CMS Responses to 60 day comments for CMS-10261 (OMB 0938-1054)

Subsequent to the publication of the 60 day Federal Register notice, CMS received over 40 comments on the Part C Reporting Requirements. The majority were germane to the new ODR reporting requirements. Specifically, many commenters questioned the new ODR data reporting elements for contract and non-contract providers. In response to many of the comments, CMS revised the requirement to capture enrollee/representative claims submitted data instead of contract and non-contract provider data. This change was made because contract provider appeal rights fall outside the Subpart M Medicare appeals process. However, the cumulative total number of data elements collected for ODR reporting remains unchanged. CMS believes the collection of this data is important because it will demonstrate how often enrollees are submitting reimbursement requests and the outcome of plan decisions, and will show better alignment with the Independent Review Entity (IRE) data.

There were also many comments about the file layout in the Plan Reporting Module in HPMS. Specifically, many commenters were concerned the reformatting of the ODR Plan Reporting Module from its current numbering system for data elements to an alpha listing of elements would cause confusion. CMS initially made this change to be consistent with Part D reporting but in response to the public comments, CMS revised the format to include numbered subsections with an alpha listing under each subsection. The revisions are included in the 30 day document.

The split between the Part C Reporting Requirements and the Part C Technical Specifications caused some concern about technical information being released in a timely manner to enable plans sufficient time to develop reporting mechanisms with CMS Reporting. CMS response is that critical information will be disseminated to plans early in the reporting year to allow sufficient time to develop reporting mechanisms that are consistent with CMS expectations. Once the Part C Reporting Requirements are approved by OMB, the technical specifications will be posted concurrently with the Part C Reporting Requirements. This process is consistent with Part D Reporting. The split between the two documents enables CMS to make timely adjustments to the technical specifications in response to feedback received through the Part C mailbox.

Finally there were many specific questions about the existing Part C Reporting Requirements which are akin to questions we receive through the Part C mailbox and were not germane to the reporting changes. We have include those questions below.

Organization	Reporting Section	Description of Issue(s) or Question	Commenters' Recommendations	CMS Response	Revised /Not Revised
Fresenius Health Partners #1k2-92yj-f6y9	**Grievances**	The SO is asking if plan organizations report a grievance in the quarter in which the plan makes the final decision or in the quarter in which the plan has notified the enrollee of its decision.	Include data element detail, "notes," and further context regarding what is required for accurate reporting for each reporting section.	Report grievances in the quarter in which the plan has notified the enrollee of the decision. CMS will consider adding more detail to the technical specifications.	No
Fresenius Health Partners #1k2-92yj-f6y9	**Grievances**	How is timely notification determined in terms of reporting grievances?	N/A	Timely notification is based on when the plan has notified the enrollee of the decision. Please refer to CMS Regulations and Guidance: 42 CFR Part 22, Subpart M and Chapter 13 of the Medicare Managed Care Manual.	No
Fresenius Health Partners #1k2-92yj-f6y9	**Grievances**	Are Expedited Grievances and Dismissals included in the "Total Grievances" calculation, or should these categories instead only be reported separately?	N/A	Expedited grievances are included in the total. Dismissed grievances are not.	No
Fresenius Health Partners 1k2-92yj-f6y9	**ODR**	Should "the total number of organization determinations made in the reporting period" exclude withdrawals and dismissals? In general, please define how this field should be calculated (i.e. which elements do we include in the total?)	N/A	For withdrawals, if a plan issues a timely decision, but the request is then withdrawn, the case should be counted in the total count. If the request is withdrawn prior to a decision being issued, the case is not included in the total count. Dismissals are not included in the total.	No

