2021 Consolidated 60-day Comments for Part C Application

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
1	CalOptima	60 Day	D-SNP State Medicaid Agency Contract Matrix	5.11	Page 84 1. How the SNP coordinates the delivery of Medicaid benefits for individuals who are eligible for such services. This includes a description of the mechanisms for coordinating Medicaid services covered under Medicaid fee-for-service, by the SNP's MA organization, the SNP itself (or a Medicaid plan offered by the SNP's parent organization or another entity owned and controlled by its parent organization), or by other	What is meant by mechanisms is not clear. Please further elaborate or define what CMS is expecting to see in the contract provision for "the mechanism". As written, it is unclear what may suffice or is inteded for this contract provision. Some examples of what mechanisms CMS would like to see would be helpful. For example, electronic/encrypted file exchange? SFTP posting? Storing in medical management system? Reporting template?	Revision	We will modify the language per the regulation.	Accept with modification.
2	CalOptima	60 Day	SNP Contract Status Review Matrix	5.12	Page 89 9. Language that indicates that your organization employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement. (422.2)	Question about timeframe and how CMS will review and approve said Policies & Procedures? By whom will they be reviewed - CMS contract manager? MMCO? Please clarify if CMS will require for the D-SNP to submit the actual P&Ps during the attestation submission in July 2020? Or in advance of the submission for CMS review & approval prior to the submission in July 2020?	Revision	We will not be requesting policies and procedures as part of the application.	Reject
3	CalOptima	60 Day	N/A	N/A	N/A	SNP Deeming timeframe for HIDE & FIDE? Please confirm that deeming rules would remain unchanged (6 months deeming, Medicare only benefits during deeming) for FIDE & HIDE.	Revision	The regulation does not affect the deeming requirements.	Reject
4	Health Care Service Corportation (HCSC)	60 Day	Background	Background	DMAO Portal	HCSC appreciates that CMS established a centralized portal through which organizations may submit questions, including questions pertaining to various application and contracting related topics (i.e., MA/SNP Applications, Change of Ownership (CHOW)/Novations, and Service Area Reductions (SARs)/Non-Renewal (NR)/Terminations). To further improve the utility of the portal and to support transparency, we recommend that CMS consider communicating a standard timeframe by which the agency expects to provide a response to the questions submitted. The standard timeframe could be included in the automated email that is generated to acknowledge each submission.	Revision	CMS will consider this revision during future applications. Thank you	Reject
6	Health Care Service Corportation (HCSC)	60 Day	Management, Experience and History	3.1	Under item "B", applicants are directed to upload "History/Structure/Organizational Charts" in HPMS.	The draft notes that the charts should reflect a brief summary of the applicant's history, structure and ownership, including subsidiaries and business affiliations. To ensure initial submissions meet CMS' expectations and to minimize the need for the agency to request additional documentation after the application is submitted, we recommend that CMS provide an example of an acceptable organizational chart and/or revise the instructions to more explicitly indicate what type of information is desirable.	Revision	CMS will consider this revision during future applications. Thank you	Reject

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
7	Health Care Service Corportation (HCSC)	60 Day	Eligibility, Enrollment and Disenrollment	3.11	N/A	Section 3.11.5 does not yet reflect the recent announcement that CMS will be changing the timeframe for plan sponsor submission of enrollment and payment certifications from monthly to quarterly. (*See* HPMS memo entitled, "Schedule for Enrollment and Payment Certifications" dated 10/3/19). We recognize that this change was announced after publication of the draft application and recommend that CMS incorporate the change into the revised draft version of the application that will be released during the subsequent 30-day PRA comment opportunity.	Revision	Thank you. CMS has updated this attestation to reflect quarterly instead of monthly based on the recent guidance that ws issued on 10/3/19.	Accept
8	Health Care Service Corportation (HCSC)	60 Day	CMS State Certification Form	4.4	N/A	As part of the MA application process, organizations must submit a "CMS State Certification Form" to demonstrate that (1) the contract being sought by the applicant is within the scope of the license granted by the appropriate State regulatory agency, (2) the organization meets state solvency requirements, and (3) the organization is authorized to bear risk. The form must include the National Association of Insurance Commissioners (NAIC) number (if there is one). We note that organizations also must populate the NAIC number separately in the HPMS Contract Management Module (CMM) as part of this process. To promote transparency and to ensure clarity, we recommend that CMS update the instructions in this section of the application to specify that the NAIC number also must be populated in the CMM and indicate the appropriate location.	Revision	Thank you. CMS has added a note reminding organizations that the NAIC number must be populated within HPMS as well.	Accept
9	Health Care Service Corportation (HCSC)	60 Day	SNP Service Area Expansion Application	5.2.2	N/A	The draft application indicates that for contract year 2021, all Dual Eligible SNPs (D-SNPs), including those seeking to expand their service area, must submit a new State Medicaid Agency Contract (SMAC) or a current contract with amendments as well as the applicable D-SNP attestations and required uploads to meet the new D-SNP integration requirements effective beginning with CY 2021. The draft also states that "for CY 2021 only, evergreen contracts with letters of good standing will not be accepted for purposes of the D-SNP State Medicaid Agency Contract review." We note that in guidance released by CMS on October 7, 2019, entitled "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)," the agency indicated that evergreen SMACs with a contract addendum that meets the new integration requirements may be submitted by D- SNPs for CY 2021. To ensure clarity and to support consistency across CMS D-SNP guidance for 2021, we recommend that the agency revise this section of the draft application to specify that while D-SNPs with an evergreen SMAC will not be able to only submit letters of good standing with a previously executed SMAC from their respective states, evergreen SMACs accompanied by a contract addendum will be permissible for CY 2021 SMAC reviews. CMS also should make similar revisions to the comparable language in Sections 5.3 and 5.4.	Revision	CMS will be updating the language to clarify this information.	Clarify
10	Health Care Service Corportation (HCSC)	60 Day	SNP Contract Status Review Matrix	5.12	N/A	To improve the clarity and utility of the SNP Contract Status Review Matrix, we strongly recommend that CMS separately list or consider creating a separate matrix for the FIDE and HIDE SNP elements. We also note that the current matrix header only refers to "Meeting the definition of a FIDE SNP" (rather than both a FIDE and HIDE SNP), and the instructions for completing the matrix are unclear. We believe revising the matrix consistent with these recommendations will better support MA organization efforts to appropriately populate the matrix and better facilitate CMS' FIDE and HIDE SNP determination reviews.	Revision	CMS will update the instructions for this matrix, including updating the matrix header to note that this also applies for FIDE SNPs. We will continue to include the requirements for both FIDE and HIDE SNPs in the one matrix.	Accept with modification.
