CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
1	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.1	149	The end of the introductory paragraph sets forth the authority for this section. The cited provisions include "422.412".	The cited provisions include "422.412". This citation should be changed to "417.412".	Revision	**Accept Revision:** CMS agrees that the recommendation is appropriate.
2	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.2	149	The end of the introductory paragraph sets forth the authority for this section. The citation is to 42 CFR 412.407(a).	That section sets forth the requirements for an organization to be a competitive medical plan (CMP). An organization is not required to be a CMP in order to obtain a Medicare cost contract. The organization may also be an HMO. We believe that a better citation to support this section would be to 417.404 or 42 CFR 417 Subpart J generally.	Revision	**Accept Revision:** CMS agrees that the recommendation is appropriate.
3	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.2, provision A.1	150	This provision currently states "Applicant is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the Applicant proposes to offer the MA product. In addition, the scope of the license or authority allows the Applicant to offer the type of MA plan that it intends to offer in the states or states."	As an initial matter, we recommend that you replace references to "the MA product" with "Medicare cost plan". In addition, we recommend that you delete the second sentence because there is only one type of Medicare cost plan.	Deletion	**Accept Revision with a Modification:** CMS will replace "MA product" with "managed care product" .
4	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.2, provision A.5	151	There appears to be a typographical error in this provision.	The word "are" should be replaced with "area".	Revision	**Accept Revision:** CMS will accept the editorial change.
5	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.3, provision A.1	152	This provision states "Applicant meets the county integrity rule as outlined in Chapter 4 of the Medicare Managed Care Manual and will serve the entire county".	We note that Chapter 4 of the Medicare Managed Care Manual, titled "Benefits and Beneficiary Protections", does not apply to Medicare cost plans. The corresponding chapter that does apply to cost plans is Chapter 17F, which is also titled "Benefits and Beneficiary Protections". We note that while CMS used Chapter 4 as the basis for developing Chapter 17F, it omitted the county integrity rule. The rule is also not included in the regulations or the statute applicable to Medicare cost plans. In fact, the statute, section 1876 of the Social Security Act, specifically refers to counties which are "in whole or part within the service area of such an organization. Thus we question whether the county integrity rule applies to Medicare cost plans.	Revision	**Accept Revision with a Modification:** CMS will remove this question from the Cost SAE application. The county integrity rules do not apply to Cost Plan SAE applicants.
6	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.6	153	The introductory paragraph to this section on contracts for administration and management services states that "further guidance is provided in [the] Medicare Managed Care Manual".	We do not believe there is guidance in the Manual on this issue that is applicable to Medicare cost plans. Thus we recommend that you delete this statement.	Deletion	**Accept Revision:** CMS will remove this statement from the Cost Plan SAE application.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
7	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.6, provision A.16	154	This provision states "Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the Part C call center operations."	Medicare cost plans are not Part C plans. Thus, we recommend hat CMS delete the reference to Part C. In addition, section 8.6 needs to be renumbered as it skips from number 7 to number 16.	Deletion, Revision	**Accept Revision:** CMS will delete the reference to Part C and will renumber section. 8.6
8	Medicare Cost Contractors Alliance (The Alliance)	60 Day	Part C Medicare Application and 1876 Cost plan Expansion Application - CY2012	8.6, provision B	155	This provision refers to the Delegated Business Function Table.	This table was not included as part of the Paperwork Reduction Act package. However, it should be reviewed to ensure it is appropriate for Medicare cost plans.	Revision	**Reject:** The delegated function table is a table that is within HPMS under the Part C Data Module. A cost plan that has delegated contracts will complete the table and have access to this table. HPMS application user guides tells organizations how to access this table.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
9	United Ovations	60 Day	Part C, MA	2.1	15	Instructions - clarifies what it means to respond "Yes" to an attestation. "By responding "Yes," the Applicant is committing that its organization complies with the relevant requirements **as of the date the application is submitted to CMS**." The 2011 application indicated that "Yes" meant that the plan will be compliant as of the date of the contract, unless an earlier date is stated.	We do not think responding Yes should always mean that the applicant is currently compliant with the attestation. For example, an applicant could be new to Medicare and would be unable to say that it currently complies with an operational requirement that it does not yet perform. Additionally, if a rule did not go into effect until the next calendar year, plans could not attest on the application they are currently compliant. Finally, an applicant might have a contract for a particular service that does not go into effect until the beginning of the plan year for which the application is filed. The plan should not have to attest that it has the contract in place at the time of the application when it is not necessary until the beginning of the plan year.	Revision	**Revision with Modification:** CMS will revise the language to read as *"By responding "Yes," the Applicant is committing that its organization complies with the relevant requirements as of the date the application is submitted to CMS, unless a different date is stated by CMS."* Also, Applicants are allowed to answer "NO" to any attestation within the Part C application. As part of the application review process, applicants are also given the opportunity to cure any CMS defined application deficiencies.
