PRA Comments

Comment: A commenter asks will CMS require Medicare Advantage organizations to complete MOC element 1A for new D-SNP contracts for the upcoming plan year? If so, the commenter requests that CMS share the proposed language that can be utilized as the Medicare Advantage organization (MAO) will not have their State Medicaid Agency Contracts and corresponding Medicaid categories approved by CMS at the time of submission. In addition, the commenter requests that CMS provide MAOs with additional development time to implement these changes, particularly since MAOs will need to incorporate the defined and requested data requirements at least 6 months prior to submissions. The commenter recommends a 2028 plan year effective date (or later), with an August 2026 collection date, instead of the potential 2027 plan year effective date and August 2025 collection date.

Response: We believe the commenter is asking if CMS intends to make these proposed changes effective for the Contract Year (CY) 2026 MOC submission requirements. We do not intend to do that. Any changes to the MOC process through this PRA would be in effect for the CY 2027 MOC submission period. Changes to the MOC Matrix will be discussed in future MOC trainings and technical assistance calls leading up to the MOC submission period for CY 2027 so that plans will have the appropriate time to gather the data for submission.

Comment: We received several comments commending CMS for considering and including caregivers in MOC requirements and expectations. A commenter suggested several recommendations to the MOC standards in order to strengthen the expectation that enrollee caregivers are identified and more meaningfully engaged in care management processes as outlined under a SNP's MOC. These comments include several targeted edits such as: requiring SNPs to detail how they engage caregivers and support them; adding staff responsibilities such as caregiver education and support; requiring plans to track and measure within enrolled population subsets how many enrollees have caregivers; and have plan outline efforts to support caregivers for the most vulnerable population.

Response: We appreciate these comments and agree that caregiver support can be an important aspect of a SNP enrollee's care management. We would like to note that SNPs can incorporate many of the commenter's caregiver suggestions into their care management processes and some may already be doing so. CMS' MOC standards, as outlined in the MOC matrix document, are based on statutory and regulatory requirements and supplementary guidance that operationalizes the model of care review process. As such, we seek to balance current care management requirements as established by statute or regulations without prohibiting innovation in practices that SNPs may implement on their own. In some instances, such as adding requirements to the roles of interdisciplinary care team members at 42 CFR 422.101(f)(1)(ix), commenters suggested changes would require rulemaking by CMS to implement, and thus, would be outside the scope of this PRA.

Comment: We received multiple comments requesting clarification regarding the MOC provider training requirements.

One commenter would like clarification on the term provider staff. They ask the following: is the training required to be provided to the enrollee's PCP if HRAs are conducted solely by internal care coordination staff?

Another commenter recommends that CMS add new language to this section clarifying the circumstances under which a provider is no longer expected to complete the training annually.

Response: The intent of the requirements at 42 CFR 422.101(f)(2)(ii) is for SNPs to focus training activities on contracted and non-contracted providers who are essential to the enrollee's care coordination and management processes – including those involved in care coordination and transition tasks – rather than all providers who are in-network or are seen regularly by members out-of-network. In other words, SNPs should focus their training on key (i.e., appropriate) providers and their staff who are integral to member's care coordination and care transition. For example, members of the enrollee's ICT are clearly critical to the SNP care coordination and care management process; therefore, they must be included in the MOC provider training.

CMS recognizes that offering training to an out-of-network provider based on a one-time encounter with a member may create an administrative burden. This means that plans can determine that some providers do not need to take the MOC training based on their roles in the provider's network or on the types of services provided. Based on this guidance, plans should determine the out-of-network providers that members see frequently, deem them "appropriate", and include them in MOC provider training.

Since the regulation stipulates that training must be offered to appropriate non-contracted providers, SNPs must describe the process for how the organization implements provider training and demonstrate or show evidence that it makes training on the MOC available to all appropriate in-network and out-of-network providers.

As far as when a provider should complete training, SNPs must offer MOC provider training, consistent with the regulation at 422.101(f)(2)(ii), for all appropriate in-network and out-of-network providers and staff (e.g., those with member care coordination and care management responsibilities) at least once per MOC approval period. For example, C-SNPs must train all appropriate in-network and out-of-network providers annually. D-SNPs and I-SNPs must train all appropriate in-network and out-of-network providers at least once during the MOC's period of approval. That means if a D-SNP receives a 3-year approval period, it must train providers a least once within this 3-year approval period. That said, the submission and acceptance of off-cycle revisions begins a new period of approval and warrants additional MOC training for all appropriate in-network and out-of-network providers.

