#15

OVATIONS
A UnitedHealth Group Company

WI080-1000
2725 Mall Drive
Eau Claire, WI 54701

To: CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: OMB Control # 0938–New
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

From: Cynthia Polich
Chief Strategy Officer
Ovations/UnitedHealth Group
CA160-0201
3120 Lake Center Drive
Santa Anna, CA 92704

Date: August 22, 2008

Re: Part C Medicare Advantage (MA) Reporting Requirements and Supporting Regulations in 42 CFR 22.516(a)
Form Number: CMS–10261; OMB# 0938–New

We have reviewed the proposed *Part C Medicare Advantage (MA) Reporting Requirements* and provide the following 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 fully support the comments submitted by America's Health Insurance Plans (AHIP) on behalf of the industry and these comments are in addition to those provided by AHIP.

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 714-825-5308 or via email at cindy.polich@phs.com or Barbara Reid at 715-832-5235 or via email at barbara_reid@uhc.com.

Part C Medicare Advantage (MA) Reporting Requirements and Supporting Regulations in 42 CFR 22.516(a)

Comments Submitted by
UnitedHealth Group/Ovations
August 25, 2008

A. Reporting Measure Category #1: Benefit Utilization

Attachment II, p 2; Attachment III, Supporting Statement, p 2 & 3.

1. **Issue**: With few exceptions, the information in Attachment III is identical to that which is collected during the annual bidding process. The proposed process for gathering the majority of the requested data is duplicative.

   Recommendation: It is recommended that CMS incorporate the small amount of additional required data into the bid process by revising the appropriate bid worksheets. In the alternative, rather than duplicate submission of data, CMS should utilize data already provided during the bid process and focus the proposed reporting on gathering the information that cannot be collected via the bid process.

   Rationale: A duplicative process is time consuming for both organizations and CMS and leads to greater administrative expense.

2. **Issue**: It is stated in Attachment II under the Data Elements column that CMS will define the procedure codes and there is no timeframe listed for the provision of the codes.

   Recommendation: It is recommended that the codes be provided as early as possible for review and at the latest, with the subsequent proposed rule which CMS has stated will have an additional 30 day comment period.

   Rationale: Plans will be better able to provide detailed feedback on whether or not the reporting requirements meet the stated objectives once the codes are provided.

3. **Issue**: The following Service Categories listed on Attachment III are not well defined and leave room for varying interpretations by plans on what should or should not be included in reporting them: Hearing (Non-covered), Health & Education (Non-covered) and Other Non-Covered.

Recommendation: We request CMS provide clarification on the Hearing (Non-covered), Health & Education (Non-covered) and Other Non-Covered service categories and recommend that the clarification include that the reporting be limited to benefits filed.

Rationale: Providing clarification on the Service Categories will assure that CMS is collecting a consistent dataset across each of the health plans which will aid in meeting the stated objective of analyzing the use of Medicare Advantage (MA) rebate dollars.

B. Reporting Measure Category #2: Procedure Frequency

Attachment II, p 3; Supporting Statement, pp 3 & 4; DRAFT Procedure, MS-DRG, and Diagnosis Codes for Proposed Calendar Year 2009 Part C Medicare Advantage (MA) Reporting

1. **Issue**: The data being collected for this reporting requirement is very similar to that of the HEDIS reporting requirements, however there are different or additional data elements required and unlike the HEDIS data, it is unaudited data that will be submitted. Also, the data due date of 2/28 of the following year would not allow for the auditing of the data consistent with that done for HEDIS which has a reporting date of June 30th of the following year.

   Recommendation: Because of the similarity to HEDIS data collection, the recommendation for this reporting measure is threefold. First, the criteria for reporting on the data elements should be the same for this reporting measure as it is for HEDIS. In the alternative, the HEDIS crossover measures should be used for the first year of reporting and the additional data elements should be phased into the regular HEDIS reporting in 2010. Second, the due date should be consistent with the HEDIS reporting due date of June 30th of the following year—this would allow for auditing of the data in a manner consistent with that of the HEDIS data and meet the CMS' future objective of auditing the data prior to submission. Third, to assure consistency with HEDIS reporting, the same population requirements currently required by CMS for HEDIS (1,000 members as of July 1st of the measurement year) should be utilized for this reporting measure.

   Rationale: Reporting of this measure in a manner consistent with HEDIS reporting allows plans time to create, test and evaluate the data prior to submission, increasing accuracy of the reporting while decreasing the disruption and burden for plans to submit this data during the critical period of data processing for HEDIS. Incorporation of the reporting measure into the HEDIS process will also reduce the processing time and burden for CMS.

2. **Issue**: The code specifications in Table 1 of the *Revised Draft Procedure, MS-DRG, and Diagnosis Codes for Proposed Calendar Year Part C MA Reporting* are not consistent with the 2008 HEDIS specifications for the following overlapping procedures: Cardiac Catheterization, Total Hip Replacement, Total Knee Replacement, CABG, Mastectomy and Prostatectomy.

   Recommendation: Ensure that the codes utilized for the Procedure Frequency Measures are the same codes specified for established HEDIS measures, i.e., align the Procedure Frequency Measures with the established HEDIS measures.

   Rationale: Aligning the codes with those currently used for the HEDIS measures will improve the consistency of health plans' reported data.

3. **Issue**: The sampling methodology does not specify how the data will be analyzed, for example, whether or not the data will be analyzed by age group.

   Recommendation: If a plan is identified as an outlier, a breakout by population, such as age group or significant illness should be considered, as some procedures are not appropriate for some age groups or illness types.

