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Industry Collaboration Effort

ICE UM WORK PLAN
UM REQUIRED REPORTS TEAM

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December 9, 2019

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WHY REPORT?

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- We need to report to the health plans so they can report to:
  - DHCS
  - DMHC
  - CMS

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WHY REPORT? (CONT.)

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- Health Plans need to have oversight of our activities, such as:
  - Beddays
  - Denials
  - Complex Case Management

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HOW DATA IS COLLECTED

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- ❑Claims
- ❑Authorization System
- ❑Case Management System
- ❑Data Warehouse

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WHERE TO START WITH UM WORK PLAN

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- ❑Instructions
  - •Use as your guide when completing the work plan
    - ▪Refer to suggestions
- ❑Definitions
  - • Work Plan Terms
  - • Inpatient stats

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WHERE TO START WITH UM WORK PLAN (CONT.)

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- ❑Definitions (Continued)
  - •Denials
  - •ER visits
  - •Referral Turn-Around-Time (TAT)
- ❑Once you enter your Organization Name it will show up on every page thereafter

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WHERE TO START WITH UM WORK PLAN (CONT.)

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- ❑Enter the Report Type, this will show up on every page thereafter
- ❑Attestation Questions
  - •Information provided MUST be Plan specific
  - •ER stats based on date of service
  - •N/A if not delegated CCM or SNP stats
  - •Over/Under STATS important Health Plan specific

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WHERE TO START WITH UM WORK PLAN (CONT.)

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- **·Tab C. SIGNATURE PAGE**

- ❑Sections I-IV
  - •Section I -III
    - ▪Complete once, unless changes in the reporting period
- ❑Sections I-IV
  - •Initial Work Plan
    - ▪Due February 15th

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WHERE TO START WITH UM WORK PLAN (CONT.)

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- ❑Section IV (Continued)
  - •Semi-Annual Reporting
    - ▪Due August 15th and February 15th
  - •Quarterly Reporting
    - ▪Due: May 15th, August 15th, November 15th and February 15th
  - •Annual Evaluation
    - ▪Due February 15th

HINT – Hide rows

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TAB 1: INPATIENT METRICS

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- ❑Complete 2019 YTD STATS
- ❑Add 2020 Goals
- ❑Check here if not delegated for LOB
- ❑Check if there are NO Inpatient STATs to report
- ❑Insert Quarterly or Semi-Annual STATS
- ❑Hide the rows or LOBs not reporting
- ***You will complete these areas in all TABs***

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TAB 1: INPATIENT METRICS (CONT.)

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INPATIENT METRICS	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Commercial		☐ Check here if you are not delegated for LOB commercial				☐ Check if NO Inpatient Data			
Member Months (Self-Reported)									
Acute Bed days/1000									
Acute Admits/ 1000									
Acute Average LOS									
Acute Readmits/ 1000									
SNF Bed days/ 1000									
SNF Admits/1000									
SNF Average LOS									
SNF Readmits/1000									
LTAC Bed days/1000									
LTAC Admits/1000									
LTAC Average LOS									
LTAC Readmits/1000									
Rehab Bed days/1000									
Rehab Admits/1000									
Rehab Average LOS									
Rehab Readmits/ 1000									

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TAB 2: INPATIENT WP & REPORTS

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Inpatient Utilization: Goals, Analysis, Interventions and Evaluation	
☐ Check if Reporting Semi Annually	☐ Check if Reporting Quarterly

- ✓Check reporting frequency

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TAB 2: INPATIENT WP & REPTS ANNUAL GOALS, ANALYSIS INTERVENTIONS AND EVALUATION (CONT.)

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Inpatient Utilization: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles

- ❑Inpatient Utilization
  - Complete once
    - Initial Work Plan Goals
    - Planned Activities
    - Target Date(s) to Complete
    - Responsible Person(s) and Titles

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TAB 2: INPATIENT WP & REPTS ANNUAL GOALS, ANALYSIS INTERVENTIONS AND EVALUATION (CONT.)

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Report Period	Key Findings and Analysis	Interventions / Follow-up Actions	Remeasurement
Q1			
Q2			
Q3			
Q4			
Annual			

Report Period (For ALL Quarters and Semi-annual reporting periods)	Key Findings and Analysis (For ALL Quarters and Semi-annual reporting periods)	Interventions / Follow-up Actions (For ALL Quarters and Semi-annual reporting periods)	Remeasurement (For ALL Quarters and Semi-annual reporting periods)
REMINDERS: Review the IOE website for all current templates. Review the IOE Semi-Annual template instructions page for examples.	List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue) REMINDERS: address metrics that are not provided in the key findings/analysis. For example, if there are no urgent concurrent metrics the comments should address there are on no urgent concurrent metrics. If the metrics are below benchmark the comments should address why goals were not met. If the metrics are below benchmark did the results improve from the previous reporting period? If lower than the previous reporting period, why are the interventions the group implement not improving (root cause) the metrics to move toward meeting benchmark?	State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.) REMINDER: If the metrics are below benchmark the comments should address the group's action plan and interventions to help meet the goals.	State target date(s) for re-measurement or completion of follow-up actions. REMINDER: If the metrics are below benchmark the comments should address the group's plan to reassess implemented by the group.
Q1			
Q2			
Q3			
Q4			
Annual			

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TAB 2: INPATIENT WP & REPTS OVER/UNDER UTILIZATION (CONT.)

