Responses to Comments Received on 60-Day Federal Register Notice on Part C Medicare Advantage Reporting Requirements and Supporting Regulations

CMS received comments on the 6/21/2013 (CMS-10261) and the 6/28/2013 (CMS-10305) 60-day notices on the proposed changes to the Part C Medicare Advantage Reporting Requirements. The 6/28/2013 notice was a duplicate of the 6/21/2013 notice. The commenters were: HealthPartners, Cigna, UCare, WellCare Health Plans, Florida Blue, AHIP, and Emblem Health. The comments could be categorized as either general or reporting-section specific. CMS will respond to both categories of comments.

General Comments on the Supporting Statement for Part C Medicare Advantage Reporting Requirements

Burden Estimates

Comment: CMS burden estimates are consistently below MA organization estimates. CMS [is] urged to consider striking a balance that permits it to carry out its oversight responsibilities without unduly burdening MAOs.

CMS Response: CMS developed its burden estimates using what it considered to be the best available data. The burden associated with this information collection request (ICR) is the time and resources it takes to develop computer code, to "de-bug" computer code, gather the 'raw" data, "clean" the data in order to eliminate errors, enter data, to compile the data, review technical specifications, and perform tests on the data. An average competitive hourly rate (including wages, benefits and overhead) of $64.57 was used to calculate estimated labor costs. The average hourly rate was based on publically-available data on computer specialists from the Bureau of Labor Statistics (refer to http://www.bls.gov/oes/current/oes151121.htm). CMS in this ICR has strived to achieve a balance that permits it to carry out its oversight responsibilities without unduly burdening MAOs.

Comments Specific to Reporting Sections

Serious Reportable Adverse Events (SRAEs)

Comment: One commenter indicated that CMS should reconsider its earlier timeframe, because it will result in a shortened lag time for data.

CMS Response: CMS needs an earlier timeframe in order to accommodate the reporting of data as a display measure prior to and during the enrollment period and also for the possible eventual use of the data in star ratings. CMS believes that the benefits of making these data available on a timely basis will more than make up for any additional costs in rerunning reports.

Comment: One commenter indicated that there would be more work for plans since they will have to rerun reports which will add to administrative costs. A second commenter also indicated that there would be an additional burden due to the proposed changes in the reporting

requirements.

CMS Response: CMS believes there will be a reduction in administrative burden since the number of SRAEs that are reported will be reduced from 20 to 4 due to the use of encounter data.

Comment: One commenter stated that there was a potential for “increased results” due to encounters including all diagnoses.

CMS Response: CMS believes that the use of encounter data in reporting SRAEs will increase reporting reliability and validity and make results more comparable among health plans. The phrase “increased results” we infer as meaning that encounter data might capture more SRAEs and therefore lead to an increase in the rates of SRAEs. Capturing the events and reporting them is the goal of this reporting section, and we would look on this as improving reporting.

Comment: One commenter requested that they be given an opportunity to see the results for this measure [reporting section] that is produced via the encounter data. We inferred that the commenter was concerned that the revised reporting methodology would not produce results similar to those reported via the current methodology.

CMS Response: CMS plans to compare encounter data results with previous reported results. CMS will not publicly release the new results until it is confident that the results are reliable, valid, and comparable among plans. CMS anticipates that the testing of results will involve at least two years of data. In addition, SRAEs reporting will continue to be subject to reporting standards such as those applied in the current annual data validation efforts.

Comment: One commenter was concerned about the timing of when data on this reporting section are run versus when the encounter data are compiled. This commenter also asked about the cutoff date for running data.

CMS Response: CMS anticipates running the data annually as is currently done. There will be a cut-off date as in previous years of reporting SRAEs data. The cut-off date for reporting will likely be 12/31 of the reporting year with the data due 2/28 of the subsequent year.

Comment: One commenter asked what will be the process for identifying which products get counted towards the contract numbers.

