Public Comments and Responses

There were 6 commenting organizational entities. They were: Blue Cross Blue Shield Association (BCBS), Kaiser Permanente (KP), America's Health Insurance Plans (AHIP), Aetna, Humana, and UCare.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
General	BCBS	G.1	We recommend that CMS delay MA data collection until the third quarter of 2009 (with submission beginning in the first quarter of 2010). This additional time is necessary because of the late adoption of final reporting requirements in relation to the start of the CY 2009 benefit year.	CMS believes that recent statutory and regulatory changes support reporting beginning at the earliest possible time, which, in our view, is 2009.
General	BCBS	G.2	We recommend that CMS establish common definitions and measurements for the reporting requirements.	CMS will be issuing a Technical Specifications document that will contain common definitions and measurements.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
General	BCBS	G.3	BCBSA suggests that CMS re-evaluate its estimated burden on Plans submitting data under the reporting requirements, particularly the $54.63 average competitive hourly rate for IT and/or data analysts.	CMS used average salary data for IT Specialists and Data Analysts to arrive at the $54.63 average competitive salary rate. CMS believes that this is a competitive rate.
General	Humana	G.4	Will HPMS be upgraded to allow for an automated or upload process for all reports? Keying the data contract by contract leaves room for human error.	The submission functionality for the HPMS Part C Plan Reporting sections will be a mixture of data entry and upload. The decision to structure the submission functionality as data entry or upload was dependent on the quantity and type of data being reported in each section.
General	AHIP	G.5	Commenter recommends that CMS develop a technical specifications document that is similar to the document developed for Part D.	CMS is developing a technical specifications document for Part C reporting. It will be sent to plans as soon as CMS receives approval for this reporting.
General	AHIP	G.6	CMS should provide sufficient time to complete changes and related testing prior to the initial reporting deadline.	CMS believes that it is providing sufficient time to complete changes and testing. Plans have been provided with information about the measures since June 2008. Much of this information, although not completely finalized, has been in sufficient detail to allow plans to prepare for changes to their IT systems and data collection procedures.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Benefit Utilization	KP	1.1	We believe that "800 series" employer group PBPs should be excluded from this reporting item. Reporting total utilization and expenses for employer groups as part of these required reports makes little sense, as employers often purchase benefits greatly in excess of Medicare-covered services, and in excess of the benefits in the "800 series" bids. The utilization of employer group members reflects these richer benefits and the induced impacts of more generous member cost-sharing. As a result, the evaluation of the use of rebates for employer groups is likely to be significantly skewed.	We agree that products offered to employer group and waiver plans (EGWPs) may have unique characteristics. However, in order to develop comprehensive program experience we must collect beneficiary utilization of services and plan revenues and expenditures for all plans, including EGWPs. The intent of this data collection is to monitor the value of benefits offered to the Medicare beneficiaries. 800-series contracts are a part of the program. CMS recognizes that profile and characteristics of 800 series plans will be significantly different than individual enrollment plans.
Benefit Utilization	KP	1.2	If CMS is determined to include "800 series" plans in this reporting item, CMS should clarify in the instructions whether "Plan Experience" (total costs) includes only Medicare Covered and Supplemental costs that were included as part of the Bids for these plans (and for which rebates may have applied), or whether "Plan Experience" also includes the "Extra" benefits that employer groups may have purchased over and above the filed plans.	The filing instructions will be updated to specify that plan experience is for all plan benefits, regardless of their representation in the approved bid.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Benefit Utilization	KP	1.3	It is unclear whether the reporting requirements apply to SNPs.	The reporting requirement applies to SNPs.
Benefit Utilization	KP	1.4	There is a specific column (column n) on the Benefit Utilization report template titled "Net Supplemental Benefits" that appears to compute the gross value of supplemental benefits. We believe, therefore, that the title is misleading and should be revised to read "Gross Supplemental Benefits." Furthermore, the value or significance of this computation is not clear.	We agree that the term “Net Supplemental Benefits” is misleading, and will change the term to “Total Supplemental Benefits.” This item represents the value of the benefit package in excess of Medicare-covered benefits.