Comment: We received recommendations from a state agency seeking to add reporting requirements specific to D-SNP MOCs.

Response: We appreciate the recommendations provided by the state and the supplemental research behind these recommendations. While we value the effort and design behind the state's D-SNP initiative, we believe these recommendations are out of scope for the PRA.

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

Response: We thank the commenter for the suggestion. As we have noted previously, CMS and NCQA will not review any state-specific MOC criteria; however, we encourage plans to provide info within the MOC off-cycle submission, such as a note in the MOC narrative or in the Matrix, noting that the plan is submitting due to state requirements.

Comment: One commenter expressed concerns with changes to MOC Element 1B that adds a request for an inclusive list of the partnerships and available services specific to the service area. Due to variation across geographic regions, plans operating in certain counties may be limited in or have no available partnerships specific to a given need of their Special Needs Plan (SNP) population. As with provider contracts, certain services may not be compatible with the organization due to quality or other reasons. They ask that CMS add language for the plan to include barriers preventing partnerships or services in the geographic region.

Response: Our proposed updated language to MOC Element 1B is as follows (in italics):

- *Describe the established partnerships with community organizations that either provide, facilitate, or assist in identifying resources for the most vulnerable enrollees and/or their caregivers, including the processes to support and/or maintain these partnerships and facilitate access to community services.*
- *Include a list of the partnerships and available services specific to the service area.*

We believe the structure of the MOC narrative should be flexible to allow SNPs to note when impediments in their service area create challenges to the establishment of the partnerships described in MOC Element1B. Therefore, we are adding the following sub-bullet to MOC Element1B:

- Explain any challenges associated with the establishment of partnerships with community organizations that impact the ability to connect enrollees to specific community services.

Comment: A commenter expressed concerns regarding the requirement that SNPs renewing their contract(s) after year two of operations must provide their own historical data instead of other local, national, or proxy data under MOC Element 1B. The commenter recommend that CMS revise the language to address existing plans applying for an H-contract at the request of the state Medicaid agency. They note that existing SNPs have historical data; however, this question is difficult to address in the MOC when the application is considered new.

Response: We appreciate the commenter's concern. In circumstances where a SNP is submitting a new application due to a request from the state, NCQA will accept population data from the

previous plan. SNPs should indicate the nature of the data and the reason for the use of the previous plan's data (i.e., request to establish plan under a different contract).

Comment: A commenter expressed concerns regarding the requirement in MOC Element 2B that SNPs describe their process for addressing challenges associated with enrollees who decline to participate in HRA completion or are unable to be reached. They recommend that CMS add new Individual Care Plan (ICP) language under MOC Element 2D to include barriers or challenges to its development. Currently, CMS instructs the plan to use the member's health records if an HRA is unavailable. In some cases, a member may have an unmanaged chronic condition and, therefore, it would not be meaningful to use the member's health record to develop the ICP.

Response: We appreciate the commenter's recommendation and concur. We are adding to MOC Element 2D the following bullet:

- *Describe how the SNP addresses challenges associated with enrollees who decline to participate in ICP process or are unable to be reached.*

As we have stated in the past to similar ICP inquires, CMS firmly believes that the ICP is an essential tool for managing care for all SNP beneficiaries, regardless of whether they complete an HRA. MA organizations that sponsor SNPs are required to complete an ICP for all enrollees under Section 1859(f)(5)(A)(ii)(II) of the Act. Additionally, MA regulations at 42 CFR 422.101(f)(1)(vii) require SNPs to develop and implement a comprehensive individualized plan, and 42 CFR 422.152(g)(2)(v) requires that as part of a SNPs' quality improvement program, it must implement an ICP for each beneficiary. Although we recognize that the information collected during an HRA along with involvement of the beneficiary and/or his/her caregiver/representative is valuable in developing an ICP, we expect that SNPs will formulate an ICP based on information gathered from assessments, medical records or other available data. CMS does not consider the addition of this bullet to be a substitution for completing an ICP for an enrollee and will consider plans in non-compliance for failing to complete ICPs as required by statute and codified in regulations.

Comment: A commenter has concerns regarding the requirement that SNPs describe how the SNP uses stratified results to improve the care coordination process under MOC Element 2B. The commenter recommends CMS add language on barriers to stratifying the results—these data may not be available or require additional IT resources to develop reporting.

