Special Needs Plan Alliance

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William N. Parham III
Director, Paperwork Reduction Staff
Office of Strategic, Operations, and Regulatory Affairs, Division of Regulations Development
Centers for Medicare and Medicaid Services, DHHS
Room C4-26-C05
7500 Security Blvd. 3
Baltimore, MD 21244-1850

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Dear Mr. Parham,

The Special Needs Plan Alliance (SNP Alliance) is a national, non-profit thought leadership organization addressing the needs of high-risk and high-cost complex care populations with chronic conditions through specialized managed care. The Alliance is the only organization exclusively representing Medicare Advantage Special Needs Plans – Dual SNPs (D-SNPs), Institutional SNPs (I-SNPs) and Chronic Condition SNPs (C-SNPs).

We represent approximately 65% of all SNPs. These plans have over 5 million beneficiaries enrolled across the country—totaling more than 65% of the national SNP and Medicare Medicaid Program demonstration enrollment. Our primary goals are to improve the quality of service and care outcomes for complex care populations with chronic conditions and to advance integration for those dually eligible for Medicare and Medicaid. The vast majority of all SNP enrollees, regardless of type of SNP, are dually eligible.

The SNP Alliance applauds the Administration's focus on Medicare Advantage and complex care populations with chronic conditions. We look forward to a positive, solutions-oriented relationship with President Trump's incoming leadership on these populations. As part of our dialogue, we will provide thoughtful input on how to best balance the need for government efficiency via payment policy with ensuring access to high quality care for America's citizens with complex care needs through quality measurement.

Our comments on this PRA Notice and supporting materials pertaining to proposed changes in the Model of Care Submission Requirements are based upon input from the substantial portion of the SNP sector represented by the Alliance. We offer these comments in the spirit of maintaining statutory intent while reducing burden and streamlining the regulatory process and the SNP Alliance welcomes the opportunity to work with CMS to accomplish these goals.

The SNP Alliance's comments are summarized at a high level as follows:

- **Consider how to further align, coordinate, and support care coordination requirements between federal and state policy and plan data submission requirements.** As versions of state requirements proliferate and expand, there is an increasing burden and some confusion. Efforts to start with federal MOC guidelines and have states understand them and adopt them first, before adding more requirements, would be appreciated. Support states as they learn about MOC federal guidelines.

- **It is crucial that any changes made through this PRA Notice also align with forthcoming MOC Scoring Guidelines, incorporate any updates made to the MOC Matrix, and match MOC audit protocols.** In the past, there have been some inconsistencies between language in the matrix, scoring guidelines, and audit protocol guidelines.

- **If there is specific interest in D-SNPs, it is important that CMS use the information already provided by special needs plans in their MOC about all aspects of HRA, ICP, ICT, etc. as they follow the Model of Care Scoring Guidelines and upload through the HPMS MOC Matrix.**

The remainder of our comment letter is comprised of an Executive Summary and our detailed comments. Thank you for the opportunity to comment and for discussion, please contact us at mcheek@snpalliance.org and dpaone@snpalliance.org.

Sincerely,

Michael Cheek

Mike Cheek
President & CEO

Deborah Paone

Deborah Paone, DrPH, MHSA
Performance Evaluation Lead & Policy Consultant, SNP Alliance

EXECUTIVE SUMMARY

This Executive Summary provides a brief reiteration of CMS' proposal as well as a shortened version of our recommendations. For an in-depth analysis, see the detailed comments beginning on page 6. Page numbers are referenced throughout for ease of review.

1. **Off-Cycle Submission Recommendations *(Pages 6-7)***
   a. Keep the HPMS MOC off-cycle submission portal open year-round.
   b. NCQA/CMS review of redline MOC submissions should occur within one month of submission in the HPMS portal (30-days).
   c. 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.

