formulary exception decisions (Element 2.S) |
| WITHDRAWN\_FORM | Number of withdrawn formulary exceptions (Element 2.T) |
| DISMISSED\_FORM | Number of dismissed formulary exceptions (Element 2.U) |
| TOTAL\_TIER | Number of tiering exceptions (Element 2.V) |
| FULLY\_FAVORABLE\_TIER | Number of fully favorable tiering exceptions decisions (Element 2.W) |
| PARTIALLY\_FAVORABLE\_TIER | Number of partially favorable tiering exceptions decisions (Element 2.X) |
| ADVERSE\_TIER | Number of adverse tiering exceptions decisions (Element 2.Y) |
| WITHDRAWN\_TIER | Number of withdrawn tiering exceptions (Element 2.Z) |
| DISMISSED\_TIER | Number of dismissed tiering exceptions (Element 2.AA) |
| TOTAL\_REDET | Number of redeterminations (Element 3.A) |
| FULLY\_FAVORABLE\_REDET | Number of fully favorable redeterminations (Element 3.E) |
| PARTIALLY\_FAVORABLE\_REDET | Number of partially favorable redeterminations (Element 3.F) |
| ADVERSE\_REDET | Number of adverse redeterminations (Element 3.G) |
| WITHDRAWN\_REDET | Number of requests for redeterminations that were withdrawn (Element 3.H) |
| DISMISSED\_REDET | Number of requests for redeterminations that were dismissed (Element 3.I) |
| TOTAL\_REOPENINGS | Number of reopened/revised decisions (Element 4.A) |

## Grievances – Part D

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-QUARTER level.

*Exclusion Criteria:* Contracts that were not required to submit Grievances data[[8]](#footnote-9), that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| QUARTER | Reporting quarter (e.g., Q1) |
| GRIEVE\_TOTAL | Total number of grievances (Element A) |
| GRIEVE\_TIMELY | Number of grievances in which timely notification was given (Element B) |
| EXP\_TOTAL | Total number of expedited grievances (Element C) |
| EXP\_TIMELY | Number of expedited grievances in which timely notification was given (Element D) |
| GRIEVE\_DISMISSED | Total number of dismissed grievances (Element E) |
| ENROLL\_TOTAL | Total number of enrollment/disenrollment grievances (Element F) |
| ENROLL\_TIMELY | Number of enrollment/disenrollment grievances in which timely notification was given (Element G) |
| BENEFIT\_TOTAL | Total number of plan benefit grievances (Element H) |
| BENEFIT\_TIMELY | Number of plan benefit grievances in which timely notification was given (Element I) |
| ACCESS\_TOTAL | Total number of pharmacy access grievances (Element J) |
| ACCESS\_TIMELY | Number of pharmacy access grievances in which timely notification was given (Element K) |
| MARKETING\_TOTAL | Total number of marketing grievances (Element L) |
| MARKETING\_TIMELY | Number of marketing grievances in which timely notification was given (Element M) |
| CUSTSERV\_TOTAL | Total number of customer service grievances (Element N) |
| CUSTSERV\_TIMELY | Number of customer service grievances in which timely notification was given (Element O) |
| COVDET\_TOTAL | Total number of coverage determinations and redeterminations process grievances (Element P) |
| COVDET\_TIMELY | Number of coverage determinations and redeterminations process grievances in which timely notification was given (Element Q) |
| QUALITY\_TOTAL | Total number of quality of care grievances (Element R) |
| QUALITY\_TIMELY | Number of quality of care grievances in which timely notification was given (Element S) |
| CMS\_TOTAL | Total number of grievances related to “CMS Issues” (Element T) |
| CMS\_TIMELY | Number of grievances related to “CMS Issues” in which timely notification was given (Element U) |
| OTHER\_TOTAL | Total number of other grievances (Element V) |
| OTHER\_TIMELY | Number of other grievances in which timely notification was given (Element W) |

## 

## Improving Drug Utilization Review Controls – Part D

**Reporting Section/Measure Details**

*Year:* CY 2017

*Level:*  Plan

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-PLAN\_ID-QUARTER level.

*Exclusion Criteria:* Plans that were not required to submit Improving Drug Utilization Review Controls data[[9]](#footnote-10), that did not have at least one enrollee in all four quarters of the year, or that did not undergo DV are excluded. Additionally, plans with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

*Data Validation:* Plans scoring less than 95% in DV for their reporting of the Improving Drug Utilization Review Controls section will be included but will have all variables other than CONTRACT\_ID, CONTRACT\_NAME, PLAN\_ID, YEAR, and QUARTER listed as *X.* This *X* indicates that CMS found issues with the plan’s data. Plans that scored 95% or higher in DV for this section but that were not compliant with DV standards/sub-standards for at least one data element will be included and will have only the specific data element(s) for which they were non-compliant listed as *X.* Data elements that were compliant with DV standards/sub-standards will be included as reported by the plan.

