2015 Consolidated 60-day comments for Part C Application

Comment Number	Source of Comment: (Company Name)	2013 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
1	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Some recruitment efforts struggle with meeting both of CMS' time and distance requirements.	Will CMS reconsider health plans as meeting criteria if at least one (time OR distance) is met? Example geographical terrain in rural areas impedes meeting criteria requirements.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: Recruitment is a plan issue as to timing, effort, flexibility on payment arrangements, use of commercially-contracted network, leverage, etc. If terrain in a rural area is a barrier to transportation and access for health care and other services, the particular circumstances should be explained during the application process for the county in question via the exception process after the initial deficiency letter is received.
2	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Because of contracting issues (providers not willing to accept MA rates), we typically do not recruit free standing radiology centers to provide Diagnostic Radiology or Mammography. Instead these services are directed to Acute Inpatient Hospitals or received at PCP or Specialist.	Will CMS reconsider Diagnostic Radiology/Mammography as a required Facility specialty type?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: This needs to be clarified. A PCP or Specialist who operates his or her own state and federally approved radiology and/or mammography equipment in the office could be used as could a hospital's OP radiology department.
3	United Healthcare	60day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov is our main source of truth in terms of comparison of our networks.	Will there ever be an opportunity to review providers based on specialty type in excess of a 25 mile range? Will CMS update their web site to offer searching criteria beyond 25 mile range?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept: CMS is looking into expanding the search radius early next year. It has not been implemented due to technical database issues.

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4	United Healthcare	60 dau	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov lists services available at an Acute Inpatient Hospital, yet the hospital operating certificate is not approved by DOH to provide those services, or the hospital confirms they do not provide those services.	How do we address a service or provider that is posted to Medicare.gov as being Medicare participating and those providers are used to judge our network adequacy/accessibility, but we find out through provider verification that they do not perform the services or are not participating? (ie outpatient cardiac catherization v. cardiac surgery)	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: Medicare.gov information should not be the sole source of information about the Medicare status of individual services or components operated by a hospital. Due dilligence with regard to this issues is the responsibility of the plan bulding a Medicare Advantage network and the specifics of what the facility says about these services needs to be confirmed by documents and written assurances, not taken over the phone from one individual.
5	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CMS requires information that is not readily or easily available for use in an automated fashion. For instance, the number of Medicare certified beds for hospitals, SNFs, ICUs and IP Psych facilities is not readily available to MCOs. This is also true of Medicare certification numbers.	We believe that CMS's requirements for this data is administratively burdensome. Therefore, we request that CMS provide certain information downloadable in excel or other data files that will assist plans in their automated production of HSD tables and population of these fields with accurate CMS information. For example, CMS should provide a resource from which MCOs can obtain Medicare Certification #s, bed counts, etc so that this information is consistent across all health plans.	Insertion	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: This type of information is well known in multiple departments aand offices of these facilities and often maintained on their website or in other public relations and business documents for external users to request. No government data base is going to be as current and up to date as the facility's own official record in the CEO or CFO's office.

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6	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Release of HSD Tables Prior to Final Release of Application in Early January.	Release of HSD Tables Prior to Final Release of Application in Early January: While it is recognized and appreciated that CMS provides draft applications earlier iin the year, we request that the final HSD Tables be made available by November or December rather than with the release of the Final Application in early January. This would allow organizations with a high volume of submissions additional time to train network personnel and sufficient time to upgrade HSD tools, excel formulas, etc. on any changes made to the tables.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: We will look into the possibility of an earlier release of the final format of the HSD Tables prior to the release of the final version of the application in January.
7	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Not all document revisions are dated in the naming convention to know that those downloaded from HPMS are the same as those posted on CMS website.	All documents posted to this site should be dated in the naming convention: http://www.cms.gov/MedicareAdvantageApps/	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: We will look into this with HPMS and our contractors for possible improvement.
8	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	For Large Metro and Metro counties that in addition to one or more urban centers also contain large rural areas where physicians are not available (forests, reservations, military bases, etc) and the number of Medicare beneficiaires is low or non-existent in these areas.	We recommend CMS consider adjusting the criteria either by using a lower level county classification or by lengthening the distance standards for certain specialists in those geographically challenged counties to better compensate for these geographical differences within a county? How do we approach this with CMS?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: This example is one of the reasons why we offer the applicant the exception process. We are aware of differences across single counties, especially large counties, and have looked very carefully at how competing applicants and existing applicants have been able to structure their delivery networks in these counties or in more rural or other unique characteristics of parts of these counties.

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9	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Medicare.gov does not provide downloadable files of providers performing these services: Cardiac Surgery, Cardiac Catheterization, Outpatient Infusion Chemo, Mammography, and Outpatient Dialysis.	How does CMS determine availability of services? What are CMS' definitions of these services?	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: Definitions of these services are available from Medicare. We determine availiabilty of these services from private and public data and FFS claims file information as well as the provider networks of other managed care organizations operating in the same area.
10	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CMS Exception form required for 2014 - DISTANCE FROM BENEFICIARIES IN THE COUNTY field.	We recommend that CMS provide clarity & direction on how they want health plans to use the Sample Beneficiary file, HSD Beneficiary Coverage by Zip Code Report, and the Part D Eligibility File, and more detailed instructions on how CMS is calculating distances.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: We will share this with the staff working to improve guidance and instructions and the automated fields for active consideration.
11	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Certification number: The lists of certified providers that we receive from CMS' (downloadable files from their website) does not always show all locations of a contracted provider. Ex: Walgreens - CMS's lists show some Walgreens' locations, but not all of the locations that we have contracted.	We need clarification from CMS if not all locations are certified or if we are to assume our national and multi-location contracts are covered under the main provider's certification number.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modfication: We will research this topic in CMS and clarify in instructions whether or not an application can assume national and multi-location contracted provider sites are covered under a "main provider" certification number.

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12	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	It is redundant/duplicative to require health plans to repeat listing the contracted providers/facilities "that will ensure access" on the Exception form when they are already listed on the HSD table.	It is suggested that the exception form only require the health plan to identify the "closest contracted provider".	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: The exception template information is reviewed on its own merits with reference to HSD Tables by an exception team reviewer and others on the national team. These staff need to understand and the plan needs to affirmatively state the choices that will be available to Medicare enrollees to get the service in the most timely manner, not just one choice.
13	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	With the suggested change in requiring complete copies of executed Medicare contracts and any applicable downstream agreements, the standard previous turnaround time may be too short.	We would like CMS to consider lengthening the time frame in which health plans have to provide complete executed Medicare agreements (including any applicable downstream agreements). The suggested timeframe would be 15 days.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: We will refer this suggestion to the workgroup revising the entire contract review approach.
14	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	CY 2014 HSD Application Instructions reference column Q (Model Contract Amendment - Indicate if contract uses CMS Model MA Contract Amendment by entering Yes or No) in the MA Provider Table section.	Will CMS be adding a column Q to the Provider Table? Column Q appears in CY 2014 Instructions but not in Provider Table sample or the CMS summary of changes. Our HSD table needs to be built to include this or be subject to HPMS upload fail. We would also need a copy of the Model Contract Amendment to know what CMS is referencing. Where is it available?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept: CMS will add column Q to the Provider Table and plans to release the CMS Medicare Advantage Contract Amendments for both provider and administrative contracts in the early fall of 2012.

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15	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	The CMS downloadable certified Transplant facilities list is in PDF format requiring considerable manual manipulation to convert to Excel or Access so that it can be used in an automated reporting	Request that CMS produce certified transplant list in a .txt or Excel/Access, similar to the other website posted downloadable files of CMS certified providers (Hospital, Home Health, DME, etc)	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: We are willing to look into making this list available in another format for a manipulable file capacity.
16	United Healthcare	60 day	Instructions	2.9 Health Services Delivery (HSD) Tables Instructions	19	Certain Orthotic & Prosthetic providers can serve a county without necessarily being located in the county, e.g. a mail order vendor supplying directly to the home. In addition, we've noticed that CMS is including retail vendors such as Walmart, CVS, etc. in the O&P category when MA plans may focus on more typical orthotic suppliers who can customize the orthotics/prosthetics, etc. or provide them through hospitals or physician offices.	Could CMS reconsider Orthotics & Prosthetics differently, for example, similar to home health?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept: We are making changes of this nature for 2014 application.
17	United Healthcare	60 day	Attestations	3.7 Fiscal Soundness	28	3.7(A)(2) is duplicative of 3.3(A)(1); that is we attest to state licensing twice.	United suggests that Section 3.7(A)(2) be deleted as it appears it is duplicative of 3.3(A)(1).	Deletion	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept: The second reference to state licensure in attestation 3.7 (A)(2) will be removed from the Fiscal Soundness section.

