Attachment A
Responses to Comments Received
CY 2022 MMP-SARAG and MMPCC Protocols
and MMPCC Supplemental Questionnaire

GENERAL COMMENTS

Comment 1: One commenter asked for clarification on the number of cases with data integrity issues during universe integrity testing that would result in universe resubmission.

Response 1: CMS will review all cases selected or documentation received for universe integrity testing, as identified in the Method of Evaluation section of each program area protocol. The integrity of the universe will be questioned if the sample case(s) or documentation reviewed during the audit do not match the data provided in the universe.

CMS Action 1: No changes were made to the protocol in response to this comment.

MMPCC PROGRAM AREA

Comment 2: Two commenters asked for clarification on *Was an Interdisciplinary Care Team (ICT) created/identified?* field in the Medicare-Medicare Plans Enrollees (MMPE) record layout, including whether CMS is requesting the names and/or disciplines of ICT members and what is meant by "created/identified".

Response 2: Within the *Was an Interdisciplinary Care Team (ICT) created/identified?* field of the MMPE record layout, CMS is collecting data as to whether an ICT has been assigned to the enrollee. Sponsoring organizations are instructed to enter 'Yes' if the enrollee has an ICT assigned and 'No' if the enrollee does not have an ICT assigned. CMS is not trying to identify more complex cases or specific ICT disciplines.

CMS Action 2: No changes were made to the protocol in response to this comment.

Comment 3: Two commenters provided feedback on when and how to populate the MMP HRA Timeliness Impact Analysis (M_HRAT-IA) record layout. One commenter asked for clarification on whether an impact analysis will be requested for one untimely Initial Health Risk Assessment (IHRA) or one untimely Annual Health Risk Assessment (AHRA). Another commenter recommended that rather than Sponsoring organizations completing M_HRAT-IA for all enrollees without a completed or untimely HRA, CMS should conduct this review through sample review.

Response 3: The M_HRAT-IA record layout will be requested if a Sponsoring organization's timeliness calculation falls below a threshold (as specified by CMS) and will only be used to mitigate any assessment deemed untimely, such as if the Sponsoring organization was unable to contact the enrollee per the three-way contract requirements.

CMS Action 3: No changes were made to the protocol in response to this comment.

Comment 4: One commenter questioned whether Care Coordination timeliness will be calculated at the contract or the universe level.

Response 4: Care Coordination timeliness is calculated at the universe level in accordance with the timeframes in the applicable demonstration three-way contract requirements.

CMS Action 4: No changes were made to the protocol in response to this comment.

Comment 5: One commenter asked for clarification on whether MMP Care Coordination Impact Analysis (M_CC-IA) record layout Column IDs W through Z are requesting information on whether an ICT meeting was conducted or a care team is documented within the Care Plan.

Response 5: CMS is confirming whether an ICT was created. *If Was an ICT created?* (Column ID W) was 'Yes' that an ICT was created, then the response for *If an ICT was created, was the ICT involved in creating and updating the enrollee's ICP?* (Column ID X) would be 'Yes' if there is documentation that the ICT was involved in creating and updating the ICP. *For Is there evidence that providers (PCPs, specialists, etc.) with appropriate clinical disciplines per the applicable demonstration three-way contract and consistent with enrollee preferences were invited to participate on the enrollee's ICT?* (Column ID Y) and *Did all members of enrollee's ICT receive training as required by the applicable demonstration three-way contract*? (Column ID Z), if the ICT was formed, respond 'Yes' if there is evidence that the appropriate clinical disciplines were invited to participate on the ICT and all members received required training.

CMS Action 5: No changes were made to the protocol in response to this comment.

Comment 6: One commenter asked if CMS can provide additional elaboration on the elements being audited to demonstrate appropriate fulfillment of care transition for the Care Coordination compliance standard 1.16.

Response 6: CMS has provided examples of the types of accepted documentation that may demonstrate compliance with Care Coordination compliance standard 1.16. However, plans are not limited to these examples and may submit additional documentation that demonstrates compliance.

CMS Action 6: No changes were made to the protocol in response to this comment.

Comment 7: One commenter asked if the MMPE field *Was an Interdisciplinary Care Team (ICT) created/identified?* should only be populated with 'Yes' if the ICT took place within a certain time period.