CMS Response: By the term “products”, we infer that the comment was referring to organization types. We expect that the same organization types that are currently reporting SRAEs will be reporting SRAEs under the new methodology.

Comment: Since the compliance date for ICD-10 is October 2014, when will these reporting changes become effective in ICD-10?

CMS Response: The reporting changes will become effective in ICD-10 on October 1, 2014. There will be no hospital-acquired conditions (HACs) and "never events" reporting via the Part C Reporting Requirements during the first 9 months of 2014. While the process and all details have not been completely decided since they are contingent on OMB approval, CMS expects that encounter data will be used beginning in 2014 for most HACs reporting. These encounter data would be compiled by CMS to develop reports on SRAEs. However, "never events" will be reported using ICD-10 codes via the Part C Reporting Requirements for three months during 2014—October through December.

Comment: Will this [reporting requirement] be [effective] for CY 2014 and reported in CY 2015?

CMS Response: This reporting requirement will be effective beginning October 1, 2014 and the results will be reported in CY 2015.

Part C Grievances

Comment: One commenter requested a "more robust definition" of the CMS grievance category.

CMS Response: The term "grievance" will be defined in the technical specifications. Note: grievances are described in detail using the definition in Chapter 13 of the Medicare Managed Care Manual, see Sections 10 & 20. Therefore, a grievance is defined as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken."

Comment: One commenter indicated that clarification of expedited grievances was needed and that Chapter 13 of the Medicare Managed Care Manual seems to suggest that expedited grievances only pertain to the Organization Determination or Reconsideration process.

Comment: Related to the above, another commenter indicated that CMS' definition of "expedited grievances" does not include most of the categories. They recommended eliminating the "number of expedited grievances" category for all but organization determinations and reconsideration process grievances.

CMS Response: An expedited grievance is defined as a grievance that "involves refusal by Sponsor to process an expedited coverage determination or redetermination request." The reporting section will be altered so that there is only one data element for "expedited grievances" which only pertain to the Organization Determination or Reconsideration process as the commenter indicates.

Comment: This commenter stated that according to the grievance requirements, they are to report the number of expedited grievances similar to what they do for Part D. However, they currently are not reporting on expedited grievances for Part D. The commenter asked when should this have started and where is the guidance that tells them to do this? The commenter assumed this is also a new requirement for Part D in 2014 and indicated that this is an additional reporting requirement and burden.
CMS Response: This is a new reporting element; however, it's always been a Part D requirement for Sponsors. Please refer to the CMS page below for additional information about expedited grievances at
http://www.cms.gov/Medicare/Appeals-and-grievances/MedPrescriptDrugApplGriev/Grievances.html.

Comment: Please define "CMS Issues."

CMS Response: This category involves grievances that primarily involve complaints concerning CMS' policies, processes, or operations; the grievance is not directed against the health plan or providers. The new 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.

Comment: Please advise if plans are to submit data at the contract level or PBP level for Part C.

CMS Response: Plans should submit data at the PBP level for Part C grievances.

Comment: Will the Plan Reporting Module (PRM) in HPMS be updated accordingly?

CMS Response: The PRM will be consistent with this reporting requirement.

Organization Determinations and Reconsiderations

Comment: Clarify and define "reopened (revised) decisions" in element 6.20.

CMS Response: This data element has been renumbered to 6.19. See below for definition.

Comment: Define the difference between reconsideration and reopening.

CMS Response: These definitions can be found in Chapter 13 of the Medicare Managed Care Manual. A reconsideration is an enrollees' first step in the appeal process after an adverse organization determination. It consists of a review of an adverse organization determination of services decision, the evidence and findings upon which it is based and any other evidence that the parties submit or that is obtained by the Medicare health plan, the QIO, or the independent review entity. A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. For

additional information, see Chapter 13 of the Medicare Managed Care Manual, Section 130. A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. For additional information, see Chapter 13 of the Medicare Managed Care Manual, Section 130.

