CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS/ Organization/Region	Application Part	Application Section *(Number/ Header)*	Application Page Number *Please note #s may vary by 1-3 pgs based on revised pagination	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	Additional Comments	Description of CMS Response (Rationale)	CMS Decision (Accept, Reject, Clarify)
3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
4	RO9	General Info	1.2	4	Application lists State Licensed PSOs as a type of Coordinated Care Plan, which implies that we accept a PSO application just as we do the others in the list: LPPO, HMO, RPPO, etc. CMS does not accept PSO applications; these organizations must apply as HMOs.	Remove PSO from the list or add a caveat that PSOs must complete the HMO application.	Deletion	RO9 had to convince an applicant to withdraw its PSO application (it had also submitted an HMO application) and had a difficult time convincing the applicant that we would not review the PSO application.		Accept
	RO2	General Info	1.2	4	Fact Sheets	Did not see any link to Product Fact sheets on this webpage.	Revision		The link will be verified.	Accept
5	RO2	General Info	1.3	5	Link for manuals incorrect	http://www.cms.hhs.gov/Manuals/	Revision		The link will be verified.	Accept
6	RO2	General Info	1.4	5	Regional Staff contact list	The phone numbers for RO2 are incorrect on in application and the list on the web.	Revision	For RO2,telephone number should be 212-616-2353 on both lists.		Accept
8	RO9	General Info	1.4	6	RO7 listing is in ALL CAPS, which is not the same format as the other addresses.	Change RO7 description to match the others.	Revision			Accept
9	RO2	General Info	1.4	7	The link for general information is PartCappcomments@cms.hhs.gov. Not sure if this is correct.	Check to see if the address should be ma_applications@cms.hhs.gov	Revision			Accept
11	RO9	General Info	1.5	7	Under Section B, the application states "Applicants are required to provide prompt entry and ongoing updates of data in HPMS. By keeping the information in HPMS current, the applicant facilitates the tracking of its application throughout the review process and ensures that CMS has the most current information for application updates, guidance and other types of correspondence." I don't understand what that means.	Suggested revision: "Applicants must promptly enter organizational data into HPMS and keep the system accurate. This ensures that CMS has timely information and is able to provide guidance to the appropriate contacts within the organization."	Revision			Accept
12	RO2	General Info	1.6	7	Access to data link did not work		Revision		The link will be verified.	Accept
14	RO9	General Info	1.6	7	The very end of the second paragraph refers to a "new MAO number". What is that? Do we mean "new contract number"?		Revision			Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
109	RO 9	General Info	1.9		RO 9 recommends that the zip code reduction (resulting in a full to partial county) come in no later than the second upload and that it must include the partial county justification. RO9 also recommends that if CMS requires an applicant to drop some zip codes, resulting in a partial county, later than the second upload, then we not require the partial county justification since we are the ones requesting that the service area only be				The revised section will now read, "Applicant organizations seeking to withdraw an entire pending application or seeking to withdraw counties from a pending application's service area must submit a written request to such effect on the organization's letterhead and signed by an authorized corporate official by May 21, 2010 (tentative date). Zip code withdrawal requests must likewise be requested through a written request by an authorized official, though must be submitted to CMS by April 5, 2010 (tentative due date for an organization's	Accept
22	RO9	Instructions	2.5	12	In the third paragraph, we fail to make it clear that our on-site visits can occur at any time during the application process as well as after contract signature and throughout the operational life of the organization.	Suggest extending the first sentence of the third paragraph to include, "…throughout the application process, as well as at any time both prior to and after the start of the contract year."	Insertion			Accept
26	RO9	Instructions	2.5	13	The paragraph under the section heading "Types of Application" does not seem to fit here as it does not discuss application types but instead encourages plans to research their requirements. RO9 thinks this language is important, but it should not be included here.	Suggest moving the paragraph, "CMS strongly encourages…revised guidance documents" to section 2.1	Revision			Accept
30	RO9	Instructions	2.6	15	Chart 1 Required Attestations: Should there be a column under SAE for MSA Demo?		Insertion			Accept
HSD 01	RO2	HSD Table 1	2.7	1	Specialty type: Gerontology	A gerontologist is not a physician. The term gerontology needs to be changed to geriatric. Geriatrics is a branch of medicine that deals with the diseases of the elderly. Geriatricians must be a MD and geriatrics is a sub specialty of Internal Medicine requiring Board certification. Gerontology is the scientific study of the process of aging and the problems of aging and is multidisciplinary. Social Workers, psychologists, Registered Nurses can obtain a PHD in gerontology and be considered gerontologists. Being a MD is not required.	Revision	Defer to training.	The word "gerontologist" was changed to "geriatrician."	Accept
HSD 11	RO2	HSD Table 3	2.7	12	Only list providers who provide Medicare required services.	Recommend changing to "Only list the Medicare-Certified providers who provide the Medicare required services". Also recommend instructions to list the name of the provider and not the parent corporation; for example a plan may list ABC Corporation for the name of a SNF or hospital instead on Okay Nursing Home or Best Medical Center.	Revision		CMS agrees that if the facility is part of a system, the applicant will name the individual facility name and not the parent organization.	Accept
58	RO7	Attestations	3.05	28	#8-plan should include procedures to report… noncompliance	LEGAL-last sentence-"This compliance plan should include procedures to voluntarily self report potential fraud, misconduct, or noncompliance related to the Part C program to CMS or its designee."	Revision			Accept
60	RO2	Attestations	3.07	30	Upload section	There is no section B which itemizes required uploads.	Revision		Subpart B for section 3.7 has been added to this version of the application.	Accept
61	RO10	Attestations	3.08	31	Require a narrative description of the service area	Require Plans to submit a narrative description of a service area or each county, describing physical boundaries, barriers to access such as rural roads and conditions, where concentration of benefits and services are located, patterns of care, absence of specialties or facilities in the area etc.	Insertion			Accept
106	RO9	Attestations	3.16	50-51	It is unclear why we are specifically referring to PSO requirements throughout this section as CMS is not accepting PSO applications and the PSO organization that submits an HMO application must meet the HMO requirements.	Delete references to PSO	Deletion			Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
89	RO7	Attestations	3.17	54	Table item #5	CLARIFICATION - Should be submitted to CMS within 7 calendar days per Medicare Managed Care Manual, Chapter 2.	Revision		The revised attestation #5 reads, "Applicant will submit enrollment, disenrollment and change transactions to CMS within 7 calendar days to communicate membership information to CMS each month"	Accept
91	RO9	Attestations	3.23	58	Does this section apply to all applicants or just RPPOs?	Clarify which applicants must complete this section of the application.	Revision		CMS has revised heading to read: "RPPO Access Standards."	Accept
95	RO7	Document Upload Templates	4.03	80	Privacy and Accuracy of records section - add citation to end	CLARIFICATION - at end add "422.504(a)13"	Revision			Accept
99	RO7	Appendix I - Solicitations for Special Needs Plan Proposal	5	101	Top of page - remove pre-populated responses from response section	CLARIFICATION	Revision			Accept
IND 045	Humana	Appendix I - Solicitations for Special Needs Plan Proposal	5	114-128	For 2011, CMS is providing the following downloads for completion and uploading with the proposal: - D-SNP and C-SNP upload docs - S-SNP State Medicaid Agency Contract Matrix - ESRD Waiver Request Upload Document - Quality Improvement Program Matrix Upload Document	The instructions do not clearly state this but it seems that we need to have a written care management plan that includes the MOC components and the Quality Improvement Plan components which are to be referenced in the matrix provided. If this is correct, then we recommend that CMS is much clearer with these instructions.	Revision		CMS will review current instructions and ensure that they clearly identify which uploads needs to be completed and which ones are in place for guidance.	Accept
IND 046	Humana	Appendix I - Solicitations for Special Needs Plan Proposal	5	93-128	Many other sections list an upload instruction as if it were a separate question. In actuality, there is no question, it is simply an instruction which is tied to the previous question.	These instructions for the uploads should be included in the related question.	Insertion		CMS will review current instructions and ensure that they clearly identify which uploads needs to be completed and which ones are in place for guidance.	Accept
IND 047	Humana	Appendix I - Solicitations for Special Needs Plan Proposal	5	99	The following question needs to be reworded since contracts may not yet be "approved": "Applicant's service area is equal to or less than the counties approved in the State Medicaid Agency(ies) contract."	Recommend changing wording as follows: Applicant's proposed service area is equal to or less than the counties included in the approved or pending State Medicaid Agency(ies) contract.	Revision			Accept
IND 086	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	5	119-125	Model of Care and Quality Improvement Program Upload Documents offer SNPs an opportunity to clarify and explain Models of Care which is a substantial improvement over last year's process.		Revision			Accept
IND 089	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	5	93	States not obligated to contract with SNPs.	CMS has indicated its support of integration on numerous occasions. While MIPPA specifically relieves states of any obligation to contract with SNPs, and it is appropriate to ensure that states understand they are not obligated, CMS has strongly emphasized this point on numerous occasions with no effort to encourage integration via SNPs. The Alliance also urges CMS to take a more balanced approach by encouraging states to at least explore opportunities and potential benefits of integration, with SNP contracts being one vehicle for achieving integration.	Revision		This is currently happening. CMS, through various vehicles has been communicating best practices, answering questions, and offering suggestions that allow for States to determine how SNP partnerships can strengthen Medicaid programs. These conversations occur on a daily basis which allows for a balanced approach. CMS has already conducted training for States, established a Resource Center to assist States in developing contracts for integrated services, and has conducted conference calls with States to clarify MIPPA	Accept
100	RO7	Appendix II - Employer/Union-Only Group Waiver Plans (EGWP) MAO "800 Series"	6.3	131	Middle of page beside box, second sentence	LEGAL - should read "No OTHER TYPES of plans will be offered to individual Medicare beneficiaries under this contract number."	Revision			Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
16	RO7	General Info	1.7 C	10	Protecting Confidential Information section. Last sentence - clarify that CMS will not release information IF applicant has shown it meets requirements for exemption.	LEGAL - New last sentence "Consistent with our approach under other Medicare programs, CMS will not release information that would be considered proprietary in nature IF APPLICANT HAS SHOWN IT MEETS THE REQUIREMENTS ABOVE FOR FOIA EXEMPTION 4."	Revision		The word " FOIA" was added to the suggested revision to ensure clarity.	Accept
15	RO2	General Info	1.7 D	9	Access to data link did not work		Revision		The link will be verified.	Accept
IND 050	AHIP	HSD Instructions	2.7 Health Service Delivery Tables Instructions	16	*Timing of issuance of default values and training.* The draft indicates that CMS intends to make the default values for the network adequacy measures available in November each year. CMS states that the purpose of making required minimum values available is to allow applicants to "gain a better understanding of the required values (i.e., providers and facilities required in each county, in addition to time and distance standards)." It is our understanding that a number of organizations are	Accordingly, for 2011 applications, we recommend that CMS issue the measures as soon as possible this fall and conduct training on both the measures and the pre-assessment tool no later than early November, so that organizations can use the standards to guide their network development and take full advantage of the pre-screening tool. We also support continued availability of the January training on the applications and application process.	Revision		Guidance and training will be provided in October.	Accept
IND 051	AHIP	HSD Instructions	2.7 Health Service Delivery Tables Instructions	16	*Network adequacy measures.* The draft signals that CMS will add time and distance values to the network adequacy criteria and allow applicants to include providers from surrounding counties as part of a county's proposed network of services.	We support this policy and recommend that when the values are released, CMS provide an explanation of the methodology used to determine these and other elements of the network adequacy measures. A detailed understanding of the measures will permit organizations to take the most effective action to meet them or to most appropriately request exceptions and provide the necessary documentation to support exception requests.	Revision		Guidance and training will be provided in October.	Accept
68	RO2	Attestations	3.10	34	Effective January 1, 2010	Suggest removing this phrase.	Revision		CMS deleted the sentence that starts with : "Effective January…42 CFR 422.504(g)(1)."	Accept
75	RO9	Attestations	3.11.A	38	At the top of the attestation table, following our instructions, "PLEASE RESPOND "YES" OR "NO" TO EACH…" we list out the applicants to which this section applies ("For all CCP Applicants including…") Yet we don't include this specific guidance in most other similar instructions.	Suggest including the specific contracts to which the section applies in ALL the attestation instructions.	Insertion		CMS deleted the sentence that starts with: "For all CCP…network."	Accept
IND 027	Humana	Attestations	3.13.A	43	Attestation 9.d and 12 appear to be duplicative.	Recommend using only one of the attestations - attestation 9.d.	Deletion		CMS has already addressed this revision.	Accept
81	RO9	Attestations	3.13.A.A.12	44	Attestation #12 is a repeat of the information in Attestation #9d	Suggest removing attestation #12	Deletion		CMS has already addressed this revision.	Accept