Response: We appreciate the commenter's remarks, but we believe stratification is an important tool in care management processes. Additionally, we believe that evidence through years of MOC reviews and SNP audits have shown that plans can and do meet these stratification requirements. As such, we will maintain the current language.

Comment: Two commenters have concerns regarding the requirement that SNPs describe how they obtain consent from enrollees to complete a face-to-face encounter and how the SNP verifies that the enrollee has granted consent prior to the face-to-face under MOC Element 2C. One commenter asks that CMS clarify its instructions on consent prior to the face-to-face

encounter. If the enrollee scheduled an appointment in-person or via telehealth, the plan assumes the enrollee has adequately provided consent for the visit. The addition of a new consent requirement to the face-to-face encounter workflow is unnecessary and would increase administrative burden on both the member and the plan.

Response: Under section1859(f)(5)(B)(ii) of the Act, all SNPs are required to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis; and CMS codified this statute at 42 CFR 422.101(f)(1)(x). With respect to each individual enrolled, the regulation states that the MA organization must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan healthcare providers. A face-for-face encounter must be either in person or through a visual, real-time, interactive telehealth encounter.

CMS interprets the language in the referenced bullet in MOC Element 2C to mean that the process used to obtain consent from enrollees to complete a face-to-face encounter is specific to encounters that the SNP initiates on its own using internal staff or contracted staffing services, for example, nursing or care management staff visiting an enrollee. CMS believes that enrollees who have scheduled a medical appointment or who have sought one have provided consent to the encounter through the initiation of the episode itself.

To clarify our position, we have edited the language in MOC Element 2 C to read as:

- *For encounters initiated by the SNP, describe the process used to obtain consent from enrollees to complete a face-to-face encounter and how the SNP verifies that the enrollee has granted consent prior to the face-to-face encounter.*

Comment: A commenter has concerns regarding the requirement that SNPs detail their process for reviewing enrollee claims data and how the data is used under MOC Element 2C. The commenter notes that some state Medicaid agencies include claims data requirements in their State Medicaid Agency Contracts (SMACs). Adding this requirement to the MOC may be redundant and would require additional labor and resources to the meet the needs of both CMS and the state. We request that CMS provide additional clarification on the claims data process and what information plans must include in the narrative to streamline reporting.

Response: While we appreciate the commenter’s concerns, MOC elements are SNP-specific federal requirements developed by CMS.. In addition, these requirements request information regarding the general process for reviewing enrollee data and how the data is used; they are not prescriptive. In our experience reviewing SMACs, we have not seen such information reflected in a SMAC. As a result, we do not believe that these requirements would conflict with state-specific SMAC requirements or require additional resources.

Comment: We received several comments concerned with the impact of the SMAC requirement at 42 CFR 422.107 on the MOC submission process, specifically, the potential increase plan submission of off-cycle MOCs as required at 42 CFR 422.101(f)(3)(iv).

A commenter expressed concerns regarding the requirement under MOC Element 2D asking D-SNPs to describe the plan's processes for ensuring that the ICP coordinates Medicare and Medicaid services and, if applicable, the D-SNP or affiliated Medicaid plan provides these services. They are concerned this new language does not consider the overall objective of the ICP from the member or caregiver's perspective.

Another commenter has concerns regarding the requirement under MOC Element 2F that D-SNPs explain how the plan coordinates with providers of any Medicaid covered services during a care transition, where applicable.

Another commenter recommends that when there are state-mandated core element changes or federal payment changes which SNPs must respond to before the next MOC approval cycle, SNPs should be granted a temporary exemption and allowed to implement them outside of the HPMS off-cycle timeframe, with review by NCQA thereafter.

These commenters are concerned that the coordination of Medicaid services may be contingent on the SMAC, which is renewed annually. The proposed MOC requirements may increase the frequency of plans making off-cycle submissions to align the MOC with a state's Medicaid requirements. The commenters are requesting that CMS remove the language from the respective MOC sections under MOC Element 2 and/or provide additional clarification on the narrative instructions or during the annual technical assistance webinars to prevent off-cycle submissions.

Response: We thank the commenter for their feedback.

