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Medicare Part D Reporting Requirements (CMS-10185)

Comment On: CMS-2013-0056-0001
Medicare Part D Reporting Requirements (CMS-10185)

Document: CMS-2013-0056-DRAFT-0001
CT

Submitter Information

Name: Lori Hughes
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General Comment

Relative to the new MTM Program reporting element Y, please clarify if CMS will provide categories of items discussed in the CMR or if individual plans may create definitions for use in reporting.

Comments for the Draft 2014 CMS Medicare Part D Reporting Requirements				
Comment/Response From: SilverScript Insurance Company (contract S5601) & Pennsylvania Life Insurance Company (S5803 and S5825)				
Contact Person's name: Dena Rus				
Email: dena.rus@caremark.com Phone 480-391-4343				
Document Title	**Page Number**	**Section Title**	**Specific Text from Document that is being commented upon**	**Comment (remember we are looking for comments to provide to CMS)**
2014 MEDICARE PART D REPORTING REQUIREMENTS	10	Section III. Medication Therapy Management Programs	H. Long term care (LTC) facility resident (at time of MTM program). (Y (yes), N (no), or U (unknown)).	CVS Caremark recommends that CMS clarify the verbiage "at time of MTM program" to mean that this should be reported as 'Y' if the beneficiary is a resident of an LTC at the time the beneficiary is first enrolled in the MTM program.
2014 MEDICARE PART D REPORTING REQUIREMENTS	10	Section III. Medication Therapy Management Programs	I. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer. (Y (yes), N (no), or U (unknown)).	We ask that CMS clarify that sponsors may make this identification either at the time the beneficiary is contacted to be offered the CMR or during delivery of the CMR, i.e., that reporting 'Y' for an identification made at either time would be considered acceptable.
2014 MEDICARE PART D REPORTING REQUIREMENTS	12	Section III. Medication Therapy Management Programs	Y. Topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. (If more than 1 topic discussed, up to 5 topics will be allowed to be reported.) These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under 'What we talked about'. Required if received annual CMR.	We are concerned that the interpretation of 'topics discussed' may be extremely broad, and today may be captured in a single free text field on the forms, which would not lend themselves to the parsing of the information into multiple topics, or to determine how to identify topic changes within the text. Additionally, it would leave it up to the provider to interpret what information to supply, which might be random information, possibly unimportant or unclear, or even be indecipherable if context and proper punctuation is not supplied. CVS Caremark strongly recommends that CMS provide a values list of specific topics for data in which you are interested. Such a list would enable the sponsors to gather more meaningful information, would be standardized and much easier for the providers, the plans and CMS to interpret.

Document Title	Page Number	Section Title	Specific Text from Document that is being commented upon	Comment (remember we are looking for comments to provide to CMS)
2014 MEDICARE PART D REPORTING REQUIREMENTS	16	Section V. Grievances	"Expedited Grievance"	CVS Caremark's understanding is that an expedited grievance is defined as a grievance that "involves refusal by a Part D Sponsor to process an expedited coverage determination or redetermination" request. However, the structure of the reporting grid on page 16 provides a column for "Number of Expedited Grievances" that suggests that expedited grievances may arise in any of the grievance categories listed, which is not the case. Therefore, to avoid confusion, CVS Caremark recommends that the reporting grid be modified to make clear that this data element would not be applicable in situations other than coverage determinations or redeterminations. Also, please confirm that the Expedited Grievances reported in the second column and the grievances with Timely Notification in the third column are subsets of the number of grievances we would report in the first column.
	16	Section V. Grievances	For reporting, Sponsors should: ... Report those grievances that may have also been reported in the Complaints Tracking Module (CTM). VERSUS For reporting, Sponsors should not: Report complaints received by 1-800 Medicare or recorded only in the CTM as grievances.	CVS Caremark requests that CMS clarify these requirements as these two statements appear to contradict one another, the first indicating to include grievances reported in the CTM, and the second to exclude grievances reported in the CTM.

