Comment#	Source Organization	Page Number	Section or Header	Organization Comment	Organization Suggestion (Insert, Delete, Revise)	CMS Action Taken
1	Florida Medicaid	34	A.3 Relationship of SNP Product to State Medicaid Services in the Event of Other Subsetting (specifically A.3.b.)	Draft application states that in addition to a list of excluded categories of beneficiaries, plans must submit the State's justifications for the exclusions. As discussed previously, it seems it may be more appropriate for the State to provide the justifications in the already required State letter under A.3.c.2., rather than the plans.	Consider Revising	REVISION TO SOLICITATION BASED ON COMMENT: CMS can't require States to provide directly the justification for excluded categories of beneficiaries. The organization is responsible for providing that information to CMS.The plan must obtain this information from the State. If the State does not want to provide the letter, the plan will not be able to obtain the subset.
2	Florida Medicaid	35	A.3.c.1.	In line with the comment above, recommend adding the requirement under c.1. that the State letter with justifications for exclusions be provided whether there is or is not a signed contract/agreement in place when the MA application is submitted. Typically, the contract/agreement with plans on the Medicaid side will not include justification details that CMS is requesting to approve subset requests.	Consider Revising	REVISION TO SOLICITATION BASED ON COMMENT: CMS requires justification from the State via the plan in order to approve the subset.
3	Florida Medicaid	35	A.3.c.2.	Florida is not certain whether the proposed July 2, 2007, deadline will be a problem, however greater flexibility in terms of what will be acceptable as evidence of an agreement is requested.	Consider Revising	REVISION TO SOLICITATION BASED ON COMMENT: Extend due date to Oct.1. CMS will require a contract addendum which would have the effect on not providing final bid approval until documentation is received.
4	Florida Medicaid	35	A.4.e.	This type of notification would be helpful and welcomed. Is CMS aware of where this notification will be sent? (State Medicaid Director, contact designated by the State, etc.?)	Comment/Question	REVISION TO SOLICITATION BASED ON COMMENT: Edit to read "State Medicaid Director"
5	Florida Medicaid	35	A.5. Exclusive versus Disproportionate Percentage SNPs	How many SNPs have been approved to serve disproportionate percentage to date?	Question	This is not addressed in the SNP application, however, CMS is working to develop policy on determining Disproportionate Share.
6	Florida Medicaid	36-38	A.7 SNP Model of Care	Is this portion of MA applications publicly available at any point? I'd assume it's proprietary, which leads me to believe that States may want to consider requiring plans on the Medicaid side to share this information with the State in addition to requesting Medicare Bid data.	Comment only	NO REVISION : CMS agrees and does not require an MAO to share proprietary information with the State.
7	SNP Alliance	N/A	N/A	We support direction of application to "keep the bar high", ensure that applicants understand that CMS has different expectations for SNPs and non-SNPs and require applicants to offer a well thought through plan for addressing special needs. We do have concerns about how the applications will be evaluated in the absence of specific criteria in areas such as models of care for frail elderly, adults with disabilities, enrollees with multiple chronic conditions and those at the end of life. Since thre is no statutory or regulatory basis for some of the information requested, there is no advance guidance to plans regarding CMS' expectations. It would be helpful to develop criteria for evaluation so that plans will have a better sense of CMS' expectations in designing their models. It also would be helpful to obtain clarification about how any new criteria or expectations would apply to existing SNPs. The SNP Alliance would appreciate the opportunity to review and comment on these SNP application evaluation criteria as well as policies related to how such criteria might be applied to existing SNPs.	Develop criteria for evaluation of SNP applications to provide plans guidance on CMS' expectations and to promote consistency in evaluating and approving SNP applications. Permit SNP Alliance and other SNPs the opportunity to comment on proposed criteria.	NO REVISION TO SOLICITATION: CMS can require applicants to demonstrate that they are providing specialized services targeted to meeting the needs of the special needs population they intend to serve. In addition, to describing the model of care for the SNP type (e.g., dual, institutional and/or chronic), CMS believes that within these populations the most complex to care for are the frail/disabled and beneficiaries with multiple chronic illnesses and who are at the end of life. Consequently, we also expect the models of care to incorporate specialized approaches to care and services for those groups - frail/disabled and beneficiaries with multiple chronic illnesses and who are at the end of life.
8	SNP Alliance	31	Sec, III: Key Definitions-Severe or disabling chronic condition	Please clarify that SNPs can target more than one chronic condition in each plan.	Insert at end of definition: "Applicants can apply to serve more than one condition or a cluster of conditions that commonly occur together under a single plan.	NO REVISION TO SOLICITATION -Application clearly allows for more than one disease category.
9	SNP Alliance	33	Sec. IV: Template for SNP SOLICITATION, line 4	The term "fully dually eligible" is more commonly referred to as "full benefit" dually eligible enrollees.	Replace ""fully dually eligible" with "full benefit dual eligible"	REVISION TO SOLICITATION BASED ON COMMENT.
10	SNP Alliance	P. 34, 40, 48	Sec. A.1.b, B.1.b, C.1.b - Number Assignment for each SNP Type	Replication of SNP applications for plans offering multiple product options may result in an unnecessary paperwork burden in some cases such as replication of information regarding provider networks, a paperwork requirement that is labor intensive.	Provide one set of HSD tables if the application is proposing to use the same provider network for all plans.	REVISION TO SOLICITATION BASED ON COMMENT. HSD tables are not required. Significant modification to the application have been made to eliminate duplication.

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11	SNP Alliance	p. 34	Sec. A.3.a and A.3.b- Relationship of SNP Product to State Medicaid Services	In it's comments on CMS subset policy for duals, the Alliance recommended, and CMS staff strongly concurred, that the justification for SNP subsets should focus on the population to be targeted, not the population to be excluded. The application is inconsistent with this direction. The focus on excluded subsets seems counterproductive to the purpose of the subset policy and it is not clear that states have a clearly articulated policy on why they exclude all populations except the target group in question. The focus on exclusion suggests that CMS continues to have questions about the legitimacy of allowing subsets.	Delete second sentence from A.3.a. Amend Sec. A.3.b to require applications to provide " the State's justification for the targeted subset and what benefits the state expects to realize from such an approach.	NO REVISION TO SOLICITATION : CMS' understanding of why some categories are excluded will help us in understand the limit requested on included categories.
12	SNP Alliance	p. 35	Sec. A.3.c.2	CMS stipulated that dual subsets only will be permitted in connection with state programs to integrate Medicare and Medicaid services. Dual SNPs offer a platform for promoting an integrated approach to health care for duals unavailable, heretofore, but only a handful of states have integrated programs. CMS staff offered assurances of flexibility in working with states and plans involved in developing new programs, recognizing that states in the development process may not be able to comply with tight MMA timeframes for the SNP application process. The July timeframes in the application do not demonstrate flexibility and could lead to a significant delay in access to subset products for beneficiaries in states with newly developing integration products.	We recommend that CMS delay the dates for signed state contracts and final decisions on "all decisions regarding the application process." We request that plans have until September 1 to obtain signed Medicaid contracts with the states and finalize SNP application decisions to provide states and plans additional time to develop new integrated programs. This date would still enable SNPs to sign 2008 CMS contracts. Further, we request that plans have the flexibility of initiating integrated product offerings later than January 1 of the contract year as long as they have a signed Medicaid contract by that date; i.e., that they have the flexibility of offering a Medicare only product effective January 1 and delaying implementation of the integrated product later in the year if their state is unable to implement the integrated program by January 1.	Same as Comment 3. Concerning integrated benefit packages becoming effective after January 1, MMA precludes that possibility. Bids and marketing material must reflect an offering that is available on January 1 of each year.
13		p. 35	A.4.c - State contracts	This application process does not provide for an integrated product - the description of the model, benefits, programs, services, performance measures and other aspects of the product are limited to Medicare benefits, not a comprehensive, fully integrated product.	We recommend that: (1) CMS and Congress work together to provide the necessary statutory and regulatory authority to offer a fully integrated product that includes a comprehensive package of Medicare and Medicaid benefits based on a risk-adjusted financing model that accounts for total primary, acute and long-term care costs. (2) CMS ask applicants to identify statutory or regulatory barriers to full integration; and (3) CMS provide applicants the Alliance's definition of fully, partially and non-integrated SNPs and require applicants to identify which approach they are taking.	NO REVISION TO SOLICITATION: #1 and #2 comments concern longterm strategy to change statutes and regulations. # 3 The CMS dual eligibles workgroup continues to work with the industry and States on opportunities within existing statutes and regulations to integrate Medicare and Medicaid benefits and administration under dual SNPs. In the 2008 application we have refined the plan's articulation of the targeted population. The full dual definition in CMS regulation is the definition that will apply to SNPs.
14		P. 35	Sec. A.4.d- Application with no Medicaid contract.	The application requires the applicant to indicate whether it intends to work with State Medicaid agency to provide integrated Medicare and Medicaid Services to duals. If the SNP does not offer a Medicaid product, it is not possible to integrate Medicare and Medicaid services. It is possible to coordinate Medicare and Medicaid services on behalf of enrollees.	Replace "to provide integrated Medicare and Medicaid services" with the following: "to assist dual eligible beneficiaries with accessing Medicaid benefits and with coordination of Medicare and Medicaid covered services.	REVISION TO SOLICITATION BASED ON COMMENT: In the 2008 application, considerable information is collected on the State's relationship to the plan. Plans are asked to report how Medicare and Medicaid services will be coordinated.
15	SNP Alliance	p. 36-38; p. 43-35; p.49-51	Sec. A.7.c.4, A.7.d.4, A.7.e.4, A.7.f.4 and related sections for Institutional (B.6.c.4, etc.) and chronic condition (C.6.c.4, etc.) SNPs. Extra benefits for enrollees who are Frail, Disabled, have multiple Chronic Illnesses, and are at the end of life.	In each section on meeting the needs of targeted enrollees, the applicant is required to list and explain how "extra benefits and services" will be provided. Since neither Congress nor CMS have provided for additional funding for SNPs, we offer two options that would provide SNPs the financial capacity to offer non-Medicare covered benefits and services: greater flexibility in the definition of "health related" supplemental benefits and payment waivers for plans that exclusively or disproportionately serve high risk enrollees. Payment waivers are intended to recognize that the CMS-HCC risk adjustment formula does not fully account for frailty and disabilty related costs and under predicts risk by about 14% for the highest cost quintile of Medicare beneficiaries. The payment waiver would allow CMS to provide high-risk plans an additional adjustment for these costs until the CMS-HCC method is sufficiently refined to full account for the risk of exclusively or disproportionately serving beneficiaries who are frail, disabled and those with multiple chronic conditions.	CMS should define "health-related" supplemental benefits more flexibly for plans that exclusively or disproportionately serve high risk beneficiaries to enable the plans to offer the "extra benefits and services" needed by high-risk populations. CMS also should include a payment waiver request in the application for plans that exclusively or disproportionately serve high-risk enrollees that will allow CMS to account for residual frailty and disability-related costs that are not accounted for by the CMS-HCC model.	NO REVISION TO SOLICITATION : What is a health benefit and how risk adjustment works are not addressed in the application. What is and is not a health related service is defined in existing Medicare policy. CMS is working with the industry and States on clarifying what flexibility is available for SNPs within existing regulations. The risk adjustment methodology is being updated and how to accomodate frailty is under consideration.

