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

CMS received comments to the 5/1/2015 (CMS-10261) 60-day notice on the proposed changes to the Part C Medicare Advantage Reporting Requirements.

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

Comment: Add an option to enter "n/a" for a date field or a selection box where the user can say that the date is not available. Health plans have issues where dates cannot be given for one reason or another.

CMS response: We will develop a means to allow the user to indicate that the date is not available.

Reporting Section Specific Comments

Reporting Section: Part C Grievances

Comment: Recommendations to reduce burden: Discontinue quarterly reporting. Go to annual reporting. Report timeliness only for the total grievances category. Go to one element numbering system that is the same for Part C and Part D, as well as for Technical Specifications and HPMS (i.e., alpha or numeric).

CMS Response: CMS thanks the commenter. CMS believes reporting of grievances quarterly is essential to monitor trends within a reporting year. Timeliness reporting for all categories is important so that CMS can monitor what grievance categories are experiencing most delays in handling. CMS will consider going to a one element numbering system that is the same for Part C and Part D.

Comment: Some plans are Fully Integrated Dual Eligible Special Needs plan (FIDE SNP) and the Part C technical specifications, including the data validation standards given to data validation auditors, do not accommodate differences in FIDE SNP grievance requirements that may exist under the Medicaid state contract approved for the DNSP plan (e.g. state contract approved by CMS may have a different timeframe). We recommend that CMS incorporate language in the Part C Reporting Requirements Technical Specifications to allow for accommodation of FIDE SNP or MMP plans that may have different timeframes due to the nature of dual eligible plan requirements.

CMS Response: CMS appreciates your comments. CMS will be working on a plan to accommodate the different timeframes in both the Part C technical specifications and the data validation standards relevant to grievances reporting.

Reporting Section: Sponsor Oversight of Agents

Comment: Change the name of this reporting section to "Sponsor Oversight of Agents," because it is more reflective of who is conducting the oversight.

Response: This was a CMS "lessons learned" comment. Accordingly, CMS agrees and will make that change.

Comment: The Commenter identified the following areas that need clarification or further specification in order to reduce reporting variation:

- Inconsistent references to sponsors, organization, plans, health plans are confusing and should be replaced with contracts;

- Inconsistent references to assistance, compensation, commission, salary, and associated are confusing and should be replaced with one definition of the level of agent involvement that forms the basis for reporting.

- References to new and renewal are confusing and should be replaced with a definition of the type of compensation that is the basis for the reports.

CMS Response: CMS has reviewed the references to plan and sponsor and have made changes to ensure consistency. CMS believes the definition of compensation is clear. This definition includes commissions, bonuses, referral fees, as well as any other compensation provided for purposes of enrolling beneficiaries into a plan. CMS understands that the new and renewal enrollment definitions are modified for purposes of these reporting requirements. However, we believe this is necessary so sponsors/organizations do not have to report enrollments that are moving from one plan benefit package into another plan benefit package. This decreases the amount of reporting for sponsors.

Comment: File 2: New Enrollments: A definition is needed of a "new enrollment", e.g., newly enrolled in the contract for the reporting year. Please note that we have heard from more than one SO there are questions about what is meant by the wording change in the Part C, File 2, CY 2015 Technical Specifications, Also, a change from one contract to another contract within the same parent organization/sponsor is not a new enrollment.

CMS Response: CMS has definitions in the technical specifications for what is meant by "new enrollment." We have added further clarification to these specifications.

Comment: File 2: Basis for the inclusion of New Enrollments

Are the enrollments in File 2 limited to enrollments for which an agent meets one or more of the following criteria?

- Has an NPN and/or is state-licensed?

- Was compensated for the enrollment? If the basis for File 2 is agent compensation, what is the definition of this compensation? Which of the following constitute "compensation"?

- Agents compensated according to MMG manual:
- Qualifies for new enrollment payment: New to Medicare Advantage
- Qualifies for renewal level of payment (changing contract or parent organization, but not new to MA0
- Enrollment-volume-dependent bonuses paid to employees on top of salary
- Department-wide bonus applied evenly to all department members according to overall department enrollments
- Dedicated open-enrollment call center hourly staff
- Straight salary for which there is no bump for in any way related to enrollment volume.
- Assisted the member with enrollment?
- Was "associated" in some other manner (would need specification)

CMS Response: All enrollments by agents need to be reported, regardless of whether they have an NPN or state license. Compensation is defined in the technical specifications. Any new enrollment for which an agent is associated needs to be submitted. This includes those which are processed through an enrollment call center with which a beneficiary speaks with agents. The requirement to submit these enrollments is not affected by how the sponsor pays the agents or the departments.

Comment: What is the definition of assistance (e.g., face-to face, interactive, telephonic)?

CMS Response: Assistance is defined by an agent providing information/answering questions to a potential beneficiary. This would include face to face, interactive, and telephonic assistance. Mailing a packet of information to a member with no further contact would not be considered "assistance."

Comment: File 2: Instructions on how to go about not reporting when there are no enrollments per specifications. Depending on how the above definitions are ultimately written, there are likely to be SOs who will not need to report. We see in the CY2015 Part C Technical Specifications, Important: Sponsors should not upload the POA New Enrollments level data file if they have no new enrollees to report. How should the SO go about not reporting? To whom and how should it communicate that the contract has no report? (We are aware that for MTMP, there are instructions on what to do if there are no members to report: Sponsors should not upload the MTM beneficiary-level data file if they have no MTM enrollees to report. Instead Sponsors should report that they have no MTM enrollees via e-mail to: partd-planreporting@cms.hhs.gov.)

CMS Response: We are investigation developing a "no data to report button."