2. **Alignment of Federal and State Model of Care/Coordination Policy and Guidelines *(Pages 8 – 9)***
   a. CMS should 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.
   b. Model of Care federal requirements are standard/consistent nationwide and the NCQA review (acting under CMS contract) should focus only on those federal requirements.
   c. 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.
   d. To address the increasing number of state-specific MOCs, CMS is encouraged 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.
   e. CMS is encouraged to create a national repository, cross-walking state and federal care coordination requirements—for clarity, transparency, training and efficiency.

3. **Specific Comments on PRA Notice Proposed Changes (*Pages 10-12)***
   a. Ensure exact match on language between MOC submission requirements and MOC scoring guidelines. Differing language and terminology creates confusion and inefficiency. *(Page 10)*
   b. MOC 1A – Description of the Overall SNP Population and the Most Vulnerable Enrollees *(Page 10)*

i. Recommend revision of this language, 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.
ii. Eliminate duplication –there are multiple areas in the MOC where the plan is describing "how care is coordinated."

c. MOC 2A – Staff Structure *(Page 11)*
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.

d. MOC 2C – Face-to-Face Encounter *(Page 11)*
Revisit and clarify language which indicates SNPs must verify the enrollee has granted consent for the face-to-face encounter when the person conducting the face-to-face encounter is a non-plan employee or provider.

e. MOC 3C – Provider MOC Training *(Page 12)*
i. Clarify the following statement, "MOC training requirements in this section now target provider staff rather than direct care provider staff. This is aimed at decreasing provider burden." Terminology and intent are unclear, as is the term, "provider."
ii. Use the same language in the MOC scoring guidelines, MOC submission requirements, NCQA review training, and CMS MOC audit protocol and guidance.
iii. Remove "initial and annual" language from this section and from the staff MOC training section (MOC 2A), given clarification by CMS at recent CMS/NCQA CY2026 MOC Training session.

4. Burden Estimates *(Pages 12 – 14)*

The estimate of the time and personnel involved in writing, reviewing, and submitting an MOC, particularly for a new submission, are widely off by a magnitude of more than 70. According to feedback from SNPs, the MOC development, writing, review, and revisions, together with the submission process represents a minimum of 450 hours of health plan personnel time per full MOC submission per contract (estimates of total time ranged from 450 hours to 600 hours).

a. Revise administrative time and cost burden estimates for full MOC submission to be at least 450 hours.

b. Regarding resubmissions, revise using a conservative estimate of $3,644 per plan/contract.

c. Regarding the D-SNP questionnaire cost burden, we recommend elimination or substantial changes, therefore we did not calculate a burden estimate.

5. Proposed D-SNP Questionnaire *(Pages 14 – 16)*

Do not implement the D-SNP questionnaire. The addition is duplicative of many items already specified in the MOC or already known to CMS through State Medicaid Agency contracting information. In addition, we find that several items are outside the scope of the Model of Care statutory language and purpose.

DETAILED COMMENTS

1. OFF-CYCLE SUBMISSION

CMS outlines its policy on Off-Cycle Submissions indicating that a D-SNP or I-SNP that finds it necessary to make "substantial changes in policies or procedures" to its care coordination infrastructure or processes must submit a red-line version of their existing, approved Model of Care document into the MOC module in HPMS for additional NCQA review and approval. There is a broad definition of "substantial changes" given by CMS as "those that have a significant impact on care management approaches, enrollee benefits, and/or SNP operations." CMS further notes that it is the responsibility of SNPs to notify CMS of substantive changes and electronically submit a summary of changes to their MOC in HPMS and, furthermore***, SNPs may not implement any changes until NCQA has approved the changes*** and that ***the HPMS module for off-cycle submissions is only open between June 1st and November 30th***

SNPA Comments:

There are two key issues with this policy that need to be adjusted, as they interfere with special needs health plans' ability to operate their SNP with efficiency—these are:

(1) The ***limited 6-month window to submit changes to the MOC through the HPMS portal which does not take into account new state or federal policy changes and mandates that impact SNPs care coordination processes;***
(2) The ***broad definition and scope of "substantial***."