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16	SNP Alliance	p. 37	Sec. A. 7.c.5, A.7.c.6 and corollary parts of Sections. B and C. Process and outcome measures for frail, disabled, multiple chronic conditions, end of life.	We strongly support alternative performance measures for SNPs that evaluate whether SNPs are meeting the unique needs of high risk populations. CMS indicated earlier this year that it will work with NCQA to develop alternative measures for SNPs. CMS needs to clarify how it intends to evaluate SNP quality before plans know how to respond to this section and to sections A. 7.c.6 and A.7.c.7. Does CMS intend to use the process and outcome measures identifed by each SNP to evaluate them individually under a CQI approach? Will plans also be required to comply with the quality improvement program and chronic care improvement provisions in Section II, page 23 of the application using the standard measures referenced in Section II.A.3? If so, how would CMS risk-adjust "minimum performance levels" to create new benchmarks for SNPs that recognize the limiations of frail, disabled, high risk enrollees? (Section II.A.4). Does CMS expect separate process and outcome measures for each targeted population - frail, disabled, those with multiple chronic conditions, etc. or would CMS support a common set of uniform measures for all special needs populations, with a selected set of unique measures for frial, disabled, end of life,etc? The performance measurement sections of the MA and SNP sections of this application need to be integrated into a single set of quality meaurements for SNPs. The comments outlined in this section for frial elderly duals also apply to duals who are disabled, have multiple chronic illnesses, are at end of life and those with end-stage renal disease. They also apply to all targeted categories (frail, disabled, etc.) for instiutional and chronic condition SNPs inder Sections B and C of this application. For purposes of efficiency, we do not repeat these comments multiple times for each separate high risk group in each of the 3 sections of the SNP application (dual, institutional, chronic condition).	We recommend that: (1) applicants be permitted to develop a single performance measurement system for all beneficiaries; (2) SNP applicants be exempt from Sec. II of the application, provided that plans employ internal and external review processes for monitoring compliance with SNP-specified process and outcome indicators; (3) until CMS and NCQA have identified SNP-specific measures, CMS should allow SNPs to use the quality domains developed by the SNP Alliance medical directors as the a guide in chosing process and outcome indicators. For example, a SNP might choose to adopt as process measures safe and effective care transitions and medication management as two quality domains. Indicators of an effective care transition might include follow-up within 72 hours upon hospital discharge and low readmission rates. An indicator for medication management might be to require an annual face to face medication review for enrollees with annual drug costs in excess of $4,000. (4) CMS and NCQA should continue working with the SNP Alliance to finalize SNP-specific measures, including the limited HEDIS measures, outcome measures for ambulatory care sensitive conditions and chronic care oriented quality domains proposed by the SNP Alliance. These measures should be applied to all SNPs when finalized.	REVISION TO SOLICITATION BASED ON COMMENT: CMS is working with NCQA, the industry and States to develop uniform performance measures for SNPs. In the interim, it is CMS' expectation that plans articulate what internal measures and processes they will use to determine the effectiveness of their SNP model of care. CMS will use this information to assess if the plan is complying with its own internal QI processes and to help in the development of standardized performance measures.
17		p. 37	Sec. A.7.c.7 and corollary parts of Sections B and C for institutional and chronic condition SNPs.	We believe it is premature to require copies of performance reports before CMS has approved the applicants proposed process and outcome measures. This should be required during the implementation stage.	Delete the requirement that plans provide a copy of the performance reports they intend to generate.	REVISION TO SOLICITATION BASED ON COMMENT
18	SNP Alliance	p. 39	Sec. A.9 - Individuals with end stage renal disease	We would appreciate clarification of why end stage renal disease only is addressed in the section on duals, and not for institutional and chronic condition SNPs, especially since the other high-risk populations (e.g., frail, disabled, etc.) are included in Sections A, B and C of the SNP Application. We do not have a suggested revision at this time.	In the title of this section, add "disease" after "end stage renal.	REVISION TO SOLICITATION BASED ON COMMENT The end stage renal disease is already part of each section and it appeared that way on the website draft.
19	SNP Alliance	p. 40	B.1 - Institutional SNP	There is a typographical error in line B.1	Change "Dual Eligible" to "Institutional."	REVISION TO SOLICITATION BASED ON COMMENT
20	SNP Alliance	p. 41	B.2.d.1 - LOC Equivalents in the community	This section indicates that a SNP could target one or more assisted living facilities as the site of service for community-dwelling enrollees who qualify for an institutional level of care. This should be clarified in the application.	Insert following statement either at B.2.d.1 or in Attachment B at the end of the third paragraph under "Background," wherever CMS deems it most appropriate: "SNPs may limit enrollment of community-dwelling enrollees who qualify for an institutional level of care to one of more assisted living facilities or other residential care facilities under contract with the SNP."	REVISION TO SOLICITATION BASED ON COMMENT: SOLICITATIONs for this type of institutional SNP will be reviewed on a case by case basis for approval and the applicant must demonstrate the need for the limitation (to the ALF) including how community resources will be organized and provided. If a community based institutional SNP is limited to specific facilities, a potential enrollee must either reside or agree to reside in the MAO's contracted ALF to enroll in the SNP.
21	SNP Alliance	p. 46	Sec. B.8.b- LTC Facility Contract	We do not believe it is appropriate for CMS to regulate contract terms between SNPs and long-term care facilities. SNPs and LTC facilities should have the ability to establish their own terms for complying with contractual obligations. Further, this requirement could require existing SNPs to amend current contracts and create an unnecessary administrative burden. This issue could be addressed by including the proposed requirements under a different section of the application.	Include the requirements listed under Sec. B.8.b in a separate section of the SNP application (e.g. under a new section B.8.c), not as a contractual obligation between the SNP and nursing facility.	REVISION TO SOLICITATION BASED ON COMMENT: CMS can require these terms in contracts because they address how the SNP model of care will be implemented in coordination with the LTC facility. Without these terms, the SNP cannot guarantee that a uniform benefit will be provided as required under MA regulations. This information must be in the LTC facility contract, or included by specific references in the contract back to the provider manual to assure an MAO is able to provide the services as specified in the SNP model of care.

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22	SNP Alliance	p. 46	Sec. B.8.b- LTC Facility Contract	The application requires the LTC facility to provide "full" access to SNP clinical staff including physicians, nurse practitioners, care coordinators, etc .Some organizations operate under a team model that includes multiple levels of clinical staff including nurse practitioners who may perform certain roles traditionally performed by physicians such as writing prescriptions. "Full" access could be interpreted as unlimited access and could be inconsistent with the SNP model of care such as in cases where nurse practitioners provide primary care that may otherwise be provided directly by the physician.	Substitute "appropriate access" in place of "full access" in the second bullet.	REVISION TO SOLICITATION BASED ON COMMENT
23	SNP Alliance	p.53	Attachment A on subsets	The last bullet indicates that CMS only will approve full benefit duals as a subset of dual eligibility. CMS already has approved contracts for serving partial benefit duals such as QMBs and should continue this practice.	CMS should permit plans to serve full benefit or partial benefits dual eligible beneficiaries under a dual SNP.	REVISION TO SOLICITATION- CMS policy and the application does allow this. There will be a new category that does not require a State contract -- QMB+ and QMB only, representing the poorest of the poor and an opportunity to target beneficiaries who would pay $0 premium below Medicare and Medicaid.
24	SNP Alliance	N/A	Entire Document	In general, please review entire document for consistency in terminology.		REVISION TO SOLICITATION BASED ON COMMENT
25	Molina Healthcare	34	SNP Section	Does a DE-SNP need to complete all sections sine dual can be chronically ill, institutionalized, etc.?	Clarify	REVISION TO SOLICITATION BASED ON COMMENT: If the organization is applying for a DE SNP only, they do not have to complete Sections B and C of the template application, unless their targetted population is DE for institutionalized or DE with a chronic illness. In these cases, they do have to complete the relevant sections in B and C.
26	Molina Healthcare	36	SNP "Model of Care"	Please provide a definition of "model of care".	Add definition - Page 31	REVISION TO SOLICITATION BASED ON COMMENT
27	Molina Healthcare	36	Meeting the needs of frail enrollees	Please provide a definition of "frail enrollees".	Add definition - Page 31	REVISION TO SOLICITATION BASED ON COMMENT
28	Molina Healthcare	34	A2a	Add QMB check box for plans not marketing to only full duals.	Insert	This is allowed by new subset for QMB+ and QMB only.
29	Molina Healthcare	34	A3b	Is this an action item for the state to complete?	Clarify	Same as Comment 1
30	Molina Healthcare	35	A3c2	State contract deadline needs to be pushed back from 7/2/2207 to September 2007.	Revise	Same as Comment 3
31	Molina Healthcare	35	A3c2	How will subsets work if the state's fiscal year is July 1 rather than January 1?	Clarify	Same as comment 3. Also, a State will need to contract on, for example, an 18-month cycle to accommodate the MA requirement that the plans become effective January 1 of the new year.
32	Molina Healthcare	36	A7	Once again, define "model of care".	Add definition - Page 31	Same as Comment 26
33	Molina Healthcare	39	A9	Infers ESRD only applies to a chronic condition SNF. DE-SNP must enroll ESRD eligible under certain conditions.	Clarify	Same as Comment 18
34	Molina Healthcare	43	B6	Once again, define "frail enrollee".	Add definition - Page 31	Same as Comment 27
35	Molina Healthcare	48	Chronic & Severe Illness SNP type	Mental Health should be a category.	Revise	NO REVISION TO SOLICITATION : CMS does not have a finite list of allowable categories for chronic SNPs. Mental illness is allowed and we have two approved serving individuals with mental illness.
36	Molina Healthcare	53	Attachment A	The SNP does not contract with the state, the organization does.	Revise	REVISION TO SOLICITATION BASED ON COMMENT
37	Molina Healthcare	54	Attachment B	Is this new policy? If so, it should not be implemented through the application process.	Merely a comment.	No action needed
38	Amerigroup	35	A. DUAL ELIGIBLE SNP TYPE	A.2.a. CMS currently limits subsetting to full dual eligible, i.e. qualified Medicare beneficiaries (QMBs) with full Medicaid benefits, an aid category commonly known as "QMB Plus". We believe that plans should be able to include QMBs along with full duals, thereby expanding the category (in fact, this would be 'supersetting' in that it would be inclusive of a greater number of beneficiaries). We note that Medicare treats QMBs the same as full duals from the perspective of cost sharing and special status. Furthermore, we understand CMS has approved inclusion of QMBs for other plans.	CMS should permit plans to also include QMBs within the definition of full dual eligible for purposes of dual eligible SNP subsetting. Revise bullet to read as follows: "• Full Duals (consisting of QMB Plus and QMB categories)"	Same as Comment 23

