Attachment A

General Comments for CCQIPE & SARAG

Medicare-Medicaid Plan (MMP) Pilot Protocols and Audit Results Several commenters encouraged us to pilot the new MMP protocols in 2017. Based on the comments received and the additional information that we are requesting, as part of the MMP protocols, CMS has determined that the new MMP audit protocols will be conducted as a pilot in 2017. This is similar to how Medicare Advantage (MA) introduces an audit protocol for the first time as well. As a result, during the pilot period, the Medicare-Medicaid Plan Care Coordination & Quality Improvement Program Effectiveness (CCQIPE) and Medicare-Medicaid Plan Service Authorization Requests, Appeals and Grievances (SARAG) program area results will be included in audit reports but will not be included in the overall audit score. MMPs will still be required to submit necessary documentation, such as Corrective Action Plans (CAPS). However, consistent with previous years, for sponsors with both MA and MMP lines of business, MMP contracts would be cited in other audit program areas in which an audit score is assigned if there is an issue of non-compliance that affects both MA and MMP beneficiaries. We will share audit results with the contract management teams (CMTs) that oversee the day-to-day operations of the MMP. Additionally, while we will not formally report best practices in the final audit report for 2017 MA/MMP program audits, we will share best practices with the respective CMTs.

Audit Timing CMS received a comment stating that the combination of the MA program audit with the MMP protocol reviews would be burdensome to sponsors and that the MMP reviews should be separated from the MA program audit by at least 60 days. We considered auditing sponsors MA and MMP lines of business separately. Ultimately, we determined that extending the program audit 1 week was less burdensome on sponsors than conducting a separate audit for the MMPs, as we realize that sponsors may undergo various types of audits and reviews throughout the year, and this consolidated audit will minimize potential burden.

We received comments regarding when MMPs will be notified if they have been selected for an audit and the amount of time they would have to implement the new protocols. We considered the timeframe for the release of the MMP audit protocols when developing the 2017 audit schedule. MMPs will receive an audit engagement letter 6 weeks prior to the start of the live audit. If a sponsor has MMP and MA lines of business, then the audit engagement letter will include all program areas. After receipt of the engagement letter, a follow-up call will be scheduled with the organization to discuss logistics and provide further details regarding universe submissions. We have also clarified that for organizations with both MA plans and MMPs, CCQIPE and SARAG portions of the audit will take place virtually via webinar during the second week of the audit and the Compliance Program Effectiveness portion will occur on-site during the third week.

Program Audit Overlap Multiple commenters asked for clarification regarding the overlap of the MMP audit protocols with other MA protocols. Organizations with both MA and MMP lines of business would submit all Medicare Parts C and D universes, in addition to the SARAG and

CCQIPE universes. However, the organization would populate the Part C Organization Determinations, Appeals and Grievances (ODAG) universes with MA cases only and populate SARAG and CCQIPE universes with MMP cases only. No other program areas will be impacted by the addition of the SARAG and CCQIPE audit protocols. Further instructions regarding universe submissions would be provided during the Follow-Up Call after receipt of the audit engagement letter.

Data CMS received comments expressing concern that the CCQIPE and SARAG protocols require MMPs to submit a burdensome amount of data. In response to these comments, we removed data fields from the record layouts as outlined in the updated protocols. Additionally the CCQIPE and SARAG protocols data elements are familiar to the industry as they closely resemble the MA ODAG and Part C Special Needs Plan-Model of Care (SNP-MOC) protocols. Several commenters also sought clarification on requests for pharmacy data in both protocols and if such data requests includes Part D drugs. We have added clarifications to both protocols. In the Review Sample Case Documentation section of CCQIPE, the Medicare-Medicaid Plan Members (MMPM) cumulative claims data totals should include all drugs, including Part D drugs. For SARAG, the Universe Preparation & Submission section mentions that prescription drugs processed under Medicare Part D or Medicaid-only drugs should be excluded from SARAG universes. In addition, both protocols have been amended to state that MMPs must submit universe data as a Microsoft Excel (.xlsx) file with a header row reflecting the field names (or Text (.txt) file without a header row). If submitting as a text file, you must specify the delimiter type utilized. We will no longer accept universe data in the form of CSV files.

