Medicare Part C Reporting Requirements

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Prepared by: Centers for Medicare & Medicaid ServicesCenter for Medicare
Medicare Drug Benefit and C&D Data Group

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Background and Introduction

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

All Part C Reporting Requirements documents will be posted at:
https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html
CMS believes providing these separate instructions will better serve the organizations reporting these data, while satisfying the Paperwork Reduction Act requirements.

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

The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA): *

- Employer DBA and Legal Name, Employer Address, Employer Tax IdentificationNumbers (Employer Group Sponsors)

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

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

Exclusions from Reporting

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

Overview of the parameters for current Part C Reporting Requirements reporting sections.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
I. Grievances	Coordinated CarePlans (CCPs), Provider Fee-For-Service Plans (PFFS), 1876 Cost, Medicare Savings Accounts (MSAs) (includes all 800series plans), Employer/Union Direct Contracts	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	First Monday ofFebruary Validation Required
II. Organization Determinations/ Reconsiderations	CCP, PFFS, 1876 Cost, MSA,RFB,PFFS (Includes all 800 series plans), Employer/Union Direct Contracts should also reportthis section regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	Last Monday ofFebruary in following year Validation required

III. Employer Group Plan Sponsors	CCP, PFFS,1876 Cost, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contracts should also reportthis section, regardless of Organization type	1/year PBP	1/1 - 12/31	First Monday ofFebruary in the following year.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
IV. Special Needs Plans (SNPs) Care Management	Local CCP, Regional CCP, RFB Local CCP with SNPs. Includes 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	Last Monday of February in the following year. Validation required
V. Enrollment/ Disenrollment	MAOs offering MA only (no Part D) plans 1876 Cost Plans with no Part D.[1]	2/Year Contract	1/1-6/30 7/1-12/31	Last Monday of August and February in the following year.
VI. Rewards and Incentives Programs	Local Coordinated Care Plans (Local CCPs), Medicare Savings Accounts (MSAs), Provider Fee-For-Service Plans (PFFS), and Regional Coordinated Care Plans (Regional CCPs) MMP's	1/Year Contract	1/1-12/31	Last Monday of February in the following year.
VII. Payments to Providers	Local CCP Regional CCP RFB Local CCP PFFS MMP	1/Year Contract	1/1-12/31	Last Monday of February in the following year.

[1] MA only. MAPD and PDPs report under Part D.

REPORTING SECTIONS

Grievances

According to MMA statute, all Medicare Advantage organizations must provide meaningful procedures for hearing and resolving grievances between enrollees, and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers. A grievance is any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested. MA organizations are required to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the organization needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a MA organization to process an enrollee's request for an expedited organization determination or reconsideration requires a response from the MA organization within 24 hours.

I. GRIEVANCES

This reporting section requires an upload.

Reporting section	Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
Grievances	01 – Local CCP 02 – MSA 03 – Religious Fraternal Benefit (RFB PFFS) 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – Employee Union Direct (ED)-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year /Contract level	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	First Monday of February in the following year.

Data Element ID	Data Element Description
A.	Number of Total Grievances
B.	Number of Total Grievances in which timely notification was given
C.	Number of Expedited Grievances
D.	Number of Expedited Grievances in which timely notification was given
E.	Number of Dismissed Grievances

II. ORGANIZATION DETERMINATIONS & RECONSIDERATIONS

This section requires a file upload.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
01 – Local CCP 02 –MSA 03– RFB PFFS 04 - PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	Last Monday of February in the following year.

Data Element ID	Data Element Description
Subsection #1	Organization Determinations
A.	Total Number of Organization Determinations Made in the Reporting Period Above
B.	Number of Organization Determinations - Withdrawn
C.	Number of Organization Determinations - Dismissals
D.	Number of Organization Determinations requested by enrollee/representative or provider on behalf of the enrollee (Services)
E.	Number of Organization Determinations submitted by Enrollee/Representative (Claims)
F.	Number of Organization Determinations requested by Non-Contract Provider (Services)
G.	Number of Organization Determinations submitted by Non-Contract Provider (Claims)
Subsection #2	**Disposition – All Organization Determinations**
A.	Number of Organization Determinations – Fully Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee

