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May 15, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attention: CMS-10261 (OMB No.: 0938-1054)

Dear Sir or Madam:

I am writing on behalf of AHIP[1] in response to the notice under the Paperwork Reduction Act (PRA) concerning the "Part C Medicare Advantage Reporting Requirements" published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* (88 FR 15726) on March 14, 2023. The draft Part C reporting requirements are of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) program.

CMS is proposing to collect, on an annual basis, data from MA plans on supplemental benefit offerings, including benefit type, cost and utilization. While we recognize CMS' interest in obtaining more granular data on supplemental benefits, we have several questions and concerns regarding the draft Supplemental Benefit Utilization and Costs section as discussed below.

Timing for new reporting requirements. The Supporting Statement and Technical Specifications documents indicate that the effective date of the new requirements is January 1, 2024. They also indicate the reporting period is the calendar year, and reports are due the last Monday of February in the following year. Our understanding of these timelines is that the first reporting period relating to the draft supplemental benefits data would be calendar year 2024, and the due date for the first annual report with those data would be February 24, 2025. We ask that CMS confirm this understanding and also issue the final requirements with sufficient lead time.

Potential need for deadline extension. MA plans work with many vendor partners to provide a variety of supplemental benefits to their enrollees, including community-based organizations and small businesses that are not traditional healthcare providers. Many of them have limited experience in a complex regulatory environment and may not be equipped to report use and cost data to MA plans in a comprehensive or standardized way. Moreover, they could have resource and other challenges in developing necessary systems to operationalize the final supplemental

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

benefit reporting requirements. As such, there is a significant risk that at least some supplemental benefits data for 2024 will not be uniform and will be difficult to aggregate. For the first year of reporting, we recommend CMS allow MA plans making good faith efforts to meet the new reporting requirements the ability to request a deadline extension when they need more time to work with their vendor partners to produce and submit the required data.

Protection of data. We appreciate and strongly support the regulatory framework for Medicare Part C reporting requirements that does not authorize public reporting of data submitted by MA plans to meet this data collection requirement under the MA program. We urge CMS to ensure that it also does not publicly disclose plan-specific information on use and cost data with respect to supplemental benefits data. As noted above there is a risk of non-standard reporting given the nature of some of these benefits and the vendors that deliver them. There is also a risk of misinterpreting data on these benefits, many of which are newly created and may be in early stages of development. Additionally, beneficiaries may have a menu of supplemental benefits options under any given plan; even if a particular benefit has lower use, it could still be of great value to those who, for example, need it to overcome barriers to accessing care. Moreover, if publicly disclosed, the plan-specific data being collected could result in the release of competitively sensitive information that could harm competition.

Other considerations. We recommend that CMS work with health plans to develop an automated reporting option for this type of data collection for future reporting years.

Value of supplemental benefits. MA supplemental benefit offerings are critical to addressing medical and non-medical needs of enrollees, including social unmet needs, ranging from food insecurity, lack of transportation, and social isolation. 97% of all Medicare-eligible enrollees have access to an integrated MA plan that covers dental, vision, hearing or fitness benefits.[2] MA plans also provide a cap on out-of-pocket costs and many plans offer comprehensive prescription drug coverage, including drug coverage at no additional cost. Data from the Medicare Payment Advisory Commission shows that 75% of all rebate dollars go toward reducing enrollee out-of-pocket costs, reduced premiums for Parts B or D, and enhanced Part D coverage.[3] Research also reveals that nearly 40% of MA plans are offering non-medical supplemental benefits in 2023 including in-home support services, caregiver supports, and social needs benefits.[4] Supplemental benefit offerings also play an important role in helping to address social drivers of health and advancing health equity. Research is demonstrating that services and interventions that address social needs of MA beneficiaries can result in improved quality of life, improved health outcomes, and reduce unnecessary health care utilization.[5] AHIP is a strong supporter of policies

[2] Kaiser Family Foundation, "Medicare Advantage 2023 Spotlight: First Look." Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.
[3] Medicare Payment Advisory Commission. March 2023 Report to the Congress. Available at: https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.
[4] ATI Advisory, "A Deep Dive on In-Home, Caregiver, and Social Supports in Medicare Advantage: Can These Benefits Meaningfully Meet Member Needs and Support Independence?" March 2023. Available at: https://atiadvisory.com/resources/a-deep-dive-on-in-home-caregiver-and-social-supports-in-medicare-advantage-can-these-benefits-meaningfully-meet-member-needs-and-support-independence/.
[5] Rizer, A, and Benzing, L."Filling The Gaps: The Role And Value Of Supplemental Benefits In Medicare Advantage." Health Affairs Forefront. August 5, 2022. Available at:

that offer supplemental benefits flexibility and allow MA plans to be more responsive to the needs of the enrollees they serve.

We appreciate the opportunity to comment on CMS' proposed supplemental benefit data collection effort. Please contact me if additional information would be helpful or if you have questions about the issues raised in this letter. I can be reached at (202) 778-3256 or mhamelburg@ahip.org.

Sincerely,

Mark Hamelburg
Senior Vice President, Federal Programs

https://www.healthaffairs.org/content/forefront/filling-gaps-role-and-value-supplemental-benefits-medicare-advantage.

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May 10, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: CMS-10261 & CMS-1450
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850.

Re: Agency Information Collection Activities: Proposed Collection; Comment Request (CMS-10261)

To Whom It May Concern:

On behalf of our 159,000 members, the American Dental Association (ADA) is writing in response to a notice of information collection request (CMS-10261), specifically on the Centers for Medicare and Medicaid Services (CMS) reporting requirements for Medicare Advantage Organizations (MAOs). As mentioned in the notice, CMS' duty is to ensure that each "MAO must have an effective procedure to develop, compile, evaluate, and report to CMS, its enrollees, and the public at the times and in the manner that CMS requires."

Part C Medicare Advantage Reporting Requirements

"CMS is requesting an OMB Revision approval type due to the changes for the CY2024 reporting requirements which includes:

- *The collection of additional data elements related to supplemental benefits cost and utilization among plan enrollees, with an effective date of January 1, 2024. CMS is adding this section in accordance with recommendations from members of the United States Congress, the Medicare Payment Advisory Commission (MedPAC), Government Accountability Office (GAO), and other industry stakeholders. These elements also align with and expand upon the new* [medical loss ratio] *MLR reporting requirements (87 FR 27704) on supplemental benefits, as well as the more limited information submitted in the Plan Benefit Package (PBP) categories and subcategories. This information will improve CMS's understanding of the accessibility and utilization of supplemental benefits by Medicare Advantage* [MA] *enrollees.*

Data elements collected for each supplemental benefit in Reporting Requirements from 2008- 2011:

- *Number of enrollees who had access to the benefit during the reporting period;*
- *Unique number of plan enrollees who used the benefit;*
- *Appropriate code to identify how you capture utilization data for the benefit;*
- *Total number of benefit services used by plan enrollees during the period;*
- *Reimbursement amount from the plan to providers for benefit services used during the period; and*
- *Total cost sharing paid by members directly to providers for benefit services used during the period.*

General data elements collected 2008-2011 for benefit utilization measure:

- *Total number of enrollees under the plan during the reporting period;*
- *Number of member months during the reporting period;*
- *Dollar figure representing premiums earned over the course of the entire reporting period for this plan;*
- *Dollar figure representing CMS revenue collected under the plan over the course of the entire reporting period inclusive of rebates applied to A/B services;*
- *Dollar figure representing CMS rebates for A and B Services under the plan over the course of the entire reporting period; and*
- *Dollar figure representing reserves for outstanding claims from the reporting period."*

Currently, due in part to the lack of reporting requirements, we are not aware of many data points. For instance, half of Medicare beneficiaries are now enrolled in MA[1] and it continues to grow in the number of enrollees each year. However, despite this growth, we still do not know a lot about the supplemental benefits offered to these beneficiaries, especially the dental benefits.

The ADA agrees with and fully supports CMS' re-inclusion of dental services as a specific supplemental benefit under MAO's reporting requirements. The collection of data to improve CMS' understanding on the utilization of supplemental benefits by MA enrollees for dental services is essential for transparency.

MLR Reporting

The ADA has been on record supporting transparency with public dollars, especially concerning the use of Trust Fund dollars, and views MLR reporting as key to maintaining transparency.[2]

We encourage CMS to go further in collecting and publishing in a timely manner a state-by-state assessment of MLR data with the percentage of allocated MA funding that is being spent on dental services and asks that CMS monitor the specific dental loss ratio. Because MA is a critical access point for dental care to millions of enrollees, tracking the correct data is just as important to ensure MA enrollees are getting the dental care they need going forward. Recently, the U.S. Government Accountability Office (GAO) issued a report on MA's supplemental benefits where they make two recommendations to CMS. The first was that CMS clarify guidance on the extent to which encounter data submissions must include data on the utilization of supplemental benefits, and the second recommendation was that CMS address circumstances where submitting encounter data for supplemental benefits is challenging for MA plans.[3] **The ADA agrees with the GAO and believes that CMS should collect and analyze data on supplemental benefits for MA enrollees and we are pleased to see that CMS agreed with the recommendations the GAO provided as an initial step in this direction of more detailed data collection.**

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[1] Kaiser Family Foundation, Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans, May 1, 2023.

[2] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/medicaid/230222_mlr_mco_letter_nosigs.pdf

[3] GAO, Medicare Advantage Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization, January 2023.

The Need for Additional Data on MA Enrollees and Their Dental Benefits

The ADA believes that it is critical that CMS analyze data on supplemental benefits in the MA program, including who is enrolled by ages, race & ethnicity, education and income, what is covered, and what benefits are being utilized. These are important data points for determining how to best advance oral health for MA beneficiaries.