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UM OVER & UNDER UTILIZATION STATISTICS			
Report Period (For ALL Quarters and Semi-annual reporting periods)	Key Findings and Analysis (For ALL Quarters and Semi-annual reporting periods)	Interventions / Follow-up Actions (For ALL Quarters and Semi-annual reporting periods)	Remeasurement (For ALL Quarters and Semi-annual reporting periods:
REMINDERS: Review the IOE website for all current templates. Review the IOE Semi-Annual template instructions page for examples.	List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue) REMINDERS: address metrics that are not provided in the key findings/analysis. For example, if there are no urgent concurrent metrics the comments should address there are no no urgent concurre nt metrics. If the metrics are below benchmark the comments should address why goals were not met. If the metrics are below benchmark did the results improve from the previous reporting period? If lower than the previous reporting period, why are the interventions the group implement not improving (root cause) the metrics to move toward meeting bench mark?	State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.) REMINDER: If the metrics are below benchmark the comments should address the group's action plan and interventions to help meet the goals.	State target date(s) for re-measurement or completion of follow up actions. REMINDER: If the metrics are below benchmark the comments should address the group's plan to reassess implemented by the group.
Q1			
Q2			
Q3			
Q4			
Annual			

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TAB 3:REFERRAL METRICS

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REQUEST METRICS	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
Commercial	☐ Check here if you are not delegated for Commercial								
Member Months (Self-Reported)	#REF!				-	-	-		
Outpatient Pre-Service									
Routine: Raw									
Urgent: Raw									
Urgent: Concurrent: Raw									
Routine: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Urgent: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Urgent: Concurrent: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Inpatient Pre-Service									
Routine: Raw									
Urgent: Raw									
Urgent: Concurrent: Raw									
Routine: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Urgent: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Urgent: Concurrent: PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Denied									
Total									
%	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PTMPY	#REF!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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TAB 5: ER METRICS

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ER UTILIZATION METRICS (Medical Necessity Only)	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
☐ Check if data was pulled from Claims (Claims Data should be Administrative)			☐ Check if data was pulled from UM Data						
Commercial	☐ Check here if you are not delegated for Commercial								
Member Months (Self-Reported)									
Total # ER visits: Raw									
Denied ER visits: Raw									
Denied ER visits by: %									
Total # ER visits: PTMPY									
Denied ER visits: PTMPY									
Medicare	☐ Check here if you are not delegated for Medicare								
Member Months (Self-Reported)									
Total # ER visits: Raw									
Denied ER visits: Raw									
Denied ER visits by: %									
Total # ER visits: PTMPY									
Denied ER visits: PTMPY									

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TAB 6: ER WP & RPTS

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Provider Organization Name:	Organization Name
Report Type:	Report Type

ER Utilization: Goals, Analysis, Interventions and Evaluation (Medical Necessity Only)

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TAB 7:COMPLEX CM METRICS

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Provider Organization Name:	Organization Name	☐ Check here if you are not delegated for Commercial
Report Type	Report Type	☐ Check here if you are not delegated for Medicare
		☐ Check here if you are not delegated for Medi-Cal

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.

COMPLEX CASE MANAGEMENT (CCM) METRICS	2019 YTD	2019 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual Average (Semi-Annual)
Total Membership (Commercial)									
Total Membership (Medicare) Include SNP Members									
Total Membership (Medi-Cal)									
Total # of CM Members Identified									
Commercial									
Medicare									
Medi-Cal									
Total # of CM Cases Declined									
Commercial									
Medicare									
Medi-Cal									
Total # of CM Cases Unable to Reach (UTR)									
Commercial									
Medicare									
Medi-Cal									

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TAB 7:COMPLEX CM METRICS (CONT.)

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Total # of CM Cases Enrolled and Managed									
Commercial									
Medicare									
Medi-Cal									
Total # of CM Cases - Open (Reporting Period)									
Commercial									
Medicare									
Medi-Cal									
Total # of CM Cases - Open (Reporting Period) >60 calendar days									
Commercial									
Medicare									
Medi-Cal									
Total # of CM Cases Closed (Reporting Period)									
Commercial									
Medicare									
Medi-Cal									
%CCM Cases Open and Closed / Enrollment									

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TAB 7:COMPLEX CM METRICS (CONT.)

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# of CCM Large claimant cases (>$75K) Identified/Accepted CMs as required by Health Plan									
Commercial									
Medicare									
Medi-Cal									
# of CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan									
Commercial									
Medicare									
Medi-Cal									
%CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan									
Commercial	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicare	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medi-Cal	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
%of Population Enrolled									
Commercial % Enrolled	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicare % Enrolled	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medi-Cal % Enrolled	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Annual Population Assessment	Enter 2019 Report under tab 8. Complex CM WP & Rpts								
Annual CCM Member Experience	Enter 2019 Report under tab 8. Complex CM WP & Rpts								
% Passive Experience									
Annual Measuring Effectiveness	Enter 2019 Report under tab 8. Complex CM WP & Rpts								
(Measure 1)									
(Measure 2)									
(Measure 3)									

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TAB 7:COMPLEX CM METRICS DEFINITIONS (CONT.)