Data Element ID	Data Element Description
B.	Number of Organization Determinations – Fully Favorable (Services) Requested by Non-contract Provider
C.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by enrollee/representative
D.	Number of Organization Determinations – Fully Favorable (Claims) Submitted by Non-contract Provider
E.	Number of Organization Determinations – Partially Favorable (Services) Requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Organization Determinations – Partially Favorable (Services) Requested by Non-contract Provider
G.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by enrollee/representative
H.	Number of Organization Determinations – Partially Favorable (Claims) Submitted by Non-contract Provider
I.	Number of Organization Determinations – Adverse (Services) Requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Organization Determinations – Adverse (Services) Requested by Non-contract Provider
K.	Number of Organization Determinations – Adverse (Claims) Submitted by enrollee/representative
L.	Number of Organization Determinations – Adverse (Claims) Submitted by Non-contract Provider
Subsection #3:	**Reconsiderations**
A.	Total number of Reconsiderations Made in Reporting Time Period Above
B.	Number of Reconsiderations - Withdrawn
C.	Number of Reconsiderations - Dismissals
D.	Number of Reconsiderations requested by or on behalf of the enrollee (Services)
E.	Number of Reconsiderations submitted by Enrollee/Representative (Claims)
F.	Number of Reconsiderations requested by Non-Contract Provider (Services)
G.	Number of Reconsiderations submitted by Non-Contract Provider (Claims)
Subsection #4:	**Disposition – All Reconsiderations**
A.	Number of Reconsiderations – Fully Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
B.	Number of Reconsiderations – Fully Favorable (Services) requested by Non-contract Provider
C.	Number of Reconsiderations – Fully Favorable (Claims) submitted by enrollee/representative
D.	Number of Reconsiderations – Fully Favorable (Claims) submitted by Non-contract Provider
E.	Number of Reconsiderations – Partially Favorable (Services) requested by enrollee/representative or provider on behalf of the enrollee
F.	Number of Reconsiderations – Partially Favorable (Services) requested by Non-contract Provider

Data Element ID	Data Element Description
G.	Number of Reconsiderations – Partially Favorable (Claims) submitted by enrollee/representative
H.	Number of Reconsiderations – Partially Favorable (Claims) submitted by Non-contract Provider
I.	Number of Reconsiderations – Adverse (Services) requested by enrollee/representative or provider on behalf of the enrollee
J.	Number of Reconsiderations – Adverse (Services) requested by Non-contract Provider
K.	Number of Reconsiderations – Adverse (Claims) submitted by enrollee/representative
L.	Number of Reconsiderations – Adverse (Claims) submitted by Non-contract Provider
Subsection #5:	**Re-openings**
A.	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
B.	Contract Number
C.	Plan ID
D.	Case ID
E.	Case level (Organization Determination or Reconsideration)
F.	Date of original disposition
G.	Original disposition (Fully Favorable; Partially Favorable or Adverse)
H.	Was the case processed under the expedited timeframe? (Y/N)
I.	Case type (Service or Claim)
J.	Status of treating provider (Contract, Non-contract)
K.	Date case was reopened
L.	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
M.	Additional Information (Optional)
N.	Date of reopening disposition (revised decision)*
O.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

The date of disposition is the date the required written notice of a revised decision was sent per 405.982*

III. EMPLOYER GROUP PLAN SPONSORS

This reporting section requires an upload.

Organization Types Required to Report	Report Frequency/ Level	Report Period (s)	Data Due date (s)
01 – Local CCP 02 – MSA 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/year PBP	1/1 - 12/31	First Monday of February in the following year.

Data Element ID	Data Element Description
A.	Employer Legal Name
B.	Employer DBA Name
C.	Employer Federal Tax ID
D	Employer Address
E.	Type of Group Sponsor (employer, union, trustees of a fund)
F.	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
G.	Type of Contract (insured, ASO, other)
H.	Is this a calendar year plan? (Y (yes) or N (no))
I.	If data element His a “N", provide non-calendar year start date.
J.	Current/Anticipated Enrollment

IV. SPECIAL NEEDS PLANS (SNPs) CARE MANAGEMENT

This reporting section requires direct data entry into HPMS.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP Organizations should exclude 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	Last Monday of February in the following year.