Document Title	Page Number	Section Title	Specific Text from Document that is being commented upon	Comment (remember we are looking for comments to provide to CMS)
2014 MEDICARE PART D REPORTING REQUIREMENTS	26	Section X. Plan Oversight of Agents	B. Agent/Broker Type.	CVS Caremark requests that CMS provide a list and explanation of each of the specific Agent/Broker types since plans may have different definitions.
2014 MEDICARE PART D REPORTING REQUIREMENTS	26	Section X. Plan Oversight of Agents	I. Agent/Broker Licensed Date.	CVS Caremark recommends that Item 'I' be stated as "Agent/Broker State License Expiration Date" because state databases do not consistently display date first licensed. Item 'J' requests the Appointment Date so proof would be provided that the person was licensed at time of appointment.
2014 MEDICARE PART D REPORTING REQUIREMENTS	27	Section X. Plan Oversight of Agents	M. In aggregate, the number of Agent/Broker complaints for the reporting period.	CVS Caremark recommends that Item 'M' be clarified to explain whether this information will be reported by Agent/Broker by State or whether the information will be reported in one field per Agent/Broker inclusive of all states.
2014 MEDICARE PART D REPORTING REQUIREMENTS	27	Section X. Plan Oversight of Agents	N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc.	CVS Caremark recommends that Item 'N' be clarified to explain whether this information will be reported by Agent/Broker by state or whether the information will be reported in one field per Agent/Broker inclusive of all states.
2014 MEDICARE PART D REPORTING REQUIREMENTS	27	Section X. Plan Oversight of Agents	R. The number of new enrollments in the reporting period.	CVS Caremark recommends that Item 'R' be clarified to explain whether this information will be reported by Agent/Broker by state or whether the information will be reported in one field per Agent/Broker inclusive of all states.

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Medicare Part D Reporting Requirements (CMS-10185)

Comment On: CMS-2013-0056-0001
Medicare Part D Reporting Requirements (CMS-10185)

Document: CMS-2013-0056-DRAFT-0003
NC

Submitter Information

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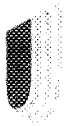
General Comment

About CMS Form 64
Confused by the use of Medical Assistance Program. Is this a separate program from Medicaid. Since Medicaid provides medical assistance to individuals in certain income bracket. Also overages should be sold to private insurers. People who are a higher on the income scale and aren't totally dependent financially on public benefits. This might allow more direct attention to Medicaid accounts that need it.

COMMENTS FOR THE DRAFT 2014 MEDICARE PART D REPORTING REQUIREMENTS	
Section Title	Comments
Plan Oversight of Agents	
	We would like more detail regarding CMS's expectation for "B. Agent/Broker Type". Is there a list of types that CMS is expecting plans to use, or are the only two types "employed" or "independent"? If there are more than the two noted types, what are the types and how are they defined? When agents are licensed in multiple states and if the plan is only selling a product in one state, is it necessary to provide the licenses for all other states the agent could be licensed in, or only the applicable state corresponding to the plan service area? We would like more detail regarding "agent/broker appointment date". Is this the hire date of the agent, or date in which they completed training and testing and began selling, or something else? We would like more detail regarding CMS's expectation for "Q. Third-party Marketing Organization (TMO)/Field Marketing Organization Name (FMO)". If a plan does not use TMO or FMO, that plan would report zero, correct? We would like more detail regarding CMS's expectation for "H. Plan assigned agent/broker identification number". We are unaware of a regulation that requires plans to assign numbers to brokers/agents. Therefore, if a plan does not assigned agent/broker identification numbers, what is CMS expecting plans to submit?
Coverage Determinations and Redeterminations	
	In the 2013 reporting requirements and technical specifications, CMS requested individual data elements for Step Exceptions, PA Exceptions, and Quantity Exceptions rather than one group CMS asked for specific breakdown. In the draft 2014 reporting requirements and technical specifications it appears CMS going back to one data element for all exceptions. Would CMS be able to explain why they are considering this change when these exceptions were reported separately in 2012, then combined for 2013 and now appear to be separated again in 2014?



