September 3, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via http://www.regulations.gov

Re: CMS Emergency Clearance Information Collection Request to Support Data Validation Under the Risk Corridors and MLR programs (CMS-10401/OMB Control Number 0938-1155)

Dear Administrator Slavitt,

We are writing on behalf of America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) information collection requirements related to the risk corridors and medical loss ratio (MLR) programs.

The information collection requirements—outlined in the notice and supporting materials and issued under emergency review procedures—are intended to assist CMS in conducting program integrity reviews of data previously submitted and resolve any potential material differences between the data collected during the EDGE sever process for risk adjustment and reinsurance and the separate data submission process and requirement for risk corridors and MLR.

We recognize and support the importance of assuring the integrity of the risk corridors and implementing the program in a timely manner to ensure the ongoing stability of the exchange risk pool. Our member plans have worked diligently to complete timely submissions of data required to administer risk adjustment and reinsurance programs (under the distributed data collection process) and through the risk corridors and MLR forms. We are committed to working

collaboratively with CMS to resolve any questions about the risk corridors and MLR data submissions.

While the Preamble to the 2015 Notice of Benefit and Payment Parameters Final Rule previewed the approach of validating risk corridors data against other data sources, CMS also recognized that it would only do this if "other data source is sufficiently reliable and can be appropriately compared, including with respect to any data submitted through the dedicated distributed data environment for 2014."[1] Because the data submitted in the risk corridors and MLR reporting form and the data submitted through the distributed data environment uses separate and distinct data fields, instructions, requirements and timeframes and is collected for separate programs, the data in those two submissions are not comparable and differences – potentially of a significant magnitude – should be expected (See Appendix A). Thus, we believe CMS should avoid using the term "discrepancies," which implies that the data from the two sources should be the same, and should simply refer to material or significant differences in the reported data.

Given the level of detail required to complete the mandatory worksheets, we believe that CMS' estimate of the burden on issuers is substantially understated. For example, one company said that their staff had spent 20 hours in meetings trying to understand the process before even attempting to complete the forms. Another estimated approximately 120 person hours for the completion of one FEIN submission. For a company with multiple FEINs, the burden for completing this submission could be hundreds of hours.

We have attached detailed comments and recommendations on the checklist and instructions to address the comparability of data, illustrate technical issues, and provide clarifications. These recommendations are based on input derived during this shortened emergency comment period from our members' health plan operational leaders and technical experts. These recommendations balance the need for assuring program integrity while promoting smooth and uniform completion of the forms and completing CMS's goal of reconciling differences between the two data sources, as appropriate, in a timely and expeditious manner.

Our comments are aimed at assuring the integrity and validity of the data submission process while facilitating the timely implementation of the risk corridors program—which plays a critical role in promoting market stability and affordability for consumers in the health insurance marketplaces. We believe it is critical for this data validation process be concluded in a timely manner in order to avoid negative downstream effects on consumer rebates under the MLR program or on the timetable for completing risk corridors payment transfers. Of note, the post-audit process—issued under final regulations[2]—provides for a post-payment audit methodology

[1] 2015 Notice of Benefit and Payment Parameters Final Rule. 79 FR 13785
[2] 2015 Notice of Benefit and Payment Parameters Final Rule 79 FR 13836

to address audit findings specific to the risk corridors programs while a separate but similar process exists to address data validation under the distributed data collection process.

We look forward to working in partnership with you to resolve any issues arising from this data validation process as expeditiously as possible in order to promote the shared goal of assuring effective and timely implementation of these critical programs.

Sincerely,

Matt Eyles
AHIP

Sincerely,

Kris Haltmeyer
BCBSA

AHIP-BCBSA Recommendations and Technical Comments on the PRA Notice and Supporting Materials

- **The instructions included in the supporting materials should clarify that plans can document and describe other differences between EDGE server and MLR/RC data submissions that do not currently appear in the checklist.** CMS appears to have identified three reasons for claims differences between MLR/RC and EDGE data (capitation, rejected claims, and hospital claims crossing benefit years) and four reasons for premium differences (billed/earned differences, impact of grace periods, retroactive adjustments, and partial month proration). As currently formatted, the worksheet could be read to imply that these are the only appropriate reasons for differences between the two data sources, which we hope was not CMS's intent. We believe issuers should be afforded the opportunity to describe other legitimate differences between MLR/RC and EDGE data that do not fall into these seven categories. At a minimum, we recommend changing the titles of Column S on the claims table (p. 16 of the instructions) and Column Q in the premium table (p. 25 of the instructions) to "Remaining Differences" and clarifying that these fields should be used to quantify and explain other acceptable material differences in the data not captured in other fields (e.g. differences driven by paid date between EDGE data - which could have been as late as early May given the 5/15 grace period - and the MLR/RC paid-through date of March 31.