11	Justice In Aging	60 Day	SNP Quality Improvement Program	5.9	N/A	The Application lays out important data collection and reporting responsibilities for SNPs. We ask that CMS maximize transparency around the data collected from SNPs, making as much data as possible available in usable format to stakeholders, policymakers and researchers. For D-SNPs, transparency is particularly important since many states are increasingly relying on D-SNPs as vehicles for innovation in integrating care to dual eligible. Data coming from plans on such items as service utilization rates, improvements in beneficiary health status, staff implementation of Models of Care, etc. can help states and all stakeholders betterunderstand which approaches among the different states offerthe most promise for successful outcomes. We have already seen the value of such transparency in assessing integrated care models. In the financial alignment demonstration in California, Cal MediConnect, dashboards tracking similar data have been of great value in spotting trends, informing policy discussions, and identifying areas for adjustment in requirements and oversight.1 We recognize that some information may need to be aggregated without identification of particular plans but urge having as much information as possible publicly and easily available. This transparency means that all affected stakeholders will be working with the same facts and ensures fuller and more productive policy development.	Revision	Thank you for your comment regarding the information collection for CMS-10636, OMB 0938-New. CMS will consider this comment as it develops the details related to SNP data collection.	No edit required.
12	Justice In Aging	60 Day		5.8	N/A	This section requires SNPs to provide some basic information on how plans conduct health risk assessments, e.g., by telephone orface-to-face and whether they use paper or computerized systems. Information on trends and practices in these areas would also help stakeholders to understand what is happening in this core function for D-SNPs.	Revision	Thank you for your comment regarding the information collection for CMS-10636, OMB 0938-New. CMS will consider this comment as it develops the details related to SNP data collection.	No edit required.
13	Americas Health Iunsurance Plans	60 Day	HIDE and FIDE SNP	N/A	N/A	We are aware of ongoing confusion around the definition of a HIDE SNP and the exclusive alignment rules. Accordingly, we recommend CMS also allow an organization to voluntarily submit and receive a written determination from CMS as to whether a contract with the State Medicaid Agency is consistent with the requirements for a HIDE SNP and whether the SNP has exclusively aligned enrollment. By enabling an organization to obtain the determination before it is required to make the relevant attestations in the application process, CMS would help plans ensure the accuracy of their attestations and further facilitate the movement to enhanced Medicare and Medicaid integration.	Revision	MMCO is happy to provide technical assistance and review contract language prior to the submission of the SMAC in July 2020, however this will not be an official determination regarding whether the contract meets the SMAC requirements.	No edit required.
14	Association for Community Affiliated Plans (ACAP)	60 Day	Bipartisan Budget Act	N/A	N/A	We are generally supportive of the process and manner in which CMS seeks information from plans to verify their compliance with the BBA's requirements, but we would ask that CMS make accommodations for the varying levels of progress states may make in producing and finalizing updated state Medicaid agency contracts (SMACs), given the timeframe for final approval of D-SNP operations for BY2021.	Revision	Thank you for your comment regarding the information collection for CMS-10636, OMB 0938-New. CMS is actively working with states to ensure the new requirements are implemented by the CMS given timeframe.	No edit required.
15	Association for Community Affiliated Plans (ACAP)	60 Day	Bipartisan Budget Act	N/A	N/A	Given the current level of state-based variation in integrated care, we would ask that CMS work collaboratively with plans during this inaugural application process to help remedy issues where plans and states have agreed to meet D-SNP requirements, but may not have included extensive details of those requirements in their SMACs. For example, we would ask CMS to be supportive of supplemental information that could provide greater detail on SMAC requirements that may be less detailed.	Revision	The SMAC is required to include specific information. CMS is available to review draft SMACs and provide techinical assistance on the requirements prior to the July 2020 submission deadline. Also, once the SMAC has been submitted plans will have an opportunity to correct any deficiencies that are noted.	Reject but inform of technical assistance opportunities

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
16	Association for Community Affiliated Plans (ACAP)	60 Day	Bipartisan Budget Act	N/A	N/A	CMS chose to interpret for the first time the phrase "arrange for benefits." Under 42 CFR § 422.107(c)(1)(i), CMS explains that "for all enrollees who are eligible for Medicaid services, the D-SNP must fulfill its statutory responsibility to arrange for the provision of Medicaid benefits by facilitating a beneficiary's meaningful access to such benefits." Subsequently, CMS now seeks information on which contract provisions describe the mechanisms for coordinating Medicaid services across FFS and managed care. We understand the need for this information and would like to point out that it may not be specifically described in the SMAC, but rather in other materials submitted to the state Medicaid agency. Therefore, we would ask that CMS approve broad contract language for this requirement with the understanding that plans will be able to provide supplemental material describing the mechanisms for coordination.	Revision	We will modify the language per the regulation.	Accept with modification.