Taken together, these two policies can substantially impede a health plan's actions when the plan needs to adjust the SNP care coordination practices due to forces outside of its control. These two policies can represent an undue administrative hurdle for special needs plans.

(1) ***Limited time window to submit changes -*** Special needs plans submit their bids in June of each year. The bid incorporates any known CMS and state policy requirements as of that month. CMS announces bid review results usually in late August for plans to have the month of September to get ready for open enrollment (October-December) for service under the new contract beginning January 1. If there are subsequent policy changes or mandates by the state where the SNP needed to make redline changes in their MOC, this leaves only a small window to submit these changes in the HPMS portal and receive an NCQA review and approval in time for the open enrollment period. The NCQA decision should be provided before the open enrollment period begins for the SNP to be assured that it can appropriately describe the care coordination and benefits available to prospective beneficiary enrollees.

(2) ***Externally driven changes due to new mandates at the state or federal level*** - States have their own procurement processes for D-SNPs and often operate on a different timeframe from the federal Model of Care HPMS processes and timeframes. These state mandates can happen at other times in the year and the changes would often be considered "substantial" by CMS, triggering the need for an off-cycle submission. For example, states are requiring specific content and processes in the health risk assessment, individualized care plans, care coordination staffing and training, and other elements of the care coordination processes. Since SNPs must comply with such state requirements, the plans may find that they cannot wait until the window for submission and NCQA review is open again next June. Having only 6 months to submit changes puts special needs plans in an untenable position.

Likewise, there may be changes in the SNP plan benefit package that are ***the result of changes in payment policy made by CMS, including changes in the HCC model, risk stratification, case-mix adjustments, quality bonus payments, or other payment policie***s outside of the SNP locus of control which impact care coordination.

RECOMMENDATIONS on Off-Cycle Submission Policy

We have three recommendations:

(1) Open the HPMS MOC Portal for Year-Round Off-Cycle Submission- We request that: ***there be no closing of the HPMS MOC off-cycle submission portal*** – so that redline changes could be submitted at any time in the year.

(2) Timely Review – We ask that NCQA/CMS commit to review of redline MOC submissions within one month of submission in the HPMS portal (30-days), including notification to the SNP of review findings.

(3) Temporary Exemption Due to New State Mandates or Federal Policy/Payment Changes or Additional Option to Accommodate New Policy for SNPs – If the Off-cycle Submission portal is not open year-round, then we request that when there are state-mandated changes to any component within the care coordination elements, or federal policy or payment changes affecting benefit and payment requiring adjustment in factors considered by CMS to be "substantial," ***then SNPs be granted a temporary exemption and allowed to implement them outside of the HPMS portal and NCQA review process and timeframe when necessary.*** The conditions under with this temporary exemption would be allowed would include:

- New state mandates requiring changes to the care coordination components and processes enumerated in the factors covered by the MOC Guidelines, and

- Changes in federal payment that impact the benefit package which can be offered by the SNP which are different from the conditions under which the SNP received MOC approval.

MOC changes would still be reviewed retrospectively by NCQA via a red-lined version of the MOC submitted by that SNP and further adjustments could be made after receiving NCQA feedback.

2. ALIGNMENT OF FEDERAL AND STATE MOC/CARE COORDINATION REQUIREMENTS

Through a previous Final Rule for D-SNPs, CMS indicated that states could use the Model of Care as a vehicle for coordinating care. At that time, the SNP Alliance described several practical issues and asked CMS to consider further regulatory guidance to avoid the problem of multiple State-issued additional requirements that do not sync with the federal requirements. We observed that health plans, providers, and beneficiaries may be caught in the middle between state and federal requirements.