The Medicare Current Beneficiary Survey (MCBS) has been an excellent source of data and incredibly enlightening as the health care and research communities try to better understand Medicare beneficiary populations and their experiences with the dental component of their plans,[4] including:

- dental benefits availability
- dental utilization
- premiums for dental plans
- coinsurance and copayments
- annual maximum and its application (i.e., whether it applies for preventive services in addition to other covered procedures)
- total annual out of pocket spending

The ADA believes CMS should collect and analyze data on supplemental benefits for lower income enrollees. While it is known that MA is covering more seniors every year, it is not known if supplemental benefits such as dental are maintained for seniors at all income levels. Nor is it known how often and where rebate dollars are most often used for dental benefits specifically.

As noted in the 2021 Kaiser Family Foundation brief mentioned above, "Plans do not use standard language when defining their benefits and include varying levels of detail, making it challenging for consumers or researchers to compare the scope of covered benefits across plans." The scope of covered services, frequency limitations, and cost-sharing requirements must be transparent to beneficiaries, CMS, and the public. **CMS should standardize the 'summary of benefits' offered by plans and also seek reporting from MAOs regarding what is covered vs. not covered, which should at least be at the level of the Current Dental Terminology (CDT) category and not just 'includes dental coverage' or arbitrary classifications such as "Basic," "Routine" or "Major".**

The ADA is aware that enrollment in MA plans is expanding and more specifically that a high percentage of Part C plan beneficiaries have access to some kind of dental benefit.[5] However the range of services covered with these plans appears to widely differ with some plans covering only a preventive benefit and others offering a more comprehensive benefit. **The ADA does not have data to quantify how many enrollees are getting the different types of dental benefits, and requests that CMS collect that data.**

In addition to collecting data from beneficiaries via the MCBS, we recommend CMS require MA plan administrators to report the following metrics pertaining to beneficiary enrollment and utilization of dental services (as a proxy measurement for dental access) and other aspects of quality of care supported by MA plans:

- total number of beneficiaries (age, race and ethnicity, income, education, …)

[4] Medicare and Dental Coverage: A Closer Look | KFF

[5] Medicare Advantage 2020 Spotlight: First Look (kff.org)

- number of beneficiaries with a dental claim in a plan year (age, race and ethnicity, income, education, …) as a measure of access
- cost sharing (average benefit paid per user [among enrollees who had a dental visit], average benefit paid per beneficiary [among all enrollees], coinsurance, annual maximums, total average out of pocket spending, …)
- applicable measures for the older adult population from the Dental Quality Alliance[6]

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We would welcome the opportunity to meet with you to discuss how we can meet these challenges. If you have any questions, please contact Mr. David Linn at 202-789-5170 or linnd@ada.org.

Sincerely,

George R. Shepley, D.D.S.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

GRS:RAC:dl

[6] Dental Quality Alliance, Measuring Oral Healthcare Quality for Older Adults Final Report, Nov. 2021.

PUBLIC SUBMISSION

As of: 5/17/23, 12:58 PM
Received: May 15, 2023
Status: Draft
Tracking No. lhp-8blg-xk5i
Comments Due: May 15, 2023
Submission Type: Web

Docket: CMS-2023-0041
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Comment On: CMS-2023-0041-0001
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Document: CMS-2023-0041-DRAFT-0010
Comment on CMS-2023-0041-0001

Submitter Information

Email: amy.luhmann@bluecrossmn.com
Organization: Blue Cross and Blue Shield of Minnesota

General Comment

Under VIII. Supplemental Benefit Utilization and Costs, please provide definitions or clarification for the terms in parens in Data Element C. How is the supplemental benefit offered? (Mandatory, Optional, Uniformity, Flexibility, SSBCI, not offered). In addition, we urge CMS to release file layouts for the new Supplemental Benefits Reporting Section as soon as possible. This is a large report that will have to be built for different systems and multiple contracts. Making the file layouts available as far in advance as possible will better equip plans for timely compliance with data submission.

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May 15, 2023

VIA ELECTRONIC SUBMISSION TO *www.regulations.gov*

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Department of Health and Human Services
Attention: CMS-10261
Baltimore, MD 21244-1850

Re: Information Collection Request: Part C Medicare Advantage Reporting Requirements (Form Number: CMS-10261)

The Cigna Group welcomes the opportunity to offer comments on CMS' Information Collection Request: Part C Medicare Advantage Reporting Requirements (Form Number: CMS-10261). As conveyed to CMS on March 07, 2022, in response to the proposed regulation, *Proposed Regulatory Changes to Medicare MLR Reporting Requirements and Release of Part C MLR Data (§§ 422.2460, 422.2490, and 423.2460) (Section II.G.)*, Cigna has two primary concerns, detailed below, and offers the following recommendation.

We recommend CMS engage with MA plans and supplemental benefit vendors to explore alternative ways to gain the information and understanding around supplemental benefits the agency is seeking. At a minimum, we recommend CMS delay implementation of the supplemental benefit cost report measure, to allow the necessary time to make updates to financial reporting systems.

First, CMS already has oversight tools and policies in place to monitor and address MLR compliance and remediation; and as CMS explains, at least one plan self-disclosed a calculation error to CMS which was remediated.

Second, we are concerned about the additional reporting of detailed cost information for a proposed list of supplemental benefit categories. We understand CMS' interest in better understanding supplemental benefit utilization and cost in MA, many of which are newer benefits resulting from positive benefit flexibility and policy changes in recent years. However, CMS is proposing to require reporting of supplemental benefits using an "incurred claims" approach, which fails to recognize how many supplemental benefits are designed and paid for by MA plans today. For example, MA plans may fund supplemental benefits in a per-member-per-month (PMPM) structure rather than by individual claim; and plans may partner with a vendor offering multiple benefits under a single construct. As such, financial systems are not set up to capture and report the type of granular financial information CMS is proposing. The resulting necessary systems changes would be costly and take time to implement. Further, we are concerned about this level of supplemental benefit financial information being reported publicly, and we believe it will reduce competition and increase costs. Given these complexities with supplemental benefits, we anticipate such reporting will cause confusion and lead to inaccurate conclusions about true cost and impact of supplemental benefits.

Thank you for your consideration of these comments. Cigna would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,

Kristin Julason Damato

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

May 15, 2023

Submitted electronically to www.reginfo.gov/public/do/PRAMain

Mr. William N. Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Agency Information Collection Activities: Proposed Collection; Comment Request; Part C Medicare Advantage Reporting Requirements [CMS-10261]

Dear Director Parham:

CVS Health appreciates the opportunity to comment on the Part C Medicare Advantage Reporting Requirements for supplemental benefit cost and utilization reporting issued by the Centers for Medicare & Medicaid Services (CMS) and published in the *Federal Register* on March 14, 2023.[1]

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses and nurse practitioners. Our unique health care model gives us an unparalleled perspective on how systems can be better designed to help consumers navigate the health care system – and their personal health care – by improving access, lowering costs, and being a trusted partner for every meaningful moment of health. And we do it all with heart, each and every day. Through our Aetna health plan, we provide comprehensive and affordable benefits to nearly 10 million lives each year through our Medicare Advantage (MA/Part C), SilverScript Prescription Drug (Part D), and MA-Part D plans.

[1] 88 FR 15726.

As CMS implements the reporting requirements for MA supplemental benefits under §422.2460, we encourage the Agency to keep the following principles in mind:

- Given the nature of these benefits and the fact that many are delivered in partnership with vendors and community-based organizations, we ask that CMS take a phased-in approach to implementation of this data collection. We want to get this right and understand the desire for enhanced reporting, but it will take time to work with our partners to build out all of CMS' elements in existing data collection, calculation, reporting, and validation processes. We also ask that CMS exercise discretion in its approach to oversight and enforcement in the early stages of this data collection.

- CMS must release the final technical specifications and clear guidance on supplemental benefit reporting as soon as possible to support the development and testing of an effective data collection infrastructure between plans and partners.

- To minimize the reporting burden on plans, CMS should align Part C requirements and data elements with those reported for the Value-Based Insurance Design Model (VBID) and state Medicaid supplemental benefit reporting where possible.

- CMS should ensure that any public reporting of supplemental benefit cost and utilization data provides CMS and the public with the necessary data to understand these benefits without the potential to disclose beneficiary-level information or proprietary plan and/or vendor data.

Additionally, we request that CMS address the following comments and requests for clarification related to timelines and specific data elements:

Clarify Date of First Reporting Period for Supplemental Benefit Utilization and Cost Data

In the "Medicare Part C Reporting Requirements" document and Supporting Statement released with this PRA notice, CMS states that these updates are "effective January 1, 2024." We request that CMS clarify that this effective date applies to reporting on utilization and costs incurred during the 2024 plan year and not earlier. ***Specifically, we ask CMS to clearly state that plans would be required to submit the first report on supplemental benefit data no earlier than the last Monday of February 2025, reflecting the reporting period of January 1, 2024 to December 31, 2024.***

Confirmation of this timeline is especially important as plans are in final preparations to submit their 2024 bids. It is important that we know each element finalized by CMS as any

elements requiring custom fields or data analyses will come at an additional administrative, financial, or staffing cost that takes away from the member benefit.