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18	United Healthcare	60 day	Attestations	3.9 CMS Provider Participation Contracts & Agreements (Section B)	30	As part of the application review process, Applicants will need to provide fully executed contracts for physicians/providers that CMS reviewers select based upon the CMS Provider and Facility tables that are part of the initial application submission. CMS reviewers will list the providers/facilities and specific instructions in CMS' first deficiency notice. 4.3 CMS Provider Contract Matrix Instructions for CMS Provider Contract Matrix This matrix must be completed by MA Applicants and should be used to indicate the location of the Medicare requirements in each contract / agreement for the Applicant's first tier, downstream and related entity providers that CMS has identified in the contract sample.	The new requirement requires more uploading since entire contracts are requested rather than just signature pages. It also requires provider matrices produced for each selected sample during the shorter deficiency period rather than with the initial application filing. Can CMS provide the sample size per application they expect to request, expected length of the window for uploading requested contracts and matrices, and the zip file size maximum that HPMS will accept?	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: Because CMS is no longer asking for provider contract templates, the agency anticipates a reduced burden for applicants in the initial application submission. CMS will identify the provider contract sample based upon the contracted network. As it has in the past with the signature page sample, the number of contracts included in that sample will depend upon the size of the requested service area and number of contracted providers serving the pending area. Thus, we cannot provide a set contract size that will apply to every applicant. CMS does not anticipate lengthening the period of time during which applicants will respond to the initial deficiency notice. The previous time frames have been adequate for applicants to locate and upload signature pages; CMS anticipates the same time frames will be adequate for the full contract upload. The upload file size remains unchanged from last year at 500 MB.

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19	United Healthcare	60 day	Attestations	3.13 Marketing (Section A.4.)	37	Applicant agrees to provide general coverage information, as well as information concerning utilization, grievances, appeals, exceptions, quality assurance, and financial information to any beneficiary upon request.	We request clarification of specifically which materials are to be made available "upon request" as this language is not reflected in 42 CFR 422.2260 through 42 CFR 422.2276, referenced in the first paragraph of Section 3.13 of the Part C - Medicare Advantage and 1876 Cost Plan Expansion Application.	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: Per 42 CFR 422.111 (c), an MA organization must disclose specific information upon request. This information includes, but is not limited to, the following: the procedures the organization uses to control utilization of services and expenditures; grievance information according to 422.564; and appeals information according to 422.578. CMS clarifies that the applicant could fulfill a request for the aforementioned information by providing the Evidence of Coverage document. Additionally, 42 CFR 422.111 (c) (5) requires the MA organization to fulfill requests for the financial condition of the MA organization, including the most recently audited information regarding, at least, a description of the financial condition of the MA organization offering the plan. MA organizations have flexibility in creating materials to fulfill a request for information on their financial condition. At a minimum, the material would need to include the elements noted in 42 CFR 422.111 (c) (5).
20	United Healthcare	60 day	Attestations	3.16 Claims (Section A.4.)	42-43	We think that the addition of the word “complete” in this attestation will more closely align with the CMS requirements and with United’s claims processing policies. For example, United does not “develop” all claims that are incomplete, such as certain claims that are missing information or have invalid coding. These claims typically involve only provider liability, so they would not affect the member. This slight change in the attestation wording would allow United to answer this attestation with a “yes” without having to qualify our response.	We believe that the addition of the word “complete” in this attestation will more closely align with CMS requirements to process complete claims promptly. We recommend that the attestation be revised by inserting the word “complete,” as follows: "Applicant will comply with all applicable standards, requirements and establish meaningful procedures for the development and processing of all complete claims including having an effective system for receiving, controlling, and processing claims actions promptly and correctly."	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Disagree: The requirement in 42 CFR 422.520 is that “clean” claims be paid promptly (within 30 days) and that all other claims be paid or denied within 60 days.

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21	United Healthcare	60 day	Attestations	3.16 Claims (Section A.3.)	42	Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M.	CMS rules do not require that plans provide notice of claim acceptance when there is no cost share involved (except for PFFS claims). There is also no requirement to notify beneficiaries of claim denials when the claim only involves provider reimbursement (such notices would be confusing to beneficiaries). Rather, the requirement is that when a claim is denied resulting in member liability, plans must provide the member with his or her appeals rights. We suggest an addition to the attestation that explains that the notice is required in all cases where there is cost-sharing or member liability. We request that the attestation be revised as follows: Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M, *in all cases where there is a member cost-sharing or member liability.*	Insertion	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with the following modifications: Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M and in accordance with CMS guidance, in all cases where there is a member cost-sharing or member liability.
22	United Healthcare	60 day	Attestations	3.28 Tiering of Medical Benefits (Section A.1.)	58	All beneficiaries have equal access to the various tiers proposed. Note: this is new for 2014	We request clarification of "various tiers" as this term is not reflected in 42 CFR 422.112.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify/Accept: Please note tiering will be deleted from the CY 2014 Part C MA application. For further clarification, tiering is not a requirement by CMS. Tieiring is optional for organizations that want to offering tiered networks in their medical benefits. Various tiers refers to the amount of tiers an organization chooses to offer within their plan. A plan may not offer more than three tiers withiin a service category. For ex. A plan may offer a three tier hopsital network, where the cost sharing would vary accoording to each tier.

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23	United Healthcare	60 day	Document Upload Templates	4.3 CMS Provider Contract Matrix (Number 3)	67	Designate if the contract uses the CMS Model Medicare Advantage contract amendment with a "(M)" next to the provider/facility name.	We believe the "CMS Model Medicare Advantage contract amendment" document has not been released and we would like to know when it will be released.	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: CMS plans to release Medicare Advantage Contract Amendments for both provider and administrative contracts in the fall of 2012.
24	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Specific Requirements for Dual-Eligible SNPs (State Medicaid Agency Contracts)	89	We encourage CMS to provide flexibility with the deadlines for completing State Medicaid Agency contracts. There may be cases where state legislative activity or the start of Financial Alignment Demonstration plans may make it difficult to complete the contract by July 1st.	We recommend removal of the reference to a July 1 deadline for submitting State Medicaid Agency contracts.	Deletion	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: We believe the July 1 deadline for submitting State Medicaid Agency contracts is flexible, and has been in place over the past 2 years.
25	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Definitions	92-93	Can clarification be provided on when the "Dual Eligible Subset - Zero Dollar Cost Share" designation or the "Dual Eligible Subset" designation should be used?	We request an example of when these designations should be used.	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: The Dual eligible subset type allows for enrollment of - any (or all) categories of eligibility provided there is State agreement. It is the most flexible classification of D-SNP. The DE Subset D-SNP type can be further designated as a zero dollar cost share when the Subset enrolled includes the Medicaid categories with 0 dollar Medicare cost share, that is, QMB and QMB + , and/or any other Medicaid category, e.g., FBDE, when the State has agreed to cover the Medicare cost share for that Medicaid eligibility group in its State plan.

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26	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	4. D-SNP Proposal Application	97	Not provided	Please clarify what material needs to be submitted for an existing D-SNP that is changing its subtype. Is the entire SNP proposal needed when changing D-SNP subtypes?		This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Clarify: An existing D-SNP will need to submit a new SNP proposal in the next year if it is changing its D-SNP type. Because this past year was the first year where a State contract was required for all D-SNPs, and there was confusion on the part of States and D-SNPs, we underwent a one time D-SNP type mismatch correction process.
27	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	11. Model of Care Attestations (Provider Network and Use of Clinical Practice Guidelines)	104	Under the "Provider Network and Use of Clinical Practice Guidelines" category, item #59 states, "Applicant conducts periodic surveillance of employed and contracted providers to assure that nationally recognized clinical protocols and guidelines are used when available and maintains monitoring data for review during CMS monitoring visits), the term "contracted providers". This statement implies that the Applicant will need to conduct surveillance of <u>all</u> providers, Therefore, this raises concerns about this applicability to the broader provider network that can be several thousand providers.	We recommend that this section be modified so that a sampling can be used in monitoring surveillance.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Reject: We do not believe this modification is necessary because sampling is an acceptable method of surveillance.
28	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	14. D-SNP Upload Document (Number 3)	115	Under the 2011 D-SNP State Medicaid Agency Contract Upload Document, item #3, bullet #3 states, "Third party liability and coordination of benefits". We believe that clarify is needed with regard to the meaning of "third party liability."	We recommend that reference to "third party liability" be removed because CMS has not provided clear direction as to what is meant be this. As an alternative, CMS needs to clarify or provide background on "third party liability" in this context.	Deletion	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: This comment is referencing an old form that is no longer in use. A new Upload form will be inserted into the application document.

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29	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	14. D-SNP Upload Document (Number 5)	115	a. There is a significant amount of confusion for both D-SNPs and State Medicaid Agencies as to whether the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Please clarify that the provision of Medicaid benefits is not always required and that increased levels of agreed-upon coordination of Medicaid benefits is also acceptable. b. Specifically, the NOTE comment only makes reference to Medicaid services "that the organization is obligated to provide under its State contract," which is confusing without a reference to coordination of services as another alternative.	We are assuming that this section would only be included if the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Broadly, if State Medicaid Agencies and MAOs determine that increased coordination will best serve dually-eligible members, the requirements should be clarified to allow this. Specifically, in item #5 and elsewhere that references providing Medicaid benefits, clarify in these areas that agreed-upon coordination is acceptable.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Accept with Modification: This comment is referencing an old form that is no longer in use. A new Upload form will be inserted into the application document. The language in the "Note" should read "provide or arrange". The old form says "provide and arrange". CMS does not feel that additional changes other than this needs to be made as the guidance in Chapter 16-B and all trainings cover this area in detail.
30	United Healthcare	60 day	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	15. D-SNP State Medicaid Agency Contract Matrix (Element #3)	117	The third element of the Dual SNP contract matrix provides that: Medicaid benefits covered under the SNP These are the Medicaid medical services that the organization is obligated to provide under its State contract, not the non-Medicare mandatory Part C services covered under the MA contract. There is confusion about what should be documented for this element. Further the above description makes it sound like the D-SNP is required to provide Medicaid benefits, when in fact most D-SNPs do not provide/cover Medicaid benefits, but rather help members to coordinate the services available through Medicare and Medicaid.	Flexibility should be provided to allow the Medicaid benefits to be documented in a variety of ways that will accommodate each state's unique negotiated approach. For example, due to the overlap of benefits covered by both Medicare (primary) and Medicaid (secondary), if a state wants a combined list of Medicaid and Medicare benefits outlining each program's responsibility for a category of service, that should be sufficient to meet this element and will help MAO's create a better Section IV of the Summary of Benefits.	N/A	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Verified that this comment was addressed in 2014 package Reject: Submission of combined lists results in CMS not being able to determine the level of actual coordination and integration.