First, we would note that while the proposed text is specific to D-SNPs and their coordination with Medicare services and providers, that the current MOC Element 2 requirements currently seek similar information, though less targeted to D-SNP operations. For instance, the current text in MOC Element 2D states:

> *The ICP components must include, but are not limited to: enrollee self-management goals and objectives; the enrollee's personal healthcare preferences; description of services specifically tailored to the enrollee's needs; roles of the enrollees' caregiver(s); and identification of goals met or not met.*

As noted above, we have long asked that SNPs provide detailed information as it relates to the tailoring of services to specific SNP populations and subpopulations. Our proposed language seeks to make this requirement clearer that we expect SNPs to detail how specific Medicare and Medicaid services are integrated across a spectrum of care. In addition, 422.107(c)(1) requires D-SNPs to coordinate the delivery of Medicaid benefits for individuals eligible for such services and, if applicable, provide coverage of Medicaid services, for individuals eligible for such services.

Second, CMS has acknowledged in the past that in order to more effectively address the specific needs of its enrollees, a SNP may need to modify its processes and strategies for providing care in the midst of its approved MOC timeframe. Per 42 CFR 422.101(f)(3)(iv)(B)(1)(ii), D-SNPs and I-SNPs must submit updates and corrections to their NCQA approved MOC if the I-SNP or D-SNP wishes to make substantial changes in policies or procedures pertinent to revising processes to develop and update the ICP. In addition, updates and corrections should be submitted if changes are made in a SNP's plan benefit package between consecutive contract years that can considerably impact critical functions necessary to maintain member well-being and are related to SNP operations [42 CFR 422.101(f)(3)(iv)(B)(3)]. As part of the April 2024 Parts C/D Final Rule codifying the latter, we noted that an off-cycle submission would be warranted when changes in Medicaid services covered by a HIDE SNP or FIDE SNP through its companion Medicaid managed care plan. This would also be the case if changes in Medicaid policy (such as benefits or eligibility) required changes to an ICP for coordinating Medicare and supplemental benefits with the new Medicaid policy. However, we also noted in the April 2024 Final Rule that D-SNPs would not need to submit an off-cycle MOC to incorporate minor changes to Medicaid benefits. We suggest that plans and states reach out to CMS to verify whether anticipated Medicaid policy changes would have an impact on the SNP MOC standards.

To the commenter's point that SNPs should be granted temporary exemptions, we note that 42 CFR 422.101(f)(3)(iv)(A) requires that C-SNPs, D-SNPs and I-SNPs submit updates and corrections to their NCQA-approved MOC when CMS requires an off-cycle submission to ensure compliance with applicable law. In addition, SNPs may not implement any changes to a MOC until NCQA has reviewed and approved the off-cycle MOC changes [42 CFR 422.101(f)(3)(iv)(D)]. As such, CMS cannot waive the off-cycle regulations.

Lastly, CMS will use the annual MOC training process and technical assistance calls to address questions plans may have regarding changes to the MOC Elements. Plans can also submit questions to the Part C Policy mailbox at https://dpap.lmi.org/dpapmailbox/mailbox.

Comment: A commenter has concerns regarding the requirement that D-SNPs explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable, under MOC Element 2E. The commenter recommends removing this new language from the MOC, which is duplicative of existing requirements whereby plans are currently instructed to provide a detailed and comprehensive description of the ICT, including membership, roles and responsibilities for each member. In addition, the MOC provides details on how ICT members contribute to improving the health status of SNP members. They argue that in most cases the plan's contracted providers are enrolled in both Medicare and Medicaid and describing coordination between providers is unnecessary.

Response: MOC Element 2E asks D-SNPs to explain how the ICT coordinates with Medicaid providers when there are needed Medicaid-covered medical or social services that the plan does not cover, if applicable. It is specific to the coordination of the enrollee's ICT and Medicaid providers, while MOC Element 2D is partly about how this relationship is captured in the enrollee's ICP. SNPs, as always, can provide this information as part of one intertwined narrative

in MOC Element 2D or 2E without reproducing the same information in two separate sections of MOC 2.

Comment: A commenter recommends keeping the HPMS MOC off-cycle submission portal open year-round.

Response: We appreciate the commenter's recommendation; however, we believe changes to the off-cycle submission period at 42 CFR 422.101(f)(3)(iv)(B) is out of scope of this PRA submission.

Comment: A commenter recommends that NCQA/CMS review of redline Off-cycle MOC submissions should occur within one month of submission in the HPMS portal (30-days).