Recommendations on Alignment:

- ***Federal Requirements for Model of Care Should Precede Additional State Requirements*** - As the MOC is a federal Medicare requirement set by Congress, this means that it is a national standard to be consistently applied to all SNPs. In the previous rule comments, we recommended that CMS encourage states to defer to federal standards on Model of Care and the care coordination elements and factors contained therein, such as on health risk assessment, individualized care plan, care coordination processes, care coordination staffing and training, interdisciplinary care teams, care transitions, and other components. States should begin with existing federal MOC guidelines (NCQA/CMS-issued Model of Care Guidelines updated annually) to determine if the extensive and comprehensive federal care coordination requirements include the components that the state is interested in requiring of SNPs that operate in their state. If so, then the state could be assured that those care coordination components are already covered by the federal standards. In this way, ***only where those items are not already covered in the federal MOC requirements, would the state add to SNP care coordination requirements***. The federal MOC is based on statutory requirements so every SNP must comply. States may not alter the federal guidelines or issue requirements that force plans to go against the federal mandates, but they can add requirements in their state health plan contracting (such as in the State Medicaid Agency Contract) pertaining to unique

aspects of their state Medicaid services or processes around care management and related activities (such as in the Financial Alignment Demonstration or other demonstrations).

- ***NCQA Consistency in Scoring the MOC*** – CMS must ensure that the NCQA review and approval is only focusing on the federal MOC guidelines/requirements. NCQA reviewers should not be distracted by additional state requirements which are outside of the federal scope. CMS is advised to conduct spot-checks or other oversight activity to review the NCQA decisions to ensure that health plan MOCs a***re not scored differently based on the state in which operate*** nor rate the MOC lower if the plan is required to submit additional information for the state. In other words, reviewers should not penalize SNPs for following state requirements, and this may occur if the NCQA reviewers are not aware of additional state-specific expectations. CMS needs to ensure that NCQA scoring of MOC submissions are based ONLY on the federal guidelines, not state additions. This is necessary to ensure national standards are applied consistently across health plans. Spot-checks would provide reassurance that the reviews are conducted consistently and fairly.

- ***Searchable Repository to Check on State-specific Requirements*** – We see a growing need for an accessible, searchable online repository of all the MOC Federal-State versions of care coordination requirements with which special needs health plans need to comply. Many health plans cross state lines and serve people in multiple states. They need to follow effective care management practices and utilize their enterprise-wide databases, predictive models, staffing and training standards, quality improvement methods, data analytics, and other enterprise-wide internal systems to serve their beneficiary members consistently.

- ***Untenable Number of Variations*****?** We are concerned that, as the number of versions for Model of Care state-specific care coordination requirements grows, this could potentially expand to 50 versions of MOC requirements. Currently the NCQA reviews and scores all MOCs on behalf of CMS. Therefore, we'd ask CMS to create and maintain a national MOC federal-state repository updated annually that would identify the State-specific additional requirements over and above the national/federal MOC guidelines. This would need to be searchable and organized by element and factor and domain as set forth in the MOC national guideline template. A searchable database platform would allow states and plans (particularly those that serve beneficiaries in multiple states) to more easily track state specific MOC additions and stay in compliance. It would also help safeguard from states applying requirements that run counter to national requirements. The plans that serve people in more than one state would need such information in a timely and accessible format. We note that the more each state individualizes the MOC requirements, the more this moves away from one national standard for Medicare

beneficiaries and adds to complexity for plans, providers, and beneficiaries. This could quickly become untenable.

- ***National Crosswalk between State and Federal Requirements*** - Toward that end we recommend creating a national repository, cross-walking state and federal requirements including MOC and quality measures/methods—for clarity, transparency, training, efficiency, and quality improvement toward the goal of making this more viable as it is scaled nationally.

3. SPECIFIC COMMENTS ON PRA NOTICE PROPOSED CHANGES

With those overall recommendations as our foundation, we provide specific comments on the changes outlined in this Notice and the corresponding materials:

- **Ensure Exact Match on Language** - ***Please be sure to check that the final wording on policy changes around MOC submission requirements are also exactly and simultaneously made in MOC scoring guidelines, NCQA training materials for reviewers, and MOC audit protocols.*** These should all be identical to avoid confusion or conflicting policy language.

