Responses to Comments and Revisions to 2nd Draft of CY2012 Part C Reporting Requirements

The table below summarizes both responses to comments and revisions made for the 2nd drafts of the CY2012 Part C/Part D Reporting Requirements. Compared to the CY2012-CY 2014 reporting requirements posted for public comment on December 17, 2010 (60-day notice), this document indicates no change in overall reporting burden for CY 2012-CY2014 as a result of the changes made after the 60 day comment period. Three changes resulted in decreases to burden and two resulted in increases. We believe the three decreases in burden cancel out the two increases in burden with a net effect of no increase in overall reporting burden.

Responses to Comments on Part C Reporting				
1	Response to Public Comments	Procedure Frequency and Serious Reportable Adverse Events	In the notes section, CMS included several references that appear to be applicable to Procedure Frequency reporting and not Serious Reportable Adverse Events reporting. Page 24 states, "All SRAEs and HACs are mutually exclusive. If a claim has a code for a hip replacement and knee replacement, the SRAE or HAC would count for both-one SRAE or HAC associated with the hip replacement and one associated with the knee replacement." Page 25 states: "Total hip replacement and total knee replacement procedures have the same MS-DRS included in Appendix 4. If the procedure identified by MS-DRG 461-462 or 466-470 with no accompanying CPT or ICD-9 CM procedure code, and no other information is available, assign the SRAE or HAC to Total Knee Replacement." and "We currently do not have a code for a kidney and liver transplant, if an enrollee undergoes a kidney and liver transplant, please code as a liver transplant." We request that CMS update/correct the Procedure Frequency reporting notes, if applicable, or provide further clarification as to how these notes apply to SRAE reporting.	We agree. When we update the Technical Specifications, we will make the needed changes.
2	Response to Public Comments	Procedure Frequency	In the notes section of Part C Procedure Frequency Reporting, page 21, CMS indicates that "For Data Elements 2.3 - 2.6, the procedures do not need to occur on the same date of service but do need to occur during the same admission." We request clarification regarding this statement, given that the instructions on page 21 are to count the number of enrollees receiving the specified procedure, not the number of procedures performed.	If an enrollee receives 2 or more of these procedures during the same admission, the enrollee should be counted under each procedure received.

3	Response to Public Comments	Provider Network Adequacy	For the Provider Network Adequacy reporting data elements, please clarify why Geriatrician is not included as a PCP Type, but Pediatrician is included. If applicable, please correct the PCP types.	We agree that one could argue that a geriatrician is a PCP. However, our classification is based on our belief that a geriatrician is likely to have a high proportion of patients with complex medical issues—certainly much higher than pediatricians. For this reason, categorizing a

				geriatrician as a specialist appears more appropriate.
4	Response to Public Comments	Special Needs Plans Care Management	The Special Needs Plans (SNPs) Care Management reporting module on HPMS is set up to require all contracts and PBPs to report, whether or not the H/PBP is filed as a SNP. This results in unnecessary reporting of "zeros" for plans not filed as SNPs. We recommend the HPMS reporting module be updated for CY 2011 to restrict reporting to only those plans that are filed as Special Needs Plans.	We are considering this recommendation. We may be able to create a “button” that indicates no data to report.
5	Response to Public Comments	Employer Group Plan Sponsor	The Employer Group Plan reporting requires sponsors to provide the current (or anticipated) enrollment for each employer group plan. Employer group plans with no or low membership may retroactively add or remove membership between the time the report is due to CMS and when CMS audits for overdue reporting. The Plan cannot anticipate or control when this membership retroactivity will occur which may cause a gap between CMS and Plan employer group membership records. When overdue notices were received, it was confirmed that all of the overdue notices received pertained to plans with no membership and/or with no employer groups. In these instances CMS instructed the sponsor to disregard the notices. However, we are concerned about how these notices will be tracked to ensure that CMS' records accurately capture plan compliance with the reporting timeframes. We recommend that when sponsors validate there is no EGHP membership or no employer groups, that CMS officially rescind or withdraw the overdue notices.	We understand the recommendation, but this does not really pertain to the “information collection requirements” per the Paperwork Reduction Act. However, we note your comment.
6	Response to Public Comments	New Measure: Part C Enrollment/Disenrollment	These changes are significant. If an existing report from our enrollment vendor cannot accommodate these changes, then this would be a very manual report, and very cumbersome to report on.	We acknowledge that this is a significant addition but we believe that this is an important if not critical performance measure and well-worth any additional burden in

