Justification for Emergency PRA Clearance for Medicare Advantage
2008 Part C Application Revision/Automation
OCN: 0938-0935.

Subject:
The Center for Beneficiary Choices (CBC), Medicare Advantage Group (MAG), Division of Qualification and Plan Management (DQPM) request OMB approval for Paperwork Reduction Act (PRA) package clearance under an emergency approval process under 5 CFR 1320.13 to accommodate the statutorily mandated timelines under the MMA.

This package contains; **CMS -10117, CMS-10118, CMS-10119, CMS- 10135, CMS-10136,** Medicare Advantage (MA) Application Coordinated Care Plans (**CMS-10117**), Medicare Advantage (MA) Application Private Fee-For-Service Plans (**CMS-10118**); Medicare Advantage (MA) Application Regional PPO Plans (**CMS-10119**); Medicare Advantage (MA) Application Service Area Expansion (SAE) for Coordinated Care Plans: Private Fee Service Plans (**CMS-10135**); ~~and~~ Medical Savings Account Plans (**CMS-10136**), and Employer Group Waiver Plans Application(**CMS-XXXXX**).

Background:
The Centers for Beneficiary Choices (CBC), Medicare Advantage Group (MAG) is requesting OMB approval for the Medicare Advantage (MA) Applications Automation to meet regulatory requirements contained in 42 CFR Section 422. In enacting Title II of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173), the Congress initiated a major Federal effort to modernize Medicare managed care.

Through this initiative, the Congress changed the name of Medicare's managed care program to the Medicare Advantage (MA) Program, making some fundamental changes while retaining other key features of the Medicare + Choice program which it replaced. The new features of the MA program were intended to encourage organizations to offer a greater selection of health plan options for Medicare beneficiaries. In implementing the MA Program, the Centers for Medicare & Medicaid Services (CMS) developed separate application formats to allow it to ensure that organizations were in compliance with the requirements for the different plan types introduced under MA and to provide potential applicants with efficient application vehicles. These application types are as follows:

CMS-10117
Organizations that may use this MA Coordinated Care Plan Initial application are: Health Maintenance Organizations (HMOs); State Licensed Provider-Sponsored Organizations (PSOs), and other State licensed risk-bearing entities eligible to offer health benefits coverage. Preferred Non-state licensed Provider Sponsored Organizations (PSOs) are not eligible to apply to offer MA Coordinated Care Plans. Regional Preferred Provider Organizations (Regional PPO), Private Fee-For-Service (PFFS), and Medical Savings Account (MSA) plans may not use this application. PFFS, Regional PPO, and MSA plans must use the applications specific to that type of MA plan.

CMS-10118
An organization may use this MA Initial PFFS application to seek to enter into an MA PFFS agreement with CMS. The MA Program has given PFFS plans the option of adding a Prescription Drug Benefit.

CMS-10119
An organization may use this MA Initial application to seek to become a Regional PPO, providing Medicare covered services throughout various regions established under the MA Program. The Regional PPO plan type was one of the program changes enacted under the MMA of 2003.

CMS-10135
Organizations that may use this MA Service Area Expansion (SAE) application are HMOs; State Licensed PSOs; PPOs and other State licensed risk-bearing entities eligible to offer Medicare health benefits coverage and who already have an approved coordinated care plan contract with CMS. PFFS plans and MSA plans may also use this application to request an expansion of their service area. Regional PPO plans may not use this application.

CMS-10136
An organization would use this application to apply to enter into a MA MSA plan contract with CMS. The MSA plan option was initially created under the Balanced Balance Budget Act of 1997 (BBA) and reestablished under the under the MMA of 2003 after the BBA authority expired in 2002.-

CMS-XXXX
An organization would use this application to apply to offer "800 series" employer/union-only group waiver plans under a contract number for which it also offers an individual market Medicare Advantage plan.

Justification:
Anticipated Revisions

The Social Security Act (the ACT) requires that applicant organizations, offering Part C benefits for January 2008 be contracted with CMS for their approved service area with open enrollment beginning on November 15, 2007.

Further, the Act requires the submission of Part C benefit bids from applicant organizations by the first Monday in June of 2007 (June 4). In order to meet MMA requirements, key preceding events must occur (see "Key Preceding Events" table). If these events do not occur according to the statutorily mandated timeline, other statutory requirements will not be met.

The applications being filed under this review contain substantive changes in the material submitted by -Applicants seeking to offer a Special Needs Plan (SNP) as part of the Part C application. These changes are precipitated by significant policy decisions regarding the types of SNPs that will be considered for 2008.

The applications for new contracts and for service area expansions have been updated to

reference CMS guidance that was developed and released throughout CY 2006.

CMS anticipates- posting of all 2008 Part C Applications no later than January 16, 2007. In an effort to meet the proposed posting date, DQPM will need final approval for all 2008 Part C Applications, no later than December 12, 2006.

For the 2008 contract year, CMS is implementing several steps to reduce the person-hours necessary to complete the Part C solicitations. These steps include automating substantial portions of the Part C Plan solicitations within CMS' Health Plan Management System (HPMS) and streamlining key information previously requested by attachments. As a result of these steps, CMS must have the final language for the solicitation completed by early December. This timeline will provide CMS with the opportunity to ensure the appropriate systems testing has been completed and applicants are educated and trained in completing the solicitations within HPMS.

CMS has developed a schedule for release, comment and approval of the application that supports the challenging industry timeline. CMS must determine qualified applicants prior to the first Monday in June of 2007 (June 4). Key dates for the application process are provided in the following table. These applications will be announced and posted on www.Medicare.gov for public comment on November 7, 2006. This is approximately one month earlier than the Draft 2007 solicitations were posted for public comment; and will provide the industry with additional time to comment directly to CMS. In addition, comment availability will be made public through the CMS User Group and through release to the various trade associations that represent the Part C industry.

2008 APPLICATION REVIEW PROCESS	
Date	Milestone
October 20, 2006	CMS receive OMB emergency justification request approval.
November 3, 2006	Draft 2008 Part C Applications and Guideline sent to OGC
November 17, 2006	Comments due from OGC
November 27~~1~~, 2006	Complete PRA package due to OSORA
November 27, 2006	Draft 2008 Part C A~~a~~pplications and Guidelines ~~posted~~ sent to ~~by CMS for~~ industry for comment.
December 1, 2006	1. Submit notice of intent to apply to CMS 2. Request HPMS Access 3. Request CMS User ID and Password
~~November 14, 2006~~ December 8, 2006	Comments due to CMS on draft applications.
~~November 20, 2006~~ December 8, 2006	Notice and Link about Part C PRA collection posted in Federal Register~~Draft applications posted in the Federal Register~~.
~~November 28, 2006~~ December 22, 2006	Comments due from Federal Register posting.

~~December 12, 2006~~ January 5, 2007	CMS receive OMB emergency package approval
January 14, 2007	Final version of applications posted by CMS
March 12, 2007	Applications due
May/June 2007	CMS sends Part C contract eligibility determination to Applicants, based on review of application. Applicant's bids must still be negotiated in a separate process.

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