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39	Amerigroup	35-	A.3.c.2	This paragraph on dual eligible subsetting and inclusion of state contracts assumes that states have worked through all these issues well in advance of the applicant's filing to CMS. In reality the lead time for the CMS contracting process is much longer thean the time afforded by state contract procurements. In our experience, final decisions by state Medicaid agencies regarding specific subsets of beneficiaries and specific contract terms may not be made until just a few months before program implementation. In addition, many state initiatives have mid-year start dates, which further complicates the sequence and timing of events implicit in the CMS policy.	Plans should be able to propose a specific plan configuration (consisting of benefits, cost sharing and enrollment subsetting) based on the current and best information available at the time of the CMS contract application filing. Plans would then have to commit to implementing that benefit plan as filed effective January 1st of the contract year, been though the corresponding state program may not start until some point later in the year.	Same as Comment 3 and 12
40	Amerigroup	37	A.6	The instruction should specify the file name of Excel county listing and direct the applicant to include the file in a specific location or exhibit number.	A.6.a. Provide in an excel spreadsheet the State and list of counties to be served by the applicant's proposed SNP. Name the file **"FILENAME.xls"** and place a printed copy in the Documents section. Include an electronic copy of the file on CDs X and Y.	REVISION TO SOLICITATION BASED ON COMMENT
41	Amerigroup	37	A.7.c.3 (also A.7.d.3, A.7.e.3 and A.7.f.3)	The question assumes that there is a uniform or standard benchmark model of care used in non-SNP Medicare managed care plans to which the applicant's SNP model of care may be compared. Based on its own experience, CMS is aware that there is wide variability in care management models used in non-SNP MA plans.	A.7.c.3. Indicate the specific features of the applicant's SNP model of care that are designed to address particular needs of the target population, such as the following: benefit design; care management, case management, medical management and disease management strategies; health delivery system configuration; and any other important aspects of the program.	Same as comment 7
42	Amerigroup	54	ATTACHMENT A	• There is no requirement that a SNP have a companion Medicaid contract or agreement with a State Medicaid agency for dual eligible. SNPs may offer dual eligible plans without State Medicaid agency coordination (other than compliance with applicable State licensing laws or laws relating to plan solvency), but may only limit enrollment in these plans to full benefit dual eligible.	CMS should permit plans to also include QMBs within the definition of full dual eligible for purposes of dual eligible SNP subsetting.	Same as Comment 23
43	Region 1	34	A.2.a	Add definition of 'All Duals/Full Duals'	Insert	Same as Comment 23
44	Region 1	29	intro	Add Congressional SNP authority expires in December 2008.	Insert	REVISION TO SOLICITATION BASED ON COMMENT
45	Region IV	37	A.7.d.4	Grammatical error: Too much spacing between "the" and "needs"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
46	Region IV	39	A.8.d	Grammatical error: Too much spacing between "," and "describe"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
47	Region IV	46	B.7.d	Grammatical error: Too much spacing between "," and "describe"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
48	Region IV	49	C.6.c.4	Gramatical error: Too much spacing between "the" and "needs"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
49	Region IV	51	C.6.f.4	Grammatical error: Too much spacing between "the" and "needs"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
50	Region IV	51	C.7.d	Grammatical error: Too much spacing between "have" and "meaningful"	delete extra space	REVISION TO SOLICITATION BASED ON COMMENT
51	State of Minnesota	30	II. Requirements for Submitting a SNP SOLICITATION	We are assuming that current SNPs with demo status will not need to complete a new application.	Clarification could be added	NO REVISION TO SOLICITATION: We work closely with all the demonstration states and have communicated that a new application is not required unless the target of their products is changing.

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52	State of Minnesota	35	A.3.c.2	Medicaid procurement and contracting requirements. The State intends to have Medicaid contracts in place with SNPs for people with disabilities by January 2008. However that will mean that some SNPs eligible to participate and wishing to serve duals will already have been approved by CMS for 2008 without any dual subset. Any new or current dual SNP (outside of our current MnDHO program) wishing to serve people with disabilities under a subset arrangement will then have to wait until 2009 to get CMS approval to focus on people with disabilities. In the mean time, this raises the issue of how the State can integrate Medicaid benefits. The SNP will be required to enroll all types of duals until they can get approval from CMS for the subset for 2009, but the State could be contracting only for the dual subset for Medicaid for at least 12 months. This means that to get started the SNP could have to have a different network, clinical approaches, two sets of member materials, enrollment procedures, marketing approaches etc, in order to meet both the State's requirements to serve the subset for Medicaid and CMS requirements to be prepared to serve all duals. Much investment would be required that would be wasted as this situation would be only temporary as the SNP applies for subsequent approval to only serve the subset. Then there is the issue of what happens to the enrollees who	Allow for conditional approval of SNP pending certain criteria if met by specified date that takes into consideration the State's procurement requirements. Allow a different start date for dual subsets under contracts with the State. Also consider whether the plan already has a contract with the State for some populations, allow for more flexibility in these cases.	Same as Comment 3 and 23
53				We appreciate CMS' requirements for more detailed information from plans about how they are going to provide different services appropriate to populations served under the SNP.		No action needed
54	State of Minnesota	30	II. Requirements for Submitting a SNP SOLICITATION	Clarify that if a health plan is simply creating a disabled dual eligible subset product offering under their existing dual eligible SNP contract then a new application is not needed but only a bid is required for the new product.	Add clarification if an existing SNP with one subset wants to add another subset to their existing SNP, this can be done by bidding by product rather than completing an additional application. This option would be easier for CMS as well. Requirement should be added that information about additional dual eligible products must be shared with States.	NO REVISION TO SOLICITATION Any changes to the target population served by the MAO requires filing a SNP SOLICITATION requesting approval.
55	State of Minnesota	48, 33	C. and IV.	Previously the term "severe or disabling condition" was used and now "chronic and severe illness" is used	Use common term through out document	REVISION TO SOLICITATION BASED ON COMMENT
56	State of Minnesota	34	A.2.a	Should be attachment A not B		REVISION TO SOLICITATION BASED ON COMMENT
57	United	30	**II. Requirements to Submit a SNP SOLICITATION/MA and Part D Applications may also be Required**	Under the section titled "Adding SNPs under Existing Medicare CCP Contract - Service Area Unchanged."	We would like CMS to clarify in writing that HSD tables will not be required for+D6 adding a SNP plan to a current contract if the network will be exactly the same and can support the addition of the SNP plan.	REVISION TO SOLICITATION BASED ON COMMENT
58	United	30	**II. Requirements to Submit a SNP SOLICITATION/MA and Part D Applications may also be Required**	Under the section titled "Adding SNPs under Existing Medicare CCP Contract - Service Area Unchanged." We would like to recommend that CMS allow for submitting a "master" SNP SOLICITATION for situations where we are adding the same type of SNP in multiple markets. In this situation, we would submit one set of answers to the SNP questions and then list the contracts and service areas that the particular SNP would be offered. We think that this would help streamline the process for submission and review. We submitted a SOLICITATION to Stephanie Vaughn-Martin with this suggestion dated 10.26.06 - copy of SOLICITATION has been sent with these comments.	We recommend including an option to submit a "master" SNP SOLICITATION for multiple markets.	REVISION TO SOLICITATION BASED ON COMMENT
59	United	33	**Solicitation For Special Needs Plan SOLICITATION: A.7. SNP Model of Care B.6. SNP Model of Care C. 6 SNP Model of Care**	We would like to clarify CMS' intent with separating out the four categories: Meeting the Needs of Frail Enrollees, Meeting the Needs of Disabled Enrollees, Meeting the Needs of Enrollees with Mulitple Chronic Illnesses, and/or Meeting the Needs of Enrollees that are at the End of Life -- within each of three broader categories of SNPs - Dual, Institutional and Chronic Illness. Are these four categories intended to be possible subsets of the broader categories? It is unclear how a plan would respond in this application if providing a general SNP that may provide for all four categories but not focus on any particular category. For example, for a dual SNP, a plan may have a care management model that can serve all four of these categories but might not focus on one of these four categories in particular. In this situation, we are unclear how we would respond to these four separate sets of questions.	As an alternative to having these four separate categories under each type of SNP, we recommend that CMS ask one set of questions about the model of care to serve the Dual, Institutional and/or Chronic Illness. The application could then ask about the applicant's ability to serve the frail, disable, multiple chronic illness and/or end of life populations. We would also like to clarify that it is not the intent with these questions to require SNP plans to design models of care around these specific categories.	Same as comment 7.