85	RO7	Attestations	3.13.B	46	Table item #2 - last sentence - should it be ID card (not IC card)?	CLARIFICATION	Revision			Accept
84	RO9	Attestations	3.13.B.A.1	46	We should be more specific in Attestation #1 that we are referring to enrollment, disenrollment and eligibility.	Suggest changing #2 to read, "Applicants will comply with all CMS regulations and guidance pertaining to enrollment, disenrollment and eligibility, including, but not limited to the managed care manual…"	Revision			Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
87	RO9	Attestations	3.13.B.A.9	47	In the event of a termination, the applicant should also agree to notify plan members of alternate MA options that are available (not just Part D).	Suggest changing #9 to read, "…alternatives for obtaining alternative MA coverage as well as prescription drug coverage under Part D…"	Revision			Accept
86	RO2	Attestations	3.13B.A.2	46	In #2 do you mean ID card?	Change "IC card" to "ID card"	Revision			Accept
88	RO9	Attestations	3.14.A.1-2	49	It is unclear what the differences are between attestations #1 and #2	Clarify these two attestations or remove one of them.	Revision		Attestation #2 was deleted and attestation #1 was revised to include the following bullets: "• Identify payers that are primary to Medicare • Identify the amounts payable by those payers; and • Coordinate its benefits or amounts payable with the benefits or amounts payable by the primary payers."	Accept
36	RO9	Attestations	3.2.A.3	19	This statement asks about current commercial business. If we are not requiring commercial membership (and as of this date, we are not) then what response are we expecting? Neither one will lead to a deficiency.	If either YES or NO is appropriate and we are only using this as an information gathering attestation, then we need to make sure we don't create a deficiency code for this attestation.	Revision			Accept
102	RO9	Attestations	3.2.A.A.4-9	19-20	The applicant should be able to meet all of these statements at the time of application, so we should specify the timing.	Recommend changing the beginning of each attestation to read, "Applicant currently has…"	Revision			Accept
90	RO9	Attestations	3.20.A.7	56	Referring to attestation #7: It might be specific to Part D rules (which would still apply to an MA-PD plan), but the applicant cannot include any portion of the SSN in the health plan ID card number.	Suggest changing attestation #7 to read, "Applicant agrees not to use any part of an enrollee's Social Security Number (SSN) or Medicare ID Number on the enrollee's identification card."	Revision			Accept
HSD 13	RO2	Attestations	3.23 Access Standards	59	Access Standards for Specific Provider Types (#4)	The second bullet asks for access standards for primary care providers. Primary care providers include General and Family practitioners, Internal Medicine and Geriatricians. Why is a separate access standard required for Internal Medicine?	Deletion	Delete (contracted specialist) internal medicine	Primary Care Physicians include general and family practitioners, internal medicine and geriatricians. CMS recognizes that there are no separate access standard required for Internal Medicine physicians.	Accept
HSD 14	RO2	Attestations	3.23 Access Standards	60	See above	See above	Deletion		In section 3.23, CMS will remove the specialty "Internal Medicine" as a category for Contracted Specialists.	Accept
107	RO2	Attestations	3.29 MSA Demo	69-70	Repetitive questions	Remove the HPMS upload items from chart on page 69 as they are listed on section B on page 70 (or should be).	Revision		In efforts to streamline the application process and minimize burden to the applicant, CMS will delete Attestations # 10-16. Consequently, CMS will create a standard attestation, which reads "Applicant attest that all contracts within this provision meets all requirements and CMS regulations under 42 CFR 422.504…"	Accept
IND 017	Humana	Attestations	3.3.A	21	For states whose licenses renew after the first Monday in June, applicant must upload into HPMS no later than the final upload opportunity a copy of its completed license application and comment that this application was timely submitted to the relevant State licensing authority.	Some states have different renewal requirements besides filing a renewal application. For those states that we do not file a renewal application, what do we need to submit? Many of our licenses automatically renew, what do we need to provide?	Revision		CMS will add language to this attestation. The revised attestation will read, "Applicant must provide evidence that the organization has followed the appropriate renewal processes (e.g., submit renewal receipt)."	Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
47	RO9	Attestations	3.3.A.B	22	The fifth and sixth bullet calls for State Licensure information specific to RPPOs, but section 3.3 of the application only applies to "CCP, PFFS and MSA Applicants".	Suggest removing the 5th and 6th bulleted statements from this section.	Deletion			Accept
48	RO9	Attestations	3.3.A.B	22	The last paragraph, beginning with "Note:…" repeats the same statement already included in the 4th attestation.	Suggest removing the NOTE section (or removing the attestation #4)	Deletion			Accept
103	RO2	Attestations	3.3AB & 3.3BB	22-23	Structure	Why not make the structure of these two the same. It looks odd that one is bulleted and the other is A-F.	Revision			Accept
55	RO9	Attestations	3.5.B	27	The Note section repeats Attestation #1 in this section (3.5.A)	Suggest removing the NOTE section	Deletion			Accept
56	RO9	Attestations	3.6.A.1	27	Attestation #1 strays from the format of beginning with "The applicant…"	Suggestion changing attestation #1 to begin with, "The Applicant has provided in the HPMS Contract Management / …"	Revision		The language for this attestation has been revised to read, "The applicant has submitted in the HPMS…"	Accept
57	RO9	Attestations	3.6.A.2	27	Attestation #2 asks the applicant to affirm that it "will provide" the position descriptions, etc. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggest changing the attestation #2 to read, "Applicant has uploaded in HPMS position descriptions…"	Revision		The language for this attestation has been revised to read, "The applicant has submitted in the HPMS…"	Accept
63	RO9	Attestations	3.8.D	32	The Note section repeats Attestation #3 in this section (3.8.A)	Suggest removing the Note statement.	Deletion		Attestation #3 will become will the Note for this topic. Attestation #2 will also be revised to say, "Applicant has indicated information on the proposed service area in the HPMS."	Accept
IND 023	Humana	Attestations	3.9.A	32	Requirement under A.1 and A.8 are duplicative.	Delete the attestation under A.8.	Deletion		CMS will delete attestation #8.	Accept
65	RO9	Attestations	3.9.A.3	32	Attestation #3 should emphasize the need for the applicant to have these contracts already in place NOW.	Suggest changing the beginning of attestation #3 to read, "Applicant currently has executed…"	Revision		The word "currently" will be added to this attestation.	Accept
67	RO9	Attestations	3.9.D	34	Re: the Note section, while CMS is still working on the specifics around requesting signature pages, we can offer some clarification to this part.	Suggestion changing the NOTE to read, "As part of the application process, Applicants will need to provide signature pages for provider contracts that the CMS reviewers select. Reviewers will provide specific instructions during the application review.	Revision			Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 034	Humana	Document Upload Templates	4.2 - Provider Contracts Matrix	70	The instructions state that the Provider Participation Contracts and/or Agreements should be completed by MA applicants and should reflect the 1st tier, downstream and related entity contracts and/or agreements.	Recommend changing "should" to "must" since this is a requirement of the application. All applicants must provide the completed matrix.	Revision		CMS will change the work "should" to "must" because this is a requirement of the application.	Accept
96	RO2	Document Upload Templates	4.5 State Certification	84	Shouldn't the instructions precede the form?	Make the instructions for completing form the first page under section 4.5.	Revision			Accept
IND 048	Humana	Appendix II - Employer/Union-Only Group Waiver Plans (EGWP) MAO "800 Series"	Certification #10	133	Certification states that the applicant will submit employer group marketing materials to CMS at the time of use.	According to Chapter 9, Section 20.3.2.1.1, beginning with contract year 2009, MAOs are no longer required to submit informational copies of these disclosure materials to CMS at the time of use. Recommend changing the certification to adequately reflect the guidance in the Medicare Manual.	Revision		The language will be revised. Additional information will be provided to say, "Applicant understands that dissemination/disclosure materials for its EGWPs are not subject to the requirements contained in 42 CFR 422.80 or 42 CFR 423.50 to be submitted for review and approval by CMS prior to use. Applicant also understands CMS reserves the right to review these materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare	Accept
IND 091	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Definitions	Page 1	Definition of Medicaid subset	Please clarify whether "Medicaid subset" includes any dual population designated in a state contract, including "all duals."	Revision		Medicaid subset is clearly defined in CMS regulations, implementation guidance, and will be clarified in application training.	Accept
IND 084	Blue Cross Blue Shield	HSD Tables	HSD Tables	17	Last year changes were being made to HSD table content up until 2 days prior to the application due date. These changes, especially late date changes, can be extremely inefficient when related to programming changes (additional cost).	All efforts should be made to bring to a close any HSD table requirement revisions prior to the Application release.	Revision		CMS does not anticipate major changes to the HSD tables.	Accept
IND 092	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Number 2: Improve access to "affordable" health care	We believe it is inappropriate to include policy objectives with no basis for measurement in the list of attestations and request that this be deleted. Alternatively, delete "affordable" and link access to health care services.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Accept
IND 108	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Training	108	5: Per CMS 2009 guidance, there are a number of methods for documenting that training materials have been disseminated to all providers. Obtaining "sign-off" that model of care training was completed by every contracted provider is not realistic.	We urge CMS to stand by guidance provided to SNP Alliance members on 4/8/09 conference call with DSP staff: "There is a great deal of flexibility about how plans will verify compliance with this requirement. Plans are not required to provide face-to-face training for all providers, nor are they required to provide CMS with written documentation directly from the providers that verifies the training has been conducted, however, documentation such as survey tools, listings of mailings, and evaluations specific to provider education should be used as verification. Direct training is required to all employees involved in the SNP operations. There are a number of ways plans can meet the training requirement; for example: 1	Revision		CMS will provide an addendum to provider contracts that just states they have read the information pertaining to the model of care and will comply with the structure. CMS expects the plan to put in place a mechanism that ensures updates and changes to the model of care are communicated through normal provider education means.	Accept
IND 102	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network	107	37: Credentialing	Recommend credentialing every 3 years, not annually, consistent with NCQA requirements.	Revision			Accept
IND 105	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network	107	44: Enrollee Contacts	This statement appears to have two parts: first – does the enrollee contact in or out of network providers to schedule services and second, is the beneficiary required to notify the plan and/or inter disciplinary team. Please separate these attestations into two separate items – plans may do one or the other but not both.	Revision		CMS will separate these attestations into two questions.	Accept
IND 058	AHIP	HSD Instructions	Requesting Exceptions	18	Under this heading CMS indicates that plans requesting exceptions to the access standards will be informed via a drop down menu in HPMS regarding what types of documentation must be submitted in connection with such a request. According to the General Instructions on page 2, such exception requests will have to be submitted "at the time of the initial application submission only."	To assist plans preparing for submission of the required documentation, AHIP recommends that CMS provide in the application instructions a description of the types of allowable exceptions and the documentation required to support the exception request.	Revision		The four allowable exceptions will be available through a drop down menu in HPMS. Further guidance and training will be provided in October.	Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 073	Blue Cross Blue Shield	Attestations	Section 3.10 Contracts for Administrative & Management Services	35	Subsection A/3rd bullet on page: References "Medicare" products.	Shouldn't this reference be "Medicare Advantage" products?	Insertion			Accept
IND 074	Blue Cross Blue Shield	Attestations	Section 3.10 Contracts for Administrative & Management Services	36	Subsection A/3rd bullet on page: There is a "2)" reference within language, but there is not a "1)".	Need to either add a "1)" within the language; or remove the "2)".	Revision			Accept
IND 076	Blue Cross Blue Shield	Attestations	Section 3.11 Health Services Management & Delivery	39	Subsection A.7: Tense inappropriate in language.	Should be "…general coverage guidelines included in original…"	Revision		CMS will edit this grammatical issue.	Accept
IND 077	Blue Cross Blue Shield	Attestations	Section 3.12 Quality Improvement Program	40	Lead paragraph/2nd sentence: Duplicative period at end of sentence.	Need to remove duplicate period at end of sentence.	Deletion		CMS addressed this comment internally.	Accept
IND 078	Blue Cross Blue Shield	Attestations	Section 3.12 Quality Improvement Program	41	Subsection A.11: Duplicative period at end of sentence.	Need to remove duplicate period at end of sentence.	Deletion		CMS addressed this comment internally.	Accept
IND 081	Blue Cross Blue Shield	Attestations	Section 3.13A Marketing	43	Subsection A.12: Appears to be a duplicate of the #9d attestation.	Delete item #12.	Deletion		Comment already addressed with a previous CMS decision.	Accept
IND 080	Blue Cross Blue Shield	Attestations	Section 3.13A Marketing	43	Subsection A.6: Hours of operation for call center.	To clarify level of importance, move the statement concerning the AEP so that it precedes the statement related to the March 2nd – November 15th period	Revision		CMS will modify this attestation. The third sentence will start with the timeframe.	Accept