- **MOC 1A – Description of the Overall SNP Population and the Most Vulnerable Enrollees –** ***We recommend some further language changes to clarify and focus this section.*** We see the potential for unnecessary burden and duplication. First, for health plan that have multiple SNP types in its H# contract (including more than one D-SNP or SNP type) where the state does not require a separate contract for each D-SNP, how would plans comply and address this section without confusing the reader, particularly regarding the request for the plan to describe the benefit structure and how care is coordinated?

  As we understand it, this factor is intended for the plan to *describe the characteristics of their enrolled population and sub-groups (most vulnerable) within that enrolled population.* The focus is not or should not be on the benefit structure pertaining to Medicaid. No reason is given in the supporting materials matrix for this change, nor is a burden assessment offered. We believe the burden could be substantial if the plan offers multiple SNP types.

  We request that CMS re-examine the scope of this and recommend that this factor focus only on having the health plan provide information on the population and sub-groups, rather than the benefit structures.

Second, there is *duplication with other sections of the MOC*, particularly in asking about "how care is coordinated." That is handled elsewhere in MOC 2 and therefore the statement should be removed from this factor.

- **MOC 2A – Staff Structure:** While it seems that CMS intended to remove the requirement to have health plans describe employed and contracted staff who perform administrative functions from this MOC factor, this is still ambiguous.

  We 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. The ambiguity comes from the disconnect from the broad introductory language and the specific language later. The introductory language is broad and reads: "Fully define the SNP staff roles and responsibilities for both employed and contracted staff, *across all health plan functions that directly or indirectly affect care coordination. This includes but is not limited to* the identification and detailed explanation of staff that perform clinical functions (e.g., direct enrollee care and education, CC, pharmacy consultation, BH counseling, etc.) and staff that perform clinical oversight functions." However, the other wording refers to only describing staff *with clinical functions and oversight of those clinical functions*. This needs to be further clarified.

- **MOC 2C – Face-to-Face Encounter:** This new language proposed raises several questions and may impact the relationship between provider and patient/enrolled member. The new language states that SNPs must *verify the enrollee has granted consent to the face-to-face encounter*, but this raises additional questions and concerns when that person conducting the face-to-face encounter is a non-plan employee or provider.

  For example, since enrollees meet with their primary care or other provider as part of a clinic or wellness visit when the information is obtained and documented, does this policy mean that physicians have to gather consent to meet and share some kind of consent form/documentation with the health plan? How would this work operationally? What if they consent to the face-to-face visit with their provider, but not to sharing the information with the health plan?

  We're concerned about this new language that says SNPs must describe how they verify that the enrollee has granted consent prior to the face-to-face encounter. This seems an unnecessary step and could cause confusion and/or duplication if another person has to conduct an additional face-to-face encounter, even if one has already been done, but the documentation is not given to the health plan. ***We recommend taking a second look at this and, at least, clarifying the language around consent—who, what, in what circumstances.***

- **MOC 3C – Provider MOC Training:**

- ***The language change here is ambiguous/unclear; we recommend clarification***. What was CMS's intent changing the term to "requiring training for 'provider staff'" instead of "providers?" They note "MOC training requirements in this section now target provider staff rather than direct care provider staff. This is aimed at decreasing provider burden." These terms need to be better defined. Does "provider" mean a clinic nurse? What about the clinic manager/administrator who does not directly see patients? We assume that if the person is not directly involved in working 1:1 with the enrollee they do not need to go through the MOC training. Please specify definition of terms to differentiate between "provider staff" and "direct care provider staff" with examples.
- Once these individuals are defined, ***please use the same language in the Model of Care scoring guidelines, MOC submission requirements, NCQA review training, and CMS MOC audit protocol and guidance.***
- ***We also recommend removing "initial and annual" language from this section and from the staff MOC training section*** (MOC 2A), given clarification by CMS at recent CMS/NCQA CY2026 MOC Training session. At that time CMS clarified that SNPs ***only need to train on the current MOC***, meaning if a D-SNP or I-SNP has a 3-year approval and does not make any updates to the MOC during that approval period (no redline submissions), staff and providers only need to be trained once on that MOC rather than annually on the same MOC. This is a welcome change.
- To remain consistent with the CY2026 MOC Scoring Guidelines that don't reference "initial and annual" training in either MOC 2A (staff MOC training) or MOC 3C (provider MOC training), ***this language needs to be changed in these submission requirements. Please also make this change in any MOC audit protocols to ensure consistency.***