Comment: File 2 - Element L Enrollment Mechanism

Recommendations:

- Replace the free text (CHAR fields 193-242) with a numeric value that corresponds to one of the enrollment mechanisms. Remove "Other" as an option.

- Specify that Enrollment Mechanism refer to the media for receipt of the enrollment application, not the level of agent involvement (which needs to be defined as a basis for reporting, as above).

CMS Response: To simplify reporting and reduce burden, CMS is already making these non-substantive changes for 2015 reporting for data element L for the Plan Oversight of Agents reporting sections for both Part C reporting requirements and Part D reporting requirements. "Other" will remain as an option.

Comment: File 2 Elements O and P – Complaints and Marketing-related complaints

Recommendations:

- Specify that confirmed allegations be reported

- Define the type of complaints that should be reported in Element O that are over and above the marketing complaints at element P.

CMS Response: CMS is requiring that all allegations be reported. Many allegations may be submitted but cannot necessarily be confirmed because there is insufficient supporting documentation. We have provided additional information in the technical specifications regarding the type of complaints in elements O and P.

Comment: File 1: Basis for Agents in File 1

Define the basis for Agents in File 1, e.g., Limited to agents represented in File 2 or, In addition to agents in File 2, includes other agents (specifications would be needed)

CMS Response: File 1 should contain all agents that earned compensation. This would include compensation for members that made no plan changes from one year to the next. File 2 should contain agents who enrolled beneficiaries new to the sponsor. We believe this is clear. File 1 specifies it is for agents who earned compensation for initial or renewal enrollments. We also define what a "new" enrollment is for File 2.

Comment: File 1: No agents to report

If the basis for agents in File 1 is the set of agents in File 2, and if the SO has no enrollments to report in File 2, how should the SO go about not reporting File 1? To whom and how should it communicate that the contract has no report?

CMS Response: We are investigation developing a "no data to report button."

Comment: File 1: Element B – Agent-Broker Type—Supply a definition of Captive agents. (e.g., type of Independent agent who sells solely for the sponsor)

CMS Response: Captive agents are those who are not employees of the sponsor but only sell for the sponsor. They do not sell for other sponsors, unlike independent agents who may represent numerous sponsors. CMS has provided a footnote to clarify.

Comment: Remove "None" as a value, because it is not defined.

CMS Response: CMS has removed "none" as a value for the type of agent.

Comment: File 1: Elements I, J, K, L (DATE Required fields): How to report a null value.

CMS Response: We can add a "fix" that allows the user to indicate that the date are not available (the date would be null in the database, because it only allows for valid date format).

Comment: File 1: CHAR required fields: How to report a null value.

CMS Response: See above.

Comment: File 1: Element I – Current license effective date. For 2014 reporting, SOs variously reported agent's original license date or agent's most recent license renewal date. CMS may want to specify that it is acceptable to report the original license date for evergreen or continuously renewed licenses or the most recent renewal date, whichever can be verified.

CMS Response: CMS has clarified that evergreen licenses should be the original license date and other licenses should be the most recent renewal date.

Comment: For 2014 reporting, SOs variously reported agent's original license date or agent's most recent license renewal date. CMS may want to specify that it is acceptable to report the original license date for evergreen or continuously renewed licenses or the most recent renewal date, whichever can be verified.

CMS Response: CMS has clarified that evergreen licenses should be the original license date and other licenses should be the most recent renewal date.

Comment: File 1: Element J- Appointment Date

For 2014 reporting, SOs variously reported:

- Original appointment date
- Date of payment of annual invoice to the state to maintain appointment status
- Date of some other type of affiliation in (several) states that do not have appointment
- A null or blank value

We recommend that CMS provide a narrow definition of appointment, along the lines of: The process required in some states whereby the sponsor formally notifies the state of the agent's marketing affiliation with the sponsor. If there is no state-required process, [leave blank/insert null value].

(CMS should be aware that appointment is not necessarily specific to Medicare Advantage.)

CMS Response: CMS has added more information to clarify that this should be the most recent date the agent is affiliated with the sponsor.

Comment: File 1: Element M –Complaints

There is a discrepancy between the Part C Technical Specifications text and the layout (found in the Part D specifications). Part C asks for "marketing complaints"; layout in Part D asks for "complaints. "

A specification is needed regarding whether to limit reporting to

- Marketing Complaints
- Confirmed complaints/allegations

CMS Response: CMS is correcting this issue.

Comment: We request that CMS review the submission process for the New Enrollments data file as we believe the process and validation timeframe can be improved. The existing file validation timeframe can take up to a week which allows for a short amount of time to address any issues. We recommend the initial file validation process via GENTRAN/TIBCO be more real-time which is similar to the uploading file process in HPMS. If this is not systematically possible, then we recommend CMS reduce the validation timeframe to up to 2 business days.

CMS Response: Normally, it takes far less than a week for us to validate and send response files. However, this was our first year doing POA Gentran so there were some "start-up issues" that delayed response files. We expect it to be better next year. Plan users do have 3 months to submit data and the deadline was extended by 10 days.

The data must be acquired securely due to the PII in the file. Currently, Gentran is being used and the data must be retrieved, processed, then response files sent. A possible solution has been proposed that might allow for more or less real time validation. Resources to test and implement this solution are non-trivial, but we will investigate.

Reporting Section: Special Needs Plans (SNP) Care Management:

Comment: Clarification about the definition of "compliant" for purposes of completing an HRA would be beneficial (e.g., if a member does not respond to requests to set up an HRA).