Comment#	Source Organization	Page Number	Section or Header	Organization Comment	Organization Suggestion (Insert, Delete, Revise)	CMS Action Taken
60	United	33	**Solicitation For Special Needs Plan SOLICITATION: Request for outcome measures, performance reports, etc. Request appears in each section titled "Meeting the Needs of" A. 7. c.5-7; A.7.d.5-7; A7.e.5-7; and A.7.f.5-7. Also appears in sections B and C under all four categories**	We appreciate and support CMS' need to collect outcome measures and performance reports. We have been in communication with CMS through the National Alliance of Specialty Health Care Programs' Medical Director Work Group regarding developing alternative performance measures for SNPs in place of the use of HEDIS. This work group has submitted some specific recommendations to CMS. (Copy of recommendations are provided as a separate attachment.)	We recommend that CMS continue working with the Medical Director Work Group in developing standard performance measures for SNPs, in conjunction with NCQA and Mathmatica. These standard measures, when finalized, would then be required by CMS for all SNP plans to evaluate performance and outcomes. This would be in place of asking each plan at the time of application for the performance and outcome measures that the plan would utilize.	Same as Comment 16
61	United	33	**Solicitation For Special Needs Plan SOLICITATION: Identifying beneficiaries with an Institutional Status B.2.e.**	We would like CMS to clarify if this section applies if applicant is applying for a model of care in the institutional setting. If a contracted SNF model, it seems the definition of "Institutionalized" that appears in the Definitions section of the application would be used -- individual who continuously resides or is expected to continuously reside for 90 days or longer in a long term care facility.	Please clarify that this section only applies if a community based model is being requested.	NO REVISION TO SOLICITATION: This definition applies to LTC facility based institutional SNPs and community based institutional SNPs.
62	United	33	**Solicitation For Special Needs Plan SOLICITATION:: Long Term Care Facilities B.8.b - contract requirements**	**Contracting Terms**: We are concerned about the level of detail that this application is requiring be added into our contracts with long term care facilities. We achieve communication and coordination through training and our provider administrative manuals and communication. SNFs often require a termination without cause provision. We are concerned that requiring plans to include a termination with cause only will impair our ability to build a SNF network. **2007 approved institutional SNP**: For 2007, CMS approved an institutional SNP allowing a nursing facility with a collaborative relationship with a physician group. **Disenrollment if contract terminates:** Based on previous direct guidance to our organization, CMS has required our Institutional SNPs to allow beneficiaries to remain in the plan until the end of the calendar year instead of requiring that the enrollee be moved or disenrolled upon the termination of a LTC contract, if we are able to maintain the comparable level of benefits in the same facility. For further discussion, see original comments.	We strongly encourage CMS to consider allowing plans to meet these requirements through policies and procedures and other provider communications, provider manuals, etc, in place of requiring in contract language. As a recommendation in place of only allowing termination for cause, we recommend in cases where the SNP can continue to provide the same level of care that enrollees coverage continue in the same SNF until the end of the calendar year. We suggest that CMS allow an Institutional SNP model that covers enrollees in a non-contracted facility within the category of Institutional SNP, as long as the model of care is appropriate to serve the special needs population. We recommend that CMS continue to allow the option for Institutional SNPs to maintain coverage for enrollees to the end of the calendar year in cases where the contract is terminated with the LTC facility.	Same as Comment 21. Also, this approval was made in error. The plan will have to come into compliance with the 2004 guidance that enrollees must be in contracted LTC facilities. Remove sentence in Attachment C that addresses disenrollment in the event of contract termination. CMS will address how best to meet beneficiary needs on a case by case basis if there is a reasonable alternative to moving or disenrolling the beneficiary.
63	United			Reporting of Quality and Performance Measures -- schedule a follow up meeting to focus on this topic.		NO REVISION TO SOLICITATION
64	Coventry Health Care			Section III. A definition of "Model of Care" should be included here.		Same as Comment 26
65	Coventry Health Care			Questions A.2.b; B.2.e.2; C.2.b. Specifics operational details may not be worked out at the time of application. We believe that turning these questions into "yes/no" statements, (similar to section VI & VII of the CCP Application and the Part D Application), will provide CMS with the information needed for the SOLICITATION. Specific operational details could be submitted at a later date.		NO REVISION TO SOLICITATION: The applicant must specify how eligibility will be verified before a SNP proposal is approved.

Comment#	Source Organization	Page Number	Section or Header	Organization Comment	Organization Suggestion (Insert, Delete, Revise)	CMS Action Taken
66	Coventry Health Care			Question A.3.b. It does not seem appropriate for the applicant to supply a State's justification for each excluded category of beneficiary based on the State's criteria. It would seem more appropriate for the State to provide this information to CMS.		Same as Comment 1
67	Coventry Health Care			Included in Sections A, B & C is the question to provide specific examples of how performance reports will be used and to provide a copy of such reports. Similar to above, this level of specificity may not be developed at the time of application. As such, again we believe that these questions should be turned into "yes/no" statements with plans providing specifics at a later date.		Same as Comment 16
68	State of New Mexico	35	A.3 Relationship of SNP Product to State Medicaid Services in the Event of Other Subsetting	A.3.c.2, should include the complete calendar year in sentence one. A State may bring up a program within the calendar year; as written, the State would be required to bring up a program by no later than January 1, 2008.	If applicant's organization will have a contract or agreement with the State to provide Medicaid services to the requested subset of dually eligible individuals that will be served during the CMS contract cycle (January 1, 2008 to December 31, 2008), include a letter from the State Medicaid director of his/her designee	Same as Comment 31
69	State of New Mexico	35	A.4. State Contracts Information if Other Subsetting is Not being requested by Applicant	A.4.d.; B.3.d; and C.3 Need to include information from the applicant as to what steps it will take to integrate Medicare and Medicaid	Add sentence at end…If so, what steps will the applicant take to provide integrated Medicare and Medicaid services to dually eligible beneficiaries.	REVISION TO SOLICITATION BASED ON COMMENT
70	MassHealth SCO		Dual Eligible SNP (A7)	Overlapping populations in existing dual models - include frail and disabled and multiple chronic illnesses and end of life - not mutually exclusive	Clarify how subsetting can include more than one of these categories	NO REVISION TO SOLICITATION: The discussion in the application on these types of health conditions does not drive subsetting but rather a discussion of how these conditions will be managed under any SNP.
71	MassHealth SCO		Dual Eligible SNP (B 2-6)	Confusion between "targeting" institutional and community NHC populations i.e. allowing other beneficiaries in, and "limiting" services to certain defined subsets	Clarify that exclusive subset enrollment is allowed, as well as "disproportionate" arrangements	REVISION TO SOLICITATION BASED ON COMMENT: Discussion in application reorganized to make this more clear.
72	MassHealth SCO		Enrollee Issues (V H)	Not enough to require "best effort" to complete initial assessment within 90 days of enrollment- this is a frail, clinically complex population	Require complete initial assessment for subset dual SNPs within 30 days.	NO REVISION TO SOLICITATION : This is not in the SNP solicitation however, we are looking into this comment to consider whether a more strict timeframe is feasible and appropriate.
73	New York State	34	A. Dual Eligible SNP Type A.3.b	First sentence is confusing as written. Not clear what is meant by the term "State's justification". What level of justification would CMS expect applicants to provide?	Delete A.3.b. as written. Suggest instead: Explain how the applicant's proposed subset of individuals coincides with the target population for State initiatives designed to integrate Medicare and Medicaid services.	Same as Comment 1.

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74	New York State	35	A. Dual Eligible SNP Type A.3.c.1, A.3.c.2 and Note to applicant	We understand CMS' concern that it only approve a subset of dual-eligibles when the state has a contract with the SNP for a Medicaid wrap around for that same subset of duals. However, the proposed requirement that states have an executed contract with the health plan in the March or July of the year prior to the benefit year (for example, March or July 2007 for calendar year 2008) is unworkable for a number of reasons: (1) it is not known at that time whether CMS will approve the SNP application; (2) the Medicare capitation rate has not been established so the wraparound rate cannot be included in the contract and it therefore could not be fully executed; (3) the state contracting process takes a minimum of 90 days so in practical terms this means that the state and the plan would need to have a contract developed and signed in the procedding January -- a year before the benefit year; (4) the state does not have precendence for entering into contracts that are contingent upon the action of a third party -- in this case CMS approving the SNP application.	In order to adress what we understand to be CMS' concerns we would suggest the following alternative. (1)In March 2007, the state submits to CMS a statement of the subsets for which it will contract with SNPs in 2008. In NYS, there would be only 2 such subsets. CMS could also require the state to endorse the subset description that is included in the proposal submitted to CMS by each health plan much like it attests to plan licensure; (2)SNPs with contracts with the state in 2007 for the same subset as proposed for 2008 would submit a copy of the executed contract with the state showing authority for the contract to be extended to 2008; (3)new 2008 SNP applicants/existing SNPs that are proposing a new susbset for 2008 would submit to CMS a copy of an unexectued contract that contains the subset description along with a joint letter from the state and the health plan stating their intent to enter into a contract for that subset contingent upon CMS approval of the SNP application and the agreement between the state and the plan on reimbursement provisions for the Medicaid wrap.	Same as Comment 3
75	AHIP		Scope of application.	AHIP has supported CMS' approach to the initial implementation of SNP authority that has provided flexibility for SNPs to enter the MA program and serve increasing numbers of beneficiaries. We recognize that expansion of the items in the SNP portion of the MA application may reflect CMS' interest in developing more detailed application requirements based upon experience with the SNP program. However, as discussed in more detail below, we have significant concerns about the goals and utility of some of the requested information and recommend that CMS reconsider the appropriateness of certain items (e.g., submission of a copy of performance reports that the SNP will use). We also have serious concerns that the proposed changes could impact not only new applicants, but current SNP contractors as well. For example, if the items in the application signal that CMS will be evaluating the performance of current contractors in specified areas, CMS should issue guidance explaining these obligations to all MAOs offering SNPs. We believe that a requirement to describe capabilities separately for each of the areas CMS has identified and for each of the sub-populations is excessive and likely to produce redundant responses. In some cases, we believe that it is inappropriate to require this information, as requested, as part of the application because the response can be expected to evolve based upon experience (e.g., process and outcome measures, and related performance reports.) If CMS is developing criteria that will be used to evaluate the applications in these areas, we recommend that CMS include information about the criteria on which they are based in the instructions to allow applicants to demonstrate their compliance. For further discussion, see comments.		Same as comment 7. CMS guidance to include elements of the model of care for existing contractors in the audit guide will be included in the Call letter.

