Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual

Appendix F: Interview Discussion Guide

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1. OVERVIEW

The *Interview Discussion Guide* is a supplemental tool to the *Organizational Assessment Instrument* (*OAI, Appendix E*) that data validation reviewers may use to obtain further information about the sponsoring organization (SO) and its reporting processes. It is intended to facilitate discussions during the site visit and includes both general and selected reporting section questions that the reviewer may choose to ask of the appropriate SO staff. The reviewer may alter these questions depending on the information needed and may combine the reporting section questions as appropriate to allow for efficient use of time should the SO's staff be involved with reporting for more than one reporting section. The reviewer is expected to include additional reporting section questions as needed and should not rely solely on the questions provided in the *Interview Discussion Guide*.

2. INTERVIEW DISCUSSION GUIDE: QUESTIONS APPLICABLE TO ALL REPORTING SECTIONS

Interview Discussion Guide for Data Validation Review
Reporting Section: <REPORTING SECTION>

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 Part C and/or Part D Reporting Requirements Technical Specifications.

2.2 Data Production and Underlying Data Sources

2.2.1 Describe the processes your organization uses 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, describe how they are managed)

2.3 Report Production Questions

2.3.1 Describe the processes involved with producing the reporting sections, 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, describe how they are 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 the organization resolved them.

2.4.2 What unique identifiers does your organization use for tracking purposes (e.g., Member ID, Provider ID)?

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

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

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

- How does your organization handle cases where data are incomplete due to delays in obtaining the data?
- 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 does your organization address duplicate records identified to ensure that they are excluded from final reporting?

2.4.6 How does your organization address and correct missing or invalid data (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 Reporting Section Questions

See Sections 3 and 4 below for additional reporting section questions to incorporate into applicable interviews. Note that not every reporting section included in the data validation review has additional questions in this *Interview Discussion Guide*. The reviewer may create additional reporting section questions depending on the information needed.

3 PART C ADDITIONAL REPORTING SECTION QUESTIONS

3.1 Grievances (Part C)

3.1.1 How does your organization identify a grievance (i.e., distinguishing between grievances, inquiries, organization determinations, and reconsiderations)? Describe any internal processes your organization uses to ensure it captures grievances appropriately.

3.1.2 How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes your organization uses to ensure it categorizes member issues correctly.

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

3.2 Organizational Determinations/Reconsiderations

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

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

3.3 Special Needs Plans (SNPs) Care Management

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

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

3.3.3 What standardized health risk assessment tool does your organization use?

3.3.4 How does your organization define a health risk assessment/re-assessment as "complete?"

4 PART D ADDITIONAL REPORTING SECTION QUESTIONS

4.1 Medication Therapy Management (MTM) Programs

4.1.1 How does your organization identify members as being eligible for the MTM program?

4.1.2 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?

4.1.3 How does your organization determine the validity of data? For example, how do you determine whether the beneficiary's MTM program enrollment status is current? What is the schedule for this type of data validation?

4.1.4 How does your organization address incorrect beneficiary enrollment status? How does your organization ensure that invalid enrollees are excluded from the final cleaned database used for the data reported to CMS?

4.1.5 How does your organization track and follow-up on offers for Comprehensive Medication Reviews (CMRs)? By what means does your organization determine whether or not an offer has been made and received by the beneficiary?

4.2 Grievances (Part D)

4.2.1 How does your organization identify a grievance (e.g., distinguishing between grievances, inquiries, coverage determinations, exceptions, and appeals/ redeterminations)? Describe any internal processes your organization uses to ensure it captures grievances appropriately.

4.2.2 How does your organization assign grievance categories (e.g., marketing, enrollment, quality of care)? Describe any internal processes your organization uses to ensure it categorizes member issues correctly.

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

4.3 Coverage Determinations and Redeterminations

4.3.1 How does your organization identify a coverage determination/exception (e.g., distinguishing between grievances, inquiries, coverage determinations (including exceptions), and redeterminations)? Describe any internal processes your organization uses to ensure it categorizes coverage determinations correctly.

4.3.2 How does your organization determine whether a request should be treated as an exceptions request?

4.3.3 How does your organization log/track/respond to identical requests for the same member multiple times?

4.3.4 How does your organization identify redeterminations (e.g., distinguishing between grievances, inquiries, coverage determinations (including exceptions), and redeterminations)? Describe any internal processes your organization uses to ensure it categorizes redeterminations correctly.

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

4.4 Improving Drug Utilization Controls

4.4.1 How does your organization identify POS rejects triggered by their CMS approved formulary cumulative opioid morphine equivalent doses (MED) edit?

4.4.2 How does your organization log/track unique beneficiaries triggered by an approved soft and/or hard formulary-level cumulative MED threshold that have multiple transactions for the same claim?

4.4.3 How does your organization identify the hard formulary-level cumulative opioid MED edits claims that lead to a coverage determination?