Disclosed Issues and Account Manager Review CMS received a comment asking to clarify when the protocols mention CMS reviewing disclosed issues that are reported to CMS prior to the receipt of the engagement letter, if the region is the plan sponsor's lead region (Account Manager) or the region that the MMP is issued in and whether the self-disclosed issues should be inclusive of Medicare and Medicaid issues tied to the MMP protocol. As described in the protocols, we are referring to the CMT Medicare representative. We have updated the protocols to clarify that the CMT Medicare representative is otherwise referred to as the Account Manager for purposes of these protocols. This is the region that includes the state where the MMP is issued. The self-disclosed issues should be inclusive of Medicare and Medicaid issues related to the MMP protocols.

CCQIPE Comments

Audit Review Period CMS received a comment noting that the audit review period date range example that was provided in the protocol was technically more than 13 months, when the protocol notes that the review period is the 13 month period preceding and including the date of the audit engagement letter. We note that in order for the MMP being audited to be able to provide 13 months of enrollment data, the period of time in the example is necessary since MMP enrollment only occurs on the first day of each month.

Sample Selection CMS was asked to clarify the methodology for case file selection when there are multiple MMPs in one universe. We will select a variety of samples based on the total enrollment size of each of the MMP contracts for a sponsoring organization.

Quality Improvement Program (QI Program) and Model of Care (MOC) CMS received comments seeking clarification on why the MMP protocol appear to focus on the QI Program, while the SNP-MOC protocol focuses on the model of care (MOC). We will evaluate MMPs against the contract requirements in addition to the MOC document. While the MOCs and contracts both address quality measurement and performance improvement, the MMP contract includes more detail about the assessment of the QI Program than the MOC requirements. The protocol has been updated to clarify that the MMP should submit all MOC documents instead of all "relevant" MOC documents to align with the SNP-MOC protocol.

QI Program Metrics CMS received a question asking if the MMP chooses the metric to be submitted and if so, whether there is guidance on how a metric is to be chosen. We would like to clarify that the protocol indicates the MMP should submit each QI Program metric and its corresponding data that were tracked during the audit review period.

Professional Credentials One commenter requested clarification for the evidence of membership with appropriate credentials in the Interdisciplinary Care Teams (ICTs). MMPs should refer to their contract to determine the required documentation for credentialing. Another commenter sought confirmation for MMPs who have delegated agencies conducting Health Risk Assessments (HRAs) that the professional credentials as specified in those subcontracts are sufficient. We would like to clarify that the professional credential requirements in the contract flow down to any delegated agencies.

Interdisciplinary Care Team (ICT) CMS received comments asking about the required composition of the ICT and the involvement of the member. They noted that the members' needs should drive the desired composition of the team—for instance, in some cases the member's behavioral health needs are primary and a behavioral health counselor, psychiatrist, pharmacist, and social worker would be the most critical members of the ICT for that member. We agree and in response are clarifying that we will review the ICT composition based on the contract requirements. In addition, we have added a compliance standard to the protocol asking whether there was an attempt to involve the member in the ICT discussions/meetings.

Health Risk Assessments (HRA) and Individual Care Plans (ICP) Records and First Tier, Downstream, and Related Entities (FDRs) CMS received comments seeking ample time for the MMPs to request HRA and ICP records from providers. The commenters expressed concern that in many instances the HRA and ICP records may be housed in other systems or there may be restrictions on data sharing. As previously indicated, MMPs will receive the audit engagement letter 6 weeks prior to the audit. Within 15 days of receipt of the audit engagement letter, MMPs must submit the universes and background documents listed in the Universe Preparation & Submission section of the protocol. The member-specific HRA and ICP documentation will not be required until the live webinar portion of the audit review. The MMP should work with the provider and have them participate in the audit session if necessary. Consistent with the contracts and CMS regulations, we have the right to review any FDR systems, medical records, etc., and the MMP must ensure that any contracts or agreements with FDRs are in compliance

with these requirements. As a result, there should not be conflicts with any privacy requirements when reviewing the requested information.