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| PLAN\_ID | Plan ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| QUARTER | Reporting quarter (e.g., Q1) |
| SOFT\_EDIT | Did the plan have a soft formulary-level cumulative opioid morphine equivalent dose (MED) edit at POS in place during the time period above? (Element A) |
| SOFT\_MED\_THRESHOLD | If yes to Element A, the cumulative MED threshold used (Element B) |
| SOFT\_PROV\_COUNT\_CRITERION | If yes to Element A, the provider count criterion used, if applicable (Element C) |
| SOFT\_PHARM\_COUNT\_CRITERION | If yes to Element A, the pharmacy count criterion used, if applicable (Element D) |
| SOFT\_REJ\_CLAIMS | If yes to Element A, the number of claims rejected due to the soft formulary-level cumulative opioid MED edit at POS (Element E) |
| SOFT\_REJ\_UNIQUE\_BENES | If yes to Element A, the number of unique beneficiaries with at least one claim rejected due to the soft formulary-level cumulative opioid MED edit at POS (Element F) |
| SOFT\_REJ\_OVERRIDE\_CLAIMS | Of the total reported in Element E, the number of soft edit claim rejections overridden by the pharmacist at the pharmacy (Element G) |
| SOFT\_REJ\_OVERRIDE\_BENES | Of the total reported in Element F, the number of beneficiaries with at least one soft edit claim rejection overridden by the pharmacist at the pharmacy (Element H) |
| HARD\_EDIT | Did the plan have a hard formulary-level cumulative opioid MED edit at POS in place during the time period above? (Element I) |
| HARD\_MED\_THRESHOLD | If yes to Element I, the cumulative MED threshold used (Element J) |
| HARD\_PROV\_COUNT\_CRITERION | If yes to Element I, the provider count criterion used, if applicable (Element K) |
| HARD\_PHARM\_COUNT\_CRITERION | If yes to Element I, the pharmacy count criterion used, if applicable (Element L) |
| HARD\_REJ\_CLAIMS | If yes to Element I, the number of claims rejected due to the hard formulary-level cumulative opioid MED edit at POS (Element M) |
| HARD\_REJ\_UNIQUE\_BENES | If yes to Element I, the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS (Element N) |
| HARD\_REJ\_BENES\_COVER\_DET | Of the total reported in Element N, the number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request for an opioid drug subject to the hard opioid MED edit (Element O) |
| HARD\_REJ\_BENES\_COVER\_DET\_PAID | Of the total reported in element N, the number of unique beneficiaries with at least one rejected claim that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit such as, but not limited to, through a favorable coverage determination or process (Element P) |

## Medication Therapy Management (MTM) Programs – Part D

**Reporting Section Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  1/Year

**PUF Details**

*File Level:* Unique at FILE\_REC\_NUM level

*Exclusion Criteria:* Contracts that were not required to submit Medication Therapy Management data[[10]](#footnote-11) or that did not undergo data validation (DV) are excluded.

*Data Validation:* Contracts scoring less than 95% in DV for their reporting of the Medication Therapy Management section are listed a single time in the PUF with all variables other than FILE\_REC\_NUM, CONTRACT\_ID, CONTRACT\_NAME, YEAR, and CONTRACT\_REC\_NUM listed as *F.* This *F* indicates that CMS found issues with the contract’s data.

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

*Minimum Size:* Contracts reporting fewer than 11 total records in their MTM data are listed a single time in the PUF with all variables other than FILE\_REC\_NUM, CONTRACT\_ID, CONTRACT\_NAME, YEAR, and CONTRACT\_REC\_NUM listed as *S.* This *S* indicates the contract’s data are suppressed from the PUF.

Contracts reporting more than 11 total records in their MTM data but fewer than 11 records in a single AGE\_BRACKET will have that specific AGE\_BRACKET listed a single time in the PUF with all variables other than FILE\_REC\_NUM, CONTRACT\_ID, CONTRACT\_NAME, YEAR, CONTRACT\_REC\_NUM, and AGE\_BRACKET listed as *S*. This *S* indicates the contract’s data are suppressed from the PUF.

