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Category	Submitter	Submitter Comments	CMS Response	Action
Submission Deadlines For ED	UCare Minnesota	Our Plan has concerns with the proposal of weekly submissions of ED. If the process fails over the weekend, plans will only have four days to identify and correct the issue. We recommend that CMS require monthly rather than weekly, reporting. Monthly reporting will allow plans time to fix errors or issues.	CMS noted that Medicare Advantage plans would be required to submit Encounter Data to CMS weekly. The requirement around the submission of weekly encounter data has generated many comments through the PRA comment process. CMS will use the opportunity to respond to those comments. For those plans that have 100,000 lives or more, CMS is requiring weekly submissions of encounter data. Since the changes to the new encounter data process increases the amount of data collected from the five elements currently collected to all of the elements on the HIPAA 5010 version of the X12 standards, CMS anticipates a significant increase in the volume of data. Therefore, the larger plans (100,000 lives or greater) will be required to submit encounter data at least weekly to avoid the possibility of overloading the Encounter Data Processing System due to large dumps of data at one time spanning a much longer timeframe. For smaller plans between 50,000 and 100,000 lives, CMS is requiring that plans submit data at least bi-weekly to avoid overloading the system. For plans with less than 50,000 lives CMS is requiring that they submit encounter data at least monthly. In addition to the requirements submitted above, CMS is requiring that plans submit all adjudicated encounters within 60 days from the date of adjudication. Furthermore, CMS will not accept any initial encounters that have a date of service greater than 13 months. CMS is doing this to align more the submission of encounter data with the timely filing requirements set forth in section 6404 of the Affordable Care Act.	Update to Section 3, 6
	Gateway Health Plan	Information in this posting is not consistent with information communicated during CMS Industry Calls on this subject. The posting states that the data must be submitted at least weekly; the industry calls have indicated that the submissions must be at least monthly.		
	Highmark	In addition, guidance was given that all claim types, including hospital inpatient, hospital outpatient, and physician encounter data would be required to be submitted at least weekly. The weekly submission requirement is referenced twice in the Supporting Statement (page 6 and 7). However, in the January 19, 2011 Encounter Data Industry Update workgroup meeting, requirement #4 on slide 11 indicates that plans are required to submit data monthly. The slide also indicates that plans may submit more frequently but does not indicate that it would need to incur on a weekly basis. The monthly submission requirement was first stated to the industry on October 29, 2010 and has since been reiterated. The verbiage in this notice contradicts what has been stated to the industry up to the point of the release of this Supporting Statement. Clear direction as to the frequency of the submission needs to be addressed by the agency, as this will impact systematic data submission processes at Highmark.		
	Wellpoint	On page 6 of the Supporting Statement, CMS describes the Encounter Data System which will be used by MAOs to submit their data. In this section, CMS notes that all claim types, including hospital inpatient, hospital outpatient, and physician encounter data would be required to be submitted at least weekly. This stated frequency of weekly submissions is inconsistent with prior statements made by CMS to MAOs, namely that the encounter data submissions are to be made monthly.		

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	AHIP	The Supporting Statement specifies that "CMS would require Medicare Advantage plans to submit encounter data at least weekly." This statement is in conflict with slide #11 in the CMS presentation from the January 19 Encounter Data Industry Update, which states that "MA Organizations are required to submit data monthly," and will permit submission more frequently. AHIP supports the position stated by CMS on January 19 and believes that this flexibility will better serve both MA organizations and the agency. We recommend that CMS confirm the position stated on January 19.		
	AETNA	Our providers have 12 months or more from the date of service of a claim to submit it to us so it would not be reasonable for MA plans to be held to the same timeline to be able to submit the data to CMS.		
	Kaiser	In its description of "Collection Frequency" on page 7 of the Supporting Statement, CMS states in the first sentence that it will require MA plans "to submit encounter data at least weekly." We believe, and we ask CMS to confirm, that "weekly" is a typo, since the remainder of this paragraph refers to monthly submissions. CMS then states that "Plans also must include each service category per month." This statement implies that CMS intends to require every MAO to submit encounter data in every category of service beginning in January, 2012, and monthly thereafter. Kaiser strongly believes that CMS should phase-in submission, no matter which start date it ultimately selects. A phase-in would be especially valuable to permit some reasonable delay for service categories where data may be more difficult to get, or where the data volume is very low. Kaiser recommends that CMS start any phase-in with institutional data first, because such data is typically easier to access and because it will fulfill not only CMS' stated risk adjustment calibration purposes but also its DSH hospital percentage calculation and Medicare coverage purposes.		
	SNP Alliance	Page 6 & 7 of the Notice indicate that encounter data must be submitted at least weekly while the National Encounter meeting and subsequent workgroup handouts indicate submission will occur at least monthly.		
Concerns With The ED process	XL Health	See submission	No comment required	None – out of scope