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31	UnitedHealthcare	60 day	APPENDIX II: Employer/Union-Only Group Waiver Plans (EGWPs) MAO "800 Series"	6.4 Attestations ; 2 Certification (Number 9)	135	Applicant understands that dissemination/disclosure materials for its EGWPs are not subject to the requirements contained in 42 CFR 422.80 or 42 CFR 423.50 to be submitted for review and approval by CMS prior to use.	We believes that the correct citations are 42 CFR 422.2262 and 42 CFR 423.2262, respectively.	Revision	This comment was received for the CY2014 package which was already approved by OMB 12/2012. A response is not applicable since the comment does not apply to this CY2015 package. CMS has already responded to the comment and that your response can be found in the CY 2014 PRA package. 2014 Response: Verified that this comment was addressed in 2014 package Accept: However, we should note that while CMS does not currently require submission of marketing materials for pre-approval it resereves the right to review EGWP related marketing material at any time.
32	Association for Community Affliated Plans (ACAP)	60 day	Special Needs Plans Application Section Apendix I / Quality Improvement Program Requirements	13	109 - 110	ACAP comments that the Quality Improvement Program Attestation section be streamlined similar to the newly revised MOC attestation section.	ACAP asks that the Quality section be streamlined to reflect an attestation of compliance with the various requirements rather than providing detailed information on the application and uploading documents that are otherwise submitted to CMS, the states or their contractors.	Streamline this section by omitting attestations in the SNP Quality section and have an attestation of compliance.	REJECT: The Quality Improvement Program Plan outlines the elements of the Medicare Advantage Organizations SNP QI program and provides a frameworkfor how the SNP is to execute quality improvement requirements at 42 CFR Section 422.152. The Quality Improvement Program Plan attestations and narrative are to encompass all aspects a SNP's quality projects, as well as all quality data collected by the SNP. Therefore, many of these attestations are appropriate. However, CMS will examine the Quality Improvement Program Requirements Attestations in the SNP application section for the next application cycle (i.e., CY 2016) to determine whether any attestations are duplicative, can be streamlined, or removed.

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33	UCare Minnesota	60 day	Special Needs Plans Application Section Apendix I / Quality Improvement Program Requirements	13 and 20	109 - 110	Duplication with the MOC and the Section 20, Quality Improvement Program Matrix, Synchronize these sections.	How does this new Domain synchronize with Section 20, Quality Improvement Program Matrix? It appears there is duplication and recommend this section be eliminated. If there are elements that are unique, recommend they should be incorporated into Section 20 rather than have a new set of requirements. The SNP leadership and management discussed in Element A is covered in the Staff Structure section. This appears to be duplicative of 2A. Similar to the removal of attestations for the SNP Model of Care, we recommend that the attestations for the #13, Quality Improvement Program Requirements be removed or reduced, as the detailed information is included in section #20 Quality Improvement Program Matrix Upload Document.	Synchronize the MOC with Section 20 and remove the section and reduce or remove the number of attestations for the Quality Improvement Program Requirements	REJECT: The Quality Improvement Program Plan outlines the elements of the Medicare Advantage Organizations SNP QI program and provides a frameworkfor how the SNP is to execute quality improvement requirements at 42 CFR Section 422.152. The Quality Improvement Program Plan attestations and narrative are to encompass all aspects of a SNP's quality projects, as well as all quality data collected by the SNP. Therefore, many of these attestations are appropriate. However, CMS will examine the Quality Improvement Program Requirements Attestations in the SNP application section for the next application cycle (i.e., CY 2016) to determine whether any attestations are duplicative, can be streamlined, or removed.
34	Cigna HealthSpring	60 day	Special Needs Plans Application Section Apendix I / Quality Improvement Program Requirements	13	109-110	Clarification on the attestations especially #21 and #27 in the Quality Improvement Program Attestations is needed.	#21 – Since supplemental benefit flexibility is not permitted for SNPs other than FIDESNPs, we request clarification as to how standard D-SNPs, C-SNPs and I-SNPs can meet this requirement. We support benefit flexibility for all SNPs – not just FIDESNPs.	States that benefit flexibility should be for all SNPs not just FIDE-SNPs.	Reject: Attestation #21 does not refer to benefit flexibility supplemental benefits as described in Chapter 16b. The add-on services and supplemental benefits referred to in the attestation are those noted in the Medicare Managed Care Manual Chapter 4, Section 30.

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35	Cigna HealthSpring	60 day	Special Needs Plans Application Section Apendix I / Quality Improvement Program Requirements	13	109 - 110	Clarification on the attestations especially #21 and #27 in the Quality Improvement Program Attestations is needed.	#27 – We do not think that this attestation question adds value, and requiring the sharing of this analysis with ICT members/providers may detract from other critical priorities as determined by the QI program. Furthermore, a QIP derived from the Care Transitions analysis would necessitate the sharing of information and results with all applicable stakeholders. In some cases, these stakeholders will be ICT members but in other cases, they may not be – considering that all plans define ICTs differently. If this question continues to be included, we suggest changing the term "interdisciplinary care team" to "applicable stakeholders."	Suggest to remove attesation #27.	Reject: suggestion to remove attestation #27. The purpose of the SNP is to provide high quality care coordination for special needs beneficiaries as well as communicate critical information, such as a transition of care anaylsis to those on the interdiscplinary care team. However, CMS will examine the Quality Improvement Program Requirments Attestations in the SNP application section for the next application cycle (i.e., CY 2016) to determine which attestations are duplicative, can be streamlined, or removed to reduce burden.
36	Cigna HealthSpring	60 day	Special Needs Plans Application Section Apendix I / Quality Improvement Program Requirements	13	109 - 110	Clarification on the attestations especially #21 and #27 in the Quality Improvement Program Attestations is needed.	All attestations begin with "For each special needs plan," however, some data such as CAHPS and HOS is collected at the contract level and therefore could include SNPs as well as regular MA plans, would you please clarify if all data is to be collected at the SNP PBP -level?	Requests clarification on whether all data is to be collected at the SNP PBP level.	Clarification: Only MAOs with SNPs having 500 or more enrolled members are required to submit HOS data. Only MAOs with SNPs having 600 or more enrolled members are required to report CAHPS information. CAHPS and HOS are collected by CMS at the contract level, not the SNP PBP level.
37	HealthPartners	60 day	Attestations	3.12 Quality Improvement Program	39	Needs clarification on what the attestation is referring to. Is the attestation referring to Quality Improvement Program or the Quality Improvement Project. Acronyms are confusing.	Are the CMS attestations and instructions related to the Quality Improvement Project (QIP) Plan or the Quality Improvement (QI) Program? The references and acronyms in section 3.12 (see below) and crosswalk are different than CMS regulations and guidance. For example, CMS references the Quality Improvement Program as "QI Program" and the Quality Improvement Project Plan as the "QIP Plan". The crosswalk has several references, including the title to "Quality Improvement Project (QIP) Plan." However, the elements to be cross walked are broader than the QIP Plan and follow the regulations applicable to the QI Program.	Revision	Accept: Clarifying the acronyms used for Quality Improvmenet Program and Quality Improvement Project. CMS is revising the attestation in section 3.12 to indicate that this is the Quality Improvement Program or QI Program.