   Rationale: Lower rates may be appropriate if a plan has a significantly older or more ill population, e.g., transplant rates in a population with an average age of 86.

C. Reporting Measure Category #3: Serious Reportable Adverse Events

Attachment II, p 4; Supporting Statement, pp 4-6; DRAFT Procedure, MS-DRG, and Diagnosis Codes for Proposed Calendar Year 2009 Part C Medicare Advantage (MA) Reporting

Issue: We share AHIP's concern regarding the plan collection of data for Serious Reportable Adverse Events. In addition, it is unclear that this reporting requirement applies only to IPPS hospitals. Also, Serious Reportable Adverse Events may reflect network quality but also may be skewed due to access needs/availability in some geographic areas.

Recommendation: We strongly support the AHIP recommendation regarding the Serious Reportable Adverse Events; it is not an appropriate data collection for MA Organizations (MAOs). Also, it is recommended CMS clarify that the reporting requirements apply to IPPS Hospitals only and cancer hospitals, LTACs, children's hospitals, Maryland Waiver Hospitals and Critical Access

Hospitals, etc., be excluded. In addition, any analysis of the data should incorporate a reflection of geographic access in reporting, e.g., "large metropolitan area" vs. "rural area," or "3 Medicare-participating medical centers and 5 Medicare-participating community hospitals within 30 miles," etc.

Rationale: Serious Reportable Adverse Events may reflect network quality but also may be skewed due to access needs/availability in some geographic areas.

D. Reporting Measure Category #8: Enrollment Verification Calls

Attachment II, p 9

Issue: The equation for determining the canceled enrollments as stated in the Objective/Justification of Attachment II is not clear.

Recommendation: It is recommended that the calculation to verify that MAOs are completing the Enrollment Verification for 100% of the enrollees be:

Total Amount Completed Records (All records where contact was made (Refusal, Completed Survey, Disenroll, etc)) + Total Letters Mailed (All records where we were never able to contact the member (Wrong Ph#, Deceased, Max Attempts etc)) / Total Enrollment in the reporting period based on TRR – enrollments via 1-800 MEDICARE, www.medicare.gov and plan websites.

Defining each of the numbers in the calculation as:

- Total amount of completed records (# of verification calls): all records in which enrollment verification contact was made including Refusal, Completed Survey, Disenroll, etc.)
- Total Letters Mailed: should be all records where plans were never able to contact the member (Wrong Ph#, Deceased, Max Attempts etc) i.e., all records in which the enrollment verification survey was not completed.
- Total Enrollment in reporting period: should be new enrollments on TRR – enrollments via 1-800 MEDICARE, www.medicare.gov and plan websites.

In addition, a separate data element should be required that specifically represents the number of enrollees that canceled/withdrew their application or disenrolled.

Rationale: Using the difference of the rate of enrollment to determine the number of cancelled enrollments is faulty since an enrollment verification survey is considered completed even if the final disposition of that survey is that the enrollee disenrolled. Also, given the short 10 day turn-around-time for completion of the Enrollment Verification process, we recommend CMS obtain the total enrollment from the TRR as defined above.

E. Reporting Measure Category #9: Provider Payment Dispute Resolution Process

Attachment II, p 10

Issue: The first data element in the chart, "# of claims rejected on first submission (i.e., not clean)," is not entirely clear as to what claims should and should not be included in the reporting. Claims may be "clean" but could be denied for other valid reasons, for example, claims that are denied for not being compliant with HIPPA transaction standards. Also, "first submission" could encompass re-processed or adjusted claims, which should be excluded from the reporting as they would have been processed.

Recommendation: We suggest CMS utilize the following terms to clarify what should and should not be reported, or provide further clarification. For example: "# of claims ~~rejected~~ denied on ~~first~~ original submission that are not submitted in accordance with CMS guidelines (i.e., not clean, not compliant with HIPAA transactions…)."

Rationale: Clarification would ensure consistent, accurate reporting among plans and the collection of appropriate data for meeting the stated CMS objective.

F. Reporting Measure Category #11: Training and Testing

Attachment II, p 12

Issue: Clarification is needed on the data elements listed, specifically, on the method of calculating the total # of agents and how CMS defines the term "index year."

Recommendation: The following clarifications are recommended:
that the # of agents = the number of agents as of December 31 of the year being reported, and that the Index Year = the reporting period, i.e. 1/1 – 12/31.

Rationale: Clarification on the data elements is required to assure that MAOs are reporting the same, consistent data to CMS.

G. Reporting Measure Category #12: Plan oversight of agents

Attachment II, p 13; Supporting Statement, pp 13 & 14

1. **Issue**: Clarification is needed on the third data element "# agents receiving disciplinary action based on complaints…," specifically regarding how CMS defines the term "disciplinary action."

Recommendation: It is recommended that disciplinary action be further defined, for example, it could include agents with all forms of corrective and disciplinary action, (i.e., agents who were alerted to a compliance infraction, directed to retake training certifications) or it could include only those whose appointment is terminated.

Rationale: Clarification of the term "disciplinary action" must be provided to assure that MAOs are reporting the same dataset to CMS.

2. **Issue**: The 800 Series plan type has been included in the scope of the Plan Oversight of Agents report. However, the materials provided do not differentiate between agents that sell directly to an employer and those who subsequently sell to the retiree.

Recommendation: It is recommended that CMS exclude agents who sell directly to employers.

Rationale: Since stronger oversight of agents was instituted due to the concern around conduct of agents toward beneficiaries it should not apply to agents selling directly to employers-employers are more sophisticated buyers and are not susceptible to possible undue pressure from agents.