September 9, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

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

Re: Part C Medicare Advantage Reporting Requirements

Dear Administrator Brooks-LaSure:

UnitedHealthcare (UHC) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information for the Part C Medicare Advantage Reporting Requirements, published in the Federal Register on July 10, 2024 (89 FR 56754).

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UHC 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.

VII. Supplemental Benefit Utilization and Costs

PBP Categories for 2025 Reporting

UHC recommends that CMS update the Plan Benefit Package (PBP) Category numbers included in the 2025 guidance to reflect the final 2025 PBP numbering in both the 2025 Part C Reporting Requirements document and the 2025 Part C Technical Specifications Document as follows:

- Inpatient Hospital – Acute Services (For B-Only Plans): update to 1a instead of 1b
- Additional Pulmonary Rehabilitation Services: should be 3-3 instead of 3-2
- Additional Intensive Cardiac Rehabilitation Services: should be 3-2 instead of 3-3
- Worldwide Emergency Transportation: should be 4c3 instead of 4c2
- Worldwide Urgent Coverage: should be 4c2 instead of 4c3
- Fitness Benefit – Memory Fitness: should be 14c4 instead of 14b4

- Non-Primarily Health Related Benefits for the Chronically Ill Other 1 to 5: should be 13i11 through 13i15 instead of 13i-O

In the section header for 4c1/4c2/4c3, it reads "Worldwide Coverage; Visitor Travel," however, the Visitor Travel (V/T) benefit is not offered outside of the United States and is not filed in PBP category 4c. Therefore, UHC recommends that CMS revise the section the header to read "Worldwide Emergency/Urgent Coverage" to be consistent with the final 2025 PBP Service Category naming convention.

In addition, UHC notes that the "Service Area-Related Services" category was removed from the Supplemental Benefit Table in the Reporting Requirements document, but not from the Supplemental Benefit Table in the Technical Specifications Document. UHC asks that CMS confirm whether it expects Plan Sponsors to report these discrete benefits categories, or whether CMS's intent was to remove this category based on the addition of Data Element F, Network Type.

If CMS's intent is to remove the "Service Area–Related Services" category, the reported values under Data Element F, Network Type, will not capture the full value of a point of service (POS) or V/T benefit because there is no place to capture utilization or spend for out-of-network and out-of-area (OON/OOA) Medicare-covered services. UHC anticipates that the majority of its V/T utilization and spend will be on OOA Medicare-covered services, and not on benefits that are not covered by Medicare. Therefore, if it is CMS's intent to only capture a portion of the supplemental utilization and spend under Data Element F, UHC encourages CMS to clarify the scope of the required reporting (particularly for the data users who use the Parts C and D Reporting Requirements Limited Data Set)

Data Element E, How is the supplemental benefit offered?

In Data Element E, the options listed for how the supplemental benefit is offered do not include value-based insurance design (VBID), whereas in f the Supplemental Benefit Utilization and Costs section of the 2025 Part C Technical Specifications Document, CMS states that "VBID plans should also submit reporting for this section, however they should not submit reporting for VBID-specific benefits." However, many MA plans file groups of benefits that include both VBID and non-VBID benefits, which count toward a combined maximum.

For example, a number of plans offer a combined benefit under which food (VBID) and over-the-counter items and services (non-VBID) count toward the same combined maximum, and for such a benefit, the majority of the spend and any utilization may be on the VBID components of the benefit. If plans only include the non-VBID spend and utilization for the combined benefits, it may appear that the benefit has much lower utilization than what is actually utilized, which may lead data users to draw inaccurate conclusions. While VBID participants do report information to the Centers for Medicare and Medicaid Innovation on VBID utilization and costs, it is not in the same format or on the same schedule as Part C reporting and is not readily available as public data, making it harder for end users to obtain all related data or combine it accurately. UHC recommends that CMS clarify that the required reporting is intended to only capture a portion of the supplemental utilization and spend for plans that participate in VBID (particularly for the data users who use the Parts C and D Reporting Requirements Limited Data Set).