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Notes:	
Total #of CM identified	Total raw number of CM cases identified for potential case management enrollment identified by the delegate during the reporting period. This includes the raw number of members included on predictive analytic reports, high dollar pharmacy, inpatient reports, reports by high risk diagnosis, claims, and the rest as all referrals from all sources.
Total #of CM Cases Enrolled and Managed	Total raw number of CM referrals serviced by the delegate during the reporting period. Service refers to members enrolled that closed during the reporting period and those still open at the end of the reporting period.
Total #of CM Cases - Open	Total raw number of open CM referrals serviced by the delegate during the reporting period. Serviced refers to members enrolled during the reporting period and the case is still open at the end of the reporting period.
Total #of CM Cases - Declined	Total raw number of declined CM referrals serviced by the delegate during the reporting period. Serviced refers to members enrolled during the reporting period that closed at the end of the reporting period.
Total #of CM Cases - Unable to Reach (UTR)	Total raw number of CM referrals serviced by the delegate during the reporting period. Service refers to members enrolled that closed during the reporting period.
% of members in CM	The number of members serviced in CM during the reporting period divided by the number of total members. Expressed as a percentage. The numbers of members serviced include cases closed during the reporting period and also the members still open during the reporting period.
# CCM Large claimant cases (>$75K) identified/Accepted - as required by Health Plan	Total number of members who accepted case management and are currently enrolled into the case management program for this reporting period with claims greater than $75K
# CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan	Total number of members reviewed for case management within 30 days from the date of identification with claims greater than $75K
% CCM Large claimant cases (>$75K) reviewed within 30 days - as required by Health Plan	Total number of members reviewed for case management within 30 days from date of identification with claims greater than $75K, expressed as a percentage.

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TAB 8: CCM WP & RPTS

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Complex Case Management (CCM): Goals, Analysis, Intervention and Evaluation (Refer to NCQA UM Delegation Report UM_D.5M & 5NP Instruction & Sample Documents) Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Title(s)
Annual CCM Population Assessment: CCM program design must meet the needs of its population. Relevant characteristics and needs of its member population and potential members must be identified annually. The assessment must include needs of children and adolescents, individuals with disabilities and individuals with serious and persistent mental illness (SPMI). Source: 2019 NCQA P+MI 6 Element A, Factor 1-4	Delivered by analytics or provider		
Annual CCM Member Experience: Evaluate separately Evaluate experience by obtaining feedback from members and analyzing member complaints. Examples: 1. Did CM help you understand the treatment plan? 2. Did the case manager help you get the care you needed? 3. Did the CM pay attention to you and help you with problems? 4. Did the CM treat you with courtesy and respect? 5. How satisfied are you with the CM program? Source: 2019 NCQA P+MI 6 CCM: Element F, Factor C			
Annual CCM Program Effectiveness Analysis: Describe 3 effectiveness measurement goals and describe activities to achieve these goals For Each Measure, the organization: 1. Uses a valid method that provides outcome 2. Uses valid method that provide quantitative results 3. Sets performance goal 4. Clearly identifies measure specifications 5. Collects data and analyzes results 6. Identifies opportunities for improvement, if applicable. Source: 2019 NCQA P+MI 6 Element A, Factor 1-3			

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TAB 8: CCM WP & RPTS (CONT.)

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Report Period (For ALL Quarters and Semi-annual reporting periods) REMINDERS: Review the ICE website for all current templates. Review the ICE Semi-Annual template instructions page for examples.	Key Findings and Analysis (For ALL Quarters and Semi-annual reporting periods) List any problems in reaching the goal or relevant data (i.e. were if goals were met or not met, include what caused the problem/issue.) REMINDERS: address metrics that are not provided to the key findings/analysis. For example, if there are no urgent concurrent metrics the comments should address there are no urgent concurrent metrics. If the metrics are below benchmark the comments should address what goals were not met. If the metrics are below benchmark did this result to improve from the previous reporting period?	Interventions / Follow-up Actions (For ALL Quarters and Semi-annual reporting periods) State what will be done to meet the goal (ie. continue with plan as listed or modify the plan, add a specific new process, etc.) REMINDERS: If the metrics are below benchmark the comments should address the group's action plan and interventions to help meet the goals.	Reassessment (For ALL Quarters and Semi-annual reporting periods) State target date(s) for re-measurement or completion of follow-up actions. REMINDERS: If the metrics are below benchmark the comments should address the group's plan to reassess implemented by the group.
CCM Population Assessment			
CCM Member Experience			
CCM Goals Not Met			
CCM Program Effectiveness Analysis: Describe 3 effectiveness measurement goals and describe activities to achieve these goals. Source: 2019 NCQA P+MI 6 Element A, Factor 1-3	Program Related Process or Outcome (PHM: Identifies a relevant process or outcome) Enter for Initial Workplan	Methodology (PHM: Uses valid method that provide quantitative results) Enter for Initial Workplan	Performance Goal (PHM: Sets performance goal) Enter for Initial Workplan
Measure 1:			
Measure 2:			
Measure 3:			

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TAB 9: SNP METRICS

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MEDICARE SPECIAL NEEDS PLANS	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
SNP Care Management (CM) Metrics									
Source: CMS Managed Care Manual: SNP MOC, MOC 2, Element C, Factor C.1		☐ Check here if you are not delegated for SNP							
Total # of SNP members									
Total # of Members Enrolled in D-SNP MOC									
Total # D-SNP MOC CM Cases- Open									
Total # D-SNP MOC CM Cases- Declined Open									
Total # D-SNP MOC CM Cases- Unable to Reach (UTR)									
% D-SNP members enrolled in MOC-CM	#DIV/0!								
% D-SNP members refusing CM (Declined/ Opt-Out	#DIV/0!								
Total # D-SNP assessments completed									
Total # D-SNP care plans developed									
Total # D-SNP CM SCPs with documentation of ICT coordination of member care									
Total # of C-SNP members									
Total # of Members Enrolled in C-SNP MOC									
Total # C-SNP MOC CM Cases- Open									
Total # C-SNP MOC CM Cases- Declined Open									
Total # C-SNP MOC CM Cases- Unable to Reach (UTR)									
% D-SNP members identified for CM	#DIV/0!								
% C-SNP members enrolled in CM	#DIV/0!								
% D-SNP members refusing CM/Opt-Out	#DIV/0!								
Total #C- SNP assessments completed									
Total #C- SNP care plans developed									
Total #C- SNP CM SCPs with documentation of ICT coordination of member care									

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TAB 9: SNP METRICS (CONT.)