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Fresenius Health Partners 1k2-92yj-f6y9	**ODR**	Will this reporting section [ODR] be based on quarters as seen in previous reporting years?	N/A	Yes, the ODR reporting section reports periods will continue to be based on quarters of the current CY.	No
Fresenius Health Partners 1k2-92yj-f6y9	**ODR**	Should the plan report an organization determination or redetermination to CMS once the plan makes the final decision or once the plan has notified the enrollee of its decision?	N/A	Report an O/D or R when the enrollee is notified of its decision. These guidelines are in the Technical Specifications.	No
Fresenius Health Partners 1k2-92yj-f6y9	**ODR**	Are the new elements "contract provider" and "non-contract provider" determined by the requesting provider or the servicing provider?	N/A	We have revised the data elements to address this question. You report who requested the service in subsection #1 in the appropriate data element. You report the disposition of the request and by whom in subsection #2.	Yes
Kaiser Permanente 1k2-9318-he68	**General**	With the split between the Part C RR and the Technical Specifications, the commenter is stressing that it is critical that this information is disseminated to plans early in the reporting year to allow sufficient time to develop reporting mechanisms that are consistent with CMS expectations.	N/A	Critical information is disseminated to plans early in the reporting year to allow sufficient time to develop reporting mechanisms that are consistent with CMS expectations.	No

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Medica 1k2-931t-6taw	**ODR**	Element E is described as: *Number of Organization Determinations submitted by Enrollee/Representative.* Our organization does not have a reportable field within the claims processing system to indicate if the request was submitted by an enrollee or representative. This will be very labor intensive to report on accurately.	N/A	The impact of this change will require the plans to reclassify data that should already be collected. This data is currently collected during audits as well as part of the timeliness monitoring project. This data is important because there are different appeal rights and different appeal paths. It will also show better alignment with the Independent Review Entity (IRE) data.	No
Medica 1k2-931t-6taw	**ODR**	Element G is described as: *Number of Organization Determinations submitted by Provider*. Our organization does not have a reportable field within the claims processing system to indicate if the request was submitted by the provider. There is concern that the provider counts may inaccurately include claims that were submitted by an enrollee or representative.	N/A	We amended the language to clarify that we are expecting here the number of ODRs reported that are submitted by a non-contract provider. However, as stated in the previous comment, plans should already be collecting this data since it is currently collected during audits as well as the timeliness monitoring project.	No
BlueCross BlueShield Association	**EGWP**	The commenter is concerned about CMS's massive data collection	BCBSA wishes to ask CMS to demonstrate that this information	Requesting this information on an ad hoc basis would not permit us to see potential	No

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1k2-939r-f0yw		effort for the agency to obtain information on employer group plans (EGWPs) and in the absence of a lack of purpose or objective.	is of value to the agency and how it will be used. They suggest an alternative that entails CMS asking for specific information upon request and not collect this data annually.	trends and could also require more resources depending on where information may be accessed.	
BlueCross BlueShield Association 1k2-939r-f0yw	**Provider Payments**	The commenter asks whether the alternative payment arrangement data is being used to support the other payer advanced APMs, as described in the recently releases CY 2019 Final Rate notice. The commenter states it is not clear to BCBSA, putting together what is in the final Rate Notice on APMs and the language used in that section, whether this data is being used for that purpose. The commenter states that the purpose of the section in the PRA is, "to determine how broadly MA organizations are using	BCBSA requests CMS clarify the relationship between this data collection and the determination of other payer advanced APM statuses. They recommend if these new proposed data sets do not apply, then they should not be collected.	CMS confirms this data collection is used to determine how broadly MA organizations are using alternative payment arrangements. It is not used to determine whether physicians qualify under other payer advanced APMs. CMS appreciates your input and will take your recommendation in the consideration in future updates to the Part C reporting requirements.	No