Member's Goals and Preferences CMS received comments stating that the member's goals and preferences are laid out in the ICP, instead of the HRA. We agree and have deleted the protocol standard condition related to whether the completed HRA included the member's goals and preferences. The protocol already includes a sample standard condition asking whether the ICP included interventions related to the member's goals and preferences identified in the HRA.

ICP - Appropriate Frequency for Review CMS received a comment that it is difficult to gauge a clear/specific standard for "appropriate frequency" to review/revise the ICP. They asked that the audit protocol provide guidance to reviewers/auditors to note that a spectrum of member conditions may indicate different timeframes for frequency in terms of checking the ICP—and may be done by different providers. We agree that the appropriate frequency to review/revise the ICP depends on the needs of the member. We will be reviewing this area based on the requirements in the contract and the health status of the member. In addition, we also wanted to note that each audit review team includes at least one registered nurse to review the clinical needs of the member.

ICP Member Involvement CMS received comments asking that we consider MMP attempts to work with the member/caregiver and attempts to involve the member in ICP development, as well as if the member does not wish for them or their caregiver to be involved in the ICP or refuses to have an ICP. We have updated the protocol to clarify that we will review the ICPs based on the contract requirements. We have also deleted the separate requirement to facilitate member or caregiver participation when developing an ICP and combined this requirement with the requirement for the MMP to complete the ICP according to the contract requirements.

Table 1: Medicare-Medicaid Plan Members Record Layout

Risk Stratification CMS received multiple comments asking if the MMP should include the initial risk stratification level or the most current risk level for Table 1. We have updated the protocol to clarify that the MMP should provide the initial risk stratification level rather than the most recent risk stratification level for this table.

HRA Completion CMS received multiple comments from MMPs related to the burden of submitting the method/setting for completion of the HRA as part of the universe request in Table 1. Based on those comments, we have removed this data element from the universe request. We will instead assess whether the HRA was completed using the appropriate method/setting according to the contract requirements during the webinar review of the 30 case samples.

We received multiple comments seeking clarification on completing Column ID J, including how to consider attempts to complete the HRA and how to account for members refusing to complete the HRA or that cannot be reached. We do take these factors into account and have updated the protocol language to note that when we are reviewing samples we will consider if the MMP made the requisite number of attempts to complete the HRA based on the requirements in the applicable contract. However, no change was made to Column ID J as the MMP indicating "No" in response to "Was an initial HRA completed within the required timeframe?" does not automatically mean that

the MMP is non-compliant. In addition, one commenter noted that other assessments beyond the HRA may be used to generate a care plan that is interdisciplinary and that includes member goals and preferences. We agree that when an MMP is unable to complete an HRA despite performing their due diligence per the contract requirements, but is able to complete an assessment in another setting (such as during or after a hospitalization) then this assessment should be used to generate an ICP.

We also received a comment about Column ID M, for the Date of Completion for HRA conducted during the current audit period, stating that the response options are in conflict with the SNP MOC protocol. We agree that Column ID M should be consistent with the SNP-MOC protocol and has revised the CCQIPE protocol language to read "Enter NA if an HRA was not conducted during the current audit period."