Provide Final Technical Specifications on Supplemental Benefit Utilization and Cost Data Elements To Support Implementation

On page 3 of the "Medicare Part C Reporting Requirements" document released with this PRA notice, CMS states "validation required on select elements; see technical specifications for further information." However, CMS does not specify these elements in the provided documentation. ***We ask CMS to provide the technical specifications as early as possible to ensure that plans have appropriate time to factor these elements into internal data collection, reporting, and validation processes as well as external processes with vendors and community-based organizations.***

The technical specifications should include a crosswalk of any codes used to measure utilization of each claims-based benefit (e.g., recognized dental claims codes for dental services). The specifications should also include clear guidance on any additional information plans must provide related to benefits not currently captured through a billing code (e.g., inpatient acute upgrades).

Additionally, we remind CMS that many of these new elements will require close coordination between the carriers, vendors, and community-based organizations that administer supplemental benefits. The current timeline proposed by CMS builds in two months between the close of the plan year and the submission of utilization data in February of the following year. This provides a short window for plans to gather end-of-year encounter data. There is no time for run out for claims for the supplemental benefits.

Validation of utilization elements may require additional time and resourcing that would add to the collection and reporting burden on both plans and benefit providers. Plans' vendors may not have the capability to provide some of these data elements and will need time and resources for IT and software changes to provide such data to plans; therefore, it is important that CMS release the final technical specifications and identify which elements may be subject to validation.

We also encourage CMS to explore updates to the Plan Benefit Package (PBP) module and reporting mechanisms that support more efficient data collection and submission through the Part C bid and reporting processes. If CMS determines opportunities to utilize the new application programming interface (API) to support data collection, we ask that plans have the opportunity to review and test any new data fields early and work through

any potential issues with CMS. We welcome the opportunity to work with CMS on this and further improvements to the PBP submission and Part C reporting processes.

Comments on Specific Reporting Elements

We recognize the importance of collecting additional data on supplemental benefit cost and utilization to better understand the value provided to MA enrollees. Our below comments focus on how to initiate this data collection and reporting while recognizing that plans continue to work with vendors and partners to develop the infrastructure for timely reporting of more detailed data elements.

Organization Types Required to Report

We recommend that CMS not require reporting by 800 series plans and employer/union direct contracts at this time. Per CMS requirements, Employer Group Waiver Plan (EGWP) PBPs are filed to reflect Original Medicare benefit design. Pricing of any benefits above or beyond Original Medicare is addressed through the underwriting process. Information on supplemental benefits, including pricing and member utilization, is shared with each individual employer/union client when designing benefits that meet the needs of their specific member populations. We recommend that CMS begin with individual plan reporting and welcome the opportunity to work with CMS to develop processes for the collection of supplemental benefit cost and utilization data for EGWPs in future years.

PBP Category Elements 1a-13i-O

We appreciate CMS utilizing the existing categories currently used under the PBP. Data and costs related to each supplemental benefit provided under individual plans are currently submitted to CMS as part of the PBP. ***We recommend that CMS limit the additional reporting of elements already provided through the annual PBP filing to minimize the submission of duplicate data to CMS.***

Element C: How is the supplemental benefit offered?

CMS proposes to require that "if the same supplemental benefit is offered in multiple ways, please report Data Elements C-J for each offering type separately." For certain supplemental benefits, vendors may have overall utilization data readily available, but a plan may have to request, sometimes at cost, additional data reports, to drill down to more specific elements such as utilization by benefit type. Furthermore, even if plans receive additional reports from vendors, manual calculation and analysis may still be required to determine if a single enrollee utilized a benefit under two offering types (e.g., where an

enrollee has transportation allowance under one benefit type and an additional allowance that kicks in once the other benefit is exhausted).

We recommend that at least for the initial reporting period, CMS require plans to report how each supplemental benefit is offered (mandatory, optional, uniformity, flexibility, SSBCI not offered) but permit Data Elements C-J on spend and utilization to be reported in the aggregate across all benefit types under a single PBP as plans work with vendors on the more granular collection of data.

Elements F-H: Enrollee Utilization

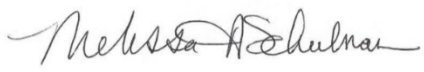
We appreciate the need to better understand enrollee utilization of supplemental benefits. As stated earlier, we believe it is important to begin with an initial set of requirements, phasing-in additional elements over time. ***For the initial reporting year, we recommend that CMS require reporting of Element G only (The total instances of utilizations among eligible enrollees).*** As we work with vendors to develop the infrastructure for the efficient collection and calculation of data, we recommend that Elements F and H be considered for addition in future years (the number of enrollees who utilized the benefit at least once; the median number of utilizations among enrollees who used the benefit at least once).

Closing

As supplemental benefits continue to play a critical role in addressing the needs of MA enrollees, we recognize the interest in additional data collection. As part of this effort, we ask that CMS continue to work with plans and stakeholders on methodologies for evaluating the value and effectiveness of supplemental benefit offerings using the collected data.

Thank you for considering our recommendations and comments and welcome any questions you have or further guidance you can provide.

Sincerely,



Melissa Schulman
Senior Vice President, Government & Public Affairs
CVS Health

May 11, 2023

Via Electronic Submission: http://www.regulations.gov

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency/Docket Number CMS-10261, Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a)

Dear Ms. Brooks-LaSure,

The Home Care Association of America (HCAOA) respectfully submits these comments to the Centers for Medicare and Medicaid Services in response to the above-referenced request for comment published in the Federal Register on March 14, 2023, at 88 Fed. Reg. 15726. We thank you for the opportunity to comment on this important topic, and to bring the concerns of the home care community to the Commission's attention.

Founded in 2002, HCAOA is the home care community's leading trade association—currently representing over 4,200 companies that employ more than 2.4 million caregivers across the United States. Our member agencies provide medical, skilled, personal and companion home care, enabling seniors and individuals with disabilities to remain in their homes as long as possible at a cost that is more affordable than institutionalized care. Home care also encompasses Private Duty Nursing (PDN), which is medically necessary nursing services under Medicaid caring for medically fragile patients, primarily children. Our members and their caregivers assist with a variety of non-medical activities of daily living, such as bathing, dressing, eating, and other services necessary for seniors and the disabled to thrive at home. It is through this community of members that the HCAOA has championed quality home care services. (See "The Value of Home Care" for a discussion of the benefits aging at home has for seniors and their families, available here.)"

HCAOA's Position on Part C Medicare Advantage Reporting Requirements Generally

CMS's Part C reporting requirements are a vital component of the Center's mission, as they help ensure accountability, transparency, and the delivery of high-quality healthcare services to beneficiaries. HCAOA believes that the reporting requirements should be streamlined and, when feasible, standardized across all Medicare Advantage plans. The current reporting requirements can be fragmented and vary between plans, making it challenging for beneficiaries to compare the quality of services provided. Standardizing the requirements will help ensure consistency and ease of compliance. Standardization will

also enable better comparison across different plans, making it easier for beneficiaries to select the plan that best meets their needs.

Reporting requirements should focus on outcomes rather than processes. Currently, the reporting requirements focus on the processes used by Medicare Advantage plans to deliver care. However, measuring the effectiveness of these processes may not accurately reflect the quality of care received by beneficiaries. Therefore, the reporting requirements should incorporate a broad range of quality measures that capture the full spectrum of care provided by Medicare Advantage plans. These measures should include not only clinical outcomes but also patient satisfaction and quality of life metrics, as these are critical indicators of the overall quality of care.

It's also important to ensure that the reporting requirements are kept relevant and up to date with the latest healthcare practices and technologies. Reporting requirements should be reviewed regularly to ensure that they remain relevant and effective in driving quality improvement in Medicare Advantage plans. A regular review process will help ensure that the program continues to provide high-quality care to beneficiaries while promoting efficiency and cost-effectiveness.

Reporting requirements for Part C Medicare Advantage plans should promote accountability, transparency, and the delivery of high-quality healthcare services to beneficiaries. Standardizing the requirements, focusing on outcomes rather than processes, and regular review to ensure relevance will help drive improvements in the program, and ultimately, improve the quality of care for Medicare Advantage beneficiaries.

More and Better Data Needed from Medicare Advantage Organizations

Many Medicare Advantage Organizations (MAOs) differentiate themselves from their competitors by offering various supplemental benefits within their Medicare Advantage (MA) plans. Home care is one of these supplemental benefits, the usage of which is rapidly expanding. However, CMS has limited information on enrollees' use of supplemental benefits generally, particularly newer offerings such as home care. The information CMS currently collects on supplemental benefits offered by MA plans is limited; it does not include complete information on the extent to which enrollees are using the supplemental benefits that plans offer. According to federal regulation, plans must submit encounter data for supplemental benefits to the extent required by CMS. However, a recent GAO report[1] found that encounter data submitted by plans do not provide complete information on enrollees' use of supplemental benefits for reasons that include confusion about reporting requirements.

Having more complete information on the extent to which enrollees are using supplemental benefits, such as from the encounter data, would put CMS in a stronger position to make more informed policy decisions, consistent with its 2022 strategic framework, and meet goals it has stated related to supplemental benefits. For example, CMS has a stated goal of gaining a greater understanding of how supplemental benefits are meeting their intended purposes, such as improving or maintaining enrollees'

[1] https://www.gao.gov/products/gao-23-105527

overall health and social needs. CMS has also established the goal of ensuring that supplemental benefits are addressing the most critical care gaps and barriers to care. A third goal is improving the transparency of how Medicare dollars are being spent on certain benefits, including supplemental benefits.