- **We recommend that CMS improve the functionality of the process by allowing plans to save work on the web form and/or provide plans with an alternative method (e.g., Excel spreadsheet) to address any contingencies, such as a system failure.** Many plans are concerned that CMS has not provided a template for completion of the claims and premium worksheets, and that the web form must be completed in one sitting. Given the complexity of the data involved and the importance of later data audits, we recommend that issuers have the ability to save progress when completing the checklist and worksheets. This functionality will enhance the accuracy of the data validation. Alternatively, CMS could provide issuers with an Excel template (including the macros that will be used to auto calculate certain fields) to assist issuers in making timely and accurate submissions.

- **We recommend plans have an additional response option when completing the Risk Corridors Submission Checklist.** The instructions for completing the checklist provide issuers with three response options: "Y" if the element is accurate, "R" if the element is not accurate but will be upon resubmission, and "N" if the element is not accurate and will not be corrected in resubmission because there is no impact on risk corridors payments or charges or MLR rebates. There are unique situations where issuers' responses may not fit into these three categories. We recommend either providing issuers the opportunity to include an explanation for a "Y" response or creating a new response (e.g. "E") that would allow issuers to fully explain how the specific element was completed.

- **Given the extremely compressed timeframe issuers have to complete these submissions, we recommend CMS identify support staff and have dedicated mailboxes specifically for questions regarding the submission process.** It is critical that issuers have a contact at CMS that can quickly respond to any problems issuers may encounter. Again, this is particularly important given that the submission must currently be completed in one sitting.

- **While we strongly support the goal of completing the data validation process as quickly as possible, we recommend CMS also consider a process for limited extensions to assure the accuracy and completeness of data necessary to administer these programs.** Some plans with large numbers of HIOS IDs are concerned about the ability to complete this submission within the required timeframe—either September 8 or September 14. While we recognize the importance of completing this validation as soon as possible, we recommend CMS consider a process for extensions under extraordinary circumstances given the volume and complexity of information that issuers must review in the data validation process.

- **We are concerned that quantities on the worksheet must be reconciled to 0.25% of the applicable amount.** For many issuers these tolerances could likely only be achieved on the largest line items. We recommend that reconciliation by tied in the aggregate to a certain percentage of total premium (e.g., 0.5% of total premium).

We also offer additional technical questions and request clarifications to the instructions and worksheets (see details below)--

  - We recommend CMS confirm a typo in Column K1 (page 22 of the instructions). This field should also exclude Column I1, which is currently not listed.

  - Premium report: Column H1 should be able to accept negative values because adjustments can go either direction.

  - List HIOS ID for which issuer has submitted discrepancy report: Do issuers need to report on all discrepancy reports, even those that have been resolved or only outstanding discrepancy reports?

Appendix A: Differences between EDGE Data and MLR/RC Reporting

The requirements for EDGE server data submissions differ substantially from the requirements for Medical Loss Ratio/Risk Corridor (MLR/RC) reporting. As a result, it is important to consider and account for these differences when comparing EDGE data to MLR/RC filings. The chart below outlines the differences in the datasets for both claims and premium.

Claims	**EDGE**	**MLR/RC**
IBNR	Not included	Included[3]
Service Dates on Claims	Discharge date or service through date in 2014	Admit date or service from date in 2014
Runout Period	Claims paid through 4/30, although EDGE submissions generally will not include all claims paid through 4/30 due to time needed for preparing and loading data to EDGE	Claims paid through 3/31
Other claims	Only claims processed on claims system included	Includes all types of claims payments, including manual checks, deductions for drug rebates and other items
Capitation	Rules require that encounters be re-priced	Actual capitation amounts paid to providers
EDGE claim rejections	Issuers prioritized claims impacting reinsurance and risk adjustment	Included
Orphan claims	Not included in reinsurance summary report	Included

[3] IBNR can be significant and vary based on such factors as HMO vs PPO, benefit design (e.g., deductible levels), use of capitation, knowledge of large claims, and use of TPAs.

Premium	EDGE	MLR/RC
Basis	Intended charged rate	Actual earned premium
Proration of premium and calculation of member months	Based on actual beginning/ending enrollment dates with 30 day months. CMS calculates member months by taking the actual number of days in a period and dividing it by 30 (even if the month had 31 days or 28). Thus contracts with full year membership will have premium overstated by the ratio of 365/360, or 1.4%.	Based on issuer conventions for proration of partial month premium. Member months represent actual months rather than calculated months.
EDGE issue on proration	CMS system assumes the full month premium is entered and calculates the proration, but some issuers entered prorated premiums for partial months.	Based on issuer conventions for proration of partial month premium
Retroactive premium terminations (90-day grace period)	Could include as active members who subsequently did not pay premium, e.g. end of year no-pays may not have terminations processed before the EDGE submission deadline	Retrospective view of premium; does not include premium for lapsed members
Retrospective enrollment changes	Enrollment reconciliation continued for 2014 after the EDGE submission and may not be reflected in EDGE	Retrospective view of premium; includes adjustments for retrospective changes
APTC premium vs full value of premium for 1st month of grace period	Includes full value of premium	Issuer may only report the APTC portion of the premium