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38	HealthPartners	60 day	Instructions	4.11 Crosswalk for Part C Quality Improvement (QI) Program Project (QIP) Plan	90	Needs clarification on acronyms in the crosswalk section 4.11.	Are the CMS attestations and instructions related to the Quality Improvement Project (QIP) Plan or the Quality Improvement (QI) Program? The references and acronyms in section 3.12 (see below) and crosswalk are different than CMS regulations and guidance. For example, CMS references the Quality Improvement Program as “QI Program” and the Quality Improvement Project Plan as the “QIP Plan”. The crosswalk has several references, including the title to “Quality Improvement Project (QIP) Plan.” However, the elements to be cross walked are broader than the QIP Plan and follow the regulations applicable to the QI Program.	Revision	Accept: Clarifying the acronyms used for Quality Improvmenet Program and Quality Improvement Project. CMS is revising section 4.11 to indicate that this is the Quality Improvement Program or QI Program.
39	Association for Community Affiliated Plans	60-day	Instructions	Appendix 1: DSNP State Medicaid Agency Contract Negotiations Status Document	127	Removal of DSNP State Medicaid Agency Contract Negotiations Status Document	Commenter supports the deletion of the requirement to upload the an actual copy of the state contract for coordination of the SNP with the Medicaid Program.	Clarification	Clarify: CMS is not deleting the requirement to upload an actual copy of the state contract for coordination of the SNP with the Medicaid Program. We have deleted the requirement to upload the DSNP State Medicaid Agency Contract Negotiation Status Document.
40	Florida Blue Cross and Blue Shield	60-day	HSD Instructions	HSD Instructions	2	Speciality Codes were eliminated in CY2014 but are showing up on the CY2015 HSD Instructions. Organizations wants to confirm this change or point out this error.	Commenter stated that Cardiac and thoracic specialty codes were eliminated in 2014 (009 and 032) and a new code was created (035). The application is now proposing to reverse this change for 2015. Florida Blue would like to confirm that this is an intended change and not an error.	Revision	Accept: CY2015 HSD instruction were not up to date and therefore CMS has revised the specialty codes on page two to reflect the deletion of 009 and 032 and added 035 Cardiothoracic surgery.
41	Florida Blue Cross and Blue Shield	60-day	HSD Instructions	HSD Instructions	5-6	Define IPA	Commenter suggested that CMS define "IPA."	Revision	Accept: Independent Practice Association (IPA) has been defined in HSD Instructions.

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42	Florida Blue Cross and Blue Shield	60-day	HSD Tables	HSD Table	N/A	Clarification needed on how the owner of a group practice is designated.	Commenter would like clarification on how the owner of a group practice is designated - would employee designation be correct?	Clarification	Clarify: If the physician listed in the HSD Table is an employee, the president, medical director, or other officer of the practice has the authority to bind the physician to see patients from a particular MAO. If the physician listed in the HSD table is an owner, partner or other, only the physician can bind him or herself by contracting on his or her own.
43	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	General Comments: Most Vulnerable Beneficiaries	A few commenters supported a number of the modified MOC requirements. However, they believed that requirements related to documentation of community partnerships in each service area and the requirement that plans repeat the exercise of describing the demographic characteristics of the target population and of the most vulnerable subset of the population is excessive. They suggested that it is not clear that the added reporting burden will be rewarded with significant improvements in health outcomes. These commenters supported the merger of the care of vulnerable population element in this description since the most vulnerable subsets are a part of the overall	Clarification	Clarify: CMS is not changing the intent of the MOC nor the expectations regarding the components of the MOC, as reflected in the MOC Element criteria. Although the number of elements have been reduced, we simply consolidated inter-related elements that previously were to be addressed as separate and distinct components. The modified structure continues to capture all relevant information previously required via those distinct elements. That said, CMS believes it has provided high-level and non-prescriptive MOC Element criteria, thereby providing SNPs with the necessary flexibility to describe a thorough and comprehensive MOC designed to meet the healthcare needs of their unique beneficiaries.
44	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	General Comments	One commenter stated that it would be helpful to know what type of evidence, if any, would be required, for example policies, standard operating procedures, reports to better understand if the plan's	Revision	Reject: CMS' expectation is the MOC be uploaded in narrative format only. No supporting documents are necessary.
45	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	General Comments	One commenter suggested that the use of the term "detailed" is not helpful. A more concise, clear term or phrase should be used. The use of 4 examples of how any requirement will be performed, as requested in the last submission, seemed excessive and not helpful to those plans with many years of experience. A SNP can provide policies, procedures, and/or examples instead of narrative.	Revision	Reject: CMS uses the term 'detailed' to emphasize that the MOC narrative should be thorough and complete in its description. CMS' does not require examples be submitted with the MOC; however, all components of the MOC should be comprehensively addressed using the modified MOC Element Criteria. CMS' expectation is that the MOC be uploaded in narrative format only. No supporting documents are necessary.

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46	Medica Health Plan	60	Appendix 1: Model of Care	N/A	N/A	General Comments	A few commenters suggested that there appears to be an underlying assumption that medical groups and plans have direct access to one another's data. This is not true for some SNPs and although they are working on agreements to access information directly from contracted medical providers [they do receive claims] they are 4 years into this process and have not made enough progress to reduce manual data collection for many, many items. Furthermore, State privacy laws are often more stringent than	Clarification	Clarify: CMS understands the constraints associated with obtaining a beneficiaries' medical records. These unique situations need to be thoroughly and clearly addressed in the MOC. CMS does not necessarily expect to see that enrollee medical information is 100% unobtainable. However, the SNP should be outlining current approaches & methods for collecting medical information as well as barriers to obtaining medical information for SNP beneficiaries (should that be the case).
47	Association for Community Affiliated Plans; Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	MOC Multi-Year Approval	A few commenters were in support of the MOC 3-year approval and requested that plans could wait until their next scheduled review to resubmit using the modified MOC Element Criteria. They also commented that NCQA has an excellent model to follow with its accreditation process	Clarification	Clarify: Currently the 3-year approval for the MOC remains intact. CMS will inform the SNPs of any changes made to the 3-year approval for the MOC. SNPs will be required to submit a MOC in its revised, finalized form, only as required, based on the MOC's current approval period.
48	SNP Alliance: Medica Health Plan, Health Partners, Inc., & Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Most Vulnerable Beneficiaries; End-of-Life Requirement	Some commenters suggest that the End-of-life requirement should be qualified; e.g., "if relevant to the target population served by the SNP". The commenters suggested modifying the end-of-life requirement with the caveat "if relevant to the target population served by the SNP."	Clarification & Revision	Clarify: The description of the sub-population is a specific congressional requirement in 42 CFR Section 422.101(f)(2)(iv), which requires all MAOs that offer SNP products to implement a MOC component that specifically addresses the coordination and delivery of specialized benefits and services that meet the needs of the SNP's most vulnerable beneficiaries, including frail/disabled beneficiaries and beneficiaries near the end of life. SNPs should be in a position to decipher the specific differences that make these beneficiaries more vulnerable than the SNP's general target population. The SNP's MOC policies and procedures should appropriately reflect any unique approaches that address the unique needs of sub-population(s) and explain the distinct differences between the most vulnerable beneficiaries and those in the overall SNP
49	Medica Health Plan, SNP Alliance, America's Health Insurance Plan, Health Partners, Inc., & Cigna HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Request to use risk stratification for HRA, ICP, ICT, and Care Transitions	Many commenters were concerned that CMS did not allow the use of a risk stratification method to identify relevant beneficiary diagnosis collected on the Health Risk Assessment tool. They also recommended that they be allowed to use a risk stratification approach for developing the Individualized Care Plan and the Interdisciplinary Care Team. The commenters also requested they be allowed to use a risk stratification approach to determine appropriate care transitions to improve their service delivery strategies. The commenters thought this was necessary	Clarification	Clarify: CMS does not object to SNP's using risk stratification processes to meet the needs of its SNP beneficiaries. The MOC Element Criteria - 2B currently supports the use of 'stratification' for the Health Risk Assessment component of the MOC. If a SNP chooses to use a risk stratification model to support elements of its MOC, CMS expects these processes to be thoroughly and completely described in the MOC narrative. Moreover, CMS also recognizes that not all SNPs use a risk stratification approach to determine member healthcare needs; therefore, this level of detail is based solely on the SNP organization's capabilities and is not considered a requirement

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50	HealthPartners, Inc., SNP Alliance, Medica Health Plan, & Health Partners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	PACE-like Model associated with ICT, Care Coordination, & Virtual Communication	PACE-like Model: Some commenters are concerned that the new MOC requirements are moving in the direction of a PACE model which is not an appropriate model for SNPs. There are concerns about the level of detail and overall "prescriptiveness" the new requirements propose. Further, the requirements for the ICT communication processes would work in a PACE model but do not work for virtual teams. The commenters highlight that in a state wide model; member, providers, and care coordinators are not co-located. Face to face meetings are rarely possible for the purpose of care coordination only. Plans do not pay clinicians for office time for this service. Clinicians' are willing to consult and advice via phone and communication is carried out but not in face to face or web meetings. Clinical notes, which are separate from the ICP, should provide the record of	Clarification	Clarify: CMS is not promoting a PACE-like Model to meet the MOC requirements. CMS is not changing the intent of the MOC nor the expectations regarding the components of the MOC, as reflected in the MOC Element criteria. CMS has provided high-level and non-prescriptive MOC Element criteria, thereby providing SNPs with the necessary flexibility to describe a thorough and comprehensive MOC designed to meet the healthcare needs of their unique beneficiaries. This includes the communications processes of the ICT, which are critical to successful care coordination processes.
51	Cigna-HealthSpring, Medica Health Plan, Health Partner's Inc., America's Health Insurance Plan, Ucare, & SNP Alliance,	60-day	Appendix 1: Model of Care	N/A	N/A	MOC-Provider Network Training Requirements	Some commenters stated that training and competency testing of all providers is unrealistic, especially for health plans that have extensive provider networks. This requirement is both repetitive and time consuming. The commentors relay that the extensive recordkeeping is burdensome and challenging. The commenters request clarification on expectations related to tracking of completed training and whether SNPs must "mandate" that all providers participate in this training. The number and variety of providers for a health plan makes this very challenging. The commenters support the need for having information on the MOC available to providers and recommend that documentation focus on notification of providers of training opportunities, not 100% compliance. The commenters also suggest receiving attestations from providers or their contracted organization that all ongoing required trainings are completed could be an acceptable alternative. It is also	Clarification & Revision	Clarify: The expectations regarding MOC training for network providers has not changed. CMS does not expect SNP's to necessarily achieve 100% compliance for training and competency of the MOC, especialy those with extensive provider networks. However, CMS does expect and requires SNPs to use innovative methods to address this issue of provider network training. SNPs have the flexibility to thoroughly describe how they meet this element requirement based on the unique structure of their organization. The examples provided by these commenters speaks to the level of uniqueness and complexity associated with MOC training requirements for providers and should be thoroughly described as such in the MOC. CMS also recognizes the strategies provided in the comments aide in the justification and rationale of adhering to the MOC Training for the Provider Network element that is unique to your organization; we cannot emphasize enough the importance of providing this level of detail in the MOC narrative. However, this does not eliminate the requirement that the SNP Provider Network needs to be informed/trained on the