Although limited, encounter data are currently the agency's primary source of information on enrollees' use of supplemental benefits. The bid pricing data submitted by plans to CMS also contain some information on the use of certain supplemental benefits. The purpose of these data, however, is to show how each plan developed its projected costs for providing those benefits. As such, there are certain factors that limit the use of these data in assessing utilization of supplemental benefits. For example, plans report utilization data separately for certain traditional supplemental benefits only: dental, hearing, transportation, and vision. The data for all other supplemental benefits—which includes other traditional supplemental benefits (such as fitness or over-the-counter items) and all newer types of benefits—are rolled up into two other categories. Furthermore, even for types of supplemental benefits reported separately, there was some variation in the units of services used by plans.

HCAOA's Position on CMS' Proposal

HCAOA supports CMS in its decision to require MAOs to annually submit data on the utilization and cost of supplemental benefits, matched to Plan Benefit Package (PBP) reporting categories and delineated by the authority under which each plan offers the benefits (mandatory, optional, mandatory-SSBCI, and mandatory-UF). Providing greater insight into the utilization of and spending on supplemental benefits will be of great benefit to the clients of our home care agencies.

Breaking out this data into discrete parts and standardizing how it is collected and conveyed will go far in helping consumers choose MA plans consistent with their needs. Tables 1 and 2, contained in the supplemental documentation[2] provided by CMS in its request for comment, are a welcome solution to many of these problems and HCAOA applauds their introduction. Specifically, PBP Categories 14c21 and 14c22, relating to In-Home Support Services and Support for Caregivers of Enrollees, respectively, represent a terrific opportunity for CMS to continue the strides it has made in supporting services that the American public has come to rely on.

HCAOA is mindful, however, of the increased administrative burden these disclosure requirements pose to our agencies. We believe the collection and submission of spend and utilization numbers related to each benefit MA plans offer would allow for greater flexibility to agencies in gathering data while offering similar levels of transparency and informational benefit to enrollees.

HCAOA believes that obtaining and employing more and better data on those who utilize MA services as well as the types of MA services offered benefits our industry as well as those we serve. Our association thanks you for the opportunity to comment on this proposed change and stands ready to offer any assistance we can.

[2] https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-10261

Sincerely,

Vicki Hoak, CEO
Home Care Association of America

PUBLIC SUBMISSION

As of: 5/17/23, 1:01 PM
Received: May 15, 2023
Status: Draft
Category: Federal Government - G0005
Tracking No. lhp-bea9-b6up
Comments Due: May 15, 2023
Submission Type: Web

Docket: CMS-2023-0041
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Comment On: CMS-2023-0041-0001
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Document: CMS-2023-0041-DRAFT-0012
Comment on CMS-2023-0041-0001

Submitter Information

Email: amy.l.schultz@healthpartners.com
Organization: HealthPartners

General Comment

HealthPartners appreciates CMS' efforts to fill data gaps related to supplemental benefits cost and utilization in the Medicare Advantage (MA) program. We have significant concerns with the level of reporting proposed and the burden on MA organizations. We offer the following recommendations for consideration.
1. CMS modify the scope of supplemental benefits to include only those services for which there is no ability to submit an encounter data record; e.g. fitness benefit, capitated vendor arrangements, reimbursement models, etc. Requiring data for PBP categories CMS has access to already is duplicative and unnecessarily burdensome to MAOs. This approach of reporting data not submitted via encounter data records recognizes other data sources, reduces the burden on the plan and provides the data CMS is seeking. In addition, HealthPartners recommends that CMS continue work to configure the MA Encounter Data System to accept 837-D files for dental services.
o If CMS moves forward with the requirement to report supplemental benefit utilization and costs for services billed as traditional medical claims and reported already via MAO encounter data, we recommend reducing the granularity of service category reporting required, for instance requiring costs and utilization to be reported as a higher-level summary rather than PBP Category level. Reporting costs at the PBP Category level represents a significant expansion of reporting requirements in many cases (for instance, requiring plans to report "additional inpatient days" beyond Original Medicare, where bidding rules currently provide a safe harbor pricing approach that obviates the need for MAOs to estimate Original Medicare coverage) and may violate rules on privacy of Protected Health Information (PHI) if released publicly for small MAOs (even if de-identified at the beneficiary level).

2. CMS exclude EGWPs from the reporting requirement. This approach would follow how CMS waives EGWPs for PBP and bid filings, regulatory filing of plan marketing and communications, and other CMS requirements. These plans are limited to members of an employer or union group health plan under waiver authority and often include multiple plan designs per group. Reporting of the data will be extremely time consuming and burdensome on the plan. Alternatively, HealthPartners recommends phasing in EGWPs in CY2025 or later.

3. The proposed data elements include sensitive pricing information, particularly if released at the detailed PBP Category level. Please clarify what information will be public data and the timing for data to be public. We also believe that HIPAA privacy rules may come into play if small sample sizes of detailed category-level data is released publicly for smaller MAOs (even if de-identified at the beneficiary level).

Humana Inc.
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Louisville, KY 40202-2946
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Humana

May 15, 2023

William N. Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; Part C Medicare Advantage Reporting Requirements [CMS-R-10261 (OMB control number 0938-1054)]

Dear Mr. Parham:

This letter is in response to the Centers for Medicare and Medicaid Services (CMS) agency information collection notice on the Part C Medicare Advantage Reporting Requirements [CMS-R-10261 (OMB control number 0938-1054)] as issued on March 15, 2023.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 5.1 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 3.5 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states. Additionally, Humana's successful history in care delivery and health plan administration is helping to create a new kind of integrated care with the power to improve health and well-being and lower costs.

Collection of Additional Data Elements

CMS proposes to update the Medicare Advantage (MA) Reporting Requirements to collect additional data elements related to supplemental benefits cost and utilization among plan enrollees, beginning on January 1, 2024.

> **Humana Comment:** Humana appreciates CMS's efforts to improve its understanding of the accessibility and utilization of supplemental benefits by MA enrollees. Supplemental benefits offered by MA plans are often a driving force behind beneficiaries choosing to enroll in MA, allowing them additional access to benefits such as hearing, vision, and dental benefits, as well

as newer benefit options, such as those offered through the Special Supplemental Benefits for the Chronically Ill (SSBCI) and Value-Based Insurance Design (VBID) Model, that permit MA plans to design benefits to address enrollees' social needs. We value recent changes CMS has made to allow MA plans additional flexibility to provide supplemental benefits that improve our members' health and wellbeing.

Humana is concerned that the proposed deadline for submission of this new, significantly more granular data on supplemental benefits – the last Monday in February of the following year – will be challenging for MA plan sponsors to meet, especially in the first few years after the proposed changes go into effect. Currently, Humana submits bids with one month of run out, ending on January 31 of the following plan year, and it can take two- to three-months to collect the data we need for the Bid Pricing Tools (BPTs). The proposed end of February due date also leaves open the amount of run out time plans should have on this data and could cause it to be out of sync with data supplied via the BPTs. We recommend that CMS adjust the due date for the supplemental benefit data to be later in the calendar year, after bid submission, to provide plans with more alignment with regard to the BPTs. Humana also recommends that the deadline be adjusted to match the run out period used in bid submissions. CMS should also consider providing plans with additional time in the first two years after the proposed reporting requirements are implemented, in order to ensure plans have ample time to comply. These new data reporting requirements will require significant investment from MA plan sponsors and aligning data reporting deadlines will assist in alleviating some of this burden.

Additionally, much of the data CMS proposes to include in the updated reporting requirements is already in the BPT submitted to CMS and would be duplicative. Humana administers 45 MA managed care organization contracts in 2023, with 823 individual MA plans and within those, varying supplemental benefit packages. Requiring the submission of data at the proposed level of granularity for all supplemental benefits will require MA plan sponsors to hire additional staff to collect and submit the data, as well as expend additional resources for new or updated systems in order to produce the required reporting and to meet the data retention requirements. Currently, Humana receives much of the data on supplemental benefits from contracted vendors and this data is not always at the level of granularity that CMS is proposing to require. Contracts with vendors may also need to be updated in order for plans to receive the data from these vendors in a format and level of detail required to meet these proposed reporting updates – a factor that does not appear to be included in CMS's burden estimates.

Lastly, these proposed requirements may not provide CMS useful data for Employer Group Waiver Plans (EGWPs). A single EGWP may have multiple group customers that offer different supplemental benefits and different benefit types. This arrangement will likely make pulling this data for submission to be complex as well as unlikely to produce clear reporting that CMS can use to further its understanding of the accessibility and usability of supplemental benefits. We recommend that CMS exempt EGWPs from the proposed supplemental benefit reporting requirements.

As always, we value this opportunity to provide comments and are pleased to answer any questions you may have. We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, focused on improving their total health care experience.

Sincerely,

Michael Hoak
Vice President, Public Policy

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

May 4, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development,
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via regulations.gov

Re: Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041

Justice in Aging appreciates the opportunity to submit comments in response to the above-referenced proposed Medicare Advantage reporting requirements and collection of supplemental benefit utilization and cost data. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

Justice in Aging supports CMS's proposal to resume collection of key data with regard to supplemental benefits offered and provided by Medicare Advantage plans. Medicare Advantage plans are permitted to offer benefits that are not available in traditional Medicare with the goal of improving the health and wellbeing of plan enrollees. Supplemental benefits are financed by rebates CMS pays to plans. Such rebates have increased significantly over recent years and Medicare Advantage plans heavily market the availability of these benefits to Medicare enrollees. Yet, despite the significant federal funding that plans are receiving to offer benefits and the gains in enrollment that plans have realized through the marketing of supplemental benefits, there is no data on the extent to which Medicare enrollees are actually receiving and utilizing supplemental benefits.