IND 065	Blue Cross Blue Shield	Attestations	Section 3.6 Key Management	27	Subsection A.#1: References "…for the following applicant contacts."; however, the list is in a separate section "below".	Wouldn't it be clearer to actually indicate "…for the applicant contacts in Subsection B. below."? (Or comparable language.)	Revision		CMS will make this change. Additional clarification to the instructions will be added.	Accept
IND 070	Blue Cross Blue Shield	Attestations	Section 3.9 Provider Contracts & Agreements	32	Subsection A.#8: Appears to be a duplicate of the #1 attestation on previous page.	Delete item #8.	Deletion		CMS will delete attestation #8.	Accept
IND 071	Blue Cross Blue Shield	Attestations	Section 3.9 Provider Contracts & Agreements	34	Note: States applicants provide a "template" of provider contract signatures.	Wouldn't it more appropriate to indicate "sample" or "copy" for a signature?	Revision		CMS has already addressed this language revision.	Accept

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 012	Aetna	HSD Instructions	Section D	12	Table HSD-3 Summary & Detail- Explanation #6	Hours of Operation per Week - this information is not currently maintained in Aetna's credentialing system and/or our provider database(EPDB). significant manual research and outreach to each facility will have to be initiated resulting in additional time and resources to accommodate this new requirement. Recommend CMS specify in the data measures a target # of hours required to assist plans when contracting with providers but not request this data be included in the HSD tables.	Revision		This data request will be deleted from the HSD tables.	Accept
IND 013	Aetna	HSD Instructions	Section F	14	Table HSD-3a Instructions	CMS did not provide this table in the revised HSD table file. Should we assume that because it was not included there were no changes to this table and it will still be required? Please confirm.	Revision		HSD Table 3A is required and will be part of the final application.	Accept
IND 014	Aetna	HSD Instructions	Section F	14	Table HSD-3a Detail Explanation #2	Reference to Tab Name - the use of "tab name' is confusing because MAOs no longer submit hard copy contract templates and instead must upload a zip file containing all contract templates used by the MAO. Each template is named in accordance with the CMS required naming convention required, which makes no reference to "tab". We have historically used the following contract references in the tab name column on this table to signify the type of contract template used to contract the providers reflected on HSD3 and recommend that CMS adopt or clarify what is acceptable: ANCILLARY, FACILITY, TRANSPLANT, HOSPITAL	Revision		The use of tab names is no longer required.	Accept
IND 101	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Staff Structure	105	Number 41: Medical Chart Reviews	Population-wide chart reviews are not a standard function. "Targeted" medical chart reviews would be more accurate and offer plans a greater comfort level for an affirmative response.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Accept
IND 053	AHIP	HSD Instructions		1	*Inclusion of providers from surrounding counties in county-level tables and maps*. A number of items in the detailed instructions for the HSD tables, as well as the requirements for maps that appear in Section 3.8 of the application, concern county-level provider information that must be submitted. It is unclear how CMS anticipates that the tables and maps will accommodate the permissible inclusion of providers located outside the county to meet network adequacy requirements	We recommend that as CMS refines the detailed instructions and application and develops the 2011 HPMS User Guide for the Part C Application, special attention be focused on ensuring that items referencing county-level provider information (including provider mapping) contain explicit instructions addressing network providers that are outside of the county.	Revision		Guidance and training will be provided in October.	Accept
IND 060	Blue Cross Blue Shield	Attestations				Please ensure the "attestation" language in HPMS, where plans actually complete attestation response, agrees with the language on the hard copy application. For CY2010, there were attestations that were: a) worded differently between HPMS & Application, b) included on HPMS, but not on the Application, and c) included on the Application, but not on HPMS. Results in inefficiencies when keying data from the Application that was used by plans as the source to actually obtain/compile responses from multiple business partners within their organization (i.e. time spent in determining if simply a language revision/ no real content change or substantive in nature, time spent addressing substantive language revisions	Revision			Accept
7	RO9	General Info	1.4	5	Application states that "CMS Central and Regional Office staff are available to provide technical support to all Applicants during the application season." This contradicts the guidance CMS provides to RO reviewers -- that the RO should not advise the applicant outside of the HPMS system dialogue (i.e., formal letters).	Advised applicants that they should contact Central Office for application guidance while preparing the application and the Regions only for very specific things in response to their deficiency letters.	Revision			Accept
17	RO9	General Info	1.8	10	It seems out of order to discuss application withdrawals (1.7E) and appeal rights (1.7F) before application due dates (1.8)	Suggest moving 1.7E and 1.7F to follow 1.8	Revision		Section 1.7E will become section 1.9. Section 1.7F will become section 1.10.	Accept
20	RO7	General Info	1.8	12	Add deadline timeframe to February 25, 2010 line	Legal - add "no later than 11:59pm EST"	Insertion		The "no later than 11:59 EST" is implied with the phrase "by"	Accept with modification
21	RO9	Instructions	2.1	12	In the second paragraph, we are once again leaving ourselves open to the applicant not actually attesting to what it HAS IN PLACE but what it intends to have -- and intentions can be faulty. We need to commit the organization to attesting to each individual statement and we can make each statement specific for a current requirement (e.g., valid provide contracts) vs. a future requirement (e.g., compliance plan).	Suggest changing the second paragraph to read: In preparing a response to the prompts throughout this application, the Applicant must mark "Yes" or "No" in sections organized with that format. By responding "Yes", the Applicant is committing its organization to being operationally compliant with the relevant requirement according to the timing the requirement stipulates. Some requirements are immediate, others are for a future date, such as when the organization signs the Medicare contract with CMS."	Revision		New language will be added to the current language. This sentence will be revised by adding, "By responding "Yes", the applicant is responding that it will be compliant as of the date of the contract, unless it is stated in the attestation or application that it requires an earlier compliance date."	Accept with modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
23	RO7	Instructions	2.1	13	3rd paragraph, last sentence not clear	Clarification - Correction to what? This is unclear	Revision		Language was revised to read, "If these issues are not corrected in a timely manner…"	Accept with modification
101	RO2	Instructions	2.5	13-14	Clarify what is considered an initial application	The bullets on pp 13-14 really do not state clearly that initial applications are for those who simply do not have a contract with CMS, though it is sort of implied. If an applicant reads the first bullet stating they are seeking a contract for the first time, some may latch on to that and assume they are not initial applicants. What about those who previously had contracts but now don't? In the last app period Red Medical did not consider its app as initial because they previously had a contract. It didn't occur to them that the fact that they do not currently have a contract made this again an initial. In the organization & experience section they wrote N/A for questions related to initial applicants	Revision		Revised the bullets to say, "Applicants that are seeking a MA contract to offer a MA product for the first time, or to offer a MA product they do not already offer. • Existing MA contractors that are seeking a MA contract to offer a type of MA product they do not current offer.	Accept with modification
29	RO9	Instructions	2.6	15	Chart 1 Required Attestations: Is an RPPO SAE not required to respond to attestations regarding Service Area, Provider Contracts & Agreements, and Contracts for Administrative and Management Services?		Insertion		Chart 1 will be revised to include the following attestation topics for RPPO SAE's: Provider Contracts, Contracts & Admin, Health Service Mgmt, and service area	Accept with modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
37	RO9	Attestations	3.0	19	Attestations (in general)	Many of the attestations require that the applicant confirm that it "will provide" or "will upload" documentation that is required as part of the application. We should revise all such attestations to state that the application "has provided" or "has uploaded" to emphasize that this isn't something that the applicant can do at a later date.	Revision		Language was revised to include the phrase, "has submitted"	Accept with modification
33	RO9	Attestations	3.01	18	In the first sentence, we say "The purpose of this section is to allow all applicants an opportunity…" but this section only applies to initial applicants, not SAEs.	Suggest the change: "The purpose of this section is to allow initial applicants…"	Revision		This paragraph will be revised to read, "The purpose of this section is to allow applicants…"	Accept with modification
54	RO7	Attestations	3.05	27	#3-add DIRECT employee of the applicant	LEGAL - next to last sentence -"This requirement cannot be delegated to a subcontractor (first tier, downstream, NOR related entities). The applicant's compliance officer must be a DIRECT employee of the applicant."	Revision		Accept revised language as: "The applicant's compliance officer must be an employee of the applicant."	Accept with modification
IND 028	Humana	Attestations	3.14	48	Attestation A.1 and A.2 appear to be duplicative.	Recommend using only one of the attestations - attestation 3.14.A.2.	Deletion		Delete attestation #2 and revise attestation #1. Attestation #1 will now say, "Applicant agrees to identify, document and report to CMS relevant coverage information for working aged, including: <insert bullets> Identify payers that are primary to Medicare, Identify the amounts payable by those payers, Coordinate Medicare benefits with primary payer benefits"	Accept with modification
94	RO7	Attestations	3.28	70	Note below table - not clear what section this is referencing	CLARIFICATION - identify correct section of the application	Revision		Delete MSA notes below table	Accept with modification
35	RO9	Attestations	3.01.A.2	18	This statement is not written to require a YES or NO.	Suggest revision: "Applicant has uploaded in HPMS a brief summary…"	Revision		Language was revised to include the phrase, "has submitted"	Accept with modification
73	RO9	Attestations	3.10.A.13	35	Attestation #13 asks the applicant to affirm that it "must provide" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestation #13 to begin with, "The Applicant has uploaded in the HPMS …"	Revision		Language was revised to include the phrase, "has submitted"	Accept with modification
76	RO9	Attestations	3.11.A.5	39	Attestation #5 asks the applicant to affirm that it "must provide" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestation #5 to begin with, "The Applicant has uploaded in the HPMS …"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification
78	RO9	Attestations	3.11.B	40	Just as in Attestation 3.11.A.5 (see previous comment), the language is not clear.	Suggest either referring the applicant to Attestation #5 or repeating the statement, "Applicant must submit a separate set of tables for each county in the service area. Applicants offering multiple plans (plan benefit packages) must submit separate tables for each plan if the plan restricts members to a subset of the entire provider network."	Revision		A new note will be added to sub section B. NOTE: Applicants offering provider specific plans must submit separate HSD Tables	Accept with modification
79	RO9	Attestations	3.12.A.12	41	Attestation #12 asks the applicant to affirm that it "will upload" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestation #12 to begin with, "The Applicant has uploaded…"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
80	RO10	Attestations	3.13.A	43	For alternative technology for Saturday, Sundays, and holidays, define what CMS includes as holidays. Also, specify hours from November 15 - March 1, 8 am to 8 pm.		Insertion		Language was revised to read, "An alternate technology…on Saturdays, Sundays, and Federal holidays."	Accept with modification
IND 029	Humana	Attestations	3.23	57-59	Nothing to indicate that these sections apply to RPPO.	Recommend adding "Regional PPO Applicants Only" before 3.23 begins - similar to how the PFFS looks.	Insertion		The heading for section 3.23 is revised to read, "RPPO Access Standards" and section 3.24 is revised to "RPPO Essential Hospitals." Section 3.25 only applies to PFFS.	Accept with modification
92	RO9	Attestations	3.23.A.4	59	Attestation #4 asks the applicant to affirm that it "will provide" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestation #4 to begin with, "The Applicant has provided…"	Revision		Language was revised to include the phrase, "has submitted." CMS deleted attestations #4-6 as it is repeated in subsection B.	Accept with modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
93	RO9	Attestations	3.27.A.8	66	Attestation #8 asks the applicant to affirm that it "will provide" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestation #8 to begin with, "The Applicant has provided…"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification
45	RO9	Attestations	3.3.A.A.4	21	Attestation #4 is written in such a way that an applicant responding "no" may be saying that it does not have a license that expires / renews after the first Monday in June or it could be saying that it has such a license but that it has not agreed to upload the document into HPMS.	Suggest rewriting that attestation (#4) to read, "Applicant's state / territory license renews after the first Monday in June. [and then bulleted below that] If the response is "Yes", the applicant must submit the new license to the Regional Office promptly upon renewal."	Revision	CMS would like to suggest more emphasis on plans to self-identify and disclose if their plan will be undergoing license renewal mid-year.	This point is already addressed in its current form. "Applicant must submit the new license to the Regional Office promptly upon renewal."	Accept with modification
49	RO9	Attestations	3.3.B.A.3-4	23	Attestations #3 and #4 ask the applicant to affirm that it "will provide" the state licensing table and the state licensure attestation. CMS should be asking for affirmation that the applicant "has uploaded" these documents.	Suggest changing attestations #3 and #4 to begin, "Applicant has uploaded in HPMS…"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification
