Medicare Program Audit and Compliance Infrastructure Development

Parts C & D Measure Data Validation Standards and Procedures

Interview Discussion Guide

Draft

Submitted to:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted by:

Booz Allen Hamilton
One Preserve Parkway
Rockville, MD 20852
Tel 1-301-838-3600
Fax 1-301-838-3606

www.boozallen.com

February 19, 2010

Booz | Allen | Hamilton

Table of Contents

1.0 OVERVIEW 1

2.0 INTERVIEW DISCUSSION GUIDE: QUESTIONS APPLICABLE TO ALL MEASURES 1

2.1 Introduction/Background 1
2.2 Data Production and Underlying Data Sources 2
2.3 Report Production Questions 2
2.4 Data Processing/Quality 2
2.5 Additional Measure-Specific Questions 3

3.0 PART C ADDITIONAL MEASURE-SPECIFIC QUESTIONS 3

3.1 Benefit Utilization3
3.2 Procedure Frequency 4
3.3 Serious Reportable Adverse Events (SRAEs) 4
3.4 Provider Network Adequacy 4
3.5 Grievances (Part C) 5
3.6 Organization Determinations/Reconsiderations 5
3.7 Special Needs Plans (SNPs) Care Management 5

4.0 PART D ADDITIONAL MEASURE-SPECIFIC QUESTIONS 5

4.1 Retail, Home Infusion, and Long-Term Care Pharmacy Access 5
4.2 Medication Therapy Management Programs 6
4.3 Grievances (Part D) 6
4.4 Coverage Determinations and Exceptions 6
4.5 Appeals 7
4.6 Long-Term Care (LTC) Utilization 7

1.0 OVERVIEW

The Interview Discussion Guide is a supplemental tool to the Organizational Assessment Instrument (OAI) that data validation contractors (reviewers) may use to obtain further information about the organization and its reporting processes. It is intended to facilitate discussions during the on-site visit and includes both general and selected measure-specific questions that the reviewer may choose to ask of the appropriate organization staff. The reviewer may alter these questions depending on the information needed, and may combine the measure-specific questions as appropriate to allow for efficient use of on-site discussion time should the organization's staff be involved with reporting for more than one measure.

2.0 INTERVIEW DISCUSSION GUIDE: QUESTIONS APPLICABLE TO ALL MEASURES

Interview Discussion Guide for On-site Data Validation Review

Measure: <MEASURE>

INTERVIEWEE INFORMATION

Name:

Title:

Primary Phone Number:

Email:

INTERVIEWER INFORMATION

Name:

Date: Time:

2.1 Introduction/Background

2.1.1 What are your roles and responsibilities in your current position?

2.1.2 Describe your expertise and experiences with CMS reporting requirements.

2.2 Data Production and Underlying Data Sources

2.2.1 Describe the processes used to produce, maintain and update the data contained in the underlying data sources. Indicate all underlying data sources involved in the reporting process, beginning with the originating data systems (e.g., claims adjudication system, enrollment system) and including all other data sources used for data collection and storage, data processing, analysis, and reporting. For each data source, discuss the following:

- Data Source Name
- Data Collection/Production Process and Schedule
- Data Validation Process (for both electronic and manual processed data)
- Responsible Entities (if external, how are they managed?)

2.3 Report Production Questions

2.3.1 Describe the processes involved with producing the measures, including:

- Data Collection
- Data Analysis
- Data Validation (for both electronic and manually produced reports)
- Report Submission (for both electronic and manually submitted reports)
- Data Sources Used
- Responsible Entities (if external, how are they managed?)

2.4 Data Processing/Quality

2.4.1 Has your organization encountered reporting issues with any of the data elements? If yes, describe the issues and how they were resolved.

2.4.2 What are the unique identifiers used for tracking purposes (e.g., Member ID, Provider ID, Agent ID)?

2.4.3 How does your organization ensure the appropriate date ranges for each measure are being reported?

2.4.4 Has your organization experienced any problems with data completeness? If yes, describe the problems and how they were resolved.

2.4.5 Describe your organization's internal control processes for assessing data completeness and accuracy (e.g., for a claims-based measure, how does your organization ensure that all data from a claim is submitted and claims for all visits are submitted)?

- In cases where data are incomplete due to delays in obtaining the data, how is this handled by your organization?

- When data are questionable or invalid (e.g., claim appears inaccurate), what are the processes for determining whether the data are accurate and should be included for reporting purposes?
- How are duplicate records identified and addressed by your organization to ensure that they are excluded from final reporting?

2.4.6 How are missing or invalid data addressed and corrected (e.g., missing data values)?

2.4.7 What edit checks are in place to validate data entry in HPMS (for both data submitted electronically (i.e., direct file upload) and data manually entered)?

2.4.8 Has your organization implemented process or system improvements as a result of previously encountered problems with data processing, data management, reporting requirements or deadlines? If yes, describe these improvements.

2.5 Additional Measure-Specific Questions

See Sections and 4 below for additional measure-specific questions to incorporate into applicable interviews. Note that not every measure included in the data validation review has additional questions in this Interview Discussion Guide. The reviewer may create additional measure-specific questions depending on the information needed.

3.0 PART C ADDITIONAL MEASURE-SPECIFIC QUESTIONS

3.1 Benefit Utilization

3.1.1 How does your organization define services and benefits that are covered/not covered for purposes of reporting this measure?

