VIA Electronic Submission via: http://www.regulations.gov

November 12, 2019

The Honorable Seema Verma
Administrator Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)
Attention: CMS 1027

Re: Centers for Medicare and Medicaid Services and the Medicare-Medicaid Coordination Office Request for Information on Proposed Revisions to the Part C-Medicare Advantage and 1876 Cost Plan Expansion Application

SNP Alliance Comments

The SNP Alliance is pleased to provide comments to CMS and MMCO regarding the proposed revisions announced September 12, 2019 to the Part C-Medicare Advantage and 1876 Cost Plan Expansion application.

The SNP Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent over 390 special needs plans (SNPs) and Medicare-Medicaid demonstration plans (MMPs), with over 2.1 million enrolled members. Our primary goals are to improve the quality of services and care outcomes for the complex populations served and to advance integration for those dually eligible for Medicare and Medicaid.

We applaud the focus on populations with complex needs and appreciate the importance of multiple models and approaches to provide individuals with options and choice. In addition to focusing on the quality of care and services, we wish to ensure beneficiaries have necessary information to make those choices that best meet their needs.

Executive Summary

On October 7, 2019, MMCO released the CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs), which included new Medicare-Medicaid integration criteria that D-SNPs must meet in at least one of the following ways:

- By meeting the requirements to be designated as a fully integrated Dual Eligible SNP (FIDE SNP), as defined at 42 CFR 422.2. A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization (MCO) to provide Medicaid benefits, including long-term services and supports (LTSS) and behavioral health benefits, consistent with state policy; or
- By meeting the requirements to be designated as a highly integrated D-SNP (HIDE SNP), as defined at 42 CFR 422.2. A HIDE SNP covers Medicaid LTSS and/or Medicaid behavioral health
benefits, consistent with state policy, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or

- By having a contract with the state specifying a process to share information with the state, or the state’s designee (such as a Medicaid MCO or an area agency on aging), on hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk individuals who are enrolled in the D-SNP, as provided at 42 CFR 422.107(d).

Following this guidance and after review of the Part C-Medicare Advantage and 1876 Cost Plan Expansion Application, the SNP Alliance, on behalf of its members, provides recommendations, comments, and questions on the following topics regarding the Part C-Medicare Advantage and 1876 Cost Plan Expansion Application:

1. Model of Care (MOC) requirements on care coordination and SNP provider networks; and
2. SNP Application.

The SNP Alliance respectfully submits the below recommendations, comments, and questions for the Part C-Medicare Advantage and 1876 Cost Plan Expansion Application, which indicate our concerns about the need for more clarity to avoid confusion from the language in the MOC requirements and SNP Application matrixes and attestations. Implementing our recommendations will align the application’s MOC requirements with the National Committee for Quality Assurance’s (NCQA) MOC factors, in addition to making the matrixes and attestations in the SNP Application clearer.

The SNP Alliance understands the difficulty and complexity involved in the administration and oversight of special needs plans, and is prepared to work with MMCO, on behalf of our member plans, to ensure administration and oversight of special needs plans is clear and avoids, to the extent possible, confusion.

**Model of Care (Sections 2.2, 5.8, 5.9, and 5.15)**

The SNP Alliance requests some modest language edits in selected MOC elements and factors in the CMS SNP Application, based on a review of the statutory language, MOC current scoring guidelines (used by NCQA for MOC review), and discussions with SNPs and with NCQA. We noted some minor, and in some cases more substantive, discrepancy between the CMS Application language and the current NCQA MOC Scoring Guidelines—this language discrepancy may cause confusion among plans. Therefore, in our comments we provide the domain, element, and factor labeling that appears in the NCQA MOC Scoring Guidelines as well as the page # that appears in the CMS Application for CY2021 to encourage the two documents required of special needs plans be cross-walked and aligned. The pertains to Section 2.2, 5.8, 5.9, and 5.15).

**Chapter 2, Section 2: Care Coordination (P. 14-17)**

Care Coordination MOC Matrix Upload requirements are discussed on pages 95-98

1. **Element A: SNP Staff Structure (P. 14-15)**

   SNP Staff Structure MOC Matrix Upload requirements are discussed on pages 95-96

   **Factor 1, 6 and 7**: The material focus here is on employed and contracted staff involved in care coordination and transitions of care.

   Regarding Factor 1, the enumerated processes are usually addressed by other staff in the plan, pertain to other CMS requirements and are not specific to care coordination, therefore we suggest clarifying that the administrative functions referenced here pertain to care coordination. Regarding Factor 6, the focus is again on training for staff involved in care coordination and transitions. Regarding Factor 7,
the intent is to describe how the plan ensures that employed and contracted staff involved in care coordination and transitions are following the MOC.

Recommendation: We recommend changing the existing language of Element A, Factor 1 (see italics):

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.

Recommendation: We recommend changing the existing language of Element A, Factor 6 (Page 15 of the CMS Application):

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/video-conferencing.