Response: We would like to note that NCQA's review processes align with the commenter's recommendation. NCQA downloads all submissions on the first business day after the 15th of each month and the results are uploaded by the 15th of the following month. For example, if SmartHealth submits on September 15, the documents will be downloaded on the first business day thereafter (September 16) and the results will be uploaded into HPMS by the 15th of October into HPMS. This is a 30-day turn around. For late submissions, e.g. submissions uploaded after the 15th, say on September 22, the documents will not be downloaded until the following month (the first business day after the 15th (October 16) and the results will be uploaded by 15 of November. NCQA only downloads submissions once per month. The only exception to these scenarios is if NCQA staff seek process guidance from CMS that requires additional internal review.

Comment: A commenter recommends that CMS provide education and resources to assist states on understanding and starting with the MOC federal guidelines before developing state-specific care coordination requirements to avoid duplication or inconsistency.

Response: Over the past few years CMS has been working closely with many states to provide education regarding the MOC federal guidelines including but not limited to referring them to the NCQA website and the training materials on the site, providing guidance on SMAC requirements and reviewing SMACs when requested to ensure they do not conflict with federal requirements, etc. In addition, we have worked closely with the Integrated Care Resource Center (ICRC) to provide education regarding models of care and care coordination, as well as worked with ICRC to develop tools with sample language for states to use in their SMACs.

Comment: A commenter recommends that Model of Care federal requirements are standard/consistent nationwide and the NCQA review (acting under CMS contract) should focus only on those federal requirements.

Response: The MOC Elements as outlined in Attachment A will be applied to all SNPs except for sub-elements that are specific to SNP subtype. Section 1859(f)(7) of the Act requires that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by NCQA based on standards established by the Secretary. NCQA does not review any of the state-specific MOC requirements as it is not part of the statutory requirement under

the Act. State Medicaid agencies review state-specific MOC requirements separately and decide whether the plan has met these goals independent of NCQA's review of federal standards.

Comment: CMS should conduct spot-checks or other oversight activity to review the NCQA plan-specific MOC approval decisions to ensure that MOCs are not scored differently based on the state in which the health plan operates.

Response: CMS and NCQA appreciate the commenter's recommendation. We would like to note that NCQA has a three-tiered review process for Model of Care (MOC) annual reviews:

- Documents are downloaded from the Health Plan Management System (HPMS) and perused by SNP staff to confirm receipt of appropriate materials, (the Matrix and the MOC documents) and the ability to access documentation. NCQA does not download additional documentation. Plans are instructed to place supporting documents in an appendix.
- Documents are then uploaded into the Interactive Review Tool (IRT – NCQA's system) for access by NCQA reviewers and assessment using the Model of Care Scoring Guidelines. First Level reviewers perform an Initial Review, entering the assessed scores.
- Next level reviewers, Executive Reviewers, assess the scores entered by the IR and make changes to scoring based upon their review.
- Lastly, the SNP staff perform a final review for accuracy – QA or quality review for Inter Rater Reliability (IRR) and consistency, especially for corporate submissions.

In the event of potential non-approval status of MOCs, CMS is alerted of the issue as well as the rationale for such responses. Additionally, NCQA seeks guidance from our CMS colleagues on complex issues, some of which may be taken to CMS leadership. These issues may encompass process changes or those that conflict with regulatory language. NCQA provides CMS with the plan name and number to review in context against the question(s) raised. The final scores are then uploaded into HPMS.

As always, we encourage SNPs to reach out to the Part C Policy mailbox with specific concerns regarding their MOC submission.

Comment: A commenter encourages CMS to create a searchable repository of state-specific additional care coordination requirements which is updated annually. This would need to be searchable and organized by element and factor and domain as set forth in the MOC scoring guidelines that are updated annually. In addition, the commenter encourages CMS to create a national repository, cross-walking state and federal care coordination requirements—for clarity, transparency, training and efficiency.

Response: We appreciate that several states have implemented care coordination requirements and appreciate the suggestion to develop a searchable national repository of state-specific care coordination requirements as well as cross-referencing the state requirements with federal requirements. We will consider it for the future.

Comment: A commenter asks CMS to ensure exact match on language between MOC submission requirements and MOC scoring guidelines. Differing language and terminology creates confusion and inefficiency.

Response: We thank the commenter and agree that the MOC Matrix language (Attachment A in the PRA package) and NCQA's Model of Care Scoring Guidelines for Contract Year (CY) 2027 (the intended start date of the new Matrix) need to align. We will work with NCQA to ensure a smooth transition to the new Matrix text.

