Kaiser Permanente Comments on
Agency Information Collection Activities: Proposed Collection; Comment Request

Attention: Document Identifier/OMB Control Number: CMS-10565
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Kaiser Permanente[1] appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) intention to collect information from the public with respect to the Medicare Advantage Model of Care (MOC) Submission Requirements published in the *Federal Register* (90 FR 321) on January 3, 2025 (Form CMS-10565, OMB control number: 0938-1296).

Kaiser Permanente offers the following recommendations and requests for clarification on the proposed data collection:

MOC Element 1A (New Language)

Kaiser Permanente agrees with the new language added to MOC Element 1A to identify the MOC submission category. However, we recommend that CMS include an additional option for when the plan's submission is driven by state Medicaid agency requirements. By including this category, CMS will add clarification when the National Committee for Quality Assurance (NCQA) surveyor is reviewing the MOC, specifically when the plan is applying for a new H-contract. In addition, it will help CMS track submissions prompted by the state Medicaid agency.

MOC Element 1B (New Language)

Include a list of the partnerships and available services specific to the service area.

Due to variation across geographic regions, plans operating in certain counties may be limited in or have no available partnerships specific to a given need of their Special Needs Plan (SNP) population. As with provider contracts, certain services may not be compatible with the organization due to quality or other reasons. We ask that CMS add language for the plan to include barriers preventing partnerships or services in the geographic region.

SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data.

We recommend that CMS revise the language to address existing plans applying for an H-contract at the request of the state Medicaid agency. Existing SNPs have historical data; however, this question is difficult to address in the MOC when the application is considered new.

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

MOC Element 2B: Health Risk Assessment (HRA) (New Language)

Describe how the SNP addresses challenges associated with enrollees who decline to participate in HRA completion or are unable to be reached.

We agree that adding new language on the HRA challenges is appropriate. However, we recommend that CMS add new Individual Care Plan (ICP) language under MOC Element 2D to include barriers or challenges to its development. Currently, CMS instructs the plan to use the member's health records if an HRA is unavailable. In some cases, a member may have an unmanaged chronic condition and, therefore, it would not be meaningful to use the member's health record to develop the ICP.

Describe how the SNP uses stratified results to improve the care coordination process.

We agree that the new language will help the plan identify member characteristics that can be used to assess potential disparities in care. However, we recommend CMS add language on barriers to stratifying the results—these data may not be available or require additional IT resources to develop reporting.

MOC Element 2C: Face-to-Face Encounter (New Language)

Describe the process used to obtain consent from enrollees to complete a face-to-face encounter and how the SNP verifies that the enrollee has granted consent prior to the face-to-face encounter.

We ask that CMS clarify its instructions on consent prior to the face-to-face encounter. If the patient scheduled an appointment in-person or via telehealth, we assume they have adequately provided consent for the visit. The addition of a new consent requirement to the face-to-face encounter workflow is unnecessary and would increase administrative burden on both the member and the plan.

Detail the process for reviewing enrollee claims data and how the data is used.

Some state Medicaid agencies include claims data requirements in their State Medicaid Agency Contracts (SMACs). Adding this requirement to the MOC may be redundant and would require additional labor and resources to the meet the needs of both CMS and the state. We request that CMS provide additional clarification on the claims data process and what information plans must include in the narrative in order to streamline reporting.

MOC Element 2D: Individualized Care Plan (ICP)

D-SNPs: Describe how the ICP coordinates Medicare and Medicaid services and, if applicable, the D-SNP or affiliated Medicaid plan provides these services, including long-term services and supports and behavioral health services.

We request that CMS remove this language from the MOC. The ICP includes components for the member's self-management goals and objectives and health care preferences. We are concerned this new language does not consider the overall objective of the ICP from the member or caregiver's perspective. In addition, the coordination of Medicaid services may be contingent on the SMAC, which is renewed annually. This requirement may increase the frequency of plans

making off-cycle submissions to align the MOC with state's Medicaid requirements. If CMS includes this new language, we request that the agency provide clarification on the narrative instructions or during the annual technical assistance webinars in order to prevent off-cycle submissions.

MOC Element 2E: Interdisciplinary Care Team (ICT) (New Language)

D-SNPs: Explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable.

We recommend removing this new language from the MOC, which is duplicative of existing requirements. Plans are currently instructed to provide a detailed and comprehensive description of the ICT, including membership, roles and responsibilities for each member. In addition, the MOC provides details on how ICT members contribute to improving the health status of SNP members. In most cases the plan's contracted providers are enrolled in both Medicare and Medicaid and describing coordination between providers is unnecessary.

MOC Element 2F: Care Transitions Protocols (New Language)

D-SNP: Explain how the plan coordinates with providers of any Medicaid covered services during a care transition, where applicable.

We recommend that CMS remove the new language from the MOC. This section is dependent on the annual SMAC, and as Medicaid covered services may change, addressing this new section may require an off-cycle MOC submission. If CMS includes this language, we request that the agency provide clarification on what specific information is requested regarding coordination with providers of any Medicaid services during the member's care transition.

MOC Element 3C: MOC Training for Provider Network Staff (Revised Language)

During the January 7, 2025 SNP NCQA Technical Assistance webinar, an attendee asked a question regarding the frequency of provider training based on the MOC approval period. NCQA replied that providers no longer need to complete the training annually and that the training cadence is contingent on the MOC approval period. We recommend that CMS add new language to this section clarifying the circumstances under which a provider is no longer expected to complete the training annually.