Public Comments and Responses

There were 14 commenting organizational entities: They were: Amerigroup Corporation, Blue Cross Blue Shiel Association, Kaiser Permanente, America's Health Insurance Plans (AHIP), Universal American, Wellpoint, Coventry, Gateway Health Plan, Ovation, Health Partners, Aetna, Ucare, Medicare Cost Plans Alliance, and the American Health Care Association (AHCA).

No.	Measure	Summary of Comment	CMS Response
G.1	General	Commenter argues that CMS may not apply to cost plans the reporting requirements indicated in its guidance document (*Attachment 1: Part C Overview*). According to the commenter, we may not do this for the following reasons: • CMS referenced in its 60-day notice only MA and Part D plans but did not reference cost plans or the pertinent statutory or regulatory authority under which cost plans would be subject to the information collection. • CMS has not referenced cost plans in this context in other pertinent guidance relating to reporting requirements, such as CMS' May 16, 2008 proposed rule or 2009 Call Letter. The commenter objected to the following cost plan reporting requirements specified in the guidance on the basis described above. The requirements include— • Benefit utilization • Procedure frequency • Serious reportable adverse events • Agent training and testing	CMS has determined that because of the unique operation of cost plans as argued by the commenter it is appropriate to not require cost plans to comply with the following reporting requirements: benefit utilization; procedure frequency; and serious reportable adverse events. However, we do not agree with the commenter's objection to reporting on agent training and testing. It is critical that all beneficiaries understand that nature and requirements of the Medicare plans which they are being invited to join. We believe that prospective enrollees in cost plans should be furnished accurate information by qualified sales people. Furthermore, we believe compliance with the reporting requirements identified below is within CMS's oversight authority to ensure cost plan compliance with the marketing activities. Accordingly, the reporting requirements that involve ensuring that beneficiaries receive accurate information about their enrollment options will also apply to cost plans. Additionally, we believe that section 1876(i)(1)(D) of the Act, which requires cost plans to "provide the Secretary with such information as the Secretary may find necessary and appropriate" and §417.126(a)(6) of the CFR permit us to require cost plans to report to CMS the reporting requirements identified below. • Provider network adequacy • Grievances • Organization

			determinations/reconsiderations • Employer group plan sponsors • Commission Structure • Agent training and testing • Plan oversight of agents
G.2	General	Diagnostic and CPT procedural codes must be provided in order to permit a comparison of the levels of services and risk adjustment of adverse outcomes in MA patients, and justify the additional cost of the MA plan or permit adjustment of the supplement paid to administrate their care.	CMS has provided relevant procedure and diagnostic codes to the MA organizations in a supporting document in this notice.
G.3	General	We recommend that CMS give additional study to this reporting design, given that the requested data and associated reporting burden are unlikely to achieve CMS' stated objective.	CMS has expended considerable effort in developing the proposed "reporting design." The proposed measures have gone through a rigorous process of internal review and assessment prior to their release. These proposed Part C measures have been shared with MA organizations (MAOs) through trade and user group calls and written communications.
G.4	General	CMS should delay these new proposed data collections until at least 2010 as we have a number of significant issues related to the timing and costs involved in many of these new proposed requirements.	CMS believes that recent statutory and regulatory changes support reporting beginning at the earliest possible time, which, in our view, is 2009.
G.5	General	We strongly oppose attempts to collect data as proposed from 2007 and 2008 Plan years as systems are not in place in many organizations to comply with many of these proposed requirements.	CMS agrees that the collection and reporting of 2007 and 2008 data might prove difficult for many plans and has eliminated 2007 and 2008 data collection from the Part C reporting requirements.

No.	Measure	Summary of Comment	CMS Response
G.6	General	Recommend ample time for the industry to work with CMS to fine-tune these requirements so there are realistic implementation timelines and also standardization for data reporting within the Medicare Advantage Organization (MAO) community to allow CMS to use this new data efficiently and effectively for oversight purposes.	CMS has pushed back the due date for several measures and is no longer requiring any retrospective data. CMS realizes that there are "start up" concerns. Therefore, CMS will not be using the first year's data for public reporting. It will also not be auditing the first year of data.
G.7	General	Collection and reporting for all measures should be prospective for which reporting previously has not been required.	All reporting will be prospective. No 2007 or 2008 reporting will be requested.
G.8	General	CMS should revise the reporting requirements to provide that CMS will not require cost plans to submit data that are available through provider claims and that CMS will provide cost plans with the data CMS utilizes.	Refer to response under G.1 above.
G.9	General	CMS should establish benchmarks or other criteria to define the compliance standard against which MAOs will be evaluated.	Benchmarks have not yet been developed. CMS plans to use the data initially for monitoring purposes and fully expects reporting accuracy and completeness to improve over time. As reporting improves, CMS intends to develop performance metrics where appropriate based on both the content and quality of the reporting measures. These performance metrics may include "benchmarks" which could be based on norms or averages or could be based on a "threshold" established by professional or expert judgment.
G.10	General	CMS should include the initial year for the Report Period(s) and Data Due Dates in Attachment I.	The initial year report period is now CY 2009 for all measures.
G.11	General	CMS should consider phasing-in the data collection and reporting timeframes.	Refer to response under G.6 above.

No.	Measure	Summary of Comment	CMS Response
G.12	General	CMS should consider publicly posting these data at the contract level on the CMS website in a manner similar to the measures on the Part D performance data page. We also support public release of matching (e.g. adverse events) Fee-For-Service (FFS) metrics.	CMS appreciates these comments and will consider them as it deliberates on strategies and approaches to using this information for monitoring and possible public reporting at a future time.
1.1	Benefit Utilization	Many Medicare benefits for which CMS requests information are already reported in pricing bids.	While there is some commonality between data reported in the MA bid pricing tool (BPT) and the MA medical utilization and expenditure experience exhibit, there are key differences in these instruments that necessitate the collection of both sets of information. The BPT data are primarily used as a basis for the bid projection, have a relatively large level of claim reserves which result in uncertainty, and include fewer data fields. The MA Medical Utilization and Expenditure Experience data, which is more detailed and complete than the BPT submission, will be used to satisfy Congress' request for MA utilization experience. Further, it is worth noting that only two data fields – total utilization and allowed cost – appear on both the BPT and the utilization exhibit.
1.2	Benefit Utilization	Plans cannot provide definitive comments in the absence of full specification of procedure codes.	Attachment IV: Mapping of MA PBP to Medical Utilization and Expenditure Experience, provides the linkage of the service categories on the MA medical utilization and expenditure experience exhibit to the MA plan benefit package (PBP) categories. As described in the Medicare Benefit Description Report, the PBP service categories are clearly defined. Thus, MA organizations have the appropriate and necessary information required to report plan experience by the categories included on the MA medical utilization and expenditure experience exhibit. (Please note that PBP item 9a Outpatient Hospital Services can be mapped to OP Facility Surgery or OP Facility Other at your discretion.)

No.	Measure	Summary of Comment	CMS Response
1.3	Benefit Utilization	It is unclear whether CMS intends plans to submit detailed data on every encounter (benefits utilization measure).	In 2009, data will be submitted at the category level. CMS will require audited data beginning in 2010. Note that under the proposed rule "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009" (CMS-1390-P), appearing in the *Federal Register* (Vol. 73, No. 84 / Wednesday, April 30, 2008 / Proposed Rule), CMS would have the authority to require MAOs to submit encounter data for each item and service provided to the MA enrollee. However, there is no schedule of collection of encounter data contained in the proposed rule.
1.4	Benefit Utilization	As an alternative to this requirement, CMS should consider doing a more comprehensive claims audit to target these areas of interest during triennial exams.	The objective of this requirement is to collect data regarding the utilization of MA services. Claim audits alone will not provide access to this information.
1.5	Benefit Utilization	We strongly oppose attempts to collect data as proposed from 2007 and 2008 Plan years as systems are not in place in many organizations to comply with many of these proposed requirements. Many of these requirements would require substantial internal Plan system changes, possible recontracting with Plan providers, and require a yet-to-be published set of common definitions for industry use in reporting this data to CMS.	CMS agrees that the collection and reporting of 2007 and 2008 data might prove difficult for some plans and has eliminated 2007 and 2008 data collection from the Part C reporting requirements. Thus we will begin with the 2009 plan year.
1.6	Benefit Utilization	Recommend ample time for the industry to work with CMS to fine-tune these requirements so there are realistic implementation timelines and also standardization for data reporting within the Medicare Advantage Organization (MAO) community.	Refer to 1.5 above.

No.	Measure	Summary of Comment	CMS Response
1.7	Benefit Utilization	Recommend CMS clarify whether data for specific services is paid with federal rebate dollars and/or member premiums or both. If just with rebate dollars, then there will be inconsistency among Plans as some benefits might be paid with rebate dollars and some with member premiums.	Data on specific services apply to plan benefits paid for with federal funding, state funding, group sponsor funding and member premiums.
1.8	Benefit Utilization	CMS clarify when these data collections are for MA contracts in the individual market and/or for employer group offering of MA options.	These data collections are for MA contracts in the individual market and for employer group offerings.
1.9	Benefit Utilization	Recommend CMS clarify the responsibility of an MA organization to verify the data received from providers for non-Medicare covered items such as dental services, vision care, wellness programs—if CMS is to hold the accuracy of this data to Plans then again this will add administrative costs to MA plans for additional new compliance audits and also call for recontracting with many providers for the collection, auditing, and retention of these elements. We urge a sense of reasonableness in this area.	It is the responsibility of an MA organization to verify the data received from providers for non-Medicare covered items such as dental services, vision care, and wellness programs. The data will be subject to audit beginning in 2010.
1.10	Benefit Utilization	Attachment III refers to a one year overlap between the proposed CMS collection of encounter data and the Part C collection of benefit utilization. CMS needs to be aware that for some services there may not be encounter data that matches an abbreviated Medicare claim as some services are not set up to be reported as such. Medicare claims generally cover only Medicare covered benefits; the dental community uses a different claim form and perhaps so do providers for other services not covered by Medicare.	CMS is aware that for some services there may not be encounter data that matches a Medicare claim and that dental services and services not covered by Medicare may be recorded on different forms.