17	United Health Care	60 Day	Background	Background	N/A	The draft CY 2021 Part C – Medicare Advantage and 1876 Cost Plan Expansion Application released by CMS on 9/12/19 was labeled at the bottom of each page as "Final". CMS should label the document as "draft" and include the date of release in the footer of the document. Items that are mislabeled and are not dated undermine document versioning integrity and tracking.	Revision	Thank you . CMS has updated the footer to reflect draft.	Accept
18	United Health Care	60 Day	Table of Contents	Table of Contents	N/A	Regional Preferred Provider Organization (RPPO) Exception to the Written Agreement Upload Template is listed as one of the documents under the Document Upload Templates section of the draft Application. However, the actual template document is not included in the application. UHC recommends the reference to this document in the Table of Contents be deleted.	Revision	Thank you CMS has deleted the RPPO exception to the written agreement upload from the table of contents.	Accept
19	United Health Care	60 Day	Due Dates for Applications	1.8	For the date, May 12, 2020, CMS indicates the following milestone: Release of CY 2019 Formulary Submission Module For the date, Mid October 2020, CMS indicates that the Annual Coordinated Election Period begins for CY 2019 plans.	UHC requests that CMS correct these dates in the final 2021 application so that the year "2021" replaces "2019" for these milestones noted in the grid.	Revision	Thank you. CMS has updated the dates in this section to refelct CY21.	Accept
20	United Health Care	60 Day	Administrative Management	3.2	Applicant attests that it has a contract that non-renewed or terminated a contract within the past two years as defined under 42 CFR 422.506(a). The past two year period for this application cycle would begin if the applicant non-renewed or terminated after 12/31/2019. If the applicant only non-renewed a demonstration Medicare-Medicaid Plan contract after 12/31/2019, the applicant should attest N/A. If the applicant attests "Yes," the applicant must upload a Two Year Prohibition Waiver Request.	The two year period prior to 1/1/2021 would be after 12/31/2018 instead of 12/31/2019.	Revision	Thank you. CMS has updated the date in this section to refelect 12/31/2018.	Accept
21	United Health Care	60 Day	State Licensure	3.3	The draft CY 2021 Part C application attestation 3.3.1 requires the applicant to attest that the organization be incorporated as of the initial application submission deadline, as follows: 3.3.1: Applicant attests that the organization is incorporated and recognized by the state of incorporation as of the initial application submission deadline. If the applicant attests "Yes," the applicant must upload proof of the organization's incorporation, such as articles of incorporation or a certificate of good standing from your state of incorporation.	We ask that CMS confirm that this attestation and upload requirement applies only to initial applications (rather than service area expansion applications), consistent with the requirement in the draft CY 2021 Part D Solicitation for Application (section 3.1.1 B): If it is correct that this requirement is only for initial applications, we also recommend CMS more clearly indicate in the CY 2021 Part C Application that this requirement is applicable to initial applications only and is not applicable for Service Area Expansion (SAE) applicants.	Revision	Thank you. CMS has updated the application to state that this section is not applicable for SAE applicants.	Accept
22	United Health Care	60 Day	HSD Reference File	3.6.9	Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy criteria as represented in the most recent version of the Health Service Delivery Reference File	Asserting that the Health Service Delivery (HSD) Reference File is the only standard CMS will use to evaluate network adequacy is inconsistent with the regulation at 42 CFR §422.112. In particular, that regulation requires CMS to consider a non-exclusive list of five factors in assessing the adequacy of a Medicare Advantage (MA) plans' network. See 42 CFR 422.112(a)(10) ("Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed Medicare Advantage (MA) plan health care delivery network include, but are not limited to the following… "). Given this language, the regulation constrains CMS from arbitrarily restricting the standard for network access and availability to only the HSD criteria. By asking Medicare Advantage Organizations (MAOs) to attest that their networks will meet network adequacy criteria as represented in the HSD Reference File, CMS is inappropriately narrowing the network adequacy requirement to which MAOs should be held. As a result, we respectfully ask that CMS remove the language related to the HSD Reference File, so that 3.6.9 reads, "Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy criteria as set forth in regulation as represented in the most recent version of the Health Service Delivery Reference File." This change would be consistent with the regulatory language that CMS included in the CY 2020 Medicare Advantage Readiness Checklist. In the Readiness Checklist, under Section J, Item I. Benefits and Beneficiary Protections, CMS states that MAOs must "Ensure MA and MMP provider networks meet CMS network adequacy requirements (42 C.F.R. § 422.112(a)(1), Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, Health Service Delivery (HSD) Instructions for Medicare-Medicaid Plans (MMPs) and Minnesota Dual Special Needs Plans (MN D-SNPs) Annual Medicare Network Submission)."	Revision	Recommended change for attestation: Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy requirements per 42 C.F.R. § 422.112(a)(1)	Accept

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
23	United Health Care	60 Day	RPPO	3.6.10	Applicant is an RPPO that has established networks in those areas of the region where providers are available to contract and will only operate on a non-network basis in those areas of a region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access and availability standards (see 42 CFR 422.2 and 422.112(a)(1)(ii)).	The language in Attestation 3.6.10 for regional preferred provider organizations (RPPOs) is not supported by the applicable regulations and we recommend its deletion. MA regulations allow RPPOs an exception to the standard network access criteria. Attestation 3.6.10, however, sets forth access requirements that fail to take into account this RPPO-specific regulatory exception. In developing the exception for MA regional plans set forth in 42 CFR 422.112(a)(1)(ii), CMS recognized that the exception "is essential to foster the growth of the MA regional plan program, a goal consistent with the Congressional intent in creating the program," and particularly to "encourage MA organizations to offer MA regional plans covering rural areas." 70 FR 4588, 4626 (January 28, 2008); 69 FR 46866, 46882 (August 3, 2004). The RPPO exception supports these goals by allowing MA regional plans to use methods other than written agreements with providers to establish that access requirements are met. CMS explained how access requirements differed for MA regional plans: Unlike local coordinated care plans, such as MA local HMOs and MA local PPOs, where we have historically required comprehensive contracted networks of providers as a condition for meeting our access requirements, we will allow MA regional plans to contract with CMS with less robust networks of contracted providers. As long as an entity proposing to offer an MA regional plan pays non- contracted providers at the Medicare FFS rate, and as long as they can guarantee access through such payment to non-contracting providers, and as long as they limit enrollee cost sharing liability to in-network levels, then we will contract with such an entity for an MA regional plan as long as other non-access requirements are met. 70 FR 4588, 4628 (emphasis added). Since 42 CFR 422.112(a)(1)(ii) creates a "special access requirement" for MA regional plans, the regulation reflects a "relaxation of comprehensive network adequacy requirements." 