Response 7: Respond 'Yes' in the *Was an Interdisciplinary Care Team (ICT) created/identified?* field only if an ICT was created/identified, regardless of timeframe.

CMS Action 7: No changes were made to the protocol in response to this comment.

Comment 8: One commenter asked if an ICT created/identified during a member's prior enrollment period should be included in the universe data.

Response 8: Only the ICT created/identified during the member's current enrollment period should be reported.

CMS Action 8: No changes were made to the protocol in response to this comment.

Comment 9: One commenter identified an inconsistency between *Did the enrollee experience a change in health status that met the requirement for a reassessment per the applicable demonstration three-way contract during the impact analysis request period?* (Column ID K) and *If enrollee experienced a hospitalization or other change in health status during the impact analysis request period, was the ICP updated?* (Column ID U) in the M_CC-IA record layout and requested the word "hospitalization" be added to Column ID K.

Response 9: CMS thanks the commenter for identifying the inconsistencies between Column ID K and Column ID U. As a result of this, CMS updated Column ID K and also identified that Column ID L *If the enrollee experienced a change in health status that met the requirement for a reassessment per the applicable demonstration three-way contract during the impact analysis period, was the reassessment conducted?* should be updated to include "hospitalization or other", as reflected in Column ID U.

CMS Action 9: CMS updated Column ID K and Column ID L of the protocol to include the words "hospitalization or other".

Comment 10: One commenter pointed out that the MMPCC Supplemental Questionnaire numbering is incorrect and skipped a number.

Response 10: CMS thanks the commenter for pointing out this error. CMS has identified that the following question was inadvertently left out of the questionnaire: "Please identify first tier, downstream, and related entities (FDRs) that you contract with that conduct MMP related care coordination activities, such as administering HRAs or outreach" and has added it back to match the SNPCC Supplemental Questionnaire.

CMS Action 10: CMS updated the MMPCC Supplemental Questionnaire and added question 10 "Please identify first tier, downstream, and related entities (FDRs) that you contract with that conduct MMP related care coordination activities, such as administering HRAs or outreach".

Comment 11: One commenter expressed concern regarding the timing of the sample selection of 10 cases one hour prior to the scheduled integrity webinar and that timing may be an issue when multiple FDRs must be coordinated.

Response 11: CMS believes that providing the samples to the Sponsoring organization one hour prior to the integrity testing webinar will provide sufficient time.

CMS Action 11: No changes were made to the protocol in response to this comment.

MMP-SARAG PROGRAM AREA

Comment 12: Two commenters asked if CMS expects Sponsoring organizations to include claims that are pending a decision in their MMP Provider Payment Requests and Appeals (M_PYMT) universe submission.

Response 12: CMS no longer requires Sponsoring organizations to include requests that are pending a decision within any of their universe submissions.

CMS Action 12: No changes were made to the protocol in response to this comment.

Comment 13: Three commenters asked questions about direct member reimbursement requests, including whether they should be included in M_PYMT and how the table should be populated in specific scenarios involving member reimbursements.

Response 13: M_PYMT does not include direct member reimbursement requests and only includes non-contract provider payment requests and non-contract provider payment appeals.

CMS Action 13: No changes were made to the protocol in response to this comment.

Comment 14: Two commenters asked why Service Coordinator was removed from the description for the *Who made the request?* field.

Response 14: We removed Service Coordinator from the *Who made the request?* field to align with the Part C Organization Determinations, Appeals and Grievances (ODAG) audit protocol. If the Service Coordinator receives the request from the enrollee, then the response to the *Who made the request?* field would be "E" for enrollee. If the enrollee's representative or purported representative made the request to the Service Coordinator, then the response to the *Who made the request?* field would be "ER" for enrollee representative.

CMS Action 14: No changes were made to the protocol in response to this comment.

Comment 15: One commenter asked for clarification on the timeliness standard CMS will apply for Part B drug service authorization requests.

Response 15: Per timeliness compliance standard 1.2, CMS will conduct the timeliness test for standard service authorization requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request in accordance with 42 CFR 422.568(b). Per timeliness compliance standard 1.4, CMS will conduct the timeliness test for expedited service authorization requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 24 hours after receipt of the request in accordance with 42 CFR 422.572(a) and 42 CFR 422.572(c).