CMS Response: Thank you for your comments. CMS requires all Special Needs Plans (SNPs) to conduct comprehensive initial health risk assessments (HRAs) and annual HRAs for enrollees per 42 CFR §422.101(f)(i). A SNP is deemed compliant with HRA requirements if (1) all initial HRAs for eligible enrollees are completed within 90 days of their effective date of enrollment, and (2) all annual re-assessment HRAs for eligible enrollees are completed at least every 365 days, in accordance with established timeframes for reporting purposes. Please note: Submission of claims data and/or other administrative data alone that indicates no direct enrollee and/or caregiver input into the HRA is not considered to be a complete HRA. Only a completed HRA that comprises direct beneficiary and/or caregiver input is considered valid for purposes of fulfilling the Part C reporting requirement.

We realize that a SNP enrollee has the right to refuse to participate in the HRA, and recognize that some enrollees may not respond to requests from a health plan (by telephone, or other means) to set up an appointment for the HRA. We also realize that this could negatively impact SNPs' compliance with Part C reporting requirements. In recognition of these difficulties, we propose to clarify and revise our policy on HRA reporting requirements.
First, we are clarifying that beginning with contract year (CY) 2016 Part C reporting requirements, all SNPs may perform an initial HRA on new enrollees *within* 90 days of the effective date of Medicare enrollment, which can be up to 90 days before or 90 days after the effective date of enrollment. For example, if a SNP enrollee's effective date of enrollment is January 1, 2016; the SNP may conduct the HRA as soon as 90 days before January 1, 2016 and up to 90 days after January 1, 2016. The annual re-assessment HRA must be completed within and no more than 365 days from the last HRA.

Second, we recognize the need to include additional data elements in the HRA Part C reporting requirements to account for enrollee refusal to participate in the HRA. The SNP must document in its internal records the date the SNP contacted the enrollee, and that the enrollee refused to participate in the HRA. The SNP will report enrollee refusals in new data reporting elements that will be added to the Part C reporting module in HPMS. Additionally, CMS will add new data reporting elements for reporting enrollees that the SNP could not reach to complete the HRA. The SNP must document in its internal records that the enrollee did not respond to at least 3 phone calls and a follow up letter soliciting participation in the HRA.

Third, CMS acknowledges that Dual Eligible SNPs (D-SNPs) need to integrate the Medicare and Medicaid processes in order to complete the HRA for D-SNP enrollees. CMS is clarifying that for D-SNPs only, CMS will accept as compliant a Medicaid HRA that was completed 90 days before, and/or 90 days after the effective date of enrollment in the D-SNP, for the purposes of the Part C reporting requirements.

"Section 13 Special Needs Plans (SNPs) Care Management" in the Part C reporting requirements will be revised to reflect these policy clarifications. Further, CMS will update Chapter 16b

Special Needs Plans and Chapter 5 Medicare Advantage Quality Improvement Program of the Medicare Managed Care Manual accordingly.

Comment: One Commenter suggested that CMS simplify specifications in order to promote a level of consistency essential for Star Ratings. The Commenter listed various exclusions as a way to do this.

CMS Response: CMS thanks the commenter. Star Ratings were not within the purview of this ICR, although CMS realizes that changes in the specifications for the reporting sections can potentially impact Star Ratings. With regards to this reporting section, CMS is proposing changes to allow for reporting of beneficiaries who have refused HRAs or have been unable to be reached. We believe this will improve the reporting section. CMS believes that the specifications are clear in terms of inclusions and exclusions for the numerators and denominators.

Comment: The word "and/or" in the following specification is problematic. It should be changed to "or". Notes: "If an enrollee has multiple reassessments within the 90-day or the 365 day time periods, just report one HRA for the 90-day period and/or one reassessment within the 365 day time period."

CMS Response: CMS thanks you for the comment. CMS agrees that "and/or" should be eliminated and changed to "or". This change will be reflected in the 2016 Technical Specifications.

Comment: There should be different or modified instructions for FIDE SNP plans the process isn't the same as it would be for a non-DSNP plan and there isn't an allowance for the difference in processes. The Gentran submission process last year took weeks (Connect: Direct wasn't as cumbersome): The instructions in the January memo, regarding the POA New Enrollment report, were inaccurate. After calling and emailing CMS help desks, Part C reporting staff, our CMS R.O. account manager, and other plans for clarification, we were advised issues had been identified by CMS, but a correction memo never went out. The more clarification, the better. Send out as much guidance as necessary to make sure we all have the same information. The naming convention was inaccurate in the January memo and it was never corrected. Plans had to either call or wait until CMS could advise them individually of the correction or they had to figure out the error on their own. Clarifying guidance is always appreciated. We are concerned with the process for reporting in Gentran under the current guidance that considers reports timely only if CMS opens and verifies the report has been received. Is there a way to have the submission and acceptance process for Gentran meshed together into one? The CMSIT helpdesk was so overloaded this year that even when we called for issues that were out of our control (our contracts were not programmed by CMS to receive our submission of the POA New Enrollment reports) we had to work with the IT desk for weeks to get resolution. Could CMS provide a notification process of known issues to plan sponsors via HPMS memo or email. POA New Enrollment: Can CMS utilize HPMS rather than Gentran to report the POA New Enrollment report?

CMS Response: CMS will attempt to be more effective and timely in communicating issues with naming conventions with uploads prior to deadlines.

Reporting Section: Enrollment and Disenrollment

Comment: CMS is proposing to add four new data elements under the "Disenrollment" section, which would require MA organizations to report the number of involuntary disenrollments for failure to pay plan premium in the specified time period and related timely requests for good cause reinstatement, favorable good cause determinations and subsequent reinstatements. In the 2016 final Call Letter, CMS indicated the agency's intention to assign the responsibility to conduct good cause reviews to plans for CY 2016 and its expectations that plans perform the work from start to finish. CMS further indicated that the agency would provide guidance regarding the application of the good cause criteria and associated activities in the Enrollment Manuals (e.g., Chapter 2 of the Medicare Managed Care Manual). However, the agency has not yet provided this guidance, which plans need in order to implement properly this new requirement including making necessary systems and operational changes along with the associated reporting. We believe that it may be necessary for CMS to reevaluate the implementation and reporting deadlines for good cause review activities which are dependent on further CMS guidance.