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76	AHIP		Adding SNPs under an existing MA contract.	For an MA organization that is applying to offer an additional SNP, the instructions indicate that the applicant must provide the cover page of the MA contract and complete the SNP portion of the application. It is our understanding that the applicant is not required to submit the remaining portions of the MA application because this information would be duplicative and unnecessary. However, the instructions do not indicate that an MA organization that is applying to offer an additional SNP of the type the organization currently offers would be permitted to follow a similarly streamlined process with respect to the SNP portion of the application. Under such a process, the organization would not be required to complete portions of the SNP application that would be duplicative of the previous application. For administrative efficiency, we recommend that CMS consider establishing such a streamlined process.		Same as Comment 58. In addition, the SNP solicitation is revised to minimize duplication across discussion of models of care.
77	AHIP		Submission of SNP application by diskette or CD.	The instructions direct the applicant to send the SNP portion of the application in hard copy. For administrative efficiency for applicants and CMS, AHIP recommends that CMS allow applicants the option of submitting the completed application on diskettes or CDs to CMS' Central Office and the applicable CMS Regional Office.		REVISION TO SOLICITATION BASED ON COMMENT: CMS is including CDs in the 2007 application for 2008. CMS expects the entire MA application, including the SNP solicitation, to be electronic in 2008 for 2009 contracts.
78	AHIP		Key Definitions	**Special needs individual.** The definition of special needs individual includes an individual who has a "severe or disabling chronic condition(s)". This terminology reflects the relevant statutory language. CMS references such individuals in many places in the application in varying ways such as individuals with "chronic and severe illness." For clarity and for consistency with the statutory language, AHIP recommends that CMS use the terms "severe or disabling chronic condition(s)" consistently throughout the application.		REVISION TO SOLICITATION BASED ON COMMENT
79	AHIP		Key Definitions	**Model of care.** The draft application uses the term "model of care" in a number of places. However, this term is not commonly used or understood. To promote consistent understanding of the term, AHIP recommends that CMS add a definition of "model of care".		Same as Comment 26
80	AHIP		Key Definitions	**Frail" enrollees.** The draft application uses the term "frail" enrollees to identify a sub-population of enrollees who may be served by SNPs. The term "frail" does not have a single well-established meaning, and we believe that applicants may not understand clearly the population that CMS intends to encompass by using this term. To promote consistent understanding of the sub-population CMS is referencing, AHIP recommends that CMS add a definition of "frail" enrollee.		Same as Comment 27
81	AHIP		Section IV Template for Completing SNP SOLICITATION	Clarifying instructions for completion of template. The draft application indicates that the template for completing a SNP SOLICITATION provides the necessary prompts for each type of SNP (i.e., dual eligible, institutional, and chronic and severe illness). For clarity, AHIP recommends that CMS specify that organizations are required to submit only the portions of the template that correlate to the specific SNP type the organization plans to offer.		Same as comment 58. While we did not select AHIPs specific suggested reorganization, we have removed the duplication and resolved the issue.
82	AHIP		Section A.2.a. Dual Eligible SNP Type	**A.2.a -- Identify what dual eligible population will be served by this SNP.** CMS identifies following three dual eligible SNP types that may be offered: (1) all dual eligible; (2) full dual eligible; and (3) other subsets. However, since the beginning of the program CMS has also allowed the offering of a SNP type that serves individuals for whom the State Medicaid agencies pay Medicare cost sharing. This would include full benefit dual eligible and QMB-only beneficiaries. To address this unintended omission, AHIP recommends that CMS add SNP types following "Full Duals" that reads, "Full Duals and QMB-Only".		Same as Comment 23
83	AHIP		Section A.2.a.	**A.2.a – Typographical error.** A typographical error in this section refers to "Other Subsets (See Attachment B)". It appears that CMS intends to reference Attachment A, "Subsets for Dual Eligible SNPs." AHIP recommends that CMS revise the language accordingly.		REVISION TO SOLICITATION BASED ON COMMENT

Comment#	Source Organization	Page Number	Section or Header	Organization Comment	Organization Suggestion (Insert, Delete, Revise)	CMS Action Taken
84	AHIP		A.3. Relationship of SNP Product to State Medicaid Services in the Event of Other Subsetting.	**A.3.b. – Justification for subsetting.** With respect to subsetting, the draft application instructs organizations to provide the "State's justification" for each excluded category of beneficiary based on State criteria. It appears that the reference to the "State's justification" is a typographical error and that CMS intended to refer to the "applicant's justification". This would be consistent with the following sentence which provides an example of the justification that must be provided by the applicant to explain how the subset of individuals that the applicant proposes to enroll and the potential enrollees that will be excluded from the SNP coincide with the target population that is the focus on the State's Medicare and Medicaid integration efforts. If we are correct, AHIP recommends that CMS revise the draft by deleting "State's justification" and inserting instead, "applicant's justification". If we are not correct, AHIP recommends that CMS clarify the language in the draft to clarify the instruction.		Same as Comment 1
85	AHIP		A.3.c.1.	**– Signed contract with State Medicaid agency.** For the purpose of subsetting, CMS is proposing that the signed contract between the State Medicaid agency and the MA organization to serve the designated population(s) through the SNP must be provided to CMS by July 2. AHIP believes that States may need additional time to finalize their programs and enter into such contracts, and a decision by CMS to require a contract by July 2 may stifle the development of programs that rely on organizations with both Medicaid managed care and MA contracts. AHIP recommends that CMS establish a September 1 deadline for CMS' receipt of signed contracts because such a deadline would provide additional opportunities for State program development but would also ensure that State contracts are in place prior to the date that CMS enters into (or renews) MA contracts in early September.		Same as Comment 3
86	AHIP		Section A.7. SNP Model of Care: Meeting the Needs of Frail Enrollees.	**A.7.c.1. – Does this model of care specifically address the needs of frail beneficiaries?** While SNPs that focus on dual eligible beneficiaries are likely to anticipate serving some members who are frail enrollees, it is unclear whether CMS would consider such a SNP as having a model of care that would "specifically address the needs" of such beneficiaries. We recommend that CMS include instructions regarding CMS' interpretation of the language "specifically address" in the context of this and other similar requirements to ensure a consistent understanding by applicants of their obligation to complete any portion of the application in which this language appears.		Same as Coomment 7 and 26
87	AHIP		Section A.7. SNP Model of Care: Meeting the Needs of Frail Enrollees	**A.7.c.5., A.7.c.6.; A.7.c.7 – Quality measures and performance reports.** In each instance in which this information is required in the application, the draft calls for the applicant to make a commitment that the SNP will use specific process and outcome measures and a specific performance report that must be provided at the time of application. AHIP supports the use of such measures and reports. However, it is our understanding that while the applicant could indicate the types of process and outcome measures and the type of performance report that would be used by the SNP, the specific measures and report that will be implemented are likely to evolve based upon the experience of the SNP and the possibility that CMS would promote consistent use of measures and reports. Further, we question the appropriateness of requiring submission of the performance reports referenced in A.7.c.6. and A.7.c.7. as part of the application. It is our understanding that such reports are an aspect of day to day operations and that CMS would more appropriately oversee this activity in the course of contract implementation. Accordingly, we recommend that CMS revise these requirements in each place they appear by removing items A.7.c.6. and A.7.c.7. and other items that are similar in content. We also recommend that CMS clarify that examples of the types of measures that would be used by the SNP are required in item A.7.c.5. In the event that items A.7.c.6. and A.7.c.7. are retained, and we recommend that CMS clarify that examples of reports must be submitted consistent with the language in A.7.c.6. of the draft application.		Same as Comment 16

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88	AHIP			**A.7.d. – Meeting the Needs of Disabled Enrollees.** AHIP's understanding is that use of the term "Disabled Enrollees" is likely to be problematic from the perspective of the disability community. Accordingly, we recommend that the term be deleted in each place it appears throughout the draft application and replaced with "Enrollees with Disabilities".		REVISION TO Solicitation BASED ON COMMENT
89	AHIP		B.2. Type of Institutional SNP	**B.2.b. -- Community based beneficiaries.** In this section, CMS identifies beneficiaries who are "Institutional living in the community but requiring an institutional level of care" as an institutional population that may be the focus of a SNP. AHIP believes this characterization is not correct. It is our understanding that the population is "Institutional living in the community but would qualify for an institutional level of care." AHIP recommends that draft application be revised accordingly.		NO REVISION TO Solicitation. The plan must determine insititutional eligibility prior to enrollment.
90	AHIP		B.8. Long Term Care Facilities	**B.8.b. -- Contract clauses.** CMS is proposing new clauses that applicants for institutional SNPs would be required to include in their contracts with long term care facilities. By establishing requirements for new SNPs, it would appear that CMS also intends to apply the same standard to existing SNPs, which would require the amendment of contracts. AHIP does not support this change. Requiring new contract provisions has the potential to necessitate renegotiation of contracts with long term care facilities, a resource intensive and potentially disruptive and lengthy process. For this reason, CMS has minimized the new contract clauses that are required and has typically directed that MA organizations include additional requirements for network providers in plan policies and procedures that are disseminated to providers. AHIP recommends that CMS revise the draft application by eliminating the requirement for new contract clauses and requiring that applicants include these provisions in the policies and procedures for network long term care facilities. If CMS intends to establish the same requirements for current SNPs, as discussed above, we recommend that separate guidance be issued.		Same as Comment 21
91	AHIP		Attachment A– Subsets for Dual Eligible SNPs.	**Inclusion of QMB only beneficiaries.** The last bullet discusses CMS' policy that pre-dates the subsetting policy and that permits an MA organization to offer a SNP for full benefit dual eligible only. As discussed in our comment above, since the beginning of the program, CMS has also allowed the offering of a SNP type that serves individuals for whom the State Medicaid agencies pay Medicare cost sharing. This would include full benefit dual eligible and QMB-only beneficiaries. We recommend that CMS add to the last bullet a reference to this type of SNP by revising the end of the last sentence to read, "but may only limit enrollment in these plans to full benefit dual eligible or to beneficiaries for whom the State agencies pay Medicare cost sharing (i.e. full benefit dual eligible and QMB-only beneficiaries)."		Same as Comment 23
92	AHIP			**Inappropriate references to SNP contracting with CMS or State.** AHIP recommends removing any reference to a SNP contracting with CMS or with a State. The MA organization rather than the SNP is the entity that enters into such contracts. AHIP recommends that CMS revise the draft application accordingly.		REVISION TO Solicitation BASED ON COMMENT
93	CHCS		Section A.3.b. (page 35).	Application asks the SNP to provide the "State's justification" for each excluded category of beneficiary. States question why the SNP would be asked to explain the state's justification.	*Recommendation*: The state could explain/justify the excluded categories (perhaps in the letter that is going to be required under A.3.c.2.). The SNP could be asked to explain how its proposed subset of individuals coincides with the target population for state initiatives designed to integrate Medicare and Medicaid services.	Same as Comment 1