50	RO9	Attestations	3.5.A.3	25	Attestation #3 includes some redundant statements.	Suggestion changing the language of #3 to read, "Applicant will implement a compliance plan that designates an employee as the compliance officer as well as a compliance committee accountable to senior management. Note: These requirements cannot be delegated to a subcontractor (first tier, downstream, and related entities).	Revision		CMS accepted the revised language in the note section.	Accept with modification
59	RO9	Attestations	3.7.A.1	28	Attestation #1 asks the applicant to affirm that it "will provide" the financial documentation. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggest changing the attestation #1 to read, "Applicant has uploaded its most recent…"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification
64	RO2	Attestations	3.9.A.2	32	What are "the following CMS required contract provisions" mentioned in the attestation #2?		Revision		In efforts to minimize burden to the applicant, CMS has revised the attestation to read, "Applicant agrees that all provider and supplier contracts or agreements contain CMS required contract provisions that are described in the CMS Provider Participation Contracts and/or Agreements Matrix template."	Accept with modification
104	RO9	Attestations	3.9.A.5-7	32-33	Attestations #5-7 asks the applicant to affirm that it "will provide" various pieces of information. CMS should be asking for affirmation that the applicant "has uploaded" this information.	Suggestion changing attestations #5-7 to begin with, "The Applicant has upload in the HPMS …"	Revision		Language was revised to include the phrase, "has submitted."	Accept with modification
IND 039	Humana	HSD Instructions	HSD 2 - Provider List of Physicians and Other Practitioners by County	8	Medical Group Affiliations (MGA): Does CMS wish to see the entity with which the applicant holds the contract through which the provider is par? For example, provider John Smith is part of ABC Cardiology. ABC Cardiology has contracted with Kentucky IPA. Kentucky IPA is contracted with the applicant for Medicare PPO. Does CMS intend MGA to list the entity with whom the applicant has contracted (in this case, Kentucky IPA)?	CMS provide clearer definition of Medical Group Affiliation. We recommend the CMS address this question in the instructions.	Revision		On HSD Table 2, CMS requires that the applicant list every provider that is included in HSD 1. On HSD 2, there is an opportunity to identify if the provider is affiliated with a medical group. CMS will be able to identify the group affiliation through the signature authority grid.	Accept with modification
IND 041	Humana	HSD Instructions	HSD 2 - Provider List of Physicians and Other Practitioners by County HSD 3 - List of Facilities and Services	7 and 10	There is a small percentage of providers who have been assigned multiple NPIs. Which of these NPIs should be entered on the tables? Do all NPIs for a provider need to be listed? The NPPES file does not currently cross-map provider group NPIs to the NPIs for their affiliated providers. In instances where a provider only bills under his/her group NPI, we may not have the individual NPI on record.	Outside of a manual lookup process, what can CMS do to help simplify this process? CMS should develop a standard table for determining the single reference list of "counties served" for each provider, by NPI. This will eliminate discrepancies (over/under-representing service areas) that would impact (No Suggestions) recommendations. In this way, if 2 payers have the same Home Health agency under contract, the counties served data would not vary.	Revision		Health plan should enter the provider/s assigned NPI number. If the provider is a part of the medical group use the provider individual NPI number.	Accept with modification
IND 069	Blue Cross Blue Shield	Attestations	Section 3.9 Provider Contracts & Agreements	32	Subsection A.#2: The attestation references "… contain the following CMS required contract provisions."; however, the provision do not follow.	Add the outline of each required contract provision.	Insertion		In efforts to minimize additional burden for the applicant, CMS has eliminated the detailed requirements for this attestation. The revised attestation will read, "Applicant agrees that all contracts for administrative and management contain the required contract provisions that are described in the CMS Administrative Contracts Matrix template."	Accept with modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 057	AHIP	HSD Instructions	Table HSD-3 SUMMARY: Arrangement for Care with Facilities & Services and Table HSD-3 DETAIL: List of Facilities and Services.	12	Both of these tables include new columns that require applicants to provide information on the "Number of Staffed, Medicare Certified Beds" for acute inpatient hospital services, critical care services (intensive care units), surgical services (outpatient or ASC), inpatient psychiatric facility services, and inpatient substance abuse services, as well as the "Hours of Operation per Week" for acute inpatient hospitals, outpatient dialysis facilities, outpatient infusion/chemotherapy facilities, and	We are concerned that these proposed additions to the application would be duplicative of information already maintained by CMS, because Medicare Advantage organizations must use Medicare certified providers who meet the standards for providers under the Medicare fee-for service program. Further, it is our understanding that this information is not commonly stored in applicants' provider databases and adding it to the HSD tables would necessitate a manual process that would be highly resource-intensive. In addition, it is unclear how CMS intends to utilize the information on the number of Medicare certified beds in evaluating network adequacy. AHIP, therefore, recommends that CMS not include these proposed new columns	Revision		The number of Medicare beds is critical for evaluating network adequacy. Although plans were not previously required to submit this data, it has always been considered by CMS in making this determination. CMS is deleting the request for hours of operations. J105	Accept with modification
IND 040	Humana	HSD Instructions	Table HSD-3 DETAIL: List of Facilities and Services	13	Can CMS provide more information regarding the business contact address required for DME and HH on HSD3?	Due to nature of DME business, the contact information for DME's is usually a 800 number that services large areas. For mail order DME's we recommend listing corporate headquarters contact information that usually resides outside the servicing area. Home health services are provided in member's home. A physical service address does not apply. For example, a DME warehouse may exist in MI, but a member that lives in CA can call their 1-800 number to order medical supplies and have them shipped. For Home Health, the nurse travels to the members' home, which may be located outside of the county the corporate facility is physically	Deletion		The maps will no longer be required for specialties. With regards to the contact/address, CMS believes that the guidance is clear, noting that the address should be "corporate address",	Accept with modification Reject
HSD 02	RO2	HSD Instructions	2.7	1	Issue-County boundaries no longer apply	If county boundaries no longer apply, does this mean a plan does not have to contract with entities located in the county? For example, there is an outpatient dialysis facility located in the county, but the plan feels members can use a facility in another county if it meets the time/distance criteria.	Revision	Defer to training.	These are process questions. CMS will be providing guidance to this regional office at the training event.	Clarify
HSD 03	RO2	HSD Instructions	2.7	2	Issue-Exception requests	If a plan submits an exception request and the request does not meet CMS criteria, will the application be rejected or will the plan be allowed to rebut the decision?	Revision	Defer to training.	These are process questions. CMS will be providing guidance to this regional office at the training event.	Clarify
HSD 04	RO2	HSD Instructions	2.7	3	Issue - Service area	The first Exception listed is "Insufficient number of providers/beds in service area. How is service area defined; is each separate county its own service area or is the service area the aggregate of all counties comprising the application?	Revision	Defer to training.	These are process questions. CMS will be providing guidance to this regional office at the training event. The service area is defined as what the plan applies for.	Clarify
HSD 05	RO2	HSD Instructions	2.7	3	Issue - Insufficient number of beds	The first Exception listed is "Insufficient number of providers/beds in service area." What criteria determines an adequate number of beds?	Revision	Defer to training.	These are process questions; CMS will be providing guidance to this regional office at the training event	Clarify
HSD 06	RO2	HSD Instructions	2.7	3	Issues - Alternate provider/facility	Who/how is it determined what constitutes an alternate provider/facility?	Revision	Defer to training.	These are process questions. CMS will be providing guidance to this regional office at the training event.	Clarify
HSD 08	RO2	HSD Table 1	2.7	4	Note states for Oncology providers, Hematology/Oncology providers should be included.	Based on the format of HSD 1, specify whether Hematology oncology is included under Oncology-Medical, Surgical or Oncology-Radiation/Radiation Oncology.	Revision	Defer to training.	Hematology oncology is included under Oncology-Medical	Clarify
HSD 10	RO2	HSD Table 3	2.7	10	Number of Staffed Medicare-Certified Beds (Column 6)	Recommend providing a source for plans to obtain the required information.	Insertion	Defer to training.	CMS suggests that regional offices utilize Medicare.gov or state information to confirm this information. This is not relevant to the application or the instructions.	Clarify
41	RO2	Attestations	3.0	19	Attestations (in general)	What guidance should be provided to applicants on this point?	Revision		Training and guidance will be provided in October.	Clarify

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 030	Humana	Attestations	3.25	59	The rules for 2011 states that CMS will not accept a non-network or partial network application that includes any of the areas identified as "network area". Can we have a partial network in the non-CCP counties or do we have to offer the deemed product?	Recommend CMS provide detailed guidance on the types of PFFS plans that can be offered in non-CCP counties since this is a new guideline for 2011. The earlier this information is made available to the industry, the better.	Revision		CMS will be issuing guidance around PFFS but not within the context of the application. Additional guidance will be provided to industry regarding the new MMA provisions related to PFFS.	Clarify
IND 031	Humana	Attestations	3.25	59	Applicants wishing to offer both network PFFS products and non or partial network PFFS products must do so under separate contracts Currently we have partial network PFFS under 2 contracts. With the PFFS network for 2011, will we be able to convert our partial network contract numbers to a full network contract or will new contract numbers be assigned?	Currently Humana has partial network contracts and deemed contracts. For 2011 since most of the counties under our partial network contract are classified as CCP counties, we recommend that CMS allow us to change the designation of the partial network contract to a full network contract and not assign a new contract number for the full network plan. This will reduce the amount of new contracts that are assigned and eliminates moving the majority of our members from the partial network contract to the full network contract. In 2010 it was a manual process to move members from our deemed contract to the newly assigned partial network contract. This	Revision		CMS will be issuing guidance around PFFS but not within the context of the application. Additional guidance will be provided to industry regarding the new MMA provisions related to PFFS.	Clarify
34	RO9	Attestations	3.1.A.1	18	This doesn't allow for the situation where the NOIA was incorrect but the plan actually intends to complete the application it has pulled up -- the application that doesn't match the NOIA.		Revision		Applicants can change their NOIA before and up to the time of submission. Once the application is submitted, they must contact the email address listed or Letticia to make the change in the system manually	Clarify
74	RO9	Attestations	3.10.B	37	The Delegated Business Function Table requests the applicant with more than six contracts to list the "five largest". We do not provide any instructions on how to measure the five largest. Is it by $$ amount?	Provide guidance on what "the five largest" actually means.	Insertion		CMS revised the language for this section to say, "the five most significant…"	Clarify
IND 025	Humana	Attestations	3.10.B	37	Appears that we will not have to provide copies of every delegated contract but that we will only have to the executed contracts for those providers listed on the Delegated Business Function Table.	What is the Delegated Business Function Table? Is this the same as the delegated function currently in HPMS? Humana supports only having to list the five largest entities and for the 6th, stating Multiple Additional Entities. Assume that this applies to any of the delegated functions like credentialing or sales?	Revision		Yes, the Delegated Business Function Table is the same one in HPMS. Applicant will only need to list the five most significant entities for each delegated business function identified.	Clarify
IND 026	Humana	Attestations	3.11.3	38	Why is this question in the application. Are we going to be able to have deemed PFFS in non-CCP areas? Assume by the question that we will.	Recommend CMS provide detailed guidance on the types of PFFS plans that can be offered in non-CCP counties since this is a new guideline for 2011. The earlier this information is made available to the industry, the better.	Revision		Yes. CMS will be issuing guidance around PFFS but not within the context of the application. Additional guidance will be provided to industry regarding the new MMA provisions related to PFFS	Clarify
IND 032	Humana	Attestations	3.27.B	64	Application asks for a Payment Reimbursement grid.	Assume that this applies to a deemed PFFS since the network PFFS pays according to contractual rates. We should not have to submit a Payment Reimbursement grid for a full network PFFS.	Revision		The payment reimbursement grid is required for all PFFS products. A new note was inserted to direct applicants. The new note states that organizations can use any format that best outlines the rates.	Clarify
IND 018	Humana	Attestations	3.6.A.2	27	Applicant will provide position description for key management staff and organizational chart for various departments. Not a new requirement but including this as part of the attestation is new.	Key management staff for Humana that is managing our current MA HMO, LPPO, PFFS contracts will be responsible for the initial and SAE contracts. In 2010 we were not required to submit position descriptions. Because existing management will be utilized for any initial or SAE, we recommend following the same approach for the 2011 applications.	Revision		SAE's applicants do not have to complete the key management section. Only initial applicants need to complete this section.	Clarify
