We appreciate CMS' proposed updates to the SMAC appendices as these updates will ensure greater transparency and compliance with the significant changes to greatly increase the number of integrated plan offerings for dual eligible beneficiaries.

In the spirit of greater transparency, AHIP sees an opportunity to support States, Plans, and CMS in including additional detail that will support and improve overall member experience and DSNP implementation. Currently, SMACs vary significantly in the level of regulatory and operational details and some key elements such as integration level, cost-sharing requirements, benefits, and material review scope and timing are sometimes not known in sufficient time to support successful implementation.

Using the existing framework, we recommend the following additions to allow for greater specificity at the Plan Benefit Package (PBP) level so that States can have greater oversight, plans are able to operationalize requirements, and most importantly, beneficiaries can benefit from enhanced integration and more seamless experience as envisioned by CMS.

- **Appendix B – Basic D-SNP SMAC Requirements Matrix (For all D-SNPs to fill out)**
    - We recommend adding the following level of detail so that CMS, States and plans can better identify specific plan offerings under these SMAC contracts. This will enable SMACs to serve as a source of truth document for all plan offerings:
        - 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. We see this as an addendum or section in the contract identifying a chart or language reflecting those details.

CMS H Contract Code	**Plan Benefit Package**	**Integration Status**	**Zero or Non-Zero Filed Plan**	**MSP Eligibles**	**Plan Name**	**Counties Served**

        - Language regarding how the state **cost share protects SLMB+ and FBDE members**. This could be additional language added to the definitions section or a cost share chart. Some states do not recognize specific federal MSP levels, states would define or update the chart below to reflect specific eligibility categories.

- This chart will also need to be tailored to **partial duals**. If states do not allow partial eligibility, the state will need to ***remove*** the partial MSP categories from this chart.

Category	**Medicare Part A Premiums**	**Medicare Part B Premiums**	**Part A Medicare Cost Sharing**	**Part B Medicare Cost Sharing**	**Other Medicaid Benefits**
QMB only	X	X	X	X	
QMB+	X	X	X	X	X
FBDE	X	X	TBD by State	TBD by State	X
SLMB		X			
SLMB+		X	TBD by State	TBD by State	X
QI		X			
QDQI	X				

- Language regarding states will send MCOs a crosswalk of eligibility codes linking what codes identify what MSP eligibility categories. *Reference from the state of PA attached.*
- Language regarding **capitated Medicaid benefits, the Medicaid service area *and* if the state requires these members to pay Part A/B Medicaid copays.**
- For Applicable Intergrated Plans, language that **indicates state material review. Language will include all of the following:**
    - Specific materials requiring review
    - 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.).

  We encourage CMS to partner with States and Plans to share model materials as soon as possible and education on MA material timeframes. Further, we recommend 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.