No.	Measure	Summary of Comment	CMS Response
1.11	Benefit Utilization	A commenter expressed concern that CMS is asking for utilization data on non-Medicare benefits that some plans do not collect. For example, a Plan may offer benefits for dental services by contracting with a dental organization for a per member per month cost allowing their members access to a network of providers for "discounts" applied to covered benefits. The cost to the Plan is not contingent on utilization; it is based on membership with a fixed monthly fee. To collect utilization data would require added costs to Plan operations/administrative costs, place administrative burdens on providers and Plans, and call for recontracting with many Plan subcontractors. We also question the value of this data being submitted to CMS. What would CMS use this data for?	CMS is committed to determining how services and rebate dollars are actually used. Without collecting actual utilization data, this is not possible.
1.12	Benefit Utilization	We oppose submission of Plan specific cost data outside of the formal bidding process as Plan payments to providers is highly confidential information and should not routinely be required to be reported specifically by procedure, etc.	CMS will protect the confidentiality of the information in line with all applicable laws and regulations. Congress has requested data regarding the utilization of MA benefits by plan enrollees. To date, CMS has not collected utilization and expenditure data to enable it to accommodate Congress' request. In addition, CMS is requesting data by service category not at the specific provider level.

No.	Measure	Summary of Comment	CMS Response
1.13	Benefit Utilization	When a Plan pays a set fee to another entity for non-covered Medicare services, such as dental, routine vision services, eyeglasses, etc. it should be noted that utilization of these services may not have any impact on the cost to the Plan for these services so reporting utilization data is often not a measurement of Plan costs.	This comment is noted
1.14	Benefit Utilization	Both Attachment I ("Part C Reporting Overview") and Attachment II ("Part C Reporting Requirements Detail") state that "1876 Cost" (Medicare Cost contractors) must report this data, but the Supporting Statement that describes the reporting requirements only mentions MAOs as required reporters. As a result, it is not clear if CMS intends that Medicare Cost contractors must report this data. We would seriously question such an intention because the concept of "rebate dollars" and the requirements governing the permissible uses of "rebate dollars" do not apply to Medicare Cost contracts. We urge CMS to remove "1876 Cost" from this item in Attachments I and II and acknowledge in the final guidance that Medicare Cost contractors do not have to report data for this item.	The requirement to file the MA medical utilization and expenditure experience exhibit does not apply to cost contractors.

No.	Measure	Summary of Comment	CMS Response
1.15	Benefit Utilization	MAOs include, in their annual bids, much of the data that CMS is here requesting, albeit in a pmpm formulation as opposed to aggregate numbers. It is not clear why CMS is requested that the data be expressed in aggregate numbers, and we urge CMS to reconsider. We believe that the pmpm formulation used for the bid is not only less burdensome for plans to report but also ensures an "apples to apples" comparison with the information in the bids. If CMS' intent in this item is to be able to make informed comparisons of the value of "rebate dollars" from the bids to the actual observed value of supplemental benefits and cost-sharing enhancements, we strongly believe that the requested data should be submitted, and comparisons made, on a pmpm basis. Believing as we do that "pmpm" is the proper analytical unit for the comparison we assume CMS wishes to make, we also believe that it would be much less burdensome for MAOs and much more internally efficient for CMS if the information requested in this item were included in the bid itself. MAOs already report historical data as part of the bid submission in the "two year look back" form. The new data that CMS is requesting could be included in a more detailed version of this form. Requiring MAOs to report this data independently from the bids requires MAOs to maintain a separate process, with separate deadlines, to manage the gathering, preparation and submission of this data. Such a separate submission also increases the likelihood that parallel staffs of CMS reviewers (one staff reviewing bids and another staff reviewing this data) will not make the same comparisons or the same connections between the same information presented in two different forums. How will CMS questions (coming from one staff) and MAO answers	We will establish processes to coordinate CMS' review of the BPT and MA medical expenditure experience filings to eliminate duplicative review and audit. We also note that the MA medical expenditure experience data are to be input in aggregate dollars. The exhibit has been revised to include PMPM values, which will be calculated as the aggregate dollars divided by the member months. Further, the 2-year lookback reporting requirement will be discontinued beginning with the CY 2009 experience.

		(going back to that staff) be shared efficiently with the other CMS staff, so that the MAO doesn't have to answer the same questions twice and so both units of CMS will reach the same conclusions?	
1.16	Benefit Utilization	CMS has said, in its Supporting Statement for these draft Part C Reporting Requirements that "All twelve measures are subject to audit." And as we know, all MA plan bids are audited as well. This raises not just the possibility, but the distinct likelihood, that two separate (and probably different) sets of auditors will audit largely the same data in two separate audits. This is very burdensome for MAOs, very inefficient and costly for CMS, and does not serve data integrity. CMS should reconsider requiring this data in a separate submission.	As discussed previously, the separate submissions are required to meet distinct needs. We will establish processes to coordinate CMS' review of the BPT and MA utilization filings to minimize any duplicative review and audit.
1.17	Benefit Utilization	If CMS retains this Measure Category, for clarity, we recommend that CMS explicitly indicate that the definitions will be the same as for the MA BPT and either cross-reference or incorporate information from the MA BPT instructions regarding the definitions.	The definitions will be the same as for the MA BPT. A crosswalk is contained in Attachment IV.
1.18	Benefit Utilization	We recommend that CMS provide definitions for the fields "Utilization," "Plan Experience," "Allowed Cost," and "Cost-Sharing" column headings in Attachment III by using footnotes to link the items listed under the "Notes" heading to the appropriate items and providing definitions for the terms not already addressed in that list.	Response: The filing instructions have been revised to include definitions for these terms.

No.	Measure	Summary of Comment	CMS Response
1.19	Benefit Utilization	We recommend that CMS expand the utilization types identified in note #4 to permit MAOs to report based upon units that relate to plan design. For example, MAOs do not capture data based upon any of the listed utilization types when coverage (e.g., vision benefits) is through an allowance.	Response: We have provided an "other" category and encourage you to use it where appropriate.
1.20	Benefit Utilization	Does this measure include SNPs?	Yes.

No.	Measure	Summary of Comment	CMS Response
2.1	Procedure Frequency	A commenter expressed concern that plans cannot provide definitive comments on the feasibility of this reporting in the absence of full specification of procedure codes.	CMS believes that sufficient information was provided for definitive comments on the feasibility of this reporting. Procedure codes were shared with the CMS user group after a June 2008 conference call. While these codes were not "final," they provided enough information for definitive comments. Also refer to no. 1 above.
2.2	Procedure Frequency	To be effective, we believe that CMS needs to undertake this initiative across the entire Medicare program instead of focusing the requirement narrowly on Medicare plans.	Medicare Advantage is a separate program with separate regulations. Moreover, in "traditional FFS Medicare," CMS is already collecting or planning to collect many of the data elements in this initiative, e.g., serious reportable events and hospital acquired conditions. Some of the data elements collected here have no counterpart in FFS Medicare such as those under "Commission Structure" and "Agent Oversight." Grievances and organizational determinations/reconsiderations are other examples of measures that have no apparent counterparts in FFS Medicare.
2.3	Procedure Frequency	MA plans may not be able to identify cancers by primary vs. secondary site as they depend completely on hospital and physician reporting.	CMS realizes that cancers will be identified from hospital and/or physician records. The codes for these cancers are contained in a supporting document to this notice.
2.4	Procedure Frequency	If one plan has a significantly higher frequency of total hip replacement, what does that mean? Does the Plan contract with the local center of excellence for that procedure; do they have a different case mix than other Plans; and are their members just more accident prone or do they have more low income members who often live in substandard conditions with more hazards. What conclusions will be drawn once this data is reported?	The meaning of any particular measurement or rate cannot be determined out of context. CMS will be using all the data to look at overall and plan-specific trends and relationships among the various measure sets.

No.	Measure	Summary of Comment	CMS Response
2.5	Procedure Frequency	Plans may not have access to group utilization data that could be with an employer.	CMS believes that employer plans should have data on the health care that they are coordinating.
2.6	Procedure Frequency	The requirement to report on selected cancer surgeries is problematic because it's not always clear that certain procedures are tied to cancer diagnoses. We also ask for clarification on the intended use of this data.	CMS will be providing diagnosis codes as well as procedure codes to plans for cancer surgeries. CMS intends to use the data to measure trends and to examine variation in procedure rates.
2.7	Procedure Frequency	We recommend that the measures be constructed solely from administrative (claims) data.	Plans that are not using HEDIS to report these measures have the option of using administrative data, medical records data, or a hybrid approach as is appropriate.
2.8	Procedure Frequency	We understand that a document might have been made available on a CMS MA User Group conference call with codes for this collection of data. Should this document be part of this notice?	The document is part of this notice.
2.9	Procedure Frequency	CMS should develop access standards (which it has not done to date, except in the most general terms), ask for industry review and input, finalize the standards, and then develop data reporting which can discern whether those access standards are being met. Unfortunately, this proposed data request has put the "cart before the horse" and the wrong horse at that.	CMS will be analyzing all the data and will be especially looking at "outliers" with utilization that is well below average and utilization that is well above average. The utilization data will be viewed in context and in terms of other indicators.
2.10	Procedure Frequency	If CMS finalizes its proposal to require reporting of utilization data for procedures currently not reported under HEDIS (organ transplants, gastric bypass, and cancer surgeries), it would be most efficient for MAOs and Cost contractors to collect and compile this data at the same time (and probably in the same process) as they collect HEDIS data. Therefore, we strongly urge CMS to change the reporting due date from February 28 to June 30, the deadline for HEDIS reporting.	Response: CMS is changing the reporting due date to be May 31. Cost contractors are not required to report this measure.

No.	Measure	Summary of Comment	CMS Response
2.11	Procedure Frequency	With respect to the new measures that are not currently included in the HEDIS data set, if CMS moves forward with implementation, we recommend that CMS follow widely accepted processes for the development of quality measures that are comparable to those utilized by NCQA.	CMS will be using these measures for monitoring purposes only at this time. Later, depending on the reliability and validity of reporting, there may be additional uses of the data.
2.12	Procedure Frequency	In the event that CMS retains this Measure Category, we recommend that CMS revise Attachment II to include clarified language in the "Type Plan" column regarding applicability to 800 series plans.	This measure will be collected for the following plan types: All CCP, PFFS, 800 series, demo, and MSA plans. Plans that report HEDIS measures that are the same as one of the listed measures (e.g., cardiac catheterization) will not be required to duplicate reporting and should continue to report through HEDIS.
2.13	Procedure Frequency	CMS should clarify whether the reporting unit for these measures is at the CMS contract level or at the CMS contract and plan benefit package level.	Reporting is at the contract level
2.14	Procedure Frequency	In defining these measures, Commenter urges CMS to consider that there are certain services that may appear underreported because they cannot be linked to a diagnosis for the condition of interest. For instance, CMS proposes that plans report "cancer surgeries." Surgeries such as biopsies to diagnose or rule-out cancer may not be billed with an associated cancer diagnosis because that diagnosis will not be known until after completion of the procedure and return of the pathology report.	CMS expects plans that are coordinating care to have access to data on why the surgeries are being performed. If plans do not have access to such data, they should develop mechanisms that allow them to compile and report these data.