UnitedHealthcare®

Michael Breher
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To: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

From: Michael Breher
UnitedHealthcare Medicare & Retirement
UnitedHealth Group

Date: 5/14/2013

Re: Medicare Part D Reporting Requirements

In response to CMS' request for feedback regarding Medicare Part D Reporting Requirements at 78 Fed. Reg. 16508, amending Title I, Part 423, § 423.514, UnitedHealthcare is providing the attached comments. These comments are provided on behalf of UnitedHealthcare Medicare & Retirement and other UnitedHealth Group affiliates, including UnitedHealthcare Community & State and XLHealth, that manage Medicare Advantage and Part D business (collectively "United").

We greatly appreciate the opportunity to comment, and we look forward to continuing to work with CMS to develop successful products and services for Medicare beneficiaries. If there are any questions or concerns about our comments, please contact me at 952-931-5121 or via email at Michael.Breher@uhc.com.

Medicare Part D Reporting Requirements
Comments Submitted by
UnitedHealthcare
3/17/2013

Section VI. Coverage Determinations and Redeterminations

1. **Generally**
   This section will require significant system enhancements to report on the Reopenings data elements. If CMS intends to adopt the reporting of these data elements for 2014 reporting year, we recommend that the reporting requirements be finalized well in advance of the 2014 reporting year so that the plan can adopt and implement the changes to facilitate this reporting. Alternatively, the Plan recommends that CMS finalize the rule in 2014 but implement the reporting of the Reopenings data elements for the 2015 Reporting year. (Reopenings can be initiated by a Part D Sponsor for any reason within one year from the coverage determination, within 4 years if "good cause" is found (defined at 120.3) or at any time if there is reliable evidence of fraud or a material clerical error.)

Section X. Plan Oversight of Agents

2. **Generally**
   Regarding the requirement that: "For each agent that received compensation in the reporting period (initial enrollments and renewal payments received), indicate.." Is this every agent that received compensation in 2014 regardless of when the application was submitted or what the effective date is? We recommend that the requirement the reporting period is based on effective dates in 2014. We also suggest that compensation be defined as commission and salary?

3. **B. Agent/Broker Type.**
   We request that CMS provide a list of expected agent/broker types.

4. **H. Plan Assigned Agent/Broker Identification Number.**
   Can CMS provide clarification if this should be 1:1 agent to ID number, specifically, will there be a distinct requirement which will determine which agent ID to use.

4. **K. Agent/Broker Training Completion Date.**
   We request CMS provide a definition of training courses to be considered for reporting Training Completion Date.

5. **L. Agent/Broker Testing Completion Date.**
   We request CMS provide a definition of tests to be completed to be considered for reporting Testing Completion Date

6. **M. In aggregate, the number of Agent/Broker complaints for the reporting period.**
   Certain complaints are not tied to a plan member and therefore would not be tied a CMS contract; therefore, we suggest that these type of complaints would be to excluded from reporting.

7. **N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc.**
   The term "related to Marketing" is quite broad. We recommend that CMS provide additional clarification on the scope of "marketing" related complaints.

8. **O. Agent/Broker Termination Date (if applicable).**
   Can CMS clarify if terminations reported would be related to complaints only? Also, should voluntary terms and layoffs be excluded?

May 14, 2013

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: 2014 Medicare Part D Reporting Requirements
CMS -- 10185
Agency Information Collection Activities: Proposed Collection; Comment Request

To Whom It May Concern:

Express Scripts appreciates the opportunity to comment on the Medicare Part D Reporting Requirements as published in the *Federal Register* on March 15th. Headquartered in St. Louis, we provide integrated pharmacy benefit management services including pharmacy claims processing, home delivery, specialty benefit management, benefit-design consultation, drug-utilization review, formulary management, medical and drug data analysis services, as well as extensive cost-management and patient-care services. We currently support many plan sponsors that have a direct contract with CMS via a prescription drug plan (PDP) or Medicare Advantage (MA-PD) benefit, as well as run our own prescription drug plan (PDP). We take an active and consultative role with these plan sponsors to ensure their Medicare solutions are comprehensive, compliant, and aligned with their beneficiaries' needs. We strive to provide the best possible support to our plan sponsors and patients to ensure optimal performance.

