Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part C	Calendar	Calendar does not mention anything about SAEs submitting a notice of intent on 11/18/08. Only mentions new MA organizations.	Recommend adding another line showing that the notice of intent for SAE's are also due on 11/18/08.	We agree with the comment and have changed the dates in the calendar. However, we have also noted that all dates are subject to change depending upon the number of applications CMS receives. (page 6)
Part C **Initial Application Question 2**	1.3.1 – State Licensure	Application states that applicant must provide an executed copy of a state license **and/or** state certification form	In the 2009 applications both a state license and signed state certification was required. If that is the case for the 2010 applications, which it appears to be, recommend stating that clearly in the application to avoid confusion. Takes a lot of time to collect this information from the state.	CMS agrees with the comment and CMS has clarified that in the vast majority of cases a State license and certification are available and necessary in those instance. However, because of issues with certain States CMS will allow other types of communications to be provided in lieu of the Certification. Additionally, we clarified the date in which the plan must submit the information in writing. (pg. 13)
Part C	1.5 - Compliance Plan	Typo for the year in the note - says 20010.	Change the date to 2010.	We agree with the commenter and have changed the date to read 2010. (Pg.16)
Part C **Initial Application Question 4**	1.8 - Filing for Partial County	Question #1 indicates a plan is attesting to the county integrity rule as outlined in Chapter 4 of the Medicare Managed Care Manual. However, if a plan is only filing for a partial county, the county integrity rule is not applicable.	It is recommended the question be updated to reflect the 2009 application that contained additional wording clarifying that YES meant the applicant was applying for a partial county.	CMS does not agree with the comment, it is possible that the commenter misread the requirement. It is incorrect, that by checking "yes" to 1.8.B1, the applicant is filing for partial counties. (Pg. 20)

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part C **Initial Application Question 5**	1.6.B – Key Management Staff	Application asks for position description for key management staff and organizational chart for various departments.	Key management staff that is managing our current MA HMO, LPPO, PFFS contracts will be responsible for the initial and SAE contracts. In 2009 we were not required to submit position descriptions, etc.; we were allowed to include an explanation in the Experience and Organization History document. Because existing management will be utilized for any initial or SAE, we recommend following the same approach for the 2010 applications.	This section in the 2010 application is the same as the 2009 application. The requirements have not been changed and therefore CMS does not accept the comment. (pg. 21)
Part C **Initial Application Question 6**	1.8 - Service Area	**A:** The requirement is to submit 4 separate service area maps.	Humana's preference is to provide map sets per "service area" versus " per "county". We believe it provides CMS with a more comprehensive network perspective. Access to care does not stop at the county line.	This part of the application clarifies CMS' intent that an applicant is required to submit by county. If they want to provide maps which show additional information, such as mountains, streets and areas they may do so but this information is not required. (pg 21)
		B: The 1st map is to reflect the boundaries of the county as well as main traffic arteries (highways, interstates) and any physical barriers such a mountains and rivers.	For 2009, Humana provided major highways and interstates only; also this information was provided only once, on map #1 as stated here. Is this sufficient for 2010 apps?	The response listed above, also applies to this comment and applicants are required to submit a first map for each county as instructed.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
		C: The 1st map should include contracted ambulatory (outpatient stand-alone) facilities with the mean travel times to each location	For 2009, Humana provided mean travel times only once on map #1 as stated here. We interpreted "ambulatory (outpatient stand-alone) to mean outpatient surgery centers to include free-standing	The commenter is correct.