No.	Measure	Summary of Comment	CMS Response
2.15	Procedure Frequency	The data being collected for this reporting requirement is very similar to that of the HEDIS reporting requirements; however there are different or additional data elements required and unlike the HEDIS data, it is non-audited data that will be submitted.	Some of the required data are similar to that required by HEDIS. Plans currently submitting HEDIS data will continue to submit those data through HEDIS reporting. Plans not submitting HEDIS measures that are required to report procedure frequency measures will use the specifications provided by CMS. These specifications are the same or nearly the same as the HEDIS specifications for the same measure. If there are differences, CMS attempted to capture the latest codes available which may or may not be part of the current HEDIS specifications. Procedure frequency data will not be audited in the first year of reporting but are subject to audit later.
2.16	Procedure Frequency	The sampling methodology does not specify how the data will be analyzed. If a plan is identified as an outlier, a breakout by population, such as age group or significant illness should be considered, as some procedures are not appropriate for some age groups or illness types.	There is no sampling methodology since these are population based measures.
2.17	Procedure Frequency	Risk adjustment data shows high risk patients – CMS already has this data. Reporting set up doesn't answer access question.	CMS will initially be using these data for monitoring plans. Case-mix and other factors will be taken into account in the resulting analyses.
3.1	SRAEs	Is there a corresponding regulation proposed for Medicare fee-for-service program that would go to the source for this information?	Refer to 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register / Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations. Also refer to: 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians/Federal Register/Vol. 73, No.

			84/Wednesday, April 30, 2008/Proposed Rules.

No.	Measure	Summary of Comment	CMS Response
3.2	SRAEs	This initiative requires significant additional data collection/reporting by plans for events that are fundamentally provider issues at their core.	CMS believes strongly that health plans and providers are accountable for the quality of care that their enrollees or patients receive. Plans should be monitoring these events as part of their credentialing and coordination of care.
3.3	SRAEs	We are not aware that there is any reporting system currently available for reporting this set of serious reportable adverse events (SRAEs). Considering the data elements that plans currently receive in provider claims, it is highly unlikely that plans would be able to identify all reportable events via claims data.	SRAEs are so rare and so serious that we believe that plans should have a means to identify them if they involve plan enrollees who are receiving care from a provider that receives payment from the plan.
3.4	SRAEs	Procedure and diagnosis codes alone are inadequate to categorize all SRAEs; reviewers likely would need narrative information to establish context. In addition, patients could be admitted with some of these 22 diagnoses from home, long term care facilities or other acute care hospitals. This opens to question how data in these cases would be distinguished from true iatrogenic events and used to improve quality where appropriate.	The SRAEs are all related to hospital care. SRAES should be distinguished from hospital-acquired conditions (HACs) which are also reportable but much less rare than SRAEs. SRAEs are "egregious" events—surgery on the wrong body part, surgery on the wrong patient, wrong surgery on a patient, foreign object left in patient after surgery, and post-operative death in normal health patient. SRAEs are true iatrogenic events. Providing context may be helpful in order to improve quality, but that does not diminish their iatrogenic origin.
3.5	SRAEs	We believe there is significant potential for double counting of surgical and medical reportable events. Many medical admissions may have a surgical intervention; the program cannot reliably count purely "medical admissions" for denominator.	The data should be traceable to the beneficiary for an event occurring on a given date.

No.	Measure	Summary of Comment	CMS Response
3.6	SRAEs	Our key concern is that Plans will have no formal mechanisms for obtaining this data from non-contracting hospitals. From an oversight perspective, we have concerns that Plans will be held accountable to reporting hospital data for hospitals for which they have no contracts. Some Plans will also need to recontract for this data with their existing hospital networks. A further complication is raised by use of "essential hospitals." These hospitals are deemed to be in-network providers within a Regional PPO, but they are not operating under a participating provider contract, and Plans have no mechanism at the present time of requiring these hospitals to report the required data.	These events are so rare and egregious that plans should have a mechanism for finding out when these events involve a provider that is receiving payment from the plan.
4.1	Provider Network Adequacy	This appears to be a duplicative requirement as CMS already reviews provider networks during its biennial monitoring visits.	CMS seeks to assess network adequacy and stability on a more consistent basis than by periodic audits (which may be less frequent for low risk MAOs). With this measure, CMS can monitor network adequacy less obtrusively and through self-reported data that we believe MAOs should maintain regardless of this reporting requirement. As such, with this measure, CMS will have more regular data for assuring network adequacy without subjecting MAOs to surprise information requests for the same information.

No.	Measure	Summary of Comment	CMS Response
4.2	Provider Network Adequacy	CMS defines PCPs for reporting purposes as general practice, family practice, internal medicine, and gynecology. This ignores the fact that plans are permitted to define other specialties as PCPs, such as geriatrics. Also, is use of gynecologists as PCPs supported in literature?	Consistent with instructions in the Medicare Advantage Application's Health Service Delivery Tables, CMS permits MAOs to count as Primary Care Providers (PCPs) as physicians that practice general medicine, family medicine, internal medicine, obstetricians pediatricians, and state licensed nurse practitioners. This is consistent CMS' longstanding policy for determining network adequacy for new applicants. CMS believes that physicians "specializing" in general practice, family practice, internal medicine, and gynecology may be considered as primary care physicians, but is aware that some organizations may include or exclude other "specialties" in their definitions of primary care physicians. Given that there is no single established definition of PCPs that is agreed upon by all oversight organizations, payers, and medical associations, CMS believes that its definition is as valid and appropriate as any other definition. Gynecologists and Geriatricians may be considered as PCPs for CMS' reporting requirements as long as providing primary care services are consistent with their provider contracts with the MAO.

No.	Measure	Summary of Comment	CMS Response
4.3	Provider Network Adequacy	We believe that this is a significant new reporting burden but the proposed data elements will produce little additional value for beneficiaries. CMS currently requires MA plans to demonstrate access to 21 physician specialties. Aggregate reporting of specialists does nothing to ensure access to individual specialties. It would make more sense for plans to submit HSD-1 tables annually.	CMS appreciates this comment with respect to aggregate specialists, but is also seeking a way to develop a reporting measure that is less burdensome than the instituting a requirement to resubmit HSDs tables annually. As such, we have revised this measure to consist of Primary Care Physicians and ten other provider and facility types, they are: (1)Hospitals, (2) Home Health Agencies (Medicare Certified), (3) Cardiologist, (4) Oncologist, (5) Pulmonologist, (6) Endocrinologist , (7) Skilled Nursing Facilities, (8) Rheumatologist, (9) Ophthalmologist, and (10) Urologist In all cases, CMS will make the definitions for reporting these provider and facility types consistent with the definitions and instructions in use for HSD as defined in 42 CFR 422.202.
4.4	Provider Network Adequacy	What standards does CMS propose to use to assess adequacy in rural vs. urban area or in terms of ratios per 1,000 members?	CMS does not employ explicit ratios such as those suggested in this question. The primary purpose of this measure is to measure network adequacy and stability over time; as such an explicit numerator/denominator ratio as suggested above is not central to CMS's present thinking about this measure.
4.5	Provider Network Adequacy	Plans cannot provide constructive, definitive comments in the absence of CMS having defined standards for PCP and specialist access. This lack of detail defeats the purpose of the review and comment process.	CMS needs these data prior to any effort to provide benchmarks for PCP and specialist access. Initial data analysis in this area will likely examine the degree of variation in access and factors associated with that variation.

No.	Measure	Summary of Comment	CMS Response
4.6	Provider Network Adequacy	A plan that terminates a contract with a large physician group may continue to have adequate access but – depending on how the measure is implemented – could appear to have access problems only because it reported the change. In addition, plans that make extensive use of subcontracted provider networks will encounter problems of downstream data reliability.	These are among a number of issues that impact data and its interpretation. Plans can make CMS aware of these factors in order to provide for more valid data interpretation. With respect to listing individual practitioners in group practices, CMS will adopt guidance along the lines of present HSD instructions, maintaining consistency between new organizations and incumbent organizations.
4.7	Provider Network Adequacy	CMS should rethink this requirement given that the requested data and associated reporting likely will not achieve CMS' stated objective.	CMS strongly supports this measure set and believes that it will be valuable in achieving CMS' stated objective. Per statements above, CMS believes there compelling reasons for this reporting requirements and we are revising this measure per comments to reduce the burden and increase its consistency with existing CMS HSD requirements, of which incumbent MAOs are already familiar.

No.	Measure	Summary of Comment	CMS Response
4.8	Provider Network Adequacy	This requirement appears to overlap with NCQA reporting requirements. We would like CMS to clarify how NCQA accreditation aligns with these requirements. Does NCQA accreditation in this area exempt a Medicare Advantage Plan from having to report this information as it appears to be a duplication of effort? Commenter recommends that if a Plan complies with NCQA, then the same organization is deemed in compliance with CMS requirements and an exemption provided for Plans meeting NCQA standards. Commenter also suggests that the timelines between NCQA and CMS reporting periods be identical to allow for more efficient operational compliance.	NCQA accreditation is independent of these reporting requirements and does not exempt an MAO from reporting these data. The timelines between NCQA and CMS reporting periods will not necessarily align. The intent of both NCQA and CMS' reporting requirements on network access and availability is to ensure that plans maintain viable networks. However there are distinct differences in the requirements. NCQA requires each MA plan to establish quantifiable and measurable standards in ratios of the number of providers per member and travel times and distances of providers. CMS does not explicitly support such numerator/denominator approaches. In addition, not all MA plans are accredited through NCQA, and many MAOs are therefore not prepared to report via NCQA or NCQA-like approaches. Further, CMS' reporting requirements are consistent with HSD requirements and will be collected in a HSD-consistent manner format (thereby lessening the burden of learning a new set of reporting rules). Reporting will be based on the total number of each provider type in a geographical location. CMS' primary goal with this measure is to identify instances of potential network decay. At this time there are no concrete plans to measure against any standards or penalize low performers. CMS does not intend to compare data across plan types. Data will be reviewed to ensure that provider networks do not deteriorate after contract award.

