CMS-10796 PRA Response to 60-day Comments

Commenter	Summary of Comment	Proposed Response
United	1. UHC believes CMS already possesses Medicaid contracts 2. Will there be a separate matrix for Medicaid contract? 3. What will CMS expect from a Medicare Advantage organization that does not have a complete Medicaid contract due to circumstances outside its control?	1. We are proposing to require that applicants include the associated Medicaid MCO contract per service area requirements at 422.2. While CMS receives versions of the Medicaid managed care contract for review of 42 CFR 438, we are seeking to collect the Medicaid managed care contract to confirm the signature, the legal entity, and the service area. As noted in the Supporting Statement, we do not believe that such an addition will be a heavy lift for plans. 2. As of now, we do not plan to require a separate matrix for the Medicaid contract. 3. We appreciate this question. We have developed language that we have shared with states to include in SMACs if a corresponding Medicaid MCO contract is incomplete.
AHIP	Support: updated appendices Recommendations: 1. Language regarding plan specific details including, but not limited to H contract code, PBP number, integration status, bid filing, eligible MSPs on that PBP, plan name and counties within that PBP. **2.** Language regarding how the state cost share protects SLMB+ and FBDE members. **3.** Include a chart regarding MSP cost sharing information. 4. Language regarding states will send MCOs a crosswalk of eligibility codes linking what codes identify what MSP eligibility categories ***5.*** Language regarding capitated Medicaid benefits, the Medicaid service area *and* if the state requires these members to pay Part A/B Medicaid copays. - For AIPs, language that indicates state material review. Language will include all of the following: - Specific materials requiring review	We appreciate the support for the updated appendices. We appreciate the suggestions regarding additional information in the SMACs. We note that with certain exceptions, the information suggested by the commenters is already required to be included in the SMAC. We do note, however, that such information is not required to be included in the table format suggested by the commenters. While we appreciate the suggestion for additional information suggested for inclusion in the SMAC, our requirements for information collected is limited to information used to make the determination that the SMAC meets the federal requirements, as required in regulation under 42 CFR 422.2 and 422.107. We do not believe that, given current regulatory requirements, we can require some of the requested information to be included as a required element in the SMAC. However, we do understand that such information could be helpful. We will plan to develop best practice suggestions to include this information for the state to include at their discretion.

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	- Timeline for review - Material filing, is approval required or can plans submit as file and use - Language indicating recourse if approval is not received timely to meet - CMS deadlines for beneficiary materials (e.g., Annual Notice of Change, Member Handbook/Evidence of Coverage, Summary of Benefits, etc.). AHIP encourages CMS to partner with States and Plans to share model materials as soon as possible and education on MA material timeframes and recommends options to streamline review as noted above with "file and use" and potential pathways to expedite review if approval is not received in time to meet MA requirements.	
MLTSS	Support: MLTSS supports proposed attestation regarding uploading effectuated Medicaid contract. Recommendations: Adding extra detail in basic matrix, including H contract code, plan name, PBP number, integration status, bid filing, MSP categories that are eligible to enroll in the PBP, and the counties served within that PBP - Would like to see this as a chart 1. Including a new requirement in the SMAC Application for plans to submit a cost share chart that details the cost sharing responsibilities for different MSP eligibility categories. - Also recommends that the SMAC Application be updated to include language	This response will be the same as the AHIP response, as the content of the letters were basically identical. We appreciate the support for the updated appendices. We appreciate the suggestions regarding additional information in the SMACs. We note that with certain exceptions, the information suggested by the commenters is already required to be included in the SMAC. We do note, however, that such information is not required to be included in the table format suggested by the commenters. While we appreciate the suggestion for additional information suggested for inclusion in the SMAC, our requirements for information collected is limited to information used to make the determination that the SMAC meets the federal requirements, as required in regulation under 42 CFR 422.2 and 422.107. We do not believe that, given current regulatory requirements, we can require some of the requested information to be included as a required element in the SMAC. However, we do understand that such information could be helpful. We will plan to develop best practice

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	that captures when states will provide health plans with a crosswalk that links the Medicaid category codes to each MSP eligibility category (see the Appendix for an example crosswalk from Pennsylvania). 2. Expanding enrollment restrictions requirement to include any eligibility requirements that require separate PBPs. 3. Adding questions to the SMAC Application for AIPs about which materials the state will review, if any; the timeline for the state's review; material filing (if approval is required or if plans can submit as "file and use"); and language indicating recourse if approval is not received with sufficient time to meet CMS deadlines for beneficiary materials. 4. Including options to streamline review of member materials, including potential pathways to expedite review if approval is not received in time to meet Federal Medicare Advantage requirements.	suggestions to include this information for the state to include at their discretion.
Humana	Support: Humana supports revisions to reduce the number of attestations required for SMAC submission, the updated matrix names to mitigate confusion, and the inclusion of H Contract number within each matrix. We feel these updates will help ensure the proper forms are being used appropriately and aid in the completion of these documents. Recommendation:	We appreciate the support for the attestations and the updated matrixes. We thank the commenter for their suggestion on attestation 4 and have made modifications to the attestation in line with this suggestion.

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	Attestation 4 was modified to require the Basic D-SNP State Medicaid Agency Contract Matrix before the SMAC submission deadline. Previously, this attestation required the matrix to be submitted by the SMAC submission deadline. Since the matrix is submitted with the SMAC, and not before, we recommend continuing to use the requirement "by the SMAC submission deadline."	