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Information Collection Requirements Notification for Medicare Part C and Part D Reporting Requirements Data Validation

E2332 – National Rural Electric Cooperative Association

General Comments on the 2010 Data Validation Requirements

* We recommend that CMS allow PBMs that use common systems with identical parameters and processes and provide similar services and reports to multiple Part D plans, that the PBM be able to obtain one data validation audit for each of their systems and processes and report the audit results to each of their Part D plans. We believe that where the parameters and processes are identical, a single audit across the systems and/or the plans the PBM serves should satisfy the Data Validation requirements for all Part D plans served by the PBM. Allowing for this provision would greatly improve efficiencies for CMS, Part D plans and PBMs.  Upon completion of such an audit, the PBM could provide the plans with a “audit certification number” to provide to their data validation auditor or for use in HPMS if tracking such information is required We agree, that to the extent that a Part D plan has other data systems or processes that support the CMS reports, that a Part D plan would need obtain specific data validation testing and auditing.
* We recommend that the timeline be moved to May through July 2011 as Part D plans will be handling the First Quarter 2011 reporting and PDE submission from March through May. In addition, because the final criteria for hiring a data validation auditor will not be released until fall 2010, it is going to be very difficult to prepare an RFP and get an auditor retained and have them complete their audit in the March to May timeframe. A shift to a May through July would streamline the activity required throughout the plan year for our plan.

Comments on the Sampling Instructions for Data Validation Contractors

* Please confirm in the final instructions how long the sponsor or PBM needs to retain interim and final stage data sets after the report is generated.
* Page 5 - Section 3.1 - In regards to the statement that “one sample must be randomly drawn from pooled data from all contracts”.

Our reporting is currently created by contract and pooling the contracts together will likely require significant database development because the current design for the reporting databases purposefully keeps the contract data separated. We believe that pooling multiple contracts will create a significant burden on us as a plan sponsor and on our PBM.

Comments on Appendix 3: Medicare Part C and Part D Measure Data Validation Standards

* There appear to be discrepancies between the 2010 Data Validation Standards and the 2010 Reporting Requirements. These appear to be requirements that were suspended, removed or changed from prior reporting requirements and technical specifications and are no longer applicable for 2010. Below you will find the areas that do not correspond with each other:
  + Page 35 - Section 3.3 Grievances - Measure Specific Criteria section  (Data Elements C & D) - 6.c. If a beneficiary files a grievance and then files a subsequent grievance on the same issue prior to the organization’s decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.

This Data Validation Standard measure is different from the approved and distributed Reporting Requirements and Technical Specifications. The 2010 Reporting Requirements, Section VII: Grievances, page 16 states “Multiple grievances by a single complainant should be tracked, followed, and reported as separate grievances.” The 2010 Reporting Requirements and the Technical Specifications do not say to combine complaints on the same topic into one grievance. We recommend that the Measure Specific Criteria be updated to reflect the actual 2010 Reporting Requirements and Technical Specifications verbiage.

* + Page 37- Section 3.4 Coverage Determinations and Exceptions - Measure Specific Criteria section (Data Element A) - 5. Organization accurately calculates the number of pharmacy transactions, including the following criteria: a. Includes pharmacy transactions with dates of service within the reporting period.

This Data Validation Standard measure is different from the approved and distributed Reporting Requirements and Technical Specifications. The Reporting Requirements document, page 19 states: “A. The total number of pharmacy transactions in the time period above. “ Neither the 2010 Reporting Requirements nor the Technical Specifications state that the transactions were to be included based on a transaction’s date of service for this report.  Only the Data Validation Standards say to use date of service. We recommend that the final Data Validation specifications be updated to indicate that the number of pharmacy transactions counted and reported is to be based upon those claims with a processing date that falls within the reporting period and that the Data Validation Standards match the published 2010 CMS Reporting Requirements and the 2010 Reporting Technical Specifications documents.

* + Page 37 – Section 3.4 Coverage Determinations and Exceptions - 7. Organization accurately calculates the number of coverage determinations and exceptions, including the following criteria: a. Includes all coverage determinations/exceptions with a date of receipt that occurs during the reporting period, regardless of when the final decision was made. This Data Validation Standard measure is different from the approved and distributed Reporting Requirements and Technical Specifications. We recommend that the Data Validation Standards match the published 2010 CMS Reporting Requirements and the 2010 Reporting Technical Specifications documents.
  + Page 37 – Section 3.4 Coverage Determinations and Exceptions - 7. f. Excludes coverage determinations/exceptions that were forwarded to the IRE because the organization failed to make a timely decision on a standard or expedited request.

This is not a stated requirement in the 2010 Reporting Requirements or in the Technical Specifications documents.  We believe was carried over from the 2009 Reporting Requirements and recommend that this requirement be removed from the Data Validation requirements. We recommend that this requirement be removed from the Data Validation requirements.

* + Page 37 – Section 3.4 Coverage Determinations and Exceptions - 8. Organization accurately calculates the total number of PAs requested and approved, including the following criteria: a. Data Element C: Includes all requests for a decision on whether a member has, or has not, satisfied a PA requirement. This section contains the 2009 Reporting Requirements and should be updated to reflect the 2010 Reporting Requirements and Technical Specification information.
  + Page 42 – Section 3.6 LTC Utilization – Measure 7. b. Include all LTC pharmacies that were active in the network for one or more days in the reporting period.

Measure 4b. and 5 b. specify to only include pharmacies that were active on the last day of the reporting period. The CMS guidelines do not state on data elements A, B, C, D & E to include only pharmacies that are contracted as of the last day of the reporting period in any of the elements like the data validation reflects.  The Technical Specifications under element D (only) does state to report: “Any pharmacy that is active in the network for 1 or more days in reporting period should be included.”. We recommend that the Data Validation Standards match the published 2010 CMS Reporting Requirements and the 2010 Reporting Technical Specifications documents