Shannon Schuster
Director, Regulatory Affairs
Government Programs
UnitedHealthcare
3100 AMS Blvd
Green Bay, WI 54313
920-661-6217

To: Centers for Medicare and Medicaid Services
Submitted electronically via: regulations.gov

From: Shannon Schuster
UnitedHealthcare
UnitedHealth Group

Date: May 25, 2018

Re: *Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a)*

Attached are comments regarding the Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a) (CMS–10261).

Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a)

Comments Submitted by
UnitedHealthcare
5/25/18

UnitedHealthcare (United) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments regarding the Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a).

Organization Determinations & Reconsiderations – Element G Number of Reconsiderations submitted by Provider (Claims)

United seeks clarification regarding the number of reconsiderations submitted by provider (claim) because contracted provider submissions should be included in the Member/Member Representative submitted totals (element E), whereas non-contracted providers can appeal on their own behalf for claim denials. To that end, we request CMS modify Element G from "Number of Reconsiderations submitted by Provider (Claims)" to "Number of Reconsiderations submitted by *Non-Contracted Provider* (emphasis added) (Claims)."

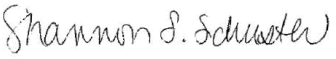
Special Needs Plans (SNPs) Care Management

The technical specifications are written at a high level, and Medicare Advantage (MA) Plans would benefit from additional CMS clarification in the technical specifications to ensure greater consistency of year to year reporting and more accurate Star Ratings. We have submitted clarifying questions to the Part C Plan Reporting mailbox over the past three years, and have received inconsistent guidance from different mailbox responders. Areas of clarity requested are requirements for members who have completion gaps, late annual completions, and multiple enrollment periods within the measurement year. We request that CMS add detail to the technical specifications to reflect CMS responses to all MA Plan submitted questions. United also recommends that CMS develop FAQs similar to Division of Medicare Advantage Operations (DMAO) Mailbox FAQs to aid in consistent interpretation of the technical specifications.

"The Health Risk Assessment (HRA) Measure - C08" compares the number of initial and annual HRAs performed to the total number of eligible enrollees. The measure includes beneficiaries who refuse or decline outreach in the total number of eligible enrollees. By including "refusals," MA Plans are penalized for respecting beneficiaries' desire not to be contacted. This negatively impacts the overall beneficiary experience. Therefore, United recommends that CMS remove beneficiaries who refuse to complete an HRA, or decline outreach, from the denominator.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,



Shannon Schuster
Director, Regulatory Affairs
UnitedHealthcare