10	United Ovations	60 Day	Part C, MA	3.9	31	CMS Provider Participation Contracts & Agreements. Attestation #4: "Applicant agrees to have all provider contracts and/or agreements available upon request and onsite." This attestation is unchanged from last year, but an applicant may utilize off-site storage vendors for some contracts while storing others electronically or onsite. For the purposes of sampling for an application or at other times, plans could agree to have contracts available onsite upon request.	We recommend that the wording of the attestation be clarified. We believe that CMS is requesting that plans have the provider contracts onsite for review, but is not requiring that plans have the contracts on-site at all times. A plan may have many of it's contracts off-site, but can certainly access them and bring them on-site if needed. In order to clarify what CMS is requiring, we would make the following suggested wording change: "Applicant agrees to have all provider contracts and/or agreements available onsite upon request."	Revision	**Reject with Modification:** CMS will revise the statement to read as *"Applicant agrees to have all provider contracts and/or agreements available upon request*." Please note: CMS has the flexibility to conduct onsite and offsite reviews. Therefore all application materials must be available upon request.
11	United Ovations	60 Day	Part C, MA	3.10	32	Contracts for Administrative & Management Services. All the attestations that had "will have" have been revised to "has." "Example: Applicant ***has*** an administrative/management contract/agreement with a delegated entity to perform..." This supports the change made in the instructions which explains that a "yes" indicated that the plan can comply as of the date of the application.	As indicated in the previous comment, the revisions would require that plans have contracts in place at the time the application is submitted. However, a plan may reasonably have a contract that does not become effective until the beginning of the plan year. We recommend CMS revise the attestations to reflect the previous wording, that plans "will have" contracts/agreements in place.	Revision	**Reject:** CMS does not require Applicants' provider and/or other contracts to be effective as of the date of application submission. These contracts, however, must be fully executed ("in place") in order for the application to be approved.
12	United Ovations	60 Day	Part C, MA	3.15	44	Attestation #1 reads: "Applicant will date and time stamp all claims as they are received, whether in paper form or via electronic submission, in a manner that is acceptable to CMS." We suggest the removal of the words "and time" to allow plans that utilize claims systems that date stamp, but do not currently also time stamp to answer Yes.	We recommend that attestation #1 be revised to read as follows: "Applicant will date stamp all claims as they are received, whether in paper form or via electronic submission, in a manner that is acceptable to CMS."	Revision	**Accept Revision:** *"Applicant will date stamp all claims as they are received, whether in paper form or via electronic submission, in a manner that is acceptable to CMS."*

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
13	United Ovations	60 Day	Part C, MA	3.15	44	Attestation #2 reads: "Applicant will ensure that all claims are processed in chronological order, by date of receipt." Plans may generally process claims in the order in which they are received. However, in order to process claims in a more efficient manner, plans may not always process claims strictly in chronological order. For example, while a large volume of claims will auto-adjudicate a smaller number of claims may require manual intervention to process. Claims are not cleared in the same order they are received because some require more work than others. Also, auto-adjudicated claims are processed before claims requiring manual work even if the manual claims are received earlier.	We recommend that attestation #2 be revised to read as follows: "Applicant will ensure that all claims are processed promptly and in accordance with CMS regulations and guidelines." We think that this change in the attestation wording will more closely align with CMS requirements and will allow plans to answer this attestation with a "yes" without having to qualify their response.	Revision	**Accept Revision:** "Applicant will ensure that all claims are processed promptly and in accordance with CMS regulations and guidelines."