Comment#	Source Organization	Page Number	Section or Header	Organization Comment	Organization Suggestion (Insert, Delete, Revise)	CMS Action Taken
94	CHCS		Section A.3.c.2. (page 36).	The timing requirements here are fairly problematic, primarily for new SNPs, given the timeframes involved in typical state managed care procurements and that states ordinarily would not enter into contracts with a plan not approved by CMS. The draft requires the contract between the State and the plan be completed by July 2, 2007. Although states understand that this ties into the bids due in 2007, it is unlikely that state agreements with new SNPs for the 2008 calendar year will be firm enough for there to be a signed contract or agreement by July 2, 2007. For states that have not yet contracted with SNPs, this could mean that SNPs would have to serve a broader population in 2008, and then narrow it to a state-defined subset in a subsequent year.	*Recommendation*: There is consensus among the states to request that CMS provide some flexibility in the July 2 date. Since the bids are due June 4, 2007, which is before the proposed July 2 deadline anyway, perhaps CMS could allow contracts between the state and a SNP up until the date the MA contract is signed in early September. CHCS also provided specific comments, from the following States which are reflected elsewhere in this document: NY, MN.	Same as Comment 3
95	CHCS		Section A.3.c.2. (page 36)	The draft requires that the State-SNP contract be effective on January 1. This may create problems with states whose contracting cycle is not on a calendar year basis or a state that cannot operationalize the program by January 1. The latter could occur for a variety of reasons – the two biggest being not having necessary CMS waiver/state plan approval and/or not having the necessary state legislative approval, etc. The timing of state legislative sessions is especially critical to keep in mind. Given that 2007 legislative sessions begin in January, a state Medicaid agency may not receive the legislative authority it needs in time in 2007 to meet the deadlines as currently proposed.	*Recommendation*: There is consensus among the states to request that CMS provide flexibility determining when the Medicaid component becomes effective. CHCS also provided specific comments from the following States which are reflected elsewhere in this document: MN, NM.	Same as Comment 31
96	CHCS		Sections A.4.c., B.3.c. and C.3.c (pages 35, 42, 48).	For dual eligible SNPs that have a contract to serve Medicaid beneficiaries, Section A.4.c. asks applicants to "describe how the applicant will integrate Medicare and Medicaid services for the targeted dually eligible population." For institutional and chronic condition SNPs, however, the comparable questions (B.3.c. and C.3.c.) ask only whether the applicant has a plan to integrate Medicare and Medicaid services for duals, and don't ask that it be described. An applicant could simply say "yes," and move on without elaboration. CMS might want to consider asking those plans that say yes to also describe how they propose to do it (consistent with what is asked of the dual eligible SNPs in A.4.c).		REVISION TO SOLICITATION BASED ON COMMENT.
97	CHCS		Sections A.4.d, B.3.d and C.3.d (pages 35, 42, 48)	Similar to the bullet point above, when the SNP applicant does not have a Medicaid contract, questions A.4.d., B.3.d., and C.3.d ask only "whether the applicant intends to work with the State Medicaid agency to provide integrated Medicare and Medicaid services to dually eligible beneficiaries." Again, the applicant could simply say "yes" without elaboration and move on. Similar to the suggestion above, CMS might want to ask those plans how/what steps they plan to take to provide integrated services.		Same as Comment 96.
98	CHCS		Section A.4.e. (page 35).	States would find this type of notification very helpful and welcome it	*Recommendation*: CMS request a designated contact from the states, which is where the notification would be sent.	REVISION TO SOLICITATION BASED ON COMMENT
99	CHCS		Section A.7. (page 36).	There could be instances where there are overlapping populations in existing dual models – frail elderly, disabled, multiple chronic conditions and end of life are not mutually exclusive	*Recommendation*: Clarify how subsetting can include more than one of these categories.	Same as Comment 70
100	CHCS		Sections A.7.c.7, A.7.d.7 and A.7.e.7 (pages 37 and 38).	While it is important that plans know what they plan to measure and how they will recognize successful outcomes, it seems unlikely that most plans (particularly new applicants) will have any actual outcome reports data to share by the time applications are due.	*Recommendation*: CMS should clarify that the performance reports required in the application are merely examples and do not need to include actual outcome data.	Same as Comment 16
101	CHCS		Section B2 through 6 (pages 40-44).	Application is potentially confusing in regard to “targeting” institutional and community nursing home certifiable populations, i.e. allowing other beneficiaries in and limiting services to certain defined subsets.	*Recommendation*: Clarify that exclusive subset enrollment as well as disproportionate arrangements are allowed.	Same as Comment 71. See B4 of the SNP solicitation. It is a specific option
102	CHCS			Existing SNPs. It is unclear how existing SNPs fit into the subset approval process outlined in the application. Assuming that new applications are not required, how will the new process apply to SNPs already in operation?		Same as Comment 54
103	AHIP		A.7.c	Delete "Frail" so that A.7.c reads: Meeting the Needs of Enrollees		REVISION TO Solicitation BASED ON COMMENT

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104	AHIP		A.7.c.1	Section A.7.c.1 should read: Do you anticipate enrolling the following types of beneficiaries? (Check all that apply). (Note: CMS recognizes that in general applicants will expect to enroll beneficiaries who fall into all of these groups.) Frail Enrollees Enrollees with Disabilities Enrollees with Multiple Chronic Illnesses Enrollees who are at the End of Life Note AHIP made further related comments to provide specific language for Sections A.7.c.2 through A.7.c.7 to accommodate a consolidated response.		Same as Comment 81
105	AHRQ		A. Dual Eligible SNP Type	Require states to provide list of subsets to CMS.		Same as Comment 3
106	AHRQ		A. Dual Eligible SNP Type	Require states to provide, to CMS, a complete contingency/assurance statement regarding the status of procurement, assurance of January 1, 2008 effective date, and potential information on subset applicants. This information would be submitted on a State/CMS developed form that would provide CMS with sufficient information to allow the SNP to move forward absent a final contract with the State.		Same as Comment 3

PART C-2008 APPLICATION COMMENT MATRIX

Comment #	Source Organization	Application Reference	Page Number	Section or Header	Comment	Suggestion (Insert, Delete, Revise)	Action Taken
53	Region VI	CCP	3	Table of Contents, General Information	Misnumbered. Shows I., II., III., VI. (6) Should be IV (4). Also needs corrected on Page 8.	Need to correct VI to IV, the number 4. Also correct on page 8.	Accepted Suggestion. Made appropriate change.
54	Region VI	CCP	3	Table of Contents, General Information, VII.	Need to show closed parenthesis	(HIPAA)	Accepted Suggestion. Made appropriate change.
24	MMC 20/20	CCP	8	Key Management Staff	The roman numeral is shown as VI (6) when it should be IV (4).	Just a formatting change.	Accepted Suggestion.
4	AHIP	CCP	10	VI. UPGRADES OF THE HEALTH INFORMATION TECHNOLOGY	**Reference to potential sources of interoperability standards.** This item indicates that the interoperability standards recognized by the Secretary "may include interoperability specifications recommended by the Health Information technology Standards Panel or specified in the Nationwide Health Information Network architecture standards, and interoperability standards recommended by the Certification Commission for Health Information Technology or other certifying bodies recognized by the Secretary."	We recommend that the draft application be revised by eliminating the quoted language. We believe that the language referencing interoperability standards as recognized by the Secretary of HHS is sufficient and is consistent with the President's Executive Order on "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs" and the recent "Four Cornerstones of Value Driven Health Care" released by HHS.	Rejected.
6	Amerigroup	CCP	10	VI. Upgrades of the Health Information Technology	Awkward phrasing	Revise to read, "VI. UPGRADES OF HEALTH INFORMATION TECHNOLOGY"	Accepted Suggestion.
1	AHIP	CCP	10	VII. Health Insurance Portability and Accountability Act (HIPAA)	**Item #5 --** Compliance with HIPAA-adopted payment and remittance advice standard. This item requires the applicant to agree to comply with the HIPAA-adopted ACS X12N 835, Version 4010/4010A1: Health Care Claim Payment and Remittance Advice Implementation Guide ("835"). This item appears to be a duplicative of Item #4 which requires the applicant to agree.	Accordingly, we recommend that Item #5 be deleted.	Accepted Suggestion.