IND 007	Aetna	HSD Instructions	All	All	HSD General Instructions:	The draft instructions do not explain how providers added from adjacent counties should be included and sorted on the new HSD tables. Please update instruction to include this critical information.	Revision		Providers that serve more than one county should be listed multiple times to account for each county served on HSD 2 with appropriate State/County code. There is going to be an addition of a column for State/County code added to HSD. This information used to be collected as a header but will now be a column similar to HSD 1.	Clarify
IND 049	AHIP	Overall	General Comment		Based upon experience with the review process for the 2009 Medicare Applications, including applications by current contractors for service area expansions, it is our understanding that CMS' review criteria for the applications has been evolving from year to year.	We recommend that when CMS finalizes the 2011 applications and conducts related training, the agency provide information about the review criteria, so that applicants will have a clear understanding of the basis for CMS' evaluation of the applications. Related to this issue, we support the agency's decision to provide a new pre-assessment screening process for network adequacy and offer several comments below that we hope will contribute to the success of this process.	Revision		Training and guidance will be provided in October.	Clarify

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 035	Humana	HSD Instructions	General Instructions for CMS HSD Tables	1	According to the instructions, a positive result from the pre-assessment screening does not mean, nor is it meant to imply, that the application has or will be approved. Based on this, should applicants provide a justification even if the pre-assessment comes out positive? Is it possible for CMS to review those specialties with a positive result and come back with a ruling that we do not meet access? If this happens will we have the opportunity to provide a justification in our response to the deficiency?	Assume that only one provider or facility type not meeting access will result in the network not meeting access which means that we will have to seek an Exception at the time of the initial application submission. Applicants need complete instructions from CMS on the pre-assessment and exception process so we understand what we need to address through the Exception request. The sooner the industry has this information, the better.	Revision		Training and guidance will be provided in October.	Clarify
IND 036	Humana	HSD Instructions	General Instructions for CMS HSD Tables	2	The instructions state that CMS expects to annually post the criteria for determining network adequacy in November of each year, prior to the last date for submitting the Notice of Intent to Apply. Therefore according to this statement the network adequacy requirements for the 2011 application will be released on November 17, 2010.	Will CMS be utilizing some sort of (Geoaccess) evaluation to determine provider network adequacy? If so, what methodology will CMS use to determine the acceptable distances or driving times from MA plan members' homes to provider service locations? Recommend CMS holding a conference call to review the methodology with MAO's and to collect feedback/suggestions. This will give the MAO's the ability to run the parameters independently (should the assessment tool be unavailable by October, for example).	Revision		Training and guidance will be provided in October.	Clarify
IND 001	AETNA	HSD Instructions	HSD Instructions	1	HSD General Instructions, 2nd paragraph	When will the automated tool and network value measures be available? Recommend CMS provide detailed training for the new access requirements and the automated HSD tool in the early November, not in January when the final applications are normally released. MAOs are currently developing their 2011 networks, therefore having the default adequacy measures for each provider specialty and the tool by fall to begin conducting pre-screening is critical for successful network development.	Revision		Training and guidance will be provided in October.	Clarify
IND 002	Aetna	HSD Instructions	HSD Instructions	1	HSD General Instructions, 4th paragraph	When will the required minimum values be available? Request CMS clarify if network access requirements will continue to be based on 30 minute travel time or if CMS is moving to a miles analysis or both with the new measures and tool. If miles, provide the new criteria and define the values for urban, suburban and rural areas.	Revision		This information is expected to be available in November.	Clarify
IND 006	Aetna	HSD Instructions	HSD Instructions	2	HSD Instructions, Bullet 2	Bullet 2, please clarify if we are required to enter the actual product plan name, ex: Aetna Medicare Value Plan (HMO) or if we can just enter HMO or PPO.	Revision		Plan name is no longer required.	Clarify
IND 043	Humana	HSD Instructions	HSD 3 - List of Facilities and Services	12	Outpatient mental health, PT, OT, and ST services can be contracted at a facility or a group level. Part 1) OP mental health: does CMS recognize that the same services are provided at an OP Facility that are provided in a psychiatrist's office? Will CMS determine network adequacy with the understanding that both the OP facilities and the MDs provide the same services and are thus interchangeable?	To avoid confusion for 2011, we plan to list PT, OT, and ST groups on HSD3.	Revision		Training and guidance will be provided in October.	Clarify
IND 003	Aetna	HSD Instructions	HSD General Instructions:	1	HSD General Instructions, 4th paragraph	Draft instructions state county boundaries will no longer apply, allowing MAOs to include providers from adjacent counties to meet access requirements. Aetna supports this approach as it will simplify the table submission/exceptions process used in the past, however CMS needs to factor in the impact to the Service Area maps required that must be produced at the county level reflecting the providers available within the county. CMS will need to develop revised direction for the Maps. We would also appreciate if CMS could advise what software is available to produce the Maps in the various data formats requested in the application. Each year we ask this question and receive no response, but each year we	Revision		Maps are no longer required.	Clarify
IND 004	Aetna	HSD Instructions	HSD General Instructions:	2	HSD General Instructions, 4th paragraph	Recommend CMS provide detailed training for new access requirements and the new automated HSD tool in the early November, not in January when the final applications are normally released as this will not give MAOs enough time to prepare and communicate the changes to internal business partners involved in the application/MSD development process	Revision		Training and guidance will be provided in October.	Clarify
IND 005	Aetna	HSD Instructions	HSD General Instructions:	2	HSD General Instructions, 4th paragraph	Instructions state "CMS expects to annually post the criteria for determining network adequacy in November of each year, prior to the last date for submitting the Notice of Intent to Apply". Need clarification on this comment, is this information intended to be used for MAOs to evaluate their existing MA network annually? If this information is to be used by MAOs to build their networks for new service areas they intend to file in the coming calendar year than November is to late for this information to be published. Aetna begins conducting market and network analysis in the late spring each year and if CMS expects the data measures to change each year earlier publication will be required.	Revision		No. The purpose of this application is to determine the organization's network adequacy for the proposed service area. However, annual adequacy network reviews will conducted outside of this application.	Clarify
IND 083	Blue Cross Blue Shield	HSD Table 3	HSD Table 3 Summary – Arrangements for Care with Facilities & Services	10 and 11	Addition of the last 2 columns, "# of Staffed, Medicare-Certified Beds" & "Hours of Operations per Week", for select facilities: These are not data fields that are maintained by plans as a norm. That being said, this would require extensive first year set-up requirements, such as funding allocation for implementation, programming changes to allow for collection of this data, time to update fields for existing related facilities, and programming changes to pull related reports. This would not qualify as a	If this will be a requirement, plans should be notified with adequate lead-time to implement internal structure to house and obtain the data. Can this be postponed until the CY2012 Application; with notification of impending requirement in CY2011 Call Letter (or other communication)?	Revision		The Hours of Operation will be removed from HSD 3. CMS will not use it in the analysis.	Clarify

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 079	Blue Cross Blue Shield	Attestations	Section 3.12 Quality Improvement Program	41	Subsection A.12 & B: References a "Template Timeline"; however, we were unable to locate said table in application upload templates (at end of document).	Need to add the referenced template to the application.	Revision		Applicant should refer to the Table of Contents to locate all Template Uploads in the paper application. For the online version, applicant should review the download section.	Clarify
IND 063	Blue Cross Blue Shield	Attestations	Section 3.5 Compliance Plan	26	Subsection A.#7: Additional language compared to CY2010 - "These procedures will be conducted on scheduled basis and the results reported to the CMS Account Manager".	Although we are currently required to have internal monitoring & auditing, the addition of a specific schedule and a reporting element will increase the "level of applicant burden" (indicates "N" on summary chart). Since plans have not yet seen the specific requirements related to this portion of the element providing the potential actual hour increase would be difficult.	Revision		CMS would like to review the health plan's internal policies and procedures. The health plan will develop their own timeline and schedules and submit it to CMS.	Clarify
IND 064	Blue Cross Blue Shield	Attestations	Section 3.6 Key Management	27	Lead paragraph & Subsection A.#1: Executive management submissions provided, and accepted, for our past applications have been in the form of an executive bio versus a position description (unless the position was open).	Can the language be revised to allow position descriptions or management biographies?	Revision		No. CV's are required as a part of the experience and history document upload template. Position descriptions should describe the duties and responsibilities of the position (e.g., compliance officer).	Clarify
IND 009	Aetna	HSD Instructions	Section A.	5	Table: HSD-1 Instructions/Specialty Tier Column (Rows 44-49)	HSD-1 (Rows 44-49- Providers Supporting Contracted Facilities), please clarify if MA plans are only to include direct contract providers, providers employed by the hospital (hospital based physicians) or both? The current draft instructions do not address these new provider type additions and we are assuming they would be populated to into HSD2.	Revision		HSD Table 2 allows the plans to indicate the type of contract arrangement. Please note that HSD Table 1 should be capture the total number of providers.	Clarify
IND 010	Aetna	HSD Instructions	Section C	9	Table HSD-2a: Instructions	CMS did not provide this table in the revised HSD table file. Should we assume that because it was not included there were no changes to this table and it will still be required? Please confirm.	Revision		Yes. HSD 2A is still required and will be included in the HSD package.	Clarify
IND 011	Aetna	HSD Instructions	Section D	12	Table HSD-3 Summary & Detail - Explanation #5	Number of Staffed Medicare-Certified Beds - this information is not currently maintained in Aetna's credentialing system and/or our provider database(EPDB). The addition of this information for the facilities specified will require significant manual workarounds resulting in additional time and resources to obtain this data. Recommend CMS specify in the data measures a target # of beds that should be available in the network but not request these counts be included in the HSD tables.	Revision		This information has historically been considered during access assessments, though was not previously required to be submitted by Applicants. HSD automation now requires that this information be submitted along with other basic HSD data.	Clarify
HSD 17	TBD	HSD Tables	Table 2; Table 5		How to verify when physicians are listed multiple times or for multiple specialties.		Revision	There is currently cross-checking that ensure that doctors are not listed multiple times or for multiple specialties. Duplications will be sent back to Applicant for clarification. Applicants must apply for an exception if there are insufficient	CMS is working to clarify the current process and determine what will be available in the future.	Clarify
IND 056	AHIP	HSD Instructions	Table HSD-2a: PCP/Specialist Contract Signature Page Index and Table HSD-3a: Contracts & Signature Page Index, Ancillary/Hospital.	9 and 14	The instructions for Tables HSD-2a and HSD-3a are included in the draft, but the tables themselves are not included in the accompanying Excel file entitled "HSD Tables 2011".	We request confirmation that Tables HSD-2a and HSD-3a are unchanged from those included in the 2010 application.	Revision		HSD 2A and 3A are required. CMS confirms that these tables have been unchanged from the 2010 application version.	Clarify
IND 054	AHIP	HSD Instructions	Table: HSD-1: County/Delivery System Summary of Providers by Specialty	5	*# of Medicare Participating Providers*. In the 2010 application, HSD-1 required applicants to provide the "# of Medicare Participating Providers by County." This column has been removed from HSD-1 in the draft application.	We support CMS' decision to remove this column because it is our understanding that the CMS data available to identify the number of Medicare participating providers has not consistently reflected the actual number of each type of provider available in each county for the purpose of Medicare Advantage network contracting. If the Medicare provider data will continue to play any role in CMS' review of network adequacy, we recommend that CMS include in the instructions an explanation of the manner in which it will be utilized.	Deletion		Comment noted. Plans will not be required to provide this information. Plans would only need to address this if requesting an exception based on the lack of available participating providers.	Clarify