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		alternative payment arrangements", rather than to determine whether physicians qualify under other payer advanced APMs			
BlueCross BlueShield Association 1k2-939r-f0yw	**Grievances**	CMS notes that Plan Benefit grievances will be removed, but is silent on the Benefit Package category. The commenter is concerned this may create confusion as Plan Benefit is a Part D category and Benefit Package is missing from the Part C list.	The commenter requests/recommends that CMS remove Plan Benefit and add Benefit Package to the deletion list.	Both Part C and D reporting requirements have removed all Grievance categories leaving five (5) remaining.	No
Capitol BCBS 1k2-939v-j0s5	**ODR**	The commenter is concerned the reformatting of the ORD Plan Reporting Module from its current numbering system to an alpha listing of elements would cause confusion.	The commenter recommends CMS retain the current data element numbering system.	Please see revised document for clarification.	Yes
Capitol BCBS 1k2-939v-j0s5	**60 day Crosswalk**	For Part C Reporting Requirements, CMS should provide a crosswalk of changes, as they did for the Part D Requirements.	Please provide Part C Crosswalk	A crosswalk of changes was provided as part of the 60 day PRA package. A revised crosswalk will be provided as part of the 30 day package.	No
Cigna 1k2-93b6-x02t	**ODR**	Element B, subsection 1	Is the removal of the timeliness element an	MA organizations no longer are required to report timeliness	No

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		(Org Deter) CMS has deleted Elements 6.2, yet there does not seem to be any request for counts of Timeliness in any of the elements now.	oversight, or do we no longer need to report timeliness?	elements for ODR reporting section.	
Cigna 1k2-93b6-x02t	**ODR**	The commenter is concerned the reformatting of the ORD Plan Reporting Module from its current numbering system to an alpha listing of elements would cause confusion.	The commenter strongly recommends that this confusion be addressed.	Please see revised document for clarification.	Yes
Aetna 1k2-93ce-hvsp	**ODR**	For organization determinations for service requests, we believe plans will need more specific direction in order to accurately capture the contracting information that CMS is seeking. For prior authorizations, the requesting provider may be different from the provider who will provide the service. Plans generally capture both providers in their prior authorization documentation at the time that the service is requested. Should plans		Please see revised document for clarification.	Yes

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		report the contracting status of the requesting provider or the status of the provider who will be performing the service?			
Aetna 1k2-93ce-hvsp	**ODR**	In the reconsideration section, CMS requires the contracting status of the provider. Per Section 40.2.3 Notice Requirements for Non-contract Providers in Chapter 13 of the Medicare Manage Care Manual, in the situation of a denial of a claim payment, only non-contracting providers have CMS appeal rights. Contracted providers are afforded plan-specific appeal rights relative to claims denials and this activity would not captured in CMS reporting**.**	Recommends that CMS remove the Reconsideration elements related to claims from contracted providers	CMS agrees and has revised the data elements to capture enrollee/representative claims submitted data instead of contract and non-contract provider data.	Yes
Aetna 1k2-93ce-hvsp	**ODR**	The commenter is concerned the reformatting of the ORD Plan Reporting Module from its current numbering system to an alpha listing of elements would cause confusion.	The commenter recommends that CMS use the previous formatting for ODR reporting.	Please see revised document for clarification.	Yes

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Fallon Health 1k2-93ce-iais	**General**	The commenter is concerned about the split between the Part C RR and the Technical Specifications because the latter assists organizations in preparing and submitting accurate datasets to CMS**.**	Can CMS let plans know when the when Part C Technical Specifications are released? Will there be any opportunity for plans to comment on them before their implementation?	CMS expects to release the Part C technical specifications when the Part C Reporting Requirements are approved by OMB. Both will be posted concurrently on the CMS.gov website. This is consistent with Part D reporting.	No
CVS Health 1k2-93ce-rm1r	**ODR**	CMS should provide clarification on pre-service cases for Part C Organization Determinations reporting.	Clarify if all pre-service cases for Part C Organization Determinations reporting are to be reported based on date of notification to the enrollee or decision date.	You report based on date of notification to the enrollee. This information will be provided in the Tech Specs.	No
CVS 1k2-93ce-rm1r	**General Comment**	The current method of providing the reporting requirements and technical specifications on CMS.gov and the file layouts on HPMS is confusing and hampers the review and response times. Additionally, it would be beneficial if all of the applicable draft versions were issued at the same time so that these could be reviewed at the same time	We recommend that CMS provide the details regarding the reporting (the Reporting Requirements, the Technical Specifications, and the File layouts) in one location. Preferably on the CMS.gov website rather than HPMS.	We believe that technical specifications germane to HPMS reporting is appropriately posted on HPMS. All approved technical and reporting requirements for Part C Reporting are appropriately placed on the CMS.gov website.	No

