60-Day PRA Comments on
CY2014 Part D Reporting Requirements
CMS-10185

Reporting Requirements					
Organization	**Reporting Section**	**Description of Issue or Question**	**Commenter's Recommendations**	**CMS ACTION**	**REASON FOR ACTION**
Cigna/CVS Caremark/Unknown/United	Plan Oversight of Agents	Element B. Agent/Broker Type. Request CMS provide a list and explanation of each of the specific Agent/Broker types since plans may have different definitions.	Recommend CMS provide a list and explanation of each specific Agent/Broker type.	Accept	A list has been added to the CY2014 Part D Reporting Requirements draft.
Unknown	Plan Oversight of Agents	Element F. Agent/Broker State Licensed. When agents are licensed in multiple states and if the plan is only selling a product in one state, is it necessary to provide the licenses for all other states the agent could be licensed to, or inly the applicable state corresponding to the plan service area?	Please clarify.	Accept	The requirement is to provide the data for each agent who received compensation in the reporting period. If the plan did not provide compensation to an agent in a particular state, because the plan does not operate in that state, CMS does not require data for that state to be submitted. For example, Plan ABC operates in Florida. Agent XYZ is licensed in Florida and Georgia. Plan ABC compensated Agent XYZ for sales made in Florida. Even though Agent XYZ is licensed in Georgia, Plan ABC is only required to provide data regarding the Florida license.
United	Plan Oversight of Agents	Element H. Plan assisted agent/broker Identification Number. Is this 1:1 agent to ID number, specifically, will there be a distinct requirements which will determinate which agent ID to use?	Please clarify.	Accept	This would be a number assigned to the agent by the plan that could be used for payment, monitoring, tracking, assigning clientele, etc. Since this is a plan designated ID CMS will not require specific information regarding the plan identification number.
Unknown	Plan Oversight of Agents	Element H. Plan assisted agent/broker Identification Number. We are not aware of a regulation that required plans to assign numbers to brokers/agents. Therefore, if a plan does not assign agent/broker identification numbers, what is CMS expecting plans to submit?	Please clarify.	Accept	There is no regulation requiring plans to assign numbers to agents/brokers. If the plan does not assign an identification number, the column should be filled with 'N/A'.
Cigna/CVS Caremark	Plan Oversight of Agents	Element I. Agent/Broker Licensed Date. State databases do not consistently display date first licensed.	Recommend that element I be stated as "Agent/Broker State License Expiration Date." Element J requests the Appointment Date so that would be proof that the person was licensed at time of appointment.	Do Not Accept	CMS has clarified the requirement to state the current license effective date. In order to ensure agents/brokers are properly licensed, plans must know when an agent's current license was effective. Because the reporting requirements are delayed the expiration date would not ensure agents were properly licensed when they enrolled beneficiaries into health plans.
Unknown	Plan Oversight of Agents	Element J. Appointment Date. Is this the hire date of the agent, or date in which they completed training and testing and began selling, or something else?	Please clarify.	Accept	Appointment date is the date that the plan has completed the State's appointment process. In states that do not have appointment laws, this item should be left blank.
United	Plan Oversight of Agents	Element K. Agent/Broker Training Completion Date.	Request CMS provide a definition of training courses to be considered for reporting this element.	Do Not Accept	CMS provides agent/broker training guidelines each year. Organizations are to develop their own training courses, using the guidelines as the minimum amount of information that should be in the training.
United	Plan Oversight of Agents	Element L. Agent/Broker Testing Completion Date.	Request CMS provide a definition of tests to be completed for reporting this element.	Do Not Accept	CMS provides agent/broker testing guidelines each year. Organizations are to develop their own testing programs, using the guidelines as the minimum amount of information that should be in the testing.