CMS Response: As outlined in the 2016 Call Letter, CMS will transfer to plans the responsibility for intake and processing of good cause reinstatement requests for individuals disenrolled effective December 31, 2015, and later. We will provide guidance regarding the application of the good cause criteria and related activities in our enrollment manuals (Chapter 2 and Chapter 17, Subchapter D, of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual). This substantial update to the enrollment manuals will be available to plans no later than August 2015 and will include examples of favorable and unfavorable good cause reinstatement scenarios, as well as updated model notices. In addition, good cause reinstatement processing will be included as a topic at the 2015 Medicare Advantage & Prescription Drug Plan Fall Conference & Webcast, to be held on September 10, 2015. As will be outlined in the guidance update memorandum, in addition to working with their CMS Account Managers, plans will have the additional resource of a CMS electronic mailbox to which policy questions can be submitted. We are confident that plans will have adequate time in which to complete the steps necessary for successful implementation of this activity in 2016.

Comment: This Commenter stated that given that good cause requests are submitted to CMS for approval, would this data be currently available to CMS?

E. Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause

F. Of the total reported in E, the number of favorable Good Cause determinations.

G. Of the total reported in F, the number of individuals reinstated.

This Commenter recommended that CMS not include these reporting elements, as the data seem to be currently available to CMS.

CMS Response: As of 1/1/16, which is the start of the period for which these reporting requirements are applicable, these elements are not duplicative of other data available to CMS. As of this date, good cause requests will no longer be submitted to CMS but, instead, will be submitted to the plan from which the individual was disenrolled for failure to pay plan premium.

Reporting Section: Organization Determinations and Reconsiderations

Comment: We strongly recommend that CMS exclude reopenings and the data elements related to reopenings (6.21 6.29) from the 2016 Part C Reporting requirements. Instead, we request that CMS first thoroughly review and reconsider the existing guidance to determine whether or not the reopening process should apply to managed care organizations. We also recommend that CMS engage in conversations with managed care organizations during this determination process to understand MAO's processes. It is our understanding that CMS will be issuing revised guidance on reopenings in Chapter 13 of the MMCM and we recommend CMS review and revise the guidance prior to requiring plans to report on it. We look forward to future information from CMS regarding reopenings.

CMS Response:

Thank you for your recommendation. CMS is currently reviewing its reopenings process and will be issuing revised guidance on reopenings in Chapter 13 of the Medicare Managed Care Manual. Under current MA rules and regulations, reopenings are a remedial action that gives plans the opportunity to change a final determination under certain circumstances instead of processing as a reconsideration. We appreciate and will consider engaging in conversations with plans to further understand current health plan reopening processes. The information we receive from reporting requirements is intended to inform our policy making and to guide forthcoming revisions to CMS guidance.   We will continue to collect reopening data for 2016.

Comment: CMS proposes to add two new data elements, 6.10 - Number of Requests for Organization Determinations - Dismissals and 6.20 - Number of Requests for Reconsiderations – Dismissals. Commenter appreciates the addition of these data elements, which align with the audit protocols going forward.

CMS Response: Thank you.

Comment: This comment was in regard to the data element Organization Determinations and Reconsiderations - Reopenings

The following areas need clarification or specification in order to reduce data variation: Specify whether a first-time member request for DMR should be reported as Organization Determinations or as Reconsiderations -

CMS Response: We do not believe further clarification to this section of the Part C reporting requirements is necessary. If the plan receives an initial payment request from the enrollee, (we

are assuming that the enrollee paid out of pocket without ever receiving an unfavorable organization determination) the request should be reported as an organization determination. If the enrollee is appealing a payment denial that included appeal rights (which should be few and far between), the request should be reported as a reconsideration.

Comment: CMS should specify that denied Organization Determinations are a count of IDNs.

CMS Response: CMS expects a Medicare health plan's total number of denied organization determinations (ODs) will be larger than the total number of denial notices (IDNs). CMS expects plans to report all adverse ODs, per CMS guidance. For example, plans are to report denials of contract provider services where there is no member liability as adverse ODs. Medicare health plans do not issue IDNs for contract provider denials – i.e., where there is no beneficiary liability. Thus, the number of ODs denied by a plan is unequal to the number of IDNs issued by the plan. Based on this information, it would be incorrect to specify that denied organization determinations are a count of IDN's.

Comment: You have specified for CY2015 reporting that concurrent review should not be reported. In that the words "concurrent review" do not appear in Chapter 13, specify that the exclusion is of determinations for purposes of NOMNC.

CMS Response: Thank you for your recommendation, however, we do not believe a clarification is needed for this issue. Again, plans should not report any concurrent reviews completed during hospitalization, or for SNF, HHA, or CORF care.

Comment: This commenter had recommendations to reduce burden for the Organization Determinations Reconsiderations section:

Discontinue quarterly reporting. Go to annual reporting. For purposes of Data Validation, as needed to reduce file size, large contracts that can supply their claims Organization Determinations data broken into quarters.

CMS Response: Thank you for your comment; however, the plan must continue to report organization determinations/reconsiderations/reopenings on a quarterly basis. CMS would like to continue to track how these requests vary across the year.

Comment: CMS should discontinue partially favorable data elements. When reported correctly, these events are few. The respective approved and denied parts can be reported under approved and denied elements. Reporting thus, would be more in line with actual industry practice.