Accordingly, we strongly support CMS's proposal to require Medicare Advantage plans to report on utilization measures for supplemental benefits categorized by the authority under which each plan offers supplemental benefits (mandatory, optional, SSBCI, uniformity flexibility) and the costs plans and enrollees expended on supplemental benefits.

We also urge CMS to require plans to report demographic data with the proposed utilization and cost measures. Utilization and cost data paired with demographic data is necessary to determine whether Medicare Advantage plans are providing equitable access to supplemental benefits. Specifically, CMS should add disaggregated reporting fields for proposed data elements E through J for race/ethnicity; age; rural/urban status; disability, language, sex, sexual orientation, and gender identity. Such data collection promotes Executive Order 13985 which calls for advancing equity for underserved

populations and advances the goals and objectives outlined in the CMS Framework for Health Equity 2022-2032 and the HHS Equity Action Plan.[1]

Lastly, we urge CMS to make the data it collects from Medicare Advantage plans publicly available and request CMS to review and analyze the data in its oversight capacity. We also ask that the data be collected and maintained in formats that facilitate analysis by researchers and other analysts.

If any questions arise concerning this submission, please contact Amber Christ achrist@justiceinaging.org or Georgia Burke at gburke@justiceinaging.org.

Sincerely,

Amber C. Christ
Managing Director, Health Advocacy

[1] Executive Order 13985, https://www.whitehouse.gov/briefing-room/presidentialactions/2021/01/20/executiveorder-advancingracial-equity-and-support-or-underservedcommunities-through-the-federal-government/; CMS Framework for Health Equity 2022–2032: https://www.cms.gov/files/document/cmsframework-healthequity.pdf; HHS Equity Action Plan, https://www.hhs.gov/sites/default/files/hhs-equity-action-plan.pdf.

LONG-TERM
QUALITY ALLIANCE

May 15, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development, Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041

Long-Term Quality Alliance (LTQA) appreciates the opportunity to provide comments on CMS' proposal to revise Part C Medicare Advantage Reporting Requirements to require annual submission of data on the utilization and cost of supplemental benefits, published in the Federal Register on March 14, 2023.[1]

LTQA is a 501(c)3 membership organization aimed at improving outcomes and quality of life for people who need long-term services and supports (LTSS), and their families.[2] LTQA advances person- and family-centered, integrated LTSS through research, education, and advocacy.

Beginning in 2019, with funding support from The SCAN Foundation, LTQA and our research partners at ATI Advisory have conducted a multi-year study tracking the industry's progress over time on the implementation of nonmedical supplemental benefits in Medicare Advantage (MA), including both nonmedical benefits under the expanded definition of "primarily health-related benefits" (PHRB)[3] as well as Special Supplemental Benefits for the Chronically Ill (SSBCI). Over the past several years, LTQA and ATI Advisory have analyzed MA Plan Benefit Package data and interviewed over 40 organizations, including MA plans, service providers, consumer advocacy groups, policy experts, researchers, and other stakeholder groups, culminating in multiple reports and data briefs on the progress of plans and providers in implementing these benefits over time and policy recommendations to advance uptake and access further.[4] LTQA's comments on this proposal draw from our extensive research on these benefits as well as our ongoing engagement with a working group comprised of national experts on MA and LTSS, known as the "SSBCI Leadership Circle," which provides guidance on our research.[5]

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[1] Agency Information Collection Activities: Proposed Collection; Comment Request, CMS-2023-0041. Available at: https://www.federalregister.gov/documents/2023/03/14/2023-05145/agency-information-collection-activities-proposed-collection-comment-request

[2] See full list of LTQA members on our website.

[3] In 2018, CMS expanded the definition of what was considered "primarily health-related" to include services that diagnose, prevent, or treat an illness or injury; compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization. This authority allowed plans to offer a broader set of supplemental benefits, starting in Plan Year 2019, as "primarily health-related," including services like In-Home Support Services and Caregiver Supports.

[4] See our project website for our research and resources for plans, providers, and policymakers to advance the availability and implementation of nonmedical supplemental benefits in Medicare Advantage.

[5] See full list of working group (known as the "SSBCI Leadership Circle") participants here.

LTQA strongly supports CMS' proposal to require Medicare Advantage Organizations (MAOs) to submit data to CMS annually on the utilization and cost of supplemental benefits, which is directly aligned with our policy recommendation that we have been promoting since November 2021.[6] This proposal, if implemented, will provide greater transparency into utilization and spending for supplemental benefits and valuable information for policymakers, researchers, beneficiaries, and the general public. This reporting requirement will open a line of sight into utilization of these benefits that has not existed since the new authorities to offer these nonmedical supplemental benefits were introduced.

In our research, we have continually emphasized how the lack of data on utilization of these benefits impedes the research and policymaking community from understanding who is accessing these benefits and how often. Without information on utilization, it is not possible to assess—even on the most basic level—whether these benefits are having the intended impacts on beneficiaries. Additionally, lack of data impedes assessment of whether benefits are being delivered equitably to individuals of diverse backgrounds (e.g., age, race/ethnicity, language, geography, disability, gender identity).

We support CMS' proposal to report utilization and cost data matched to Plan Benefit Package (PBP) reporting categories and categorized by the authority under which each plan offers the benefits (mandatory, optional, mandatory-SSBCI, mandatory-UF). We also encourage CMS to consider implementing the following guidelines to improve the quality and value of the data that are collected:

- Require reporting of key demographic data – We urge CMS to require plans to report key demographic data along with the proposed utilization and spending measures. The SSBCI Leadership Circle highlighted equitable receipt of SSBCI as a guiding principle for the implementation of these benefits,[7] and yet it is not possible to assess this without demographic utilization data. One way that CMS could address this important data gap is by requiring plans to report data elements E-J (number of enrollees eligible for the benefit, through total out-of-pocket cost per utilization for enrollees) disaggregated by key demographic variables, starting with age and race/ethnicity/language. This would help to advance President Biden's Executive Order 13985 which calls for advancing equity for underserved populations as well as the CMS Framework for Health Equity 2022-2032 and the HHS Equity Action Plan.

- Provide more specific guidance around unit of utilization (data element D) – Currently, CMS has proposed an open-text field for the unit of utilization used by the plan when measuring utilization (e.g., admissions, visits, procedures, trips, purchases). We caution CMS that in the absence of more specific definitions/standards around unit reporting, the data CMS receives will likely be highly inconsistent and impede CMS' ability to conduct apples-to-apples comparisons across MAOs. For example, for non-medical transportation, some plans may report trips as one-way trips while others may report roundtrips, without specifying this in the open-text field. CMS can mitigate this by providing more detailed specifications around the different types of units, particularly for the nonmedical benefits that may follow more unconventional unit reporting.

[6] In our Fall 2021 Policy Report, we recommended that CMS develop incentives for plans to submit data on utilization for all supplemental benefits, including key demographic information, to support efforts to measure and ensure equitable access to these benefits. We reinforced this recommendation to implement reporting requirements and incentives in our Spring 2022 policy recommendations for Congress, as well as in multiple comment letters to CMS, including in response to the CY 2023 Medicare Advantage and Part D Proposed Rule and CMS' Request for Information on Medicare Advantage (August 2022).
[7] See the Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill here.

- Consider additional guidance around utilization reporting for supplemental benefits accessed via debit cards – As more MAOs are moving towards offering supplemental benefits through debit cards, CMS should also consider how utilization of these benefits will be reported, especially in cases where multiple benefits can be purchased via a debit card. It may be useful to explore whether plans can report categories of spending from the debit cards. The CMS Value-Based Insurance Design (VBID) model has released guidance on reporting benefits made available via spending cards that should be used as a starting point for broader reporting on these benefits across all MA plans.

- Add a data field for MAOs to submit information on eligibility criteria for each benefit – Under the current proposal, plans would be required to submit data on the number of enrollees eligible for the benefit (data element E). While plans are required to submit in their bids the chronic conditions to which eligibility for supplemental benefits are tied, the new utilization and cost dataset would be enhanced by the inclusion of information on how plans determine who is eligible for a benefit across all three parts of SSBCI eligibility criteria. In addition to the chronic condition eligibility criterion, beneficiaries eligible for SSBCI must have a high risk of hospitalization or other adverse health outcomes and require intensive care coordination. Plans may also use social determinants of health (SDoH) as secondary targeting criteria. Thus, we recommend that CMS require plans to clearly specify all eligibility criteria for supplemental benefits (e.g., targeted chronic conditions plus hospitalization, or targeted chronic conditions plus prior year spending in the top 10 percent of members). Notably, for some PHRB for which all members are eligible, plans would report "none" for this field. Requiring reporting of these data will support CMS' and researchers' ability to compare eligibility, uptake, and spending across plans. Furthermore, as appropriate, CMS should consider how to collect data to distinguish between the eligible population and the targeted population for these benefits and should carefully consider which data fields to make publicly available. CMS may garner lessons from the new VBID utilization reporting that is currently underway, which makes this distinction.

- Consider adding a data field for "maximum number of utilizations among enrollees who utilized the benefit at least once" – While the current proposal would require plans to report the median number of utilizations among utilizers (data element H), collecting data on the maximum usage for each benefit would provide helpful context to interpret the median values. These data would offer a sense of variation in utilization for each benefit and which way the utilization curve skews.

- Explore potential options to capture incremental cost of service vs. overhead costs – In collecting cost data, CMS could consider asking plans to separate out cost to administer a benefit from the cost to deliver a service, in an effort to understand how much a unit of service is actually costing the plan. Having a more granular view of the unit costs vs. overhead costs would add additional insights to the MLR-related questions that are being posed around supplemental benefits.