Recommendation: We recommend changing the existing language of Element A, Factor 6:

Existing Language: Describe how the SNP documents and maintains training records as evidence to ensure MODEL OF CARE training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE training competency testing, web-based attendance confirmation, and electronic training records.

Recommended Language: Describe how the SNP ensures that the MODEL OF CARE training provided to its employed and contracted staff involved in care coordination and transitions of care was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, and electronic training records.
Factor 7 (page 15 of the CMS Application)

**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.

**Recommend 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.

2. **Element B: Health Risk Assessment Tool (HRAT) (P. 15)** Attestations are on page 79

   Health Risk Assessment Tool (HRAT) MOC Matrix Upload requirements are discussed on page 96

   It is important to recognize that the care of people with complex physical, medical, behavioral, and social health issues fluctuates and that one issue may predominate in one time period, and then wane, while another condition or social health risk issue comes to the fore. This is not static, and in the course of serving the beneficiary, more information beyond the HRAT can be gathered and would be important. Therefore we have recommended minor language edits as shown below.

   **Recommendation:** We recommend changing the existing language of Element B, 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).

   **Factor 2:** 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.

3. **Element C: Individualized Care Plan (ICP) (P. 15-16)**

   Individualized Care Plan (ICP) MOC Matrix Upload requirements are discussed on pages 96-97
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.

**Recommendation:** We recommend changing the existing language of Element C, 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.

**Recommendation:** We recommend changing the existing language of Element C, 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 how the stratification results are incorporated into each beneficiary’s ICP.

4. **Element D: Interdisciplinary Care Team (ICT) (P. 16)**

   *Interdisciplinary Care Team (ICT) MOC Matrix Upload requirements are discussed on page 97*

   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.

   **Recommendation:** We recommend changing the existing language of Element D, 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.

**Element D: Interdisciplinary Care Team, Factor 4:** 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.

**Recommendation:**

**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.

5. Element E: Care Transitions Protocols (P. 16-17)

*Care Transitions Protocols MOC Matrix Upload requirements are discussed on pages 97-98*

**Recommendation:** We recommend consolidating the Care Transitions Protocols portion of Section 3, Element B under Section 2, Element E.

**Recommendation:** We recommend changing the existing language of Element E, 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.*

Chapter 2, Section 3: SNP Provider Network (P. 17-18)

*SNP Provider Network MOC Matrix Upload requirements are discussion on pages 98-99*

1. Element B: Use of Clinical Guidelines & Care Transitions Protocols (P. 17-18)

*Use of Clinical Guidelines & Care Transitions Protocols MOC Matrix Upload requirements discussed on pages 98-99*

**Recommendation:** 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.

2. Element C: MODEL OF CARE Training for the Provider Network (P. 18)

*MODEL OF CARE Training for the Provider Network MOC Matrix Upload requirements discussed on page 99*

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.

**Recommendation:** We recommend changing the existing language of Element C, 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.*

**Recommendation:** We recommend changing the existing language of Element C, Factor 2 (Page 18):

**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.

**Recommendation:** We recommend changing the existing language of Element C, Factor 3:
**Existing 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.

**Section 2.2, 5.9 and 5.15 (18-20, 81-83, and 99-101) SNP Quality Improvement Program and Performance Plan**

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.

**Chapter 5 | Appendix I: Special Needs Plan (SNP) Application (P. 72-94)**

1. **Sections 5.2.2. and 5.3. (P. 73-74)**
   a. 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)

**Recommendation:** 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.

2. **Section 5.4. (P. 75)**
   a. **Attestation 1:** Attestation contains “NOTE” that for CY 2021, evergreen contracts with letters of good standing will not be accepted.

**Recommendation:** 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.

**Recommendation:** 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.

b. **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.

**Question:** What should a D-SNP do if a state is not interested in or ready to implement unified G&A processes?

**Recommendation:** 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 the effective date of new requirements.

3. **Section 5.12. (P. 86-88)**
   a. 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.

   **Recommendation:** 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.

b. **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.

**Question:** What should a D-SNP do if a state is not interested in or ready to implement unified G&A processes?
c. **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.

**Recommendation:** 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.”

**Recommendation:** 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.”

d. **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.

**Recommendation:** We recommend CMS clarify what is meant by “your organization” for FIDE SNPs and the language be consistent whenever possible.

e. **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.

**Recommendation:** 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.

**Recommendation:** 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.

Closing Comments and General Concerns

The SNP Alliance understands the difficulty and complexity involved in the administration and oversight of special needs plans. As demonstrated above, we recommend increased clarity in the Part C-Medicare Advantage and 1876 Cost Plan Expansion Application to reduce potential confusion. Implementing our recommendations will align the application’s MOC requirements with NCQA’s MOC factors, in addition to making the matrixes and attestations clearer in the SNP Application. The SNP Alliance is prepared to work with MMCO, on behalf of our member plans, to ensure administration and oversight of special needs plans is clear and avoids, to the extent possible, confusion.

We appreciate the opportunity to comment and look forward to working with MMCO.

Respectfully,

Cheryl Phillips, M.D.
President and CEO SNP Alliance