CMS Response: When a plan decides not to provide or pay for a benefit request, in whole or in part, then the decision is an adverse organization determination. To ensure consistent reporting by all plans, CMS has included data fields for plans to report partially favorable decisions and expects decisions that are only partially favorable are not reported as favorable decisions. Plans must continue to report partially favorable decisions.

Comment: One commenter made recommendations to "promote reporting" as defined in Chapter 13 of the Medicare Managed Care Manual. The recommendations were followed by a table that

could be used to modify or strengthen definitions of terms and fields involved in reporting reopenings.

CMS Response: CMS thanks the commenter. However, CMS considers the comments to be outside the purview of this information collection request.

Comment: To reduce burden, CMS should go to annual reporting instead of quarterly reporting.

CMS Response: Thank you for your comment; however, the plan must continue to report organization determinations/reconsiderations/reopenings on a quarterly basis. CMS would like to continue to track how these requests vary across the year.

Comment: Some plans are Fully Integrated Dual Eligible Special Needs plan (FIDE SNP) and the Part C technical specifications, including the data validation standards given to data validation auditors, do not accommodate differences in FIDE SNP grievance requirements that may exist under the Medicaid state contract approved for the DNSP plan (e.g. state contract approved by CMS may have a different timeframe). We recommend that CMS incorporate language in the Part C Reporting Requirements Technical Specifications to allow for accommodation of FIDE SNP or MMP plans that may have different timeframes due to the nature of dual eligible plan requirements.

CMS Response: CMS agrees with this recommendation. We will incorporate clarifying language.

It is important to note that the information we are collecting is not only being used to evaluate the network adequacy of a given MAO. CMS also will use this information to better understand the level of provider and facility turnover that MAOs experience during a given year. Specifically, the data will allow CMS to identify the range of network changes that occur during the normal course of business, and identify those that are outside the norm.

This collection of information is not duplicative of the information being collected as a part of the pilot Medicare Advantage (MA) program audit protocol to evaluate Provider Network Adequacy. These audits impact a limited number of parent organizations each year, and are for the purpose of auditing network adequacy. Alternatively, the Mid-Year Network Change reporting requirements will help CMS to better understand the extent of network changes an MAO may experience in a given year as a result of provider and facility contract terminations.

Reporting Section: Rewards and Incentives:

Comment: We understand that CMS needs to collect Rewards and Incentives Program data to track MAO's offerings of such programs and how those programs are structured. However, we

do not recommend that CMS include this new reporting section and related data elements as part of the 2016 Part C Reporting Requirements. The inclusion of this new reporting section for 2016 doesn't align with the approach CMS is taking for other reporting sections. Instead, CMS could capture Rewards and Incentive Program data in a different format outside of the Part C Reporting Requirements such as through online surveys or an online tool where plans could provide the requested information.

CMS Response: Thank you for your comment. After consideration, CMS will proceed with the proposed reporting requirements, including the section on RI Programs.

Comment:

> It would be ideal if CMS could release the parameters for the text portion of this reporting requirement so we know size limits and have a general understanding of the key language CMS would like to receive.
>
> We appreciate the increased flexibility with the updated rewards and incentives (R&I) guidance. With that being said, we do have limits on the amount of R&I we can provide in light of our organizational budget, which may not be the case for all plans. Please keep that in mind when creating guidance on the monetary limits.
>
> Managed Care Organizations that operate both MA plans and FIDE SNP plans have inconsistent guidance for R&I – e.g., SNPs seem to have no limits and MA plans have language about reasonableness of the R&I offered. Consistency between the two would help us manage our entire programmatic offerings because the R&I are often shared between the products.

CMS Response: Thank you for your comment. We will include parameters for the text portion of this requirement in the final reporting requirements document. The monetary limits on Rewards and Incentives (RI) programs can be found in the December 4, 2014 Health Plan Management System (HPMS) memo titled, *Rewards and Incentives Program Guidance*. Additionally, the December 2014 guidance, as well as the regulations at 42 CFR § 422.134 apply uniformly to both Medicare Advantage (MA) plans *and* Special Needs Plans (SNPs). The rules and requirements regarding RI programs are consistent across the entire Part C program.

Comment: The reporting requirement regarding due dates and what data elements to include is unclear.

Recommendation: Would CMS please clarify:

1. Report Due Date: Is the first Rewards and Incentives Programs annual report due on 2/28/2016 for the measurement period of CY2015? Or does this go into effect for a 2016 program where reporting is due on 2/28/17?

2. Report Content:

a. Should the report include rewards earned in measurement period and paid in measurement period and following measurement period?

b. Do the reward actions need to have been taken by end of the measurement period?

c. How should the Plan report enrollees who tried to obtain rewards in measurement period and could not obtain until the following measurement period?

CMS Response: Thank you for your comment. The measurement period for the first Rewards and Incentives (RI) Programs annual report will be contract year (CY) 2016 to be reported on the last Monday in February 2017.

If your organization has an RI Program, you should report the rewards earned in the measurement period. If the number of rewards earned differs from the number of rewards paid within the specified measurement period, it would be appropriate to report both.

The only requirement regarding the timing of when rewards must be given is that, in order for an enrollee to earn a reward, the health-related service/activity must be completed in full.

The organization should report the number of rewards earned by enrollees during the measurement period as well as the number of rewards actually awarded. CMS will clarify this language in our final reporting requirements.

Comment: For data element 15.6, how many enrollees are currently enrolled in the program - it is unclear whether or not the plan should report the number eligible members.

Recommendation: Please clarify: If the program is available to all eligible enrollees where members are not required to opt into the program, should the Plan report the number of eligible members?

CMS Response: Thank you for your comment. The organization should report how many enrollees are actually enrolled in the program. It would also be helpful for plans to report whether the program has optional participation. CMS will clarify this language in our final reporting requirements.