14	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	6	93	Under the "D-SNP State Medicaid Agency(ies) Contract(s)" category, it is unclear what to submit in the following situations: 1. A State Medicaid Agency contract that is already effective for the application year, but has not yet been amended to reflect the application year's service area. 2. A State Medicaid Agency contract that is currently effective for the year prior to the application year, but the agreement has not been amended or a new contract signed to establish the relationship for the application year. In each of these cases, it would help to know whether CMS wants applicants to complete the D-SNP upload document or submit the existing State Medicaid Agency contract.	To help draw a clear line on what to do in situations where only technical updates are needed to the State Medicaid Agencies category, we recommend inserting under Section 6, Attestation, State Medicaid Contract, Item 1, the following sentence: (Note: If an updated contract or contract amendment will be needed for the application year, applicant should go to question #3.)	Insertion	**Accept Revision**, CMS will insert the recommended note: "*(Note: If an updated contract or contract amendment will be needed for the application year, applicant should go to question #3.)*
15	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	98	Under the "Staff Structure and Care Management Roles" category, there are several items that are general health plan operational items not unique to SNPs (e.g., process enrollment, verify eligibility, or process claims).	We recommend removing the attestations of general operational duties that are applicable to all types of plans so the "Staff Structure and Care Management Roles" are more focused on items applicable to SNP plans.	Deletion	**Reject:** Verifying eligibility is important to Dual Eligible SNPs now that disproportionate share SNPs are no longer allowed.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
16	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	98	The "Staff Structure and Care Management Roles" category, item #24 ("Assures maintenance and sharing of healthcare records") is not clear and could be interpreted to mean that staff and resources are required to assure maintenance of health care records by network providers, which providers are required to do through participation agreements.	We recommend revising item #24 to read "Assures sharing of health care information as appropriate."	Revision	**Accept with modification:** *"Assures maintenance and sharing of health care records in accordance to CMS regulations and policies."*
17	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	99	The "Staff Structure and Care Management Roles" category, item #41 ("Conducts medical chart reviews") is not clear and could be interpreted as a comprehensive medical chart review. Further, chart reviews are only regularly done at time of discharge from a facility. Otherwise, targeted medical chart reviews are done as needed.	We recommend revising item #41 to read "Conducts appropriate medical chart review as needed."	Revision	**Accept Revision with Modification:** *"Conducts targeted medical chart reviews needed"*
18	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	100	"Provider Network and Use of Clinical Practice Guidelines" category, item #1 ("Applicant has a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. The provider network includes:") Confusion has arisen on this item as reviewers have interpreted this to mean that the plan employs all of the individuals with the required level clinical expertise. However, health plans can provide access to specialized clinical expertise for the targeted special needs population through employed, contracted or vendor relationships with clinicians.	We recommend modifying this language to make it more consistent with 42 CFR 422.101(f)(2)(ii) that requires SNPs to "[h]have appropriate staff (employed, contracted, or non-contracted) trained on the SNP model of care to coordinate and/or deliver all services and benefits. For example, revise #1 to read "Applicant provides access through contracted or employed relationships to a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. The provider network includes:..."	Revision	**Accept Revision with modification:** " *Applicant has a network of provider and facilities through employed, contracted, or non contracted arrangements with specialized clinical expertise pertinent to the targeted special needs population. The provider network includes:..."*

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
19	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	100	"Provider Network and Use of Clinical Practice Guidelines" category, item #18 ("Applicant assures that the provider and facility network having specialized clinical expertise pertinent to the targeted special needs population delivers services. Specific services include:…:"). Reviewers of this item believe the SNP should have providers that only see members of the targeted special needs population. However, plans create and leverage provider networks that can service both the SNP population as well as the broader Medicare Advantage population. Having a broad network of contracted providers does not diminish the clinical expertise of the network to meet the needs of the targeted population. Rather, having a broad network of physicians - particularly providers who may not otherwise normally agree to see the targeted population (i.e. dual-eligibles) - provides beneficiaries with expanded access and choice. We believe this should be encouraged by CMS.	We recommend revising #18 to read "Applicant provides access through contracted or employed relationships to a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. Specific services include:	Revision	**Accept with Revision: "***Applicant provides access through contracted or employed relationships to a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. Specific services include:"*