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

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| FILE\_REC\_NUM | Incremental count of number of records across all Contract IDs in PUF |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| CONTRACT\_REC\_NUM | Incremental count of number of records within Contract ID in PUF |
| AGE\_BRACKET | Beneficiary age, categorized into an age bracket, as of December 31, 2017 according to date of birth reported by contract in Element F  A: Under 65  B: 65-74  C: 75-84  D: 85+  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| MET\_CRITERIA | Indicates if beneficiary met the specified targeting criteria per CMS – Part D requirements (Element G)  Y: Yes  N: No  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| COGNITIVELY\_IMPAIRED | Indicates if the beneficiary was identified as being cognitively impaired. (Element H)  Y: Yes  N: No  U: Unknown  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| ENROLLMENT\_DATE | Date of MTM program enrollment (Element I). CCYYMMDD format. |
| DATE\_MET\_CRITERIA | Date the beneficiary met the specified targeting criteria per CMS – Part D requirements, if applicable (Element J). CCYYMMDD format. N if beneficiary did not meet the specified targeting criteria per CMS – Part D requirements. |
| OPT\_OUT\_DATE | Date of MTM program opt out, if applicable (Element K). CCYYMMDD format. N if beneficiary did not opt out. 99999999 if opt-out reason is death. |
| OPT\_OUT\_REASON | Reason participant opted out of MTM program, if applicable (Element L). Listed as ‘NA’ if beneficiary did not opt out.  01: Death  02: Disenrollment from plan  03: Request by beneficiary  04: Other  NA: Beneficiary did not opt out  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| CMR\_OFFERED | Indicates if beneficiary was offered a comprehensive medication review (Element M)  Y: Yes  N: No  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| CMR\_OFFER\_DATE | If beneficiary was offered a comprehensive medication review, date of (initial) offer (Element N). CCYYMMDD format. N if beneficiary was not offered a CMR. |
| CMR\_RECEIVED | Indicates if beneficiary received a comprehensive medication review (Element O)  Y: Yes  N: No  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| NUMBER\_CMRS | The number of CMRs received (Element P). 0 if beneficiary did not receive a CMR. |
| FIRST\_CMR\_DATE | If beneficiary received a comprehensive medication review, first date of annual comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive a comprehensive medication review. |
| LAST\_CMR\_DATE | If beneficiary received more than one comprehensive medication review, date of last comprehensive medication review (Element Q). CCYYMMDD format. N if beneficiary did not receive more than one comprehensive medication review. |
| CMR\_METHOD | Method of delivery for the annual CMR (Element R)  01: Face to face  02: Telephone  03: Telehealth consultation  04: Other  NA: Beneficiary did not receive a CMR  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| CMR\_PROVIDER | The qualified provider who performed the CMR (Element S).  01: Physician  02: Registered Nurse  03: Licensed Practical Nurse  04: Nurse Practitioner  05: Physician’s Assistant  06: Local Pharmacist  07: LTC Consultant Pharmacist  08: Plan Sponsor Pharmacist  09: PBM Pharmacist  10: MTM Vendor Local Pharmacist  11: MTM Vendor In-House Pharmacist  12: Hospital Pharmacist  13: Pharmacist – Other  14: Supervised Pharmacy Intern  15: Other  NA: Beneficiary did not receive a CMR  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| CMR\_RECIPIENT | The recipient of the annual CMR (Element T).  01: Beneficiary  02: Beneficiary’s prescriber  03: Caregiver  04: Other authorized individual  NA: Beneficiary did not receive a CMR  F: Issues with section-level DV  S: Data suppressed due to minimum size criteria  X: Issues with element-level DV |
| TMR | Number of targeted medication reviews (Element U) |
| THERAPY\_RECOMMENDATIONS | The number of drug therapy problem recommendations made to prescriber(s) as a result of MTM services (Element V). |
| THERAPY\_RESOLUTIONS | Number of drug therapy problem resolutions made as a result of MTM recommendations (Element W) |

## 

## Enrollment and Disenrollment – Part C and Part D

**Reporting Section/Measure Details**

*Year:* CY 2017

*Level:*  Contract

*Frequency:*  2/Year

**PUF Details**

*File Level:* Unique at CONTRACT\_ID-YEAR-PERIOD level.

*Exclusion Criteria:* Contracts that were not required to submit Enrollment and Disenrollment data[[11]](#footnote-12) or that did not have at least one enrollee in both periods of the year are excluded. Required submissions that were missing are listed with missing values (‘.’). Additionally, contracts with an average monthly enrollment of less than 11 over the full reporting year (January 2017 - December 2017) according to HPMS are excluded.

*Data Validation:* The CY 2017 Enrollment and Disenrollment data did not undergo DV.