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Annual SNP Program Education Efforts									
Staff (Note target completion date under goal; indicate annual completion under reporting period. Reference if training will be requested at the time of enrollment. Source: SNP MOC, MOC 2, Element A (A.5-A.6); MOC 3, Element C (C.1-C.2)									
Practitioners (Note target completion date under goal; indicate annual completion under reporting period. Reference if training will be requested at the time of enrollment. Source: SNP MOC, MOC 2, Element A (A.5-A.6); MOC 3, Element C (C.1-C.2)									
SNP Care Transition									
Data Elements: Transition to Health Care Settings									
Total # Home Health									
Total # SNP hospital admits									
Total # SNP member SNF/LTC admits									
Total # Rehabilitation Facility									
Total # of outpatient/ambulatory care/surgery center transitions (as depicted by Health Plan)									
Compliance with Care Coordination									
% Care plan transfer between health care settings									
% Practitioner notification within set timeframe									
% Member/caregiver communication and education about changes in member's condition and self-management as result of transitions									
% Member/caregiver provided consistent person or unit responsible through transitions									
Annual Population Assessment	Annual 2019 Report Under Tab 10: SNP-ICE & Goals								

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TAB 10: SNP GOALS

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Special Needs Plans: Goals, Analysis, Interventions and Evaluation
(Refer to ICE UM Delegation Report UM, CCM & SNP Instruction & Example Document)

Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
SNP Care Transition:			
Data Elements: Transition to Health Care Settings Enter planned activities on how group will track transitions to the various Health Care Settings. Source: CMS: SNP MOC: MOC 2, Element E, Factor: E.1			
Compliance with Care Coordination: Enter planned activities on how group will track and document compliance with Transition of Care Coordination: 1. Care plan transfer between health care settings 2. Practitioner notification within set timeframe 3. Member/caregiver communication and education about changes in member's condition and self-management as result of transitions 4. Member/caregiver provided consistent person or unit responsible through transitions Source: CMS: SNP MOC: MOC 2, Element E, Factor: E.1, E.3, E.5, E.6			
Annual SNP Program Education CMS: SNP MOC: MOC 2, Element A (A.5-A.6); MOC 3, Element C (C.1-C.2)			

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TAB 10: SNP GOALS (CONT.)

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UTILIZE THIS SECTION IF HEALTH PLAN REQUIRES SEMI-ANNUAL REPORT ONLY

Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e. stated f goals w ere met or not met, include what caused the problem/issue)	Interventions / Follow-up Actions State what w ill be done to meet the goal (i.e. continue w th plan as listed or modify the plan; add a specific new process, etc.)	Remeasurement State target date(s) for re-measurement or completion of follow -up actions.
1st Semi-annual **A. Data Elements- Transition to Health Care Settings** **B. Compliance with Care Coordination:** 1. Care plan transfer betw een health care settings 2. Practitioner notification w ithin set timeframe 3. Member/caregiver communication and education about changes in member's condition and self-management as result of transition within set time. 4. Member/caregiver provided consistent person or unit responsible through transitions			

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TAB 11: CMC METRICS

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MEDICARE CMC PLANS	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
CMC Care Management (CM) Metrics		☐ Check here if you are not delegated for CMC							
Total # of CMC members									
% CMC members identified for CM									
% CMC members enrolled in CM									
% CMC members refusing CM Opt-Out									
Total # CMC assessments completed									
%CMC care plans developed									
% CMC ICP's with documentation of ICT coordination of member care									
Measuring Effectiveness									
% Positive Experience									
1. Beddays per 1000 = 700/1000									
2. Member Participation in ICT									
Quality Metrics									
% CMC members with discussion of care goals documented in ICP									
% CMC members with documentation of flu vaccine in ICP									
% CMC members with documentation of fall risk assessment and education on fall prevention in ICP									
For CMC members receiving Behavioral Health Services (e.g., County Mental Health), % of CMC ICP's with documentation of Behavioral Health Care Coordination									

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TAB 11: CMC METRICS (CONT.)

