CMS Response to 30 day comments for Part C Reporting Requirements

WELLCARE

Comment #1 (General)

- The proposed 2017 Part C Reporting Requirements reference reporting due in February, 2017. Section 5 (Grievances), page 7; and section 6 (Organization Determinations/Reconsiderations), pg. 12, both state "2/27/2017 reporting will include each quarter." WellCare asks CMS to clarify whether or not the date for these sections should be 2/27/2018.

Comment #2 (General)

- Section 14 (Enrollment and Disenrollment), pg. 29, states that the due dates for data to be submitted to CMS are August 29, 2016 and February 27, 2017. WellCare seeks clarification on whether or not these dates should reflect August 29, 2017 and February 27, 2018.

Comment #3 (Sponsor of Oversight Agents)

- In review of the proposed 2017 Part D Reporting Requirements, the section for Sponsor Oversight of Agents was removed; however, it remains in the Part C Reporting Requirements. WellCare asks CMS to provide guidance on that data required for this reporting requirement. Specifically, we ask CMS if plans should interpret this as only CCP data being required for this section and PDP data not being required for this section.

CMS Response (All)

- In response to the first two comments, the 2017 technical specification require that reporting for Organization/Determination are due by the last Monday in February in the following year, and that Enrollment and Disenrollment be due by the last Monday of August and February. This language was adopted because the date can change from year to year, and that language was in the 60 day package. For the last comment, we can confirm that the requirements for Sponsor of Oversight Agents has been suspended for 2017 which is evident in the 60 day package and has been addressed in the 60 day comments.

UNITED HEALTHCARE

Comment #1 (Organization Determinations/Reconsiderations)

- United requested additional clarification to our response to their 60 day comment regarding Organization Determinations/Reconsiderations and the Reason(s) for Reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other). They requested that CMS clarify whether "Other Error" is a new and distinct reason code from "Other" as well as describe how each should be used. Additionally, we ask that CMS clarify what numeric value it will be assigned.

CMS Response:

- Yes, “Other” is a "is a new and distinct reason code" from “Other Error” and should be reported as data element 6.32 in the Part C Reporting Requirements,. As stated in our 60 day response “Other” refers to cases that would not be considered a “clerical error” or “other error.” Examples of “other” may include policy/procedure change, business configuration change, provider update, other adjustment etc. To further clarify, these are not considered “errors,” and that specific examples of a clerical error are in Chapter 13.

Comment #2 (Organization Determinations/Reconsiderations)

- United Health Care was unclear of what CMS was looking for regarding the data item “Additional Information” that is required for Organization/Determination reporting. They requested that CMS better define “Additional Information” and provide examples of what should be included.

CMS Response

- This comment is duplicative of another comment submitted as part of the 60 day comment period. The response provided was: “This new data element is an optional field. This field can be populated by plans if they wanted to provide more information such as a subcategory or notes.” It is data element 6.33 in the Part C Reporting Requirements. The same response is applicable to this recent comment.

Comment #3 (Mid-Year Network Changes)

- Regarding mid-year network changes, United wanted CMS to expand on what it meant by the language “network change protocol” in the Part C Reporting Requirements.

CMS Response

- To provide clarity, CMS removed the term “Medicare Advantage (MA) network change protocol” and added language that that the data reported will enhance CMS’ ability to

improve its policy and process surrounding significant network changes (see section 110.1.2 of chapter 4 of the Medicare Managed Care Manual for more information).

Comment #4 (Mid-Year Network Changes)

- United requested that CMS remove footnote 3 on page 33 from the technical specification for Measure 16 (of Part C Reporting Requirements), contending that Footnote 3 introduced a new concept of "disruption in the ability of enrollees to see the provider(s)." The concept appeared to be distinct from the term "affected enrollees" that CMS defined in the measure's technical specifications and included in several of the data elements (16.42 to 16.52) which MAOs are required to report to CMS. They believed the additional concept of "disruption in the ability of enrollees to see the provider(s)" was not necessary. Also, the reporting on "affected enrollees," using the clear definition of that term CMS provided helped ensure that all reporting MAOs construe the technical specification consistently and, therefore, submit more accurate data. For these reasons, United requested that CMS preserve "affected enrollees" as the measure of reporting enrollees who are impacted by terminations of MAO and provider contracts, and delete footnote 3 from the technical specification.

CMS Response

- CMS disagreed with the request to delete Footnote 3 because it is necessary to clarify the type of provider terminations that should be reported. The example in the footnote could potentially happen, but organizations should not report this type of termination because the enrollees are not "affected" in the sense that they can continue seeing the provider, as the provider remains in the organization's network. If organizations follow the guidance in the footnote, then they will correctly exclude these types of provider terminations from data elements 16.2 and 16.14-16.22, and then the "affected enrollees" data elements (16.42 and 16.43-16.51) will not be impacted. However, CMS revised the language in the footnote slightly for clarification purposes. The concept of affected enrollees' inability to continue seeing the terminated provider(s) in-network (footnote 3) does not conflict with the clear definition of an "affected enrollee" provided in the reporting requirements.

Comment #5 (Payments to Providers)

- United was unsure whether CMS is asking us to report payments by incurred period or some other timeframe. For example, it was not clear if capitation reporting should be for a capitation that is paid in total. Payments to providers for the reporting period CY2016 would not include all payments by the time of reporting of February 2017. As a result, a recommendation was made to CMS to report allocated spending when the actual payment (amount) is unavailable due to it being issued after the report submission due date.

CMS Response

- CMS disagreed with the recommendation because MAOs are to report payments made during the reporting year (e.g. 2016), regardless of when services were furnished. Additionally, we are aware that due to payment reconciliation, performance evaluation, etc., that some payments are made after the reporting year has ended. Therefore, MAOs should only report payments made in the reporting year (e.g. 2016) based on the data that is available at the time of reporting (e.g. February 2017).