# PUBLIC SUBMISSION

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Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a) (CMS-10261)

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Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a) (CMS-10261)

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## Submitter Information

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**Organization:** Kaiser Foundation Health Plan

## General Comment

Reporting Requirements and Technical Specifications should align for the Table of Contents sections. We found that section II. Organization Determinations & Reconsiderations was missing from the Technical Specifications table of Contents. Please add to the Technical Specifications.

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## Submitter Information

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## General Comment

The crosswalk states that the Service Area Related Services section/ visitor/travel program and out-of-network categories were removed to include as reported PBP elements. However, the Service Area Related Services section remains in the Reporting Requirements, but the section was removed from the Technical Specifications. This should be removed from the Reporting Requirements to align with the crosswalk and technical specifications.

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## Submitter Information

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## General Comment

Can you please provide more information on what the required criteria for MA plan members is to participate in an accountable care arrangement for the PCP-PCG Focused Accountable Metrics (elements GG – II).

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## Submitter Information

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## General Comment

While we appreciate that CMS is seeking greater visibility to the required D-SNP reporting of inpatient hospital and SNF admissions, we question the value of this reporting requirement as it doesn't account for the differences in reporting processes in place at the State level. Because CMS gives State Medicaid Agencies broad discretion to establish the reporting parameters, entities and mechanisms, a standardized Part C reporting requirement is likely not going to capture the unique aspects of State-specific reporting required for all D-SNPs. For example, in California, the State Medicaid Agency requires that for applicable integrated plans, facilities report admissions directly to the D-SNP (as under the current model, the beneficiaries are enrolled in both a D-SNP and Medi-Cal Managed Care plan offered by the same organization). Under the proposed reporting element, this would mean that such plans have no activity to report under element "B." We encourage CMS to work directly with the State Medicaid Agencies to acquire the necessary visibility to reporting practices, data, and outcomes.

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## Submitter Information

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## General Comment

While we understand that CMS implementation of the Enrollee Advisory Committee (EAC) requirement was to ensure that enrollee feedback is heard by managed care plans, we question the value of this reporting requirement given the lack of substantive data that is available to report. For example, it is atypical for a reporting requirement to include “yes/no” responses—such a framework is more aligned with an attestation as opposed to a reporting requirement. Also, the standardized approach to collecting information might not represent the most effective approach given that CMS gives state Medicaid agencies flexibility to establish more specific requirements—including reporting. For instance, California DHCS, requires EAC committees meet quarterly, and provide the state with meeting minutes and attendance reports. We encourage CMS to establish another mechanism to collect information about the EACs and to consider working with the State Medicaid Agencies to collect information and avoid duplicative reporting expectations.