CMS Action 15: No changes were made to the protocol in response to this comment.

Comment 16: One commenter identified a typo in the MMP Standard and Expedited Service Authorization Requests (M_SAR) record layout, Column ID IL *AOR/Equivalent notice Receipt Tim*e, and noted that the Column should be "L" rather than "IL".

Response 16: We thank the commenter for identifying the typo. The protocol has been updated.

CMS Action 16: M_SAR field *AOR/Equivalent notice Receipt Time* Column ID "IL" has been changed to "L".

Comment 17: One commenter asked for clarification on whether the M_PYMT *Date written notification provided to provider* field should be populated with the date the written notification was mailed.

Response 17: Sponsoring organizations may enter the date the notification was deposited in the courier drop box or external outgoing mail receptacle or enter 'None' if no notification was sent to the provider for the M_PYMT *Date written notification provided to provider* field.

CMS Action 17: No changes were made to the protocol in response to this comment.

Comment 18: One commenter asked for clarification on whether Part B drug claims should be included in the M_PYMT universe only if the claims were initially processed under Part C, or whether Part B drug claims that were initially denied under Part D and subsequently processed under Part C should also be included.

Response 18: Sponsoring organizations must include Part B drug requests in SARAG universes based on the way the request was processed. If the Sponsoring organization processed the Part B drug claim and issued payment or a denial notification under Part C, then the case would be included in the M_PYMT universe.

CMS Action 18: No changes were made to the protocol in response to this comment.

Comment 19: One commenter questioned whether SARAG timeliness will be calculated at the contract level or at the universe level per the updated protocol.

Response 19: SARAG timeliness is calculated at the universe level in accordance with the timeframes in the demonstration three-way contract requirements.

CMS Action 19: No changes were made to this protocol.

Comment 20: One commenter asked for clarification on how CMS will evaluate timeliness at the universe level for requests that include both Part C medical and Part B drug (primary or ancillary) requests.

Response 20: CMS will test timeliness according to the Part B drug timeframes when a request for a Part B drug is primary. Sponsoring organizations should enter 'Y' in the *Part B Drug Request?* field to indicate pre-service requests that were processed under the Part B drug timeframes.

CMS Action 20: No changes were made to the protocol in response to this comment.

Comment 21: One commenter recommended a split of the issue description and type of service in the *Issue description and type of service* field to facilitate in the monitoring of universes.

Response 21: We appreciate the comment but aligned the SARAG protocol with the ODAG protocol, which includes the issue description and type of service in one field. We think this will reduce burden for plans.

CMS Action 21: No changes were made to the protocol in response to this comment.

Comment 22: One commenter asked if point of sale (POS) pharmacy claims, claims from non-contract pharmacies, and/or contract provider claims and payment appeals should be included in M_PYMT.

Response 22: Drugs processed as paid or rejected at the point of sale should not be included in M_PYMT. CMS confirms, as per the instructions for the M_PYMT record layout, Sponsoring organizations should include all claims and payment appeals the Sponsoring organization approved, denied, or dismissed from non-contract providers and non-contract pharmacies during the universe request period. Contract provider claims and payment appeals should not be in M_PYMT.

CMS Action 22: No changes were made to the protocol in response to this comment.

Comment 23: One commenter asked for clarification or a definition of the term "retrospective review".

Response 23: For audit purposes, retrospective reviews do not qualify as organization determinations and therefore should be excluded from the universe data. Only a Sponsoring organization's decision on coverage that is effectuated as approved/paid or denied should be in the universe submission. Any circumstance where a coverage decision is made after the services have been rendered (retrospective reviews) does not qualify as a coverage decision until the claim is approved or denied.

CMS Action 23: No changes were made to the protocol in response to this comment.

Comment 24: One commenter asked for clarification on which fields may be reviewed to verify accuracy of data during universe integrity testing and recommended that CMS verify dates and times provided in the universe submission for universe integrity testing.

Response 24: At a minimum, CMS will verify the accuracy of dates and times provided in each universe during integrity testing. However, CMS declines to make the change recommended by the commenter. CMS and Sponsoring organizations have occasionally identified issues within fields (other than those requesting dates and times) that would result in inaccurate timeliness testing results. Therefore, CMS maintains it needs flexibility in the fields it reviews to verify accuracy of the data that would be precluded if spelled out in the protocol.