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52	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Use of 'member risk methods' for HRA, ICP, ICT and Care Transition Protocols.	A few commenters were concerned that CMS does not allow or promote the use of 'member risk methods' to tailor beneficiaries risk level and associated healthcare needs. They are concerned that CMS is requiring SNPs to provide the same intensity of services to high and low risk members who require minimal intervention or who do not wish to participate in care management programs. They believe more SNP resources should be used to care for the highest risk most vulnerable members	Clarification	Clarify: CMS encourages use of 'member risk' methods to achieve appropriate care coordination efforts for their SNP beneficiaries; however, it is not a requirement that all SNPs use these type of 'member risk methods'. SNPs have the flexibility and autonomy to describe how they meet these MOC element requirements based on the unique and relevant structure of their organization. The example this commenter has provided speaks to the level of uniqueness and complexity associated with SNP beneficiaries' healthcare needs and should be thoroughly described as such in the
53	America's Health Insurance Plan & Health Partners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	MOC Requirements in the MA Application and Medicare Managed Care Manual	Some commenters requested that the release of SNP Model of Care updates be released in the SNP-specific Chapter 16b instead of the MA Application process. Furthermore, they urged CMS to rely upon this process for updating the Manual chapter as the means for issuing for comment and finalizing substantive revisions to the MOC rather than initially proposing such changes in the draft MA application.	Clarification	Clarify: CMS' Chapter 16b will be updated to reflect the current modifications for the MOC Element Criteria once finalized. CMS is mandated to include the MOC Element Criteria with the MA Application through the Office of Management & Budget - Paper Reduction Act process every year which allows for the appropriate public comment period; therefore, Chapter 16b of the Medicare Managed Care Manual is not the proper vehicle through which to seek comment and effectuate modification to the MOC elements. We would note that the PRA process also includes a 30-day
54	Cigna-HealthSpring, SNP Alliance, Health Partners, Inc. & UCare	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement: MOC Quality Performance Improvement Plan and clarification on expectations of SNP leadership & management roles.	A few commenters requested CMS to clarify the requirement to describe how SNP leadership, management groups, other personnel, and stakeholders are involved with the quality performance process. They specifically asked 'what is CMS' goal and what problem is this new requirement intending to address'?	Clarification	Clarify: CMS believes quality healthcare reasonates from the leadership of an organization down to its front-line staff. CMS seeks to identify those individuals in leadership/management postions involved with the quality performance of the MOC outcomes and how the results of the MOC outcomes inform administrative decisions for improving quality of care for SNP beneficiaries. CMS believes this level of
55	HealthPartners, Inc., SNP Allicance, Medica Health Plan, & Cigna HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Transitions Protocols	Some commenters were concerned that CMS is requiring 'all' SNP providers to ensure care transition protocols are being used to maintain care continuity. Furthermore, they stated that "Any transition of care" is too broad and implies an MCO is aware of everything that is happening to the enrollee. It would be impossible for the MCO to manage every transition. MCOs should focus on where there is risk for readmission and/or adverse outcomes.	Clarification & Revision	Clarify: The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. SNPs have the flexibility to describe how they meet this element requirement based on the unique and relevant structure of their organization. Therefore, it is each SNP's responsibility to identify its specific care transitions they monitor routinely as well as the rationale and justification for doing so. CMS does not expect SNP's to be accountable for every care transition; therefore, we have changed 'any' transition in care to 'applicable' transitions in care.

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56	Kaiser Foundation Health Plan, Inc., Medica Health Plan, Health Partners, & America's Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	MOC Quality Measurement and Performance Improvement Plan	Some commenters recommended that the NCQA review for purposes of the 3-year approval focus on performance monitoring and outcomes rather than structure and process. They also thought a tighter alignment with the SNP Structure & Process Measures related to goals and improvement activities would be helpful to SNPs. Furthermore, they were concerned that the	Revision	Reject: The SNP Structure & Process Measures are not directly linked to the MOC narrative or the MOC implementation. This comment is outside the scope of the current information collection process; however, should CMS consider alignment of the MOC and S & P Measures in the future, we will solicit appropriate comment.
57	HealthPartners, Inc., SNP Alliance, & Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Clarification of 'continuous evaluation' by ICT members	Some commenters requested clarification on what it means by ‘continuous evaluation’ by the ICT. They requested that the term ‘continuous’ be changed to ‘periodic’. Furthermore, they requested that the requirement regarding the use of outcomes for “continuous” evaluation of processes to manage changes in beneficiaries’ health be modified to “periodic” evaluation. They further requested that the meaning of “periodic” be defined by plans in relation to the needs of the specific population they serve since Some needs will vary significantly by SNP subset.	Clarification/ Revision	Clarify: CMS expects SNPs to evaluate if the structure/processes developed by the ICT are working and effective for the beneficiary. It is up to the SNP to determine how often an evaluation is needed, which CMS assumes would be dependent on the structure of the ICT, beneficiary need/s and other applicable care coordination structures of the SNP. The example/s provided speaks to the level of uniqueness and complexity associated with SNP beneficiaries' healthcare needs and should be thoroughly described as such in the MOC, and not simply on an "as-needed" basis." Accept: CMS has modified MOC Element 2D to reflect the following: 'explain how the ICT used
58	Cigna-HealthSpring & Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: SNP Staff Structure	Some commenters requested clarification about how the organizational chart should look. They recommended changing the requirement to “an organizational chart that also shows staff responsibilities identified in the MOC.” They also suggested removing the reference to job descriptions as it is redundant with staff responsibilities. Furthermore, SNP Structure: The focus on job titles should be eliminated. Focusing on job functions and job responsibilities is	Clarification & Revision	Clarify: CMS does not recommend a 'standard' organizational chart for the MOC. SNPs have the flexibility and autonomy to make this determination based on the structure of their unique organization. CMS has changed the language used in MOC Element 2A - Bullet 2 to reflect 'job title' versus 'job description'. We continue to capture job functions in Element 2A.
59	SNP Alliance, Cigna HealthSpring, Health Partners, Inc., & Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	SNP Provider Network; Specialized Expertise & Credentialing	Some commenters were concerned that CMS was requiring a duplicative requirement for provider credentialing in the SNP MOC. They cited that documentation requirements associated with provider credentialing should be limited to the competency of specialized healthcare providers that are not accounted for under the standard credentialing rules. They	Revision	Accept: CMS has deleted MOC Element 3A - bullet 3 'provide evidence that appropriate provider credentialing information in accurately documented, updated, and maintained'. This will eliminate redundancy of this MOC requirement. However, MOC Element 3A - Bullet 2 has been retained.
60	SNP Alliance, Health Partners, Inc., & Cigna HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	SNP Staff Structure	Some commenters are seeking clarification on CMS’ expectations regarding “contingency planning for staff continuity.” They suggested that this requirement be reframed in the context of human resource workforce policies consistent with the general MA requirements and not structured as a unique SNP requirement.	Clarification & Revision	Clarify: CMS expects SNPs to identify the processes associated with filling critical staff functions when staff turnover occur; this will ensure that the SNP has a plan in place to maintain continuity of care for SNP beneficiaries. Accept with Modification: CMS has changed MOC Element 2A to reflect 'Identify the SNP