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Burden on Plans (Delayed Deployment) Increased Resources Needed Within A Short Timeframe	Highmark	Currently, Highmark submits risk adjustment data through the less extensive data stream requirements governed by CMS. As CMS has indicated that they currently do not require diagnosis data to be filtered only to the applicable CMS HCC and RXHCC model, we as an organization have had to filter these diagnosis codes. This filtering is due to the number of beneficiaries Highmark has and the volume of diagnosis data that they generate. If we were to submit all diagnosis codes to CMS, we would exceed the current file size limitation threshold. The transition from the limited data stream to the vastly more extensive data stream will require significantly more staff time to manage the data submission process and system resources for storing and sending of information. Thus, there is also concern at Highmark about the limitations we may face due to the volume of data that will be sent to CMS and their ability to accept the data.	CMS appreciates that the system implementation timeline for encounter data and ICD-10 may place additional burden on some of the Medicare Advantage Organizations (MAO) and Third Party Administrators (TPA). We have conducted numerous workgroups, updates, and regional technical assistance sessions to assist the industry in encounter data implementation. We have added information on these sessions to the PRA. We have also updated the sections on Burden Estimates and Capital Costs to reflect an increased cost to the industry.	Revised Section 8, 12, 13
	Wellpoint	In prior discussions with MAOs and in the Supporting Statement, CMS has stated its expectation that MAOs will begin reporting encounter data in January 2012. Up to this point, however, CMS has not made available detailed, technical specifications for use by MAOs as they plan for and execute systems to accommodate the data submission requirements. Without this technical guidance, MAOs will be unable to complete the significant systems changes that will be required to meet the January 2012 timeline, nor will MAOs be able to plan for and dedicate the appropriate resources necessary to implement the changes. Additionally, MAOs that have already made proactive modifications to their systems in anticipation of the encounter data submission requirements may find themselves in the position of having to engage in costly rework due to unanticipated details set forth in the specifications. Another concern is the fact that CMS' plans call for collection of encounter set data using ICD-9 diagnosis codes, but then converting to ICD-10 in time for the October 2013 ICD-10 implementation deadline. Converting from ICD-9 to ICD-10 coding will likely entail significant system changes in addition to those mentioned above.		

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	AHIP	From previous experience with submission of MA risk adjustment data, the process of navigating front end and back end edits, reviewing data submission reports, addressing any rejected data and resubmitting as needed, can be a complex and time consuming process that requires a substantial investment on the part of MA organizations and CMS. For these reasons, we urge CMS to initiate encounter data collection through a well-defined and focused set of data elements and technical specifications under a longer timeline that permits MA organizations to receive notice of CMS requirements sufficiently far in advance of implementation to carry out systems development and end-to-end testing in an orderly manner.		
	AETNA	As a result of the 12 month rule, the MA plans would need to request a greater number of charts than necessary, based on incomplete claims data. The Chart Review process will also potentially be compressed to a shorter time period, which will disrupt the providers. It will not be practical to review medical charts during the first 9 months of the Date of Service period and charts with dates of service in January and February would need to be collected and reviewed before the Service period expires.		
	Kaiser	The Office of Management and Budget Clearance Package Supporting Statement ("Supporting Statement") indicates, on page 7, that CMS anticipates "data collection commencing in January 2012." We believe such a start date is extremely unrealistic and very problematic.		
	Blue Cross Blue Shield Association			
	SNP Alliance	We understand that plans need at least 12-18 months to implement the system after full information and technical resources become available. This not only creates significant time pressures for plans but many plans did not have sufficient information to include additional needed costs in their 2011 bids. A number of plans are also concerned about the added complexity and costs associated with implementing this new system under the ICD-9 coding system when the ICD-10 system will be implemented shortly.		

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Intended Use of ED	AHIP	Purpose(s) for which required MA encounter data elements will be used. On page 5, the Supporting Statement indicates that Table 1 summarizes the purposes for which encounter data will be used. However, the categories that appear in the table do not provide sufficient detail to explain the use(s) that CMS intends for the various data elements in the electronic 5010 format that MA organizations will be required to submit.	We have updated Section 2 to say: The commenters on the December 2010 PRA package asked us to address other uses of the data. Other uses for the data would include geographical acuity studies, utilization trends and detection of abuse as defined in the False Claim Act. Additional uses for the data include verifying the accuracy and validity of the reasonable costs claimed on Cost Reports submitted by §1876 Cost HMOs/CMPs and §1833 HCPPs.	Update to Section 2
	Highmark	The lack of clarity regarding the usage of the encounter data raises concerns at Highmark, since the claim data includes proprietary information.		
	Aetna	The Agency already has an existing process (RAPS) to collect information on Medicare Advantage beneficiaries. This RAPS process places appropriate burdens on Medicare Advantage Organizations to report member conditions required for risk adjustment purposes. The new EDS process substantially increases amount and type of information required to validate beneficiary conditions for risk adjustment and can not necessarily be justified based on this need. The need for the Agency's other rationale for the new EDS process, recalibration of the risk model, has not necessarily been demonstrated.		
	Wellpoint	Although the primary use for the encounter data submitted will be to establish a risk adjustment model that is appropriate for MAOs, CMS notes on pages 5-6 of the Supporting Statement that "there are other important uses for the data that will improve other key functions undertaken by CMS", such as calculation of the Medicare Disproportionate Share Hospital payments and quality review and improvement activities. These stated uses are vague and not well-defined. CMS needs to provide MAOs specific information regarding the purpose for which each encounter data element will be used. Doing so will provide needed transparency that is essential for the encounter data process.		

