October 25, 2023

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Part C Medicare Advantage Reporting Requirements

Submitted Electronically: http://www.reginfo.gov/public/do/PRAMain

Dear Sir/Madam:

UnitedHealthcare (UHC) is responding to the September 25, 2023 Federal Register notice from the Centers for Medicare & Medicaid Services (CMS) titled, *Part C Medicare Advantage Reporting Requirements* (88 FR 65689). UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UnitedHealthcare is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

Supplemental Benefit Utilization and Costs

Timing for Annual Reporting

In UHC's comments to the Part C Medicare Advantage Reporting Requirements dated 5/15/2023, we requested CMS reconsider the timing of when Medicare Advantage Organizations (MAOs) are required to report Supplemental Benefit Utilization and Costs Data to CMS to allow for more complete data acquisition and reporting. In response, CMS indicated that MAOs would be required to submit the first set of data in February of contract year (CY) 2025 and that the "submission would cover all supplemental benefits furnished during CY 2024" as CMS believes that will give MAOs sufficient time to accurately report and "ensure that vendors are prepared to submit all necessary data."

UHC recognizes the importance of providing CMS with complete and accurate data, and we continue to have concerns about the timing of when MAOs are required to submit their first data set due to the differences in the supplemental benefits that MAOs offer and how they are processed and paid.

For example, some supplemental benefits process in real time (e.g., over-the-counter (OTC) benefits) which requires MAOs to maintain real-time balances, whereas others are provided on a monthly or per member per month (pmpm) basis and are provided by medical providers and submitted to MAOs on claims. Some supplemental benefits are not covered by Medicare but are submitted by providers who also submit claims for Medicare-covered benefits. Examples include an ophthalmologist who bills for both Medicare-covered post cataract eyewear and routine eyewear, a podiatrist who bills for both Medicare-covered and routine foot care, and Medicare-covered benefits rendered by an out-of-network (OON) provider under a point-of-sale (POS) benefit.

An MAO may not even know about services provided under a POS or OON benefit until it receives a claim because OON services are not subject to prior authorization requirements. Given the number of scenarios that supplemental benefits fall under and the established timeframes for reimbursement of these claims, it may not be possible for an MAO or service provider to submit the data by February 2025.

This result is particularly true in situations where a provider is not required to submit a claim for reimbursement and/or an MAO has no authority to require that a claim be submitted for reimbursement by the end of calendar year 2024. For example, OON providers have one year from the date the services are rendered to submit a claim for those services. In that scenario, because the provider is OON, MAOs have no authority to require the provider to submit a claim for any service rendered prior to the end of the calendar year in order to ensure it is included as part of the required reporting.

In addition, MAOs also offer supplemental benefits that are commonly paid through beneficiary reimbursement and beneficiaries typically have 12 months to submit those claims to the MAO for reimbursement. Requiring a beneficiary to submit their claim to the MAO by the end of the calendar year to meet the first data set reporting requirement may prevent beneficiaries from being able to the benefits that they are entitled to through the end of the calendar year which could cause beneficiary harm or dissatisfaction.

All existing Part C Reporting Requirements involve reporting for activities processed by the MAO during the calendar year. In the Payments to Providers section, for example, MAOs are required to report on provider payments, “based on the year payment was made, regardless of when services were furnished.” The reporting timeframe results in substantially complete data when MAOs are reporting on services processed during the preceding calendar year. It is not possible for MAOs to report actual, non-estimated data on all utilization when CMS is requesting data on benefits that are furnished irrespective of when they are processed.

To be consistent with other reporting requirements, UHC urges CMS to reconsider extending the date that the first data submission is due to May 1 or later. Allowing MAOs additional time to complete the reporting will not only provide CMS with more accurate and complete data, but it better aligns with the claim completion rates used in the bids and helps mitigate any potential differences or inaccuracies that will be created in comparing the benefit data across MAOs. If CMS does not make any changes to the submission date, CMS should not subject MAOs to any compliance or enforcement actions for these reporting requirements if the MAO is unable to timely obtain the data from providers, vendors, or beneficiaries prior to the reporting deadline.

MMP Reporting

In the *Medicare Part C Technical Specifications Document for Contract Year 2024*, CMS includes in the notes for the Supplemental Benefit Utilization & Costs reporting requirement section the following additional clarification:

> A mandatory supplemental benefit is defined at 42 CFR 422.100(c)(2)(i)(A) as "Services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost sharing."

However, in the Medicare-Medicaid Plan (MMP) Submission of Plan Benefit Packages for Contract Year 2024, CMS instructs that "MMPs will use the Bid Submission Module to annually submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits." Although MMPs may submit benefits that are supplemental to Medicare Part A and B required benefits, those supplemental benefits are considered an extension of Medicaid coverage, not Medicare coverage. These supplemental benefits are not funded through bid rebate. Therefore, "mandatory supplemental benefit" as defined in the Part C regulations would not apply to MMPs.