Finally, we strongly urge CMS to make the data publicly available in a timely manner and in formats that facilitate analysis by researchers. From a research perspective, publicly releasing data within six months to a year after the end of a contract year would support responsive evaluation of the implementation of these benefits and continuous quality improvement. We have also heard concerns from MA plans that more detailed reporting may reveal sensitive information around benefit design, payment arrangements, etc. that could discourage plans from offering these benefits. We believe nonmedical supplemental

benefits are valuable for supporting Medicare beneficiaries with complex care needs, and we support proposals that advance these benefits and advocate for continued investment and growth in these benefits while avoiding a cooling effect on these offerings. We support public reporting of the data if they are released on a lagged time frame and report the most granular data feasible.

We are thrilled to see CMS taking this critical step to increase transparency into utilization and spending for supplemental benefits – a necessary step to move the needle on these benefits and to improve regulations around their design and delivery. We encourage CMS to start thinking ahead to capture lessons learned from this aggregated reporting to develop incentives and requirements for standardized beneficiary-level reporting in the future. Beneficiary-level reporting will be crucial to truly understanding the impacts of these benefits on health outcomes, healthcare utilization, and costs in the future.

We welcome the opportunity to discuss the policy changes in this proposed rule as well as our policy recommendations based on several years of research on the landscape of nonmedical supplemental benefits in Medicare Advantage. If you have any questions, please contact me at mkaschak@ltqa.org.

Sincerely,

Mary Kaschak
Chief Executive Officer

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Coverage Year (CY) 2024 Part C Reporting Requirements (2023-05145; CMS-10261)

Lumeris appreciates the opportunity to respond to the Centers for Medicare & Medicaid Service's (CMS) proposed changes for the Coverage Year (CY) 2024 Part C Reporting Requirements. Lumeris supports CMS' strategic vision and its core principles of person-centered care through its operation of Essence Healthcare's plans and as a leader in value-based care solutions for provider systems. Essence originated as a purposely built provider-aligned Medicare Advantage (MA) plan with the aim of producing the industry's highest quality clinical outcomes and highest rated consumer satisfaction while driving market leading reductions of inpatient utilization and overall medical costs. As an organization, Lumeris is dedicated to the idea that radical change in health outcomes and performance occurs by placing patients at the center of care and decisioning, support by committed provider, payers, and technologies moving synergistically toward the goal of improving and maintaining a patient's health. Our commitment to our Essence members is the same – high quality care can be accessible and affordable to all beneficiaries when supported by value-based agreements that drive both quality outcome measures and cost management.

We welcome the agency's openness to stakeholder input and ongoing commitment to enhancing the types of data collected to evidence the successes of the MA program. Below is feedback from Lumeris team members and key stakeholders regarding the proposed changes.

Element A – PBP Category

It is unclear from the current version of the Reporting Requirements whether items/services included under a specific PBP category value should be lumped together into one line item or reported separately. For example, PBP category 13i under Supplemental Benefits for the Chronically Ill (SSBCI) includes distinct services such as "food and produce," "pest control," "transportation for non-medical needs," and "structural home modifications." Given the diversity in types of benefits that may be offered under a specific PBP category, Lumeris recommends that CMS provide clarity in the final Reporting Requirements on how organizations should report sub-items under a PBP category.

Element D – Unit of Utilization

We appreciate CMS providing flexibility to plans on how to define a unit of utilization; however, we are concerned that differences in reporting on benefits could result in a lack of ability to accurately compare data across plans. Using the example of supplemental out-of-network (OON) services, if some plans report by the number of visits (rolling up all services from a visit into one item) and others report by the individuals procedure/service, the comparison of utilization rates and subsequent calculations on a per utilization basis would be differential. We recommend that CMS consider the potential differences in interpretation when finalizing how to contextualize the unit of utilization.

Element E – Number of Eligible Enrollees

Lumeris recommends that CMS provide clarification in the final Reporting Requirements on whether the number of enrollees eligible for a benefit should reflect the number eligible at the beginning of the coverage year or at the end of the coverage year for the applicable reporting period. Given that the number of individuals eligible for a benefit may change month to month, we believe standardizing how plans count eligible individuals will reduce confusion and potential differences in reporting across plans.

Element G – Total Instances of Utilization

Lumeris recommends that CMS provide clarification on whether the total instances of utilization among eligible enrollees should include both paid and denied services. Given that claims may deny for a variety of reasons, we believe it is essential to standardize either inclusion or exclusion of denied claims for the purposes of understanding benefit utilization through the Reporting Requirements.

Element I – Total Amount Spent by the Plan

Some supplemental benefits are paid on a fee-for-service basis while others fall under per member per month (PMPM) arrangements with delegated vendors. While the element states that this should be the "total amount spent by the plan for enrollees who utilized the benefit," Lumeris requests clarification from CMS on whether PMPMs should be included in the total cost regardless of enrollee utilization or only if an enrollee utilized the benefit at least once during the reporting period.

Element J – Total Out-of-Pocket Cost

Lumeris seeks clarification from CMS around which out-of-pocket costs should be included in this calculation. Member liability may be dependent on a variety of factors and may be the result of denied claims. It is unclear whether plans should include all out-of-pocket costs (including for denied items, non-covered items under the benefit, and approved items where the cost of the services exceeds the maximum benefit limit) in the calculations for this element. We would recommend that CMS described more in-depth which costs are eligible for reporting under this element. Additionally, comparability across plans with respect to this element will be highly dependent on how each plan defines their unit of utilization.

VIA ELECTRONIC SUBMISSION: https://www.regulations.gov/

May 12, 2023
Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

CMS-10261: Part C Medicare Advantage Reporting Requirements

Dear Administrator Brooks-LaSure,

Introduction
The Special Needs Plan (SNP) Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent 27 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs). These plans have over 3 million beneficiaries enrolled in 47 states and the District of Columbia—totaling more than 55% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid. On behalf of our 27 members, the SNP Alliance appreciates the opportunity to comment on these proposed reporting requirements.

Proposed Medicare Part C Reporting Requirements
Supplemental benefits and Supplemental Benefits for the Chronically Ill (SSBCI) are integral to meeting the needs of beneficiaries enrolled in special needs plans (SNPs). Populations that qualify for enrollment in SNPs have higher rates of chronic conditions and complex care needs—requiring access to supplemental benefits, such as SSBCI, to receive whole-person centered care. For beneficiaries enrolled in SNPs, over 26% have five or more chronic conditions.

The SNP Alliance supports this effort by CMS to establish reporting requirements for supplemental benefits with three primary concerns as outlined below. We encourage data to be collected to demonstrate the impact and use of supplemental benefits and SSBCI to improve understanding of services provided to SNP beneficiaries. Due to the complex nature of SNP enrollees and their reliance on these benefits, increasing reporting to demonstrate benefit offerings, enrollment, cost, and outcomes will increase our knowledge of these populations and the benefits upon which they rely. CMS is proposing reporting requirements such as but not limited to:

- How the benefits are offered
- The unit of benefit utilization
- Number of enrollees eligible for the benefit
- The number of enrollees who utilized the benefit at least once
- Total amount spent by the plan for enrollees who utilized the benefit
- The total out-of-pocket cost per utilization for enrollees who utilized the benefit

SNP Alliance Concerns with Reporting Requirements

While the SNP Alliance supports reporting of SSBCI, we would like to highlight three areas of concern:

1. Operational difficulties.
2. Data is reported at the contract level.
3. Reporting requirements do not accurately account for how supplemental benefits are offered.

1. Operational Difficulties

Subcontracting Coordination and Management of Benefits and Services

These reporting requirements will prove especially difficult for dual eligible SNPs (D-SNPs), who are charged with integrating Medicare and Medicaid, and therefore collecting data for both programs. The difficulties will primarily occur with reporting requirements for HCBS, as MCOs often subcontract coordination and management of some (or all) HCBS. Additionally, D-SNPs may also subcontract supplemental benefits for both Medicare *and* Medicaid services to be managed and coordinated. Taken together, many D-SNPs are overseeing Medicare Parts A and B services, Medicare supplemental benefits, HCBS, and Medicaid supplemental benefits, often with multiple subcontracts for benefit coordination and management. Incorporating all information and data to meet the reporting requirements will be operationally difficult, as many community organizations, who are often subcontracted to provide services, do not have sophisticated data tracking or exchange systems that allow for robust data exchanges with the plans.

Example: Many supplemental benefits are from small entities such as local culturally embedded or specialized service community organizations that, as mentioned above, do not have sophisticated data tracking or exchange systems that would allow for robust data exchange with the plan. This may limit the timeliness or completeness of data available to the plan to report.

Standardizing Units of Service

"Units of service" also poses difficulties for reporting, as there is difficulty standardizing and defining units of service for tracking, aggregating, and comparison purposes. Plans often contract with entities to provide packages or episodes of care with multiple touch points. Therefore, standardized definitions of units of service need to be outlined by CMS to ensure clarity and uniformity.

Example: A plan may contract for a bundled service that provides multiple home visits, such as the evidence-based CAPABLE program, which has 10 home visits by an OT and RN, plus home repair services which are usually provided in two visits. Would this be counted as one service or twelve visits, and how would the physical home repairs be unitized? There are other evidence-based programs which also provide multiple sessions and service components.

Caregiver Services

Family and friend care partners (caregivers) are integral to better management of activities of daily living and care management of chronic conditions at home. Plans are recognizing and trying to support these caregivers. When the supplemental benefit is a supportive service for the caregiver, we assume the service would be attributed to the beneficiary, which is why standardized service definitions and units will be important for consistent reporting.