No.	Measure	Summary of Comment	CMS Response
4.9	Provider Network Adequacy	Please clarify that these requirements do not apply to non-network PFFS plans.	They do not apply to non-network PFFS plans.
4.10	Provider Network Adequacy	We would again reference the need for specifications and common definitions for network information. What is the definition of PCP, does this include OB/GYNs, and also how will this collection be used in the context of comparisons among Plan options such as HMOs vs. PPOs. In HMOs there is a clear need for PCPs but that is not always the same need in PPOs. How also will the RPPOs be considered as to their network adequacy not being held to the same standards as local coordinated care plans? We also recommend that this data be collected once a year and not twice a year to better align with Plan processes to update this data.	Reporting requirements for provider network adequacy will apply to all network MA plan types. However, the requirements will not change network flexibility for RPPOs and partial-network PFFS plans. CMS will review data within product-specific cohorts for comparison purposes. With respect to RPPOs, CMS may use this data to see if networks are gradually expanding over time. Although partial-network PFFS plans will be required to report, they will suffer no consequences for submitting zeros for providers and facilities for which they have no network benefits. We also note that the reporting frequency will be once per year.
4.11	Provider Network Adequacy	We also question the requirement to have data on the available openings within a provider's practice. Some Plans commented that they do not keep ongoing data on whether particular providers have an open practice – they normally collect such data only at time of a credentialing and recredentialing of providers and not on an on-going basis. We ask for this element to be deleted in the final requirements.	CMS believes these measures are important in monitoring provider network adequacy and will retain them. We will retain the measures on open practices for primary care physicians (PCPs) but will eliminate those measures for specialists.
4.12	Provider Network Adequacy	Some Plans do not allow specialists to close their panel. Would there be an option for a Plan to attest to this instead of uploading the same numbers for number of specialists and number of specialists accepting new patients?	See response to previous question.

No.	Measure	Summary of Comment	CMS Response
4.13	Provider Network Adequacy	In this item, CMS is requesting the number, availability and "stability" of network primary care physicians and specialists, so that it can develop standards for network adequacy and continuity of care. However, CMS does not indicate when those standards will be issued - before, during or after the first reporting period, or the first deadline for reporting? As a result, MAOs may be reporting data without knowing what CMS' standards are or will be.	To date, CMS does not have quantitative "standards" for network adequacy and stability nor does it have a date when such standards might be issued. New Medicare Advantage applicants must submit rigorous documentation of network adequacy through Health Service Delivery (HSD) tables, and this measure will permit CMS to assure that there is not substantial network decay in proceeding years.
4.14	Provider Network Adequacy	It is unclear how CMS will use the various "rates" that it says it will calculate. Will these rates be used by CMS for data-driven monitoring/oversight of MAOs, for release as public information, or as required disclosures by MA plans to their prospective and/or current enrollees? CMS should clarify this in its final guidance.	CMS has not committed to using a specific rate or set of rates to calculate network adequacy. We will use this data to measure MAO network stability over time, and assure that particular MAOs do not experience network decay in out years, after the approval of their HSD tables in their initial application year.

No.	Measure	Summary of Comment	CMS Response
4.15	Provider Network Adequacy	CMS already has access to similar data via county-specific HSD tables and GEO-access analyses, both of which CMS can (and frequently does) request in advance of site visits for new applications, for service area expansions, and for monitoring visits, and as part of Caps (Corrective Action Plans). MA plans must already inform CMS (and affected members) of any material changes in their provider networks, so this existing requirement plus expanded (or more frequent) HSD table submissions should be an acceptable alternative to the reports required by this item. These "movement" data don't really measure whether there is an appropriate number of primary care physicians or specialists (either overall or in any particular specialty) to meet members' needs; whether either primary care physicians or specialists are situated in locations that are accessible and convenient for members; or whether the wait times to see these primary care physicians or specialists are reasonable. The "patient acceptance" data may be misleading as well.	CMS believes the data requested are valid indicators of network adequacy and stability. It also believes that the collection and reporting of these data do not impose an unreasonable burden on health plans. Network adequacy and stability are critical in ensuring enrollee access to care, one of the most important functions of health plans and this reporting requirement allows CMS to collect this important date less obtrusively than via audits. CMS will modify the aggregated specialist category to include PCPs and ten of the most important specialist and facility categories (refer to no. 70 above). All data collected for this measure will be collected in a manner consistent with the long-established rules and definitions established for HSD, minimizing the need for MAOs to learn new rules or develop new internal systems for this reporting requirement.

No.	Measure	Summary of Comment	CMS Response
4.16	Provider Network Adequacy	In the Supporting Statement, CMS indicates that the purpose of this measure is to assure continued network adequacy under MA contracts. The proposed reporting twice each year of aggregate numbers of providers at the beginning and end of the reporting period can be expected to add little, if any, additional insight into ongoing MAO compliance with network adequacy requirements. However, reporting will require significant additional resources for MAOs to produce the new reports and CMS to review and evaluate them (e.g., outreach to all providers twice a year to ascertain whether they are accepting new patients at a single point in time will be highly resource intensive but will not provide any ongoing information about network adequacy).	CMS has considered this comment and will only request this data annually.
4.17	Provider Network Adequacy	CMS currently has requirements in place that permit the agency to identify network adequacy and access to care issues that may arise and require action by MAOs to address them. For example, as part of monitoring site visits, CMS requires completion of HSD tables that call for such information as the number of providers by specialty and the names of providers by county by provider specialty. In addition, MAOs are obligated to report to CMS material changes in their networks and notify affected beneficiaries, and CMS has established a systematic complaint tracking process that can alert CMS to any patterns of beneficiary complaints regarding access to care. Taken together these steps provide CMS with the ongoing ability to ensure that MAOs meet requirements for provider network adequacy. We recommend that CMS reevaluate whether this measure would add sufficient value to warrant its implementation. If the agency retains it, we recommend that reporting be required on an annual basis.	CMS believes that the measure is warranted as provider stability remains a central determiner of member satisfaction and health care quality based upon CMS's own and external research. Through monitoring visits (which are less frequent than annual), CMS may collect and audit network information for MAOs, and CMS does review HSD Tables to assure network adequacy for new applicants. In addition, CMS does receive and aggregate network adequacy complaints. However, none of these data sources, even collectively, is as reliable as the network adequacy information discussed in the reporting requirements. Further, requiring such information via surprise audits is more burdensome than routine self-reporting in a manner consistent with the HSD guidelines/tables with which MAOs are already familiar.

No.	Measure	Summary of Comment	CMS Response
4.18	Provider Network Adequacy	The data elements for this Measure Category in Attachment II require a plan to report on the number of both primary care physicians and specialists under several data elements. To promote a consistent understanding of the reporting requirement, we recommend that CMS define the terms "primary care physician" and "specialist."	Based upon comments received, CMS will revise this measure to more closely align with existing HSD definitions with which MAOs are already familiar. PCPs will be reported consistent with HSD definitions, and the aggregated specialist category will be replaced by ten provider and facility types (see list in no. 70 above) already required in HSD table submission.
4.19	Provider Network Adequacy	Attachment I indicates that this reporting requirement applies to PFFS plans, but makes no distinction between network and non-network PFFS plans. It appears that this measure would not apply to PFFS plans that meet access requirements through deeming, because providers have the opportunity to decide to treat enrollees on a visit by visit basis. The data elements also do not appear to apply to non-network MSA plans. We recommend that CMS revise the proposed reporting requirement to clarify that non-network PFFS and MSA plans are not required to report these data elements.	The data elements do not apply to non-network PFFS and MSA plans. We agree that PFFS plans that meet access requirement through deeming are considered non-network PFFS plans and should not be required to report.
4.20	Provider Network Adequacy	Commenter recommends that CMS collect these data only once annually rather than twice a year to better align with plans' own schedules for updating this information.	CMS will collect data for this performance measure annually.
4.21	Provider Network Adequacy	CMS should clarify that non-network plans (i.e., PFFS plans) do not need to report on these measures.	Non-network plans do not need to report these measures.

No.	Measure	Summary of Comment	CMS Response
4.22	Provider Network Adequacy	In order to allow time to sufficiently develop our data tracking and reporting mechanisms. Commenter recommends that CMS begin collecting these data on July 1, 2009, rather than January 1, 2009.	As PFFS are already required to maintain dispute resolution process, and information related to this process may be requested and audited by CMS, CMS chooses to maintain the proposed data collection schedule with collection beginning January 1, 2009.
5.1	Grievances	We do not understand why CMS would want to combine "enrollment/ disenrollment/ access/benefit package" and confidentiality/privacy" into a single reporting measure. Lumping together the data for four significant operational processes into a single measure defeats the purpose of reporting.	CMS believes that grievances are often difficult to categorize into precise categories but some categorization is possible. These categories were viewed as the most useful for purposes of reporting.
5.2	Grievances	CMS should provide guidance to MA-PD plans and Cost-PD plans when the same grievance categories are reportable under both Part C and Part D. Commenter also notes possible confusion in grievance categories, questions the uses to which CMS will put the grievance rates, and asks CMS to clarify these issues in its forthcoming technical memorandum.	CMS will provide technical guidance on reporting of this proposed requirement. CMS believes that tracking of rates in these categories may help in interpreting other measures such as plan oversight of agents.
5.3	Grievances	Plans currently track/report these data for Part D. Plans would need to update their systems to collect this information for Part C as this data collection is currently not in place.	CMS expects plans to update their systems to collect this information for Part C if this data collection is currently not in place.
5.4	Grievances	There is concern about the potential for overlapping/duplicate reporting where there is a question about whether a grievance should be reported under Part C or Part D (or both).	Plans should report a grievance as either Part C or Part D, as a result of their process to investigate/resolve the grievance. This is the current policy for the Parts C and D Complaints Tracking Modules (CTM). For most complaints or grievances, a Plan will be able to determine which is more applicable. For the minority of cases where a clear distinction is not available for a MA-PD, complaints should be reported as Part C complaints.