Cigna/CVS Caremark	Plan Oversight of Agents	Element M. In aggregate, the number of Agent/Broker complaints for the reporting period.	Please clarify. Recommend that element M be clarified to explain whether the information will be reported by Agent/Broker by State or whether the information will be reported in one field per Agent/Broker inclusive of all states.	Accept	Complaints should not be reported by state. CMS will clarify that the complaints should be reported in one line when multiple lines are used for one agent.
Cigna/CVS Caremark	Plan Oversight of Agents	Element N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, terminations, etc.	Please clarify. Recommend that element N be clarified to explain whether the information will be reported by Agent/Broker by State or whether the information will be reported in one field per Agent/Broker inclusive of all states.	Accept	Disciplinary actions should not be reported by state. CMS will clarify that the disciplinary actions should be reported in one line when multiple lines are used for one agent.
United	Plan Oversight of Agents	Element N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, terminations, etc. The term "related to Marketing" is quite broad.	Recommend that CMS provide additional clarification on the scope of "marketing" related complaints.	Accept	By "related to marketing" we mean disciplinary actions taken as a result of agent behavior in the selling of products. For example, if an agent is found to provide inaccurate cost sharing information to beneficiaries and undergoes additional training, this would be reported.
United	Plan Oversight of Agents	Element O. Agent/Broker Terminations Date (if applicable). Can CMS clarify if terminations reported would be related to complaints only? Also, should voluntary terms and layoffs be excluded?	Please clarify.	Accept	Only terminations relating to marketing should be reported. These may not always include complaints. For example, if an organization terminates an agent because the agent does not fully understand the products, but no complaints have been reported, this termination should be reported.
Unknown	Plan Oversight of Agents	Element Q. Third-party Marketing Organization (TMO)/Field Marketing Organization Name (FMO). If a plan does not use TMO or FMO, that plan would report 0?	Please clarify.	Accept	The plan would report 'N/A'.
Cigna/CVS Caremark	Plan Oversight of Agents	Element R. The number of new enrollments in the reporting period.	Recommend that element R be clarified to explain whether the information will be reported by Agent/Broker by State or whether the information will be reported in one field per Agent/Broker inclusive of all states.	Accept	Report by state
United	Plan Oversight of Agents	Element M. In aggregate, the number of Agent/Broker complaints for the reporting period. Certain complaints are not tied to a plan member and therefore would not be tied to a CMS contract.	Suggest that these types of complaints be excluded from this reporting.	Do Not Accept	In many cases a complaint against an agent can be tied to a contract number even though it is not tied to a member. Organizations should make their best effort to link all complaints to a contract number.
United/AHIP	Plan Oversight of Agents	Section 1. Agent/Broker: "For each agent that received compensation in the reporting period (initial enrollments and renewal payments received), indicate…" Is this every agent that received compensation in 2014 regardless of when the application was submitted or what the effective date is?	Recommend that the requirement the reporting period is based on effective dates in 2014. Also suggest that compensation be defined as commission and salary.	Accept	We have modified the requirements for effective dates and are using the definition of compensation found in the MMG at 120.4.1.
AHIP	Plan Oversight of Agents	Section 1. Agent/Broker: "For each agent that received compensation in the reporting period (initial enrollments and renewal payments received)."	Recommend CMS define this phrase and include an explanation that addresses this issue in the next version of the draft Part D Reporting Requirements and/or Technical Specifications.	Accept	We have more clearly stated compensation to be consistent with MMG 120.4.1.

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Cigna/CVS Caremark	Medication Therapy Management	Element H. Long-term care (LTC) facility resident (at time of MTM program). (Y (yes), N (no), or U (unknown)).	Please clarify. Recommend CMS clarify the verbiage "at time of MTM program" to mean that this should be reported as 'Y' if the beneficiary is a resident of an LTC at the time the beneficiary is first enrolled in the MTM program.	Accept	CMS has made the decision to remove the LTC facility resident element from the reporting requirements.