70 FR 4588, 4625. Attestation 3.6.10, however, fails to recognize this relaxation of network adequacy requirements for MA regional plans. It requires MA regional plans to establish networks "where providers are available to contract" and only operate on a non-network basis "where it is not possible to establish contracts." Not only is this standard contrary to the policy behind MA regional plans, which is to encourage availability of those plans, but there is no support in the RPPO regulations for this standard. CMS has stated it will contract with an RPPO if it limits enrollee cost-sharing to in-network levels and pays non-contracted providers the Medicare fee-for-service rates to ensure access. Another challenging aspect of Attestation 3.6.10 is that it requires RPPOs to have already established a network of contracted providers ("Applicant is an RPPO that has established networks in those areas of the region where providers are available to contract…"). This past-tense language creates a requirement that is more stringent than what is required for the general network access attestation relating to non-regional MA plans. See, for example, Attestation 3.6.8 ("Applicant attests that it will have a contracted network in place…"). The other RPPO attestation does not contain these problematic issues and is consistent with the RPPO regulations. See Attestation 3.6.11. ("When using methods other than written contract agreements to provide enrollees with access to all covered medical services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, the RPPO applicant agrees to establish and maintain a process through which they disclose to their enrollees in non-network areas (Counties/specialties) how the enrollees can access plan-covered medically necessary health care services from non-contracted providers at in-network cost sharing rates (see 42 CFR 422.111(b)(3)(ii) and 42 CFR 422.112(a)(1)(ii)).") Because of the issues with Attestation 3.6.10, and because the other RPPO attestation fully addresses the RPPO-specific network standard, we respectfully request that CMS remove Attestation 3.6.10 and instead rely solely on Attestation 3.6.11 in order to address RPPOs for which methods other than written contracts are used to supply enrollees with adequate access to covered services.	Revision	As summarized below we have reviewed the relevant statute, regulations and related preamble and manual guidance. Based on that review we believe our current Attestation at 3.6.10 referenced in your note and its related requirements are supported in the relevant guidance. RPPOs are Medicare Advantage coordinated care plans that are required to serve one or more entire regions that have the flexibility, subject to CMS review and approval, to operate through non-network means in those areas of a region where they are unable to establish contracts with providers (see 42 CFR section 422.112(a)(1))(ii)). For your reference we have included the definition of RPPO plans from section 422.2 of the CFR: MA regional plan means a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out of the network. Consistent with the definition of RPPOs CMS expects that RPPOs will establish networks in those areas of the region it is being offered in where providers are available to contract with. The RPPO will only operate on a non-network basis in those areas of a region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access & availability standards. The RPPO exception was never intended to allow an RPPO to operate exclusively through non-network means. Rather, since RPPOs are required to serve one or more entire regions as defined by CMS an exception was made to the prevailing network adequacy requirement applicable to coordinated care plans. The exception process is in place to allow CMS to grant an exception to the network adequacy standards when necessary. This is supported by CMS manual guidance at Chapter 4 section 110.5.1 (see below). Under the requirements of 42 CFR 422.112(a)(1)(i), CMS may grant an exception to the use of a written agreement to achieve network access requirements (42 CFR 422.112(a)(1)(ii)). See also the preamble response below from a final rule published in the Federal Register on Jan. 28, 2005 responding to public comments on a proposed rule published on August 3, 2004 (FR 69 46866) available at web link below: https://www.federalregister.gov/documents/2005/01/28/05-1322/medicare-program-establishment-of-the-medicare-advantage-program Specifically, see Page 4627 Comments & Response: **Comment:** Many commenters expressed concern that CMS seemed to be relaxing the community access standards with the "exception" process we provided for MA regional plans in § 422.112(a)(1)(ii). Some commenters stated that to the extent CMS will pay MA regional plans more through various mechanisms, such as the "stabilization" fund, risk corridors in 2006 and 2007, and the new MA	Clarify
24	United Health Care	60 Day	Organization Determination and Appeals	3.16.1	The 8th and 9th attestations under section 3.16.1 are listed as follows: 8) Applicant agrees to establish and maintain a process designed to track and address in a timely manner all organization determinations and reconsideration requests, including those transferred to the IRE. 9) Administrative Law Judge (ALJ) or some	These do not appear to be separate attestations. In the CY 2020 Part C Application, these two statements were combined as one attestation. We believe, based on how they are written, that CMS intends they be combined again in the CY 2021 Part C Application.	Revision	Thank you. CMS has combined the two attestations.	Accept
25	United Health Care	60 Day	Two Year Prohibition	4.3	Under 42 CFR 422.506(a)(4)(a) CMS will not enter into a contract with a Medicare Advantage (MA) Organization for 2 years unless there are special circumstances that warrant special consideration as determined by CMS. If organization attests "yes" to attestation #1 under Administrative Management the MA Organization is required to submit the Two Year Prohibition Waiver Request Upload Document for review and consideration by CMS. The MA organization should provide a description of the circumstance that warrant special consideration related to the non-renewal of your MA contract. The past 2 year period for this application cycle would begin if the MAO non-renewed or terminated after 12/31/2019.	We believe the correct date should be 12/31/2018 which would reflect the two year period prior to 1/1/2021.	Revision	Thank you. CMS has updated the date in this section to refelect 12/31/2018.	Accept