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Annual CMC Program Education Efforts									
Staff-serve target completion date under goal; fields are actual completion under reporting period)									
(Practitioners serve target completion date under goal; fields are actual completion under reporting period)									
CMC Transitions of Care									
Data Elements									
Total # CMC hospital admits									
Total # CMC member SNFs, TC admits									
Total # CMC admits through ER									
Total # ER visits, CMC members									
Total # of outpatient ambulatory care interactions as required by readmission									
Total # CMC members with follow up visit within 30 days of hospital discharge									
Compliance with Timeframes									
Managing Transition									
% Care plan transition in 1 business day									
% Practitioner notification within set timeframe									
Supporting Member									
% Member/caregiver communication about care transition process within set timeframe									
% Member/caregiver communication about changes to member's health status and plan of care within set timeframe									
% Member/caregiver provided consistent person or unit responsible through transitions									
Reducing Unplanned Transition									
% Monthly identification of members at risk of admission. (Information maybe extracted from the following: data from claims, UM/Reports (e.g.Readmission Report, Frequent ER Visit, provider report, predictive modeling, etc.)									
% Annual identification of members at risk of admission through analysis of member admissions to hospital and ED visit									

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TAB 12: CMC WP & RPT

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Cal MediConnect: Goals, Analysis, Interventions and Evaluation

Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
Case Management Care Coordinator to member ratio ICP Completion ICT documentation			
Measuring Effectiveness Member Experience Beddays Readmission rate			
Quality Withholds Discussion of care goals Flu Vaccine documentation Fall Risk assessment and education Behavioral Health Care Coordination			
Annual CMC Training of Staff and Providers			
CMC Transition of Care			
Reducing Unplanned Transition			

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TAB 12: CMC WP & RPT (CONT.)

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UTILIZE THIS SECTION IF HEALTH PLAN REQUIRES SEMI ANNUAL REPORT ONLY			
Report Period (For ALL Quarters and Semi-	**Key Findings and Analysis (For ALL**	**Interventions / Follow up Actions**	**Remeasurement (For ALL Quarters**
1st Semi-annual 1.Case Management 2.Measuring Effectiveness 3. Quality Metrics 4. CMC Training for Staff and Providers 5. CMC Transition of Care 6. Reducing Unplanned Transition			
2nd Semi-annual 1.Case Management 2.Measuring Effectiveness 3. Quality Metrics 4. CMC Training for Staff and Providers 5. CMC Transition of Care 6. Reducing Unplanned Transition			
ANNUAL			
Annual 1.Case Management 2.Measuring Effectiveness 3. Quality Metrics 4. CMC Training for Staff and Providers 5. CMC Transition of Care 6. Reducing Unplanned Transition			
UTILIZE THIS SECTION IF HEALTH PLAN REQUIRES QUARTERLY REPORT ONLY			
Q1 1.Case Management 2.Measuring Effectiveness 3. Quality Metrics 4. CMC Training for Staff and Providers 5. CMC Transition of Care 6. Reducing Unplanned Transition			

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TAB 13: UM TAT METRICS

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UM REQUESTS TIMEFRAME COMPLIANCE	2019 YTD	2020 Goal	Q1	Q2	1st Semi Annual	Q3	Q4	2nd Semi Annual	Annual
Commercial ☐ Check here if you are not delegated for this									
Urgent Concurrent *decision and notification within 24 hours of the request*									
Total # decision compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # notification compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Urgent Pre. Service *decision and written notification not to exceed 72 hours after receipt of request.*									
Total # decision compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # notification compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Non-Urgent Preservice *decision within 5 business days of receipt of request, written notification within 2 business days of decision*									
Total # decision compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # notification compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Postservice *decision and written notification within 30 days of receipt of request*									
Total # decision compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # notification compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									

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TAB 14: UM TAT WP & REPORTS

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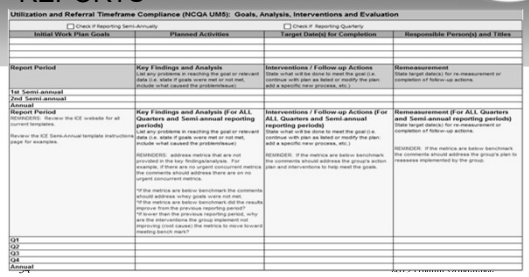

Utilization and Referral Timeframe Compliance (NCQA UM5): Goals, Analysis, Interventions and Evaluation

☐ Check if Reporting Semi-Annually ☐ Check if Reporting Quarterly

Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	**Interventions / Follow-up Actions** State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	**Remeasurement** State target date(s) for re-measurement or completion of follow-up actions.
1st Semi-annual			
2nd Semi-annual			
Annual			
Report Period REMINDER: Review the ICE website for all current templates. Review the ICE Semi-Annual template instructions page for examples.	**Key Findings and Analysis (For ALL Quarters and Semi-annual reporting periods)** List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue) REMINDER: address metrics that are not provided in the key findings/analysis. For example, if there are no urgent concurrent metrics, the comments should address there are on no urgent concurrent metrics. If the metrics are below benchmark the comments should address why goals were not met. If the metrics are below benchmark did the results improve from the previous reporting period? If the metrics are below benchmark why are the interventions the group/plan not improving (root cause) the metrics to move toward meeting bench mark?	**Interventions / Follow-up Actions (For ALL Quarters and Semi-annual reporting periods)** State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.) REMINDER: If the metrics are below benchmark the comments should address the group's action plan and interventions to help meet the goals.	**Remeasurement (For ALL Quarters and Semi-annual reporting periods)** State target date(s) for re-measurement or completion of follow-up actions. REMINDER: If the metrics are below benchmark the comments should address the group's plan to reassess implemented by the group.
Q1			
Q2			
Q3			
Q4			
Annual			

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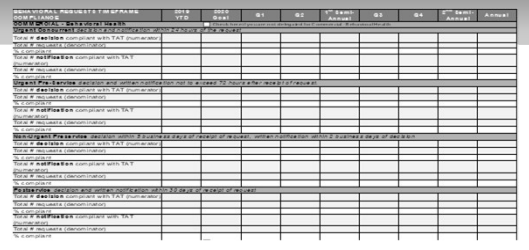
TAB 15: BH METRICS

2019 Annual Conference

Industry Collaboration Effort



BEHAVIORAL REQUEST TIMEFRAME COMPLIANCE	2019 YTD	2020 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
BEHAVIORAL - Behavioral Health									
Urgent Concurrent decision and notification within 24 hours of receipt of request									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Urgent Pre-Service decision and written notification not to exceed 72 hours after receipt of request									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Non-Urgent Preservice decision within 5 business days of receipt of request, written notification within 2 business days of decision									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Retrospective decision and written notification within 30 days of receipt of request									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									

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TAB 16: PHARMACY METRICS CALMEDICONNECT (CONT.)