Since MMPs do not offer supplemental benefit as Mandatory, Optional, Uniformity Flexibility, or Special Supplemental Benefits for the Chronically Ill (SSBCI) as defined by CMS, we seek clarification as to what type of information MMPs should report in the Supplemental Benefit Utilization & Costs section.

Special Needs Plans (SNP) Care Management

Re-enrollment and Disenrollment Guidance

In the Medicare Part C Technical Specifications Document, CMS states the following with respect to a member's Health Risk Assessment (HRA):

> When a member enrolls, disenrolls, and re-enrolls, into any SNP under the same contract number, the previous HRA is still considered valid and can continue to be used as long as it is not more than 365 days old. Even if the member is re-enrolling into the same plan, the member would still not be counted more than once in any category.
>
> A member cannot be counted more than once in the same data element for the same plan in the same measurement year.

UHC seeks clarification on which HRA should be reported if an HRA was completed for both disenrollment and re-enrollment. Specifically, we request that CMS clarify that in the example scenario below (1) that the member should be reported with a 1/1 effective date; and (2) the HRA that would be reported is for the 2/1/2023 effective date since it would still be valid as of the date of re-enrollment on 6/1/2023.

Example Scenario:

New Member:		Enrollment/Re-Enrollment Effective Date	Disenrollment Date	HRA
	003	1/1/2023	4/30/2023	2/1/2023
	003	6/1/2023	12/1/9999	6/15/2023
Report:	**003**	**1/1/2023**	**12/1/9999**	**2/1/2023**

Data Elements

In the proposed guidance, CMS removed the following language from Data Element B (Number of Enrollees Eligible for An Annual Re-Assessment HRA):

> The enrollee is a new enrollee who missed both the deadline to complete an initial HRA and the deadline to complete a reassessment HRA and is enrolled for all 365 days of the measurement year.

UHC asks CMS to confirm that enrollees with January 1 effective dates of coverage would be reported in Data Element A (Number of New Enrollees Due for an Initial Health Risk Assessment) only, and not in Data Element B since they do not meet the 365 continuous enrollment requirement.

For Data Element C (Number of Initial HRAs Performed on New Enrollees), CMS stated under Inclusions:

> For members who disenrolled from and reenrolled into the same plan, includes HRAs (initial or reassessment) performed during their previous enrollment if the HRAs are not more than 365 days old.
>
> For members who disenrolled from and reenrolled into the same plan, excludes any HRAs (initial or reassessment) performed during their previous enrollment unless the re-enrollment occurred the day after the disenrollment.

UHC poses four hypothetical scenarios for CMS's review and consideration related to Data Element C.

First, for enrollees with a break in coverage, UHC asks that CMS confirm whether the reporting should include both completed HRAs if they were performed within the past 365 days. For example, if an initial HRA that was completed on 12/15/2022, and an annual HRA that was completed 6/15/2023, we would like to confirm if both be included in Data Element C.

Example 1 Scenario:

New Enrollees:		Effective Date	Disenrollment Date	HRA	HRA_2
	001	1/1/2023	4/30/2023	12/15/2022	
	001	6/1/2023	12/31/9999	6/15/2023	
Report:	**001**	**1/1/2023**	**12/31/9999**	**6/15/2023**	**12/15/2022**

Second, UHC asks CMS to confirm whether an enrollee in Scenario 1 should be reported as an annual enrollee with a 6/1/2023 HRA completion date.

Example 2 Scenario:

Annual Enrollee:		**Effective Date**	**Disenrollment Date**	**HRA_1**	**HRA_2**
	003	1/1/2022	3/31/2023	2/15/2023	
	003	5/1/2023	12/1/9999	6/1/2023	
Report:	**003**	**1/1/2022**	**12/1/9999**	**6/1/2023**	**2/15/2023**

Third, UHC asks CMS to confirm whether the 7/1/2023 re-enrollment date is the only date that should be reported.

Example 3 Scenario:

Annual Enrollee:		**Effective Date**	**Disenrollment Date**	**HRA_1**
	003	1/1/2022	3/31/2023	
	003	7/1/2023	12/1/9999	8/1/2023
Report:	**003**	**7/1/2023**	**12/1/9999**	**8/1/2023**

Fourth, UHC asks CMS to clarify whether the 5/1/2023 re-enrollment date should be the only reported date in this scenario because the previous HRA is greater than 365 days old.

Example 4 Scenario:

Annual Enrollee:		**Effective Date**	**Disenrollment Date**	**HRA_1**
	003	1/1/2022	3/31/2023	2/1/2022
	003	5/1/2023	12/1/9999	6/1/2023
Report:	**003**	**5/1/2023**	**12/1/9999**	**6/1/2023**

CMS's clarification on how the information from these scenarios should be reported will provide better and more uniform data reporting across MAOs.

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

Sincerely,

Jennifer Martin
Director, Regulatory Affairs
UnitedHealthcare
jennifer_j_martin@uhc.com
763-283-4469