26	United Health Care	60 Day	D-SNP State Medicaid Agency Contract	5.4	N/A	For items number 2, 3, and 4, CMS is requiring the applicant to attest to specific content within the applicable State Medicaid Agency Contract (SMAC). As SMACs will not be submitted until July 2020, it is feasible that the applicant will not know in February 2020 if the state will request that an existing D-SNP become a FIDE SNP or a HIDE SNP. This scenario is even more likely for the 2021 plan year as this will be the first year for such a designation. UHC recommends CMS combine items 2, 3, and 4 and revise the language to the following: Applicant's contract with the State Medicaid Agency(ies) will qualify it as a fully integrated dual eligible SNP (FIDE SNP), a highly integrated dual eligible SNP (HIDE SNP) or will have language that stipulates that the SNP notifies, or arranges for another entity to notify, the State Medicaid Agency and/or its designee(s) of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals identified by the State Medicaid Agency. The applicant must upload the completed SNP Status Contract Matrix with your State Medicaid Agency Contract before July 6, 2020. Should the language in the draft application be finalized as is, we request that CMS describe the process to address attestations items that do not match the D-SNP State Medicaid Agency Contract Matrix. For example, how can a plan update its D-SNP designation if the plan attests yes to item #4 but subsequently is requesting a HIDE or FIDE designation and enters N/A for items 11 through 16 on the State Medicaid Agency Contract matrix?	Revision	Made edits to instructions for 5.4.	Clarify
27	United Health Care	60 Day	D-SNP State Medicaid Agency Contract	5.4	N/A	For item number 5, CMS is requiring the applicant to attest to a state requirement that may not be known in February 2020. It is completely at the states' discretion to require the applicant to enroll full-benefit dual eligible members into both the D-SNP and the Medicaid Managed Care Organization, and the timing of this discussion is outside of the applicant's control. In addition, item number 5 includes language that the applicant will abide by the 2021 unified appeals and grievance procedures. Should the plan qualify as a HIDE or FIDE with an exclusively aligned enrollment, 42 CFR Subpart M requires the plan to adhere to the unified appeals and grievance procedures at sections 422.629 through 422.634, 438.210, 438.400 and 438.402. Therefore, there is no need to attest to this requirement during the initial application in February 2020. UHC recommends CMS remove item number 5 from this attestation and instead identify plans that are required to adhere to the unified appeal and grievances through items 1 and 2 of the Special Needs Plan (SNP) Contract Status Review Matrix.	Revision	Made edits to instructions for 5.4.	Clarify

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
28	United Health Care	60 Day	Direct Contract MA Attestations	Page 112	Under the Certification language in the Direct Contract MA Attestations section of the draft CY 2021 Part C Application, there is the following language: 6) Applicant understands that dissemination/disclosure materials for its Direct Contract MAO plans are not subject to the requirements contained in 42 CFR § 422.2262 to be submitted for review and approval by CMS prior to use. However, applicant agrees to submit these materials to CMS at the time of use in accordance with the procedures outlined in Chapter 9 of the MMCM. Applicant also understands that CMS reserves the right to review these materials in the event of beneficiary complaints, or for any other reason it determines, to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan. (See Medicare Operations Section of the 2019 MA Application)	It appears the reference to the 2019 MA Application is incorrect and this should instead state, "See Medicare Operations Section of the 2021 MA Application." [As reference, the CY 2020 Part C Application referenced the "2020 MA Application" in this same section.]	Revision	Thank you. CMS has updated the date to refelct 2021.	Accept
29	United Health Care	60 Day	Network Adequacy	Triennial Review	We support CMS' decision to eliminate the network adequacy review from the Initial and SAE application process that was first effective for the CY2019 application cycle. We believe it is more appropriate, effective, and efficient for CMS to monitor MAO network adequacy through the new proposed three-year network adequacy review process rather than through the application process. Eliminating the requirement for network adequacy review in the application process helps to reduce the overall annual burden on CMS and MAOs.	However, we recommend the earlier release of updated Reference Files, Sample Beneficiary Files, and Templates for Network Adequacy. UHC recommends CMS release the annual updated Reference Files and the Sample Beneficiary Files in early October. CMS' release of the updated Reference Files and the Sample Beneficiary Files currently occurs in January. This release date can create a situation where all the counties and specialties in a service area may be meeting the health service delivery (HSD) criteria throughout the year leading up to the January release date, but then the updates by CMS lead to new network variations (HSD failures) due to changes in maximum time and distance criteria and shifts among the beneficiary sample being assessed. We recognize the need for and value of updating these files, but an earlier release date of October would allow MA plans more time to contract with providers and facilities needed for both a Service Area Expansion (SAE) or Network Adequacy Review (NAR) and ultimately to comply with CMS network rules and regulations. For instance, plans are determining whether to apply for a SAE before January and the adequacy of the network being proposed for the expansion is part of that decision. A delay in releasing the updated files until January impacts that decision making, whereas an earlier release of October will eliminate an unnecessary administrative burden when plans are considering expansion. Similarly, UHC proposes that any modifications to the templates MA plans use to submit data to CMS should be shared with plans with enough advance notice to adapt to the new template. MA plans need sufficient time to change their internal systems when CMS modifies the format of the templates that plans must populate with data and upload to the Health Plan Management System (HPMS) or otherwise submit to CMS. For instance, CMS changed the format of the MA provider and MA facility templates for network adequacy on June 14, 2019; although no advance notice of this change was sent to MA plans. Then one business day later, on June 17, 2019, CMS sent plans a notice to upload their SAE or NAR HSD tables. To reduce unnecessary administrative burdens, UHC recommends template changes like this occur with notice to plans preferably in early quarter one/January and no later than mid-April, so that plans are ready for submissions to CMS in June and that no further changes be made to the templates once released for that calendar year's submission.	Revision	**1st paragraph -** Currently we receive the HSD reference file beginning of August so that the contractor in HPMS has enough time to program it into HPMS for a release date of January 4th. We could post it earlier so plans can see the changes but I am not sure we are able to have it programmed in HPMS in October since the netwrok review for the current year is still ongoing and measured against the current criteria. The posting of the file would allow them to see the changes and they would have from January 4th until June to test their netwroks against the new criteria. **2nd paragraph -** We appreciate the feedback. CMS will keep this in mind as we move forward if there are any changes to the templates.	Clarify