We received multiple comments about Column ID N, date of previous HRA/reassessment. They stated that some members could have more than one HRA/reassessment in the current audit period. They asked us to clarify if MMPs should include dates of previous HRAs occurring within the same audit period, or if the intent is to list the last HRA/reassessment that occurred prior to the current audit period. We have updated the field name and clarified the instructions for Column ID N to "Date of previous HRA/reassessment." Specifically we are requesting the date the HRA was conducted prior to the one that was conducted during the audit period. In the field description we addressed circumstances where more than one HRA was conducted during the audit period, or no HRA was conducted during the audit period.

ICP completion CMS was asked to clarify whether the ICP completion field should be populated with "yes" if an ICP was developed for the member regardless of whether the ICP was developed within or outside the 13th month audit period. We have clarified Table 1, Column ID O to instruct the MMP to indicate whether the ICP was developed for the member any time before the end of the audit review period.

Format CMS received several technical questions and comments about the format for fields in Table 1. Based on those comments, we are making the following clarifications and, where appropriate, updates to Table 1:

- For Field Types 'CHAR' with a specific field length, the field length is the maximum number of characters allowed per field. MMPs do not need to include extraneous characters to reach the character limit prescribed for each field.
- For data fields there is a maximum of 4,000 characters per record row and spaces count toward this 4,000 character limit. If the entry requires additional characters, enter the additional information on the next record at the appropriate start position for the variable that requires more space for response.
- Description fields are free text, which allows the MMPs to enter the information available from their system. MMPs may enter NA when no data is available. Depending on the field, NA responses could require clarification during the webinar portion of the audit.
- If only partial data is available for a free text field e.g., member specific address is incomplete) the MMP should enter the information available from their system.

Claims Data CMS received multiple comments related to our request for claims data for the universe in Table 1. This included several comments on the burden of submitting the full universe for the data elements related to the breakout of the number of claims and the claims amounts for behavioral health, substance use, and long term supports and services (LTSS). Based on those comments, we have removed the request for the breakout of those data elements from the universe request as described in Table 1. We will instead assess these data elements during the webinar review of the 30 case samples. However, we have updated the protocol to note that the cumulative claims data should include claims for behavioral health, substance use, and LTSS. In addition, we have updated the table to note that the claims data should include claims from capitated providers in response to a question. Finally, we received a question asking how the MMP accounts for the same claim denied multiple times for different reasons. Per the record layout for Table 1, the MMP should only exclude claims from these totals if they are duplicate claims, payment adjustments to claims, claims that are denied for invalid billing codes, billing errors, denied claims for bundled or not separately payable items, or denied claims for members who are not enrolled on the date of service and claims denied due to recoupment of payment.

CCQIPE Protocol and SNP MOC Protocol CMS received a comment that recognized the importance of reporting the additional data fields within the new CCQIPE universes, but also recommended that we consider aligning the CCQIPE universe with the SNP-MOC universe for Table 1 and incorporating MMP specific fields as new columns at the end of the record layouts to allow for synergy between the processes. While we have attempted to keep the fields as similar as possible between the SNP MOC audit and the CCQIPE audit, there are some differences in these audits that don't allow us to line them up exactly. For example, we will not be looking at the enrollment mechanism and some other enrollment fields for the CCQIPE audit because the State enrollment broker handles enrolling members in MMPs, instead of the plans. However, we have deleted several new fields in Table 1, as previously described, in order to reduce the burden on MMPs.

We also received a comment asking that language in the CCQIPE protocol related to the care and case management documentation as well as the timing of HRA completions be incorporated into the SNP-MOC protocol. Sponsors had an opportunity to comment on the SNP-MOC protocol through the Paperwork Reduction Act (PRA) process. Comments submitted through PRA have been considered in the final version of the protocol, which will be released upon approval from the Office of Management and Budget. Although we are unable to accommodate the request for the next release of the SNP-MOC protocol, we will take the suggestions under advisement for future versions of the SNP-MOC protocol.