Comment: Provide clarification on the file format and requirements for 6.20.

CMS Response: The file format for revised decisions will be defined in the plan reporting module (PRM), which will be made available to plans. Data will be uploaded.

Comment: CMS should explain the need for additional data. Significant administrative burden seems to outweigh value. If CMS moves forward, [we] request that proposed changes be delayed and implemented instead for 2015 reporting.

CMS Response: The rationale for these changes is that revising the Part C appeals and organization determination/reconsideration requirements will further clarify reporting requirements for this reporting section for Part C plans and will allow CMS to better utilize these data for purposes of data trending, policy development, and plan-level auditing and compliance monitoring. Also, the proposed updates attempt to bring the Part C reporting requirements in line with the Part D reporting requirements, help coordinate and improve our monitoring and compliance efforts and further CMS policy development in the area of organization determinations and appeals. CMS believes that these benefits outweigh the costs of the additional reporting burden. CMS also believes that these changes should be made effective for CY 2014 reporting and not delayed to CY 2015, because the sooner these benefits of improved reporting can be realized, the more cost-effective will be these changes.

Comment: Are the IRE decisions counted as a reopened case?

CMS Response: Yes, per Chapter 13 of the Medicare managed Care Manual, IRE decisions may be reopened and should be counted.

Comment: Would the IRE decisions be categorized as an "Other" reason for reopening?

CMS Response: No. Other would be any decision not reopened for the reasons listed.

Comment: Would the IRE decisions be categorized as an "Other" reason for reopening?

CMS Response: Only count cases reopened the IRE as reopened.

Comment: Reconsiderations: For the reopened cases, is this a data entry or an upload measure?

CMS Response: This is a data entry measure.

Comment: Plan Oversight of Agents: When requiring agent/broker specific records and beneficiary-specific records, is this a data entry or an upload measure?

CMS Response: This is an upload measure.
Comment: In general, we would like CMS to provide more clarification on the definitions of "re-opened cases", "retrospective reviews" and "reconsiderations."

CMS Response: These are contained in Chapter 13 of the Medicare Managed Care Manual.

Comment: On the UM side, does (would) the inclusion of "re-opened cases" impact any current processes? For example, if "new or material evidence" (clinical documentation) was provided in follow up to a UM denial today, it would be sent as a reconsideration/appeal review; is there any expectation that we would now handle that differently?

CMS Response: We do not anticipate that the inclusion of reopened cases as a Measure 6 reporting requirement will impact your current UM processes.

Comment: For retrospective UM reviews, we currently process two types: one driven after a claim is submitted/denied, and the other is simply a late authorization request but before a claim is submitted. Do these differ in how they should be reported, i.e. are both reportable as a standard retrospective UM decision?

CMS Response: Measure 6 updates should not impact your reporting of organization determinations – i.e., plans are required to report their substantive decisions to pay for or provide services.

Comment: When a retro denial is appealed by the provider (w/o risk of member liability), is that now to be reported as a reconsideration?

CMS Response: Plans are required to report claim denials appealed by non-contract providers.

Comment: Please provide an example of a re-opening of appeal for a clerical error. Can you please clarify and give an example of this?

CMS Response: A claim submitted with a missing modifier is an example of a case subject to reopening based on a clerical error.

Comment: Please provide an example of a re-opening of appeal for other. Can you please clarify and give an example of this?

CMS Response: Other reasons a plan may choose to reopen an appeal include instances where new and material evidence, unavailable at the time the plan initially considered the case, becomes available.

Comment: If the IRE decision is to overturn the health plan decision after case is closed do we re-open current case or launch a new case to finish out IRE requirements?

CMS Response: Reconsideration cases remain open pending the Medicare health plan's receipt

of the final reconsidered determination letter.

Comment: How will CMS evaluate plans based on the information requested?

CMS Response: CMS will primarily look for plans that are outliers in terms of the percent of adverse organization determinations. However, it will take into account other factors –for example, the percent of reconsiderations that are favorable and the percent of reopened cases.