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2	AHIP	CCP	10	VII. Health Insurance Portability and Accountability Act (HIPAA)	**Item #6 -- Reporting to CMS of unauthorized public disclosures of protected health information within 48-hours of the Applicant's detection of such disclosure.** While AHIP recognizes the importance of notifying CMS when individual beneficiary information is compromised by an unauthorized public disclosure, we are concerned that forty-eight hours could be insufficient to permit an MA organization or Part D plan sponsor to investigate a suspected security incident, conduct an investigation, and notify CMS following a security breach that affects Medicare beneficiary data.	We recommend that CMS delete the reference to the 48 hour period and insert a reference to a "reasonable time" to provide an opportunity for further discussion regarding the time frame for reporting. In addition, we recommend that CMS develop a practical, more detailed policy regarding the reporting of data security breaches to CMS by MA organizations and Part D sponsors.	Accepted Suggestion. The time frame to report the findings to CMS is still under policy discussion. CMS has eliminated the 48 hours time frame to report findings. CMS will let the industry know when a new time frame for reporting has been established.
3	AHIP	CCP	10	VII. Health Insurance Portability and Accountability Act (HIPAA)	**Item #8 – External review, certification, and re-certification of systems, policies and procedures to protect individual beneficiary information from unauthorized disclosure**. This item requires the applicant to attest that it will comply with future CMS guidance that will require external review, certification, and re-certification of systems, policies, and procedures to protect individual beneficiary information from unauthorized disclosure. There is no requirement in the HIPAA Security Rule for a covered entity to have an external "unrelated organization" review or certify systems, policies, or procedures. The re-certification process is also not required and in many cases will be burdensome and costly.	We recommend Item #8 be revised to be consistent with the HIPAA Security Rule.	Accepted Suggestion. CMS will revised this section.
7	Amerigroup	CCP	13	VIII. SERVICE AREA – [422.2]	"ALL APPLICANTS MUST ENTER ITS REQUESTED SERVICE AREA IN HPMS" is incorrect grammar	Revise to read, "NOTE: THE APPLICANT MUST ENTER ITS REQUESTED SERVICE AREA IN HPMS."	Accepted Suggestion.
27	Molina	CCP	14	Continuation Area	CMS needs to move away from hard copies and allow the complete filing to be done electronically.	Revise	CMS is hoping to automate all Part C applications in the near future.
63	State of New Mexico Medicaid Program	CCP	14	State Authorization	Add question regarding the authority the applicant is authorized to operate within the State	Under what State authority is the applicant authorized to operate as a risk bearing entity that may offer health benefits in the requested CA(s).	Reject for now. CMS will consider this recommendation for the 2009 application. Discussions are taking place to determine the necessity of the state certification form.

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64	State of New Mexico Medicaid Program	CCP	17	Legal Entity & State Authority to Operate	Modify I(A) to include all states the applicant is authorized to operate	Provide information regarding how the applicant is organized under any state in which it operates.	Reject for now. All applicants are asked to describe how its organization is organized under the state. This question can be found in the organizational and contractual section of the application.
55	Region VI	CCP	18	III. RISK SHARING	Reference to *legal-1.xls* file. This is actually a Word file	Change to *legal-1.doc*	Accepted Suggestion. Made appropriate change.
56	Region VI	CCP	18	IV. CONTRACTS FOR ADMINISTRATIVE/MANAGEMENT SERVICES - D	This section refers to the file *matrixadm.doc.* My comments are about the matrix.	On the matrix, the correct reference for the first topic is: 422.504(i)(4)(v). On the second topic, the correct reference is 422.504(a)(13). On the third topic, shouldn't this be 10 years instead of 6? On the 7th topic, remove the period after MAO in the last sentence. On the ninth topic, change the wording from "...entities are monitoring by the MAO..." to "...entities are monitored by the MAO...".	Accepted Suggestion. Made appropriate change.
57	Region VI	CCP	19	V. PROVIDER CONTRACTS AND AGREEMENTS	First paragraph under Note: at the end of the paragraph it references {422.505(i)(3)}. I do not find this reference in the regs.	Need to correct the reference to the appropriate one.	Accepted Suggestion. Made appropriate changed.
58	Region VI	CCP	19	V. PROVIDER CONTRACTS AND AGREEMENTS - D	Third paragraph, beginning NOTE. Says "...who is actually <u>rending</u> the service…"	Reword to say "…who is actually <u>rendering</u> the service…"	Accepted Suggestion
59	Region VI	CCP	19	V. PROVIDER CONTRACTS AND AGREEMENTS - D	Third paragraph, beginning Note: at the end of the paragraph it references {422.505(i)(3)}. I do not find this reference in the regs.	Need to correct the reference to the appropriate one.	Accepted Suggestion. Made appropriate change.

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23	MMC 20/20	CCP	19	V. Provider Contracts and Agreements (2nd Paragraph, Questions A., B., and C.)	Second paragraph states " Executed written agreements with providers should be submitted at the time the application is submitted to CMS". Question A. states "For each proposed service area or distinctive delivery system(s) applicant should provide the provider contracts and/or agreements." Question B. states "B. Provide a sample copy of each category of provider contract(s) and/or agreement(s) between the applicant and its primary health care contractors". Question C. states "C. The signature pages from contracted and subcontracted providers actual contract(s) and or agreement(s) must be available onsite and upon request."	It is confusing as to whether all contracts need to be submitted, and then what sample templates need to be submitted (this seems duplicative). It also states in question C that signature pages need to be avaialbe onsite upon request. However, they will be in the application since all contracts are being included. Perhaps some clarity on these requirements and a purpose for all three(actual contracts, sample templates, and signature pages) would help.	Clarification: CMS is not requesting the applicant to send copies of all provider contracts. CMS is requesting the applicant to submit a template copy of of the actual provider contract(s). (One template may represent several providers) CMS request/prefer that all contracts are executed at the time the application is submitted, which will allow the applicant to complete Legal table 2. **CMS will request a sample of the actual provider contract and signature pages as a part of the application review. Action:** CMS will revise to his section for clarity.
65	State of New Mexico Medicaid Program	CCP	20	Business Integrity	Modify A. to include all information requested in C, including legal name of parties, status, etc. This will give complete background information on any pending and closed lawsuits.	Other than government actions addressed in paragraph C below, give a brief explanation and status of current and previous legal action for the past three years, including 1. Legal names of the parties; 2. Circumstances; 3. Status (pending or closed); and 4. If closed, provide the details concerning resolution and any monetary payments, or settlement agreements.	Accepted Suggestion.
66	State of New Mexico Medicaid Program	CCP	20	Business Integrity	Add new section VIII. Fraud and Abuse. The applicant should be required to provide information regarding its fraud and abuse activities, including employee education and detection.		Reject for now. CMS will consider adding this section in the near future.
60	Region VI	CCP	22	I. MEDICARE HEALTH BENEFITS AND PROVIDERS - A. 4.	Name of table is shown as Arrangements for Mandatory Supplemental Benefits by County. This differs from the actual name of the table which is HSD-4 ARRANGEMENTS FOR ADDITIONAL AND SUPPLEMENTAL BENEFITS BY COUNTY	Correct name on this page or on the HSD-4 table.	Accepted Suggestion. Change the name on this page.
61	Region VI	CCP	23	I. MEDICARE HEALTH BENEFITS AND PROVIDERS - A. 5.	Name of table is shown as Signature Grid Authority. This differs from the actual name of the table which is HSD-5 SIGNATURE AUTHORITY GRID.	Correct name on this page or on the HSD-5 table.	Accepted Suggestion. Changed the name on this page.
62	Region VI	CCP	28	III. HEALTH SERVICES MANAGEMENT - F	In heading, Encounter Data, the reference shows 422.257. I cannot find this reference in the regs.	Need to correct the reference to the appropriate one.	Accepted Suggestion. Changed citation to 422.310. Change word encounter data to risk adjustment data.

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70	United-Ovations	CCP	10	VII. Health Insurance Portability and Accountability Act (HIPAA), item #6	We are concerned about the short time frame included in item #6 in the attestation. The statement is as follows: Applicant will report to CMS any unauthorized public disclosures of protected health information within 48 hours of the Applicants' detection of such disclosure. We believe that the proposed language creates a reporting time frame that will result in reporting before relevant facts have been determined. We also are concerned that the proposal will require reporting in situations where there is no realistic risk to any individuals and any impact from the breach can be promptly remedied through mitigation actions (e.g., retrieval of an EOB sent to the wrong provider).	We suggest that the language be modified as follows: "report to CMS any material unauthorized public disclosures of protected health information that present a material risk of injury to any individual, promptly upon discovery of the facts related to the disclosure." If CMS determines that a specific timeframe must be required, we recommend requiring reporting within 5 days in place of 48 hours.	Accepted with explanation. The time frame to report the findings to CMS is still under policy discussion. CMS has eliminated the 48 hours time frame to report findings. CMS will let the industry know when a new time frame for reporting has been established.
21	MassHealth Senior Options	CCP		Enrollee Issues (V H)	Not enough to require "best effort" to complete initial assessment within 90 days of enrollment- this is a frail, clinically complex population	Require complete initial assessment for subset dual SNPs within 30 days	Rejected suggestion for now. CMS needs to consider this is comment whether a more strict timeframe is feasible and appropriate.
20	MassHealth Senior Options	CCP		Health Service Management	No LTC reference, only coordination of care with community "social" (not medical) agencies.	coordination of care with community long term care entities	Rejected Suggestion.
19	MassHealth Senior Options	CCP		Provider Contracts	Unclear definition of "provider" and or "legally" binding written agreements	"memorandum of agreement with contingency provisions pending award of contract"	Rejected Suggestion.

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5	AHIP	CCP		VI. UPGRADES OF THE HEALTH INFORMATION TECHNOLOGY	**Implementation of interoperability standards.** AHIP recognizes the importance of implementing a consistent set of interoperability standards, and we support the work of the U.S. Department of Health and Human Services (HHS) and CMS to harmonize health information technology (IT) standards. It is important that when Medicare Advantage (MA) organizations and Part D plan sponsors are required to implement these standards, there is a phased and transparent process for interoperability standard adoption that is consistent across all federal health programs, specifically: -A standards testing and validation program to determine effectiveness in real world situations. -- Opportunity for the public to comment on the proposed implementation timeline and costs. -- Implementation of the standards through a phased approach. It is also important that MA organizations and Part D plan sponsors be given ample time to adopt these standards, especially if the standard is not widely implemented in the health care marketplace, as is the case of some of the recommended Health IT Standards Panel Standards.	We urge CMS to use these principles in developing and implementing the requirements referenced in the draft application.	CMS will take these recommendations into considerations as we develep and implement the interoperability standards.
48	Region IV	EPOG	7	Certification, Item 6	First line of paragraph: "If" Suggest "In."	Revise	Accepted Suggestion.
47	Region IV	EPOG		Certification: Item 4	Last line of paragraph: "is it" Suggest "it is."	Revise	Accepted Suggestion.