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		and taken as a whole, allowing comments to be more meaningful as reviewers will have the full picture of the reporting ask.			
UCARE 1k2-93cg-anrq	**General**	Since the forthcoming Technical Specifications document will provide important details about the data elements, UCare requests that CMS allow plans an opportunity to review and comment on the document before it is finalized.	UCare requests that CMS allow plans an opportunity to review and comment on the document before it is finalized.	The technical specifications will be posted concurrently with the Part C RR pending OMB approval.	No
UCARE 1k2-93cg-anrq	**Grievances**	The Grievances section, page 4 states: "When categorizing grievances into core categories, organizations may report based on their investigations subsequent to the enrollees' filing of the grievances." Since CMS will no longer require plans to report grievances based on category, what are "core categories" referenced in the Reporting Requirements?		Thank you for your comment. This sentence has been removed.	Yes

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UCARE 1k2-93cg-anrq	**Mid-Year Network Changes**	UCare supports the suspension of the Mid-Year Network Changes reporting section.		Thank you for your comment.	No
Regulatory Relief Coalition 1k2-93cg-bor6	**ODR**	We support the inclusion of the proposed new data elements to provide CMS with additional information regarding the circumstances under which ODRs are made. In addition, we believe that it is critical to add a number of additional new data fields to collect information relating to MAOs' use of Organization Determinations that are made pursuant to Prior Authorization (PA) processes and procedures.	We believe that it is critical to add a number of additional new data fields to collect information relating to MAOs' use of Organization Determinations that are made pursuant to Prior Authorization (PA) processes and procedures.	Thank you for your recommendation. We may consider exploring this recommendation at a later date.	No
Regulatory Relief Coalition 1k2-93cg-bor6	ODR	The commenter requests the ODR section of the form entitled "Medicare Part C Reporting Requirements be modified to: • Make it clear that each request for PA is a request for an organization determination;		Thank you for your recommendation. The current guidelines states that a request for prior authorization is considered an organization determination request. At this time, CMS is not requesting the specific procedure or service involved. We currently require plans to submit the rest of your recommendations.	No

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		• Require all MAOs to report the following information for each procedure subject to PA: • The specific service or procedure involved; • The number of requests for PA received for the procedure; • The number of requests for PA for the service or procedure that were approved in full, approved in part, denied in full and denied in part. • The number of denials appealed; • The number of denials reversed on appeal and the number of denials affirmed on appeal;			
Regulatory Relief Coalition 1k2-93cg-bor6	**ODR**	The commenter believes that requiring MAOs to report this PA data in a uniform and consistent manner is a necessary first step to ensuring appropriate access for Medicare beneficiaries who choose to enroll in a MA plan and will	Require all PA data elements be reported separately from other organization determination data and facilitates data aggregation.	Thank you for your recommendation. We will consider this recommendation in the future.	No

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		facilitate the oversight requested by patient and provider groups.			
Blue Cross/Blue Shield of IL,MT, NM,OK,TX 1k2-93cg-ptwj	**General**	The commenter was supportive of all the part C proposed changes; 1) the suspension of Mid-Year Network Changes and Private Fee For Service Provider Dispute Resolution Process; 2) the separation of the Part C Reporting Requirements from the Part C Technical Specifications; 3) the streamlining of the reporting requirements for Medicare Medicaid Managed Care Plans.		CMS appreciates the positive response.	No
Medical Mutual of Ohio 1k2-93cg-x773	**ODR**	The commenter is concerned the reformatting of the ORD Plan Reporting Module from its current numbering system to an alpha listing of elements would cause confusion.	Can CMS label these as they do in other universes - A through Z, and if needed AA, AB, AC, etc.?	Please see revised document for clarification.	Yes
Medical Mutual of Ohio 1k2-93cg-x773	**ODR**	Table 4 is used to report organization determinations classified as Direct Member Reimbursements (DMR). By definition a DMR claim is one in which the enrollee	Can consideration be given to changing the criteria for Table 4 to include all claims paid to an enrollee regardless of whether	We have updated data elements to provide clarification.	Yes