				reporting.
7	Response to Public Comments	General	We request CMS publish a guide to the validation standards that the data files must pass in order to be accepted by HPMS. During the upload for Measures, our organization experienced a few rejections based on the validation standards, but did not have clear sight as to what those standards were. Without knowing what the standards are, errors can be difficult to correct, and, once corrected, plans may experience another error based on a different standard during submission of the same file. If organizations understood the validation standards, files could be quality checked and errors avoided during uploading of the files	We believe the commenter is confusing the data reporting with the Part C/D Data Validation Standards. The submitted data should be accepted into HPMS if there are no formatting issues. QA procedures such as outlier analysis are performed on the data after they have been accepted into HPMS and, therefore, should not result in rejection during the upload.
8	Response to Public Comments	Non-Specific	We request CMS provide Plans with the Part C and Part D Reporting outlier statements and calculation methodology for each of the required reports. This information could be used to assist Plans in the interpretation of the Part C and Part D Reporting Requirements and Technical Specifications; support reporting decisions; and support Plans internal identification of potential data issues. If CMS will not provide the calculation methodologies, we request, at a minimum, that the outlier statements be provided.	CMS will not make outlier information available to the Plans at this time. Currently, we do not have fixed thresholds for all the sections. Plans would not be able to duplicate our process, and, therefore, we do

				not believe it would be beneficial to supply this information.

Part C Changes				
#	**Category**	**Section**	**Change/Reason**	**Effect to reporting burden**
1	Response to Public Comments	Procedure Frequency	For the Part C Procedure Frequency report, CMS has stated that organizations that will report a subset of the elements are to enter "0" into the Procedure Frequency report. This direction suggests that CMS will combine the HEDIS data and the Procedure Frequency data to analyze whether there are barriers to care for these semi-elective procedures. However, HEDIS is a counting of the procedures whereas Procedure Frequency is a counting of the number of enrollees who receive these procedures. Therefore, these data sets are related but not directly comparable. Our recommendation is for CMS to have Plans report all Procedure Frequency data going forward, regardless of whether the similar but incomparable data information is also reported through HEDIS.	Increase
2	Response to Public Comments	Revised Measure: Part C Grievances	Revised Measure: Part C Grievances CMS should consider excluding the timely notification reporting requirement for fraud grievances. This type of grievance does not have a timeframe for notification like other grievances do, and therefore does not make sense to report on this. Reporting total number of fraud grievances should be sufficient.	Decrease

Part C Changes				
#	Category	Section	Change/Reason	Effect to reporting burden
3	Response to Public Comments	Enrollment and Disenrollment	Revised the introduction due to CMS' enrollment processing changes effective 4/18/2011.	None
4	Response to Public Comments	Enrollment and Disenrollment	Revised data element 1.B for Part C to clarify the definition of "complete."	None
5	Lessons Learned	Enrollment and Disenrollment	Revised data element 1.D for Part C to clarify the party making the determination and party that is ineligible.	None
6	Lessons Learned	Enrollment and Disenrollment	Revised data element 1.F for Part C to clarify that type of enrollment requests denials that should be reported.	None
7	Lessons Learned	Enrollment and Disenrollment	Revised data element 1.H for Part C to remove the word "plan" to be consistent with data element 1.I.	None
8	Response to Public Comments	Enrollment and Disenrollment	Revised data element I.J for Part C to clarify what is meant by "employed agents and brokers."	None
9	Response to Public Comments	Enrollment and Disenrollment	Removed data element 1.M, 1.Q, 1.R, and 1.S for Part C due to CMS already having access to this data.	Decrease
10	Response to Public Comments	Enrollment and Disenrollment	Added an additional data element to Part C– data element 1.P – to capture the number of enrollment transactions for individuals affected by a contract renewal, plan termination or service area reduction.	Increase
11	Response to Public Comments	Enrollment and Disenrollment	Revised data element T for Part C to clarify that voluntary disenrollment requests should be reported. Data element T was re-lettered.	None
12	Response to Public Comments	Enrollment and Disenrollment	Revised data element data element U for Part C to clarify what is meant by "complete." Data element U was re-lettered.	None
13	Response to Public Comments	Enrollment and Disenrollment	Revised data element V for Part C to clarify that the number of denied disenrollment requests reported should include all denials. Data element V was re-lettered.	None
14	Response to Public Comments	Enrollment and Disenrollment	Deleted data element W for Part C due to CMS already having access to this data.	Decrease
15	Response to Public Comments	Enrollment and Disenrollment	Data elements T through Y for Part C have been revised and re-lettered to mirror Part D.	None