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61	HealthPartners, Inc. & SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Individualized Care Plan	Some commenters are concerned that CMS' did not acknowledge and address how MOCs should approach the development of an ICP for members that refuse to participate in the care management process.	Clarification	Clarify: SNPs have the flexibility and autonomy to develop an appropriate approach for members that refuse to participate in their healthcare processes; this process should be thoroughly and completely described in the MOC narrative. Therefore, it is the plan's responsibility to address
62	SNP Alliance & America's Health Insurance Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement:	Some commenters requested clarification on CMS' expectations that the SNP requirements will be related to or integrated with MA contract level quality improvement program requirements, and they recommended that CMS revise the draft to address this issue. Furthermore, the commenters recommended that this domain be streamlined.	Revision	Reject: The Quality Performance Improvement Plan is specific to the MOC. CMS acknowledges that the quality improvment program requirements could be streamlined and the revision of the MOC Element Criteria is the first step in that direction. We believe we have structured a high-level MOC Element criteria that provides SNPs with the flexibility to describe a thorough and comprehensive MOC designed to meet the healthcare needs of their unique beneficiaries. SNPs have the flexibility and authority to describe how they meet this element requirement based on the unique and relevant structure of their organization; this includes those areas that address
63	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Individualized Care Plan: One commenter stated that CMS assumes all plans share medical records. Further, for plans without a common electronic record, access to documents is not easy. A requirement to identify the processes that are used to keep ICT members informed, such as telephonic outreach or faxed documents, is preferred if an integrated medical electronic records is	Revision	Reject: CMS understands the constraints associated with obtaining beneficiaries' medical records. Some unique situations need to be thoroughly and clearly addressed in the MOC and the SNP has the flexibility to identify what their specific processes are for meeting this ICT element. The example provided (telephonic outreach and/or faxed documents) should be addressed in the MOC (if this is appliable).
64	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdisciplinary Care Team: A few commenters requested clarificaiton of what is meant by "continuously evaluate established processes." Further, they requested that the word "continuous" change to the word "periodic or as needed for the target population." If the ICT is working with an individual, they would evaluate the plan of care more than the ICT processes for an individual member. The health plan should evaluate ICT processes with input from all the ICT teams.	Clarification/ Revision	Clarify: CMS expects SNPs to evaluate if the structure/processes developed by the ICT are working and effective for the beneficiary. It is up to the SNP to determine how often an evaluation is needed, which CMS assumes would be dependent on the structure of the ICT, beneficiary need/s and other applicable care coordination structures of the SNP. The example/s provided speaks to the level of uniqueness and complexity associated with SNP beneficiaries' healthcare needs and should be thoroughly described as such in the MOC, and not simply on an "as-needed" basis." Accept: CMS has changed this MOC Element
65	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Care Transitions Protocol	One commenter suggested that the Eric Coleman model works well but not for cognitively impaired individuals. How does self-management apply to those with cognitive and severe mental health issues?		Clarify: CMS' relies on the SNP to address this in their MOC narrative (if applicable). We recognize that Self-Management Support would not be feasible for certain beneficiaries. The SNP would be expected to discuss its Self-Mangement Support activities that are taking place for those SNP beneficiaries where it is feasible and any

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66	Medica Health Plan	60-day	Appendix 1: Model of Care	N/A	N/A	SNP Provider Network	Clinical Practice Guidelines: A few commenters stated that most guidelines do not address those over 70 nor do they address how to adapt when multiple chronic conditions are present. Clinicians do not document why they adapt a guideline, they simply document their orders and their plan of care. The ICP should identify problems, goals, and interventions not rationales for the interventions. Discussions among the ICT often clarify the rationale, but documentation is rarely available. The	Clarification	Clarify: The focus on clinical practice guidelines has not changed as part of the proposed elements; the previous structure also promoted the use of accepted clinical practice guidelines. If the SNP uses a modified approach for meeting this element (Use of Clinical Practice Guidelines) then this should be thoroughly described in its MOC, with the applicable justifications for making the modificaitons and beneficiaries for whom the modified approach applies. CMS has provided high-level and non-prescriptive MOC Element criteria, thereby providing SNPs with the
67	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	ICT Expectations	A few commenters stated that the expectation that there are regular, face-to-face interactions with the ICT is neither realistic nor appropriate for an entire population of SNP members. A virtual model through telephonic and/or electronic means is appropriate as this model provides very effective team-based care. They encouraged CMS to allow plans to develop innovative and flexible methods in which to communicate within the ICT. In an environment where electronic health records are used as a means for communicating patient updates to multiple provider types, we encourage CMS to support MCOs in the development of ICT meetings in a “virtual” world. Althoug they do support face-to-face team-based care when appropriate but we	Clarification	Clarify: CMS does allow and encourages SNPs to develop innovative and flexible methods to communicate with the ICT; it is the SNP's responsibility to thoroughly and completely describe these processess in the MOC.

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68	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Health Risk Assessment: A few commenters recommended that CMS change the verbiage as follows: Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MOC Element 2C) for each beneficiary and how the HRAT information is disseminated to the Interdisciplinary Care Team (MOC Element 2D).	Revision	Reject: CMS expects to know how the ICT uses the HRAT to meet SNP beneficiaries' healthcare needs. SNPs have the flexibility to determine when a beneficiary's ICP needs to be updated; however, CMS expects this update process to be 'timely'. Since the HRAT is completed on an annual basis, it would be expected that SNPs update their beneficiaries' ICP on an annual basis at the very minimum.
69	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdisciplinary Care Team: A few commenters stated that the requirement to explain the role of personnel responsible for developing the ICP seems duplicative of the requirements under staff structure which requires plans to “fully define SNP staff roles across all health plan functions, . . .”	Clarification	Clarify: If the staff structure descriptions in the MOC include those staff that oversee the ICP; then, this must be comprehensively addressed in the MOC. CMS believes the individuals responsible for developing the ICP play a critical role and this needs to be described thoroughly and completely in the MOC. Moreover, the MOC Staff Structure likely includes staff that are not
70	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Individualized Care Plan: One commenter stated - MCOs should be able to develop an ICP that is individualized and centric to the member.	Clarification	Clarify: CMS agrees with this statement and encourages SNPs to develop an ICT that meets the member's specific health care needs.
71	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdisciplinary Care Team: Some commenters stated that the description of the roles and responsibilities of each ICT member is excessive & exhaustive as it applies to specifying how their expertise aligns with the clinical and social needs listed on the care plan and how these	Clarification	Clarify: SNPs have the flexibility to succinctly and comprehensively describe how they meet this element requirement based on the unique and relevant structure of their organization.
72	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdiciplinary Care Team: One commenter stated that the ICT composition should be determined primarily at the plan level based on the Medicare subset the SNP was approved to serve.	Clarification	Clarify: CMS agrees with this statement and believes SNPs have the necessary flexibility and autonomy to make these determinations.

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73	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdisciplinary Care Team: One commenter requested clarification about the requirement to have “regular” exchange of information within the ICT. Communication with the ICT may vary widely from SNP to SNP type and depending on the level of care requirements of the member.	Clarification	Clarify: CMS believes exchanges in communication among the ICT members is a critical function in order for the ICT to meet the healthcare needs of the beneficiary. CMS understands that ICT communication will differ in the types and levels of communication that takes place and will be dependent on the needs of the individual beneficiary. SNPs have the flexiblity and autonomy to decide how this 'regular'
74	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	Interdisciplinary Care Team: One commenter recommended that the ICT should be composed of care team members that directly have a major role with the members’ care and not all care givers need to be included. They also recommended that the following language changes: “Explain how the beneficiary’s HRAT and ICP are used to identify ICT composition in cases where additional team members are needed to meet the unique needs of an individual	Revision	Accept with modification: CMS has changed the language in MOC Element 2D - Bullet 1; sub-bullet 2 which now reads ' Describe how the beneficiary's HRAT (MOC Element 2B) and ICP (MOC Element 2C) are used to determine the composition of the ICT, *including* those cases where additional team members are needed to meet the unique needs of the individual beneficiary'.
75	HealthPartners, Inc.	60-day	Appendix 1: Model of Care	N/A	N/A	SNP Provider Network	Use of Clinical Practice Guidelines & Care Transition Protocols: One commenter stated that the need to modify CPGs or protocols should not be limited to vulnerable subset. It is relevant to all SNP enrollees with	Clarification	Clarify: CMS agrees with this statement. SNPs have the flexibility to describe how they meet this element requirement based on the unique and relevant structure of their organization.
76	America's Health Insurance Plan	60-day	Appendix 1: Model of Care	N/A	N/A	Individualized Care Plan	One commenter suggested that the first bullet and first sub-bullet in the description of the elements of the Individualized Care Plan (ICP) require that ICP components must include beneficiary self-management goals and objectives and if the beneficiary’s goals are not met, a description of the process employed to reassess the ICP. This commenter recommended that the language in the first sub-bullet of the MOC Element for the ICP be revised to also refer to the role of the caregiver(s)	Revision	Accept: CMS has added the 'role of the caregiver(s) to Element 2C - Bullet 1.
77	Ucare & SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Interdisciplinary Care Team: Composition	Some commenters felt that they should be able to determine the composition of the ICT, and to determine the frequency with which the ICT meets. The composition should be tailored to the individual needs of each member, and should be acceptable that the ICT consist of, at minimum, CC, member, and PCC, with other providers added on a short term basis as the CC deems appropriate. The CC should be able to determine the frequency of ICT communication, and plans should not be required to	Clarification	Clarify: CMS supports this comment and the examples provided by the commenters speaks to the level of uniqueness and complexity associated with the composition of the ICT. SNPs have the flexibility and authority to describe how they meet this element requirement based on the unique and relevant structure of their organization. CMS recognizes the innovative strategies provided in your comment also identifies the justification and rationale of adhering to the MOC ICT element that is unique to your organization; we cannot emphasize enough the importance of providing