		D: Application states that "on the second map, each **specialty type** should be delineated as a separate color or symbol."	Should read "facility type."	CMS has accepted this comment and amended the application to reflect the suggested language. (pg. 23)
Part C **Initial Application**	1.8 - Service Area	Application states that on the fourth map, each type of facility should be delineated as a separate color or symbol,	This should read 'specialty type". Software limitations allow a legend for decoding 12 plotted specialties and there are over 20 specialties on HSD 1. For 2009, Humana submitted the map legend as a separate file. We recommend that this	The commenter has a good suggestion and CMS will explore the possibility for future applications

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part C **Initial Application Question 8**	1.9.C – Provider Contracts and Agreements	Application asks for the sample copy of each provider contract and corresponding matrix.	We use the same contract template for each of its product type (i.e. HMO, LPPO). Recommend that either we enter the sample contracts once and have the ability to copy over to each of the applications it applies to or a drop down box (similar to the Marketing module) where we designate what contracts these providers contracts apply to. This will help reduce the possibility of error because we do not have to submit the same contracts multiple times under different file names. Additionally this will also assist CMS in the review of the application. CMS will not have to look at the same contracts multiple times.	The commenter has a good suggestion and CMS will explore the possibility for future applications
Part C **Initial Application**	1.9.C – Provider Contracts and Agreements	Under #2, the statement "Providers and suppliers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records" seems to be missing a bullet.	This statement appears to be a bulleted list. Recommend adding a bullet and making sure the list has the bullets where appropriate.	CMS agrees with the commenter and have corrected the application. (pg 21-22)

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part C **Initial Application Question 10**	1.10.C – Contracts for Administrative & Management Service	Application asks for an executed copy of each delegated administrative services/management contract and corresponding matrix.	Many of our delegated administrative contracts apply nationwide. As mentioned with the provider contracts, we recommend that either we enter the sample contracts once and have the ability to copy over to each of the applications it applies to or a drop down box (similar to the Marketing module) where we designate what contract these administrative services contracts apply to. This will help reduce the possibility of error because we do not have to submit the same contracts multiple times under different file names. Additionally this will also assist CMS in the review of the application. CMS will not have to look at the same contracts multiple times.	The commenter has a good suggestion and CMS will explore the possibility for future applications
Part C **Initial Application**	1.10.3 - Contracts for Administrative & Management Services	The statement "Note: This question is not applicable to PFFS and MSA PFFS network model applicants" may be confusing, as there is no MSA-PFFS plan type.	For clarity, this should be reworded to "This question is not applicable to network-based PFFS and network-based MSA plan applicants."	CMS agrees with the commenter and changed the language to read: This question is not applicable to non-network-based PFFS and non network-based MSA plan applicants." (pg. 24)

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms Question 13	2.4 - Instruction for CMS Provider Arrangements by County Table	Instructions asks for one separate table for each county	Recommend that applicants have the ability to submit one file per service area and within that table have different tabs for the different counties in that service area as we did in 2009.	CMS does not accept this comment, the applicant must have each service area delineated in order for CMS to assure adequate access to services.
Part 5 - Instructions for Completing CMS Forms Question 14	2.7.1 - HSD 1 Table	The draft HSD 1 table still contains the "Available Medicare Providers by County" Column.	Humana still has concerns about obtaining that data. We have had discussions with CMS about obtaining www.medicare.gov physician finder data (PECOS file which powers the medicare.gov directory data) but it does not appear that we can get access to this file. Therefore we recommend that we continue to pull the data from the same source where we pulled the 2009 information and add a footnote to the HSD 1 table explaining where we wpulled this information . We recommend that CMS provide a standard data extract from the medicare.gov physician finder (representing available providers) to all applicants. This would ensure consistency within submitted applications/HSD tables (avoid variation when one	This is not a new requirement and CMS will continue the current policy that applicants may select among various source of data for this information

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms Question 14	2.7.1 - HSD 1 Table	The draft HSD 1 table now asks for counts for providers on the HSD 3 table.	The list of provider types that must be reported on HSD 1 has been expanded beyond what is reported on HSD 2 to include provider types from HSD 3. HSD-3 is currently designed to capture hospitals that offer several of these services. However, if we list the hospital on HSD-3, do we list it multiple times (once for each service provided)? If so, how would we arrive at the correct unique	this is not a new requirement and CMS will continue the current policy which is, that applicants may select among various sources of data for this information.
