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To: Terry Lied
Centers for Medicare & Medicaid Services
Department of Health & Human Services

From: Barbara Reid
PSMG Regulatory Affairs
UnitedHealth Group

Date: June 18, 2010

Re: CMS-10305 (OMB#: 0938-NEW); *Medicare Part C and Part D Data Validation*
(42 CFR 422.516(g) and 423.514(g))

We have reviewed the *Medicare Part C and Part D Data Validation* collection in response to the notice published in the April 19, 2010 Federal Register (75 FR 20366) and provide the attached comments.

These comments are provided on behalf of Ovations and other UnitedHealth Group affiliates, including AmeriChoice, 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 you have any questions or concerns on our comments, please contact me at 715-834-3329 or via email at barbara_reid@uhc.com.

Medicare Part C and Part D Data Validation
Comments Submitted by
UnitedHealth Group/Ovations
June 18, 2010

1. **Derivation of “Pass” or “Not Pass” Determination, Overall Supporting Statement – Part A, p 5**

Issue: It is unclear how CMS will derive the "Pass" or "Not Pass" determination. In addition, there is no indication what the process will be for correcting an initial “Not Pass” determination.

Recommendation: We recommend clarifying how CMS will derive an overall "Pass" or "Not Pass" determination. For example, will each standard be rated the same or will there be over/under weighting of certain standards? In addition, please clarify if the "Pass" or "Not Pass" determination will be made at the organization or contract level.

We further recommend CMS clarify the process for correcting a "Not Pass" determination.

2. **Data Validation Schedule, Overall Supporting Statement –Part A, pp 10, 13**

a. Annual Validation

Issue: It appears that the cost and total time involved in this data validation audit has been underestimated. The estimates appear to be for a small plan with only a handful of contracts and a single set of systems for delivering CMS reports. Given the number of systems that may be used by larger plans to report on the broad scope of the measures, this places a significant burden on the handful of qualified Audit Contractors to review both the plan and its delegated entities systems and appropriate documentation within the 12 week timeframe.

Recommendation: We recommend that a limited set of reports be validated each year, as CMS had initially planned, with a three year overall schedule. For example, 1/3 of reports would be validated year 1, the next 1/3 in year 2 etc. We further recommend that the Appeals/grievances measure be included in the first set of reports to be validated. Measures with the first reporting due in 2011 should be included in the third validation set.

In the alternative, we recommend allowing a minimum of six months for the validation, which would allow sufficient time for a thorough, quality validation of plan and delegated entities systems, as well as all appropriate documentation.

b. Time of Year

Issue: CMS intends the Data Validation Audits to begin March 1 and occur over a three month time period; however, this is the period in which plans are preparing bids.

Recommendation: We recommend the Data Validation Audit be scheduled in the summer so it does not conflict with Plans' bid development. This will also allow for retrospective data review of the 2010 reports that are not due to CMS until May and August of 2011.

3. **Error Rates and “no” Findings, *Findings Data Collection Forms (All), top right, "Recording Review Findings" and Overall Supporting Statement, Part B, p 15***

Issue: The Review findings instructions indicate that any inaccuracies result in a "no" finding. However, the sampling instructions indicate that the process is designed to "detect error rates of 15% or more."

Recommendation: We recommend clarifying the standard that applies and that auditor(s) have the discretion to determine that negligible errors would not exclude a data element from being met.

4. **Findings Data Collection Form Improvements, *Benefit Utilization Form, p 8 and Employer/Union Sponsored Group Health Plan Sponsors (Part D) Form, p 89***

Issue: On both the Benefit Utilization and Employer/Union Sponsored Group Health Plan Sponsors (Part D) forms, Standard 3.a "Data elements are accurately entered into the HPMS tool..." does not apply. These reports are file uploads.

Recommendation: We recommend marking Standard 3.a as "N/A" on both forms, similar to the manner that the file upload is marked "N/A" for those that are entered via HPMS.

5. **Contract Types, *Organizational Assessment Instrument - General Questions, Section 3.1, p 2***

Issue: Provided in section 3.1 is a list of contract types that includes CCP, SNP, PFFS and Employer/Union "800 Series," etc. However, these types are not mutually exclusive as a contract may be a CCP or PFFS and have some employer group and non-group Plan Benefit Packages (PBPs) within the contract.

Recommendation: Since there is specific reporting for SNPs and Employer/Union plans, we recommend identifying the overall contract type, then indicating under that contract type, if there are SNP or 800 series type plans. To accomplish this, we recommend adding an additional 2 columns to identify underlying plan types (PBPs). "Include SNP?" and "Include Employer/Union "800 Series?" These should then be answered as either Yes or No.