New Data Element F, Network Type

For the new data Element F, it is not clear whether CMS intends for MA plans to report each benefit line once for each PBP and specify whether the benefit must be obtained in-network only, can be obtained out-of-network, or via V/T; or whether CMS expects that each benefit line be broken out into multiple rows. UHC urges CMS to clarify that it is only requiring MA plans report each benefit line once for each PBP. If CMS were to require MA plans to break out each benefit line into multiple rows for each network type, it will result in an a significantly high number of benefit rows. For example, there are 16 PBP subcategories for dental. Reporting on each of these 16 subcategories would result in 96 rows for a single dental PBP–and many of those rows will reflect $0 or extremely low values in the cost and utilization fields. Having data in this type of format/level of detail will not only be confusing, but it will make it difficult to consume for many of the data end users.

UHC requests that CMS confirm whether it expects plans to report all three network types for every Supplemental Benefit category on every plan even if, for example, a Supplemental Benefit is only available INN. If so, should plans populate the other lines with "Not Offered" or only include the available network types.

UHC also requests that CMS confirm whether Data Element N (How the plan accounts for the cost of the benefit) and O (Total OOP Cost per utilization) should be broken out by network type .

In addition, UHC offers a non-network Private Fee for Service plan which does not fit into either the "in-network" or "out-of-network" labels. UHC requests that CMS confirm what label it should apply for this type of plan.

Data Element H, The number of enrollees eligible for the benefit.

UHC's V/T benefit requires a member to call and notify us before they travel to activate their benefit. While any member can use V/T, not all members travel or choose to activate this benefit. For Data Element H (The number of enrollees eligible for the benefit), please clarify whether it is CMS's expectation that all members who could activate the benefit be included in the count or whether UHC should only count those enrollees who called to activate the benefit. Note, for the data elements focused on utilizing members, UHC intends to only include claims paid OOA while the V/T benefit was activated and not include enrollees who called to activate the benefit, but didn't have any claims (i.e., didn't utilize the benefit).as 'utilizers.'

Allowable Field Values

UHC recommends CMS make the following updates to the allowable field values so that plans can enter the data as directed.

- Under the Notes section, CMS indicates that plans may also write "Not applicable" for the necessary data elements where appropriate and includes as an example, Element O (Total out-of-pocket-cost per utilization for enrollees who utilized the benefit). However, the Quality Assurance Checks section provides that Element O should be a dollar amount. UHC recommends that CMS update the Data Element reference from Element O to, for example,

Element M (The type of payment arrangement(s) the plan used to implement the benefit), a character text field to avoid any potential confusion on when the use of "not applicable" may be appropriate.

- For all Supplemental Benefit categories, UHC requests that CMS clarify how lines should be filled out for benefits that are not offered. The instructions state "Report on all supplemental benefit categories and subcategories. You may include zeros for any categories or subcategories that your plan does not offer." In addition, Data Element E (How is the supplemental benefit offered), lists "not offered" as one of the acceptable options. Based on the requirements as written, plans could report "Not Offered" or "NO" for Data Elements E (offer type), F (network type), G (utilization unit), M (payment arrangements), and N (cost accounting) wand report all the numerical fields as zero (0) or $0. However, for the waiver categories, CMS notes "...plans may report $0 spending if no costs are associated. Plans may also write "Not applicable" for the necessary data elements where appropriate" which implies that if a benefit is not offered, the non-numerical fields could be completed as "Not applicable" instead of $0. UHC encourages CMS to update how plans should report for these situations. (Note: This is also an error in the DRAFT CY2024 File Record Layout. Data Element C, How is the supplemental benefit offered. There is a mention of "not offered" being an option, but an acceptable five letter value that can be used when this occurs was not provided.)

Data Elements Lettering and Description

There are some labelling discrepancies between the 2025 Part C Reporting Requirements Document and the 2025 Part C Technical Specifications Document, as illustrated in the table and discussion below.

2025 Part C Reporting Requirements Document	2025 Part C Technical Specifications Document
J.	J.
The total instances of utilizations among eligible enrollees.	The total instances of utilizations among eligible enrollees
J.	K.
The median number of utilizations among enrollees who utilized the benefit at least once.	The median number of utilizations among enrollees who utilized the benefit at least once
K.	L.
The total net amount incurred by plan for to offer the benefit.	The total net amount incurred by plan to offer the benefit
L.	M.
The type of payment arrangement(s) the plan used to implement the benefit.	The type of payment arrangement(s) the plan used to implement the benefit.
M.	N.
How the plan accounts for the cost of the benefit	How the plan accounts for the cost of the benefit
N.	O.