Comment: It would be ideal if CMS could release the parameters for the text portion of this reporting requirement so we know size limits and have a general understanding of the key language CMS would like to receive. We appreciate the increased flexibility with the updated rewards and incentives (R&I) guidance. With that being said, we do have limits on the amount of R&I we can provide in light of our organizational budget, which may not be the case for all plans. Please keep that in mind when creating guidance on the monetary limits. Managed Care Organizations that operate both MA plans and FIDE SNP plans have inconsistent guidance for R&I e.g., SNPS seem to have no limits and MA plans have language about reasonableness of the R&I offered. Consistency between the two would help us manage our entire programmatic offerings because the R&I are often shared between the products.

CMS Response: Thank you for your comment. CMS will include parameters for the text portion of this requirement in the final reporting requirements document. The monetary limits on Rewards and Incentives (RI) programs can be found in the December 4, 2014 Health Plan Management System (HPMS) memo titled, *Rewards and Incentives Program Guidance*. Additionally, the December 2014 guidance, as well as the regulations at 42 CFR 422.134 apply uniformly to both Medicare Advantage (MA) plans *and* Special Needs Plans (SNPs). The rules and requirements regarding RI programs are consistent across the entire Part C program.

Mid-Year Network Changes

Comment: Commenter believes that the proposed reporting requirements would create a significant and unnecessary burden on Part C sponsors without added value to CMS. The proposed reporting requirements would not inform CMS as to whether changes result in inadequate access to care or whether providers or enrollees are provided with timely and appropriate notification. None of the data elements could assess these issues, which are adequately assessed through analysis of the HSD table submissions in the Pilot on Provider Network Adequacy.

In addition, CMS sites the following as the legal basis for the proposed Mid-Year Network Changes section: "In accordance with 42 CFR § 422.112 (a) (1) (i), each MA organization under Part C Medicare that offers a coordinated care plan is required to "maintain and monitor a network of appropriate providers that is…sufficient to provide adequate access to covered services to meet the needs of the population served."

Commenter believes the reporting requirements will not inform CMS as to whether a plan is maintaining and monitoring a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served as required in §422.112 (a)(1)(i). We reiterate that analysis of HSD table submissions in the Pilot on Provider Network Adequacy is the appropriate tool for this purpose. It would not be an efficient use of CMS or Plan resources to create a duplicative reporting structure for this purpose and ultimately will add administrative cost for plans without adding any value.

CMS states that the agency is seeking a better understanding of how often MAOs undergo mid-year network changes and how many enrollees are affected. Commenter and our member plans would be happy to discuss these issues with CMS to provide information about how and why changes occur throughout the year. As a normal course of business providers terminate, retire or die and health plans add other providers. Contract negotiations occur throughout the year in an effort to optimize networks, improve quality of care and provide efficient services. This is especially true as health plans strive to meet the HHS Secretary's goals to move toward greater use of alternative payment models and population-based payments.

Providers terminate their network affiliation for a variety of reasons outside of the control of the health plan including for example, death, retirement, relocation, refusal to accept quality or payment terms or acquisition by a hospital system. New providers are added as they move into the area, become part of a new system, new contracts are negotiated, etc. All of these changes could theoretically affect every member in the contract; however, access requirements generally

are not affected by these changes as the bulk of providers remain constant and provide sufficient access to care for Plan members according to the CMS network adequacy standards.

For the reasons above, Commenter strongly recommends that CMS eliminate the proposed Mid-Year Network Changes reporting section from the 2016 Part C Reporting Requirements. The more appropriate tool for monitoring network adequacy will be implemented soon through the CMS Pilot on Provider Network Adequacy that requires loading of HSD tables and evaluation based on published CMS standards.

CMS Response: Thank you for your comments. CMS does not believe the reporting requirement creates a significant and unnecessary burden on Medicare Advantage Organizations (MAOs) as the data requested (i.e. the number of terminated primary care providers (PCPs), certain specialists and certain facilities) is the type of information MAOs should already have available. However, based on the comments we received on this reporting requirement we are revising these questions, as well as making changes to the instructions to clarify the specific information we are requesting. We believe these changes will further reduce the reporting burden regarding the mid-year network change data elements.

Comment:

- How would a plan determine the following - number of enrollees affected by:
    - termination of PCPs
    - the addition of new PCPs
    - the termination of specialists
    - the addition of new specialists
    - the termination of facilities
    - the addition of new facilities?

CMS Response: Thank you for your comments. We have decided to delete the questions requesting information about enrollee impact when providers or facilities are added to a network. Also, as clarification, when we use the term “affected” we would like the organization to provide information on those enrollees who have been treated by a terminated provider within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: The actual number of affected enrollees seems to be speculative in nature.

CMS Response: Thank you for your comment. We have defined affected to mean those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP

Comment: Commenter believes certain clarifications about the following data elements would promote common understanding of the agency’s expectations for reporting. Recommendations for additional CMS guidance for this proposed new reporting section are detailed below.

Numbering of the Proposed New Reporting Section. On the top of page 34 of the draft Part C reporting requirements document, the reporting section row for "Mid-Year Network Changes" is labeled as number 15. CMS should correct the numbering to reflect number 16 for this new reporting section.

PCPs, Specialists and Facilities. To ensure consistency in reporting, CMS should include definitions for these terms (e.g., by reference to existing CMS network adequacy criteria guidance).

Contract Terminations. CMS should clarify which terminations should be included in the reporting under the above-referenced data elements.

Affected Enrollees. For data elements 16.3, 16.5, 16.7, 16.9, 16.11 and 16.13, CMS is proposing to require MA organizations to report on the total number of enrollees affected by terminations and additions of PCPs, specialists and facilities during the reporting period. To ensure a common understanding of the agency's expectations for reporting, CMS should clarify how the affected enrollee count is to be determined.