Cigna/CVS Caremark	Medication Therapy Management	Element I. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer. (Y (yes), N (no), or U (unknown)).	Please clarify that sponsors may take this identification either at the time the beneficiary is contacted to be offered the CMR or during delivery of the CMR, i.e., that reporting 'Y' for an identification made at either time would be considered acceptable.	Accept	Sponsors may identify and report that a beneficiary is cognitively impaired at either the time of the CMR offer or delivery of the CMR. Element I has been revised to include this clarification.
Cigna/CVS Caremark/AHIP	Medication Therapy Management	Element Y. Topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. (If more than 1 topic discussed, up to 5 topics will be allowed to be reported.) These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR. There is concern that "topics discussed" may be too broad and would leave it up to the provider to interpret what information to supply.	Recommend CMS provide a values list of specific topics for data in which CMS is interested.	Do Not Accept	CMS defers to the MTM industry to develop a consensus based approach to adequately identify, track, and report MTM program recommendations and resolutions. CMS notes that clinicians have the discretion to choose how to make reference to the medication or care issue to best meet the needs of the beneficiary. CMS envisions standardized nomenclature and code sets for categories of care issues for reporting purposes, although plain language is used when information is presented to the beneficiary in the Medication Action Plan.
Cigna/CVS Caremark/AHIP	Grievances	The structure of the reporting grid on page 16 provides a column for "number of expedited grievances" that suggests that these types of grievances may arise in any of the grievance categories listed, which is not the case. An expedited grievance is defined as a grievance that "involves refusal by a Part D Sponsor to process an expedited coverage determination or redetermination request."	Recommend the reporting grid be modified to make clear that this data element would not be applicable in situations other than coverage determinations and redeterminations. Confirm that Expedited Grievances reported in the 2nd column and the grievances with Timely Notification in the 3rd column are subsets of the number of grievances we would report in the first column.	Accept	Clarifications for the Expedited Grievances category will be made in the technical notes.
Cigna/CVS Caremark	Grievances	Intro - For reporting, Sponsors should:…Report those grievances that may have also been reported in the Complaints Tracking Module (CTM). VERSUS For reporting, Sponsors should not:… Report complaints received by 1-800 Medicare or recorded only in the CTM as grievances.	Please clarify these requirements as these two statements appear to contradict one another.	Accept	Introduction modified. CMS' intention with these notes was to let plans know that they should not simply take their CTM records and submit them to CMS for their grievances reporting. Plans should have a separate process to track grievances. A person could certainly call 1800 and log a complaint in CTM, and also file a grievance; this would not be excluded in the grievances reporting.
Unknown	Coverage Determinations and Redeterminations	For CY2013 Reporting Requirements and Technical Specifications, CMS requested individual data elements for Step Therapy, PA exceptions, and Quantity exceptions rather than one group. Now for CY2014, it appears CMS is going back to one data element for all exceptions. Please explain why CMS is considering this change when exceptions were reported separately in 2012, then combined for 2013 and now appear to be separated again for 2014.	Please clarify.	Accept	For CY2013 changes, CMS wanted to get more descriptive reporting; therefore, the various types of exception requests were separated out. CMS has now been charged with reviewing all requirements placed on Plan Sponsors such as the Reporting Requirements and where possible reducing the burden associated with such reporting. As a result, CMS has proposed CY20014 reporting elements that capture the total for exception requests as a whole, which we believe reduces burden on plans in meeting these requirements.