The total out-of-pocket-cost for enrollees.	The total out-of-pocket-cost per utilization for enrollees who utilized the benefit
O.	
The median out-of-pocket cost for enrollees	

- While both the 2025 Part C Reporting Requirements Document and the 2025 Part C Technical Specifications Document describe Data Elements A-O, the Reporting Requirements document has two different items labeled Data Element J (One is labeled "The total instances of utilization among eligible enrollees" and the other is labeled "The median number of utilizations among enrollees who utilized the benefit at least once") while the Technical Specs only lists one Element J ("The total instances of utilization among eligible enrollees.") and the second Data Element J in the Reporting Requirements document is listed as Data Element K in the Technical Specifications Document.

- The Reporting Requirements include an element not in the Technical Specifications Document: Data Element O, The median out-of-pocket cost for enrollees (note: this would be Data Element P if the letter J hadn't been assigned twice in the Reporting Requirement as discussed above). UHC recommends CMS correct the labeling in both the tables and the Quality Assurance Check section and include the same elements in both. In addition, if CMS intends to include the last Data Element (The median out-of-pocket cost for enrollees), UHC requests that CMS clarify whether the calculation is based on all enrollees or only those who used the benefit at least once (to mirror the second Data Element J in the Reporting Requirement, and K in the Technical Specifications Document).

- Similarly, the Technical Specifications Document includes Data Element O (The total out-of-pocket-cost per utilization for enrollees who utilized the benefit) while the Reporting Requirements includes Data Element N (The total out-of-pocket-cost for enrollees) which is intended to be a sum of all enrollee out-of-pocket costs for a service category, broken down by the Data Element E. Since one data element is limited only to utilizers while the other isnot, we believe CMS's intent is for these to be two different measures. If that is the intent, UHC asks that CMS align the wording between the Technical Specifications Document and the Reporting Requirements to ensure accurate data reporting.

- In addition, UHC understands that the Note: (Note this should be a sum of all enrollee out-of-pocket costs for a service category, broken down by the Data Element E) to mean that we should repeat the same Data Element E total for each Data Element F value. For example, for each benefit category (such as 16c3 Periodontics) we should list the same total OOP cost for Mandatory benefits on the in-network, out-of-network and V/T lines for each benefit category, even though members may pay different cost sharing if they access the benefit in-network versus out-of-network. UHC asks that CMS confirm this is consistent with its intent and if not, to modify the Note accordingly.

In the Edits and Validation Checks section, there is also a labelling error in the statement "The number of eligible enrollees who utilize the service (E) should be less than or equal to the number who are eligible for the service (F)." This statement should read "The number of eligible enrollees who utilize the service (I) should be less than or equal to the number who are eligible for the service

(H).” (Note: This is also an error in the CY2024 Technical Specification. The references to E and F are flipped. 2024 Data Element F ‘The number of eligible enrollees who utilize the service’ should be less than or equal to Data Element E ‘the number who are eligible for the service’ – and not the other way around.)

The Reporting Requirements contains a statement for Data Element E (How is the supplemental benefit offered?’) that is not in the Technical Specifications Document: “If the same supplemental benefit (as identified by a specific PBP Category) is offered in multiple ways (e.g., as an optional benefit, and also as an SSBCI), please report Data Elements C-J for each offering type separately.” Given the confusion around Data Element J (above) please confirm whether the requested breakout for Data Elements C-J is correct or whether CMS would like a different range once the element labelling is corrected. For consistency please also include this direction in the Technical Specifications Document.

The Reporting Requirements Data Element K (The total net amount incurred by the plan to offer the benefit) contains a statement that is not in the Technical Specifications Document for Data Element L (The total net amount incurred by the plan to offer the benefit): “**NOTE:** When computing this amount…” For consistency, it would be helpful if this direction was also included in the Technical Specifications Document.

The Reporting Requirements Data Element M (How the plan accounts for the costs of the benefit…’) contains a statement that is not in the Technical Specifications Document for Data Element N (How the plan accounts for the costs of the benefit…’): “**NOTE:** CMS will not voluntarily release data ….” For consistency, it would be helpful if this direction was also included in the Technical Specifications Document.