No.	Measure	Summary of Comment	CMS Response
5.5	Grievances	It is not clear whether CMS intends to use grievance rates solely for its own data-driven monitoring/oversight activities, or whether CMS will require MAOs and Cost contractors to provide the rates to prospective and/or current enrollees, or whether CMS will release the rates publicly. Nor has CMS said what threshold of grievance rate would be acceptable, after which higher rates would trigger closer scrutiny or CMS intervention. We urge CMS to address these questions in the October 1, 2008 technical memorandum.	CMS will use these rates to monitor MAOs. CMS has not determined if it will use these rates for any other purposes. CMS has not established a threshold of an "acceptable" grievance rate.
5.6	Grievances	Clarify that only grievances finalized during the reporting period should be included, regardless of when the grievances were received.	Only grievances finalized during the reporting period should be included.
5.7	Grievances	Clarify whether employer-sponsored plans should be combined at the contract level, or reported separately at the plan level.	Employer sponsored plans should be reported separately at the plan level.
5.8	Grievances	How should plans classify grievances that are not clearly Part C or Part D.? For instance a grievance related to the monthly premium amount for a Medicare Advantage Prescription Drug (MA-PD) plan could be classified as either Part C or Part D.	In this example, the premium in question should be drilled down to determine if it is in regards to a Part C or D premium. If it is both a Part C and Part D premium, CMS would view this as 2 different grievances, and therefore each would be filed in its respective module.
5.9	Grievances	Clarify whether the list of grievance categories is meant to be all inclusive, and if so, if plans should collapse additional categories they track, but that aren't specifically listed, into the "other" category.	The list is meant to be "all inclusive." Plans should collapse additional categories they track but not specifically listed into the "other" category.

No.	Measure	Summary of Comment	CMS Response
5.10	Grievances	Commenter suggests that CMS make modifications to the Part C requirements to further align them with those for Part D. For instance, commenter recommends that the category of "enrollment/disenrollment access/benefit package" be broken out into separate categories as they are for Part D reporting. These elements would be more meaningful to beneficiaries and CMS as discrete items. CMS might consider including customer service as a category of grievances.	CMS has aligned the categories for Part C and Part D grievances to the extent practicable.
5.11	Grievances	Commenter suggests that CMS allow plans at least three months between the release of the final reporting requirements and the start of data reporting to ensure that necessary systems are prepared to collect the required data. The commenter expressed the need to coordinate multiple data collections systems in order to report aggregate grievance data for all Part C enrollees. Assuming the final requirements are available by October 1, 2008, commenter recommends that CMS begin data collection on grievances on or after January 1, 2009.	The requirements listed in this document still await a 30-day comment period as of the date of this release. We suggest, however, that MAOs do not wait until the requirements become finalized to enact the changes in their systems that are needed to implement this reporting. The data collection will begin on January 1, 2009.
5.12	Grievances	Please clarify this applies to SNFs.	This applies to SNFs
5.13	Grievances	The more significant concern is focused on intended use of the collected data with perhaps the assumptions that CMS and others will make judgments and compliance risks based on data. We are not confident that "apples will be compared to apples," and that all plans will interpret the requirements in the same manner and report in the same manner.	This concern which is one that applies to all self-reported data. CMS will be using the data to monitor plans, and the data will be viewed in context along with other relevant data.

No.	Measure	Summary of Comment	CMS Response
6.1	Organization Determinations/ Reconsiderations	CMS should define the terms "total substantive determination" and "total substantive reconsiderations". The use of “substantive” as a modifier in the totals categories of organization determinations and reconsiderations is unclear and confusing. We recommend that CMS either eliminate the word or explain its intended meaning.	We have dropped the term “substantive” from both data elements.
6.2	Organization Determinations/ Reconsiderations	The commenter is concerned CMS links organization determinations/reconsiderations with grievances indicating that one can be an indicator of how a Plan handles the other.	CMS understands that organization determinations and reconsiderations involve authorizations for services or items or payments for services or items and grievances involve complaints about anything other than payment or service authorization. CMS believes that the handling of organizational determinations, reconsiderations, and grievances are important plan activities that significantly impact enrollee experience with the plan.
6.3	Organization Determinations/ Reconsiderations	There is a concern that Part D items also could be confused with Part C items and run into duplication and ties to determinations, reconsiderations, IRE reviews etc.	CMS expects plans, including those that provide both MA and Part D benefits, to maintain the necessary processes and procedures to ensure the integrity of the self-reported data.
6.4		Commenter questions whether a category of partial denials is really meaningful because such a category would aggregate cases in which an expensive service was approved and a low cost item was denied with other cases where the opposite was true.	CMS believes that the category “partially favorable” (to enrollee) is meaningful in monitoring determinations/reconsiderations in the context of including two other categories: “fully favorable” and “adverse.”
6.5	Organization Determinations/ Reconsiderations	We ask CMS to clarify the use it will make of the reported data, especially how CMS will use the reported data, the "number of appeals to the Independent Review Entity (IRE) and the outcome of the appeals", to calculate "an appeal rate".	CMS will use the data for monitoring organization determinations and reconsiderations and to strengthen the assessment of the overall appeals program, because it will furnish a denominator for calculating appeals.

No.	Measure	Summary of Comment	CMS Response
6.6	Organization Determinations/ Reconsiderations	The Supporting Statement links organization determinations and reconsiderations with grievances. However, it is our understanding that organization determinations and reconsiderations are part of the appeals process only and do not apply under the grievance process. We recommend that CMS revise the Supporting Statement accordingly.	"Grievances" and "organization determinations and reconsiderations" are separate measure sets. We agree that the first two statements in the original supporting statement under organization determinations and reconsiderations imply a linkage that does not exist. We have modified the text in the revised supporting statement
6.7	Organization Determinations/ Reconsiderations	Commenter recommends that CMS confirm that the collection period for reconsiderations and organizational determinations includes those cases where final decisions were made during the reporting period, regardless of when the case was initially received.	CMS confirms that the collection period for reconsiderations and organizational determinations includes those cases where final decisions were made during the reporting period, regardless of when the case was initially received.
6..8	Organization Determinations/ Reconsiderations	With regard to organizational determinations, plans' current contracts with medical groups or utilization management vendors may not support the ongoing reporting of utilization data, including organizational determinations, requiring plans to revise their contracts with vendors. Also, compiling the required data will require significant time and effort by plans, which will need to pull data from multiple systems and vendors and compile it into one format for reporting. Thus, Commenter recommends that collection of organizational determinations data begin sometime after January 1, 2009 (for instance, July 1, 2009), and that CMS require annual, rather than quarterly, collection of determination data.	The collection of organizational determinations data should begin January 1, 2009 as initially proposed.
6..9	Organization Determinations/ Reconsiderations	Please clarify if this applies to SNPs.	This applies to SNPs.

No.	Measure	Summary of Comment	CMS Response
7.0	Employer Group Sponsors	Plans consider the names, size, and benefit plans of their employer groups to be confidential information that needs to be protected from public disclosure. Requiring Plans to provide employers' tax ID numbers can also be a challenge – a lot of groups/employers are very reluctant to provide this information as it is also highly confidential. We also understand unions do not have tax ID numbers. Also some Plans may have very small groups and this would be again a challenge to report this information in a timely and accurate manner.	CMS has statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union sponsored plans offered by Medicare Advantage Organizations (MAOs), set forth in Section 1857(i) of the Social Security Act. Under the above-referenced statutory authority, MAOs are permitted to utilize these waivers to contract with employer and union group sponsors to facilitate the enrollment of their Medicare-eligible retirees into MA plans (please note that in addition to these "indirect contract" arrangements. CMS also has separate statutory authority to directly contract with employers and union group plan sponsors to offer a Medicare benefit to their retirees). When exercising our discretion to grant these statutory waivers or modifications to MAOs offering these plans, these waivers and/or modifications are conditioned upon the MAO meeting a set of conditions and complying with certain requirements, which may include these kinds of reporting requirements. In addition to being a condition of receiving these waivers, the information requested is necessary for CMS to fulfill its affirmative oversight obligation to ensure MAOs and the employer groups that contract with the MAOs are properly utilizing these waivers and modifications and that CMS' statutory waiver authority is being implemented in accordance with the requirements of the Section 1857(i) of the Act.. The Tax Identification Number (TIN) is the standard unique employer identifier. The Medicare program uses the TIN to identify employers and businesses in other areas of the program. For example, MAOs and other insurers are required to report TIN information in order to comply with the mandatory Medicare Secondary Payer

			insurer reporting requirements of Section 111 of the Medicare Medicaid, and SCHIP Extensions Act of 2007 (Public Law 110-173). Thus, some of these same entities (MAOs and employer/union sponsors) affected by our reporting requirements will similarly be required by law to collect and report TIN information to CMS for Medicare secondary payment purposes. Additionally, while we understand that it can be a challenge for the MAOs to collect TINs from the employer/union sponsors, as outlined above, this information is necessary to ensure that our statutory waiver authority is being properly implemented. If employer/union sponsors are unable or unwilling to provide TINs or other required information necessary to ensure our waiver authority is being properly implemented, MAOs should notify these sponsors that they will be unable to utilize the waivers available to employer/union group health plans to take advantage of these kinds of unique Medicare options and should work with them to explore other Medicare options for their retirees. We consider employer name, TIN, and employer address to be proprietary and, therefore, not subject to public disclosure.
7.1	Employer Group Sponsors	Does this apply to all employers who purchase an MA plans or only those who purchase a PFFS option?	This applies to all employer/union sponsored individual and "800 series" MA plans, not just PFFS plans.
7.2	Employer Group Sponsors	Even though CMS is proposing that the data be reported twice a year, the only data element that is likely to change from report to report is the group membership. Therefore, we suggest CMS finalize a requirement for an annual report, not a biannual one	It is not uncommon for employer group plans to start/end in the middle of the calendar year. This is especially true for employers who offer non-calendar year plans. A biannual report will allow MAOs to submit updated information to CMS for these kinds of employer/union sponsors. Also, as this is the first time CMS is collecting this information, we will consider changes to the frequency of providing this data in the future, after we have had a chance to evaluate the data received.