Part 5 - Instructions for Completing CMS Forms Question 15	2.7.1 - HSD 1 Table	For the HSD-1 table, are there any guidelines on what types of subspecialties we should pull from the Medicare.gov website to populate the Medicare provider counts for HSD 1 (e.g. - if we go to a state and county and pull cardiology, several subspecialties come up. We know there are some that should be ruled out).	We would appreciate CMS developing and providing additional guidance on how to select the appropriate subspecialties to populate HSD 1.	CMS agrees with the commenter . The applicant can count the hospital for each service it provides. For example. If the hospital as a laboratory and radiology facility, the hospital would be included in the total count for hospital, laboratory and radiology.
		Can plans request a provider file from CMS containing the Medicare participating providers available within a county - defined by specialty and number of providers available?	If yes, please advise how this type of report can be requested.	CMS does not have a report that applicants can use to determine this data nor would we prescribe a data source. We rely on applicants to obtain the requested data in whatever manner they decide.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms Question 16	2.7.1 - HSD 1 Table	Facilities new to HSD 1: Are there any look-up guidelines for facilities?	Some facilities can be located on the Medicare.gov website, however, we recommend CMS provide guidance and make available other websites/URLs to assist in identifying all applicable facility counts for a county.	As mentioned above, this is not a resource CMS provides, therefore, applicants should use whatever recourse suits their needs. Furthermore, the application already provides this information on HSD 3 table.
Part 5 - Instructions for Completing CMS Forms Question 17	2.7.1 - Table HSD 1 and 2.7.2 - Table HSD 2	The instructions state that applicants should use the EXCEL Spreadsheet Data/Sort Function of HSD 2 to populate HSD 1 "Total # of Providers."	The list of provider types that must be reported on HSD 1 has been expanded beyond what is reported on HSD 2 to include provider types from HSD 3. Recommend that CMS expand the instructions to include counting methodology for the expanded list.	CMS agrees with the commenter and the instructions with be clarified in the next years contract.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms Question 18	2.7.1 - Table HSD 1 and 2.7.2 - Table HSD 2	Release of HSD tables prior to final release of application in early January	While it is recognized and appreciated that CMS has provided the draft application earlier this year, it is requested the final HSD tables be made available by November or December 1 rather than with the released of the final application in early January. This would allow organizations with a high volume of submissions additional time to train network personnel and sufficient time to upgrade HSD tools, Excel formulas, etc. on any changes made to the tables. In addition, it is recommended that the tables to consistent from year to year.	CMS agrees with the comment and will take comment into consideration for future applications.
Part 5 - Instructions for Completing CMS Forms- Question 19	2.7.2 - Table HSD 2	Instruction #6 regarding admitting privileges states that if the provider does not have admitting privileges other than one contracted hospital, to use an abbreviation and place a footnote at the bottom of each page.	This is a new instruction. Need further clarification from CMS on what is expected.	CMS believes the instruction is clear as it currently reads. We will take the comment under advisement and if additional instructions are necessary we will issue them at a future date.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms- Question 20	2.7.2 - Table HSD 2	Instruction #12 states that applicants must input "DC" for direct contracted Medical Group Affiliations in column number 3	This is not a new instruction, however, not consistent with instruction #3 "Contract Type". Instruction #3 says "D" for Direct and "W" for Downstream are the only variables to use, however, instruction #12 introduces a 3rd variable--"DC". This should be consistent, either use "D" or use "DC".	CMS agrees with the comment and amended the application so that uniform terminology is used. (Pg. 121)
Part 5 - Instructions for Completing CMS Forms- Question 21	2.7.2 - Table HSD 2	Instruction #13 asks whether the provider is an employee of a medial group/IPA or whether a downstream contract is in place for that provider.	As stated above for instruction #12, this is not a new instruction, however, not consistent with instruction #3 "Contract Type". Additionally column/instruction #3 addresses the "downstream" question so why is it being asked again? Isn't the real intent here to identify the employed providers, so the options would be "E" or blank?	CMS agrees that the commenter has a good suggestion and CMS will explore the possibility for future applications