SNP Alliance Request: The SNP Alliance asks CMS to consider not implementing reporting requirements on all data elements at once, and instead implement reporting requirements over multiple years. This will allow for plans and those they subcontract to manage and coordinate services and benefits to build the appropriate reporting infrastructure.

2. Data Reported at the Contract Level

Data collected on supplemental benefits feeds into MLR filing. The result of this is the data is only presented at the contract level and contains both individual MA and employer group plans. The SNP Alliance is concerned the data collected around supplemental benefits will lead stakeholders to erroneous conclusions

about the benefits being offered across MA plan types, resulting in a lack of clarity on offering, enrollment, and cost of supplemental benefits, in addition to the population-level measures of supplemental benefits.

SNP Alliance Request: We urge CMS to be transparent about any limitations to the dataset in future dissemination of the data.

3. Reporting Requirements Do Not Account for How Supplemental Benefits are Offered and Tailored

The great variety in types and scope of services that can be offered through the SSBCI option is of great value and part of what Congress intended when creating this policy. We are concerned this variety and scope of services will not be represented or displayed when beneficiaries are reviewing specific plans. In serving beneficiaries with complex care needs, SNPs are often balancing beneficiary choice of supplemental benefits with tailoring supplemental benefits to the needs of a target population. Many SNPs allow beneficiaries to choose supplemental benefits from a larger menu of options. This ensures beneficiaries have access to a variety of supplemental benefits and have choice in their benefits as well. SNPs also tailor supplemental benefits to specific populations and subpopulations that are targeted by their models of care. Due to beneficiary choice and plan tailoring of supplemental benefits to meet the needs of specific populations and subpopulations targeted in models of care, there is concern that data collected will not demonstrate the relative value of supplemental benefits to specific populations and plan types, in addition to being inaccurate when a beneficiary reviews a specific plan, especially with data being reported at the contract level.

Example: As noted above, SNPs target specific populations and subpopulations, evidenced by their models of care. To serve a specific population, SNPs offer a menu of supplemental benefits—tailored by the SNP to serve this population—that beneficiaries choose from to meet their needs. Due to beneficiary choice, some supplemental benefits offered are not chosen, yet the beneficiary possesses supplemental benefits that have been tailored for their specific needs by the SNP—balancing beneficiary choice with tailored benefits. The proposed reporting requirements, with the contract-level issues discussed earlier, will not demonstrate the relative value of supplemental benefits to specific populations and plan types, or reflect true beneficiary choice. The result could be misrepresentation and beneficiary confusion when beneficiaries are reviewing specific plans.

SNP Alliance Request: To avoid beneficiary confusion and misrepresentation, we ask CMS to collect and communicate the data in a way that reflects the many ways plans are tailoring and packaging supplemental benefits for specific populations and beneficiary choice. If CMS is unable to do so, we again urge transparency about the limitations of the dataset.

Conclusion

The SNP Alliance encourages proper reporting of supplemental benefits and this effort to increase and improve reporting. We agree there will be a benefit to increased reporting, primarily for beneficiaries and the ability to target needed supplemental benefits to particular and vulnerable populations. We also encourage CMS to be aware of the three concerns outlined by the SNP Alliance. We thank CMS for this opportunity to comment and look forward to working with CMS.

Respectfully,

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PUBLIC SUBMISSION

As of: 5/17/23, 12:48 PM
Received: May 10, 2023
Status: Draft
Category: Health Plan or Association - HP010
Tracking No. lhh-sw5j-sd7n
Comments Due: May 15, 2023
Submission Type: Web

Docket: CMS-2023-0041
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Comment On: CMS-2023-0041-0001
Part C Medicare Advantage Reporting Requirements (CMS-10261)

Document: CMS-2023-0041-DRAFT-0004
Comment on CMS-2023-0041-0001

Submitter Information

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General Comment

Upon review of the Supplemental Benefits portion of the requirement, this is a pretty significant requirement and would entail a great amount of work and conversations around specifics and how best to pull and report this information.

PUBLIC SUBMISSION

As of: 5/8/23, 12:03 PM
Received: May 05, 2023
Status: Draft
Tracking No. lha-p7bv-flud
Comments Due: June 26, 2023
Submission Type: Web

Docket: CMS-2023-0069
Medicare Part C and Part D Data Validation (CMS-10305)

Comment On: CMS-2023-0069-0001
Medicare Part C and Part D Data Validation (CMS-10305)

Document: CMS-2023-0069-DRAFT-0002
Comment on CMS-2023-0069-0001

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General Comment

Part C Reopening
2023 Part C Technical Specs https://www.cms.gov/files/document/cy2023-part-c-technical-specifications-222023.pdf

Under “Re-openings (Organization Determinations and Reconsiderations)” section, page 20, it does not specifically states which date should be used to pull in reopen cases.

Should report be pulled by when case was reopen or when reopen case was decisioned?

For example, if case was reopen on 11/01/22 and reopen decision was made on 03/01/23, for 2023 reporting year, should this case be reported in Q1 2023?

May 15, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10261 / OMB Control Number: 0938-1054
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Part C Medicare Advantage Reporting Requirements (CMS-10261)

Submitted Electronically: http://www.regulations.gov

Dear Sir/Madam:

UnitedHealthcare (UHC) is responding to "Part C Medicare Advantage Reporting Requirements," a request for information from the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register on March 14, 2023 (88 FR 15726). UHC is dedicated to helping people live healthier lives and making the health system work better for everyone by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. UHC offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries, and contracts directly with more than 1.3 million physicians and care professionals, and 6,500 hospitals and other care facilities nationwide.

UHC is pleased to submit the following comments, questions, and recommendations related to CMS's proposed new reporting section, *VIII. Supplemental Benefit Utilization and Costs*.

Section I - General Recommendations

Benefits that Combine Multiple PBP Categories
Our organization seeks guidance from CMS as to how Medicare Advantage Organizations (MAOs) are to report utilization of benefits that combine multiple PBP categories.

For example, an MAO may offer a plan that has a combined benefit allowance for Routine Chiropractic Care and Acupuncture Treatments. An individual member may choose to use the entire benefit allowance on one service or a combination of these two services. It is unclear whether CMS's expectation is for MAOs to report on each benefit separately even though it is a combined benefit, or whether CMS's expectation is for MAOs to combine the utilization data.

Recommendation: UHC recommends that MAOs be allowed to report the utilization data based on how the benefit was filed in the PBP. For example, in the case of a PBP-filed combined benefit, utilization would be reported to CMS as a combined benefit.

PBP Segments
Our organization seeks guidance from CMS as to how MAOs are to report utilization on PBPs when the PBPs include segments that offer differing benefits as segmented plans may have drastically different benefits within a single benefit category.

A single Medicare Advantage PBP may include a number of plan segments that offer different benefits, along with different values (i.e., cost-sharing or allowances) for those benefits. For example:

- One segment within a PBP may offer Over-the-Counter (OTC) or Personal Emergency Response System (PERS) benefits while other segments do not.
- One segment may offer a routine chiropractic benefit only, while the other segment offers a combined chiropractic/acupuncture benefit.

Recommendation: UHC recommends that CMS provide clarification as to how MAOs are to report the utilization on PBPs with segments that offer differing benefits.

Employer Group Waiver Plan (800-series) PBPs

In the Organization Types Required to Report, CMS indicated that organizations should include all 800 series plans. As CMS may be aware, EGWP benefits are not offered at the PBP level which means that a single EGWP PBP may support a large number of client plans with different ancillary benefits, including differences in coverage, cost-sharing and/or vendor/contracted rates. Because MAOs don't file EGWP-offered benefits in the PBP, the data reported will not tie back to the specific benefit designs/plans offered to EGWP clients.

Recommendation: Since reporting at the PBP level for 800 series plans will not provide insight into the experience within a particular benefit design, UHC recommends that CMS exclude EGWPs (800 series plans) from organization types that are required to provide reporting under Section VIII.

Value Based Insurance Design (VBID)

Recommendation: UHC supports not including the supplemental benefits offered through the Value Based Insurance Design (VBID) CMMI program in the Supplemental Benefit Utilization and Costs reporting since it is still currently a demonstration program managed by CMMI.

MMPs

CMS included "05-MMP" in the list of Organization Types Required to Report, however, CMS has also indicated that MMPs will sunset at the end of 2024. Given that MMPs are combined benefit plans (Medicare and Medicaid), the Medicare specific data cannot be carved out, these plan types will be sunsetting, and CMS will only receive one year of data, UHC recommends that CMS consider removing "05-MP" as an Organization Type that is required to report.

Recommendation: UHC recommends that MMPs be excluded from this reporting requirement.

Timing of Annual Reporting

UHC requests that CMS reconsider the timing of when MAOs are required to report Supplemental Benefit Utilization and Costs data to CMS. Members often wait until the end of the calendar year to utilize supplemental benefits. This means that if MAOs are required to report the last Monday in February of the following calendar year, they may not have received all of the utilization data for the prior calendar year.

Recommendation: UHC recommends that CMS give MAOs a due date of April 1 to allow for complete data acquisition and more complete reporting.

2024 Part C Technical Specifications

In addition to having the opportunity to comment on the Part C Medicare Advantage reporting elements, it will be important for MAOs to have the opportunity to provide comments to CMS on the 2024 Part C Technical Specifications which provide a more detailed description of the elements as compared to the Part C Plan Reporting Requirements, which are largely a description of the data elements.

Recommendation: UHC recommends that CMS issue the 2024 Part C Technical Specifications in draft form and allow organizations the opportunity to comment on the new Supplemental Benefit Utilization and Costs section prior to the Technical Specifications being finalized.