CMS Response: Thank you for your comments. CMS agrees with these comments and will revise the reporting requirements, accordingly. CMS has defined affected to mean those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: It is unclear how CMS is defining "mid-year network change."

Recommendation: Consistent with guidance provided in the CY 2015 CMS Call Letter related to substantial mid-year provider network terminations, we believe that it is CMS' expectation that MAOs would report as mid-year network changes those network changes that are initiated by an MAO without cause (i.e., those network changes that are non-routine, non-normal course of business) and are effective on a date other than 1/1/XX.

We would appreciate CMS confirmation of this and recommend that CMS include clarifying language to ensure consistent interpretation by MAOs.

CMS Response: Thank you, CMS agrees with this comment and will add clarifying language to the reporting requirement, accordingly.

Comment: It is unclear whether enrollees who have disenrolled during the year should be excluded at the time of reporting.

Recommendation: Given that this is an annual report, we believe that the MAO should exclude enrollees who have left the plan when reporting out on the data elements.

CMS Response: CMS thanks you for this comment. MAOs should report the number of enrollees impacted by provider terminations even if the enrollee(s) subsequently disenrolls from the plan.

Comment: It is unclear as to how MAOs are to calculate the addition of specialists. If we contract with a specialist provider group, we would count that as the addition of one contract. Is this CMS' intent or if we are contracted with a provider group that has employed specialists or subcontracted specialists, are we to include the total number of specialists being added?

Recommendation: We believe that CMS is looking for the number of providers that were added. Therefore, we suggest that CMS change the data element title from "Specialist Contracts" to "Specialist physicians" so that is more clear. In addition, we recommend that CMS confirm that specialists are limited to cardiologists, oncologists, pulmonologists, endocrinologists, rheumatologists, ophthalmologists, and urologists.

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers and facilities, CMS has defined affected to mean those enrollees who have been treated by a terminated provider within 90 days preceding the provider termination or who were assigned to a terminated PCP. CMS is requiring MAOs to report terminations of specified specialists and the number of enrollees affected. CMS is requesting information on the following specialty types: cardiology, endocrinology, oncology, ophthalmology, pulmonology, rheumatology, and urology. CMS is requesting information on the following facility types: Acute Inpatient Hospitals, and Skilled Nursing Facilities.

Comment: It is unclear what is meant by "affected by addition of new specialists."

Confirmation Requested: We interpret this to mean the number of members who reside in the county on the plan for which the providers were added as calculated in data element 16.8. We would appreciate CMS confirmation of this.

CMS Response: Thank you for your comments. CMS has defined affected to mean those enrollees who have been treated by a terminated provider within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: It is unclear what is meant by "affected by addition of new facilities."

Confirmation Requested: We interpret this to mean the number of members who reside in the county on the plan for which the facilities were added as calculated in data element 16.12 (i.e., How many facility contracts were added?). We would appreciate CMS confirmation of this.

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: When reporting the addition or deletion of PCPs/specialists for the Mid-Year Network Changes reporting section in the event that a group terminates a plans network containing multiple PCPs and providers of varied specialties, should the change be reported for both PCPs and specialists categories? Likewise, if a group is added to the network containing both PCPs and specialists, should the addition be reported under both categories?

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: Many PCPs, Specialists, Facilities, etc. are part of a group contract that is the umbrella over multiple practitioners/providers. When you use the term "contracts" in a question such as this: "How many PCP contracts were terminated?" there are organizations and people in organizations who read that as they are ONLY being asked to report on the contract & not at the level of the individual PCP, or Specialist, or facility. To clarify that your intent is to capture the data for each INDIVIDUAL PCP, Specialist, facility etc. that is part of the network, please revise the question to read as " How many individual PCPs; Specialists; Facilities: (etc.) were terminated. (Whether contracted with individually or contracted as part of a group contract.) "Same with the questions that ask "How many PCP/Specialist/Facility etc. contracts were added?" Again noting that many can be included on one group contract. We'd like CMS to clarify that it is indeed looking for data to be produced at the individual provider/practitioner level. Regarding the questions that begin "How many enrollees were affected by termination of....."? What is the guidance on how to decide which enrollees to use? Should we use JUST the members that were paneled with that provider, or who were patients seeing that provider? Or should a MAO include all enrollees in the H#? Can you please clarify exactly how we are to calculate which enrollees to include? Same with the questions that ask "How many enrollees were affected by addition of new PCPs/Specialist etc." Can you please clarify exactly how we are to calculate which enrollees to include?

For the question "How many facility contracts were terminated?" Does facility mean the same provider types on the HSD facility table? (i.e., PT/OT/ST is on the HSD table facility list so do we bucket them as specialty or facility?)

CMS Response: Thank you for your comments. CMS is requiring an MAO to report on the number PCPs, certain specialists and certain facilities the MAO has terminated within the last year. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: How would a plan determine the following - number of enrollees affected by: termination of PCPs, the addition of new PCPs, the termination of specialists, the addition of

new specialists, the termination of facilities, the addition of new facilities? The actual number of affected enrollees seems to be speculative in nature.

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: We would like bring awareness to CMS that MAOs do not necessarily use the same approach to contracting with providers. Some plans contract at the clinic level whereas other plans contract at the individual physician/practitioner level and the proposed data elements do not account for differences in contracting approaches. Our organization contracts at the clinic level. A primary care physician (PCP) or a specialist may leave a clinic in our network, but that particular clinics contract does not necessarily terminate. Therefore, we may not have any responses for data elements 16.2 (How many PCP contracts were terminated?) and 16.6 (How many specialist contracts were terminated?) even though a physician leaves a clinic in our network because the contract may not be with the individual physician. We request that CMS address MAOs differing approaches to provider contracting if considering adding this new reporting section to 2016 Part C Reporting. In addition, we request that CMS provide clarification that 1876 Cost plans are in fact excluded from this data collection.

