2018 DV 60-Day Comment Response Document

Overview of Comments

CMS received various comments from Data Validation organizations, Pre-assessment consultants and other associations. We received 36 comments regarding the following data validation sections: Coverage Determinations and Redeterminations, Grievances, Improving Drug Utilization Review Controls, Medication Therapy Management and Organization Determinations and Reconsiderations. There were several major comments regarding the new section-Improving Drug Utilization Review Controls and Coverage Determinations and Redeterminations.

Detailed Summary of Comments

Section	Comment
CD/RD	Reporting Section Criteria 5: Is there a typo in k., l., m., and n. in which the reference to Element 4.B.5 should state Element 4. B. 11?
CD/RD	Reporting Section Criteria 5: Should this read: Note that Data Elements 1.A.- 1. S. relate to Coverage Determinations data…? It currently says Organization Determinations data.
CD/RD	Reporting Section Criteria 14: Fully favorable determinations where the enrollee was notified untimely but within 24 hours of the expiration of the adjudication timeframe and thus not autoforwarded to the IRE.
CD/RD	Reporting Section Criteria 20 (c.): What is meant by 'Includes withdrawals and dismissals input by the IRE'?

CD/RD	Appendix B: Pg #28, 15b: Includes untimely coverage determinations decisions auto-forwarded to the IRE."
CD/RD	Appendix B: Pg # 26: Section 16, Part C: Includes withdrawals and dismissals input by the IRE.
CD/RD	Appendix B: Pg # 26: Section 20, Part C:Includes withdrawals and dismissals input by the IRE.

CD/RD	Appendix B: Pg # 24, 25 and 29: Section 5: Number of redeterminations by outcome (Data Element 3.E + Data Element 3.F + Data Element 3.G) is equal to total number of redeterminations (Data Element 3.A). Interpretation: 3.A = 3.E + 3.F + 3.G

CD/RD	Appendix B: Pg # 24, 25 and 29: Section 20: Each number calculated for requests for redeterminations that were withdrawn (Data Element 3.H) and requests for redeterminations that were dismissed (Data Element 3.I) is a subset of the number of redeterminations decisions made (Data Element 3.A). Interpretation: 3.A = 3.E + 3.F + 3.G + 3.H + 3.I

CD/RD	Appendix B: Reporting Section Criteria 5: CMS clarifies that the Total Number of CDs should include withdrawals and dismissals. However, the same section does not require inclusion of withdrawals and dismissals in Total Number of RDs, whereas Reporting Section Criteria 17 requires inclusion of dismissals and withdrawals. This has led to confusion on whether dismissals and withdrawals should be included in the Total Number of RDs.

CD/RD	Appendix B: Data Validation Standards: Pg #23: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.

CD/RD	Revise the Standards to indicate that the total number of coverage determinations reported (see 5.f.iii) should include withdrawals and dismissals (i.e., Data Elements 2.H and 2.I, respectively). However, we note that for reporting the total number of redeterminations (see RSC 5.g), CMS is not proposing inclusion of withdrawals and dismissals. In addition, we note that in RSC 17 (“Organization accurately calculates the total number of redeterminations (Part D only) …”), CMS is proposing to require inclusion of dismissals and withdrawals.

Grievances	Appendix B: Data Validation Standards: Pg #19: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.

Grievances	UCare does not support the 100% accuracy threshold for Standard 3a in the Part C and Part D Grievances reporting sections.

DUR	DV Standards: Sections 6aii: The rejected opioid claim due to the soft formulary-level cumulative opioid MED POS edit is not associated with an early refill rejection transaction
DUR	DV Standards: Sections 6bii: The rejected opioid claim due to the hard formulary-level cumulative opioid MED POS edit is not associated with an early refill rejection transaction

DUR	DV Standards: Sections 4ai: Organization provides documentation that its soft and/or hard formulary-level cumulative opioid MED POS edit was properly tested and validated prior to its implementation date.
DUR	Is RTS a requirement for DUR reports? Should we be excluding claims from the summary that contain refill too soon errors? If RTS is a requirement, how are we supposed to know the reasonable overlapping fill date time for RTS edits?