2019 Annual Conference

Industry Collaboration Effort

Non-Urgent Preservice *decision within 5 or 14 (Health Plan Specific) business days of receipt of request, written notification within 2 business days of decision*

Turn Around Times	☐ Check here if you are using 5 Days			☐ Check here if you are using 14 Days					
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									

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TAB 17: PHARMACY METRICS

2019 Annual Conference

Industry Collaboration Effort

COMMERCIAL - Pharmacy ☐ Check here if you are not delegated for Commercial - Pharmacy									
Urgent Concurrent *(exigent) decision and notification within 24 hours of the request*									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Urgent Preservice *(exigent) decision and notification within 24 hours of the request*									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Non-Urgent Preservice *decision and notification within 72 hours of receipt of request*									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Postservice *decision and written notification within 30 days of receipt of request*									
Total # **decision** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									
Total # **notification** compliant with TAT (numerator)									
Total # requests (denominator)									
% compliant									

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TAB 18: EXPERIENCE WP & RPTS

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Industry Collaboration Effort

Experience with UM Process (NCQA QM 4,Element G, DMHC 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G)(5)): Goals, Analysis, Interventions and Evaluation

☐ Check if Reporting Semi-Annually ☐ Check if Reporting Quarterly

Initial Work Plan Goals (Review annual goal for both member and practitioner experience)	**Planned Activities** (Detail, and analyze complaints and appeals or use survey data to assess member and practitioner experience with the UM Process)	**Target Date(s) for Completion Complete Q_ 2020, present to committee Q_ 2020**	**Responsible Person(s) and Titles**
Member experience			
Practitioner experience			

Report Period	**Key Findings and Analysis** (List type of survey. Identify areas of improvement. List any problems in reaching the goal or relevant data (i.e. status if goals were met or not met, any barriers that caused the problem/s exist)	**Interventions / Follow-up Actions** (State when the results were presented to committee. State what will be done to meet the goal (i.e., continue with plan as listed or modify the plan and a specific new process, etc.)	**Remeasurement** (State target date(s) for remeasurement or completion of follow-up actions.
1st Semi-annual	Member experience. Practitioner experience.		
2nd Semi-annual	Member experience. Practitioner experience.		
Annual			

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TAB 20: IRR WP & RPTS

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Industry Collaboration Effort

Report Period	**Key Findings and Analysis** Document review methodology Document the data, score and type of review conducted for physician and non-physician reviewers. Document results and if benchmark was met	**Interventions / Follow-up Actions** Document training activities for those that did not meet the benchmark. Document dates and follow up activities Document date to committee.	**Remeasurement** (State target date(s) for re-measurement or completion of follow-up actions.
1st Semi-annual			
2nd Semi-annual			
Annual			
Report Period	**Key Findings and Analysis** Document review methodology Document the data, score and type of review conducted for physician and non-physician reviewers. Document results and if benchmark was met	**Interventions / Follow-up** Document training activities for those that did not meet the benchmark. Document dates and follow up activities Document date to committee.	**Remeasurement** (State target date(s) for re-measurement or completion of follow-up actions.
Q1			
Q2			
Q3			
Q4			
Annual			

Need to capture specifics for Clinical staff (nurses and physicians specifically) as well as non-clinical staff handling UM requests

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TAB 21: MISC. REPORTING (OPTIONAL ONLY)

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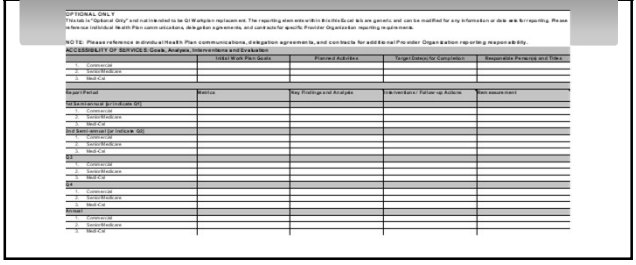

OPTIONAL ONLY

This tab is "Optional Only" and not intended to be QI Workplan replacement. The reporting elements within this Microsoft Excel tab are generic and can be modified for any information or data set for reporting. Please reference Individual Health Plan communications, delegation agreements, and contracts for specific Provider Organization reporting requirements.

NOTE: Please reference individual Health Plan communications, delegation agreements, and contracts for additional Provider Organization reporting responsibility.