4. BURDEN ESTIMATES

In this PRA Notice, CMS indicates it is adjusting its estimates on the MOC submission volumes in HPMS, from 273 to 410 for initial submissions, from 14 to 15 for resubmissions, and from 139 to 150 for off-cycle submissions. CMS has also adjusted the number of SNPs tracking face-to-face encounters from 734 to 1340. Lastly, CMS is including a new burden related to the D-SNP Questionnaire, which they estimate is an additional 1-hour burden for 173 D-SNPs.

CMS further estimates that the MOC will take six hours of a nurse's time to complete.

SNPA Comments: ***The burden and impact of these regulations are profoundly underestimated. We recommend using our analysis and information gathered from special needs health plans on the actual time it takes and the cost burden estimates.***

The estimate of the time and personnel involved in writing, reviewing, and submitting a Model of Care, particularly for a new submission are widely off—by a magnitude of more than 70. According to feedback from special needs plans, the Model of Care development, writing, review, and revisions, together with the submission process represents a minimum of 450 hours of health plan personnel time per Model of Care submitted (estimates of total time range from 450 hours to 600 hours).

Special needs health plans that are members of the SNP Alliance (representing almost 70% of SNP enrollment) have shared the processes and extensive input needed to put together their Model of Care, review it, submit it, and monitor it over the approval period. The Model of Care personnel investment goes much beyond a single nurse providing 6 hours of time. This is not about writing a document. It is an enterprise-wide endeavor around care coordination and related practices for special needs populations.

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.

The effort begins in the fall of the year prior to submission. Each subject matter expert needs to weigh in and address the respective MOC factors over which they have jurisdiction and/or responsibility. That is then compared to current procedures to affirm/check. Plans describe an internal MOC workgroup that shepherds the writing and integrates the information. Plans describe the processes and action steps to get the information organized, write the description, and then shepherd an internal review process across departments to check that the written description corresponds to actual practices. Lead personnel have shared that “the staffing chart, roles, and descriptions alone can take hours.” When the MOC is fully drafted, then it must go through a final internal review and approval process before it is finally submitted through the HPMS portal.

Even after submission, the SNP's care coordination processes must be monitored. When changes are needed—due to staffing, reorganization, state mandates, changes in provider actions, or other environmental factors—then the MOC workgroup needs to reassemble to discuss whether the change is "substantial" trigging the need for an off-cycle submission. This is very time-consuming.

Table 1. Revised Time and Cost Burden Estimates – *Per SNP contract*					
National Occupational Mean Hourly Wage and Adjusted Hourly Wage Occupation Title and expected hours for the MOC	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)	Total Labor cost for this occupation personnel
Registered nurse, 400 hours	29-1141	45.42	45.42	90.94	$36,376
Health Information Technologist, 25 hours	29-9021	33.78	11.82	45.60	$1,140
Medical and Health Services Manager, 25 hours	11-9111	64.64	22.62	86.26	$2,157
Total cost per MOC submission for each SNP contract:					***$39,673***

The burden estimates by the federal government need to reflect the actual time the MOC takes and include the costs of a variety of personnel involved, in order to properly account for costs to the health plan. See Table 1.

