CMS Response to 30 Day Comments, Part C Reporting Requirements PRA (CMS-10261)

Part C Measure	Organization	Comment No.	Summary of Comment	CMS Response
Enrollment/ Disenrollment	AHIP	Item 14-p. 6	***Element L.*** Proposed element L. incorporate into the new Part C reporting requirement the waiver for 800 series and employer/union direct contract plans that is currently included in the Part D Technical Specifications.	We agree with the recommendation. 800 series and employer/union direct contract plans should not report this measure.
Enrollment/ Disenrollment	AHIP		***Element L.*** Proposed element L. also appears to include inadvertently a reference to Part D and we recommend that this reference be eliminated.	We agree with the recommendation. CMS will eliminate this reference.
Enrollment/ Disenrollment	AHIP	Item 14-p. 6	***Element J.*** In the description for element J., CMS appears to have included inadvertently language that references stand-alone PDPs. AHIP recommends that CMS delete the reference to stand-alone prescription drug plans (PDPs).	We agree with the recommendation. CMS will delete the reference to stand-alone prescription drug plans (PDPs).

Enrollment/ Disenrollment	AHIP		***Element O.*** Proposed element O. would require sponsors to report enrollment transactions "using the SEP Election Period code 'S' that coordinates with the Medicare Advantage Disenrollment Period" (MADP). If we understand this language correctly, it appears that it may be in error, because no enrollments will be permissible under the MADP and therefore no code "S" enrollments would be associated with the MADP. AHIP recommends that CMS revise or delete this element.	We agree with the recommendation. CMS will eliminate this reference.

Part C Measure	Organization	Comment No.	Summary of Comment	CMS Response
Enrollment/ Disenrollment	United HealthCare		We recommend that Data Element L, the reporting of transactions for initial coverage election period, be removed as CMS has access to this data. This data is sent by plans during normal enrollment transaction processing under enrollment code "I."	We agree with the recommendation. CMS will eliminate this reference.

Enrollment/ Disenrollment	United HealthCare		We request CMS clarify Data Element P. Does the data element refer to a beneficiary who moves to a new Part C or Part D Sponsored Plan due to another Sponsor's contract nonrenewal, plan termination or service area reduction? Or, is the data element capturing a current member of a plan who is moved internally to another plan within the same organization, due to contract nonrenewal, plan termination or service area reduction? For current members who are moved internally due to contract nonrenewal, plan termination or service area reduction are considered disenrollments, and not enrollments, and are sent to CMS using code "X-administrative change." In this instance then, CMS has access to the data and we would recommend removing the requirement.	

Provider Network Adequacy	Group Health Cooperative		The instructions for Element 4, Provider Network Adequacy, say to "Report the number of providers based on their contracting date, and not credentialing date." How do we account for providers who move from a solo practice to a contracted group or from a contracted group to solo practice, but remain in the same service area? Their contracted date would change to that of the new contract they are under, which would disable our ability to count them as ongoing/continuous.	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.
Grievances	HealthPartners.com		We would like to suggest that CMS provide definitions of various grievance types to ensure plans are properly categorizing all grievances.	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.
Organization Determinations/Reconsiderations	HealthPartners.com		In Measure 6 we are unclear on if plans are to report concurrent review. For example, we are unsure if we report the initial pre-authorization approval and all continuing approvals until there is a possible denial. We suggest that CMS clarify the reporting of continuing reviews in Measure 6.	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.

Several Part C Measures	HealthSpring		**Organization Determination & Reconsideration:** Tech specs need to provide clarity on reporting Plan/IRE decisions (Original, final or both) **Grievances:** Tech specs can provide clarity on few exceptions such as accepting Grievances by members whose eligibility date is post dated, and clarify on reporting Part D Grievances for LIS beneficiaries & LIS statues at the time of reporting. **SNP:** Tech specs to provide clarity on HRA's due from previous years and those completed following year and how it should match the ratios of the 4 data elements. **Agent Oversight:** Would like to see a list of categories for types of allegations/complaints that have to be counted **Appeals:** Do C31 and C32 include both member and provider appeals? **New reporting element (B) – Number of redeterminations made within required timeframes:** Is there information outlining what this measure covers?	These questions do not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.