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms - Question 22	2.7.4 - Table HSD 3	Instruction #1 says applicants must arrange contracted entities alphabetically by county and then alphabetically by provider.	Are we allowed to include more than one county in a single HSD 3 file and not separate in county level worksheets (tabs within the file)? Instruction #1 and the file name in Part 6 - "List of Requested Document" indicates that we separate HSD 3 by county which would eliminate the need to sort by county. We recommend the option of either having separate HSD 3 by county or having on single HSD 3 file with county level worksheets (separate tabs within the file)	In response to the question are applicants allowed to include more than one county in a single HSD table the answer is "yes". CMS expects applicants to maximize the excel spreadsheet to be able to include more than one county per work sheet. Applicants may also have a single HSD 3 table with county level worksheets, separated by tabs.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms- Question 23	2.7.4 - Table HSD 3	Column explanation instructions provide a set of specialty abbreviations to use	This is not a new instruction, however, we would like to use specialty codes other than what is prescribed. For example, instead of stating "OTHER" for DME providers we want to actually state "DME" in the "Type of Provider" column. This would allow efficiency by eliminating the steps to convert our PIMS codes to CMS codes for the HSD 3 and then back to PIMS codes for the purposes of mapping.	CMS agrees that the applicant may identify the type of provider in the "other" category.
Part 5 - Instructions for Completing CMS Forms - Question 24	2.7.6 - Table HSD 4	Instructions say to arrange benefits alphabetically by county and then numerically by zip code. Instructions for Steps 2-5 say that we need to list the **county** the provider serves from this location.	This is not new text. The instructions indicate that applicants need to separate HSD 4 worksheets by county which would eliminate the need to sort by county. As mentioned above, we recommend the option of having one single HSD 4 file with county level worksheets (separate tabs within the file). We had this ability for the 2009 applications.	The commenter has a good suggestion and CMS will explore the possibility for future applications

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms Question 25	2.8 - Part D Schedule, Pharmacy Access, MA-PD	This section indicates that there will be a courtesy submission window and a final submission window for Part D but does not contain the dates or the open duration of the windows.	Please clarify the dates and length of time for both submission windows.	CMS agrees with the comment and has amended the application to use the same calendar as Part D but all dates are subject to change depending upon CMS workload.
		In addition to clarification, it is recommended that CMS apply the Part C application scheduling correction timeframes to the Part D application process. This would include having the same corrections windows scheduled in HPMS for responses to the incompleteness and intent to deny letters.	At a minimum, an opportunity to make corrections to Part D applications should be made available prior to April. This would provide plans with an opportunity to correct discrepancies or supply minor information and avoid unnecessary Notices of Intent to Deny.	CMS agrees with the comment and has amended the application to clarify the data needed..
Part 5 - Instructions for Completing CMS Forms-Question 26	3.1 - Access to Services	The statement references both full and partial networks for PFFS plans.	Please clarify if CMS considers a partial network type of plan to be network-based or non-network-based. And, if a PFFS plan files with a partial network in 2010 will it be required to complete another application in 2011 if it is located in a service area with two or more coordinated care plans?	CMS has not competed its analysis regarding the PFFS competition rule and cannot respond to this question at this time.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 5 - Instructions for Completing CMS Forms-27	3.1 - Access to Services	Both statements refer only to contracted networks where providers are paid less than Original Medicare.	Please clarify why there is a distinction in these statements between paying above Medicare, paying less than Medicare, and paying at Medicare.	CMS agrees with the comment and has amended the application to clearly explain what is necessary for each type of provider
Part 6 -List of Requested Documents - Question 28	Part 2 Initial Applications - Section 1 - All Applicants	Application requests that the applicant submit the following documents: - Insurance Table Coverage - History/Structure/Org. Charts - Audited Financial Statement	As mentioned with the provider contracts and administrative services contracts, these documents apply nationwide. We again recommend that either we enter the sample contracts once and have the ability to copy over to each of the application it applies to or a drop down box (similar to the Marketing module) where we designate what contracts these documents apply to. This will help reduce the possibility of error because we do not have to submit the same contracts multiple times under different file names. Additionally this will also assist CMS in the review of the application. CMS will not have to look at the same contracts multiple times.	CMS agrees with this comment and has amended the application to clearly explain what is necessary for each type of provider. (pg 113)

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Part 6 -List of Requested Documents - Question 29	Part 2 Initial Applications - Section 1 - All Applicants	According to the file name, HSD tables are to be submitted by county.	Recommend that we have the ability to submit one file per service area and within that table have different tabs for all the different counties in that service area. We had this ability for the 2009 applications. This would apply to HSD 1 - 5.	CMS agrees with this comment and will explore the recommendation for future automation.
