OVATIONS
A UnitedHealth Group Company

WI080-1000
2725 Mall Drive
Eau Claire, WI 54701

To: CMS, Office of Strategic Operations and Regulatory Affairs
Attn: Document ID: CMS-2008-0104-001; CMS-2008-0103-001
OMB Office of Information and Regulatory Affairs
Attn: CMS Desk Officer

Submitted electronically at: http://www.regulations.gov.

From: Michael Warschauer, Sr. Project Manager, Product Administration, Ovations
Barbara Reid, Manager, Regulatory Affairs, Ovations

Date: October 20, 2008

Re: CY2010 Master Application Automation Consolidated Collection:

- CMS-10237, Medicare Advantage - Part C
- CMS-10214, MA Organizations to Offer New Medicare Advantage Employer/Union-Only Group Waiver Plans
- CMS—10137, Part D Plan Applications

We have reviewed the CY2010 Master Application Automation Consolidated Collection in response to the notice published under the Paperwork Reduction Act in the September 18, 2008 Federal Register (73 FR 54160) and provide the attached comments concerning the following applications:

-Part C – Medicare Advantage Application;
-Service Area Expansion Application for Medicare Advantage;
-Application for Prescription Drug Plans (PDP); and
-Application for Medicare Advantage Prescription Drug (MA–PD);

These comments are provided on behalf of Ovations and other UnitedHealth Group affiliates, including AmeriChoice, that manage Medicare Advantage and Part D business (collectively "United").

We greatly appreciate the opportunity to comment, and we look forward to continuing to work with CMS to develop successful products and services for Medicare beneficiaries. If you have any questions or concerns on our comments, please contact Michael Warschauer at 740-824-5142 or via email at michael_j_warschauer @uhc.com or Barbara Reid at 715-832-5235 or via email at barbara_reid@uhc.com.

CY2010 Master Application Automation Consolidated Collection

Comments Submitted by
UnitedHealth Group/Ovations
October 20, 2008

1. Part D Application

Part D Schedule, Pharmacy Access, MA-PD, Section 2.8
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.

In addition to the 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.

2. Part D and Part C - Medicare Advantage Applications

a. Communication Channels
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 on 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 proceed through the process without delay. That information could then be uploaded into HPMS either by the reviewer or by the applicant during the next available window.

b. Change History Document
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 due, 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.

3. Part C - Medicare Advantage Applications

a. Filing for Partial County, Section 1.6
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.

b. Contracts for Administrative & Management Services, Section 1.10, Statement #8
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."

c. Health Services Management & Delivery, Section 1.11, Statement #4
Same comment as in 3.b., above.

d. Quality Improvement Program, Section 1.12
Both the table of contents and the title indicate that this section applies to CCP and RPPOs only. However, MIPPA requires that PFFS participate in quality improvement programs beginning in 2010. Therefore, PFFS plans should be required to complete this section of the application as well.

e. Access to Services, Section 3.1, Statement #4
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?

f. Access to Services, Section 3.1, Statement #4 and Statement #5
Both statements refer only to contracted networks where providers are paid less than Original Medicare. Please clarify why is there a distinction in these statements between paying above Medicare, paying less than Medicare and paying at Medicare.

g. Schedule for correction windows-State Licensure
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.

h. 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 that the final HSD Tables be made available by November or December 1 rather than with the release 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 be consistent from year to year.

i. HSD Tables-addition of HSD 3 to HSD 1 and Reporting Participating Providers

Please clarify the intent of adding the HSD 3 providers to the HSD 1 table. The value of the addition is not immediately clear. The addition of "HSD3" providers to the HSD1 table requires plans to report the number of the HSD 3 providers that are participating in the Medicare program. This requires use of the Medicare.gov website which does not always have the information available or makes the information available in inconsistent formats (by county or zip code). This requires plans to do manual counts which become administratively burdensome. It is recommended that CMS supply a more workable data source for determining the Medicare participating providers by county field or, in the alternative, not requiring this field to be completed for these "HSD3" providers. It is further recommended the tables remain consistent with the provider types from year to year unless there is a compelling reason for the change.

j. Claims - Section 1.13.4 Claims, # 2
Currently Attestation #2 reads: “Applicant will ensure that all claims are processed in chronological order, by date of receipt.” Claims are generally processed in the order in which they are received. However, in order to process claims in a more efficient manner, an applicant may not always process every claim in strict chronological order. For example, some claims may auto adjudicate earlier than claims requiring some type of manual review, even if the manually reviewed claims are received earlier.

It is recommended that this attestation be revised to read as follows:

- "Applicant will employ a process that seeks to process claims in accordance with CMS regulations and guidelines.”