IND 055	AHIP	HSD Instructions	Table: HSD-1:County/Delivery System Summary of Providers by Specialty	4	*Specialty Type*. The column labeled "Specialty Type" in HSD-1 includes a new category for "Providers Supporting Contracted Facilities" and specifies several provider types. The instructions do not provide an explanation of this category. It is unclear whether this category is intended to include only providers who are affiliated with the facilities with which the organization contracts, so that providers not under direct contract to the organization would not appear here.	To promote consistent understanding by applicants, AHIP recommends that CMS explicitly address this issue in the instructions.	Revision		This category is to capture the organization's contracted provider types that are not otherwise identified on the list. CMS believes that the current guidance describes this process.	Clarify

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
1	RO9	Overall		1	We use a lot of passive (vs. active) voice throughout the application, sometimes leaving question about who actually performs certain tasks or who is responsible for certain things.	RO9 requests a final review of the application that incorporates all the comments in order to change some of the language to active voice in attempt to clarify our instructions or requirements.	Revision	Contact Ann Duarte for this action (415-744-3770)	CMS will be working with RO9 to determine next steps	Clarify
HSD 15	TBD	HSD Instructions			Standardization of cross-referencing tables that Applicants submit.	Request Applicants to provide Medicare Provider Number on the HSD Tables so that CMS can conduct analysis of data provided by the same facility. The information will also help with manual review of applications.	Revision	Most of this is done through the automated cross-checking system using NPI and not the Medical Provider Number.	CMS is working to clarify the current process and determine what will be available in the future.	Clarify
10	RO9	General Info	1.5	7	Under the description for HPMS, it seems the primary (Letter A) description of HPMS should be specific to the application process and not include the other things (e.g., bid submission, ongoing oversight, reporting, etc.)	Make Letter A only about applications. Add the other functions later under Section 1.5	Revision		The HPMS system is the resource that applicants will use to communicate with CMS during the application process. Consequently, section A should remain as written.	Reject
13	RO9	General Info	1.6	7	First paragraph, second sentence reads: "Upon submitting the completed form to CMS, the organization will be assigned a pending contract number…" but this does not apply to service area expansions.	Change the sentence to read, "Upon submitting the completed form to CMS, the agency will assign any new organization a pending contract number…"	Revision		The suggested revised language is not operationally accurate. A current plan may get a pending contract number if they are applying for a new type of service.	Reject
19	RO9	General Info	1.8	11	The Review Process milestones skips all the back and forth steps included in the application process	Include some of the intermediate steps (e.g., revisions due) with general dates, (e.g., early April(what year), TBD) at least to keep them aware of these steps even if we can't give them the exact date at this point.	Insertion		Dates are subject to change and have not yet been finalized. This information will be provided in training.	Reject
25	RO9	Instructions	2.5	13	This section on "Types of Applications" should include a discussion of the actual types of applications: HMO, LPPO, RPPO, etc.	Include information similar to what is in section 1.2	Insertion		This information is already readily available and is general information section. Furthermore, the applicant should already be aware of the different types of products before applying.	Reject
27	RO9	Instructions	2.5	14	The last section "Service Area Expansion Applications are for:", we should add that SAEs apply if the product type is also approved.	Suggest changing the sentence to read, "Existing MAO contractors that are seeking to expand the service area of an existing contract number and approved product type."	Insertion		The applicant cannot switch product type.	Reject
28	RO9	Instructions	2.6	15	Chart 1 Required Attestations: While it seems evident that we would not ask for Key Management Staff to apply to SAEs, if we expand SAEs to include new contracts across the country from the existing organization, there may be instances where the Key Management Staff for the "expansion" area is different from the current staff. This may cause a problem in HPMS with recording this information.	IF CMS expands the concept of an SAE across state lines, then we need to request Key Management Staff information for an existing organization if any of the staff are different from the current lines of business.	Insertion		This suggested insertion would require a major system change. This information is already captured in the request for the main contact information in the Key Management template. Applicant must designate only one POC for on the contract.	Reject
HSD 07	RO2	HSD Instructions	2.7	3	#10-First bullet says to set print area and page set to ensure all columns fit one 8.5 inch by 11 inch sheet of paper	Recommend instructions for the larger tables (HSD 2 and HSD-3 Detail read "Set print area and page set-up to ensure all columns fit within one 8.5 by 14 inch sheet of paper as it is wasteful to print extra pages and very difficult to match to the original if manual review is required.	Revision		Each reviewer can set up their own page according to preference.	Reject
HSD 09	RO2	HSD Table 3	2.7	10	Number of Staffed Medicare-Certified Beds (Column 6)	Recommend requiring the number of Medicare-certified dialysis stations to correspond with Row 7 (Outpatient Dialysis).	Revision	Defer to training.	This information is not counted in the HSD analysis.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
HSD 12	RO 2	HSD Table 3	2.7	12	Number of Staffed Medicare-Certified Beds (Column 5)	Recommend requiring the number of Medicare-certified dialysis stations to correspond with Row 7 (Outpatient Dialysis).	Revision	Defer to training.	This information is not counted in the HSD analysis.	Reject
31	RO9	Instructions	2.8	17	We provide loose guidance on application file names. Can't we require certain names for our template documents and then provide guidance on naming additional files?		Revision		Many of the applicants never follow the suggested nomenclature. The current upload system has a naming system that CMS will employ.	Reject
32	RO9	Instructions	2.9	17	Toward the end of the first paragraph, we advise applicants that they can find the Part D application on our website or contact Marla Rothouse or Linda Anders. Will Marla and Linda provide a copy of the application?	Clarify the guidance that Marla and Linda will provide applicants.	Revision		Contact information will be deleted.	Reject
38	RO2	Attestations	3.0	19	Attestations (in general)	The legal concept of "attestation" needs to be more clearly defined in the context of the application process not only for applicants, but for CMS reviewers as well, i.e. is the statement true in the present or the future? In the last app season, I had a number of discussions with other reviewers who had varying opinions on what attestation means in this context. While some attestation statements read in the present tense, others are often interpreted to refer to a future condition and not the current state of affairs. For example, if they attest that they have executed agreements (in the present tense) for administrative services.	Revision		Defer to application Standard Operating Procedure.	Reject
39	RO2	Attestations	3.0	19	Attestations (in general)	a. When they often don't have them as a result of intensive review verification, but say they do are they being untruthful or are they saying that they will have them in the future?	Revision		Defer to application Standard Operating Procedure.	Reject
40	RO2	Attestations	3.0	19	Attestations (in general)	b. If the attestation is patently false in the face of what is or is not uploaded, what are the consequences?	Revision		Defer to application Standard Operating Procedure.	Reject
42	RO2	Attestations	3.0	19	Attestations (in general)	d. What guidance should be provided to reviewers who often find attestations are consistently not true?	Revision		Defer to training.	Reject
51	RO7	Attestations	3.04	26	#1 in table, after "General Services" add Administration. Last sentence- clarify that any member of ANY Entity are bound	LEGAL - 2nd and 3rd sentences - "Please note that this includes any member of ANY ENTITIES' board of directors, key management or executive staff or major stockholders. The applicant's compliance officer must be a DIRECT employee of the applicant."	Revision		CMS added the word "Administration" after "General Services." It is already implied that an employee has a direct relationship with the applicant	Reject
52	RO7	Attestations	3.04	26	#2 in table, first sentence-same as above, should include ANY ENTITIES	LEGAL - new first sentence "Applicant agrees it does not have any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration brought involving the Applicant (and Applicant's parent organization if applicable OR its subcontractors (first tier, downstream, and related entities), including ANY ENTITIES' key management or executive staff", etc.	Revision		The language is already pre-set/determined by CMS.	Reject
66	RO7	Attestations	3.08	33	Last table entry	Need "N/A" option for response to question posed	Revision		This has been deleted per a previous suggestion.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 019	Humana	Attestations	3.08	30-31	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.	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 020	Humana	Attestations	3.08	30-31	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 and hospital outpatient surgery centers. Are we interpreting CMS intent correctly, i.e. Mean travel times on this map and depicting outpatient surgery locations?	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 021	Humana	Attestations	3.08	30-31	Application states that "on the second map, each **specialty type** should be delineated as a separate color or symbol."	Should read "facility type."	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 022	Humana	Attestations	3.08	30-31	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 2010, Humana submitted the map legend as a separate file. We recommend that this approach be sufficient for the 2011 applications.	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
97	RO2	Appendix I - Solicitations for Special Needs Plan Proposal	5	90		Include a NOTE that applicant should determine which dual categories are covered under the respective States in which the applicant operates. This applies to all plans not just SNPs.	Insertion		This issue is covered in the State Medicaid agency Contract Matrix portion of the application and will be clarified during industry training.	Reject
98	RO7	Appendix I - Solicitations for Special Needs Plan Proposal	5	100	Table item #3 - note needs date added	CLARIFICATION - new note - "NOTE: Applications must have a signed State Medicaid Agency(ies) contract by OCTOBER 1 of the MA application year, etc."	Revision		The date for submission of State Medicaid agency contracts has not yet been determined. However, if CMS adds a date, it would coincide with the date for plan benefit package bid submissions which typically occurs by the month of July.	Reject
IND 087	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	5	119	Clarify CMS expectations regarding required responses: The draft 2011 SNP MOC Worksheet distributed to the SNP Alliance last Spring clarified which MOC attestation statements were expected functions by limiting the response options only to "yes" vs. which items were discretionary with "yes/no" options in the "standard" column of the work sheet.	We request that a final worksheet be provided along with the application and that CMS clarify in an unambiguous way which attestations are actually requirements or conditions of application approval vs. which ones are discretionary.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations. CMS will not construct the application in a way that restricts MAOs flexibility to design a model of care that is tailored to the target population. The training will identify recommendations versus mandates.	Reject
IND 088	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	5	93	Plan responsible for "providing, or contracting for benefits to be provided."	Given lack of clarity on CMS expectations regarding a plan's benefit obligation under MIPPA rules, it would be helpful in this section to reference specific CMS guidance on plan obligation in this regard.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 090	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	5	94	MOC requirement for ALL SNPs to accommodate most vulnerable subsets, including ESRD.	The SNP Alliance objects to the requirement that ALL SNPs establish special capabilities to serve beneficiaries with ESRD. While this is a reasonable requirement for SNPs targeting diabetics, those with chronic kidney disease and other precursors to ESRD, we believe it is inappropriate to mandate ESRD capacity for ALL SNPs; e.g., SNPs targeting frail elderly subsets, chronic conditions such as heart disease or mental illness, etc. We recommend that the ESRD mandate be limited to conditions related to risk of developing ESRD.	Deletion		MAOs may enroll special needs beneficiaries who develop ESRD after enrollment. CMS believes that MAOs must anticipate and plan for the vulnerable beneficiaries who develop ESRD as a progression of their chronic condition. This expectation is clearly stipulated in CMS regulation.	Reject
18	RO7	General Info	1.7F	11	The first sentence of the Application Determination Appeals Rights section after citation of SSA Act - put in parentheses (hereinafter the "Act")	CLARIFICATION - will clarify what you are calling "the Act" throughout the document	Revision		"The Act" is not described in other sections of the application. As such, there is no need to use the term "the Act."	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
69	RO9	Attestations	3.10	34	The opening paragraph refers to beneficiary protection language required in all contracts. Is this also true for administrative and management contracts?		Revision		This has been addressed per a previous suggestion.	Reject
70	RO2	Attestations	3.10	35	In #8, should we remove reference to non network PFFS		Revision		This is applicable to non-network PFFS. The term "non-network" is now hyphenated.	Reject
72	RO9	Attestations	3.10.A.10	35	Attestation #10 refers to "the Part C program", yet the rest of the application uses "the MA program".	Suggest replacing "Part C" with "MA"	Revision			Reject
105	RO9	Attestations	3.10.A.14	35-37	Attestation #14 lists a large number of requirements in the admin/mgmt contracts. A "no" response will not provide any information about which provision is missing.	Suggest breaking out each requirement into a separate attestation.	Revision		In efforts to minimize burden to the applicant, CMS will create a standard attestation that will read: "Applicant attest that all contracts within this provision meets all requirements and CMS regulations under 42 CFR 422.504…"	Reject
83	RO7	Attestations	3.13.A	45	Table item #6	CLARIFICATION - Clarify hours of support required at end of item #6 (24 hours a day).	Revision		24 Hour support is not currently available	Reject