30	SNP Alliance	60 Day	Element A SNP Staff Structure	Factor 1	**Existing Language:** Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other	**Recommended Language:** Specific employed and/or contracted staff responsible for performing administrative functions, with regard to care coordination.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
31	SNP Alliance	60 Day	Element A SNP Staff Structure	Factor 6	**Existing Language**:Describe how the SNP conducts initial and annual MODEL OF CARE training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.	**Recommended Language:** Describe how the SNP conducts initial and annual MODEL OF CARE training for its employed and contracted staff involved in care coordination and transitions of care, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/videoconferencing.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
32	SNP Alliance	60 Day	Element A SNP Staff Structure	Factor 7	**Existing Language:**Explain any challenges associated with the completion of MODEL OF CARE training for SNP employed and contracted staff and describe what specific actions the SNP will take when required MODEL OF CARE training has not been completed or has been found to be deficient in some way.	**Recommended Language:** Explain any challenges associated with the completion of MODEL OF CARE training for SNP employed and contracted staff involved in care coordination and transitions, and describe what specific actions the SNP will take to ensure that these staff can access and participate in the care coordination and transitions of care components, as needed by the population(s) served, and what actions are taken when these staff do not follow the protocol/MODEL OF CARE.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
33	SNP Alliance	60 Day	Element B HRAT	Factor 1	**Existing Language:**Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MODEL OF CARE Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MODEL OF CARE Element 2D).	**Recommended Language:** Description of how the HRAT, or other assessment information gathered in the course of serving the beneficiary is used to develop and update, in a timely manner, the Individualized Care Plan (MODEL OF CARE Element 2C) for each beneficiary and how the HRAT, or other pertinent information is disseminated to and used by the Interdisciplinary Care Team (MODEL OF CARE Element 2D).	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
34	SNP Alliance	60 Day	Element B HRAT	Factor 2	N/A	We have no suggested changes to Factor 2; however, we want to note that this language is substantially different from what appears in the NCQA MOC Scoring Guidelines, and also differs substantially from the HRAT Attestations in section 5.8. Alignment and consistency between and across the language in the application, the attestations, and the MOC scoring guidelines is important.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
35	SNP Alliance	60 Day	Element C Individualized Care Plan	N/A	N/A	We suggest taking out the phrase "roles of the beneficiaries' caregiver(s)" to mirror the language in the NCQA MOC Scoring Guidelines for Factor 1. This may have been removed given the potential for confusion between profession/clinical caregivers and family caregivers. Research findings and practical experience in working with family caregivers suggests that there are challenges and differences of perspective in determining who are primary, secondary, or extended caregivers, what their roles should be, and how their perspectives can be taken into account, particularly if their goals or perspectives for care differ from the beneficiary's. For Factors 2 and 3, there is reference to stratification models We recommend language changes to avoid inadvertent harm and to conform more closely with the way and manner in which stratification is employed. First of all, the stratification methods used by plans vary widely—some rely on claims information and therefore results would not be available initially for every beneficiary upon enrollment (no claims experience). Other methods use several data sources including social determinant of health risk information, claims data, demographic and condition or diagnostic data, etc. There are several concerns with how the application language reads regarding stratification which might lead one to believe that all beneficiaries receive a detailed directive or specific service guidelines from the plan's stratification process/model and that this is able to be done immediately upon enrollment, that the stratification results should direct the ICT composition or the care plan—which is not the case. First, the timing of having results from stratification modeling may not correspond to a window of time when the ICP is being written or updated, nor have immediate bearing on the composition of the ICT. Moreover, stratification may help inform response by a care management team or ICT but it may not be something that is incorporated into every beneficiary's plan of care—if and when this happens and under what circumstances may be considerations that plans and providers need to discuss and tailor. Finally, note that there is no corresponding language about stratification in the NCQA MOC Scoring Guidelines. The language modification we have offered helps to address these issues.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
36	SNP Alliance	60 Day	Element C Individualized Care Plan	Factor 1	**Existing Language:** The ICP components must include but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiaries' caregiver(s); and identification of goals met or not met.	**Recommended Language:** The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; and identification of goals met or not met.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
37	SNP Alliance	60 Day	Element C Individualized Care Plan	Factor 3	**Existing Language:** Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary's ICP.	**Recommended Language:** Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary's healthcare needs change. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of the stratification grouping results, and how the stratification results help guide the care management approach including informing the ICP.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
38	SNP Alliance	60 Day	Element D Interdisciplinary Care Team	N/A	N/A	We find language about stratification here, again, to be confusing. The issue is both with the grouping results (data sources and categorization) and timing. It is unlikely that the stratification alone would "determine SNP beneficiaries' health care needs" nor "determine the composition of the ICT." Stratification can be thought of a process to divide an entire SNP enrollment population into more distinct groups—it is (at this time) not sufficient to provide a detailed profile of each person and his/her unique needs or preferences, nor direct the interdisciplinary team. It is a good additional piece of information/data element. The timing of the stratification is another point. Also, people may shift into different groups depending on progression of a disease course or changes in life situations. The re-stratification would always be retroactive—so, for now, other methods for triggering need for additions or changes to the ICT may be more timely and instructive.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
39	SNP Alliance	60 Day	Element D Interdisciplinary Care Team	Factor 1	**Existing Language:** Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.	**Recommended Language:** Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used , then each SNP must provide a detailed explanation of how the stratification results inform the understanding of the beneficiary's risk profile and how they are communicated to the ICT.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