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78	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Description of the SNP Population	One commenter stated that the detailed profile of the medical, social, cognitive, and other health factors should be described at the product level. Even environmental factors, such as for duals, may not differ substantially across many service areas. We recommend modifying this requirement such that plans describe the characteristics of the population served at the product level – dual, institutional, C-SNPs, based on national and plan specific data related to the target population, and that the service area requirement be limited to situations where there is a notable difference from the usual	Revision	Reject: The example provided speaks to the uniqueness and complexity associated with the SNP Population. CMS believes SNPs have the flexibility and autonomy to describe how they meet this requirement based on the structure of their organization. SNPs should determine how they identify and describe their SNP population.
79	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination	One commenter stated they serve a wide range of Medicare beneficiaries, all with special needs, but with a diverse set of needs. If SNPs are required to offer an intensive level of care management for every beneficiary enrolled, we are concerned that more resources than necessary will be expended on some beneficiaries, resulting in resource shortages	Clarification	Clarify: CMS understands there are a wide variety of differences associated with the healthcare needs of SNP beneficiaries. SNPs have the flexiblity and autonomy to determine how they manage their beneficiaries using the appropriate care management procedures; differences in care management approaches should be thoroughly and completely described in the SNP MOC narrative.
80	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Staff Structure	One commenter requested a revision for the MOC training requirements for staff; specifically the staff training methods for employed and contracted staff “may” include, but not be limited to, printed	Revision	Accept: CMS will change Element 2A to indicate that staff training methods for employed and contracted staff 'may' include, but not be limited to, printed materials, etc.
81	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Staff Structure	One commenter requested an explanation for the need to maintain MOC training records; specifically, how long is a plan required to maintain such records and for what purpose?	Clarification	Clarify: SNPs should be able to provide evidence to meet CMS expectation that the MOC training requirement has been accomplished; this becomes especially important during a CMS audit. Each SNP has the flexibility and autonomy to make the determination of how they maintain and record such information based on the structure of their organization. This process needs to be thoroughly

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82	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Staff Structure	One commenter requested clarification about CMS' expectations regarding MOC training for employed or contracted staff. They believe that staff involved in the implementation of the model of care should be required to participate in the MOC training, but that staff who are not involved in the MOC implementation, such as mail room clerks or certain administrative staff should be exempted from the training. Further, they stated that it would be helpful for CMS to identify the type of staff that would not be expected to participate in MOC training, but SNPs also should be able to exempt staff for which the training would not be relevant. The resources for training and record-keeping are significant for large and should only be expended if it makes a difference for beneficiary care and outcomes. This commenter also urged CMS not to adopt a one-size-fits-all approach to the ICP and to give plans the	Clarification	Clarify: SNPs have the flexiblity and autonomy to determine which providers and staff need to be informed and trained on the contents of the MOC.
83	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Individualized Care Plan	One commenter requested clarification about the requirement to identify which goals have been met and not met. How does CMS anticipate plans will meet this goal? This requirement seems more appropriate for a PACE model where the ICT meets routinely to discuss the various care plans and treatment goals of PACE center beneficiaries. We believe this requirement would be more appropriate in Domain 4B under Measureable Goals and Health Outcomes	Clarification	Clarify: The issue raised by the commenter is not related to the SNP's overall goals and health outcomes, which is what is addressed in Element 4B. The comment relates specifically to beneficiary-level goals based on the beneficiary's unique ICP. If a SNP beneficiary has current and active risk factors with identified goals to maintain his/her health status, progress should be noted in the beneficiary's ICP. Re-assessment of a beneficiary's health goals should be routinely assessed and documented in the ICP as necessary.

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84	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Interdisciplinary Care Team	Some commenters requested clarification of the requirement that the exchange of beneficiary information occurs “regularly” within the ICT. The commenters have similar concers about the requirement for “continuous” evaluation of changes in health care needs. In some cases, the exchange of information about beneficiaries may occur weekly while in other cases it may occur only quarterly or less often if the beneficiaries’ health condition is stable and they do not have an encounter with the health care system. Further, in some cases, the exchange of information may occur between selected members of the ICT and the provider network, not only within the ICT. They requested that this requirement be focused on the concept of “timeliness” which will vary in relation to the needs of	Clarification	Clarify: The example provided speaks to the uniqueness and complexity associated with SNP beneficiaries' healthcare needs and should be thoroughly described in the MOC. The SNP should determine how often the ICT communicates with the beneficiary; CMS understands that communication will vary from beneficiary to beneficairy and is dependent of other factors. SNPs have the flexibility and autonomy to describe how they meet this element requirement based on the structure of their organization as well as the beneficiaries' healthcare needs.
85	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Interdisciplinary Care Team	One commenter requested clarification on what is meant by the requirement that communications are overseen by personnel who are “knowledgeable and connected to multiple facts of MOC.” Does this mean the medical director, the primary care manager,	Clarification	Clarify: SNPs are responsible for ensuring the staff involved with beneficiaries' healthcare needs are fully capable of interpreting such needs. Each SNP has the flexiblity and autonomy to determine which staff meet this criteria and provide a thorough description of this in its MOC narrative.
86	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Care Transitions Protocols	One commenter supported the requirement that beneficiaries and their family caregivers be provided information on self-management and indicators of whether the patient’s condition has improved or worsened. However, plans should not be held accountable for ensuring that the patients and/or caregivers understand the information provided. Despite plans’ best efforts, an older person and/or their older spouse or someone with cognitive limitations may have a limited or no ability to manage their own care. In fact, SNP plans serving persons with behavioral health, mental health and cognitive	Clarification	Clarify: CMS relies on the SNP to address this in their MOC narrative (if applicable). If there are instances where 'ensuring beneficiaries and/or caregivers understand the contents of their ICP' are not feasible, the SNP should describe these in its MOC. Moreover, the SNP should discuss their Self-Mangement Support activities for those beneficiaries where it is feasible and identify/discuss any modified approaches, as applicable, for cognitively-impaired individuals.
87	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	SNP Provider Network	Use of Clinical Practice Guidelines & Care Transition Protocols: One commenter stated that the need to modify CPGs or protocols should not be limited to vulnerable subsets. It is relevant to all SNP enrollees with comorbidities.	Clarification	Clarify: CMS agrees with this statement; the use of Clinical Practice Guidelines and Care Transition Protocols is not limited to vulnerable subsets in the SNP population; Clinical Practice Guidelines and Care Transition Protocols apply to ALL SNP enrollees.

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88	SNP Alliance	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement:	One commenter indicated they believe that "less can be more," that the ongoing expectation for SNPs to provide excessive documentation of every aspect of their model of care diminishes SNPs' and CMS' ability to focus on the elements and issues that are most important.	Clarification	Clarify: CMS expects SNPs to provide a thorough and complete MOC narrative based on the specified criteria. CMS does not require additional supporting documents to be included with the MOC Narratives. All elements should be addressed comprehensively in a single document.
89	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Description of the SNP Target Population	One commenter was concerned that the requirement regarding community-based services seems a little excessive since it is not a Medicare service and we are not paid for this function. They suggested limiting it to fully integrated DSNPs and IE-SNPs. They supported expanded flexibility on supplemental benefits that would make this question more relevant to non-FIDE SNPs.	Clarification	Clarify: CMS does not believe this is excessive and expects SNPs to identify and thoroughly describe what is applicable to their specific SNP-type in their MOC. SNPs have the flexibility to describe how they meet this element requirement based on the structure of their organization as well as the beneficiaries' healthcare needs.
90	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: SNP Staff Structure	One commenter requested revising the staff MOC training element, specifically, whether the training documentation MAY include or MUST include all of the formats listed: printed instructional materials, face-to-face training, web-based instruction, etc.	Revision	Clarify: CMS has changed the language used in MOC Element 2A - Bullet 4 to reflect 'may' versus 'must'.
91	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination:Health Risk Assessment Tool	One commenter requested clarification of the requirements regarding HRA and ICP linkage. Is the expectation that every issue (clinical or functional) identified on the HRA be included in the ICP?	Clarification	Clarify: CMS believes that pertinent information discovered on a beneficiary's HRA needs to be identified in the ICP even though it may not be an active problem it could be an associated risk factor(s) for future reference. SNPs may determine how they meet this requirement based on the healtcare needs of their beneficaires and should describe this in the MOC.
92	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Individualized Care Plan	One commenter requetsed clarification on how they should address the comprehensive ICP requirements (e.g. self-management goals and objectives and goal progress tracking) for members whom they are unable to reach (did not provide current address, will not answer phone calls or letters, etc.).	Clarification	Clarify: CMS does not expect that a large proportion of the SNP's population will be unreachable and/or unwilling to participate in health care management processes. We expect the SNP to thoroughly account for such situations in its MOC.
93	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination : Individualized Care Plan	One commenter was concerned that the hard copies of ICPs need to be provided to all members? Are web-based or telephonic communications of ICPs acceptable?	Clarification	Clarify: CMS does not expect each beneficiary be handed a 'hard copy' of their ICP. CMS does allow web-based and telephonic communications between ICP members; however, evidence to support these types of communication exchanges needs to be available should the SNP be audited.