DUR	Should strength and dosage form be included fields on the report?

DUR	Appendix B: Data Validation Standards: Pg # 32: If the organization received a CMS outlier/data integrity notice based on their soft/hard/provider/pharmacy formulary-level cumulative opioid morphine equivalent dose (MED) threshold, validate whether or not an internal procedure change was warranted or resubmission through HPMS.

DUR	Reporting Section Criteria Sections 4-9): United does not believe that the data elements outlined in the Reporting Section Criteria for sections 4-9 align with the latest (2017) Part D Reporting Requirement or Technical Specifications. Only data elements A-P exist per the latest Part D Reporting requirements, rather than data elements A-S as referenced in the Data Validation Standards document.
DUR	Edit and Validation section C on page 40: the Data elements listed do not match the recent HPMS layout data elements. We believe this is due to the CY2017 Medicare Part D Reporting Requirements not also being updated with the latest added data element that can only be found in the HPMS Layout.

DUR	On page 132 there is a statement that refill too soon (RTS) claims should not be included in the report. This requirement is not mentioned anywhere in the CMS reporting requirements, technical specification or HPMS layout documents for this report. Should this question truly be in this section?

DUR	RSC-5.cv: The number of unique beneficiaries with at least one claim rejected that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit such as, but not limited to, through favorable coverage determination (data element S) is a value less than or equal to the number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request (data element R). (Should be Data Element P not R). **Note:** Data element S is from the CDE report for 'The total number of fully favorable Utilization Management exceptions made in the reporting period.' It is Data element Q on the opioid report that is for 'Num_Uniq_Bene_Rejected_Paid_POS'
DUR	RSC-8.c: c: Includes all coverage determinations (fully favorable, partially favorable, and adverse). Data Element says R but we know from above that it is for P.
DUR	Data elements referenced in this section don't always line up with the data elements from the current layout that is in HPMS. **Example 1:** 2.e RSC-5a mentions data element 'D' and or 'L' but it looks like this should be 'B' and or 'J' instead. **Example 2:** There is reference up to data element 'S' in this section for Improving Drug Utilization Review Controls (Part D) 2017, but the HPMS layout only goes to data element 'Q'.

DUR	The measure entitled "Improving Drug Utilization Review Controls" is a new reporting requirement and, currently, slated for audit during CY2017MDV season. It is Priority Health's concern that interpretation issues will arise from the new reporting measure that require CMS responses within a short timeframe.
MTM	Appendix B: Data Validation Standards: Pg #16: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.

MTM	Reporting Section Criteria: The 2018 Data Validation Standards state, "...excludes members who disenroll and then re-enroll in the same contract, if the gap of MTM enrollment is equal to 60 days or less." However, the 2017 Part D Technical Specifications removed the 60 day gap requirement verbiage and now states, "…Regardless of the duration of the gap in MTM program enrollment, report the initial date of MTM program enrollment, no date of MTM program opt out, and all other applicable elements for activity across all MTM program enrollment periods within the reporting period."

OD/RD	Reporting Section Criteria 22: It appears that the following elements were excluded from the data validation standards: **6.28** Was the case processed under the expedited timeframe (N/Y) **6.29** Case Type (Service or Claim) **6.30** Status of treating provider (Contract, Non-contract) **6.33** Additional Information (Optional)

General	Appendix B DV standards: Pg 12 #9b and pg 13 #12d: How CMS is defining members who are "unable to be reached"?

General	Appendix B: Data Validation Standards: The Data Validation Standards often remove the uncertainty when reviewed in accordance with the Reporting Requirements and Technical Specifications.

General	Appendix E: Organizational Assessment Instruction: 4.3 - Supplemental Questions Regarding Reporting Processes: "Did your organization receive an outlier/data integrity notification for any of the reporting sections that are currently undergoing data validation review (as identified in Table 5) for the contract(s) included in this OAI? If so, the organization is required to retrieve such notices via the Download Files page of the Monitoring Parts C and D Reporting Website received for the reporting section and any corrective actions taken to address the issue."