CMS Response: Thank you for your comments. CMS expects MAOs offering coordinated care plans (i.e. PPOs & HMOs) to be aware of contracted provider terminations. Additionally, the MAO should provide notification of these terminations to their enrollees per (see 42 CFR section 422.111(e)).

Comment: The reporting requirements will not inform CMS as to whether a plan is maintaining and monitoring a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served as required in §422.112 (a)(1)(i). We reiterate that analysis of HSD table submissions in the Pilot on Provider Network Adequacy is the appropriate tool for this purpose. It would not be an efficient use of CMS or MAO resources to create a duplicative reporting structure for this purpose and ultimately will add cost for enrollees without adding any value.

CMS states that the agency is seeking a better understanding of how often MAOs undergo mid-year network changes and how many enrollees are affected. Commenter would be happy to discuss these issues with CMS to provide information about how and why changes occur throughout the year. As a normal course of business, providers terminate and health plans add other providers. Contract negotiations occur throughout the year in an effort to optimize networks, improve quality of care and provide efficient services. This is especially true as health plans strive to meet the HHS Secretary’s goals to move toward greater use of alternative payment models and population-based payments.

In addition, providers terminate for a variety of reasons outside of the control of the health plan including for example, retirement, relocation, death, refusal to accept quality or payment terms or acquisition by a hospital system. New providers are added as they move into the area, become part of a new system, when new contracts are negotiated, etc. All of these changes could

theoretically affect every member in the contract; however, access requirements generally are not affected by these changes as the bulk of providers remain constant and provide sufficient access according to the CMS network adequacy standards.

For the reasons above, Commenter strongly recommends that CMS eliminate the proposed Mid-Year Network Changes reporting section from the 2016 Part C Reporting Requirements. The more appropriate tool for monitoring network adequacy will be implemented soon through the CMS Pilot on Provider Network Adequacy that requires loading of HSD tables and evaluation based on published CMS standards.

CMS Response: Thank you for your comments. CMS does not believe the reporting requirement creates a significant and unnecessary burden on Medicare Advantage Organizations (MAOs) as the data requested (i.e. the number of terminated PCPs, certain specialists, and certain facilities) is the type of information MAOs should already have available. However, based on the comments we received on this reporting requirement we are revising these questions, as well as making changes to the instructions to clarify the specific information we are requesting. We believe these changes will further reduce the reporting burden regarding the mid-year network change data elements.

It is important to note that the information CMS is collecting is not only being used to evaluate the network adequacy of a given MAO. CMS also will use this information to better understand the level of provider and facility turnover that MAOs experience during a given year. Specifically, the data will allow CMS to identify the range of network changes that occur during the normal course of business, and identify those that are outside the norm.

Comments: If CMS decides to move forward with the proposed Reporting Section 16, Mid-Year Network Changes, Commenter has the following specific comments and recommendations.

Data Elements - Pages 34 – 35 16.1: In the previous contract year, did you make any mid-year network changes? (“0”=”No”; “1” = “Yes”).

Mid-year network changes are a normal course of the health insurance business for the reasons stated previously. As such, this element does not add value to understanding network adequacy as it would be an anomaly for an MAO to not experience network changes. Further, it is unclear whether this is intended to include provider-initiated changes, plan-initiated changes, or both.

Recommendation: HCSC recommends CMS eliminate data element 16.1. Alternatively, if CMS decides to retain the data element, we recommend that CMS restate the question as follows: In the previous contract year, were there any mid-year changes? 16.2: How many PCP contracts were terminated? 16.6: How many specialist contracts were terminated? 16.10: How many facility contracts were terminated? It is unclear what constitutes a contract termination. For example terminations could include or exclude providers/specialists that retired, relocated, died, were acquired by a hospital system, refused to accept quality or payment terms, were terminated for cause, or terminated for other reasons.

Recommendation: CMS clarify which providers would be included in the definition of a terminated PCP contract.

CMS Response: Thank you for your recommendation. CMS will clarify that MAOs are to report on no cause mid-year terminations of PCPs, certain specialists, and certain facilities initiated by the MAO.

Comment: It is unclear how CMS is defining "affected" in data elements 16.3, 16.7, and 16.11. While any enrollee could be affected by a termination, in practice we suggest several items to consider. Many enrollees, especially those in a PPO health plan, do not have a PCP and are not required to select and report one to the MAO. MAOs do not typically attribute enrollees to specialists or facilities. In these cases the MAO would have no way of knowing whether a member would need to choose a new provider when one is terminated. Also, it is unclear if a member would be considered affected if the provider is outside of the distance access requirements. Recommendation: The term "affected" in these data elements is defined to mean that the beneficiary has visited the provider within the last six months.

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.

Comment: It is unclear how CMS is defining "affected" in data elements 16.5, 16.9, and 16.13. Any enrollee could be affected by the addition of a provider since they have more choice of providers. However, for practical purposes enrollees are likely affected only if they utilize the new provider within a specified period of time or if they live within the distance access requirements. Recommendation: Commenter recommends that the term "affected" in these data elements is defined to mean that the beneficiary has visited the provider within the last six months of the reporting time period.

CMS Response: Thank you for your comments. CMS has deleted the questions regarding enrollee impact when providers or facilities are added to a network. With respect to terminated providers/ facilities by affected CMS is referring to those enrollees who have been treated by a terminated provider or received services from a terminated facility within 90 days preceding the provider termination or who were assigned to a terminated PCP.