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		has paid a healthcare related expense for which they are seeking reimbursement under the provisions of the health care coverage. The lack of a standard reliable way to identify a DMR claim using information available on a HCFA 1500 claim form requires a manual review of all claims from the universe of claims that are potential DMR claims, i.e. non-electronic and paid to the enrollee It would make the reporting effort more straightforward and eliminate the manual intervention required today. The revised approach would still capture all the DMR Claims as they are defined today. The only difference would be it would capture any additional claim paid to an enrollee which was not submitted for the purpose of seeking reimbursement.	reimbursement is being sought?		

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Medical Mutual of Ohio 1k2-93cg-x773	**O/D R**	The 2019 reporting requirements request totals for claims and services submitted by enrollee vs provider. There is no data element on the HCFA 1500 claim form which allows for the classification of the submitter as the enrollee or provider. We do not currently track the claim submitter by classification of any kind. A manual process would also be subject to error.	We respectfully request CMS reconsider the requirement to classify claims and services by submitter. As currently designed the process to meet this requirement would be manual and therefore place an undue burden on our plan.	This data is currently collected during audits as well as the timeliness monitoring project. This data is important because there are different appeal rights and different appeal paths. It will also show better alignment with the Independent Review Entity (IRE) data.	No
Anonymous- 1k2-93ci-kxfj	**O/D R & Grievances (MMPs)**	Regulations. Page 2 of the Part C 2019 Crosswalk indicates that MMP plans will no longer be required to report data specific to ODR and Grievances under Part C reporting.	Will Pre-service Determinations be required as a new requirement within 2019 MMP Core Reporting?	Under Core Measure 4.2, MMPs are to report all non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals. They should not include pre-service coverage decisions in the measure. MMPs seeking technical guidance for reporting Core Measure 4.2, may contact MMCOCapsReporting@cms.hhs.gov.	No

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Tufts Health 1k2-93ci-x37b	**ODR**	There are currently multiple elements assigned to each letter (A, B, C, etc.). For example, "Total Number of Organization Determinations Made in the Reporting Period Above" would be 1A and "Number of Organization Determinations – Fully Favorable (Services) – Contract Provider" would be 2A and "Total number of Reconsiderations Made in Reporting Time Period Above" would be 3A. 6-8	CMS is asked to add subsection numbers to differentiate the lettered elements.	Please see revised document for clarification.	Yes
Tufts Health 1k2-93ci-x37b	**ODR**	We ask CMS to clarify whether Part B claims should be included in this report. If yes, does that include Part B drugs that are rendered at the point of sale without prior authorization required?		Thank you for your comment. We are reviewing this issue and will provide guidance in the Part C Tech Specifications.	No
Tufts Health 1k2-93ci-x37b	**ODR**	Element G: Number of Organization Determinations submitted by provider (claims) 6 We ask CMS to clarify whether the pharmacy		Thank you for your comment. We are reviewing this issue and will provide guidance in the Part C Tech Specifications	No

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		should be considered the provider (submitter) for Part B claims rendered at the point of sale without prior authorization. - For Part B drugs rendered at a pharmacy, we ask CMS to clarify whether plans should report contract versus non-contract provider according to whether the rendering pharmacy is contracted with the plan/PBM.			
Tufts Health 1k2-93ci-x37b	**ODR**	For pre-service organization determinations, there are circumstances where a contract provider requests services on behalf of a member to be rendered by a non-contracting provider.	We ask CMS to clarify whether plans should report these requests according to the requesting provider (contracted) or according to the servicing provider (non-contracted)?	We have updated the data elements to address this question.	Yes