RECOMMENDATIONS on Burden Estimate Recalculations

Revise Administrative Time and Cost Burden Estimates - ***We recommend revising the estimated administrative time to be at least 450 hours***. The estimate used of 6 hours of a nurse is widely off-base. It represents only a tiny fraction of actual time to prepare, review, and submit a Model of Care. Therefore, we checked with SNPs and recalculated the burden estimate with updated personnel hours and cost estimates as follows:

Using the lower estimate of 450 hours and $39,673 per SNP for each full MOC submission, in the aggregate this would represent 18,450 hours (for 410 SNPs) at a cost borne by special needs plans of over $16.2 million (410 SNPs x $39,673 = $16,265,930).

Regarding resubmissions, the time for revising the MOC is also underestimated in this PRA Notice. ***We recommend using an estimate of 30 RN hours ($2,782) and 10 Medical/Health Services Manager hours ($862), for a total cost per resubmission of $3,644.*** The 15 SNPs would then experience a combined cost of $54,660. Therefore, the overall cost to special needs plans annually is more than $16.3 million ($16,265,930 + $54,600 = $16,320,590).

Regarding the questionnaire, we recommend elimination or substantial changes, therefore we did not calculate a burden estimate. See additional comments provided.

5. COMMENTS ON PROPOSED D-SNP QUESTIONNAIRE

SNPA Comments – We find that the proposed D-SNP questionnaire is duplicative of many items already specified in the MOC or already known to CMS through State Medicaid contracting information. In addition, we find that several items are outside the scope of the Model of Care statutory language and purpose. ***Our recommendations:***

- ***Delete this questionnaire and set up a separate survey process*** that is specific to the areas outside of the MOC factors and elements already included by D-SNPs in their MOC submissions. Some of the questions in this proposed questionnaire are around state Medicaid contracting requirements that affect the D-SNP. CMS should already be able to access the information through their review of SMACs for D-SNPs.

- ***Use the information that is already provided by the D-SNP in their MOC***, as they follow the MOC guidelines (there is overlap and duplication where the same items are already described in the MOC). The MOC is already thorough and comprehensive. It is inefficient to have to repeat the information again.

Attachment B – D-SNP Questionnaire - *Scope and Purpose Unclear - Duplicative*: The questionnaire includes only a handful of questions that are D-SNP-specific and most items are already covered in the MOC narrative. Many of the questions seem duplicative. This D-SNP questionnaire seems outside of the scope statutory requirements for SNPs to write and submit for review a Model of Care following consistent MOC guidelines. Please clarify the purpose of this.

- We recommend that CMS eliminate this questionnaire and use the MOC information and SMAC information as the source documents to answer these questions.
- At the very least, the questionnaire could be much shorter, with removal of Questions 1 through 8, 10, and 14. See below:
    - Qs 1-6 & Q8: All of these questions pertain to general MOC requirements that are not specific to D-SNPs and are already addressed in MOC Element 2 (e.g., HRA administration method, ICP updates, ICT communication). This is redundant and inefficient to require plans to re-state what is already in the MOC.
    - Q7: This question about Health Risk Assessment is also not specific to D-SNPs - it asks about how D-SNPs make referrals to community resources when the HRA identifies food, housing, or transportation needs. This is already addressed in proposed updates to MOC 1A that require a description of how the SNP addresses enrollees' social determinant of health needs. It also could be incorporated into MOC2B where SNPs must describe how HRA results are addressed in the ICP.
    - Q10: Community partnerships are already addressed in MOC 1B.

    - Q14: This factor is already addressed in the MOC.

- Where there are state-specific questions, such as Q 11, 12 (coordinating with state-specific HRA requirements), and Q 13, 15 (authorization, coverage, and tracking of state Medicaid services), we believe that CMS could obtain these answers directly from the state Medicaid contracts with D-SNPs. These questions seem outside of the scope of Model of Care statutory requirements and policy. Furthermore, the answers are not easily contained in the multiple choice options given. This needs to be more thoroughly understood by the questionnaire developer before distributing a survey that would raise more questions than provide answers.