Data Element ID	Data Element Description
A.	Number of new enrollees due for an Initial Health Risk Assessment (HRA)
B.	Number of enrollees eligible for an annual reassessment HRA
C.	Number of initial HRAs performed on new enrollees
D.	Number of initial HRA refusals
E.	Number of initial HRAs not performed because SNP is unable to reach new enrollees
F.	Number of annual reassessments performed on enrollees eligible for a reassessment
G.	Number of annual reassessment refusals
H.	Number of annual reassessments where SNP is unable to reach enrollee

Notes:

If a new enrollee does not receive an initial HRA within 90 days of enrollment that enrollee's annual HRA is due to be completed within 365 days of enrollment. A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.

V. ENROLLMENT AND DISENROLLMENT

This reporting section requires an upload into HPMS.

Organization Types Required to Report*	Report Frequency Level	Report Period	Data Due date (s)
MAOs offering MA- only (no Part D) plans 1876 Cost Plans (enrollments that do not include a Part D optional supplemental benefit)	2/Year Contract	1/1 - 6/30 7/1 – 12/31	Last Monday of August and February

CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests.

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

Note: Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30).

For questions specific to enrollment/disenrollment requirements please contact the following mailbox: https://enrollment.lmi.org

Data Element ID	Data Element Description
Subsection #1	**Enrollment**
A	The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS.
B.	Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).
C.	Of the total reported in A, the number of enrollment requests for which the sponsor was required to request additional information from the applicant (or his/her representative).

Data Element ID	Data Element Description
D.	Of the total reported in A, the number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (i.e. individual not eligible for an election period).
E.	Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F.	Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
G.	Of the total reported in A, the number of paper enrollment requests received
H.	Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism).
I.	Of the total reported in A, the number of electronic enrollment requests received via an electronic device or secure internet website (if sponsor offers this mechanism).
J.	Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.
K.	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.
Subsection #2:	**Disenrollment**
A.	The total number of voluntary disenrollment requests received in the specified time period. Do not include disenrollments resulting from an individual's enrollment in another plan.
B.	Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).
C.	Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.
D.	The total number of involuntary disenrollments for failure to pay plan premium in the specified time period.
E.	Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause.
F.	Of the total reported in E, the number of favorable Good Cause determinations.
G.	Of the total reported in F, the number of individuals reinstated.

VI. REWARDS AND INCENTIVES PROGRAMS

This is a partial data entry into HPMS and upload.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
01- Local CCP 02- MSA 03- RFB PFFS 04- PFFS 05- MMP 11- Regional CCP 12- 14- ED-PFFS 13- 15 - RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-12/31	Last Monday of February in following year

A plan user needs to select "*Yes" or "No*" for data element A. on the edit page. If the plan user selected "No", no upload is necessary. If the plan user selects "Yes", then the user will be required to upload additional information in accordance with the file record layout.

Data Element ID	Data Element Description
A.	Do you have a Rewards and Incentives Program(s)? (“Yes“ or “No” only;)
B.	Rewards and Incentives Program Name
C.	What health related services and/or activities are included in the program? [Text]
D.	What reward(s) may enrollees earn for participation? [Text]
E.	How do you calculate the value of the reward? [Text]
F.	How do you track enrollee participation in the program? [Text]
G.	How many enrollees are currently enrolled in the program? [NUM]
H.	How many rewards have been awarded so far? [NUM]

VII. PAYMENTS TO PROVIDERS

This reporting section requires a file upload.

Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements. See Technical Specs for additional information.

Organization Types Required to Report	Report Frequency Level	Report Period (s)	Data Due date (s)
01 – Local CCP 04 - PFFS 05 – MMP* 11 – Regional CCP 15 – RFB Local CCP	1/Year Contract	1/1-12/31	Last Monday of February in the following year.

*MMPs should report for all APMs not just Medicare APMs.

Data Element ID	Data Element Description
A.	Total Medicare Advantage payment made to contracted providers.
B.	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1).
C.	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2).
D.	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3)
E.	Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework)
F.	Total Medicare Advantage payment made using population-based payment (category 4).
G.	Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)
H.	Total number of Medicare Advantage contracted providers.
I.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1).
J.	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2).
K.	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3).
L.	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
M.	Total Medicare Advantage contracted providers paid based on population based payment (category 4).
N.	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).