General	Procedure Manual Appendix B: CMS Outlier/Data Integrity Notices: CMS states "If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS." However, we are unsure why this would be considered a finding if the plan had completed the correction. We also seek clarification on whether there would only be a finding if a correction is required and plan does not make the change.
General	UCare requests that CMS provide additional details about the new “data integrity check” to help sponsors ensure that they have the sufficient documentation and/or explanations for data validation.
General	Please align the instructions in the Data Validation Procedure Manual, section 3.2.2.1 Process for Sponsoring Organization, with the instructions in the March 15, 2017 HPMS memo, Instructions for Requesting Consultant Access or Electronic Signature Access to the Health Plan Management System. The instructions are not identical and having two different sets of instructions is confusing.

Commenter's Recommendation	CMS Response	Revised Documents	Revised Burden Estimates
We are seeking clarification.	Correction has been made.	Yes	No
We are seeking clarification regarding the footnote on page 23.	Correction has been made.	Yes	No
Please validate these are counted as untimely and therefore excluded from the total timely count.	Yes, these are counted as untimely and therefore excluded from the total timely count.	No	No
Please expand/provide additional information.	Statement has been removed.	Yes	No

We respectfully request CMS clarify that it intended to remove the words "(as adverse)" in the following sentence—as compared to the 2016 DVA note.	Yes, we intended to remove the word "as adverse". CMS intends for plans to include ALL untimely coverage determinations decisions auto-forwarded to the IRE.	No	No
ESI respectfully requests CMS provide an example/scenario along with its definition/description of the term “Input” as noted in the following sections, as it is newly-introduced term in this collection.	The term input has been used in previous Data Validation PRA packages. This term is not a newly-introduced term in this collection.	No	No
ESI respectfully requests CMS provide an example/scenario along with its definition/description of the term “Input” as noted in the following sections, as it is newly-introduced term in this collection.	The term input has been used in previous Data Validation PRA packages. This term is not a newly-introduced term in this collection.	No	No

We again respectfully request CMS reaffirm its intent to include withdrawn and dismissed Redeterminations as a subset of data Element A in this document. ESI is concerned that—absent additional clarification from CMS—the interpretation of Item #1 conflicts with the interpretation of item #2.	While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn redetermination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to redetermination requests that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements were added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.	No	No

We again respectfully request CMS reaffirm its intent to include withdrawn and dismissed Redeterminations as a subset of data Element A in this document. ESI is concerned that—absent additional clarification from CMS—the interpretation of Item #1 conflicts with the interpretation of item #2.	While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn redetermination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to redetermination requests that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements were added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.	No	No

We request CMS' clarification on whether the Total Number of RDs should include withdrawals and dismissals for the reporting year.	While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn redetermination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to redetermination requests that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements were added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.	No	No

Itasca Medical Care is requesting that CMS provide some direction as to the expected timing of the release of the OAI to the DV contractors, with consideration to the timing of the release of the outlier/data integrity reporting outcome. We suggest that CMS provide direction that the OAI should not be released to the DV contractors until after the outlier/data integrity reports have been released and the plans have had necessary time to react to the results. We recommend that this timing be two weeks (fourteen calendar days) after the outlier/data integrity report is available, guaranteeing that the plan has adequate time to respond to results of the report. For example, if the outlier/data integrity report is available on March 28, the OAI package would be released to the DV contractor on April 11. With this direction, if the outlier/data integrity reports become obtainable earlier or later than in the past, this timing would be flexible enough that it wouldn't need future amendment.	CMS evaluates the integrity of data submission following the last Monday of February (2/26) reporting deadline. Plans have ample time to respond to outlier and data integrity flags and resubmit data by 3/31 if necessary. This is a routine part of the reporting requirements process.	No	No

For clarity, we recommend that CMS specify whether the total number of redeterminations under RSC 5.g should include withdrawals and dismissals.	While CMS does not currently prescribe the manner in which Part D plans should process invalid or withdrawn redetermination requests, as a best practice, we do expect plans to develop policies and procedures for processing and responding to redetermination requests that are either withdrawn by the requestor or dismissed by the plan. CMS expects that coverage requests that are withdrawn or dismissed represent a very small percentage of total Part D coverage requests a plan receives. However, these elements were added to provide plans with a means to report requests that are received and processed but are not adjudicated as either favorable or adverse by the plan.	No	No