Part 6 -List of Requested Documents Question 30	Part 2 Initial Applications - Section 3 - PPO Applicants	Part 2 Initial Applications - Section 3 - **PPO** Applicants is incorrect.	Need to change the title to **PFFS** Applicants since this applies to PFFS not PPO.	CMS agrees with the comment and has amended the application to read PFFS.
Part 6 -List of Requested Documents - Question 31	Part 3 - SAE Applications - Section 1 - All Applicants	According to the file name, HSD tables are to be submitted by county.	Recommend we have the option to have the ability to submit one file per service area and within that table have different tabs for all the different counties in that service area. We had this ability for the 2009 applications. This would apply to HSD 1 - 5.	CMS agrees with this comment and will explore the recommendation for future applications.
MAO ("800 Series) EGWP Application - 32	Application Instructions, 1st bullet	Instructions state the application must be submitted by 3/10/08	Need to change the filing date to 2/26/09.	CMS accepts the comment and will amend that application to have the 2/26/09 filing date.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Miscellaneous -33	Communication Channels Part A	Last application season, communication was effectively discouraged between the CMS Regional Offices and the applicants, since the content of those communications were not considered part of the official application record in HPMS. This limited the free exchange of information and increased the number of issues in the appeals process.	Applicants and CMS reviewers should be encouraged to communicate so that necessary information can be supplied and reviewed with the understanding that critical information be added to the HPMS record prior to an approval. For example, a reviewer requires a document that was not uploaded in the incompleteness window of March 30th. Instead of issuing an Intent to Deny Letter of April 24th and the applicant having to wait until April 24th to supply the required information, it could be supplied directly to the reviewer. This would allow the application to process through without the delay. That information could then be uploaded into HPMS either by the reviewer or by the applicant during the next available window.	CMS has formed a workgroup to address this comment and there will be future communications to the applicants. In the meantime, CMS requires that the information be uploaded into HPMS as designated deadline for State licensure is May 4, 2009.
	Change History Document - Part B	During the 2009 application process, CMS was not always aware when plans had made changes as requested by CMS in an incompleteness letter. This may have been, in part, because the electronic process in HPMS apparently did not alert CMS reviewers that certain files had been re-uploaded or updated.	Adding a "Change History" document to the HPMS module or a mechanism to upload such a document as part of the plan response to an incompleteness letter would alert CMS reviewers to changes and facilitate a more efficient review.	CMS will consider this comment when preparing future application automation..

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
	Schedule for Correction Windows - State Licensure Part C	During the 2009 application process, a 1 day window of time was provided for uploading state licensure information by the June deadline. The 2010 tentative schedule does not reflect a window for this purpose. The last window per the 2010 schedule ends on May 4.	Since the deadline for information regarding the state licensure is the first Monday in June, please provide a later window for plans to submit that information.	CMS agrees with the comment.
	Application Submission Deadline - Part D	The deadline for the 2010 application submission is more than two weeks earlier than the 2009 applications were due. Aetna has been tracking towards a mid-March filing date.	This change in the timeline negatively impacts our network contracting efforts, as each year the application deadline is moved forward, allowing less time to execute contracts with providers required for the network to meet network adequacy requirements.	As mentioned above the dates provided in the calendar are subject to change.