Section II – Data Element Recommendations: *UHC recommends that CMS* ***remove*** *the following PBP Categories from the proposed list of required Supplemental Benefit Reporting:*

Inpatient Hospital Services Additional Days (PBP Categories: 1a IP Acute Additional Days, 1b IP Psychiatric Additional Days)

Our recommendation to remove 1a IP Acute Additional Days and 1b IP Psychiatric Additional Days is based on the following information:

- Claims data for these services are identical to claims data for Medicare-covered days and there is nothing on a claim to indicate whether the claim is for an additional day.
- For bid purposes, MAOs are not required to identify specific claims associated with additional days. Per the 2023 BPT Instructions: Inpatient Facility Additional Days CMS developed a 1.2-percent factor based on FFS data that the certifying actuary may use as a "safe harbor" for the proportion of the costs of inpatient facility days that are non-covered. Further, the certifying actuary may use the inpatient facility "safe harbor" as a basis for determining the inpatient facility cost-sharing Medicare-covered percentages.
- Because the additional day is not broken out today either on the claims or in the bids, MAOs would have to develop new processes to try to identify claims that would have exceeded a Medicare Benefit Period if plans are following a Medicare Benefit period for both IP and SNF stays. Since most MAOs waive the 3-day hospital day for SNF, it is unclear whether SNF days following a 0-2 day hospital stay would count toward the Benefit Period days/breaks. As a result, MAOs will likely develop different ways to account for the days, which will likely drive different results between plans for similar stays and potential inconsistencies in the data that is reported.

SNF Waive Hospital Stay (PBP Categories: 2 SNF–Waive Hospital Stay and 2 SNF–Waive Hospital Stay, 3 days)

Our recommendation to remove 2 SNF - Waive Hospital Stay and 2 SNF – Waive Hospital Stay, 3 days is based on the following:

- Per 42 CFR §422.101(c), MA organizations may elect to furnish coverage of post-hospital SNF care in the absence of the prior qualifying hospital stay that would otherwise be required for coverage of this care as part of their Medicare covered benefits. In this case, the coverage is a basic benefit, not a supplemental benefit.
- For bid purposes, because SNF stays without a prior 3-day hospital stay are not considered supplemental benefits, plans are not required to identify specific SNF claims that were not preceded by a qualifying stay. The bid instructions state, "A skilled nursing facility (SNF) waiver of a qualifying 3-day inpatient hospital stay and the associated SNF stay are Medicare-covered benefits."
- While FFS Medicare requires specific billing elements to indicate that a SNF stay was preceded by a qualifying IP stay (occurrence span 70), MAOs typically do not require this coding and have these data elements since they are not used to calculate MA plan benefits.

Blood Deductible (PBP Category: 9d Three (3) Pint Deductible Waived)

Our recommendation to remove 9d Three (3) Pint Deductible Waived is based on the following:

- For simplicity and because emergency care is covered nationwide, most MAOs file a waiver of the blood deductible uniformly on all PBPs and do not track whether the blood was obtained in a donor state or not. Original Medicare doesn't apply the blood deductible in all states, and donor states do not have a charge associated with the acquisition of blood, which is often donated through blood banks.
- Because MAOs do not apply the blood deductible, providers may not routinely bill the value codes Original Medicare uses to track blood donations in non-Donor states (Value Code 37 Units of Blood Furnished, 38 Blood Deductible Units; 39 Units of Blood Replaced). As a result, MAOs have no way of knowing how many pints of blood were paid for that Original Medicare wouldn't have paid for.
- Because it will be very difficult to accurately capture this data due to the variations across the states, UHC recommends that CMS remove this category from the required reporting.

Out-of-network Services (PBP Category: OON)

UHC recommends that CMS remove the Out-of-Network (OON) Supplement Benefit category because OON services are not always supplemental benefits. OON services for HMO and PPO plans, and some OON services for POS plans (e.g., emergency services and Out -of-Area renal dialysis) are Medicare-covered.

In the event CMS decides to keep the OON category, UHC recommends that the category be redefined as Point-of-Service (POS) since services obtained out-of-network and covered under a POS benefit are considered supplemental and that CMS issue instructions to MAOs on how this data should be reported due to the wide variation of POS within a particular plan (e.g., an MAO can cover one service or all plan services under the POS). In addition, because POS benefits vary widely and will be difficult to aggregate, UHC recommends that CMS provide detailed instructions to MAOs on how they should aggregate benefits, as we anticipate that without instruction, the results CMS will receive will also vary widely making it difficult for CMS to compare results across MAOs.

Section III – Combination Recommendations: *UHC recommends that CMS* ***combine*** *the following PBP Categories in their proposed list of required Supplemental Benefit Reporting:*

Worldwide Coverage (PBP Categories: 4c Worldwide Emergency Coverage, 4c Worldwide Emergency Transportation, 4c Worldwide Urgent Coverage)
UHC recommends that CMS combine the Worldwide Coverage; Visitor Travel PBP Categories for the following reasons:

- Most out-of-country providers are unable to submit claims to MAOs in the same manner as domestic non-contracted providers. Typically, services received outside of the United States are paid at point of service by the member and receipts are submitted to the MAO for manual reimbursement. Receipts are typically in the language of the country where services were obtained and can be difficult to translate in enough detail to ensure the services were indeed relevant medical services. While organizations try to capture services that appear to be Emergency Room (ER) services in a foreign country, not all countries have ER services or define it in the same way. In addition, foreign countries often don't indicate urgent versus emergent coverage.
- UHC believes there is a large degree of crossover between these three Worldwide Coverage/Visitor Travel categories (dependent on how the member's receipt was written and how the claim was translated and manually entered), and because of the variation in how these services are categorized and/or reported, we recommend that CMS consolidate these subcategories into one Worldwide Coverage PBP Supplemental Benefit Category for Part C reporting.

Transportation (PBP Categories: 10b Transportation to Plan-approved Location, 10b Transportation to Any Health-related Location)
UHC recommends that CMS combine the Transportation PBP Categories for the following reason:

- There is no meaningful difference between Transportation to Plan-approved Location and Transportation to Any Health-related Location. In fact, there can be overlap between these two PBP Categories; MAOs may put the same/similar services into these different PBP subcategories depending on how they choose to explain the benefit to enrollees. Because MAOs may subcategorize the same services differently, consolidating the transportation PBP categories will provide greater consistency in the reporting.

Preventive Dental Services (PBP Categories: 16a Oral Exams, 16a Prophylaxis (Cleaning), 16a Dental X-Rays, 16a Fluoride Treatment)
UHC recommends that CMS combine the 16a (Preventive) Dental PBP Categories for the following reason:

- Utilization of preventive services outlined in the categories above generally occurs during the same member visit and viewing the data at the overall preventive level (rather than breaking the dental services into smaller categories) will help ensure CMS is receiving meaningful data.

Comprehensive Dental (PBP Categories: 16b Dental Non-Routine Services, 16b Dental Diagnostic Services, 16b Dental Restorative Services, 16b Endodontics, 16b Periodontics, 16b Extractions, 16b Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)
UHC recommends that CMS combine the 16b (Comprehensive) Dental PBP Categories for the following reason:

- The services that fall within each of these categories are not defined by CMS and MAOs are not required to split costs between these categories in their bids. Because MAOs may include different

services in each category. UHC recommends that they be combined to ensure consistency in reporting.

Vision Eyewear (PBP Categories: 17b Contact Lenses, 17b Eyeglasses (lenses and Frames), 17b Eyeglass Frames, 17b Eyeglass lenses, 17b Eyewear Upgrades)
UHC recommends that CMS combine the 17b (Vision Eyewear) Visions Service PBP Categories for the following reason:

- There is an overlap between these descriptors and MAOs may put the same/similar services into different PBP subcategories, depending on how they choose to explain the benefit to enrollees. Because MAOs may subcategorize the same services differently, it may lead to inconsistencies in reporting. In addition, utilization of many of the services are included within the same claim, so grouping and reporting data at the overall PBP category of Vision Eyewear, will likely provide CMS with more comparable, meaningful data from MAOs. In addition, this approach will allow for greater process efficiencies for MAOs.

Fitness Benefit (PBP Categories: 14c4 Fitness Benefit - Physical Fitness, 14c4 Fitness Benefit - Memory Fitness)
UHC recommends that CMS combine the 14c4 Fitness Benefit PBP Categories for the following reason:

- Fitness products are generally structured across the industry to include both physical and memory fitness components and the costs of these two items may not be split out by MAOs when filing bids. Therefore, allowing MAOs to report on this category in a manner that is consistent with how they file their bids will allow for greater process efficiencies and consistency in reporting.

Additionally, UHC recommends that *CMS **update** the following PBP Category in their proposed list of required Supplemental Benefit Reporting:*

- Fitness Benefit - Memory Fitness is listed under PBP Category '14b4'. It should instead be listed under '14c4'.

Hearing Aids (PBP Categories: 18b Hearing Aids (All Types), 18b Hearing Aids – Inner Ear, 18b Hearing Aids – Outer Ear, 18b Hearing Aids – Over the Ear)
UHC recommends that CMS combine the 18b Hearing Aids PBP Categories for the following reason:

- There is an overlap between these descriptors and MAOs may put the same/similar services into different PBP subcategories, depending on how they choose to explain the benefit to enrollees. Because MAOs may subcategorize the same services differently, UHC recommends that the category be consolidated to ensure consistency in reporting across MAOs.

UHC appreciates the opportunity to provide comments and looks forward to CMS's feedback.

Sincerely,

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