This change to the attestation wording will more closely align with the CMS requirements and will allow applicants to answer this attestation with a "yes" without having to qualify the response.

k. Claims -- Section 1.13.4 Claims, # 3
Currently, Attestation #3 reads as follows: "Applicant will give the beneficiary prompt notice of acceptance or denial of a claims' payment in a format specified by CMS."

There are two concerns with the current attestation as worded. First, the phrase "prompt notice of acceptance or denial of a claims' payment" implies that a notice of acceptance or denial is required for all claims. There are some cases where a notice is not required. For example, when there is no beneficiary cost sharing involved (except for PFFS claims), a claim approval notice is not sent to the beneficiary and the provider will receive a provider remittance advice or similar document with payment. In addition, plans might not notify beneficiaries of claim denials when the claim only involves provider reimbursement/liability. Rather, plans may comply with CMS's requirement that, when a claim is denied resulting in member liability, the member is provided with his or her appeals rights.

Second, the current wording of the attestation suggests that plans are required to utilize a format specified by CMS. The understanding from the CMS guidelines is that CMS provides a form notice that can be used for these denials, but this form is not required and plans may provide it in an alternative manner when approved by CMS.

It is recommended that this attestation be revised to read as follows:

- "Applicant will provide CMS required notices of claims'determinations to beneficiaries."

The suggested change in the wording of the attestation will more closely align with the CMS requirements and will allow applicants to answer this attestation with a "yes" without having to qualify the response.

l. Claims -- Section 1.13.4, Attestation # 4

It is recommended that this attestation be revised to read as follows:

- "Applicant will comply with all applicable standards and requirements and establish meaningful procedures in accord with CMS requirements for the development and processing of claims including having an effective system for receiving, controlling, and processing claims actions promptly and correctly."

This revision will more closely align with the CMS requirements. For example, plans may not "develop" all claims that are incomplete, such as certain claims that are missing information or have invalid coding. These claims typically involve only provider liability, so they would not affect the member. This slight change in the attestation wording would allow plans to answer this attestation with a "yes" without having to qualify the response.

4. Part C – Medicare Advantage Applications – Special Needs Plans Section (SNP)

a. State Medicaid Agency Contracts, pp 71, 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 requires that SNPs have a contract with the state to provide for or arrange for benefits for dual eligible individuals. In a number of states, the MA organization sponsoring a SNP may already have an existing agreement with a state Medicaid agency that addresses the dual-eligible population, but does not address each of the identified eight elements. Rather than requiring SNPs to reapproach states in this situation, we recommend that CMS provide SNPs and states with as much flexibility as possible in identifying and designing the contract that will satisfy the MIPPA requirements.

b. Checklist of providers, p. 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 responses for each SNP application and for each particular county which drastically increases the number of responses required. It is recommended that this section be removed and CMS refer to the HSD tables to analyze the SNP network.

c. State Assessment Tool, p 82

In this portion of the SNP section, the application states that institutional SNPs 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 UnitedHealth Group, have distinct affiliates which could perform the assessment outside of the health plan. This would create operational efficiencies and reduce costs while maintaining an arm's length transaction. Please clarify that CMS does not intend to preclude affiliated companies, who are distinct entities from the health plan, from performing the State Assessment for their sister companies.

d. Service Area Expansion Application (SAE), 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 SNP 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 contracts/service areas. The reduced set of documentation could be supplied via HPMS if that option was made available so that there is an electronic record. For example, if a plan wants to add a chronic SNP to a dual SNP area, the Part C application requirements are the same. If there is a different network, then the plan could submit the additional HSD table(s). If utilizing the same network, then the plan could use the tables filed for the existing plan.

e. Contract with Assisted Living Facilities (ALF)

The purpose of the question regarding whether or not the plan has a contract with assisted living facilities 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. This would remain true even if the Institutional SNP wishes to offer an Institutional SNP for qualified beneficiaries in a community setting. It is suggested CMS remove the word "contracted" and/or clarify the purpose of the question.

f. SNP Care Management Requirements- Targeted Special Needs Individuals, 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 the applicant has specialized models of care to serve each identified population. For example, a plan may have one model of care that is designed to meet the needs of individuals who are dual eligible and medically complex. Does the plan check the box that will identify the type of SNP they are applying for or each model of care that is applicable? It is recommended that the plan identify the model of care that is relevant to the SNP for which they are applying.

g. 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 plans 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 costs and personnel, and is not necessary to ensure that the individual is receiving appropriate services/benefits from the plan. It is recommended that CMS allow plans flexibility to identify and design assessment tools that meet the requirements under MIPPA, and allow plans to conduct comprehensive assessments on those individuals who would most benefit.