ACCESSIBILITY OF SERVICES: Goals, Analysis, Interventions and Evaluation

	Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Title(s)
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				

Report Period	Metrics	Key Findings and Analysis	Interventions/ Follow-up Actions	Reassessment
1st Semiannual (or indicate Q1)				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
2nd Semiannual (or indicate Q2)				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Q3				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Q4				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Annual				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				

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TAB 20: EXPERIENCE WP & RPTS

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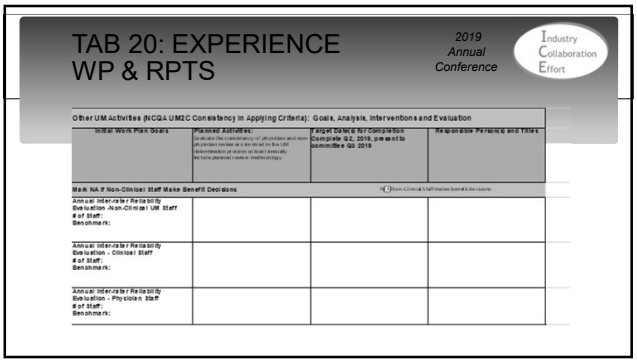

Other UM Activities (NCQA UM2C Consistency in Applying Criteria): Goals, Analysis, Interventions and Evaluation

Initial Work Plan Goals	Planned Activities: Evaluate the consistency of physician and non-physician reviewers involved in the UM determination process at least annually. Include planned review methodology.	Target Date(s) for Completion: Complete Q2, 2019, present to committee Q3 2019	Responsible Person(s) and Title(s)
Mark NA if Non-Clinical Staff Make Benefit Decisions		( ) Non-Clinical Staff makes benefit decisions	
Annual Inter-rater Reliability Evaluation -Non-Clinical UM Staff # of Staff: Benchmark:			
Annual Inter-rater Reliability Evaluation - Clinical Staff # of Staff: Benchmark:			
Annual Inter-rater Reliability Evaluation - Physician Staff # of Staff: Benchmark:			

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TAB 21: MISC. REPORTING (OPTIONAL ONLY) (CONT.)

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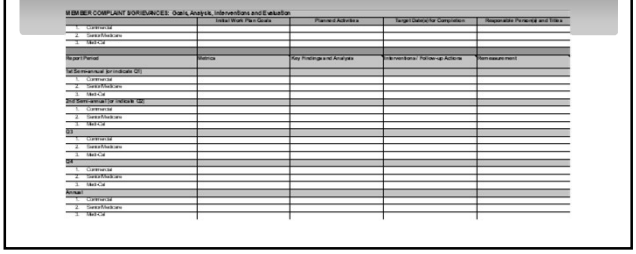

MEMBER COMPLAINT S/GRIEVANCES: Goals, Analysis, Interventions and Evaluation

	Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Title(s)
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				

Report Period	Metrics	Key Findings and Analysis	Interventions/ Follow-up Actions	Reassessment
1st Semiannual (or indicate Q1)				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
2nd Semiannual (or indicate Q2)				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Q3				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Q4				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				
Annual				
1. Commercial				
2. Senior/Medicare				
3. Medi-Cal				

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QUESTIONS

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ICE WEBSITE

2019 Annual Conference

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- Library
  - APPROVED ICE DOCUMENTS
    - QI/UM Required Reports Team
      - QI/UM Required Reports UM Documents 2020

http://www.iceforhealth.org/library.asp?sf=&sc=APPROVED+ICE+DOCUMENTS

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2019 CMS PART C REPORTING

December 9, 2019

Paula Gumpher, Clinical Compliance Manager, Anthem

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DEFINITIONS:

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Organization Determination:

- An organization determination is any decision made by a Medicare health plan regarding:
  - Authorization or payment for a health care item or service;
  - The amount a health plan requires an enrollee to pay for an item or service; or
  - A limit on the quantity of items or services.

2

2

DEFINITIONS:

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Reopening:

A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

3

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DEFINITIONS:

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- **Completed organization determinations and reconsiderations:**

(e.g., plan has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received.

- *Plans are to report an organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with*

4

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DEFINITIONS:

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Completed organization determinations and reconsiderations (continued):

the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M and the 'Enrollee Grievances, Organization/Coverage Determinations, and Appeals' Chapter of the Medicare Managed Care Manual via the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/MMCAG/

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2019 PART C "WHAT'S CHANGED?"

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- Data is based on member notification dates
- Element numbering is now alpha characters and the order
- Additional Category Elements
  - Enrollee/Provider Organization Determinations
  - Non-Contracted Provider Organization Determinations

6 December 9, 2019

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SOURCE DATA ELEMENTS

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The following source data elements are required for each organization determinations:

- Unique Plan Assigned ID
- Contract number
- Medicare Beneficiary ID (MBI) if available
- Plan ID (Plan Benefit Package)
- Delegated Entity Name

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SOURCE DATA ELEMENTS (CONTINUED)

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The following source data elements are required for each organization determinations:

- Pre-service Requestor: [CP, NCP, E, ER]
- Member ID Number
- Member Last Name
- Member First Name
- Member Date of Birth [MMDDYYYY]

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SOURCE DATA ELEMENTS (CONTINUED)

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The following source data elements are required for each organization determinations:

- Authorization Number (Case ID)
- Internal Determination Description (Pre-Service)
- Case Type:
  - S = Standard (14 days),
  - SE = Standard with Extension (28 days),
  - E = Expedited (72 hrs),
  - EE = Expedited Extension (17 days)

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SOURCE DATA ELEMENTS (CONTINUED)

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The following source data elements are required for each organization determinations:

- CMS Determination Reporting Category:
  - FF=Fully Favorable,
  - PF=Partially Favorable,
  - AD=Adverse
- Time Zone: P=Pacific, C=Central, E=Eastern