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Tufts Health Plan 1k2-93ci-x37b	**ODR**	A request might be received from a contracting provider on 1/28. The request is approved on 2/2, but the provider's contract was terminated on 1/30; on 2/2 the submitting provider is no longer in our network. Would this be reported as a contract or non-contract organization determination?	We ask CMS to clarify whether plans should report the provider's status (non/contract) as of the date the request was received **or** as of the date the request is authorized/denied?	The plan must determine under which data element this request should be reported because it is based on how the plans process such a request.	No
United Health Care 1k2-93cj-v4mw	**ODR**	United seeks clarification regarding the number of reconsiderations submitted by provider (claim) because contracted provider submissions should be included in the Member/Member Representative submitted totals (element E), whereas non-contracted providers can appeal on their own behalf for claim denials.	We request CMS modify Element G from "Number of Reconsiderations submitted by Provider (Claims)" to "Number of Reconsiderations submitted by *Non-Contracted Provider* (emphasis added) (Claims)."	CMS agrees with this recommendation. We have revised the data element to capture enrollee/representative claims submitted data instead of contract and non-contract provider data.	Yes
United Health Care 1k2-93cj-v4mw	**SNP**	With respect to Special Needs Plans (SNPs) Care Management	United requests that CMS add detail to the technical	Thank you for your recommendations. We will take them into consideration in	No

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		the technical specifications are written at a high level, and Medicare Advantage (MA) Plans would benefit from additional CMS clarification in the technical	specifications to reflect CMS responses to all MA Plan submitted questions and develop FAQs similar to Division of Medicare Advantage Operations (DMAO) Mailbox FAQs to aid in consistent interpretation of the technical specifications	developing future Qs and As for Part C Reporting.	
United Health Care 1k2-93cj-v4mw	**SNP**	"The Health Risk Assessment (HRA) Measure - C08" compares the number of initial and annual HRAs performed to the total number of eligible enrollees. The measure includes beneficiaries who refuse or decline outreach in the total number of eligible enrollees. By including "refusals," MA Plans are penalized for respecting beneficiaries' desire not to be contacted. This negatively impacts the overall beneficiary experience. Therefore,	Therefore, United recommends that CMS remove beneficiaries who refuse to complete an HRA, or decline outreach, from the denominator**.**	Any changes to a Star Ratings measure needs to be proposed through the Call Letter and regulatory process.	No

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		United recommends that CMS remove beneficiaries who refuse to complete an HRA, or decline outreach, from the denominator.			
Health Partners 1k2-93ck-10dz	**ODR**	The commenter is referring to the revised reporting format for Part C ODR Reporting. The change will result in the updating the labeling of elements in each subsection to the same lettering format that is consistent with Part D Reporting.	They request CMS consider including differentiation in the alpha format to separate each subsection as they all start with the letter "a" and are not differentiated with any numerical values.	Please see revised document for clarification.	Yes
Health Partners 1k2-93ck-10dz	**ODR**	Recommends that CMS consider changing Reporting Section II - Part C Organization Determinations to a file upload from a data entry submission to be consistent with Part D Reporting.	Consider changing Reporting Section II - Part C Organization Determinations to a file upload from a data entry submission.	Thank you for your comment. This will go into development for CY 2019 Plan Reporting Module.	No
MMM Healthcare (PR) 1k2-93cm-fg8x	**ODR**	The commenter is requesting clarification regarding the definition of contracted provider. Regarding the new elements for Organization Determinations (A-L) and for		A contract provider is a provider with which an MA organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an	No

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		Reconsiderations (A-L) - the contractor is requesting clarification regarding the definition of contracted provider. For claims, does the term contracted provider means the billing provider or the provider that rendered the service? For authorization requests, Does it referred to the requesting provider or the provider that will render the service? In addition, we understand that additional clarification must be included to address the scenario when a Contracted provider is cancelled, and was active with the Plan only for a short term (e.g. 2 months) during the reporting period.		MA coordinated care plan or network PFFS plan. For claims it is based on who submits the claim; who is requesting reimbursement. For authorization, it refers to who is requesting the service.	