Benefit Utilization	KP	1.5	It is unclear whether ESRD expenses should be excluded (as it is in the bids) or included. We believe that CMS should clearly state that such expenses are to be excluded in the reporting of this item, consistent with bidding.	The submission is to include experience for all plan enrollees, including those in ESRD status. Because benchmarks supporting the MA bid pricing (BPT) tool exclude ESRD, it is necessary to exclude associated ESRD revenue and expense projections from the BPT.
Benefit Utilization	KP	1.6	The definitions of the columns should be spelled out clearly in a template of instructions.	The definitions are now spelled out.
Benefit Utilization	BCBS	1.7	A delayed deadline for data submission will provide Plans with more time to undertake what may be significant administrative changes.	CMS has already pushed back the due date and is no longer requiring retrospective data. The current reporting due dates will stand.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Benefit Utilization	BCBS	1.8	We ask CMS to consider different approaches to data collection for Medicare and non-Medicare benefits.	CMS believes that using the same approach for Medicare and non-Medicare benefits will facilitate data comparisons.
Benefit Utilization	BCBS	1.9	In the Medicare Part C Reporting Requirements for Contract Year 2009, however, the list of data elements is shorter than the corresponding list in the Supporting Statement.	The list of reporting data elements to refer to are contained in the reporting template. This list will also appear in the Technical Specifications document which will be made available pending OMB approval.
Benefit Utilization	BCBS	1.10	CMS states that "only rebates applied to A/B services are to be included in reporting of rebates," meaning rebate dollars used to provide non-Medicare covered services would not be included in the reported data. This statement suggests that CMS may be requiring Plans to submit data that does not enable the agency to conduct its intended analysis.	The filing instructions will be updated to read "only rebates applied to A/B services and additional non-prescription drug benefits are to be included in reporting of rebates," This change clarifies that all rebates are to be included except for those designated to reducing Part B and Part D premiums.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Benefit Utilization	BCBS	1.11	Whether a supplemental benefit is funded through rebate dollars or premium dollars also may vary year by year for a Plan (and vary among Plans each year), depending on the relationship of the Plans' bids to the applicable benchmarks, resulting in inconsistent data among Plans and frustrating data analysis and comparisons. CMS should provide additional clarification on these issues.	The core analysis of results will be a comparison of total plan revenues to plan expenses by category (benefit, non-benefit expense, and margin). This analysis is not biased by the source of revenue: CMS bid-based payment, CMS rebate, member premium, or group contribution.
Benefit Utilization	BCBS	1.12	CMS should note that some data may not reflect "how rebate dollars are being used." If a Plan transfers risk to a downstream entity, utilization data may not reflect the Allowed Cost to the Plan or cost-sharing incurred by the enrollee, undermining CMS's very purpose for the data collection.	The reporting should not be affected by the provider contractual arrangement. In all cases, the allowed cost represents the gross receipts of the provider; a portion of which will be direct payments from plan sponsors and the balance received from enrollee cost sharing.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Benefit Utilization	AHIP	1.13	CMS already collects annually through the Bid Pricing Tool the information that is most relevant to evaluating MA organization use of rebate dollars. The proposed reporting requirements are less informative than the data already collected. The new reporting requirements would be duplicative.	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.
Benefit Utilization	UCare	1.14	Clarify in the final guidance whether or not optional supplemental benefits must be reported.	The filing instructions will be updated to specify that experience for optional supplemental benefits is to be excluded from the data submission.
Benefit Utilization	UCare	1.15	Clarify in the final guidance whether all individualized employer plans under a PBP should be blended.	Experience is to be reported at the PBP level. Thus, experience for groups within an EGWP is to be consolidated.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Procedure Frequency	BCBS	2.1	Plans request that CMS specify the level (*e.g.*, contract or plan benefit package level) for data collection and submission. Neither the Supporting Statement nor Reporting Requirements address this issue.	Collection is at the contract level.
Procedure Frequency	BCBS	2.2	CMS should consider establishing a minimum enrollment threshold for this reporting requirement, such as a minimum 1,000 Members (as is the case for HEDIS reporting).	We will first look at the 2009 data when they become available to determine if setting minimums is needed.