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94	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Interdisciplinary Care Team	One commenter is concerned that the requirement to explain the roles and responsibilities of each ICT member and the requirement to explain the use of case managers in the ICT process are redundant. They recommended only including one of	Clarification	Clarify: It is the SNPs responsibility to determine the composition of the ICT; if case managers are utilized by the SNP and are members of the ICT; this can be documented succinctly in the MOC.
95	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Interdisciplinary Care Team	One commenter had concerns about MOC Element 2D - Bullet 3: Regarding the communication plan, could you please clarify the use of the term “regularly” regarding the exchange of information, as the frequency can and should vary widely	Clarification	Clarify: CMS believes communication should be conducted on a 'regular' basis between the ICT members depending on the SNP beneficiary's healthcare needs. SNPs should determine the appropriate intervals and describe this in their MOC.
96	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Interdisciplinary Care Team	One commenter requested clarification regarding proposed MOC Element 2D - Bullet 3, Sub-bullet 1. Specifically, the commenter asked CMS to clarify what is meant by “knowledgeable and connected to multiple facets of the MOC?” Is it acceptable for those with oversight responsibilities to be knowledgeable (but not always directly involved) in multiple	Clarification	Clarify: SNPs are responsible for ensuring that the appropriate staff involved with beneficiaries' healthcare needs are fully capable of interpreting such needs. The SNP should describe how this is determined in their MOC.
97	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Care Transition Protocols	One commenter requested that 3B - Bullet 2 be deleted to avoid redundancy; the commenter suggested moving the reference to element 2A.	Revision	Reject: The language in MOC Element 2A is directly linked to MOC Element 2E. Therefore, the MOC narrative addresses both components comprehensively, and without redundancy.
98	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Care Coordination: Care Transition Protocols	One commenter requested that MOC Element 3B - Bullet 5 be modified because some members will not be able to self-manage their condition; therefore, this requirement would be most relevant to low and medium risk members	Clarification	Clarify: CMS' relies on the SNP to address this is in the MOC narrative (if applicable). Self-Management Support would not be feasible for certain beneficiaries. The SNP would want to discuss its Self-Mangement Support activities that are taking place for those SNP beneficiaries where
99	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement: MOC Quality Performance Improvement Plan	One commenter requested clarification of MOC Element 4A-Bullet 1: Are plans required to detail the specific data and performance measures if they are described in 4B?	Clarification	Clarify: SNP should only describe their specific data and performance measures in MOC Element 4B.
100	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement: Measuring Patient Experience of Care	One commenter requested CMS to define what is meant by a “Patient Experience of Care” survey. Does the survey need to be SNP-member specific or are we able to use the same survey for our regular MA	Clarification	Clarify: Patient Experience of Care is another term used to address patient satisfaction. SNPs have the flexibility to design this survey in the manner they choose.
101	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement: Ongoing Performance Improvement Evaluation	One commenter suggested that MOC Element 4B could be consolidated into element 4.A and 4.E since the content is very similar.	Revision	Reject: These particular elements are separate and distinct. MOC Element 4B relates specifically to the identified measurable goals and health outcomes; MOC Element 4A speaks to what the MOC performance plan entails; and, MOC Element 4E speaks to how the outcomes of the MOC performance measures are communicated

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102	Cigna-HealthSpring	60-day	Appendix 1: Model of Care	N/A	N/A	Quality Measurement & Performance Improvement: Dissemination of SNP Quality Performance	One commenter requested CMS to define 'routine' in MOC Element 4E They also suggested changing the wording of this bullet to indicate that the list of stakeholders MAY include SNP leadership, boards of directors, etc. since the groups listed are communicated with under specific circumstances and some only on an "as-needed" basis.	Clarification & Revision	Clarify: CMS expects SNPs to inform plan management/leadership and other stakeholders of the MOC performance based on the MOC specific outcomes/goals identified for their MOC. It is up to the SNP to determine how often this level of reporting is needed and to whom it needs to be communicated based on the organizational structure of the SNP. This type/level of communication should be occurring on a routine and/or regular basis. Accept: CMS has changed the language of MOC Element 4E - Bullet 1 to reflect 'communication of
GENERAL COMMENTS									
103	America's Health Insurance Plans	60-day	Model of Care Attestations	N/A	108	Removal of Attestations	One commenter stated: the "CMS Summary of Substantive and Technical Changes..." for the draft Medicare Advantage Part C Application indicates on page 6 that CMS has removed 240 Model of Care attestation questions from the application and retained 2 uploads. They appreciate CMS' effort to streamline the application process and support the reduction in the number of attestations.	N/A	N/A - supportive of CMS approach.
104	Association for Community Affiliated Plans	60-day	Model of Care Attestations	N/A	108	Removal of Attestations	One commenter supports the agency proposals which eliminate numerous duplicative attestations regarding the MOC.	N/A	N/A - supportive of CMS approach.
105	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Description of the SNP Population	One commenter supports the requirement to identify limitations and barriers that pose potential challenges for beneficiaries. This information will allow SNPs to further document the challenges plans face in meeting the needs of high-risk/high-need populations, including barriers or challenges originating in statute or standard MA regulations that are inconsistent with the needs of the population. For example, while IE- beneficiaries require a range of home and community-based services to avoid nursing home care, these benefits are not covered by Medicaid and supplemental benefit requirements only allow FIDESNPs meeting certain criteria to offer such benefits.	N/A	N/A - supportive of CMS approach.

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106	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Streamlined MOC Elements	One commenter supports the reorganization of the MOC domains and elements. They support the logic of having all of the care management related functions under a single domain, addressing the communications issues within the domain or element, instead of having a separate communications domain, moving the provider training requirements into the staff structure and SNP provider network requirements and moving care of the most vulnerable into the description of the target population. They believe that these types of	N/A	N/A - supportive of CMS approach.
107	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Purpose Elements	One commenter supports and appreciates the purpose statements included at the beginning of the domains and a number of the elements. It helps provide direction and a sense of CMS' expectations for the domains and elements.	N/A	N/A - supportive of CMS approach.
108	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	New Care Transition & Member Experience of Care Elements	One commenter supports the concept of including care transition and patient experience of care elements as they are appropriate to the MOC and it is well known that "breakdowns" in care most often occur during transitions. Inclusion of these elements also is consistent with other SNP stakeholder recommendations to better	N/A	N/A - supportive of CMS approach.
109	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Social Determinants of Health	One commenter supports the focus on health disparities and social determinants of health and believe this focus will help clarify and document the how social determinants affect beneficiares' health and how plans need to respond to effectively meet their health care needs. Social determinants have significant implications for cost and quality that need to be	N/A	N/A - supportive of CMS approach.

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110	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Policy of MOC Approval status under New MOC Requirements	One commenter requested that the new MOC requirements apply to plans moving forward and that SNPs that have received NCQA approved for a 2-3 year period not be required to resubmit models of care until their approval period has expired; i.e., that approved MOCs be “grandfathered” for the current approval period. We also request that any changes to the MOC be provided to plans no later than December 1, 2013 and that NCQA conduct a training on MOC changes during the first week of December so that plans understand CMS’ expectations before they begin developing new MOCs or making changes to current MOCs for the February 2014 submission. Many plans begin working on their MOCs as soon as they file their NOIAs. Early access to	N/A	Currently the 3-year approval for the MOC remains intact. CMS will inform the SNPs of any changes made to the 3-year approval for the MOC. SNPs will be required to submit a MOC in its revised, finalized form, only as required, based on the MOC's current approval period. Additionally, CMS will take the proposed training timeline into consideration; however, other agency constraints may prevent us from offering MOC training prior to the end of 2013.
111	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Description of the SNP Population	One commenter supports the focus on health disparities and related social/economic determinants of health. This focus is consistent with existing SNP requirements such as cultural competence, having translators available, having marketing materials printed in different languages, etc. The relationship between social determinants and health care practice and outcomes has gained increasing prominence in the health community over the past decade. They believe that the requirements to address social determinants in SNP models of care will help document the impact of these determinants on the health of the population, the type of atypical interventions plans must employ to address beneficiary needs and obtain positive outcomes, the additional costs of effective care delivery for enrollees affected by social determinants and the need to adjust performance measurement in relation to social determinants. Documentation of health disparities and the relationship to the SNP model of care will help illustrate over time the need for changes to our current payment and performance evaluation systems for special needs beneficiaries, most of whom are dually eligible and at higher risk of social determinant impacts.	N/A	N/A - supportive of CMS approach.

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112	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Staff Structure	One commenter supports and appreciates the opportunity to explain challenges related to the MOC training requirements as we believe it can help improve the MOC training process in the future.	N/A	N/A - supportive of CMS approach.
113	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	Care Coordination	One commenter supports the reorganization of the Model of Care to include key care coordination or care management functions from health risk assessment to care transitions under the single umbrella domain of "care coordination." They believe it provides an opportunity to coordinate these	N/A	N/A - supportive of CMS approach.
114	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	SNP Provider Network	Use of Clinical Practice Guidelines & Care Transition Protocols: One commenter supports the requirement to define the challenges of overseeing patients with complex healthcare needs where CPGs need to be modified to fit unique needs of vulnerable beneficiaries. This will provide SNPs an opportunity to document long-standing concerns that there are very few evidence-based protocols for beneficiaries over 70 years old with special needs and few if any CPGs that modify individual disease state protocols to accommodate the health care needs of individuals with	N/A	N/A - supportive of CMS approach.
115	SNP Alliance	60-day	Model of Care Criteria Modifications	N/A	N/A	SNP Provider Network	One commenter supports the requirement to explain challenges as a way of helping CMS recognize the standard is unrealistic for most network model plans.	N/A	N/A - supportive of CMS approach.