SARAG Comments

Review Period CMS received a comment regarding the discrepancy between the ODAG and SARAG review periods and requested that they be the same. Review periods are based on enrollment. For ODAG, the sponsor's total enrollment for all audited contracts determines the

audit period. For SARAG, the sponsor's total enrollment for all audited MMP contracts determines the audit period. In line with ODAG, organizations with less than 50,000 enrollees in their MMPs have a 3 month audit period.

Service Authorization Requests and Plan Level Appeals Samples CMS received comments regarding Section II, Appropriateness of Clinical Decision-Making & Compliance with SARAG Processing Requirements, asking us to identify whether denied service authorization requests and denied plan level appeals samples will include both standard and expedited cases. The protocol has been updated to reflect that standard and expedited denied service authorizations, and 10 plan level appeals will be sampled. As reflected in the protocol, both standard and expedited approvals will be sampled as well. However, due to the potential of sampling for multiple MMPs with different contracts, it will be left to the auditor's discretion how many to sample of each type.

Service Coordinator Timing of Service Authorization Requests CMS received a comment regarding timing of processing service requests for the Audit Elements Section, I Timeliness. The commenter requested clarification on the timing of LTSS service requests submitted by the member's Service Coordinator. We clarify that the timing would start when the Service Coordinator submits the request for authorization.

SARAG Compliance Standard CMS received a comment regarding the differences between the ODAG and SARAG protocols. Specifically, the commenter identified that the ODAG compliance standard "Was the request reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise including knowledge of Medicare coverage criteria?" was not included in the SARAG protocol. We have included an equivalent compliance standard in the SARAG protocol in Section II Appropriateness of Clinical Decision Making & Compliance with SARAG Processing Requirements, Clinical Appropriateness of Denials 3.2.4. "Was the service authorization request reviewed by the appropriate personnel?"

Quality of Care Grievances CMS received a comment noting that we did not include documentation for quality of care grievances. We have added this documentation to the protocol.

SARAG Universe CMS received multiple comments related to the unique universes collected for purposes of this protocol.

> General One commenter requested clarification on whether certain case types would be excluded from the universes. We have updated the protocol to clarify the types of cases to be excluded and clarified that requests for extensions of previously approved services must otherwise be included. Another commenter asked if it would be appropriate to include a "pend" status for cases in the universes collected for Tables 1 through 5 related to Column ID U “Request Disposition”. The commenter also asked for more information as to why we considered pended cases denials for the purposes of the Request Disposition Field in Record Layouts 1-5, and MMPs must enter approved or denied. Untimely cases are considered denied the moment they become untimely. Therefore, any open, pended untimely cases should be treated as denials throughout the universes.
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> We received a comment regarding Medicaid value-added services and if they would be included in the universe. MMPs should include both Medicare and Medicaid value-added services.

Grievance Universe We received a comment regarding whether the timeliness test calculation located in the Universe Preparation & Submission Section would exclude grievances in which oral notice to the member has been unsuccessful to the member, and no written notice was given. MMPs may populate the oral notice field for SARAG universes with the date of the first or last good faith attempt within the notification timeframe. A good faith attempt made within the notification timeframe that is properly documented in the MMP system would be considered timely oral notification. The criteria under which an MMP must provide written notice of grievance resolution to meet the notification requirement are delineated in the contracts. We also received a comment asking whether Part D related grievances or calls would be included in the universe for Standard Grievances (Table 10). We clarify that SARAG universes should include prescription drugs processed under Medicare Part B only, but will exclude all other prescription drugs including Part D.

Part B Point of Sale Drugs We received comments asking whether Part B point of sale drugs should be included in the universes. Part B point of sale transactions should be included in the SARAG universes.

Universe-Claims Data Availability We received comments regarding the availability of claims data given the timeframe providers have to submit claims for payment. We are aware that claims data may not be available in certain circumstances and would make due consideration. However, for the Provider Requests for Payment universe, claims should be retrievable, as the universe itself should be populated based on the date the claim was paid or denied, or should have been paid or denied (the date the request was initiated may fall outside of the review period). As stated in the protocol, timeliness will not be evaluated for this universe.

