DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

TO: All Part C and D Sponsors

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SUBJECT: CMS First Public Use File (PUF) of Plan-Reported Data

DATE: April 28, 2014

The purpose of this memo is to outline the proposed release of plan-reported data in a public use file (PUF). The first PUF will be released this Spring using CY2012 Part C and Part D Reporting Requirements data[1]. Any comments about this PUF should be submitted by May 12, 2014.

Since 2006, CMS has established reporting requirements for Part C and D sponsors. In 2011, for a subset of these data, CMS implemented Data Validation (DV) standards in order to ensure accuracy and consistency in sponsors' reporting. These data have primarily been used for internal monitoring within CMS and in aggregate form by other government entities. Recently, some of these data have been used to generate publicly reported display measures, and CMS may add some of these display measures to the Star Ratings in the future.

CMS has been encouraged to expand the availability of these data in support of transparency in the government. In the Office of Inspector General's (OIG) March 2014 report entitled "CMS Regularly Reviews Part C Reporting Requirements Data, But It's Follow up and Use of the Data are Limited" (OEI-03-11-00720), OIG recommended that CMS release PUFs containing plan-reported data collected via the Part C and D Reporting Requirements to increase accountability in the Medicare Program. In addition, since CMS has already received Freedom of Information Act (FOIA) requests for plan-reported data, we plan to construct this PUF. We believe the availability of these data for the general public, researchers and academic institutions, health care organizations, and government agencies will increase the accountability of plan sponsors and the quality of the care and services provided to Medicare beneficiaries.

[1] PUF will contain CY2011 SNP Care Management data, as validation of CY2012 data is not completed until June 2014.

CMS will release plan-reported data for the following CY2012 reporting sections:

- Enrollment and Disenrollment (Part C and Part D)
- Grievances (Part C and Part D)
- Special Needs Plans (SNPs) Care Management (Part C)
- Coverage Determinations and Exceptions (Part D)
- Organization Determinations/Reconsiderations (Part C)
- Long-Term Care (LTC) Utilization (Part D), excluding pharmacy identifiable information. LTC pharmacy data will be aggregated.
- Medication Therapy Management (MTM) Programs (Part D), excluding beneficiary identifiable information.
- Redeterminations (Part D)

Please refer to the Appendix for more information about the specific data elements to be included in the PUF, and about reporting sections that are excluded from the PUF. In general, CMS will not release data for sections that have been suspended by CMS, or reporting sections and/or data elements that contain highly sensitive data.

Each annual PUF will contain individual datasets for each reporting section, showing the raw data as reported by contracts. Contract and plan IDs will be included. Beneficiary-specific, proprietary, confidential, or otherwise sensitive information will be excluded. No calculations or performance thresholds will be applied. Only data meeting minimum enrollment criteria (denominator data < 11 will be excluded) will be released. For reporting sections that undergo DV, only data for contracts passing DV for the given section or element will be included. Contracts that did not pass DV will be shown as "CMS identified issues with plan's data." More information about the data validation standards can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartCDDataValidation.html.

Technical specifications such as reporting frequency and schedule, inclusions/exclusions, and other information that is important for accurate interpretation of the data elements will be provided with the PUF.

Please submit any comments about the plan-reported PUF to the mailboxes by May 12, 2014:

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

We ask that commenters provide support for any requests to exclude certain data, and specifically advise us about any potential effects if the data are released. For example, commenters may wish to say they believe some data contain confidential commercial information, and that the release of this information in a PUF could cause organizations substantial competitive harm or injury. Generalized conclusions of competitive harm are not a sufficient basis for CMS to exclude plan-reported data. Broad designations are not useful because, by law, we must disclose any reasonably segregable data that contains non-exempt information. We will consider all comments as we finalize the PUF specifications.

Thank you for your continued support of the Medicare Program.

Appendix A: Part C and D Reporting Requirements PUF: Reporting Sections and Data Elements

I. The following reporting sections will be included in the PUF. Data elements are listed as they appear in the CY2012 Part C and D Reporting Requirements documents.

Organization Determinations and Reconsiderations – Part C

Contract level

6.1 Number of organization determinations – Fully Favorable
6.2 Number or organization determinations – Partially Favorable
6.3 Number of organization determinations – Adverse
6.4 Number of reconsiderations – Fully Favorable
6.5 Number of reconsiderations – Partially Favorable
6.6 Number of reconsiderations – Adverse

Special Needs Plans (SNPs) Care Management – Part C

Contract level

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

Coverage Determinations and Exceptions – Part D

Plan level

A. The total number of pharmacy transactions
B. Of the total reported in A, the number of pharmacy transactions rejected due to formulary restrictions, including non-formulary status, PA requirements, step therapy, and quantity limits (QL)
C. Total number of PAs
E. Number of approved PAs (PA requirements satisfied)
F. Total number of UM exceptions
H. Number of favorable UM exceptions
I. Total number of tier exceptions
K. Number of favorable tier exceptions
L. Total number of formulary exceptions
N. Number of favorable formulary exceptions