Procedure Frequency	AHIP	2.3	We note that in Attachment V, Table 1, there is a row for bone marrow transplant. Bone marrow transplants are not listed as a reportable transplant in either the supporting statement or Attachment II.	Bone Marrow transplants should be included in the supporting statement and Attachment II. We will make the change.
Procedure Frequency	AHIP	2.4	Where PFFS plans voluntarily report HEDIS data they should be exempt from the requirement to report the same measures under Part C reporting requirements.	CMS agrees. We have made the change in the supporting documents.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Procedure Frequency	AHIP	2.5	Attachment II indicates that SNPs must report this measure but Attachment I does not.	SNPS should report this measure. However, SNPs are a type of coordinated care plan (CCP), and, therefore, were not shown separately in the initial document. We have made changes in both Attachments I and II to indicate clearly that SNPs are required to report this measure and, in fact, all measures that a CCP is required to report.
Procedure Frequency	Aetna	2.6	Indicate which elements are eligible to report via HEDIS.	These elements are now in Attachment II and the supporting statement.
Serious Reportable Adverse Events	AHIP	3.1	We urge CMS to recognize that this is not appropriate for use as a MAO performance metric.	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. Moreover, 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.
Serious Reportable Adverse Events	Aetna	3.2	Some of the never events are not codified. Strongly recommend CMS require hospitals to report and provide this information to MAOs to meet the annual reporting requirement.	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.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Provider Network Adequacy	KP	4.1	We urge CMS to return to aggregate reporting for this item, or at the very least, to permit aggregate reporting for those "types" of PCPs that are fungible.	Aggregate reporting of PCPs and specialists does not ensure effective monitoring of access to individual specialties. Therefore, we will continue with the current data requirements.
Provider Network Adequacy	BCBS	4.2	As this reporting requirement appears to overlap with NCQA and HEDIS reporting requirements, BCBSA and Plans request that CMS adopt an annual June 30th submission deadline. This would be consistent with the HEDIS reporting date and enable Plans to comply with NCQA's accreditation timeframes as well.	CMS has pushed the date back to May 31. The data are needed by this date if they are to be maximally useful for performance monitoring.
Provider Network Adequacy	AHIP	4.3	We recommend that CMS re-evaluate whether this measure adds sufficient value to warrant its implementation.	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.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Provider Network Adequacy	Aetna	4.4	Recommend allowing reporting at a single point in time once per year given that systems do not currently support/permit retrospective participation reports.	CMS' primary goal with this measure is to identify instances of potential network decay. Data will be reviewed to ensure that provider networks do not deteriorate after contract award. Reporting for a single point in time does not allow CMS to measure network decay.
Grievances	KP	5.1	CMS should include further specification of grievance categories in the final Reporting Requirements, and should also provide guidance as to how an MAO should report a grievance that has elements of both Part C and Part D.	This guidance is contained in the Technical Specifications document that will be made available to plans.
Grievances	BCBS	5.2	Plans request that CMS provide more specific guidance regarding reporting of grievances and organization determinations and reconsiderations, specifically addressing at what stage a grievance/organization determination/reconsideration should be reported.	See above response.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Grievances	BCBS	5.3	Recommend that data be submitted only for those grievances/organization determinations/reconsiderations finalized during a reporting period (as opposed to received or open during the reporting period). Such a standard will provide Plans with a definitive standard for data collection and also provide consistency among reported data, enabling more accurate data comparisons.	We agree. This is now in the supporting documentation.
Grievances	BCBS	5.4	Plans urge CMS to address the potential for overlap and duplication between the proposed Part C reporting requirements and existing Part D submission.	This is addressed in the Technical Specifications.
Grievances	BCBS	5.5	Plans request that CMS reduce the frequency of data submissions from quarterly to semi-annual periods in order to reduce the administrative burden imposed by these requirements.	CMS believes that plans should have mechanisms in place to regularly monitor grievances and that quarterly reporting is not unduly onerous.
Grievances	AHIP	5.6	Commenter recommends CMS guidance on differentiating Part C and Part D grievance and making an attribution.	See response to 5.1 above.