43	RO9	Attestations	3.3.A.A.1	21	For Attestation #1, can't CMS require that the applicant provide the state licensure requirements for each state in the service area? This would save us time from having to find that information out.	Suggest adding an uploaded document in which the applicant must provide explanation and evidence of the state licensure requirements	Insertion		Please use available resources on the HHS Portal and Regional Managers to research license requirements.	Reject
44	RO9	Attestations	3.3.A.A.2-3	21	Both these attestations #2 and #3 require the applicant to upload a document, but we don't specify where to upload it.	Include more specific instructions to the applicants regarding where in HPMS the applicant should upload documents.	Insertion		The system has an upload section and addresses this. Additional information can be found in the instructions section.	Reject
46	RO9	Attestations	3.3.A.B	22	The second bullet requests a "CMS State Certification Form" but this is not always a requirement.	Suggest adding "as applicable" to the second bullet	Revision		The suggested language is incorrect, as it is always applicable.	Reject
53	RO9	Attestations	3.5.A.8	26	Attestation #8 refers to "the Part C program", yet the rest of the application uses "the MA program".	Suggest replacing "Part C" with "MA"	Revision		CMS prefers to include the term "MA" instead of Part C.	Reject
62	RO10	Attestations	3.8 c-d Service Area	31	Provide example maps	Provide examples of maps . This is an area that typically requires more than one attempt to get a legible map. If we provide best-practice examples, we have a better shot at receiving adequate and legible maps on the first submission	Insertion	Add as an attachment	Maps are no longer required. Once applicants input address for provider facilities, Quest Analytics system will use population density of beneficiaries to create maps that calculate time and distance.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 052	AHIP	Attestations	3.8 Service Area	30	Under Section 3.8, the draft requires plans to submit maps of their service areas, including maps showing the location of their contracted providers. It is unclear how CMS anticipates that the maps will accommodate the permissible inclusion of providers located outside the county to meet network adequacy requirements.	AHIP recommends that CMS provide explicit instructions addressing mapping requirements for network providers that are outside of the county. We also recommend that CMS provide examples of mapping software that is likely to have the functionality necessary to meet CMS mapping requirements.	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 033	Humana	Document Upload Templates	4.1 - Experience and Organization History	68	Section 1 states that all applicants (new and existing) must complete this section. Section 1.3 asks for the CVs of all key personnel.	Key management staff that is managing our current MA HMO, LPPO, PFFS contracts will be responsible for the initial and SAE contracts. In 2010 we were not required to submit position descriptions. Because existing management will be utilized, we recommend following the same approach for the 2011 applications.	Revision		Position descriptions are important if management staff changes from year to year. Initials and SAEs are required to submit CV's SAE's do not need to submit position descriptions	Reject
108	RO10	Overall	All		Want a Cheat Sheet to Determine what Sections of the Application Require Completion	This was created in the past, 2008 or earlier; Ex. MA-PD wants a SAE; the MAO only has to fill out HSD tables instead of the entire app	Insertion	Add as an attachment	Please see Chart 1. This information is already available	Reject
IND 115	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Care Management for the Most Vulnerable Subpopulations	111	5: ESRD	Request that worksheet clarify that specialization in ESRD services is only required upfront for SNPs serving populations at risk for this condition.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 037	Humana	HSD Instructions	General Instructions for CMS HSD Tables	1	CMS states that county boundaries no longer apply and that contracted providers who meet time and distance requirements can be included in the Part C application to prove network adequacy. However, tables are still set up on a county level basis. In what format does CMS expect to receive data regarding servicing providers who do not practice within the county lines?	When a network requires supplemental information we recommend that plans submit this information via a corresponding HSD 2 or HSD 3 by county.	Revision		If plans fail to meet the criteria during the pre-assessment phase, plans will still have an opportunity to submit supplemental information through the exceptions process.	Reject
IND 109	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	2: 90 day timeframe	Please clarify in MOC worksheet or some form of guidance that plans will not be expected to complete new assessments for all existing enrollees within 90 days or by end of first quarter. Existing SNPs with thousands or tens of thousands of beneficiaries would be overloaded. Further, since many beneficiaries receive routine assessments of functional, physical and psychosocial health issues – and at different times of the year – not complete comprehensive assessments once per year, we assume that assessments conducted within the past 12 months could be used to meet this requirement. Please clarify the flexibility CMS will offer on this item.	Revision		This flexibility exists and additional information will be provided. CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 110	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	5: Face to face	Recommend that face-to-face assessments not be required as paper or telephone assessments for at least some parts of the survey may be appropriate for some targeted SNP populations.	Revision		This flexibility exists and additional information will be provided. CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 111	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	7: Self assessment	This should not be requirement as some beneficiaries may not be able to comply with this requirement on their own.	Revision		CMS has clearly stated in other guidance that the beneficiary or an identified person is able to complete this assessment. CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 112	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	11: Electronic tool	Please clarify whether special steps need to be taken to allow all providers to have access to an electronic assessment tool and results to avoid HIPPA compliance issues.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 113	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	13: Standard tool	Please clarify that any standardization would be limited to a particular population subset – not a wide variety of beneficiaries with different special needs.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 114	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Health Risk Assess	109	17: Credentialed professional	Please clarify what is meant by "credentialed health professional." Does this include MSW, Masters in Gerontology or Human Services?	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 038	Humana	HSD Instructions	HSD 2 - Provider List of Physicians and Other Practitioners by County	7	How does CMS distinguish between Cardiac Surgery, Thoracic Surgery, and Vascular Surgery? Is this distinction based on ABMS criteria? If so, can CMS provide the ABMS classifications that fall into each of these categories? For example, how would CMS classify a provider credentialed in Thoracic Cardiovascular Surgery?	Recommend CMS provide information on the ABMS classifications that fall into each of these categories, if applicable. This information should be released with the network adequacy requirements.	Insertion		In general, cardiac surgeons concentrate on CABG and heart valve surgery, while thoracic surgeons concentrate on lung resections, and other non-cardiac thoracotomy procedures. Vascular surgery involves peripheral vascular interventions, particularly carotid, abdominal aorta, and femoral arteries. There is always some overlap (particularly between cardiac and vascular surgery), but commonly thoracic surgeons who perform tumor resections, chest tube insertions/pleurodysis, etc. do not perform CABG or heart valve procedures	Reject
IND 042	Humana	HSD Instructions	HSD 3 - List of Facilities and Services	12	How should we display Home health providers who provide PT and OT services?	For the 2010 applications we listed the Home Health provider and placed an "X" in the columns for Home Health, PT and OT. Since the HSD 3 for the 2011 applications no longer includes the columns where we mark what services a facility may provide, how do we indicate this?	Revision		As directed in the instructions, facilities that provide more than 1 service type should be listed once for each such service.	Reject
IND 044	Humana	HSD Instructions	HSD 3 - List of Facilities and Services	12	Currently applicants can only consider essential hospital status when determining network adequacy for RPPO's. Applicants cannot consider essential hospital status for other network based products such as LPPO or HMO.	CMS should consider essential hospital status granted to each payer when evaluating network adequacy. In these instances, the hospital is non-par for valid reasons and it should be deduced that by simply changing a product/network name will not change the provider's unwillingness to contract with a payer.	Revision		CMs does not have the legal authority to accept the comment and implement this recommendation.	Reject
IND 082	Blue Cross Blue Shield	HSD Table 1	HSD Table 1: County / Delivery System Summary of Providers by Specialty	4	Addition of "Providers Supporting Contracted Facilities": Applicant organizations contract with groups and not the individual physicians. The groups ensure coverage at par hospitals. Due to the movement of these physicians organizations may have difficulty in providing absolute counts and providing a listing of what physician covers what hospital. The data is available, but extremely time intensive to keep it updated	Can this be revised to allow segmentation to reflect number of individual physicians and/or physician groups? If the requirement is not revised this would qualify as an "increase" in the level of applicant burden.	Revision		CMS has always required plans to list out the individual providers. Therefore, CMS does not anticipate that this will increase the applicant's level of burden.	Reject
IND 085	UCare	HSD Tables	HSD Tables		HSD tables are incredibly time consuming to complete and add little value to the application for rural counties in particular. In rural counties, when most health care is accessed in an adjacent county or regional health care hub, HSD tables do not adequately explain where people access care.	Eliminate the requirement to complete HSD tables and implement a system that uses GeoAccess to map providers to Medicare Beneficiaries – just like the Part D application does. This would eliminate the problems that we experience with the rural counties, when most of the health care is accessed in an adjacent county.	Deletion		The information gathered through the HSD tables are critical for CMS to determine the network adequacy.	Reject
IND 093	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Number 6 and 7: Assuring "appropriate" utilization and cost-effective delivery.	Plans cannot guarantee stated outcomes; a more appropriate expectation would be conveyed by terms such as "promote" or "facilitate."	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 094	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Numbers 8, 9, and 10: Improvements to health	We do not believe these goals are realistic for nursing home residents. We recommend CMS clarify that these goals are not expected for institutional I-SNPs – or that these goals be targeted "where appropriate based on targeted conditions."	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 095	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Number 10: Improve mobility and functional status	Some special needs beneficiaries such as frail elderly or disabled may be incapable of improving mobility and/or functional status (wheel-chair bound, paraplegics, blindness, amputee, etc.). We recommend as a more appropriate goal that plans "prevent, delay or minimize" functional decline.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 096	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Number 11: Pain management	We recommend that this goal either be expanded or a new goal be established to improve beneficiaries' outcomes via provision of "palliative care to promote comfort and dignity at the end of life" and supportive care. These could be combined or 2 new separate goals.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 097	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	Number 13: Satisfaction with health status may be unrealistic goal for very frail, impaired or disabled beneficiaries.	Satisfaction with health services is a more realistic goal for special needs beneficiaries.	Revision		Each individual has a level of quality of life that can be measured. This discussion should occur during the development of than plan of care and the MCO should work towards achieving the stated goals established. CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 098	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Model of Care Goals	103	All Numbers: CMS Expectations	The SNP Alliance urges CMS to include guidance re CMS expectations regarding improvements in the 15 separate goal areas. Plans should not be expected to demonstrate improvements in all 15 areas every year or to demonstrate the same level of improvement year after year. We recommend that the Model of Care worksheet clarify expectations in two areas: first, that plans should identify a limited number of goal areas for improvement in health care domains each year; second, that plans will be measured under a CQI approach that allows plans to show annual improvements, including incremental gains or stable quality performance once certain benchmarks have been achieved.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 116	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	111-112	2-7 Improvements	At a minimum, plans would need at least two years to demonstrate improvements since the first year would involve establishing a baseline for measuring improvement. Under this method, plans would need to be evaluated on a CQI basis against themselves unless CMS elected to establish benchmarks in each of these areas.	Revision		CMS reserves the right to determine how QI efforts will be monitored. CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 117	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	111-112	2-7: Improvements	CMS should clarify in the worksheet or some other form of guidance that plans can select a few areas for improvement each year in conjunction with their CCIP or QIP requirements, not be expected to tackle each area every year.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 118	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	111-112	2-7: Improvements	CMS should clarify expectations that regarding degrees of improvement from year to year since plans would not progress at same rate each year – esp. once they achieve certain high levels of quality.