**File Layout**

| **Variable Name** | **Definition** |
| --- | --- |
| CONTRACT\_ID | Contract ID |
| CONTRACT\_NAME | Name associated with Contract ID |
| YEAR | Reporting year (e.g., 2017) |
| PERIOD | Reporting period (e.g., P1) |
| E\_TOTAL\_REQUESTS | Total number of enrollment requests received (Element 1.A) |
| E\_INITIAL\_COMPLETE | Total number of enrollment requests complete at the time of initial receipt (Element 1.B) |
| E\_INITIAL\_INCOMPLETE | Total number of enrollment requests that required requests for additional information (Element 1.C) |
| E\_DENIED\_INELIGIBLE | Total number of enrollment requests denied due to the sponsor’s determination of the applicant’s ineligibility to elect the plan (Element 1.D) |
| E\_INCOMPLETE\_TIMELY | Number of incomplete enrollment requests received that are completed within established timeframes (Element 1.E) |
| E\_DENIED\_INCOMPLETE | Number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes (Element 1.F) |
| E\_REQUESTS\_PAPER | Number of paper enrollment requests received (Element 1.G) |
| E\_REQUESTS\_PHONE | Number of telephonic enrollment requests received (Element 1.H) |
| E\_REQUESTS\_PLAN\_WEB | Number of internet enrollment requests received via plan website (Element 1.I) |
| E\_REQUESTS\_OEC | Number of Online Enrollment Center (OEC) enrollment requests received (Element 1.J) |
| E\_REQUESTS\_SALES | Number of enrollment requests effectuated by sales persons (Element 1.K) |
| E\_SEP\_CREDITABLE | Number of enrollment transactions submitted using the SEP Election Period code “S” related to creditable coverage (Element 1.L) |
| E\_SEP\_SPAP | Number of enrollment transactions submitted using the SEP Election Period code “S” related to SPAP (Part D only) (Element 1.M) |
| E\_SEP\_MA\_DISENROLLMT | Number of enrollment transactions submitted using the SEP Election Period code “S” that coordinates with the Medicare Advantage Disenrollment Period (Part D only) (Element 1.N) |
| E\_SEP\_NONRENEWALS | Number of enrollment transactions submitted using the SEP Election Period code “S” for individuals affected by a contract nonrenewal, plan termination or service area reduction (Element 1.O) |
| E\_SEAMLESS\_ADV\_NOTIF | The total number of individuals included in the advance notification for seamless conversion enrollment for effective dates occurring within the reporting period (Approved MA plans only) (Element 1.P) |
| E\_SEAMLESS\_ELIG\_AGE | Of the total reported in 1P, the number of individuals whose Medicare eligibility is based on age (Approved MA plans only) (Element 1.Q) |
| E\_SEAMLESS\_ELIG\_DISABILITY | Of the total reported in 1P, the number of individuals whose Medicare eligibility is based on disability (Approved MA plans only) (Element 1.R) |
| E\_SEAMLESS\_ENROLLMENTS | Of the total reported in 1P, the number of enrollments submitted to CMS (Approved MA plans only) (Element 1.S) |
| D\_TOTAL\_REQUESTS | Total number of voluntary disenrollment requests received in the specified time period (Element 2.A) |
| D\_INITIAL\_COMPLETE | Total number of disenrollment requests complete at the time of initial receipt (Element 2.B) |
| D\_DENIED\_ANY | Total number of disenrollment requests denied by the sponsor for any reason (Element 2.C) |
| D\_INVOLUNTARY\_PREMIUM | Total number of involuntary disenrollments for failure to pay plan premium in the specified time period (Element 2.D) |
| D\_REQUESTS\_GOOD\_CAUSE | Total number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause (Element 2.E) |
| D\_ FAVORABLE\_DET | Total number of favorable Good Cause determinations (Element 2.F) |
| D\_FAVORABLE\_REINSTATE | Total number of individuals reinstated (Element 2.G) |

# Appendix A: Part C Reporting Requirements Summary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reporting Section | CY 2014 | CY 2015 | CY 2016 | CY 2017 | CY 2018 |
| Enrollment and Disenrollment | ✓ | ✓ | ✓ | ✓ | ✓ |
| Grievances | ✓ | ✓ | ✓ | ✓ | ✓ |
| Employer Group Plan Sponsors | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sponsor Oversight of Agents[[12]](#footnote-13) | ✓ | ✓ | ✓ |  |  |
| Organization Determinations and Reconsiderations | ✓ | ✓ | ✓ | ✓ | ✓ |
| Special Needs Plans (SNPs) Care Management | ✓ | ✓ | ✓ | ✓ | ✓ |
| PFFS Plan Enrollment Verification Calls | ✓ | ✓ | ✓ |  |  |
| PFFS Provider Payment Dispute Resolution Process | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rewards and Incentives Programs[[13]](#footnote-14) |  |  | ✓ | ✓ | ✓ |
| Mid-Year Network Changes13 |  |  | ✓ | ✓ | ✓ |
| Payments to Providers13 |  |  | ✓ | ✓ | ✓ |