Comment: We request that CMS work with the industry to develop metrics that provide information needed by CMS in an efficient manner rather than implementing a broad, costly new reporting burden.

CMS Response: CMS continues to consider industry comments and concerns as well as its own reporting needs and requirements.

Comment: Could CMS clarify if both Part C and Part D reporting groups are reviewing industry comments to ensure a consistent understanding and response to the questions and concerns it has received in both comment processes.

CMS Response: Both Part C and Part D reporting groups are reviewing industry comments to ensure a consistent understanding and response to the questions and concerns it has received in both comment processes.

Comment: Data elements 6.3-6.8: Define the difference in “services” versus “claims”.

CMS Response: “Services” refers to appeals of MA organization denials of requests for services and “claims” refers to denials of payments for services.

Comment: Define “withdrawn”.

CMS Response: A withdrawn organization determination or reconsideration is one that is withdrawn upon the enrollee’s request, but excludes appeals that the organization forwards to the IRE for dismissal.

Comment: Regarding DE # 6.2 [data element number 6.2], define “timely”.

CMS Response: This will appear in the technical specifications. Timely notification of grievances means grievances for which the member is notified of decision according to the following timelines: for standard grievances, no later than 30 days after receipt of grievance; for standard grievances with an extension taken, no later than 44 days after receipt of grievance; for expedited grievances, no later than 24 hours after receipt of grievance.

Comment: Regarding DE # 6.20 [data element number 6.20], how is “reopened” defined?

CMS Response: A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

Plan Oversight of Agents

Comment: Clarify and define “compensation” under the Agent/Broker section. Further clarify and define what “associated” means under the new enrollments section.

CMS Response: Compensation is defined as any payment for purposes of the reporting requirements. CMS will modify the reporting requirements to reflect this. By “associated” CMS means that the agent is listed as the agent for a particular enrollee.

Comment: Explain the need for additional data.

CMS Response: The data requirements are to assist CMS in monitoring the marketplace. Regulations require agents to be trained and tested. These reporting requirements provide CMS with the necessary data to ensure agents are trained and tested. In addition, the data will assist CMS in monitoring agent behavior (i.e. complaints) so CMS can properly oversee the marketplace.

Comment: If CMS moves forward, request proposed changes be delayed and implemented instead for 2015 reporting.

CMS Response: CMS has received this comment but is not changing the implementation date.

Comment: The “more granular-level data on agents/brokers who assist in the enrollment of Medicare beneficiaries into health plans” under two categories, “1. Agent/Broker” and “2. New Enrollments” are unclear and administratively burdensome.

CMS Response: CMS does not believe the data is unclear. The commenter would need to provide specific issues they believe need to be clarified. As for the administrative burden, CMS believes that organizations, as part of their oversight, should already be tracking this information, including complaints.

Comment: We recommend that CMS provide an explanation of the reporting elements in the “Notes” section of the “Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2014” for this reporting section.

CMS Response: Explanations of reporting elements are already included in the technical specifications.

Comment: We encourage CMS to continue its efforts to ensure alignment of the Part C and Part D requirements when the program requirements are consistent.

CMS Response: CMS will continue to review reporting requirements as a whole to ensure consistency. If there is a specific element that the commenter does not believe is consistent please identify the element.

Comment: CMS should allow plans to submit the data directly via upload and provide a template.

CMS Response: CMS will provide for an electronic data upload and a template.

Comment: CMS should not require data to be reported at agent/broker specific level and beneficiary specific level due to extensive labor/resource efforts required.

CMS Response: CMS is requiring this information in order to oversee the Medicare Parts C and D programs.

Comment: Need additional clarification to understand whether reporting is required when licensure is not required by the state.

CMS Response: Reporting is required even if licensure by the state is not required. Even if a state does not require an agent to be licensed, the agent must still meet CMS' regulatory requirements, not including licensure.