Itasca Medical Care is requesting that CMS provide some direction as to the expected timing of the release of the OAI to the DV contractors, with consideration to the timing of the release of the outlier/data integrity reporting outcome. We suggest that CMS provide direction that the OAI should not be released to the DV contractors until after the outlier/data integrity reports have been released and the plans have had necessary time to react to the results. We recommend that this timing be two weeks (fourteen calendar days) after the outlier/data integrity report is available, guaranteeing that the plan has adequate time to respond to results of the report. For example, if the outlier/data integrity report is available on March 28, the OAI package would be released to the DV contractor on April 11. With this direction, if the outlier/data integrity reports become obtainable earlier or later than in the past, this timing would be flexible enough that it wouldn't need future amendment.	The Organizational Assessment Instrument (OAI) (Appendix E) focuses on how the SO collects, stores, and reports data. Completing the OAI is mandatory and CMS highly recommends that SOs complete this document in advance of the DV, as the DV review relies significantly on the information captured in this tool. The completed OAI may reduce required DVC resources, and make the DV review more efficient and effective. SOs should provide the completed OAI to their selected DVC electronically. CMS estimates that the OAI should take a minimum of two weeks to complete and should be submitted to the DVC no later than early April. SOs may not send their completed OAI or source code, SOPs, etc. to their DVCs prior to the start of the DV cycle on April 1.	No	No

UCare does not believe that only a 100% score demonstrates compliance and requests that Standard 3a for Grievances use the 90% accuracy threshold that is used by all other reporting sections.	CMS does not believe that only a 100 percent score demonstrates compliance, and has established a threshold whereby a minimum of 90% of records are accurate (e.g., sample or census records, source documents, policies and procedures, data entry records) in order to record a “Yes” finding for any standard. Applying this threshold to standards that require the review of policies and procedures should be done when it is possible to readily quantify the adherence to or implementation of said policies and procedures (see Exhibit 16). Exhibit 15 provides examples of how to calculate this minimum threshold specifically for Standard 3.a, for which the DV involves samples or the complete census of records and/or data values. Note that the 90% accuracy threshold does not apply to the individual grievance categories in the Part C and Part D Grievances reporting sections; 100% correct records are	No	No

These statements do not appear to be in the related CMS Technical Specifications for this reporting section. Given the difference, we want to make sure that plans should abide by the statements in the DV Standards and exclude soft and hard edit rejections due to early refills from DV reporting. Please advise.	Early refill exclusion is not stated in the Technical Specification document, however Page 14 of the Reporting Requirements document states our expectation of sponsors to apply specifications to “minimize false positives such as reasonable overlapping dispensing dates for prescription refills or new prescription orders for continuing fills. The 2018 TS has been updated with clarification on this issue.	No	No
These statements do not appear to be in the related CMS Technical Specifications for this reporting section. Given the difference, we want to make sure that plans should abide by the statements in the DV Standards and exclude soft and hard edit rejections due to early refills from DV reporting. Please advise.	Early refill exclusion is not stated in the Technical Specification document, however Page 14 of the Reporting Requirements document states our expectation of sponsors to apply specifications to “minimize false positives such as reasonable overlapping dispensing dates for prescription refills or new prescription orders for continuing fills. The 2018 TS has been updated with clarification on this issue.	No	No

We are seeking guidance from CMS as to what types of documentation you would recommend we secure from clients in order for us to comply with this review standard. Any examples or direction you could provide in this regard would be greatly appreciated.	CMS would expect documentation stating the dates and sample prescriptions that were run through the cumulative edit and either did or did not trigger the edit as expected. If a dummy case was developed possibly screen-shots of the response and the dummy case prescription profile.	No	No
We have conflicting information as RTS isn't a requirement on the Part D Plan report Requirement/Technical Specifications, however it is mentioned in the Medicare Part C and Part D Reporting Requirements - Data Validation document.	Early refill exclusion is not stated in the Technical Specification document, however Page 14 of the Reporting Requirements document states our expectation of sponsors to apply specifications to “minimize false positives such as reasonable overlapping dispensing dates for prescription refills or new prescription orders for continuing fills. The 2018 TS has been updated with clarification on this issue.	No	No