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38	Region IV	Form- Cert.doc (State Certification Form)	State Certification Form		Add space where the State can indicate service area.	Revise	Rejected suggestion with explanation. Further discussion is needed on this topic.
22	MMC 20/20	Form- HSD Tables 2A & 3A			HSD 2A has columns for reference to templates (A through D), but table 3A has a reference for "Tab Name".	Table 2A and 3A seem to serve the same purpose, one being for physicain proivider contracts and one for facility contracts. Why are they setup differently and wouldn't it be more clear to have templates A through D in table 3A as well?	Reject the comment for now. CMS will discuss this suggestion, and consider revising table 3A in CY 2009.
25	MMC 20/20	Form- Legal Table 2	Legal-2 Table	Date Executed Column	In the instructions for this table they do not address the situation for varying dates of execution when the number of agreements is greater than 1 and the dates vary.	It would be helpful to note that the word "Various" should be used when there are multiple dates for multiple agreements	Accepted Suggestion. Applicant can insert the number of aggreements and the executed date. For example- 10 agreements executed Jan 1, 10- executed Feb 1, xx.

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15	Gateway	Form- Matrix Adm	Matrix Adm		Matrixadmin showed an update date, so Gateway compared it to last year's 2007 Matrix Admin and we could not find any differences other than the addition of "and" in the last item. Please advise what, if any, other changes were made to the document.	Clarification of changes, if any.	No major changes were made to this document. Regulartory citations have been updated.
28	Region IV	Form- Matrix1.doc	Matrix1.doc	Provider Participation Matrix	The timeline for HHS, GAO and its designees to audit is now 10 years rather than 6 years.	Revise	Accepted Suggestion. Corrected Citation
29	Region IV	Form- Matrix1.doc	Matrix1.doc	Provider Participation Matrix	Confidentiality and Accurary of Enrollee Records: The citation 42 CFR 422.188 listed for appears incorrect. The latest edition of 42 CFR doesn't list this citation.	Delete	Accepted Suggestion. Corrected Citation
30	Region IV	Form- Matrix1.doc	Matrix1.doc	Provider Participation Matrix	Hold Harmless: 42 CFR 422.504(g)(1)(I) appears incorrect. The latest edition shows 422.504(g)(1).	Revise	Accepted Suggestion.
31	Region IV	Form- Matrix1.doc	Matrix1.doc	Provider Participation Matrix	Accountability Provisions:422.504(i)(3)(ii)(A) appears incorrect. The latest edition shows 422.504(i)(3)(ii)	Revise	Accepted Suggestion.
26	MMC 20/20	Form- Matrix2.doc	Matrix2.doc	Header	The header states "Must be included in procedures, standards, and manuals".	Many of these provisions are included in the contracts themselves as opposed to procedures, standards, and manuals. If they need to occur in both places (contracts and internal P&P's) then it should be made clear in the instructions that they may appear in both places but CMS is looking for the refernce to the internal documents (P&P's) as opposed to the location in the contracts (unless CMS will accept either place). It could be more beneficial to add Provider contract requirements through policies, standards, manuals, AND/OR contracts themselves. (If they appear only in contracts and not in manuals, then they must be in every contract?+D3)	Accepted Suggestion. CMS will clarify the instructions for Matrix2.
32	Region IV	Form- Matrixadm.doc	Matrixadm.doc	Administratives Contracting Matrix	Compliance with Medicare laws, regulations, etc.: The citation is listed as 422.504504.	Revise	Accepted Suggestion.
36	Region IV	Guidelines	30	Medicare Advantage Guide	First sentence "Reviewers" including should be included	Revise	Accepted Suggestion.
37	Region IV	Guidelines	30	Medicare Advantage Guide	Third paragraph " If a type of provider" - if the normal pattern of care is to obtain services from another county, should this providers also be listed on HSD tables or is the narrative sufficient.	Clarification	Accepted Suggestion.

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49	Region VI	PFFS	3	Table of Contents, Organizational & Contractional	Misnumbered. Shows I., II., III., VI. (6) Should be IV (4). Also needs corrected on Page 14.	Need to correct VI to IV, the number 4. Also correct on page 14.	Accepted Suggestion.
8	BCBS of Tennessee	PFFS	7	II Medicare Contract Information	Typo on phone number for Don Freeberger	Revise - (410) 786-4586	Accepted Suggestion.
9	BCBS of Tennessee	PFFS	7	II Medicare Contract Information	Typo on phone number for Yvonne Rice	Revise - (410) 786-7626	Accepted Suggestion.
10	BCBS of Tennessee, Region IV	PFFS	8	IV. Key Management Staff	Utilization Management listed twice	Delete - one of the Utilization Management lines	Accepted Suggestion.
67	Tuffs	PFFS	9	General Information - VI. Service Area	B. & C.reference information related to a "network" model PFFS. Would be helpful to have text that indicates what sections are not needed for "Non-Network" model PFFS.	Insert "Applies only to "network" model PFFS plan"	Accepted Suggestion.
35	Region IV	PFFS	13	Organization and Contractual	B. states that state certification is use to verify that the applicant is authorized to operate in the service area requested.	Include space on the state cert for the state to list the service area that the applicant is requesting.	Rejected suggestion with explanation. Further discussion is needed on this topic.
16	Health Partners	PFFS	14	Contracts for Adm. Mgmt Svc	Is numbered VI, should be V.	Revise	Accepted Suggestion with modification. The number has been changed to read: IV
17	Health Partners	PFFS	14	Prov. Cont. and Agreements A.	The yes and no responses reference section VI, which should be Section V.	Revise	Accepted Suggestion. Revised section read " Do not continue with Section V."
39	Region IV	PFFS	14	V. Provider Contracts & Agreements	Sec. A: Change "any" to "all" categories of service.	Revise	Rejected Suggestion. This would imply that the applicant needs to pay all categories at the same rate, which is not true. The applicant must pay at LEAST Medicare rates but can pay more under a non-network model for each category of service.
40	Region IV	PFFS	14	V. Provider Contracts & Agreements	NO: Include "partial network" along with network model. Include a description of the deeming process.	Revise	Accepted Suggestion.
50	Region VI	PFFS	16	VI - D	It is unclear why we are asking the applicant if they will be required to provide conflict of interest statement. Is there a typo in this sentence?	I assume we want each applicant to furnish financial and organizational conflict of interest information.	Clarification: The applicant must attest to this item. Changed lanaguage to read " Applicant **agrees** to provide"
43	Region IV	PFFS	17	Health Services Delivery	1st Sentence: Applicants may decide to contract with providers by paying the Medicare allowable payment rates. We are making an assumption that the applicant will only contract with providers if paying less than the Medicare allowable payment.	Revise	Rejected Suggestion for now. PFFS team will consider this change for 2009 applications. Futher discussion is needed.

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41	Region IV	PFFS	17	Health Services Delivery	Change"any" to "all categories of service.	Revise	Rejected Suggestion. This would imply that the applicant needs to pay all categories at the same rate, which is not true. The applicant must pay at LEAST Medicare rates but can pay more under a non-network model for each category of service.
42	Region IV	PFFS	17	Health Services Delivery	NO: Include "partial network" along with network model. Include a description of the deeming process.	Revise	Accepted Suggestion.
68	Tuffs	PFFS	17	Health Services Delivery - Opening	This Part opens with choice btw *"Yes This is a Non-Network model PFFS plan. Do not complete Sections II and III. Instead, describe the 'deeming process' (422.216 (f)) and how providers will be paid. Include a copy of the terms and conditions of payment."* and *"No. This is a network model PFFS plan....."* The Non-Network model statement says, *"Do not complete Sections II & III."* What about Section I? Except for I.A., where the "deeming process" can be explained, I.B-D do not apply to a Non-Network model PFFS plan.	Change Non-Network model statement to *"Do not complete Sections I.B-D, II and III."*	Accepted Suggestion.
44	Region IV	PFFS	17	Section D, 3rd paragraph	Since this is an initial application, there should be no reference to "new" service areas	Delete	Accepted Suggestion.
51	Region VI	PFFS	19	IV - C		Add statement that the payment terms and conditions are subject to ongoing review by the RO	Accepted Suggestion.
69	Tuffs	PFFS	20	Health Services Delivery V. Health Services Management	B & and C are not applicable to Non-Network model PFFS	Change text at beginning of V to *(Section A is applicable to both network and non network PFFS model. Section B & C are applicable to network PFFS model. Section C.1. Is not applicable to non-network PFFS model.)*	Accepted Suggestion.
45	Region IV	PFFS	22	Claims	Under the Note section, 2nd sentence: Should this read "each or all" categories of service as opposed to just one category of service?	Revise	Accepted Suggestion.
52	Region VI	PFFS	22	III - B	It is my understanding that CMS no longer "approves" or "tests" certain claims systems. Applicant shoud be required to substantiate the process they use to test the claims system they plan to rely upon for processing claims.	Delete items 1-2 under B-Claims System validation. Renumber remaining items.	Accepted Suggestion with modification. CMS retained item number 1, and deleted item number 2.

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11	BCBS of Tennessee	PFFS	22	III. Claims A.	Typo on phone number for Mervyn John	Revise - (410) 786-1141	Accepted Suggestion.
18	Health Partners	PFFS	23	Claims System Validation D.	#2 regarding submission of procedureal codes not allowed or automatically denied. This seems like a document that could potentially change frequently and could be made availablefor submission as needed or at an	Delete	Reject recommendation for now. Internal discussion is needed. CMS may consider this recommendation in the future.
12	BCBS of Tennessee	PFFS	23	d.	Last sentence word left out.	Revise - This report will outline the investigation and the resolution including the completion **of** a CMS designed worksheet.	Accepted Suggestion.