United/AHIP	Coverage Determinations and Redeterminations	This section will require significant system enhancements to report on the Reopenings data elements.	Recommend that the reporting requirements be finalized well in advance of the 2014 reporting year so that the plan can adopt and implement the changes to facilitate this reporting or that CMS finalize the rule in 2014 but implement the reporting of the Reopenings data elements for the 2015 reporting year.	Do Not Accept	CMS plans to finalize these requirements in time for Plans to build mechanisms needed for this reporting. The deadline for this reporting is 02/28/2015. CMS believes that one year should be sufficient time for plans to implement changes and submit reports. While CMS understands that system modifications can take some time to implement, we do not believe that the proposed reopening reporting requirements would necessitate significant changes. Most of the elements CMS is requesting in the data file are elements the plan is already required to report (elements VI(3)(B1-B6). Additionally, CMS believes that in order to ensure compliance with our existing Part D reopening requirements at 42 CFR 423.1978 through 1986 and Chapter 18, section 120, including providing the enrollee with notice of the revised determination and any right to appeal if that determination is adverse, and ensuring that the reopening occurs within the appropriate timeframes based on the date of the original disposition, plan sponsors should already be capturing this data and should not require significant system enhancements. CMS would like to clarify that proposed element VI(3)(B)(8) asks for the general reason for the reopening, and expects that any reopening that does not fall into a category in the drop down list (e.g., determinations reopened within one year pursuant to 423.1980(b)(1) would be classified as "other" for reporting purposes). For clarification, CMS is proposing to add an additional reason to the list for "fraud or similar fault." Initial determinations made be reopened and revised pursuant to our rules within 4 years for good cause as defined in 423.1986. Plan sponsors would only be expected to populate an entry from the drop down list and would not be expected to provide additional detail about the rationale for the reopening for reporting purposes.
Express Scripts	General	All of the extra reporting necessary in support of the documented requirements is likely not being captured in the burden estimates provided.	Recommend revising levels of reporting and increasing burden estimates.	Do Not Accept	Burden estimates have been revised to account for reporting levels among several reporting sections.
Express Scripts	Grievances	Year after year changes have been applied and in many cases do not appear to add value and in fact, could detract from a Sponsor being able to perform an adequate level of comparison of their performance across contract years.	Recommend consistency of this reporting from year to year to ensure the most accurate, complete and truthful information is officially provided in the timeframes required.	Accept	CMS is working to make this reporting more consistent from year to year. The grievance categories have been revised based on feedback from plans and help support CMS monitoring efforts. The grievance rate used for Display Measures can be used from year to year as it uses the total number of grievances and does not break down by each grievance category.
Express Scripts	Medication Therapy Management	General: Since 2006, there has been a 500% increase in the number of elements reported for MTM. In addition, reporting elements are now at the beneficiary level versus the contract level.	Recommend pushing back the due date of this report to allow sufficient time to generate and check.	Do Not Accept	Although, CMS acknowledges that this reporting has increased over the years, it has not significantly increased from 2013 to 2014.
Express Scripts	Medication Therapy Management	Long-term Care Status: It is not clear from "at time of MTM program" if the process for establishing LTC status is determined by "at any time during" or "for the entire time of" MTM participation. In addition, CMS is aware of LTC status through the LTI report.	Recommend removing this element.	Accept	CMS has made the decision to remove the LTC facility resident element from the reporting requirements.
Express Scripts	Medication Therapy Management	Element Y. Topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. (If more than 1 topic discussed, up to 5 topics will be allowed to be reported.) It is not clear what CMS plans on learning from the collection of recommendation level detail. We believe this element would go against CMS' stated reporting requirements on page 3 by: pushing the administrative burden beyond minimal and utility of data element.	Recommend removing this element.	Do Not Accept	CMS believes this will not be an administrative burden once the MTM industry adopts available HIT for MTM services, including standardized nomenclature and available code sets, and integrates MTM elements into EHRs. This element also helps identify beneficiary-focused recommendations made by MTM providers.

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AHIP	Grievances	CMS Issues: We believe that additional information about the category would promote a common understanding of the agency's expectations for reporting.	Recommend CMS provide in the Technical specifications a definition of this category and examples.	Accept	CMS added this element to prevent unfair measurement of some (less common) grievances against the plans. The "CMS Issues" grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control, from the total number of grievances filed against the contract. Please refer to the attached CTM Standard Operating Procedure for categories that are currently excluded (i.e. CMS Issues, SSA premium withhold) and examples of CMS Issues. CMS will provide clarifications in the technical notes.