No.	Measure	Summary of Comment	CMS Response
7.3	Employer Group Sponsors	Our experience with collecting these data elements from employer groups and trust funds leads us to remind CMS that sometimes, despite our very best efforts, one or more required data elements will not be available. Sometimes an employer group will be uncooperative. At other times, it is due to the way the employer group is structured. For example, some employer groups may have combined a number of their divisions into a single entity for the purpose of purchasing health care benefits for their retirees, and there is no single TIN that corresponds to the entity that contracted with the MAO to purchase the "800 series" plan. As a result, MA plan members whose former employers have different legal names and different TINs might be grouped under a contract with the first entity (the purchasing entity) in an MAO's membership systems. CMS should give MAOs the flexibility to leave certain fields blank if they are unable, or a group is unwilling, to provide a particular data element.	See response to comment 7.1 above. MAOs are required to submit all required data.
7.4	Employer Group Sponsors	We also recommend that CMS consider expanding the categories of "Organization type" to Professional, Corporation, Partnership, Limited Liability Company, Sole Proprietorship, Small Business, Taft Hartley Trust, and Trust. Even though there is an "Other" category, CMS is likely to get more meaningful data if it adds more specific categories.	This suggestion merits consideration for a future version of this reporting measure.
7.5	Employer Group Sponsors	We note what appears to be a typo. In Attachment II ("Part C Reporting Requirements Detail"), for item #7, the "Plan Type" states "PFFS" while under "Data Elements" there is a statement that "All individual MA plans and '800 series' MA Plans sponsored by employer groups will report." Presumably this latter statement belongs in the "Plan Type" column and "PFFS" does not.	The typing error is noted and has been corrected in the revised document.

No.	Measure	Summary of Comment	CMS Response
7.6	Employer Group Sponsors	The Supporting Statement and Attachment I indicate that reporting under this Section will be required of "All individual MA plans and 800 series plans sponsored by employer groups." However, it appears that CMS intends to refer to MA plans and 800 series plans offered to employer/union groups through contracts with MAOs. Employer/union groups also are permitted to sponsor MA and Part D plans by contracting directly with CMS. To avoid confusion, we recommend that CMS revise the last paragraph under Section 7 of the Supporting Statement and the "Type Plans Required to Report" column in Attachment I by removing "sponsored by" and inserting instead "offered to."	We have added references to Employer/Union Direct Contracts where appropriate to avoid any confusion.
7.7	Employer Group Sponsors	Attachment II lists only PFFS plans in the Plan Type column. We recommend that CMS revise Attachment II to include the same revised language as recommended above for the Supporting Statement and Attachment I.	See response to comment 7.7 above.
7.8	Employer Group Sponsors	It is our understanding that "Organization Type" in the list of data elements means for profit or not for profit. If this is correct, we recommend that CMS add a parenthetical to this effect to this data element in the Supporting Statement and in Attachment II.	"Organization type" refers to: state government, local government, publicly traded organization, privately held corporation, non-profit, church group, and "other".
7.9	Employer Group Sponsors	Sponsorship of employer group plans differs from the individual market in that information is competitive and proprietary, as plans often negotiate directly with employers to craft specific benefit packages. Commenter is cautious about releasing the names of employers with whom it contracts, as well as other data, with the concern that such data may become publicly available. Similarly, employers or unions may be hesitant to provide Federal Tax ID data.	See response to comment 7.1 above.
7.10	Employer Group Sponsors	Commenter requests clarification that the elements in this category are the only ones to be collected and reported for employer group plans. That is, reporting for the other measure categories should be for individual plans only, not for employer group plans.	MAOs are required to report a number of the measures for "800 series" plans. Attachment I and Attachment II clearly indicate which measures should be reported for such plans. All measures should be reported for employer/union sponsored individual plans.

No.	Measure	Summary of Comment	CMS Response
7.11	Employer Group Sponsors	The "Plan Type" column says "PFFS", but the "Data Elements" column says "all individual MA and 800 series MA plans sponsored by employer groups will report". Clarify that this report is only applicable to PFFS plans – not the other types of MA plans.	See responses to comments 7.2 and 7.6 above.
7.12	Employer Group Sponsors	The PFFS organization may not know if an employer group is sponsoring their retirees in an individual plan.	The requirements of the statutory waiver authority is that the MAO "contract with employer and union group sponsors" to offer these kinds of Medicare benefits, including offering individual plans. Thus, if the MAO is utilizing employer group waivers or modifications in offering individual plans to its retirees, it would certainly be aware of the fact that the employer group is sponsoring an individual plan and must comply with these reporting requirements and ensure that the MAO and the employer/union sponsor are properly utilizing CMS' statutory waiver authority.
7.13	Employer Group Sponsors	PFFS organizations may not have access to the employer's tax ID.	Please see response to comment 7.1 above.
8.1	Enrollment Verification Calls	Please clarify that this does not apply to group PFFS coverage as post-enrollment verification calls are currently not required for group MA members.	Correct, this does not apply to group PFFS coverage for the reason stated.
8.2	Enrollment Verification Calls	Since a number of the new requirements [in MIPPA] are designed to serve the same goal as this Measure Category, we recommend that CMS defer finalizing the proposed data elements on enrollment verification calls pending implementation of the new statutory and regulatory requirements. In the interim, CMS can continue to rely on a variety of current tools for carrying out oversight responsibilities, such as complaints tracking, focused reviews of PFFS plan documentation of enrollment verification activities, and audits.	As the supporting statement indicates, CMS has received complaints from beneficiaries who claim they either did not enroll in a PFFS plan initially or they did so without receiving a follow-up verification call or letter as required by guidance memorandum. CMS feels that delaying implementation of this measure set would not serve beneficiaries well. Therefore, CMS intends to implement this measure as proposed.

No.	Measure	Summary of Comment	CMS Response
8.3	Enrollment Verification Calls	Attachment II and the Supporting Statement indicate that this reporting requirement applies to PFFS plans. Attachment I lists both PFFS and 800 series plans. CMS has issued guidance indicating that enrollment verification requirements do not apply to PFFS 800 series plans. Accordingly, AHIP recommends that CMS remove the reference to 800 series plans from Attachment I.	We have removed 800 series plans from Attachment I.
8.4	Enrollment Verification Calls	Data Elements and Calculation of Rate of Enrollment. The language of the first data element in Attachment II, "Number of initial enrollee taken enrollment verification calls completed in reporting period" is unclear. It appears to mean the number of times the MAO reaches the prospective enrollee with the first call of up to three required attempts. If this is correct, we recommend that CMS clarify the language and include the same language in the description of the rate of enrollment.	CMS agrees this was unclear. We have changed this data element description to read "the number of times the MAO reaches the prospective enrollee with the first call of up to three required attempts."
8.5	Enrollment Verification Calls	Commenter recommends that CMS commence data collection on July 1, 2009 to allow it to incorporate this request into its contract with its vendor and to allow its vendor sufficient time to make the appropriate coding changes.	CMS will maintain the proposed data collection schedule with collection beginning January 1, 2009.

No.	Measure	Summary of Comment	CMS Response
8.6	Enrollment Verification Calls	The equation for determining the canceled enrollments as stated in Attachment II is not clear. It is recommended that the calculation to verify that MAOs are completing the enrollment Verification for 100% of the enrollees be: Total Amount Completed Records (All records where contact was made (Refusal, Completed Survey, Disenroll, etc)) + Total Letters Mailed (All records where we were never able to contact the member (Wrong Ph#, Deceased, Max Attempts, etc.)/ Total Enrollment in the reporting period based on TRR -enrollments via 1-800 MEDICARE, &.medicare.gov and plan websites. Total amount of completed records (# of verification calls): all records in which enrollment verification contact was made including Refusal, Completed Survey, Disenroll, etc.) .Total Letters Mailed: should be all records where plans were never able to contact the member (Wrong Ph#, Deceased, Max Attempts etc) i.e., all records in which the enrollment verification survey was not completed. Total Enrollment in reporting period: should be new enrollments on TRR -enrollments via 1-800-MEDICARE, www.medicare.gov and plan websites. In addition, a separate data element should be required that specifically represents the number of enrollees that canceled/withdrew their application or disenrolled. Using the difference of the rate of enrollment to determine the number of cancelled enrollments is faulty since an enrollment verification survey is considered complete even if the final disposition of that survey is that the enrollee disenrolled. Also, given the short 10 day turn-around-time for completion of the enrollment verification process, we recommend CMS obtain the total enrollment from the TRR as defined above.	Refer to number 8.4 above.

No.	Measure	Summary of Comment	CMS Response
8.8	Enrollment Verification Calls	Making the enrollment verification calls and documenting the process is already a PFFS plan requirement. Why do we have to report it separately?	Refer to no. 8.2 above.
8.9	Enrollment Verification Calls	Clarify that the calls only need to be made to individual enrollees – not EGWP enrollees.	This measure only pertains to calls made to individual enrollees.
9.1	Provider Dispute Resolution Process	We request clarification on how rejection rates are defined – e.g., a rejected claim because it was not a covered benefit vs. other reason code, and whether this applies to both contracted and non-contracted providers. Also please clarify whether this is for network and non-network PFFS plans? Also what is the definition of a provider payment dispute and does the scope include services that require prior authorization prior to delivery of care?	This is an error. The data elements and measures pertaining to claims have been removed from this measure set.
9.2	Provider Dispute Resolution Process	In order to allow time to sufficiently develop our data tracking and reporting mechanisms, commenter recommends that CMS begin collecting these data on July 1, 2009, rather than January 1, 2009.	As PFFS plans are already required to maintain dispute resolution process, and information related to this process may be requested and audited by CMS, CMS chooses to maintain the proposed data collection schedule with collection beginning January 1, 2009.

No.	Measure	Summary of Comment	CMS Response
9.3	Provider Payment Dispute Resolution Process	Already a PFFS plan requirement. Why do we have to report separately?	The data we are requesting is for CMS' monitoring purposes. CMS does not have these data. For example, CMS does not have data on determinations fully vs. partially favorable to the enrollee.
9.4	Provider Payment Dispute Resolution Process	The first three bullets are asking about claims payment. How is this relevant to collecting information regarding provider payment disputes?	This is an error. The data elements and measures pertaining to claims have been stricken from this measure set.
9.5		The first data element in the chart, "# of claims rejected on first submission (i.e., not clean)," is not entirely clear as to what claims should and should not be included in the reporting. Claims may be "clean" but could be denied for other valid reasons, for example, claims that are denied for not being compliant with HIPP(A transaction standards. Also, "first submission" could encompass re-processed or adjusted claims, which should be excluded from the reporting as they would have been processed. We suggest CMS utilize the following terms to clarify what should and should not be reported, or provide further clarification. For example: "# of claims denied on original submission that are not submitted in accordance with CMS guidelines (i.e., not clean, not compliant with HIPAA transactions.. .)." Rationale: clarification would ensure consistent, accurate reporting among plans and the collection of appropriate data for meeting the stated CMS objective.	Refer to 9.4 above.