Grievances	Aetna	5.7	Clarify if grievance categories reflected under enrollment/disenrollment/access/ benefit package should be separately reported.	No, they should be reported as one aggregate.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Grievances	Aetna	5.8	Recommend CMS expand categories to provide an accurate picture of grievances received by MAOs in effort to reduce additional follow-up.	CMS believes that the categories in the current supporting documents best capture the data needed to monitor grievances.
Grievances	Aetna	5.9	Separate into individual categories enrollment/disenrollment, access, and benefit package.	CMS believes that it is often difficult to differentiate these categories. That is why they are aggregated.
Grievances	Aetna	5.10	Clarify the requirement in the final guidance.	See response to 5.1 above.
Organization Determinations/ Reconsiderations	Aetna	6.1	Recommend CMS allow for organization determination data to be reported separately from reconsideration data.	Organization determination and organization reconsideration have separate data elements and must be reported separately.
Organization Determinations/ Reconsiderations	Aetna	6.2	Clarify in the final guidance the correct reporting level. We recommend the contract level.	We have clarified this in the guidance and will require reporting at the contract level as recommended.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Employer Group Plan Sponsors	KP	7.1	The only CMS waiver applicable to employer groups that purchase Medicare Cost plans is a waiver that governs the Part D benefits offered as part of these plans. If CMS' rationale for this measure is its concern about its waiver authority, CMS should pursue that concern by requiring employer group plan sponsor reporting in its Part D reporting requirements. Employer groups that purchase Medicare cost plans for their retirees are not using any Part C waiver.	CMS' employer group waiver authority only applies to the Part D portion of the coverage provided by Cost Plans, not Parts A and B. Thus, Cost Plans may only use the Part D waiver authority to offer Part D EGWPs as an optional supplemental benefit. Although the MA employer group waiver authority does not apply, a Cost Plan may negotiate with employer/union group health plan sponsors to offer extra benefits in addition to Medicare Part A and Part B benefits (including allowing the employer/union group to buy-down cost sharing for Medicare Part A and B benefits). These benefits are not supplemental benefits and are not subject to CMS review or approval. However, CMS has traditionally allowed Cost Plans to customize marketing materials for employer group plans to add the additional benefits offered by an employer group. Also, when a Cost Plan offers Part D EGWPs as an optional supplemental benefit, it is offered as an integrated product. Therefore, like all MA-PD plans, Cost Plans are required to report information on employer groups.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Employer Group Plan Sponsors	BCBS	7.2	Plans recommend CMS require data submission on an annual basis.	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.
Employer Group Plan Sponsors	BCBS	7.3	CMS should require reporting of current enrollment only.	CMS will now be requiring reporting of current enrollment only.
Employer Group Plan Sponsors	AHIP	7.4	Meaning of organization type is unclear. Commenter recommends this language be clarified.	This is now clarified in the attachment which shows the following organization types: state government, local government, publicly traded organization, privately held corporation, non-profit, church group, other.
Employer Group Plan Sponsors	AHIP	7.5	Recommend eliminating requirement to report Employers DBA.	CMS will continue to require that Employer's DBA be reported.
PFFS Plan Enrollment Verification Calls	Aetna	8.1	Remove 800 series plans from the list of plans required to report.	800 series plans have been removed.
PFFS Provider Payment Dispute Resolution Process	Humana	9.1	Does this report only apply to those PFFS plans that have a network attached?	This applies to all PFFS plans, whether or not they have a network attached.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
PFFS Provider Payment Dispute Resolution Process	Humana	9.2	Are plans required to have a provider payment dispute resolution mechanism for non participating providers?	This requirement applies to providers who are participating and non-participating under Original Medicare who furnish services to PFFS enrollees.
PFFS Provider Payment Dispute Resolution Process	Humana	9.3	Please provide a definition for "Appeals". CMS is using "dispute" and "appeal" interchangeably.	The correct terminology is "dispute", not "appeals". "Appeals" has been changed to "dispute" in the "Data Elements" section of measure 9.
Agent Compensation Structure	KP	10.1	We strongly believe that CMS should not finalize any reporting requirement with respect to agent/broken commissions until CMS finalizes its guidance to the industry on this subject.	These requirements do not conflict with the guidance CMS sent the industry on November 10, 2008.