We also see conflicting information regarding Drug(strength and dosage form) between the two documents. Strength and dosage form isn't a requirement on the Part D Plan report Requirement/Technical Specifications, however it is mentioned in the Medicare Part C and Part D Reporting Requirements - Data Validation document.	No conflict found. Note #9 of the Technical Specifications document states that “Rejected claims are counted at the unique contract, beneficiary, prescriber, pharmacy, drug (strength and dosage form), quantity, and date of service (DOS)". This field should at least be populated with a National Drug Code (NDC) which is a unique product identifier that codifies a drug’s characteristics e.g. dosage form/strength.	No	No

Itasca Medical Care is requesting that CMS provide some direction as to the expected timing of the release of the OAI to the DV contractors, with consideration to the timing of the release of the outlier/data integrity reporting outcome. We suggest that CMS provide direction that the OAI should not be released to the DV contractors until after the outlier/data integrity reports have been released and the plans have had necessary time to react to the results. We recommend that this timing be two weeks (fourteen calendar days) after the outlier/data integrity report is available, guaranteeing that the plan has adequate time to respond to results of the report. For example, if the outlier/data integrity report is available on March 28, the OAI package would be released to the DV contractor on April 11. With this direction, if the outlier/data integrity reports become obtainable earlier or later than in the past, this timing would be flexible enough that it wouldn't need future amendment.	CMS evaluates the integrity of data submission following the last Monday of February (2/26) reporting deadline. Plans have ample time to respond to outlier and data integrity flags and resubmit data by 3/31 if necessary. This is a routine part of the reporting requirements process.	No	No

United recommends that CMS correct the Data Validation Standards document to remove any references to the following data elements from sections 4-9 and align with the data element numbering reflected in the 2017 Part D Reporting Requirements and Technical Specifications: **E.** If yes to element A, the minimum number of days meeting or exceeding the MED threshold criterion used. **N.** If yes to element J, the minimum number of days meeting or exceeding the MED threshold criterion used. **S.** Of the total reported in element O, the number of claims resolved and paid at the POS (either through a favorable decision through the coverage determination or appeals process, or other mechanism).	CMS has since corrected Appendix B to align with the Reporting Requirements data elements.	Yes	No
We are noticing the data elements are not lining up to the definitions. It would be helpful if all the documents that pertain the reporting requirements and data elements are revised to match when there is a change in the HPMS layout.	CMS has since corrected Appendix B to align with the Reporting Requirements data elements.	Yes	No

N/A	Yes, early refill exclusion is not stated in the Technical Specification document, however Page 14 of the Reporting Requirements document states our expectation of sponsors to apply specifications to “minimize false positives such as reasonable overlapping dispensing dates for prescription refills or new prescription orders for continuing fills. The 2018 TS has been updated with clarification on this issue.	No	No

N/A	CMS has since corrected Appendix B to align with the Reporting Requirements data elements: RSC-5.dv The number of unique beneficiaries with at least one claim rejected that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit such as, but not limited to, through favorable coverage determination (data element P) is a value less than or equal to the number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request (data element O).	No	No
N/A	See above	No	No
Please confirm the documents and data elements used in the making of the data validation questions.	CMS has since corrected Appendix B to align with the Reporting Requirements data elements.	Yes	No

Priority Health requests that CMS postpones the audit for this new measure until the CY2018 MDV season. This change will allow for the settlement of any interpretation issues prior to the audit occurring against the measure reported data.	CMS respectfully disagrees. If you have specific questions please feel free to ask.	No	No
Itasca Medical Care is requesting that CMS provide some direction as to the expected timing of the release of the OAI to the DV contractors, with consideration to the timing of the release of the outlier/data integrity reporting outcome. We suggest that CMS provide direction that the OAI should not be released to the DV contractors until after the outlier/data integrity reports have been released and the plans have had necessary time to react to the results. We recommend that this timing be two weeks (fourteen calendar days) after the outlier/data integrity report is available, guaranteeing that the plan has adequate time to respond to results of the report. For example, if the outlier/data integrity report is available on March 28, the OAI package would be released to the DV contractor on April 11. With this direction, if the outlier/data integrity reports become obtainable earlier or later than in the past, this timing would be flexible enough that it wouldn't need future amendment.	CMS evaluates the integrity of data submission following the last Monday of February (2/26) reporting deadline. Plans have ample time to respond to outlier and data integrity flags and resubmit data by 3/31 if necessary. This is a routine part of the reporting requirements process	No	No