No.	Measure	Summary of Comment	CMS Response
10.1	Commission Structure	In assessing the data elements to be reported, the proposal appears to take a rather simplistic analytical approach to commission arrangements while failing to take into account the complexity and variation in such arrangements. We are concerned that the requested data are inadequate to reach any meaningful conclusions concerning commission structures	The requested data are based on requirements listed in Section 103 of MIPPA and the final rule.
10.2	Commission Structure	We note that CMS' proposed marketing regulations contemplate major changes in broker commissions. The current reporting proposal does not appear to be coordinated with the proposed changes in the marketing rule. We are curious why this proposal is being developed outside of the concurrent rule making and question whether it is appropriate or worthwhile to measure a system that is about to undergo fundamental changes.	We have now aligned the measures with the changes in the marketing rule.
10.3	Commission Structure	CMS states that variances in commission structure can incentivize agents to steer beneficiaries to plans that are the most profitable for the agent. We question how analysis of such aggregate data will not identify the agents engaged in steering.	The aggregate data that we propose to be reported are not agent-specific. We are proposing data elements that pertain to numbers of new and retained enrollees by year and total compensation (related to volume of sales) paid to agents for new and retained enrollees by year. We do not see how these data could identify agents.
10.4	Commission Structure	In light of the foregoing, we believe CMS should rethink this requirement given that the requested data and associated reporting burden likely cannot achieve the objective that CMS has set.	CMS believes that the requested data do not impose an undue reporting requirement. CMS also believes the data will be useful in achieving its objective
10.5	Commission Structure	Plans do not have access to the average salary of an independent agent and broker as generally the only dollars that transfer between a Plan and the broker/agent are commissions. The attachment also uses the terms "captive agents" and "contract agents" Please define captive agent.	This measure has been changed to be consistent with Section 103 of MIPPA and the final rule.
10.6	Commission Structure	Commenter recommends these requirements apply only to state licensed independent agents and brokers and that these new provisions are coordinated with state laws and also the pending CMS rule expected to be issued this fall.	These requirements will apply to all state licensed agents and brokers. These new provisions are consistent with Section 103 of MIPPA and the final rule.

No.	Measure	Summary of Comment	CMS Response
10.7	Commission Structure	These requirements specifically should not apply to staff within a Plan who is salaried.	Consistent with the interim final rule, an MA plan and Part D sponsor or other entity may provide compensation (related to volume of sales) to an agent or other representative for the sale of a MA or Medicare Prescription Drug Plan (PDP) product only if the first year compensation is no more than 200 percent of the compensation paid for selling or servicing the enrollee in the second year and subsequent years. Therefore, agent compensation is required to be reported for all agents connected with a sale.
10.8	Commission Structure	Since a new final rule will be changing the allowable practices as to commissions, we question why would there be an indication on page 11 of the attachment that this data might be collected for 2009. Again we ask that this requirement not apply until 2010 so to have consistency reporting under the new CMS program-wide requirements.	The measure has been changed to be consistent with the interim final rule. However, CMS is requiring collection of these data for the CY 2009 reporting period. The data, however, would be reported in 2010.
10.9	Commission Structure	We strongly believe that CMS should wait until it issues a final rule governing compensation for agents and brokers before it finalizes any data reporting requirement related to such compensation.	This measure has been changed to be consistent with the interim final rule.
10.10	Commission Structure	If CMS does not set agent compensation, but finalizes a requirement that MAOs and Cost contractors must report their agents' compensation, it will take some time to get the systems and infrastructure in place for the collection, compilation and reporting of such compensation. Therefore, we believe that data collection should not be retrospective, but should 2010.	Data collection will not be retrospective, but will begin January 1, 2009, for a reporting due date of February 28, 2010.

No.	Measure	Summary of Comment	CMS Response
10.11	Commission Structure	CMS' statement that it intends to compare agent-related data to "rapid disenrollment rates to identify outliers" is puzzling, because there is no definition of "rapid disenrollment rates" and no identified source for such rates for purposes of this proposed comparison. In any final version of this data item, CMS should clarify this issue.	This entire statement has been deleted from the document.
10.12	Commission Structure	We recommend that CMS defer inclusion of the commission Measure Category in the reporting requirements pending issuance of the final regulations, which is expected to occur in the near future. We recommend that CMS evaluate the nature and type of reporting that may be appropriate, engage in dialogue with MAOs to inform the process of developing data elements, and propose new reporting requirements for review and comment if the agency determines that such requirements would be an efficient and effective part of its oversight strategy.	This measure has been changed to be consistent with the interim final rule.
10.13	Commission Structure	In the event that CMS retains the proposed data elements, we recommend that CMS address the following technical issues: The terminology “captive agents” and “contract agents” is imprecise and unclear. We recommend that CMS revise the data elements to use terminology that is consistent with the provisions of the proposed rule and refer instead to licensed marketing representatives who are employees of the MAO and licensed independent agents.	CMS will use the terms “licensed marketing representatives who are employees of the MAO” and “licensed independent agents,” instead of “captive” and “contract” agents.
10.14	Commission Structure	To ensure consistent understanding of the terms “average total annual commission” and “average total commission” which appear in the Supporting Statement and Attachment II, respectively, we recommend that CMS provide a detailed definition that specifies whether totals reported should include such components as amounts paid for both first year and renewal year commissions for agents actively marketing, amounts for renewal year commissions for agents not actively marketing, and amounts paid to agents who provide referrals only	This no longer applies. We have changed the data elements to be consistent with the interim final rule.

No.	Measure	Summary of Comment	CMS Response
10.15	Commission Structure	We note that Section 10 of the Supporting Statement includes an italicized discussion of §422.2274 and §423.2274 of the proposed regulations, which address agent training and testing. It appears that inclusion of the language in this section was in error, and we recommend that it be moved to Section 11.	CMS agrees and this italicized discussion has been removed from section 10 and placed in Section 11 as recommended.
10.16	Commission Structure	Collection of the proposed data on captive and contract agents will likely require many changes to existing systems in order to automate the data collection and reporting process. For instance, some systems do not distinguish between captive versus contract agents. If sufficient time is not provided for plans to update data collection systems, these data would have to be sorted manually, resulting in a significant time and resource burden for plans. Thus, commenter recommends that data collection commence on July 1, 2009. Furthermore, commenter requests that annual collection begin on April 1 of the following year, rather than February 28, in order for all retroactive enrollment transactions to be completed and captured in the reported data.	The data collection and reporting dates will remain as listed in this document.
10.17	Commission Structure	Please clarify if this measure includes SNPs.	This measure includes SNPs.
10.18	Commission Structure	Contract agents – how to report commissions paid by plan to General Agencies and then the GA pays the individual broker?	CMS understands that this will make it more difficult for the plan to obtain the data but still expects plans to report this measure.
10.19	Commission Structure	Report number of agents or those who actually made a sale during the reporting period?	CMS expects reporting to be on the number of agents who actually made a sale.
10.20	Commission Structure	This is duplicative of a requirement in the proposed rule.	This is designed to provide the data needed to monitor whether regulatory requirements are being met.

No.	Measure	Summary of Comment	CMS Response
11.1	Training and Testing of Agents	We are concerned that this requirement imposes a significant reporting burden on plans but probably will not provide the results that CMS anticipates. Reporting these data would make more sense if all plans were using the same standardized test. Outside of the context of a standardized test, data reported by plans would provide little conclusive information.	We believe this requirement is important to monitor compliance with new regulatory requirements.
11.2	Training and Testing of Agents	There is continuous flux of agents moving from plan to plan during the year. Agents may have completed the Medicare portion of their training with a standardized test and then the product portion with the plans they represent. CMS should consider how these data would be reported in commingled or separated batches and the resulting implications for analysis.	CMS is interested in successful completion of training rates, first and second test successful completion rates, rate of agents taking the test 3 or more times, and the average score of agents successfully completing the test. Therefore, CMS does not foresee a problem with the reporting of information that would be "commingled" or in "separated batches."
11.3	Training and Testing of Agents	As an alternate approach, CMS should consider adding training and testing review elements to the monitoring guide and conduct reviews of this area during its plan monitoring visits. It should also begin a dialogue with state regulatory agencies so that it can understand data in the context of the state's monitoring programs	CMS appreciates these suggestions. However, this notice is concerned only with Part C reporting requirements. Adding training and testing review elements to the monitoring guide and conducting reviews of this area during its plan monitoring visits is not within the purview of this notice.
11.4	Training and Testing of Agents	We recommend that CMS give additional consideration to this requirement, weighing the substantial reporting burden against the value of the data that will be realized and evaluating other options for assessing effectiveness of agent training.	CMS has weighed the reporting requirements and does not consider them an undue burden. The proposed requirements have strong regulatory support.
11.5	Training and Testing of Agents	Current agent training/testing requirements only applies in individual PFFS market. Please clarify that this is also applicable to this section.	This measure will apply to all of the following plan types: CCP, PFFS, 800 series, Demo, 1876 cost, and MSA.
11.6	Training and Testing of Agents	We assume agent training and testing is for independent brokers and agents, not any internal salaried staff within a Plan who may have separate training/licensing/education programs as part of their employment within a Plan.	Agent training and testing is for both salaried and contracted agents.