3.1.2 Describe your organization's method for assigning utilization types to the services indicated in the measure. For example, does your organization use "Admits" or "Days" to identify Inpatient Services?

3.1.3 Provide evidence of the mapping of PBP categories to service categories (per Part C Reporting Requirements Technical Specifications).

3.1.4 Describe how member cost-sharing amounts are derived.

3.2 Procedure Frequency

3.2.1 How many diagnosis and procedure codes are captured by your organization's claims data systems? To what digit are the diagnosis and procedure codes specified?

3.2.2 Does your organization map non-standard codes to the standard codes provided by CMS in the Part C Reporting Requirements Technical Specifications? If yes, provide details on the mapping schema.

3.2.3 Does your organization use global billing for any of the services identified in this measure?

3.2.4 Does your organization include services based on claims that were denied for payment?

3.3 Serious Reportable Adverse Events (SRAEs)

3.3.1 How many diagnosis and procedure codes are captured by your organization's claims data systems? To what digit are the diagnosis and procedure codes specified?

3.3.2 Does your organization map non-standard codes to the standard codes provided by CMS in the Part C Reporting Requirements Technical Specifications? If yes, provide details on the mapping schema.

3.3.3 Does your organization include services based on claims that were denied for payment?

3.3.4 How does your organization determine whether the adverse event (signified by ICD-9 Diagnosis E876.5) was related to Surgery on Wrong Body Part, Surgery on Wrong Patient, or Wrong Surgical Procedures on a Patient?

3.4 Provider Network Adequacy

3.4.1 When a provider is no longer part of the network (e.g., provider does not renew contract), how is this monitored and tracked?

3.4.2 How do you determine validity of data? For example, how do you determine whether the provider is contracted to provide services in a specific network? What is the schedule for this type of data validation?

3.4.3 If contracting issues are encountered (e.g., expired contracts, new contracts), how are these addressed? How do you ensure that these updates are made and incorporated into final HPMS reporting?

3.5 Grievances (Part C)

3.5.1 How does your organization identify a grievance (i.e., distinguishing between grievances, inquiries, organization determinations, and reconsiderations)? Describe any internal processes used to ensure grievances are captured as appropriate.

3.5.2 How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes used to ensure member issues are categorized correctly.

3.5.3 How does your organization log/track/respond to identical grievances reported by the same member multiple times and/or to multiple departments?

3.6 Organization Determinations/Reconsiderations

3.6.1 How does your organization identify an organization determination (i.e., distinguishing between grievances, inquiries, organization determinations, and reconsiderations)?

3.6.2 How does your organization assign a final disposition category (i.e., definitions for fully favorable, partially favorable, adverse)?

3.7 Special Needs Plans (SNPs) Care Management

3.7.1 How does your organization identify enrollees that are eligible for an annual reassessment?

3.7.2 How does your organization identify the health risk assessments that are performed on enrollees to determine whether they are initial assessments or annual reassessments?

4.0 PART D ADDITIONAL MEASURE-SPECIFIC QUESTIONS

4.1 Retail, Home Infusion, and Long-Term Care Pharmacy Access

4.1.1 When a pharmacy is no longer part of the network (e.g., pharmacy does not renew contract), how is this monitored and tracked?

4.1.2 How do you determine validity of data? For example, how do you determine whether the pharmacy is contracted to provide long-term care services or home infusion services? What is the schedule for this type of data validation?

4.1.3 If contracting issues are encountered (e.g., expired contracts, new contracts), how are these addressed? How do you ensure that these updates are made and incorporated into final HPMS reporting?

4.2 Medication Therapy Management Programs

4.2.1 How does your organization identify members as being eligible for the MTMP?

4.2.2 How does your organization identify and track MTM interventions, including comprehensive medication reviews, targeted medication reviews, prescriber interventions, and drug therapy changes as a result of MTM interventions?

4.2.3 How do you determine validity of data? For example, how do you determine whether the beneficiary's MTMP enrollment status is current? What is the schedule for this type of data validation?

4.2.4 If a beneficiary's enrollment status is incorrect, how is this addressed? How do you ensure that invalid enrollees are excluded from the final cleaned database used for HPMS reporting?

4.3 Grievances (Part D)

4.3.1 How does your organization identify a grievance (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and appeals/redeterminations)? Describe any internal processes used to ensure grievances are captured as appropriate.

4.3.2 How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes used to ensure member issues are categorized correctly.

4.3.3 How does your organization log/track/respond to identical grievances reported by the same member multiple times and/or to multiple departments?

4.4 Coverage Determinations and Exceptions

4.4.1 How does your organization identify a coverage determination/exception (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and appeals/redeterminations)? Describe any internal processes used to ensure coverage determinations/exceptions are categorized correctly.

4.4.2 How does your organization determine whether a request is subject to the coverage determinations or the exceptions process?

4.4.3 How does your organization log/track/respond to identical requests for coverage determinations/exceptions requested for the same member multiple times?

4.5 Appeals

4.5.1 How does your organization identify an appeal (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and appeals/redeterminations)? Describe any internal processes used to ensure appeals are categorized correctly.

4.5.2 How does your organization assign a final disposition category (e.g., definitions for fully favorable, partially favorable, and adverse)?

4.6 Long-Term Care (LTC) Utilization

4.6.1 How does your organization determine whether a member resides in a long-term care facility at the time a Part D claim for that member is processed?

4.6.2 How does your organization distinguish between network LTC pharmacies and network retail pharmacies?