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SOURCE DATA ELEMENTS (CONTINUED)

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The following source data elements are required for each organization determinations:

- Received Date: [MMDDYYYY]
- Received: [HHMMSS]
- Date of Decision: [MMDDYYYY]
- Time of Decision: [HHMMSS]
- Date of Verbal Notification: [MMDDYYYY]
- Time of Verbal Notification: [HHMMSS]

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DATA ELEMENTS

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Elements	Data Elements
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)
F.	Number of Organization Determinations requested by Non-Contract Provider (Services)
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
B.	Number of Organization Determinations – Fully Favorable (Services) Requested 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
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

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RE-OPENING DATA ELEMENTS

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Elements	Data Elements
Subsection #5:	**Reopenings**
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)*
P.	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

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2019 PART C SUMMARY COUNTS

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If your organization makes determinations for several health plans, report data for each health plan separately.

		SS #1-A	SS #1-B	SS #1-C	SS #1-D	SS #1-F	SS #2-A	SS #2-B	SS #2-E	SS #2-F	SS #2-I	SS #2-J	SS #2-A
Month	Year	**Total** Number of Organization Determinations Made in Reporting Time Period	Number of Requests for Organization Determinations Withdrawn	Number of Requests for Organization Determinations Dismissals	Number of Organization Determinations **requested by enrollee/representative or contracted provider on behalf of the enrollee** (Services)	F. Number of Organization Determinations requested by **Non-Contract Provider** (Services)	Number of Organization Determinations – **Fully Favorable** (Services) **Requested by enrollee/representative or provider on behalf of the enrollee**	Number of Organization Determinations – **Fully Favorable** (Services) **Requested by Non-contract Provider**	Number of Organization Determinations – **Partially Favorable** (Services) **requested by enrollee/representative or provider on behalf of the enrollee**	Number of Organization Determinations – **Partially Favorable** (Services) Requested by **Non-contract Provider**	Number of Organization Determinations – **Adverse** (Services) **Requested by enrollee/representative or provider on behalf of the enrollee**	Number of Organization Determinations – **Adverse** (Services) Requested by **Non-contract Provider**	Total number of reopened (revised) decisions, for any reason, in Time Period Above
1	2019	#	#	#	#	#	#	#	#	#	#	#	#
2	2019	#	#	#	#	#	#	#	#	#	#	#	#
3	2019	#	#	#	#	#	#	#	#	#	#	#	#
TOTAL		0	0	0	0	0	0	0	0	0	0	0	0

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2019 PART C SOURCE DATA CHANGES

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- Updated HIC to MBI number
- No longer separate EOD or SOD received, decision, notification dates and times
- Person who made the request
  - Enrollee [E]
  - Enrollee Representative [ER]

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REPORTING INCLUSIONS

2019 Annual Conference

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Organization Determinations for contract and non-contract providers/suppliers:

- All fully favorable service-related organization determinations
- All partially favorable service-related organization determination
- All adverse service-related organization determinations

16 December 9, 2019

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PART C DATA EXCLUSIONS

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- Data from Medicare/Medicaid Programs (MMPs) organizations.
- Independent Review Entity (IRE) decisions.
- Re-openings requested or completed by the IRE, Administrative Law Judge (ALJ), and Appeals Council.

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PART C DATA EXCLUSION (CONTINUED)

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- Concurrent reviews during hospitalization.
- Concurrent review of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care.
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.

18 December 9, 2019

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REOPENING DEFINITION

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- A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

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REOPENING GUIDELINES

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A reopening request:

• May be initiated by a plan, the IRE, ALJ or attorney adjudicator, the Council, or requested by an enrollee or any other party to the determination or decision;

• May be made verbally or in writing;

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REOPENING GUIDELINES (CONTINUED)

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• Should include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening); and

• Must be made within the timeframes permitted for reopening (as set forth in §80.3).

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REOPENING GUIDELINES

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80.2 – Reopenings Separate and Distinct from Appeals

The reopening process is separate and distinct from the appeals process. When a party has filed a valid request for a level 1 appeal, level 2 appeal, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen a case that is under appeal until all appeal rights for that case are exhausted or a subsequent request by the appellant to withdraw the appeal has been granted.

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REOPENING GUIDELINES

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80.2 – Reopenings Separate and Distinct from Appeals

The reopening process is separate and distinct from the appeals process. When a party has filed a valid request for a level 1 appeal, level 2 appeal, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen a case that is under appeal until all appeal rights for that case are exhausted or a subsequent request by the appellant to withdraw the appeal has been granted.

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REOPENING GUIDELINES AND EXAMPLES

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- When a determination or decision is reopened and revised (including revision of the rationale for a decision that is not revised), the plan, IRE, ALJ or attorney adjudicator, or the Council that reopened the decision must deliver written notification to the parties to that determination or decision, as described in §80.6.

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REFERENCES:

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Industry Collaboration Effort

- Medicare Part C Plan: Technical Specifications Document Contract Year 2019 (Effective Date: January 1, 2019). Retrieved from:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/CY-2019-Medicare-Final-Part-C-Plan-Technical-Specifications.pdf

- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Released February 2019). Retrieved from:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

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REFERENCES:

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- Supporting State for Paperwork Reduction Act Submission: Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR § 422.516 (a). Released June 21, 2013.

- 42CFR422.574

NOTE: Slides were created based on the references above and the ICE QI/UM Main Team Part C documentation. Conference participants are responsible to ensure they are using the most current and up to day specifications.

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