No.	Measure	Summary of Comment	CMS Response
11.7	Training and Testing of Agents	As we noted in our comment on item #10, there are no definitions in this item #11 for the terms "captive agent" and "contract agent", and we believe using the term "captive agent" to refer to a regular salaried employee of an MAO or Medicare Cost contractor is confusing and even misleading. We repeat our recommendation that CMS define, and use, the terms "employed agent" and "contract agent."	CMS will use the terms “licensed marketing representatives who are employees of the MAO” and “licensed independent agents,” instead of “captive” and “contract” agents.
11.8	Training and Testing of Agents	CMS states that it intends to use the reported data to determine "if...captive agents score better than contracted agents. However, the data elements to be reported appear to be for all agents, with no separation for "captive agents" and "contract agents." It is not clear how CMS intends to develop rates and thereby make comparisons for MAOs and Cost contractors that use both "captive agents" and "contract agents." We note that an MAO or Cost contractor might directly conduct training and testing of its "captive agents" while accepting the results of training conducted by third parties or other MAOs for "contract agents". Does CMS intend to require that both results be included in reported data?	CMS will use the terms “licensed marketing representatives who are employees of the MAO” and “licensed independent agents,” instead of “captive” and “contract” agents. Results for each should be reported separately.
11.9	Training and Testing of Agents	We believe that the proposed data elements will be duplicative of information CMS would request and evaluate as part of a monitoring site visit or as part of a focused review in the event that a trend in complaints or other triggering events suggest that a problem may exist. Based upon past experience, it is likely that MAOs will invest resources in programming, systems development, training, ongoing staffing, and other activities in order to ensure that the required data can be provided to CMS, but the investment will be of low value for CMS oversight of plan performance because little actionable information will be captured. In addition, CMS and MAOs will continue to expend resources on site visits and on focused reviews as needed.	CMS does not agree that the proposed data elements will be duplicative of information CMS would request and evaluate as part of a monitoring site visit or as part of a focused review.

No.	Measure	Summary of Comment	CMS Response
11.10	Training and Testing of Agents	We recommend that CMS defer inclusion of the agent training and testing Measure Category in the reporting requirements pending issuance of the final regulations, which is expected to occur in the near future and recommend that CMS evaluate the nature and type of reporting that may be appropriate, engage in dialogue with MAOs to inform the process of developing data elements, and propose new reporting requirements for review and comment if the agency determines that such requirements would be an efficient and effective part of its oversight strategy.	CMS believes these data elements will be useful in monitoring MA plans and at this time sees no reason to defer their inclusion as part of the proposed reporting requirements.
11.11	Training and Testing of Agents	In the event that CMS retains the proposed data elements, we recommend that CMS address the following technical issues: Contract Year vs. Index Year. In the Supporting Statement other than data element A ("Total number of agents in current year"), all elements require data from the "contract year." In Attachment II, the corresponding elements require data from the "index year." The terms "contract year" and "index year" are unclear and CMS has not provided an explanation that defines them. Commenter recommends that CMS use the same term in the corresponding data elements in the Supporting Statement and Attachment II and add a definition.	We have eliminated the term "index year" and replaced it with "contract year." We have also defined "contract year" as the "365 day period in which the contract is in effect, except in the case of 'leap years' in which case the contract would be in effect for a 366 day period."
11.12	Training and Testing of Agents	For this Measure Category in Attachment II, CMS asks for data on "Total number of agents in current year." We assume that CMS expects only agents who are actively marketing on behalf of the MAO to complete training and that only these agents would be included in the total. Therefore, this number would not include those who are not certified to market for the plan and who are inactive (e.g., agents may be receiving only renewal or referral commissions). For clarity, we recommend that CMS include language that explicitly defines the agents who must be included in the total.	CMS agrees with this assumption. This language is now included in the supporting statement.
11.13	Training and Testing of Agents	Commenter requests that CMS clarify that this reporting requirement does not extend to customer service representatives.	This reporting requirement applies to all licensed marketing representatives who are employees of the MAO and all licensed independent agents.

No.	Measure	Summary of Comment	CMS Response
11.14	Training and Testing of Agents	Clarification is needed on the data elements listed, specifically, on the method of calculating the total # of agents and how CMS defines the term "index year." Recommendation: The following clarifications are recommended: that the # of agents = the number of agents as of December 31 of the year being reported, and that the Index Year =the reporting period, i.e. 111 -12131. Rationale: clarification on the data elements is required to assure that MAOs are reporting the same, consistent data to CMS. Please clarify if this measure includes SNPs.	Additional clarification has been provided. This measure includes SNPs.
11.15	Training and Testing of Agents	100% broker training and pass rate of at least 80% is a requirement. Reporting will all be 100%. What's the purpose of the report?	The purpose of this measure is to monitor plan compliance with CMS regulatory requirements.
11.16	Training and Testing of Agents	Provide clarification on the purpose for data requested for bullet # 4 & 7.	The data elements in question have changed. We are now requesting average scores, not the sum of scores. Average scores will supply a measure of the extent to which agents have mastered the test content.
12.1	Agent Oversight	Reporting of aggregate rates provides enough data only for simplistic analysis that will not achieve CMS' stated goal of detecting agents engaged in steering. We believe it would be much more effective to assess plan oversight by reviewing plans' agent records during routine monitoring audits and through coordination with state regulatory agencies. In addition, plans will report grievance data covering marketing and sales complaints; these reports will give CMS much more specific, focused information.	CMS does not believe that routine plan monitoring audits will provide the data needed to provide for adequate monitoring and oversight of agents. Therefore, we are retaining this reporting requirement.
12.2	Agent Oversight	We have identified several related reporting issues for consideration. CMS should provide additional definition of categories; e.g. does disciplinary action mean action taken by the MA plan or by a state oversight agency?	Disciplinary action refers to action taken by the MA plan.

No.	Measure	Summary of Comment	CMS Response
12.3	Agent Oversight	Data for employed and contracted agents should be reported separately given that compensation and an MA plan control of activities is markedly different for the two groups.	CMS will use the terms “licensed marketing representatives who are employees of the MAO” and “licensed independent agents,” instead of “captive” and “contract” agents. Results for each should be reported separately.
12.4	Agent Oversight	Current agent training/testing requirements only applies in individual PFFS market. Please clarify that this is also applicable to this section.	This measure will apply to all of the following plan types: CCP, PFFS, 800 series, Demo, and MSA, and 1876 cost plans.
12.5	Agent Oversight	We assume agent training and testing is for independent brokers and agents, not any internal salaried staff within a Plan who may have separate training/licensing/education programs as part of their employment within a Plan.	Agent training and testing is for both salaried and contracted agents. CMS will use the terms “licensed marketing representatives who are employees of the MAO” and “licensed independent agents,” instead of “captive” and “contract” agents.

No.	Measure	Summary of Comment	CMS Response
12.6	Agent Oversight	When CMS requests data on the "number of agents investigated based on complaints", it is not clear if "complaints" refers only to complaints from the HPMS Complaint Tracking Module (CTM), or to other complaints and grievances made directly to the MAO or Cost contractor, or both .	CMS is referring to both HPMS CTM and to other complaints made to the MAO.
12.7	Agent Oversight	When CMS asks for the "number of agents receiving disciplinary action based on complaints," there is no definition of "disciplinary action." Depending on the nature of the complaint and the performance history of the agent, a substantiated complaint could result in action along a broad continuum, from manager-coaching, documented verbal warning, re-training, charge-back of the agent's commission, documented corrective action plan, suspension, or even termination of employment/contract. Would any action along this continuum be reportable?	Any action along this continuum would be reportable.
12.8	Agent Oversight	When CMS asks for the "number of agents whose selling privileges were revoked. . .", it should clarify if it wants data about revocations of any duration. There are circumstances in which an agent may be given a very short-term revocation of his/her selling privileges -- for example, for 1 or 2 days, until completion of retraining on a given topic. Is this type of revocation among those which CMS will require to be reported?	Yes, this type of revocation is among those which CMS will require to be reported.

No.	Measure	Summary of Comment	CMS Response
12.9	Agent Oversight	Complaints Reported to State. The rate calculation for complaints reported to the state is based upon the number of complaints reported to the state by the MAO divided by the number of enrollees. We believe that a more valid and accurate rate calculation would be the number of complaints divided by the number of agent-assisted enrollments. We recommend that CMS revise the rate calculation accordingly.	CMS agrees with this comment. A data element has been added: number of agent-assisted enrollments.
12.10	Agent Oversight	One of the required data elements under this Section is “Number of agents whose selling privileges were revoked by the plan based on conduct or discipline.” Agents may be terminated for a variety of reasons unrelated to their marketing conduct. For example, an employed agent may be terminated for unexcused absences. Commenter recommends that CMS clarify that reportable revocations of selling privileges are those that stem specifically from marketing conduct.	CMS agrees and has included this clarification in the supporting documents in this notice.
12.11	Agent Oversight	Commenter suggests that CMS define “agents” in order for plans to accurately gauge the impact of this reporting requirement, and take necessary steps to develop data collection systems that target appropriate employees.	Agents are all licensed marketing representatives who are employees of the MAO and all licensed independent agents.
12.12	Agent Oversight	Clarification is needed on the third data element "# agents receiving disciplinary action based on complaints.. .,"specifically regarding how PMS defines the term "disciplinary action." It is recommended that disciplinary action be further defined, for example, it could include agents with all forms of corrective and disciplinary action, (i.e., agents who were alerted to a compliance infraction, directed to retake training certifications) or it could include only those whose appointment is terminated. Rationale: clarification of the term "disciplinary action" must be provided to assure that MAOs are reporting the same dataset to CMS.	CMS agrees that clarification is needed. The first definition provided by the commenter is now contained in the supporting documents. Disciplinary action is defined as “all forms of corrective and disciplinary action (e.g.,, agents who were alerted to a compliance infraction, directed to retake training certifications).”

No.	Measure	Summary of Comment	CMS Response
12.13	Agent Oversight	The third data element under this Section is the "Number of agents receiving disciplinary actions based on complaints." MAOs take a variety of actions in response to complaints about the conduct of an agent, from coaching to retraining to more severe actions such as suspension or termination. However, neither the Supporting Statement nor Attachment II defines "disciplinary action" for the purpose of CMS' proposed reporting requirement. To promote consistent understanding of the data element and consistent reporting, we recommend that CMS add a definition of this term.	See previous comment and response.
12.14	Agent Oversight	The 800 Series plan type has been included in the scope of the Plan Oversight of Agents report. However, the materials provided do not differentiate between agents that sell directly to an employer and those who subsequently sell to the retiree. It is recommended that CMS exclude agents who sell directly to employers. Rationale: Since stronger oversight of agents was instituted due to the concern around conduct of agents toward beneficiaries it should not apply to agents selling directly to employers-employers are more sophisticated buyers and are not susceptible to possible undue pressure from agents.	CMS will continue to require 800 Series plans to report on this measure.
12.15	Agent Oversight	Does this measure include SNPs?	Yes