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November 12, 2021

William N. Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Notice of Proposed Collection [CMS–10305] Agency Information Collection – 2022 Medicare Part C and Part D Reporting Requirements – Data Validation

Dear Director Parham,

Thank you for the opportunity to submit comments in response to the Center for Medicare & Medicaid Services' (CMS) information collection request, specifically the agency's collection of information related to the Medicare Part C and Part D Data Validation Audit (DVA), published at 86 *Federal Register* 57,571 on October 14, 2021.

CVS Health serves an estimated 39 million people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses, and nurse practitioners. Our unique health care model gives us an unparalleled perspective on how systems can be better designed to help consumers navigate the health care system – and their personal health care – by improving access, lowering costs, and being a trusted partner for every meaningful moment of health. And we do it all with heart, each and every day.

We would like to submit the following comments regarding the frequency of DVAs and the proposed changes to CMS information collection in connection with DVAs for 2022.

I. Change Frequency of MA Data Validation Audits for High-scoring Plans

The DVA is designed to validate that the information we and other health plans provide in our Part C and D reports is accurate. CVS Health understands the importance of accurate reporting, which is relied upon by CMS and Congress for oversight purposes. The DVA was unquestionably necessary when initially provided for in law, but in recent years few plans have scored less than 100%. This is not a question of rigor, rather it shows that MA plans are providing accurate information. Currently, CMS requires that health plans hire an external independent auditing firm to conduct these audits, which is a costly annual administrative expense that diverts health plan resources away from the administration of benefits for our members.

CVS Health is subject to a host of annual audits, and the volume of annual CMS oversight activities—audits, reviews, validations, and others—has dramatically increased over the past few years. While smaller plans with few contracts may not be subject to all these oversite activities every year, CVS Health is subject to the majority. Further, the impact of these audits are intensified because samples for many of them are selected at the contract level, not at the parent organization level. During 2021, CVS Health-sponsored Medicare plans have been subject to over 25 different CMS audits. In addition, CVS Health has supported 45

health plan clients in over 600 CMS audits during the same period. Again, as stated above, CVS Health must divert critical resources to these audits that would otherwise be used to care for our members.

- ***Recommendation:***
  - *For plans that consistently scored above 98% to 99% over the previous three years, require the DVA less frequently, e.g., every three years; and*
  - *For those plans that do not score as well, continue to audit, annually.*

II. Comments on CMS–10305 "Medicare Part C and Part D Data Validation"

Document Title	Page Numbers	Section Title	Specific Document Text for Comment	Comments
2022 Medicare Part C and Part D Reporting Requirements - Appendix B Data Validation Standards	32	Improving Drug Utilization Review Controls	RSC 8-biii: Includes all coverage determination or appeal requests subject to the opioid naive edit specific to the same drug and date.	**Appendix B and Appendix J criteria do not match for RSC8biii.** Appendix B states "RSC 8-biii: Includes all coverage determination or appeal requests subject to the opioid naive edit specific to the same drug and date." And Appendix J states "RSC 8biii: Includes all coverage determination or appeal requests subject to the opioid naive edit."
2022 Medicare Part C and Part D Reporting Requirements - Appendix J Part D DUR	5	N/A	RSC 8biii: Includes all coverage determination or appeal requests subject to the opioid naive edit.	**Appendix B and Appendix J criteria do not match for RSC8biii.** Appendix B states "RSC 8-biii: Includes all coverage determination or appeal requests subject to the opioid naive edit specific to the same drug and date." And Appendix J states "RSC 8biii: Includes all coverage determination or appeal requests subject to the opioid naive edit."

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Thank you for the opportunity to comment on these important issues. We would be happy to respond to any follow-up questions you may have.

Sincerely,

Melissa Schulman
Senior Vice President
Government & Public Affairs

cc: Chanelle Jones, CMS