Universe Submission—State Fair Hearing Decisions We received a comment regarding the submission of universe data elements that have not been previously reported to CMS or to the State by the MMP. Specifically, the commenter asked about Table 6: State Fair Hearing Decisions Requiring Effectuation. As per the protocol, we will not review timeliness for Table 6. The protocol has been updated to remove the data fields: "Time of receipt for State Fair Hearing decision" and "Time service authorization entered/effectuated in the MMP's system". Another commenter asked if we would provide MMPs with the pre-populated State Fair Hearing and IRE data they need to submit for their universes. We will not be providing such data to the MMPs and rely on the MMPs to have accurate data in its systems related to the State Fair Hearing and IRE data.

Call Log Universe We received multiple comments on the burden associated with the Call Log universe in Table 12 and questions regarding what types of calls should be included. The Call Log universe should include calls from members and/or representatives (i.e., your customer service line(s)), not prescribers or calls unrelated to a member request. We note that while the record layout presented in the protocol provides a description of the minimum types of information that should be included in the Call Log universe, MMPs may choose to reconfigure the layout as suitable for the manner in which the MMP records and tracks calls. Additionally, certain fields such as Contract ID,

have been updated to “optional”. Lastly, while the 4 week review period for the MMP Call Log is based on the Call Log review timeframes established in the ODAG audit protocol, the MMP Call Log timeframe is based on MMP contract enrollment only, which is not expected to exceed 50,000 members.

We received a comment regarding the burden of providing call audio files during the audit. We will not request audio file submissions prior to the live audit. Rather, during the review of call logs, auditors may request to listen to a call if the audio file is available or the documentation of the call is insufficient to determine what happened. If an audio file is unavailable, auditors will utilize the call notes. We will be reasonable with timeframes when requesting access to audio files from MMPs. Another commenter asked if the MMPs should include follow-up calls to members who left voicemails after hours that required the MMP to place a return call. MMPs should include these calls in the universe, as they are the point at which the MMP made contact with the member to record the member's question/ issue.

Table Clarifications CMS received multiple comments related to the tables and unique data elements that MMPs will complete for purposes of this protocol.

Multiple Tables

Record Layout Field Terminology (multiple tables) We received a comment about the substitution of the word "member" for "beneficiary" or “enrollee” in the response options to multiple record layout fields. We have standardized its terminology throughout its protocol to reflect the term “member” for consistency; however we will not ask MMPs to recode their systems to reflect the term “member”.

Substance Use CPT Codes (multiple tables) We received multiple comments asking for a definition of CPT codes that would apply to Substance Use services. We expect an MMP to determine which CPT codes would be classified as Substance Use.

Good Faith Effort (multiple tables) We received a comment asking for guidance regarding good faith effort, regardless of success in reaching the member. For SARAG universes, oral notification can be populated with the first or last good faith attempt during the required time frame. However, it may be to the MMP's advantage to populate the field with the last good faith attempt for the purposes of the timeliness review. A good faith attempt within the notification timeframe that is properly documented in the MMP system would be considered timely oral notification.

Claims Categorization (Tables 1 and 3) We received comments regarding categorization of claims for type of service. Each MMP may submit the data according to how they process the claims according to state regulations and the contract.

ICD Codes (Tables 1 through 9) We received questions if the submission of the response NA for the SARAG Diagnosis fields was acceptable for point of sale drugs in multiple areas of the protocol. For drugs, if the ICD-10 is unavailable, please provide the 11 digit National Drug Code (NDC) in the Diagnosis field. We also received multiple comments regarding whether the 11-digit National Drug Code (NDC) and the ICD-10 code related to a request should be included in the SARAG Diagnosis field or the Issue

Description Field. As written in the protocol, we intend to collect this information separately, in the Diagnosis field.