	Website Updates _ Part E	How often is Medicare.gov refreshed with updated provider information?	Provider information that is as recent and accurate as possible would assist plans in the application process.	The Nursing Home Compare part of the website is updated monthly. All other parts of the website are updated quarterly.
Special Needs Plans Section				
State Medicaid Agency Contracts	Pages 71 and 78.	We are in the process of reviewing and commenting on the proposed regulations, which contain the same requirements provided under the draft application. We note that MIPPA requri3s that SNPs have a contract with the state to provide for or arrange for benefits for dual eligible population but does not address each of the identified eight elements. Rather than requiring SNPs to reproach states in this		CMS will take comment into consideration and provide both flexibility and guidance to implement MIPPA.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
Checklist of providers	pg 87	This section has a series of questions (checklist) asking whether the SNP network includes various types of providers. If the purpose of the checklist is for plans to attest to the presence of each type of provider, it seems unnecessary and redundant, since plans are already supplying HSD tables. Also slight variations may require a different set of		CMS will consider for future revisions.
State Assessment Tool	p 82	In this portion of the SNP section, the application states that institutional snaps serving those in a community should base their enrollment on a state assessment tool. It further states that the assessment must be performed by an entity other than the organization offering the SNP. Large healthcare companies, such as United Health , have distinct affiliates which could perform the assessment outside of the health plan, this		MIPPA requires the assessment to be performed by an entity other than the organization offering the plan. CMS believes this to mean that the entity should be not related or controlled by the MA>
Service Area Expansion Application.	p 78 et.al.,	The draft application indicates that adding a SNP type to an existing contract would require a full SAE Application. Previously CMS allowed organizations that were adding a SNP to their existing service area to file the SNIP section of the application along with HSD tables to CMS outside of the regular application process.	CMS should continue to make this option available to plans that seek to only add a SNP type product to their existing contract/service areas. The reduced sort of documentation could be supplied via HPMS if that option was made available so that ether is an electronic record. For example, if a plan wants to	The requirements have not changed for requesting a new SNP type. CMS will allow organizations that were adding a SNP to their existing service area to file the SNIP section of the application. This process will be performed using HPMS.
Contract with Assisted Living Facilities (ALF)		the purpose of the question regarding whether or not the plan has a contract with assisted living faculties is unclear. Since ALFs do not provide Medicare reimbursable services, plans do not typically contract with ALFs to serve the members that reside in the ALF.	It is suggested CMS remove the word "contracted" and/or clarify the purpose of the question.	CMS concurs with the commenter but the present application reflects the spirit of the commenter.

Application	Section	Description of Issue or Question	Comments/Impact	CMS Responses
SNP Care Management Requirements	P 84	It is unclear when indicating which model of care applies to a plan whether each plan must have a special model of care for end-stage renal disease. Please clarify that a plan only needs to check the model of care to manage the delivery of specialized services and benefits for individuals with ESRD if the plan has requested an ESRD waiver. Also it is unclear whether this section is designed to identify which type of special needs plans the applicant is providing or to identify whether	It is recommended that the plan identify the model of care that is relevant to the SNP for which they are applying>	CMS concurs with the commenter.
Health Risk Assessment	p 91	MIPPA requires that SNPs conduct "an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs, and "develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided." It appears that the application has placed additional requirements on the plan regarding the format and content of the assessment. Based on our experience, often the member is best served if the plan can conduct an initial baseline assessment to identify whether the individual would benefit from a more comprehensive assessment. To require a comprehensive assessment on every individual creates an undue burden on the plan both in terms of overall cost and personnel, and it not necessary to ensure that the individual is receiving plans flexibility to identify and design assessment tools that meet		CMS recognizes that some MAs may be perfuming more than required in MIPPA. The SNP proposal application is designed to identify those MAs performing more than the MIPPA requirements, not to place additional requirements on the plan regarding the format and content of the assessment. The MA should report the applicability of their processes and procedures in the SNP proposal application.