We appreciate that CMS has asked for comments on information collection activities. We respectfully provide the following comments and recommendations for your consideration:

General Comments:
As a Pharmacy Benefit Management company, we provide the required reporting for the Part D Plans Sponsors that we support. In addition to the data we extract and provide to Part D Sponsors and the rigor associated with ensuring the most accurate information for them to provide to the CMS, there are many additional levels of report detail that we are faced with providing to ensure that the Sponsors have the appropriate level of oversight in our operations and information. All of the extra reporting necessary in support of the documented requirements is likely not being captured in the burden estimates provided.

Grievances/Coverage Determinations and Redeterminations (previously Exceptions):
This area of the required reporting has historically been subject to churn. Year over year changes have been applied and in many cases do not appear to add value and in fact, could detract from a sponsor being able to perform an adequate level of comparison of

their performance across contract years. While many of the changes appear to not impact the 'intent' of the report, the reformatting and changing definition all require close attention and review by a wide audience to ensure that the most accurate, complete and truthful information is officially provided in the timeframes required.

Medication Therapy Management:

General: Since 2006, there has been a 500% increase in the number of elements reported for MTM. In addition, reporting elements are now at the beneficiary level versus the contract level. As reports cannot be generated until the close of the period and multiple entities are checking the data's accuracy (i.e. vendor, PBM, Sponsor) to ensure it passes the rigors of data validation, it seems reasonable to push back the due date of these reports to allow sufficient time to generate and check.

Long-term Care Status: While the LTC status should be determined for the beneficiary during their enrollment in the MTM program, it is not clear from "at time of MTM program" if the process for establishing LTC status is determined by "at any time during" or "for the entire time of" MTM participation. In addition, as CMS is aware of LTC status through the LTI report, we do not feel it should be required in the MTM reporting.

"What we talked about" (Element Y): It is not clear what CMS plans on learning from the collection of recommendation level detail. One significant way value can be shown from an MTM program is through its ability to produce medication changes which is already being captured in the reporting elements. While a CMR is an important component of an MTM program, it is just one component. Data gathered from the MMC's comprehensive multi-faceted program has shown that the majority of therapy changes occur through the TMR process given the targeted aspect of the intervention. Also, with the relatively low CMR engagement rate and understanding that the majority of medication recommendations occur outside of the CMR – it seems unreasonable to believe any value could come from reporting only up to 5 recommendations on the MTM members that actually receive a CMR (and still not knowing which of those 5 were actually accepted or not). This element would also be a free text element which further limits its utility. Additionally, it is our belief that this element would go against CMS' stated reporting requirements on page 3 by:

- Pushing the administrative burden beyond "minimal"; with every additional administrative requirement, MTM providers spend less time in patient care; reporting needs to be contained to only those elements that are necessary and useful so MTM can focus on the patient care aspect of MTM and not the administrative part of MTM.
- Utility of data element – as described above, we do not see the value CMS will receive from this information from a small subset of the MTM population.

We recommend proposed Element Y be removed from the CY2014 requirements.

Thank you for the opportunity to comment on the Medicare Part D 2014 Reporting Requirements. We appreciate the opportunity to share our views with you. Please don't hesitate to contact us if we can be of any assistance.

EXPRESS SCRIPTS®

Sincerely,

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May 14, 2013

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10185 (OMB# 0938–0992)
Room C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS–10185 (OMB#: 0938–0992)

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice under the Paperwork Reduction Act concerning the "Medicare Part D Reporting Requirements" published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register (78 FR 16508) on March 15, 2013. The draft CY 2014 Part D reporting requirements are of significant interest to AHIP's member organizations, many of which participate in the Medicare Part D Prescription Drug Benefit (Part D) program. Our comments appear below.