Reconsiderations (Tables 4 and 5) We received multiple comments related to reconsiderations for both standard and expedited plan level appeals. One commenter sought clarification as to whether payment reconsiderations should be included in the universes. As noted in the bullets for Tables 4 (MMP Standard Plan Level Appeals Record Layout) and 5 (MMP Expedited Plan Level Appeals Record Layout), payment reconsiderations should be excluded from the universes. Another commenter requested clarification as to whether standard and expedited pre-service reconsiderations would be included in the review for Tables 4 and 5. MMPs should include standard pre-service reconsiderations in Table 4 and expedited pre-service reconsiderations in Table 5.

Table 1: Standard Service Authorization Requests Record Layout

Service Authorization Request We received a comment stating the MMP's systems were not configured to report multiple services for one service authorization request. For purposes of populating the audit universes, MMPs should combine all of a request's line items into a single row. To simplify, MMPs may use an authorization number of any item in the request when populating Column ID F, the "Authorization number" field.

Service Coordinator We received a comment regarding a request to add Service Coordinator as an option to the data field "Who made the request" in Column ID G. We have updated the protocol to include this option.

LTSS Authorization Request We received a comment regarding Column ID J requesting additional information on how to process an LTSS authorization request provided by a Service Coordinator that does not contain a diagnosis code. The guidance in Column ID J explains that a description of the diagnosis can be provided if an ICD code is not available.

Record Layout Field We received multiple comments regarding the data field "Was the request made for a Medicare, Medicaid, or Medicare/Medicaid service?" in Column ID K. Some commenters asked for clarification on the use of "other" as a response option. Another commenter asked for the data field to be removed from the record layouts because the commenter stated that the MMP might not know which benefit type will cover the request. The protocol has been updated to remove "other" as a response option, as we expect the MMP to know which benefit type(s) will apply to a particular service.

Issue Description Field We received a comment asking for clarification and whether "NA" would be a sufficient response for Column ID N, the Issue Description field. The purpose of this field is to provide a basic description of the case to the auditor. The issue description need not be overly detailed, and can be copy and pasted from the MMP's system (i.e., CSR notes). An example of an acceptable response would be "For example, request denied due to not being used for a medically accepted indication". Additionally, MMPs are only expected to include an explanation of why the service was requested if the reason is known to the MMP. If an MMP is unaware of why a service was requested, it may populate this field with the issue description only.

New York MMPs We received a comment regarding the record layout specific to New York MMPs in Column ID O. The specific requirements are per the contract in New York. For New York MMPs, these categories of services authorization requests require different processing timeframes. All audit requirements listed in the protocols take into consideration the specific contracts for each demonstration.

Service Authorization Requests We received a comment asking if the data elements for Column IDs V and AA: "Date of MMP Decision" and "Date service authorization entered/effectuated in the MMP's system" could be the same date. These data fields are requesting different information, the date the MMP adjudicated the service authorization request and the date that the member would be able to access the service. If the MMP made a determination on the request and effectuated the request in its system on the same day, then the dates for those fields would be the same.

Table 3: MMP Provider Payment Requests Record Layout

Duplication of Information We received multiple comments regarding the duplicate Columns ID M and O. We agreed and the protocol has been updated to remove the duplicate information.

Type of Service We received a comment regarding Column IDs L and N indicating that they are both requesting "Type of Service." We removed "Type of Service" from Column ID N in Table 3 and "Type of Service" will be captured in Column ID L.

Notification to Provider We received a comment asking whether to populate the data field for Column ID T "Date written notification provided to provider" with NA or the date of the denial if the provider is notified electronically of the claim's adjudication status. As described in the data description, "provided" means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Thus, the electronic notification date is sufficient for the purposes of this field.

Table 4: MMP Standard Plan Level Appeals Record Layout

Dismissals We received a comment pointing out a reference to dismissals. That reference has been removed from the protocol. The SARAG universes should not include dismissals.