VI. Payments to Providers

The Frequently Asked Question indicates the sum of all elements B through R should equal A. We ask that CMS clarify if this is accurate when only Data Element ID A includes both in and out of network providers and the remaining elements are limited to contracted providers.

- Data Element ID A: Total dollars paid to providers (in and out of network) for Medicare Advantage enrollees in [CY 20XX] or most recent 12 months.

UHC also asks that CMS clarify if data element ID E is a subtotal for data elements IDs C as FAQ indicates the sum of all elements B through R should equal A.

- Data Element ID E: Total dollars paid in Category 2 in [CY 20XX] or most recent 12 months.

In addition, we ask CMS for clarification on whether data element ID J is a subtotal for elements F through I as the FAQ indicates the sum of all elements B through R should equal A

UHC is also seeking definitions and examples for the following to understand how to breakout out payments based on the new guidance:

- Data Element ID D - Can CMS provide the definition and examples for “foundational spending?”
- Data Element ID F - Can CMS provide the definition and examples for “traditional shared-savings?”
- Data Element ID G – Can CMS provide the definition and examples for “utilization-based shared-savings?”
- Data Element ID H – Can CMS provide the definition and examples for “fee-for-service based shared-risk savings?”

Additionally, we request that CMS clarify if data element ID Q is a subtotal for elements L through P as the FAQ indicates the sum of all elements B through R should equal A.

UHC is also seeking definitions and examples for the following to understand how to breakout out payments based on the new guidance:

- Data Element ID L – Can CMS provide the definition and examples for “condition-specific, population-based” payments?
- Data Element ID M – Can CMS provide the definition and examples for “condition-specific, bundled/episode” payments?
- Data Element ID N – Can CMS provide the definition and examples for “population-based payments NOT condition specific?”
- Data Element ID O – Can CMS provide the definition and examples for “full or percent of premium population-based payments?”
- Data Element ID P – Can CMS provide the definition and examples for “integrated finance and delivery system programs?”

Finally, UHC is seeking further clarification on data element ID GG. Is the covered lives based on payments made to providers or regardless of payments made to providers?

- Data Element ID GG: Total Medicare Advantage covered lives in [CY 20XX] or most recent 12 months.

IX. D-SNP Transmission of Admission Notifications

UHC acknowledges the importance of collecting and analyzing data on hospital and skilled nursing facility (SNF) admissions/notifications for full benefit dual eligible beneficiaries as part of the new Part C Medicare Advantage Reporting Requirement. However, the variation across state Medicaid agencies’ admission notification requirements creates reporting challenges for Medicare Advantage organizations (MAOs) and interpretation challenges for CMS.

First, the population for which dual eligible special needs plans (D-SNPs) are reporting hospital and SNF admissions is not the same from state to state. Some state Medicaid agencies limit “high-risk full-benefit dual eligible individuals” to beneficiaries who qualify for a specific waiver program while other state Medicaid agencies mandate admissions reporting for all full-benefit dual eligible individuals. As a result, the admissions data that MAOs provide will not allow CMS to perform meaningful comparisons between states.

Second, what constitutes an "admission" is not the same from state to state. For example, some state Medicaid agencies require D-SNPs to report all categories of hospital and SNF admissions (i.e., inpatient, emergency, outpatient, observation, rehabilitation, etc.) whereas other Medicaid agencies require only "inpatient" or "inpatient and emergency" admissions to be reported. Again, this lack of standardization diminishes the utility of data submitted to CMS.

Third, because D-SNPs report all qualifying admissions to state Medicaid agencies, the admissions data reflect the total number of admissions but don't provide important context such as how many of those admissions are the same individual.

UHC recommends that CMS consider modifying or eliminating the Transmission of Admission Notifications reporting requirement to address these challenges. UHC also recommends that CMS allow MAOs to submit the Transmission of Admission Notifications reporting through a file upload rather than data entry. If UHC must manually enter the Transmission of Admission Notifications data, the amount of time required to enter the data may cause the HPMS system to "time-out" before all information is accurately entered because UHC offers numerous D-SNP plan benefit packages on single contracts.

We appreciate CMS's consideration of our comments. Please feel free to contact me if you have any questions.

Sincerely,

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