COMMENTS

Section III. Medication Therapy Management Programs (Pages 10 - 12)

- *Data Element Y.* CMS is proposing to add a new data Element Y, which would require sponsors to report for each beneficiary the topics discussed during the Comprehensive Medication Review (CMR), including the medication or care issue to be resolved or behavior to be encouraged. We believe that the addition of examples to illustrate the approach plans should take in summarizing the topics would promote a common understanding of the agency's expectations for reporting, and recommend that CMS include this information and any other explanation that may be appropriate in the next version of the draft Reporting Requirements and/or in the related Technical Specifications.

Section V. Grievances (Pages 15 – 16)

- *Grievances Related to CMS Issues Row.* We note that the current version of the CMS Part D Plan Reporting Requirements Technical Specifications includes details such as

definitions, examples and methods for calculations for each data category under the Grievances reporting section, with the exception of the category related to "CMS Issues." We believe that additional information about the category would promote a common understanding of the agency's expectations for reporting. Accordingly, we recommend that CMS provide in the Technical Specifications a definition of this category and examples.

- ***Number of Expedited Grievances Column.*** CMS is proposing to require sponsors to report for each grievance category, the number of grievances that were expedited. However, in the Prescription Drug Benefit Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals, Section 20.3 – Procedures for Handling a Grievance, the guidance indicates that an expedited grievance is available when a Part D plan sponsor has refused to grant a request for an expedited coverage determination or an expedited redetermination, and the enrollee has not received the drug in dispute. In light of this requirement, it appears that expedited grievances may only be associated with the Coverage Determination and Redetermination Process Grievances row. For clarity and to ensure consistency in reporting, if the Number of Expedited Grievances Column is not intended to apply to all rows, we recommend that CMS revise the chart of data to be reported to indicate the rows to which it applies. If the column is intended to apply to all rows, we recommend that CMS include in the next version of the draft Reporting Requirements and/or in the related Technical Specifications an explanation of how this reporting category applies to each row and include examples.

Section VI. Coverage Determinations and Redeterminations (Pages 17 – 19)

- ***Reopenings.*** CMS is proposing to add a new category under this section of the Reporting Requirements related to "Reopenings." Sponsors would be required to report the total number of reopened decisions in the specified time period and for each case that was reopened, would be required to upload in a data file, 10 data elements. It is our understanding that due to the scope of the proposed elements, sponsors may need to implement considerable systems enhancements to ensure compliance and will need sufficient time following issuance of the final reporting requirements to do so. We note that on page 3 of the CMS Supporting Statement, CMS states that a final Part D reporting requirements document will be delivered for OMB review by October 14, 2013. We understand that this anticipated timing would not be sufficient for sponsors to complete the necessary systems development for implementation in 2014, and we recommend that CMS defer implementation of the "Reopenings" category until 2015.

Section X. Plan Oversight of Agents (Pages 26 – 27)

1. **Agent/Broker**

- ***Definition of "Received Compensation".*** Under the "Agent/Broker" category, CMS is proposing to require sponsors to report a number of data elements for each agent that "received compensation in the reporting period (initial enrollments and renewal payments received)". We understand that an agent/broker may earn compensation associated with an enrollment submitted in a particular month but may not receive payment until three months have elapsed as a safeguard against rapid disenrollment. In these circumstances, it is not clear whether CMS intends the phrase "received compensation" to encompass compensation that has been "paid" to the agent/broker during the reporting period or compensation that has been "earned" by the agent/broker during the reporting period but paid to the agent/broker in a subsequent reporting period. To ensure sponsors have a consistent understanding of how the agency is defining the phrase, AHIP recommends that CMS include an explanation that addresses this issue in the next version of the draft Part D Reporting Requirements and/or in the related Technical Specifications.

We have appreciated the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues we have raised. I can be reached at (202) 778-3209 or cschaller@ahip.org.

Sincerely,

Candace Schaller
Senior Vice President, Federal Programs