November 27, 2024

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10261
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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

Re: *Part C Medicare Advantage Reporting Requirements* (Document Identifier: CMS–10261)

Dear Sir/Madam:

UnitedHealthcare (UHC) is pleased to respond to CMS*'s* request for comments regarding the *Part C Medicare Advantage Reporting Requirements* published in the Federal Register on October 28, 2024 (89 FR 85539).

UnitedHealthcare 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.

VII. PAYMENTS TO PROVIDERS

Data Element ID A
UHC requests clarification on the calculations for 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). If Data Element A can equal more than the sum of Data Elements B-S, is CMS expecting the subtotals for Data Element ID F, K and R to be duplicated in the total payments for Data Element ID A?

- Data element ID F for category 2 is a subtotal of data elements (C-E);
- Data element ID K for category 3 is a subtotal of data elements (G-J); and
- Data element ID R for category 4 is a subtotal of data elements (M-Q).

In the *Medicare Part C Technical Specifications Document CY 2025: PLAN INQUIRIES Payments to Providers* section, item #2 (page 44), CMS indicates that the definition of "contracted providers" includes both physicians and clinicians for Part C reporting requirements and that payments for administrative services and payments to hospitals, facilities, pharmacies, or labs are not to be reported.

With CMS's proposed addition of new data elements in Categories 2, 3, and 4, UHC is seeking confirmation that any reporting of payments to providers as referenced in the data element descriptions, should also be limited to physicians and clinicians.

VIII. SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS

UHC requests that CMS address the following in the final version of the Reporting Requirements:

1. Add the VBID language to the "Organization Types Required to Report" table in the Technical Specifications.

2. Add an asterisk for SNF – Waiver of 3 Day Hospital Stay to correspond to the additional verbiage about the PBP Category numbering that was added at the end of PBP Category table.

3. Update the PBP categories below to include the additional lettering that CMS added to give each benefit a unique identifier:
    a. Remote Access Technologies – Nursing Hotline*: Update to 14c7a instead of 14c7
    b. Remote Access Technologies – Web/Phone-based Technologies*: Update to 14c7b instead of 14c7

UHC requests that CMS address the following in the final version of the Technical Specifications:

1. Add "other" to Data Element F (Network type) to align with the change made in the Reporting Requirements to allow plans to add a network type for PFFS plans.

2. Update the Data Element description for Element O (The total out-of-pocket-cost per utilization for enrollees) to align with the description used in the Reporting Requirements to address CMS's supporting statement that the name of Data Element O (N in the Supporting Statement) was updated because CMS wants organizations to report the element differently in 2025 than what was required in 2024.

3. Add Data Element P (The median out-of-pocket cost for enrollees) to the bullet "Data Elements L and O should be reported as dollar amounts" since Data Element P is also a dollar amount (the median of data element O--The total out-of-pocket-cost for enrollees).

4. Update the bullet “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)” in the Edits and Validation Checks section to change Data Element E to I and Data Element F to H.

5. Align Data Element E (How is the supplemental benefit offered) with the data element letters referenced in both the Technical Specifications and Reporting Requirements documents as follows:
   - In the Reporting Requirements, in the data element table, the reference to C-J should be updated to G-M, O,P.
   - In the Technical Specifications, under the Quality Assurance Checks/Thresholds section, data elements O and P should be added to the current list of G-M.

6. Add the note for Data Element L (The total net amount incurred by plan to offer the benefit) that was added to the Reporting Requirements.

7. Add the note for Data Element N (How the plan accounts for the cost of the benefit) that was added to the Reporting Requirements.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

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