Comment: CMS should revise the instructions to indicate what types of agents should be included in this reporting: employed, captive, and independent. If employed agents are included, CMS must alter compensation language because employed agents are exempt from compensation requirements.

CMS Response: Employed, captive, and independent agents are all included. The current requirements are clear on which agents plans must report on.

Comment: In section 1, specify acceptable agent/broker types and define what plans must report for each type.

CMS Response: All agents, independent, employed, or captive should be reported. All applicable elements should be filled out for each type of agent.

Comment: Please clarify what should be reported for the following elements in states like CA where licensure is not required and an agent/broker does not have an NPN: F) agent/broker state licensed; NPN; agent/broker appointment date.

CMS Response: N/A should be reported for any item which is not applicable, such as license, appointment date, or NPN.

Comment: We require 2 annual trainings. An agent/broker training completion date; agent/broker testing completion date. What date should plans report—general Medicare training completion date or plan's product and benefit completion date?

CMS Response: CMS regulations require that agents be trained in both Medicare and plan specific products. The training date reported should be the most recent date that covers all required training.

Comment: Section 1. Data elements M-P, CMS should specify whether the data should be reported at the individual level or at the aggregate plan level.

CMS Response: The data elements M through P already state whether they should be reported at the individual level or the aggregate level.

Comment: In Section 2, what is the definition of a "new enrollment?" Would the following be considered new enrollments: PBP changes within the same organization, cancellation as the result of an Outbound Education Verification call, rapid disenrollments?

CMS Response: CMS is defining "new enrollments" for reporting purposes as new to the organization. A change from one PBP to another PBP is not considered a "new enrollment" for purposes of this reporting requirement. CMS will revise the reporting requirements accordingly.

Comment: In Sect. 2, CMS should clarify whether plans should report on external, independent agent/brokers since initial and renewal enrollments are compensation terms applicable only to independent agent/brokers?

CMS Response: Plans should report on all agents/brokers. We will revise the reporting requirements accordingly.

Comment: In Sect 2, how should plans report an enrollment where there have been multiple agent/brokers involved? Would the last agent/broker touch point associated with the beneficiary be the agent attributed to the new enrollment?

CMS Response: The agent/broker that is receiving the compensation should be the one associated with the beneficiary. In cases where this is not applicable (e.g. employed agent) the last touch point associated with the beneficiary should be attributed to the enrollment.

Comment: In Sect 2, CMS should provide clear definitions of each designated enrollment mechanism.

CMS Response: CMS believes the designated enrollment mechanisms are clear.

Comment: When requiring agent/broker specific records and beneficiary-specific records, is this a data entry or an upload measure?

CMS Response: We expect that agent/broker-specific and beneficiary-specific data will be uploaded.

Comment: Is every agent that received compensation in 2014 to be included in reporting regardless of when the application was submitted or what the effective date is? We strongly recommend that CMS clarify that the reporting period is based on member effective dates in the report year.

CMS Response: CMS will modify the requirements to make clear that the information is based

on effective date.

Comment: Please clarify if “compensation” is defined as commission and salary.

CMS Response: Compensation is defined as any payment for purposes of the reporting requirements. CMS will modify the reporting requirements to reflect this.

Comment: Agent/broker type—we request that CMS provide a list of expected agent/broker types.

CMS Response: The expected list of agent/broker types is already defined in the reporting requirements.

Comment: Agent/broker completion date—we request that CMS provide a defined list of training courses to be considered for reporting Training Completion Date.

CMS Response: CMS does not have a defined list of training courses. Each organization is responsible for developing their own training that meets the regulatory requirements and the requirements in the MMG.

Comment: Agent/Broker Testing Completion Date— We request CMS provide a defined list of tests to be completed to be considered for reporting Testing Completion Date.

CMS Response: CMS does not have a defined list of tests. Each organization is responsible for developing their own tests that meet the regulatory requirements and the requirements in the MMG.

