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#3

Contract Year 2008 Reporting Requirements				
Comment / Response Form				
Contact Person's Name: Tim Hughes, Compliance Officer, Sun Health MediSun				
Email: tim.hughes@sunhealth.org Phone: (623) 974-7441				
Org Name	**Section**	**Page #**	**Description of Issue or Question**	**Suggested Revision/Comment**
	I-Retail, Home Infusion, and Long-Term Care Pharmacy Access	5	This report captures the pharmacy networks to ensure access standards are being met.	Because plan sponsors must attest each year to the adequacy of their network and because pharmacy networks are required to accept any willing provider, an additional mid-year report may prove administratively burdensome and unnecessarily redundant to the Plan Sponsor.
	I-Retail, Home Infusion, and Long-Term Care Pharmacy Access	5	This report captures the pharmacy networks to ensure access standards are being met.	The reports' due dates correspond with reports required for Plan Sponsors making significant changes to their pharmacy network. In February of 2009, we will be reporting 2008 data as well as 2009 data for new and existing clients with changes. This provides enormous administrative overhead with little value to the data. Although we would prefer that this report not be a requirement, if CMS feels that this report is necessary, please consider alternate dates (run in March or April).
	IV-Reversals	9	This report looks at information related to claim reversals.	We request CMS explicitly define final disposition.
	IV-Reversals	9	This report looks at information related to claim reversals.	Should we be including RetroLICS reversals in this report since they were not generated by pharmacies?
	V-Medication Therapy Management Programs	10	This report verifies Plan Sponsor's MTM programs are meeting CMS requirements.	We would like to request clarification on whether we are able to count someone as pended if contact was attempted, but the individual never responded to the program. Alternatively, can the member be considered declined?
	V-Medication Therapy Management Programs	10	This report verifies Plan Sponsor's MTM programs are meeting CMS requirements.	We recommend reporting data element J during both reporting periods instead of suppressing it during the second period. Because of our and many other PBMs' current reporting setup, allowing suppression of the element on one report but not another would result in additional developmental costs and hours, making this modification administratively burdensome.
	VII-Home Infusion Utilization	14	This report tracks home infusion drug utilization.	We feel that the data CMS is looking for is already available through the PDE. The addition of a second report with the same information would require both CMS and Plan Sponsors to spend time and resources checking the report and cross referencing it to the PDE. Also, it is difficult to track home infusion drugs, and there is no apparent need for the report.
	VIII-Grievances	15	This report tracks the amount and types of grievances received by the Plan Sponsor.	Please clarify in final guidance if data element L should contain LIS grievances found in data element M.
	X-Transition	18	This report looks at the minimum CMS Transition Requirements.	We fully support the updated Transition Report. It is necessary for Plan Sponsors to report how they are meeting the CMS requirements.
	XV-Long-Term Care (LTC) Rebates	25	This report discloses rebates or other price concessions received by LTC network pharmacies.	Because information on LTC rebates will not change from network to network or Sponsor to Sponsor, we recommend LTC Rebate Reports on all PBMs be provided to CMS by Smith Premiere. LTC Networks are created at a national level, and the report should be given at the national level. We believe that receiving this information from a single source would reduce or eliminate duplicate work for both CMS and plan sponsors..
	XVII-Drug Benefit Analysis	30	This report discusses the way a Plan Sponsor provides their benefits to the beneficiary.	Providing monthly reports will be a better way to ensure plans are providing their benefits correctly.
	XVII-Drug Benefit Analysis	30	This report discusses the way a Plan Sponsor provides their benefits to the beneficiary.	We recommend CMS please state that the plan should use their benefit design, not the standard benefit.
	XVII-Drug Benefit Analysis	30	This report discusses the way a Plan Sponsor provides their benefits to the beneficiary.	It is stated how to proceed if the standard benefit is absent, but not when the benefit design is different. We recommend CMS explicitly state how plans with coverage gaps that differ than the standard defined benefit or different deductible limits should report.
	General Comment		General Comment	Historically, the FAQ documents have included important information and certain requirements for compliance. For example, the 4/26/2006 FAQ originally contained the exclusion of Part B drugs which was not specified in the original reporting requirements. We recommend including any FAQ clarifications into upcoming releases of the Reporting Requirements.
	General Comment		General Comment	While we disagree with the inclusion of these requirement in FAQs, it is imperative that Plan Sponsors have visibility to any updates, and these updates should be submitted through HPMS.

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Contract Year 2008 Reporting Requirements				
Comment / Response Form				
Contact Person's Name: Lydia Nesemann, Director of Clinical & Part D Services, Sun Health MediSun				
Email: lydia.nesemann@sunhealth.org Phone: (623) 974-7474				
Org Name	**Section**	**Page #**	**Description of Issue or Question**	**Suggested Revision/Comment**
	I-Retail, Home Infusion, and Long-Term Care Pharmacy Access	5	This report captures the pharmacy networks to ensure access standards are being met.	Because plan sponsors must attest each year to the adequacy of their network and because pharmacy networks are required to accept any willing provider, an additional mid-year report may prove administratively burdensome and unnecessarily redundant to the Plan Sponsor.
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