CMS Action 24: No changes were made to the protocol in response to this comment.

Comment 25: One commenter asked for clarification regarding the denial notification standard and how CMS defines clinical accuracy and what documentation may be used to determine this.

Response 25: To determine clinical accuracy, CMS ensures Sponsoring organizations adhere to all National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and, in the instance of no existing NCD, LCD, or guidance on coverage in original Medicare manuals exist, a Sponsoring organization's own internal coverage policies. CMS relies on the information a Sponsoring organization received and reviewed in making its decision to determine compliance.

CMS Action 25: No changes were made to this protocol in response to this comment.

Comment 26:   One commenter asked CMS why the following description language in the *Part B Drug Request?* field was not included in the MMP Standard and Expedited Service Authorization Requests (M_SAR)and MMP Standard and Expedited Plan Level Appeals (M_PLA) universes: "…or Part D drug that is part of a Sponsor's step therapy requirement for a Part B drug."

Response 26: This *Part B Drug Request?* field is aligned with the corresponding ODAG field. Sponsoring organizations should enter 'Y' if the request for a Part B drug is primary and processed by their Part C line of business.

CMS Action 26: No changes were made to the protocol in response to this comment.

Comment 27: One commenter suggested that responding 'None' to the *Date appeal effectuated in the system* field in the M_PLA universe would be appropriate if the appeal was not yet effectuated.

Response 27: CMS thanks for commenter for their suggestion of responding 'None' would be appropriate if the appeal was not yet effectuated and believe that adopting this change will provide clarification.

CMS Action 27: CMS updated the Descriptions for the *Date/Time appeal effectuated in the system* fields to reflect that responding 'None' would be appropriate if the appealed service was not effectuated, regardless of whether it was dismissed, denied, or approved but not authorized.

Comment 28: One commenter questioned how to respond to the *Was the initial claim denied for medical necessity?* field in M_PYMT for corrected claims with different reasons for denial that ultimately denied for medical necessity.

Response 28: If the initial claim determination was denied for lack of medical necessity, then respond 'Y' for Yes to the *Was the initial claim denied for medical necessity?* field.

CMS Action 28: No changes were made to the protocol in response to this comment.

Comment 29: One commenter asked for clarification on how to report appeals if they contain both Medicaid only and Medicare covered services in M_PMYT.

Response 29: CMS clarifies the Sponsoring organization should respond 'Y' for Yes in the *Is the requested service a Medicaid-only service?* field if the appeal includes only Medicaid-only services.

CMS Action 29: No changes were made to the protocol in response to this comment.

Comment 30: One commenter suggested to exclude Value Added Services from the data request in order to align with the ODAG protocol.

Response 30: CMS thanks the commenter for noting this inconsistency and believes that adopting the suggested change will bring the SARAG protocol into alignment with the ODAG protocol.

CMS Action 30: The M_SAR, M_PLA, and M_PYMT record layout criteria were updated to exclude value added items and services, which aligns with the ODAG protocol.

Comment 31: One commenter suggested including cases in the M_SAR, M_PLA, M_PYMT, and M_GRV universes based on determinations or notifications that "should have been made" during the review period but were not. The commenter feels that without including these cases, CMS is eliminating untimely cases from the timeliness review.

Response 31: CMS no longer requires Sponsoring organizations to include requests based on when the determination or notification "should have been made". CMS believes that it will still be able to assess timeliness compliance effectively without the inclusion of these requests.

CMS Action 31: No changes were made to the protocol in response to this comment.

Comment 32: One commenter recommended that each issue identified in a single grievance be submitted on multiple lines in M_GRV to ease burden on the Sponsoring organization.

Response 32: CMS does not expect Sponsoring organizations to separate each issue involved in a grievance as separate line items in the universe and believes it would be more burdensome for all Sponsoring organizations to implement the commenter's recommended change at this time. Grievances with multiple issues should be listed as a single line item in the M_GRV universe unless the Sponsoring organization treated the issues individually and issued separate notifications.

CMS Action 32: No changes were made to the protocol in response to this comment.