Grievances – Part C and Part D

Plan level

A. Total number of grievances – Enrollment, plan benefits, or pharmacy access
B. Number of grievances in which timely notification was given – Enrollment, plan benefits, or pharmacy access
C. Total number of grievances – Customer service

D. Number of grievances in which timely notification was given – Customer service
E. Total number of grievances – Coverage determinations and Redeterminations process (e.g. untimely decisions)
F. Number of grievances in which timely notification was given – Coverage determinations and Redeterminations process (e.g. untimely decisions)
G. Total number of grievances – Other
H. Number of grievances in which timely notification was given – Other

Long-term Care (LTC) Utilization – Part D

Contract level

A. The total number of network LTC pharmacies in the service area (PDPs and regional PPOs will report for each state, MA-PDs will report for the service area)
B. The total number of network retail pharmacies in the service area (PDPs and regional PPOs will report for each state, MA-PDs will report for the service area)
C. The total number of beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract
D. Aggregated for all network LTC pharmacies in the service area:
   5. Number of 31-day equivalent formulary prescriptions dispensed
   6. Number of 31-day equivalent non-formulary prescriptions dispensed
   7. Cost of formulary prescriptions
   8. Cost of non-formulary prescriptions
E. Aggregated for all retail pharmacies in the service area:
   1. Number of 30-day equivalent formulary prescriptions dispensed
   2. Number of 30-day equivalent non-formulary prescriptions dispensed
   3. Cost of formulary prescriptions (aggregated)
   4. Cost of non-formulary prescriptions (aggregated)

Medication Therapy Management (MTM) Programs – Part D

Contract level, where each record will represent a beneficiary:

A. Contract Number
F. Age band will be provided in lieu of Beneficiary date of birth (under 65, 66-74, 75-84, and 85 and above)
G. LTC Enrollment
H. Date of MTM program enrollment
I. Date of MTM program opt-out, if applicable
J. Reason participant opted-out of MTM program
K. Offered annual comprehensive medication review
L. If offered, date of (initial) offer
M. Received annual comprehensive medication review (CMR)
N. If received, date(s) of annual comprehensive medication review(s)
O. Number of targeted medication reviews
P. Number of prescriber interventions
Q. Number of changes to drug therapy made as a result of MTM interventions

Redeterminations – Part D

Plan level

A. Total number of redeterminations
C. Number of partially favorable redeterminations
D. Number of fully favorable redeterminations

Enrollment and Disenrollment – Part C and Part D

Contract level

Enrollment:

A. The total number of enrollment requests received
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 that required requests for additional information
D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not having a valid enrollment period)
E. Of the total reported in C, the number of incomplete enrollment requests received that are 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 offered)
I. Of the total reported in A, the number of internet enrollment requests received via plan website (if offered)
J. Of the total reported in A, the number of Online Enrollment Center (OEC) enrollment requests received
K. For stand-alone prescription drug plans (PDPs) only: Of the total reported in 1, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual)
L. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage
M. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP
N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the total number of enrollment transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period
O. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period Code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction

Disenrollment:

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

II. Reporting Sections excluded from the PUF:

- Data that are non-validated and are used for CMS monitoring only:
  - PFFS Plan Enrollment Verification Calls (Part C)
  - PFFS Provider Payment Dispute Resolution Process (Part C)

- Reporting sections that have been suspended by CMS:
  - Provider Network Adequacy (Part C)
  - Procedure Frequency (Part C)
  - Fraud, Waste, and Abuse Compliance Programs (Part D)
  - P&T/Provision of Part D Functions (Part D)
  - Pharmacy Support of Electronic Prescribing (Part D)
  - Prompt Payment by Part D Sponsors (Part D)
  - Plan Oversight of Agents (Part C and Part D)

Additional Exclusions

- Data reported for the Serious Reportable Adverse Events (Part C) reporting section and data elements reported for the Organization Determination/Reconsiderations (Part C), Coverage Determinations and Exceptions, and Redeterminations (Part D) reporting sections related to timeliness of decisions will not be released due to low reliability and inconsistent reporting.

- CMS considers data reported for the Retail, HI, and LTC Pharmacy Access/Waivers (Part D) and the Employer Group Plan Sponsors (Part C and Part D) reporting sections to be sensitive and will not include those data in the PUF. CY2012 data reported to CMS for the reporting section, Retail, HI, and LTC Pharmacy Access/Waivers will not be released, as they were primarily used to for piloting the submission process and geocoding reports.