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 119	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	111-112	2-7: Improvements	Comparison on non-SNP members may be difficult to structure and may require use of FFS benchmarks in some cases.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 120	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	112	8-14: Quality and/or improved.	Please clarify the use of the term "quality or improved." How is "quality" defined? How will CMS evaluate improvements?	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 121	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	112	21: Actions to improve the model of care.	Please clarify the benchmark for "improving the model of care." Does this mean from year to year in relation to self-defined model of care goals?	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 122	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	112	11-26: Collection, analysis, reporting and measurement.	We recommend that CMS consider some type of standardization of these elements to reduce the reporting and measurement burden on SNPs and to improve CMS' ability to benchmark SNPs against other. We also request that CMS work with the SNP Alliance and its plans to identify opportunities to streamline reporting and data collection where possible.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 123	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	112	27: Documentation of MOC effectiveness with all stakeholders	Please clarify CMS' expectations regarding how plans would share documentation with "all stakeholders" and how this would be accomplished. This seems like an excessive requirement. We urge CMS to consider requiring plans to make information about MOC effectiveness available upon request and to provide it to regulators, but not be required to actively distribute to every possible stakeholder.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 124	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Performance Outcome Measurement	111	1: Model of Care Evaluation	Plans wish to clarify that a variety of staff functions will be involved in the evaluation of the model of care such as care managers, utilization management staff, quality improvement staff, etc.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 103	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network	107	42: CPGs	Please clarify whether this attestation refers to any functions beyond utilization management	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 104	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network	107	43: Referrals	To suggest that a beneficiary needs the ICT teams' permission for a routine doctor appointment seems overly restrictive.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations. CMS is not requiring providers to discuss routine care with the IDT, but to communicate significant changes that require update of the individualized care plan. This conceptual issue is best addressed in a training forum.	Reject
IND 106	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network	107- 108	46, 47, 50, 52, 54: Coordination of Service Delivery	These items are all potentially delegated functions to providers. Please clarify by indicating that the applicant either performs the function or has a process in place to have the function carried out.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 107	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Provider Network & Interdisciplinary Care Team	108	Provider Network #51; Interdisciplinary Care Team Number 7: Updating on Transitions of Care and Care Plans	Given the frequency with which transitions can occur and care plans can change, some plans feel that notification of all parties is an unrealistic goal. We recommend that this item be modified to indicate that the care manager (or ICT manager) be notified and that individual can determine which other "stakeholders" need to be notified in what timeframe.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
IND 059	AHIP	HSD Instructions	Requesting Exceptions		The draft indicates that exceptions may be requested only at the time of initial application submission, but also explains that the pre-assessment tool is not a substitute for the intensive review conducted by CMS Reviewers, who may identify deficiencies not revealed by the tool.	Consequently, it appears that in the course of the review process, applicants could learn of unforeseen circumstances that they may be interested in addressing through the exceptions process. We recommend that in such cases, CMS permit exceptions to be submitted during the review process.	Revision		Plans will have two pre-assessment opportunities to determine if they need to request an exception, prior to application submission. However, failure to meet other network related requirements (e.g., contracts) could result in a deficiency for county that initially that was found to meet the criteria.	Reject
IND 062	Blue Cross Blue Shield	General Info	Section 1.7A Additional Information-Bid Submission & Training	8	First sentence states, "On or before the first Monday of June every year,…"; however, historically the bid submission due date has actually been on the first Monday of June each year.	Why include "or before"?	Revision		Applicant can submit before the due date. This suggestion is not a substantive revision.	Reject
IND 072	Blue Cross Blue Shield	Attestations	Section 3.10 Contracts for Administrative & Management Services	34	Subsection A.#2: Does this include temporary and/or contract staffing agencies used by the plan organization for internal staffing that work with MA data?	If so, please add language clarifying this requirement includes such relationships.	Revision		Yes, temporary staffing is included. Additional language is not necessary to clarify this attestation.	Reject
IND 075	Blue Cross Blue Shield	Attestations	Section 3.10 Contracts for Administrative & Management Services	37	Subsection B: References a "Delegated Business Function Table"; however, we were unable to locate said table in application upload templates (at end of document).	Need to add the referenced table to the application	Revision		This document is a module built within HPMS. There is no paper version. Only applicants that have access to this section will be able to complete it. CMS will determine if this table can be added as an exhibit.	Reject
IND 066	Blue Cross Blue Shield	Attestations	Section 3.8 Service Area	31	Subsection A.#2: The attestation description addresses the service area map (1) and the four (4) required county level maps.	Clarify by segmenting the service area map requirements, then each county map type (4) required map descriptions (i.e. a=Service Area map, b=County map 1, c=County map 2, d=County map 3, e=County map 4).	Revision		Maps are no longer required per CMS decision/discussion above.	Reject

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
IND 067	Blue Cross Blue Shield	Attestations	Section 3.8 Service Area	31	Subsection D: The description addresses the four (4) required county level maps.	Clarify by segmenting the each county may type (4) required map descriptions (i.e. a= County map 1, b=County map 2, c=County map 3, d=County map 4).	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 068	Blue Cross Blue Shield	Attestations	Section 3.8 Service Area	31		General: Can more detailed instructions be added to provide a clearer understanding of the CMS needs/requirements, comparable to Appendix X in the 2011 Part D application?	Revision		Maps are no longer required per CMS decision/discussion above.	Reject
IND 015	Aetna	HSD Instructions	Section G	15	Table HSD 4	Recommend that MAOs who are offering MAPD products not be required to submit outpatient pharmacy information on this table since we are required to submit our entire pharmacy network for approval under the Part D application review process. The addition of pharmacy provider information can significantly increase the size of this HSD table depending on the size of the county.	Insertion		This information is vital to CMS' analysis. This is a necessary factor of the Part C access analysis.	Reject
IND 016	Aetna	HSD Instructions	Section I	18	Requesting Exceptions	Recommend CMS provide examples in the revised instructions of the type of documentation that will be considered acceptable to initiate an exceptions request. Instructions indicate this will be noted in the drop down menu of HPMS tool, but plans need to know this information in advance.	Insertion		CMS cannot provide specific examples in the application. However, CMS is developing special guidance, which will be released in October.	Reject
IND 125	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	SNP Quality Improvement Program Requirements	113	Numbers 3, 4 and 5	The SNP Alliance is concerned about the volume of reporting required of SNPs by Medicare, Medicaid and NCQA. We request the opportunity to consolidate wherever possible and eliminating duplicative reporting is a good starting point. MAO Internal QI activities, CCIP requirements and QIP requirements all require the SNP to describe the various quality improvement projects and how they relate to the target population; how they identify the beneficiaries that would benefit from participation in the QI activity, how the benefits and outcomes will be monitored, etc. We strongly urge CMS to work with the SNP Alliance, its members, state Medicaid agencies and NCQA in consolidating QI requirements around a single	Revision		These reporting requirements are mandated through regulation by various CMS Part C and D components. CMS is currently engaged in an initiative to consolidate quality assurance and performance improvement reporting. Until the agency determines how it will require evidence of performance improvement from its contracted health plans, CMS will expect MAOs to meet the quality reporting requirements currently in regulation.	Reject
IND 099	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Staff Structure	104	Numbers 1-9 and 24-31: Duplicative of standard MA functions.	Eliminate duplication of other parts of the MA application by deleting these sections and making reference to other section of application where this information is provided; or exempt SNPs from completing the same information in the general MA component of the application.	Deletion		The applicant is expected to explain how the SNP model of care differs from the care management systems used in other product lines. As a unique model of care, applicants must describe all elements in relation to the care of special needs individuals.	Reject
IND 100	SNP Alliance	Appendix I - Solicitations for Special Needs Plan Proposal	Staff Structure	104	Number 10: Survey beneficiaries, plan personal, network providers, oversight agencies and the public.	Please clarify expectations re surveys of enrollees, staff and providers – is a new requirement being proposed? E.g., aren't beneficiary satisfaction surveys typically conducted by outside vendor? Also, what surveys of "oversight agencies and the public" are being referred to? Are these requirements standard MA requirements or something specific for SNPs? The SNP Alliance has concerns about existing reporting requirements far in excess of standard MA plans and urges CMS to ensure that any additional requirements clearly provide tangible value. Also, surveys of "oversight agencies and the public" seems like a public sector function, not a plan function and we urge CMS not to impose this requirement on SNPs.	Revision		CMS will conduct training and publish guidance on the SNP model of care that will clarify CMS expectations.	Reject
HSD 16	CO	HSD Tables	Table 2A		This section of the table was accidentally excluded in the review.	This table can be distributed during the 30 day comment period or can be uploaded under the Provider Contract section.	Insertion		The table section should be reinstated in the location of the HSD tables where it was in 2010 to provide consistency for Applicants.	Reject
24	RO9	Instructions	2.3	13	The heading for Section 2.3 refers to "MAO", yet elsewhere (including 2.2 and 2.4) we talk about "Plans" -- suggest keeping our format the same	In the section heading, change "MAO" to "Plans"	Revision		CMS prefers to include the term "MAO" instead of the plans in this section	Reject with Modification
71	RO9	Attestations	3.10.A.9	35	Attestation #9 includes a note that PFFS and MSA plans are not required to perform UM functions. Is this true for network PFFS plans as well as non-network PFFS plans?		Revision		Attestation #9 will be split into 2 attestations: Attestation #9 will address operations management. PFFS and MSA's do not have to complete attestation #9. Attestation #10 will address quality improvement operations, which PFFS and MSA have to complete.	Reject with Modification

3	RO2	General Info	1.2	4	Link to fact sheets is incorrect		Revision		The link will be verified.	Accept
77	RO9	Attestations	3.11.A.5	39	The language in attestation #5 is not clear.	Suggest changing attestation #5 to read, "Applicant has uploaded in HPMS completed HSD tables 1-5, with a separate set of tables for each county in the service area. Applicants offering multiple plans (plan benefit packages) must submit separate tables for each plan if the plan restricts members to a subset of the entire provider network.	Revision		Attestation #5 has been deleted since the applicant is required to upload information as requested in subsection 3.11 B. An additional note was added to subsection B, which states that, "Applicants offering provider specific plans must submit separate HSD Tables."	Reject with Modification
82	RO9	Attestations	3.13.A.	44	The attestations are missing a requirement about using brokers and agents that meet state licensure requirements.	Suggest adding a new attestation #16 asking the applicant to affirm that it will employ / contract with agents and brokers that meet state requirements for licensure and/or certification.	Insertion		Attestation #15 will be revised to read: "Applicant agrees that brokers and agents selling Medicare products will be trained and tested on Medicare rules and will satisfy all other CMS requirements prior to selling."	Reject with Modification
IND 024	Humana	Attestations	3.9.A.2	32	The statement "Providers and supplier contracts or agreements contain the following CMS required provisions" appears to be missing the CMS required provisions	This statement should have a bulleted list. Recommend adding a bullet with the CMS required provisions.	Insertion		In efforts to minimize additional burden for the applicant, CMS has eliminated the detailed requirements for this attestation. The revised attestation will read, "Applicant agrees that all contracts for providers and supplier contracts contain the required contract provisions that are described in the CMS Provider Contracts Agreement template."	Reject with Modification
IND 061	Blue Cross Blue Shield	Overall				Please provide the final documents in Word format. Given the attestations, and supporting data files are now submitted via HPMS, the historical risk that existed related to plans potentially changing/revising the document(s) prior to final submission is non-existent. Allows plans to work directly from the document in an electronic format, optimizing time necessary to gather data from business partners. (Word documents are much more user friendly than PDFs.)	Revision		CMS will determine if an "editable" .pdf version or word (.doc) version is available.	Under Consideration