40	SNP Alliance	60 Day	Element D Interdisciplinary Care Team	Factor 4	N/A	The focus and intent of this Factor is on how the SNP promotes regular information exchange—their process and structure, and how this is supported. This may be in a "communication plan" or another way—e.g., via a health information exchange mechanism which extends beyond a single organization or plan… Therefore, this Factor may need to be updated to reflect emerging health information exchange technology, structures, and processes. We have offered alternative draft language as a start.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
41	SNP Alliance	60 Day	Element D Interdisciplinary Care Team	Factor 4	**Existing Language:** Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including but not limited to, the following: • Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MODEL OF CARE. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders. • The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other. • How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.	**Recommended Language:** Provide a clear and comprehensive description of how the SNP ensures that necessary exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following: • Identification of a structure and process that is established for effective and ongoing communication between those involved in serving the SNP beneficiary. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders. • The types of evidence used to verify that communications have taken place, e.g., through secure platforms, shared data repositories, or health information exchange with tracking/audit feature • How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
42	SNP Alliance	60 Day	Element E Transitions Protocols	N/A	N/A	We recommend consolidating the Care Transitions Protocols portion of Section 3, Element B umder Section 2, Element E	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
43	SNP Alliance	60 Day	Element E Transitions Protocols	Factor 2	**Existing Language:** Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MODEL OF CARE Element 2A.	**Recommended Language:** Describe which personnel (e.g., case manager,) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MODEL OF CARE Element 2A. Providers involved in care and part of the ICT are notified and involved in follow-up as warranted by the beneficiary's condition, preferences, and goals, to maintain continuity	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
44	SNP Alliance	60 Day	Element B Use of Clinical Guidelines & Care Transitions Protocols	N/A	N/A	We recommend removing Factor 3 on ensuring care transitions protocols are being used to maintain continuity and moving it to Section 2, Element E, Factor 2, to consolidate, streamline and clarify—otherwise there is significant overlap within the guidelines.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
42	SNP Alliance	60 Day	Element C Model of Care Training for the Provider Network	N/A	N/A	We believe the intent of this is to ensure that providers serving beneficiaries in the plan are able to effectively access and participate in the Care Coordination process. We strongly recommend this Element be re-focused toward ensuring providers can effectively and easily access guidance on the care model, including training, when needed and receive timely care coordination support from the health plan. It is most important that these providers have information at their fingertips about the enhanced care coordination services and other beneficiary to participate effectively in this process. The current focus on documenting training that is offered but which providers often disregard, does not achieve the intent.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
43	SNP Alliance	60 Day	Element C Model of Care Training for the Provider Network	Factor 1	**Existing Language:** Explain, in detail, how the SNP conducts initial and annual MODEL OF CARE training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.	**Recommended Language:** Explain, in detail, how the SNP provides MODEL OF CARE orientation, training, and supportive resources for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: video links, personal communication, printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website. Training targets providers involved in care coordination and care transitions and who serve plan beneficiaries on a regular basis.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
44	SNP Alliance	60 Day	Element C Model of Care Training for the Provider Network	Factor 2	**Existing Language:** Describe how the SNP documents and maintains training records as evidence of MODEL OF CARE training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MODEL OF CARE training.	**Recommended Language:** Describe how the SNP provides real time access to the care coordination and care transitions protocol and plan guidance to providers, as they serve beneficiaries enrolled in the SNP.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
45	SNP Alliance	60 Day	Element C Model of Care Training for the Provider Network	Factor 3	**Exisiting Language:** Explain any challenges associated with the completion of MODEL OF CARE training for network providers and describe what specific actions the SNP Plan will take when the required MODEL OF CARE training has not been completed or is found to be deficient in some way.	**Recommended Language:** Explain any challenges associated with participation in the MODEL OF CARE by providers, and describe what specific actions the SNP Plan will take to address these challenges.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
46	SNP Alliance	60 Day	SNP Quality Improvement Program and Performance Plan	N/A	N/A	We recommend that the language for these sections in the application be consistent and aligned and that the language is cross-walked to the Elements and Factors within NCQA MOC Scoring Guidelines which used to review plans' Model of Care submissions.	Revision	CMS appreciates the comments, however, these comments are outside of the scope of this collection. CMS recently finalized collection of information (COI) for Initial and Renewal Model of Care Submissions, and Off-cycle Submission of Summaries of Model of Care Changes (CMS-10565), OMB 0938-1296. In order for an MA plan to operate as a new SNP in the upcoming contract year(s) and as part of the SNP application process, NCQA and CMS use information collected in the HPMS Application module to review and approve MOC narratives. Since the MOC Matrix requirements and scoring guidelines are captured through a separate COI request, CMS is unable to make changes to the MOC guidance at this time. CMS will take these comments under consideration when the MOC COI is due for OMB renewal.	Reject
47	SNP Alliance	60 Day	Appendix I SNP Application	5.2 and 5.3	Both sections contain a "NOTE" that for contract year (CY) 2021 only, D-SNP evergreen contracts with letters of good standing will not be accepted for purposes of the D-SNP State Medicaid Agency Contract (SMAC) review. A SMAC that reflects requirements effective CY 2021 is required. However, the October 7, 2019 HPMO memo, CY2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs), states: All D-SNPs are required to submit a new SMAC (or an evergreen SMAC with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by Monday July 6, 2020. (emphasis added)	We recommend the "NOTE" language in these sections be changed to clarify that a 2020 evergreen SMAC with a contract addendum is acceptable for CY 2021 SMAC reviews.	Revision	CMS will be updating the language to clarify this information.	Clarify