United seeks clarification on which requirement should be applied. We recommend that CMS update the 2018 Data Validation Standards to mirror the reporting requirement outlined in the 2017 Part D Technical Specifications to reflect “regardless of duration” instead of the “60 days or less”.	CMS agrees with United's recommendation. RSC 8 d. in Appendix B will be "Excludes members who disenroll from and re-enroll in the same contract regardless of the duration of the gap of MTM program enrollment.". The FDCF will also be updated appropriately.	Yes	No

United recommends that CMS update section 22 to align with the 2017 Part C Technical Specifications. Section 22 would be updated with the following: Organization accurately reports the following information for each reopened case. a. Contract Number b. Plan ID c. Case ID d. Case level (Organization Determination or Reconsideration) e. Date of original disposition f. Original disposition (Fully Favorable; Partially Favorable or Adverse) g. Was the case processed under the expedited timeframe? (Y/N) h. Case type (Service or Claim) i. Status of treating provider (Contract, Non-contract) j. Date case was reopened k. Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other) l. Additional Information (Optional) m. Date of reopening disposition (revised decision) n. Reopening disposition (Fully	We appreciate the commenter's suggestions, and we will take it under advisement.	No	No

Requiring 3 phone attempts and a follow-up letter works when we have an accurate phone number for a member, but we have a large number of members who have not provided a good phone number. While we attempt to locate a good phone number for all members, if the phone number is incorrect the first time we call, we are unlikely to make two more phone calls to that same non-working number. Additionally, for some members, we do not have any phone number to make even one attempt. With the current specifications and standards, these members would not fall into any of the measured areas (having an assessment, refusing, or unable to reach) and would affect our scores negatively. We respectfully ask CMS to let us know a way to categorize these types of members.	Document what happened and yes, report at 13.5 or 13.8, whichever is appropriate	No	No

Itasca Medical Care would like to recommend that CMS consider releasing the Data Validation Standards at the same time as the draft or final versions of the Reporting Requirements and the Technical Specifications. We believe that if CMS provided the complete set of expectations at one time this would enable better understanding of the requirements as well as possibly preventing misinterpretations of the information.	CMS will consider this request in the future.	No	No

Itasca Medical Care is requesting that CMS provide some direction as to the expected timing of the release of the OAI to the DV contractors, with consideration to the timing of the release of the outlier/data integrity reporting outcome. We suggest that CMS provide direction that the OAI should not be released to the DV contractors until after the outlier/data integrity reports have been released and the plans have had necessary time to react to the results. We recommend that this timing be two weeks (fourteen calendar days) after the outlier/data integrity report is available, guaranteeing that the plan has adequate time to respond to results of the report. For example, if the outlier/data integrity report is available on March 28, the OAI package would be released to the DV contractor on April 11. With this direction, if the outlier/data integrity reports become obtainable earlier or later than in the past, this timing would be flexible enough that it wouldn't need future amendment.	CMS evaluates the integrity of data submission following the last Monday of February (2/26) reporting deadline. Plans have ample time to respond to outlier and data integrity flags and resubmit data by 3/31 if necessary. This is a routine part of the reporting requirements process.	No	No

United recommends that this should not be a finding if the data correction (resubmission) occurs prior to the CMS prescribed deadline. Further, if the data correction does not occur, then the Sponsoring Organization would receive a finding.	CMS will consider this request in the future.	No	No
Provide additional details.	CMS evaluates the integrity of data submission following the last Monday of February (2/26) reporting deadline. Plans have ample time to respond to outlier and data integrity flags and resubmit data by 3/31 if necessary. This is a routine part of the reporting requirements process.	No	No
Please align the instructions.	Correction has been made.	Yes	No