Comment: A commenter recommends a revision to the language describing requirements around MOC 1A, so that the health plan is only asked to provide information on the population and vulnerable sub-groups, rather than the benefit structures such as those funded by Medicaid which is outside of the scope of the MOC—and could lead to confusion if the plan operates in multiple states with different benefit structures.

Response: We thank the commenter for their recommendation. The proposed language in MOC Element 1A, which the commenter refers to, was as follows:

> *For D-SNPs: Indicate if the D-SNP(s) are seeking to be fully integrated dual eligible (FIDE) SNP, highly integrated dual eligible (HIDE) SNP, coordination only D-SNP, or includes multiple SNP types. Describe the eligibility categories and criteria for the D-SNP (Qualified Medicare Beneficiary (QMB Only); QMB Plus; Specified Low-Income Medicare Beneficiary (SLMB Only); SLMB Plus; Qualifying Individual (QI); Qualified Disabled and Working Individual (QDWI); Full Benefit Dual Eligible (FBDE). Describe the overall benefit structure and how care is coordinated.*

Upon reviewing the commenter and the proposed language, we share their concern that a focus on overall benefit structure is inconsistent with the goal of the MOC Element 1A, which is to provide context and understanding of the SNP population that is being covered by the MOC. We have removed the text "Describe the overall benefit structure and how care is coordinated" from the sub-element as we believe the factors before this portion adequately address the goal of describing the plan's relevant population.

Comment: Two commenters asked that CMS eliminate duplication regarding multiple areas in the MOC where the plan is describing "how care is coordinated."

Response: We appreciate the commenter's suggestion and have reviewed the proposed revised MOC matrix to ensure that duplication does not occur. Based on the edit to MOC Element 1A (as outlined above), we believe that any duplication specific to care coordination has been remedied.

Comment: A commenter recommends CMS update and clarify the language to state that SNPs only need to describe staff roles with care management and clinical functions and oversight of those clinical functions. The current language is unclear, creating challenges and administrative inefficiencies. They recommend that CMS update this language to clearly state that SNPs only need to describe staff with clinical functions and oversight of those clinical functions.

Response: We appreciate the commenter's suggestion and have made an edit to MOC Element 2A. The proposed language in the first bullet was as follows:

- *Fully define the SNP staff roles and responsibilities for both employed and contracted staff, across all health plan functions that directly or indirectly affect the care coordination. This includes but is not limited to the identification and detailed explanation of:*

We have made the following edit to clarify the staff information we are seeking:

- *Fully define the SNP staff roles and responsibilities for both employed and contracted staff, across all health plan functions that directly or indirectly affect the care coordination, excluding administrative staff with responsibilities unrelated to care coordination. This includes but is not limited to the identification and detailed explanation of:*

We believe this edit will address the commenter's concern regarding the lack of clarity of the current language.

Comment: A commenter suggests that the PRA's burden estimates do not capture the actual time it takes to cover these requirements. They note that plans use personnel through the plan organization with different subject matter expertise and accountabilities—including Clinical and Care Management Services, Member Services, Quality, Data Analytics, Call Center, Population Health, Provider Contracting/Relations, Compliance, and Community Outreach.

Response: CMS appreciates concerns expressed by this commenter. All SNPs are required to develop and implement a MOC to serve as the basic quality framework and infrastructure to promote care management and coordination and meet the individual needs of SNP enrollees. A MOC submission, as outlined in this PRA, is considered a collection of information and CMS has accounted for this burden. CMS does not account for the effort required to collaborate within the organization as this is inherent to a SNPs' MOC development process and is unique to each organization. In addition, we increasingly see duplication of MOC content done at the parent organization level across SNP plan benefit packages, contracts, or across SNP types, which we believe does alleviate burden for the many Medicare Advantage organizations with multiple SNPs.

Comment: A commenter asks that CMS not move forward with the D-SNP questionnaire. They believe it is duplicative of many items already specified in the MOC or already known to CMS through State Medicaid Agency contracting information. In addition, they find that several items are outside the scope of the Model of Care statutory language and purpose.

Response: We thank the commenter for their recommendations. While we believe there is value in collecting this information, we are not moving forward with the addition of the D-SNP questionnaire as part of this PRA package. As such, the questionnaire and its associated burden has been removed from the Supporting Statement.