Comment: In aggregate, the number of Agent/Broker complaints for the reporting period— We request clarification on how we should report complaints that are not tied to a plan member and therefore would not be tied to a CMS contract.

CMS Response: Please report the aggregate complaints for the agent, regardless of which contract or member they are tied to. Organizations should be able to determine how many total complaints, regardless of the member/contract, that the organization has received on each agent. CMS will modify the requirements to reflect this change.

Comment: In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing)—the term “related to marketing” is quite broad. We request that CMS provide additional clarification on the scope of “marketing” related complaints.

CMS Response: Although “related to marketing” may be considered broad, CMS believes this statement is clear. Some examples of “related to marketing” would be aggressive sales tactics, failure to provide correct information to beneficiaries, and failure to inform the organization of planned events. Items that would not be considered “related to marketing” would be failure to submit timely administrative data to the organization or failure to attend organization meetings.

Comment: Sect 1-Element A: Contract number—should agents be listed under all contract in which they receive commission?

CMS Response: Yes.

Comment: Sect 1-Element B: Agent/Broker Type-Would this element capture contracted/employed agents/brokers?

CMS Response: Yes.

Comment: Sect 1-Element I: Agent/Broker Licensed Date-Should plans capture the most recent or original date for this element?

CMS Response: The most recent date.

Comment: Sect 1-Element K: Provide clarification on “training” and “completion date.” Does this mean most recent or original?

CMS Response: The date provided should be the most recent date where all regulatory and sub-regulatory (MMG) required training has been met.

Comment: Sect 1-Element L: Agent/Broker Testing Completion date-How does this differ from Training Completion?

CMS Response: Regulations and the MMG require training and testing. Organizations must provide both the training and testing dates. It is possible the dates are the same.

Comment: Sect 1-Element M: The number of Agent/Broker Complaints- Please provide a definition of "complaint". For example, does it include complaints from CMS, beneficiary, or from anyone? Or is this marketing complaints only?

CMS Response: The complaints should be from any source. However, we are only referring to marketing complaints. CMS will modify the reporting requirements.

Comment: Sect 2: Opening statement-Define "renewal" when section is labeled "new enrollments."

CMS Response: CMS is referring to renewals that are new to the organization. Beneficiaries that move from one plan in one parent organization to a like plan in a different parent organization would be considered renewal members. CMS will add clarification to the reporting requirements.

Comment: Sect 12-A: Contract Number-Florida Blue permits brokers to sell all MA contracts. Does that mean all contract numbers should be reported?

CMS Response: Yes.

Comment: Sect 12-A: Clarification is needed of Agent/Broker Licensed Date and Appointment Date.

CMS Response: CMS is unsure of the question. The licensure date is the date on the agent's state license, if applicable. The appointment date is the date the agent is appointed to sell the products, if applicable. Both dates should be the most recent dates.

Comment: Sect 12A: Training Completion Date: Does "training" include in-house training as well as external, vendor-provided training or just external training?

CMS Response: Training refers to the training required by regulation and CMS' MMG. This training could be in house or a vendor.

Comment: Sect 12A: A definition of "third party marketing organization" is needed.

CMS Response: A third party marketing organization is an entity in which the MA-PD or PDP contracts with to provide agents. An example would be a Field Marketing Organization.

Comment: Does the phrase "received compensation" encompass compensation that has been "paid" to the agent/broker during the reporting period or compensation that has been "earned" by

the agent/broker in a subsequent reporting period?

CMS Response: CMS intends for the compensation to have been earned during the reporting period. CMS will modify the requirements.

Comment: Element 1.M (number of agent/broker complaints for the reporting period) could be understood to mean complaints reported during the reporting period or complaints with investigations closed during the reporting period. CMS should provide an explanation in the notes section of the technical specifications.

CMS Response: CMS intends for this to be complaints reported during the reporting period. CMS will modify the requirements.