Grievances	Independence Blue Cross		It is our position that, as with the fraud investigations, privacy matters should be exempt from the timely notification reporting.	We agree.
Organization Determinations/Reconsiderations	Independence Blue Cross		CMS Part C Appeal Specifications require the Part C appeals (reconsideration) data to be broken out by contracting and non-contracting providers to eliminate the non-participating providers from element 6.6. If a member writes in to appeal two claims for example, and those two claims are two different providers: One is participating, the other is not, how should this appeal be counted and what element should it be reported?	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.

Provider Network Adequacy	SCAN Health Plan		CMS responded to the PNA question regarding why geriatricians are considered specialists but did not respond to the question about why pediatricians are included in the primary care categories given that Medicare is primarily for seniors. Is the reason pediatricians are included is that we are expected to offer a full network to blind/disabled Medicare beneficiaries under 65?	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.

Enrollment/ Disenrollment	United HealthCare		The Part C Technical Specifications released with this comment request have not been updated with the new reporting requirements for Part C, i.e., Enrollment and Disenrollment reporting requirements. Also, the Notes sections within the Part C Technical Specifications for some requirements were not updated with clarifications that we had received, e.g., for SRAE reporting. These were not updated for CY2012, nor were the Notes sections updated for 2010 or 2011. We recommend that going forward, CMS update the Technical Specifications document with all changes and clarifications provided to plans in conjunction with the release of the draft reporting requirements for comment.	This question does not relate to the PRA. Plans have been informed to submit these questions to the Part C Plan Reporting dedicated mailbox.

Several measures involving claims data.	United HealthCare		In 2012, CMS will receive plans' claims data via the Encounter Data Submission (EDS) process. Therefore, many of the Part C claim reports, such as Procedure Frequency and Organization Determinations, etc. may be duplicative of the information received through EDS. We recommend that CMS review the Part C reporting data elements and remove those that are claims-based so that Plans are not required to collect and submit the same data twice.	CMS will be reviewing data elements to see if there is any duplication.
	United HealthCare		For the Part C Procedure Frequency report, CMS noted as its reasoning for this report that "Plans with lower than expected rates of these procedures may have barriers to care." We request that CMS provide the "expected rates" that are being referred to in the statement and explain how the rates were derived, that is, are they industry standards? In the alternative, please provide the published source where the rates can be found or a link to the source.	We have been looking at outliers but have not been able to establish specific expected rates for health plans, in part due to variability in reporting. We believe that lessons learned through the data validation process may lead to more reliable and valid reporting that can eventually get us to a point where expected rates could be considered.

	United HealthCare		The notes section on page 24 of the SRAE Reporting states "report the SRAE or HAC associated with the most costly procedure and the procedure that ostensibly involves the most resources. That is, prioritize according to cost." However, the data elements conflict with that and require the "number" of SRAEs to be reported. When requesting clarification, CMS notified our plan in February 2011 that we are to report each SRAE that occurred, not the one associated with the most costly procedure. We request that CMS revise the written requirements to reflect the correct reporting requirements. The requested update would assure that all plans are consistently reporting the correct SRAE data and would also assure comparability of data across plans.	We will be revising these requirements.

	United HealthCare		The 10/26/10 Part C Reporting Requirements Technical Specifications, page 39, notes to include all 800 series plans in the Plan Oversight of Agents report. Please clarify in the specifications and reporting requirements that this direction is incorrect and that plans are not to include 800 series plans in the Part C Plan Oversight of Agents Reporting.	This will be revised in the 2011 specifications. This was erroneously included in the document that you are referring to.

All	United HealthCare		We request that CMS provide a guide explaining the technical requirements for files and edits that occur when uploading the reporting measures data into HPMS. A guide to the technical requirements and uploading edits that are in place would reduce the amount of error messages when uploading extensive data on the measures and conserve HPMS Helpdesk resources.	CMS has this guide called the HPMS Plan Reporting Module Systems Requirements Specification Document.