# Appendix B: Part D Reporting Requirements Summary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reporting Section | CY 2014 | CY 2015 | CY 2016 | CY 2017 | CY 2018 |
| Enrollment and Disenrollment | ✓ | ✓ | ✓ | ✓ | ✓ |
| Retail, HI, LTC Pharmacy Access | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medication Therapy Management (MTM) Programs | ✓ | ✓ | ✓ | ✓ | ✓ |
| Grievances | ✓ | ✓ | ✓ | ✓ | ✓ |
| Coverage Determinations and Redeterminations | ✓ | ✓ | ✓ | ✓ | ✓ |
| Long-Term Care (LTC) Utilization[[14]](#footnote-15) | ✓ |  |  |  |  |
| Employer/Union-Sponsored Group Health Plan Sponsors | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sponsor Oversight of Agents[[15]](#footnote-16) | ✓ | ✓ | ✓ |  |  |
| Improving Drug Utilization Review Contracts[[16]](#footnote-17) |  |  |  | ✓ | ✓ |

# Appendix C: Part C and Part D Data Validation Summary

| Reporting Section | DV 2014 | DV 2015 | DV 2016 | DV 2017 | DV 2018 |
| --- | --- | --- | --- | --- | --- |
| Serious Reportable Adverse Events (SRAEs)[[17]](#footnote-18) | CY 2012, CY 2013 |  |  |  |  |
| Organization Determinations/ Reconsiderations | CY 2013 | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Special Needs Plans (SNPs) Care Management | CY 2012, CY 2013 | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Medication Therapy Management (MTM) Programs | CY 2013 | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Grievances - Part C | CY 2013 | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Grievances - Part D | CY 2013 | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Coverage Determinations and Exceptions | CY 2013 |  |  |  |  |
| Appeals/Redeterminations[[18]](#footnote-19) | CY 2013 |  |  |  |  |
| Coverage Determinations and Redeterminations[[19]](#footnote-20) |  | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Long-Term Care (LTC) Utilization[[20]](#footnote-21) | CY 2013 | CY 2014 |  |  |  |
| Sponsor Oversight of Agents (Part C and Part D)[[21]](#footnote-22) |  | CY 2014 | CY 2015 | CY 2016 | CY 2017 |
| Improving Drug Utilization Review Controls |  |  |  |  | CY 2017 |

1. See 42 CFR §422.516(g) and §423.514(g) [↑](#footnote-ref-2)
2. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-3)
3. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-4)
4. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-5)
5. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-6)
6. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-7)
7. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-8)
8. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-9)
9. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-10)
10. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-11)
11. Data submitted by sponsors not required to submit solely due to termination are included if all other inclusion criteria are met. [↑](#footnote-ref-12)
12. The Plan Oversight of Agents reporting section was suspended in CY 2013; however, a revised data collection was introduced in CY 2014. This section was renamed Sponsor Oversight of Agents in CY 2016 and was suspended in CY 2017. [↑](#footnote-ref-13)
13. New reporting requirement for CY 2016. [↑](#footnote-ref-14)
14. The Long-Term Care (LTC) utilization section was suspended in CY 2015. [↑](#footnote-ref-15)
15. The Plan Oversight of Agents reporting section was suspended in CY 2013; however, a revised data collection was introduced in CY 2014. The section was renamed to Sponsor Oversight of Agents in CY 2016 and was suspended in CY 2017. [↑](#footnote-ref-16)
16. New reporting requirement for CY 2017. [↑](#footnote-ref-17)
17. The SRAEs reporting section was suspended in CY 2014. [↑](#footnote-ref-18)
18. The Appeals reporting section was renamed Redeterminations in CY 2012. [↑](#footnote-ref-19)
19. The Coverage Determinations/Exceptions and Redeterminations sections were combined into a single section beginning in CY 2014. [↑](#footnote-ref-20)
20. The Long-Term Care (LTC) utilization section was suspended in CY 2015. [↑](#footnote-ref-21)
21. The Plan Oversight of Agents reporting section was suspended from data validation for CY 2013; but was reintroduced in CY 2014. The section was renamed to Sponsor Oversight of Agents for CY 2016. [↑](#footnote-ref-22)