Agent Compensation Structure	KP	10.2	We believe that it is inappropriate for CMS to require MAOs to report total compensation of employed sales representatives when CMS has suspended enforcement of the regulations governing employed sales representative compensation until it finalizes the Interim Final regulations on this issue.	CMS will be requiring compensation data only on licensed independent agents, not employed agents.
Agent Compensation Structure	BCBS	10.3	Strongly urge CMS to postpone data collection on actual paid agent commission data until 2010, so that CMS can finalize its requirements and Plans can prioritize compliance with the new requirements.	See response to 10.1 above.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Agent Compensation Structure	BCBS	10.4	Plans also urge CMS to modify its request for data on the number of beneficiaries "making an enrollment change," as enrollment forms and systems do not distinguish between new members that are aging- in to Medicare and new members that are changing from another MA Plan (or FFS Medicare).	CMS believes this is a critical data element in monitoring agent compensation. It will remain in the requirements.
Agent Compensation Structure	BCBS	10.5	CMS should clarify the level at which the data is aggregated for data element (D), Initial total agent compensation (related to volume of sales) for enrolling beneficiaries…by agent type. Plans recommend that CMS adopt a contract-level reporting unit, which will provide additional protection to Plan's proprietary information.	Agent compensation structure is reported at the contract level.
Agent Compensation Structure	Humana	10.6	Please provide a definition of "volume of sales". Some agents are compensated on a per sale basis and not by achieving a volume of sales.	Volume of sales is the number of sales generated by an agent within a specified period.
Agent Compensation Structure	Humana	10.7	Please clarify the purpose of Data Element D with regard to licensed marketing representatives who are employees of the MAO.	CMS will not be requiring data on marketing representative who are employees of the organization.

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Agent Compensation Structure	Humana	10.8	Please distinguish between Data Element C and D. An agent could facilitate an enrollment change from one plan to another within the same MAO, thereby retaining a beneficiary. Does "retained" mean a beneficiary who does not make a plan change and is effective as of 01/01/2010?	A beneficiary who is retained" is one who remains in the same plan after initial enrollment or is enrolled by an agent or broker in a different plan of a "like plan type." A "like plan type" refers to PDP, MA or MA-PD, or cost plan. Refer to the interim final regulation with comments (CMS 4138-IFC2) addressing agent/broker compensation that was published on November 10, 2008.
Agent Compensation Structure	Aetna	10.9	Please clarify if the dollar amount only applies to incentive compensation or will it be inclusive of salary + incentive compensation?	We will only be collecting data for licensed independent agents and are only interested in "compensation related to sales". That is, "incentive compensation."
Agent Training	KP	11.1	CMS should make it clear that MAOs need not report testing data if the MAO chooses to test its employed sales representatives and/or contracted agents and brokers working in the employer group market.	CMS will not be requiring testing data from employer/union group plans

Measure	Organization	Comment No.	Summary of Comment	CMS Response
Agent Training	KP	11.2	CMS should also acknowledge in the final instructions that because MAOs must report data about training for all employed sales representatives and contracted agents/brokers, including those who service employer groups, but need not conduct or report testing for those who service employer groups, the number of those reported as having been trained may not match the number of those reported as having been tested.	Employer/union groups are not required to test or report testing data to CMS. Since training is a requirement the data will not be consistent with those who are trained and tested.
Agent Training	Aetna	11.2	Please confirm if the training requirement is inclusive of sales support staff.	The training requirement does not include sales support staff; it only applies to sales agents.
Plan Oversight of Agents	Humana	12.1	Please define "number of agents". There are agents who sell and those who are licensed but do not sell. Does this definition include all agents who are licensed, appointed, trained and tested?	CMS is requesting data on the number of licensed marketing representatives who are employees of the MAO and licensed independent agents. These are agents who are licensed to sell and do sell.
SNPs Care Management	KP	13.1	CMS is premature in this reporting requirement, because the MIPPA statute does not take effect until January 1, 2010. Therefore 2010 would be the first year that a SNP would have to perform these assessments and reassessments, and 2010 the first year for which data could be reported.	CMS believes it is important to collect these data for CY 2009 for monitoring purposes even though the MIPPA statute does not take effect until 2010.