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To: Centers for Medicare and Medicaid Services
Submitted electronically via: regulations.gov

From: Gayle Coyle-Ikemoto
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Date: January 7, 2019

Re: Off-cycle Submission of Summaries of Model of Care (MOC) Changes

Attached are comments regarding the Off-cycle Submission of Summaries of Model of Care (MOC) Changes (CMS-10565).

Off-cycle Submission of Summaries of Model of Care (MOC) Changes

Comments Submitted by
UnitedHealthcare
1/7/19

UnitedHealthcare (United) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) request for comments regarding submissions of Model of Cares for Medicare Advantages Special Needs Plans (SNP). We appreciate this opportunity to have this dialogue with CMS regarding ways to enhance the quality, utility, and clarity of the information to be collected. United believes this dialogue creates the opportunity to align and strengthen the Model of Care submission and review process.

United believes that the submission, review and approval process for all MOCs should be consistent across all SNP types. As Chronic Special Needs Plans (CSNP) must now have an annual submission and review process, it makes sense to apply the same requirement to Institutional Special Needs Plans (ISNP) and Dual Eligible Special Needs Plans (DSNP) MOCs. This change would allow health plans to implement improvements in technology, processes, and the changing needs of their SNP beneficiaries. In order to reduce burden and increase efficiency of an annual submission, United recommends the following changes.

Our first recommendation focuses on the submission due date. Currently, MOC submissions are due in February. This means, health plans are submitting MOCs for review of contracts that may not ever be available to members. Moving the submission date until after CMS sends qualification determinations to health plans would eliminate unnecessary work for CMS and NCQA. In addition, the current submission date does not allow for more integrated DSNPs to include language that states may require be in the MOC. It has been our experience that if a state will require specific information for the corresponding MOC it will be communicated through the annual State Medicaid Agency Contract (SMAC) process. In fact, in the Draft Calendar Year 2018 Call Letter, CMS instructed states to include such language in the SMAC. As SMAC submissions are not due until the first week of July, plans may not have the required language from the state until then. Based on these two factors UHG recommends that CMS change the annual MOC submission deadline to mid-July.

Our second recommendation focuses on the review process itself. Currently NCQA conducts a full review of initial MOCs and those at the end of their approval cycle with no comparison of the two MOCs and the changes that may have been made. United recommends that all MOCs be submitted ANNUALLY using the existing off-cycle review process for MOCs that previously scored 75% or better. The benefit of this is the elimination of the off-cycle process and NCQA could review changes and improvements only. This change would provide greater consistency with established MOC processes and reduce the burden of an annual review of all MOCs.

Our final recommendation focuses on the information to be collected. There has been discussions in the industry that CMS auditors expect all enrollees to have a standalone Individual Care Plan (ICP) and that it is inferred in the existing guidance that this should include beneficiaries that the health plan was unable to reach. Currently the Medicare Managed Care Guidelines state that the ICP should contain the beneficiary's self-management goals and objectives and their personal healthcare preferences. Beneficiary participation is also supported by Medicaid regulations which stress person-centered goals created with enrollee participation (§438.208(c)(3)(i) and the 2018 SNP-MOC Audit Protocol that asks – "Did the sponsor facilitate beneficiary and/or caregiver participation when developing the beneficiary's ICP?" The beneficiary's participation in the ICP is vital to the success in reaching the measurable goals contained within their ICP. If the beneficiary chooses not to engage in the Health Risk Assessment (HRA),

the health plan should respect their wishes and encourage them to speak with their primary care provider. As such, United recommends CMS modify the MOC guidance to state that ICP is not required for beneficiaries who do not complete an HRA.

Respectfully,

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