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	SNP Alliance	While the SNP Alliance understands CMS's interest in capturing more information about ongoing practice, and the potential for using encounter data to improve risk adjustment and to help address a variety of other proposed uses, we are concerned about: 1. The absence of clarity about the methodology that CMS will use to calibrate risk adjustment and the absence of information about plans for other cited uses.		
Applicability to Cost Plans	AHIP	The statutory and regulatory citations included in the Supporting Statement apply solely to the Medicare Advantage program, and no authority is cited regarding application of encounter data reporting requirements to the Cost Plan program. Nevertheless, under the "Data Collection" heading, CMS states that Cost Plans would be required to submit encounter data. We recommend that CMS explicitly identify the statutory and regulatory authority on which the agency will rely for the application of encounter data requirements to Cost Plans or clarify that they will not be subject to these requirements.	We have updated the PRA throughout to clarify that the encounter data policy applies to cost plans and PACE plans.	Updates throughout
	Kaiser	In this Notice, as reflected in its very title, CMS sets forth its intent to collect certain encounter (utilization) data from MAOs, and describes how it will implement that collection and the purposes for which the collected data will be used. With one exception, the documents that support this Notice all (a) state that the data is to be collected from MAOs, and (b) state collection purposes facially applicable to MAOs. However, the Supporting Statement describes, on page 6, the entities from which CMS intends to collect encounter data, and that description includes "cost plans" and "§1876 Cost HMOs/CMPs." (We assume both of these terms refer to the same entities). These two terms constitute the only reference to Medicare Cost contractors in the Notice, in the Supporting Statement, or in any of the other supporting documents. There is no description of CMS' need to collect encounter data from Medicare Cost contractors,		

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	Blue Cross Blue Shield Association	• New PRA notice needed because of how cost plans were referenced • 44 USC §3507(a)(1)(D)(V) requires an agency to published a notice in the Federal Register setting forth an estimate of the burden that shall result from the collection of information. CMS discussed the burden beginning on page 8 of the Clearance Package Supporting Statement. Nowhere in this discussion does CMS mention Medicare cost plans or take into account the fact that most Part A claims for Medicare cost plans are processed by Medicare FFS. Thus it is impossible to tell whether the estimate burden reflects the burden to Medicare cost plans.		Update

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Coordination Between Medicare and Medicaid	National Health Policy Group	The new ED system is an important example of the need for better coordination of reporting requirements for plans providing Medicare and Medicaid coverage.	The Centers for Medicare and Medicaid Services (CMS) is currently coordinating its strategy with the Medicaid and CHIP programs on a national level for the collection of encounter data. CMS is working with these programs to consistently align requirements with states that currently have successfully functioning Encounter Data Systems in place. CMS is the agency taking the lead on this initiative and has incorporated the expert knowledge and skills necessary to fulfill the requirements of this initiative. CMS' overall approach is to harmonize and align requirements. The implementation of 5010 and ICD-10 formats is an example of how the projects can align and collect data in similar formats. However, since the collection of encounter data by CMS occurs on a national level and has a broader scope than the states' initiatives under Medicaid and CHIP, there will be subtle differences in the requirements. For example, the pricing methodologies that CMS will implement will be more complex than state initiatives as we have a requirement that more data be collected and processed. It is our intent that the way we design our encounter data initiative will help alleviate unnecessary administrative burden with respect to dual plans and enrollees.	None – out of scope
	SNP Alliance	A key concern for plans with contracts for Medicaid services is that CMS is implementing a new encounter data reporting system without coordinating this effort with state requirements for encounter data reporting. This is not only going to result in significantly higher costs and unnecessary administrative complexities for dual plans focused on advancing integration, in any form; but it will further bifurcate the administration of Medicare and Medicaid programs for duals at the very time that CMS is advocating for full integration through the Center for Medicare and Medicaid Innovation. This is not only true for programs that may evolve under *new* demonstration authority but for plans that have long-standing practices established through *prior* demonstration authority.		

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Other	CareMore Health Plan	See Submission		None – out of scope