48	SNP Alliance	60 Day	Appendix I SNP Application	5.4	Attestation 1: Attestation contains "NOTE" that for CY 2021, evergreen contracts with letters of good standing will not be accepted.	We recommend the "NOTE" language in this section be changed to clarify that a CY 2020 evergreen SMAC with a contract addendum that includes the new 2021 requirements is acceptable for CY 2021 SMAC reviews. We recommend CMS develop and provide separate policy guidance to clarify that a CY 2020 evergreen SMAC with a contract addendum that includes the new 2021 requirements is acceptable for CY 2021 SMAC reviews. Separate policy guidance on this issue will reduce last minute confusion among states and D-SNPs that could ultimately result in disruption of reduced access of services for enrollees.	Revision	CMS will be updating the language to clarify this information.	Clarify
49	SNP Alliance	60 Day	Appendix I SNP Application	5.4	Attestation 5: Attestation contains a "NOTE" that does not consider the possibility some states will not want to or be ready to implement unified grievance and appeals (G&A) processes.	What should a D-SNP do if a state is not interested in or ready to implement unified G&A processes? We recommend CMS informally, on a case by case basis, allow for additional time to meet the new requirements. CMS has commonly allowed for more time, when necessary, by extending	Revision	The regulation requires that all applicable integrated plans have a unified appeals and grievance process by CY 2021.	Reject
50	SNP Alliance	60 Day	Appendix I SNP Application	5.12	In the header to section 5.12., starting on page 86, it states the matrix used by CMS in conducting HIDE and FIDE SNP determination reviews, followed by a "NOTE" at the top of page 87 about which specific contract provisions must be provided and met to be determined a FIDE and HIDE SNP with the potential of answering "N/A" if not applicable. The "NOTE" states: To be designated as a HIDE SNP, a D-SNP must provide contract language for provisions 3 and 5 or 6. To be designated as a FIDE SNP, a D-SNP must provide contract language for provisions 3-9. Please answer all questions, including N/A if not applicable. The language in the "NOTE" is not clear and could be read as "identify contract language for provision 3 and provision 5 or 6," or it could be read as "identify contract language for both provision 3 and provision 5, or identify contract language for provision 6." In addition, the top of the matrix provisions list is entitled "Meeting the definition of a FIDE SNP – CMS 4144-F," which has no mention of HIDE SNPs. HIDE SNPs are required to answer some of these provisions, which is confusing. If CMS adopts the recommendation, this confusion should be reduced.	We recommend CMS list the provisions for HIDE and FIDE SNPs separately, even if this means overlapping or duplicating provisions and charts. Listing the requirements for FIDE and HIDE SNPs separately would be preferable to simply changing the header or allowing "N/A" answers.	Revision	We will clarify language in the instructions to this matrix.	Reject
51	SNP Alliance	60 Day	Appendix I SNP Application	Provision 2	The provision requires certain plans with "exclusively aligned enrollment" to use unified G&A processes but does not address what occurs if the state is not interested in or ready to implement unified G&A processes in the required time.	What should a D-SNP do if a state is not interested in or ready to implement unified G&A processes?	Revision	The regulation requires that all applicable integrated plans have a unified appeals and grievance process by CY 2021.	Reject
52	SNP Alliance	60 Day	Appendix I SNP Application	Provision 3	The provision as written, excluding the "NOTE," appears to apply to HIDE SNPs, but includes the "NOTE" about FIDE SNP status, which is confusing.	We recommend CMS list the provisions for HIDE and FIDE SNPs separately, even if this means overlapping or duplicating provisions and charts. Listing the requirements for FIDE and HIDE SNPs separately would be preferable to simply changing the header or allowing "N/A" answers. The "NOTE" in provision 3, referring to a definition of entities required for FIDE SNP status, mentions "same entity," but uses different language for the required entity. In other documents for FIDE SNPs, CMS has clarified that this must be the "same legal entity that also has a state contract with the Medicaid agency as an MCO to provide Medicaid benefits," or has also used the term "same legal entity." As part of separating the requirements list into FIDE vs. HIDE, we recommend CMS use	Revision	We will clarify language in the instructions.	Reject

Comment Number	Source of Comment: (Company Name)	2021 MA Application 60 day or 30 day	Application Part	Application Section	Application Text (If applicable)	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	SME Response	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
53	SNP Alliance	60 Day	Appendix I SNP Application	Provision 3	N/A	As part of separating the requirements list into FIDE vs. HIDE, we recommend CMS use clarified language regarding legal entities and the language used to define the required entities be consistent whenever possible. CMS could change the reference in the "NOTE" from "same entity" to "legal entity."	Revision	We added the word legal to entities and added the requirements for the HIDE entity to the note.	Clarify
54	SNP Alliance	60 Day	Appendix I SNP Application	Provision 4	This provision says "your organization but does not describe what entity that organization is. The provision appears to only apply to FIDE SNPs.	We recommend CMS clarify what is meant by "your organization" for FIDE SNPs and the language used be consistent whenever possible.	Revision	We believe your organization is clear enough for the organiztion completing the application	No edit required.
55	SNP Alliance	60 Day	Appendix I SNP Application	Provision 5	Provision 5 says the "organization has a capitated contract with the State Medicaid Agency that provides coverage, consistent with State policy, of behavioral health." CMS has said in other documents that covering behavioral health isn't required for FIDE SNP status when not consistent with state policy. We agree that CMS should collect this information for all FIDE and HIDE SNPs, but CMS should clarify that while provision of behavioral services by FIDE SNPs might be desirable, it is not a requirement if state policy does not permit it.	We recommend CMS clarify that while provision of behavioral health services by FIDE SNPs might be desirable, it is not a requirement in cases where it would not be consistent with state policy. Although CMS notes that "N/A" is an acceptable answer, we continue to recommend CMS separate this into two lists or matrixes (HIDE and FIDE) in order to make the provisions clearer for applicants and reviewers as well. We have had many comments from states and plans indicating confusion about FIDE vs. HIDE requirements, and this is one area that CMS could clarify that would help to reduce confusion.	Revision	Added note indicating that for FIDE SNP coverage of behavioral health services is not required when it is consistent with state policy.	Clarify
56	SNP Alliance	60 Day	Appendix I SNP Application	Provision 5	N/A	We recommend CMS list the provisions for HIDE and FIDE SNPs separately, even if this means overlapping or duplicating		We will clarify language in the instructions to this matrix.	Reject