20	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	101	"Provider Network and Use of Clinical Practice Guidelines" category, item #45 ("45. Applicant has the beneficiary notify the plan and/or interdisciplinary team regarding necessary services"). In this section, it is not clear whether SNPs are being directed to have members contact the plan each time they want a service or only in cases when they are having trouble obtaining needed services. If the intent is to require members of SNPs to contact the plan each time "regarding necessary services," this will cause member confusion as this may be seen as a prior authorization requirement and may inadvertently reduce access for members that are reluctant to make such calls to their health plan. Further, plan's can only require prior authorization to the extent this is reflected in the bid filing. Finally, beneficiary compliance is beyond the plan's control. If this item is intended to require plans to make available a means for members to call into a plan for assistance in obtaining necessary services, we believe it should be restated.	We recommend deleting item #45 because the scope is too broad. In the alternative, we recommend item #45 be revised to read: "Applicant provides a means for beneficiaries to notify the plan and/or interdisciplinary team regarding services the beneficiary feels are necessary."	Deletion, Revision	**Accept Revision with Modification:** New Language will read *"Applicant has a mechanism in place that allows beneficiaries to notify the plan/and or interdisciplinary team for assistance in obtaining necessary services. "*
21	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	102	"Provider Network and Use of Clinical Practice Guidelines" category, item #52 requires notification to the interdisciplinary care team and respective providers when transitions of care occur, however, it is not always necessary to notify all members of the interdisciplinary care team.	We recommend revising #52 to read "Applicant has written procedures that require notification to appropriate members of the interdisciplinary care team and providers when transitions of care occur."	Revision	**Reject:** It is important to CMS that all interdisciplinary team member are made aware of all transition activity and decisions.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
22	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	102	Under the "Provider Network and Use of Clinical Practice Guidelines" category, item #54 ("Applicant disseminates the results of the transition of care analysis to the interdisciplinary care team."), there is concern that some providers will serve a very small number of SNP members and it will be difficult for them to give us updates on care transitions, which may impact transition of care analysis.	We recommend revising #54 to read "Applicant analyzes transitions of care and identifies area of improvement to meet member needs as appropriate." With these changes, this item may fit better with the quality improvement sections of the application.	Revision	**Reject:** However CMS will add the following attestation to the Quality Improvement Section of the SNP Proposal "*For each special needs plan, Applicants agrees to disseminate the results of the transitions of care analysis to the interdisciplinary care team. "* Please note: It is important to CMS that all interdisciplinary team members are made aware of all transition activity and decisions.
23	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	104	There are two categories labeled "Health Risk Assessment." We believe the 2nd category labeled "Health Risk Assessment" was intended to be labeled "Communication," as it was labeled in year's application.	We suggest revising the category "Health Risk Assessment" found on page 104 to "Communication."	Revision	**Accept Revision with modification:** "Health Risk Assessment to Communication Systems".
24	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	105	"Care Management for the Most Vulnerable Subpopulations" category, item #2 ("Applicant delineated additional services it will provide for its most vulnerable beneficiaries. These add-on services address the specialized needs of the following vulnerable special needs individuals within each target population"). The term "additional services" can mean items in the Plan Benefit Package and items in the PBP are to be available to all members of the plan, not just the most vulnerable. However, care management services are designed to change based on the member's specific conditions.	We recommend changing "additional services" to "care management services" to clarify what we believe is the CMS intent of this attestation.	Revision	**Accept Revision:.** *"CMS will change "additional services to "care management services"*
25	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	11	106	Under the "Performance and Health Outcome Measurement" category, item #29 ("Applicant communicates the results of its model of care evaluation to all stakeholders"), what is meant by stakeholders? If stakeholders is defined too broadly, the audience will be too large resulting in little benefit from the communication.	We recommend revising "all stakeholders" to "all appropriate internal and external stakeholders."	Revision	**Accept Revision with Modification:** "*Applicant communicates the results of its model of care evaluation to all stakeholders as identified by CMS and SNP."*

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
26	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	14 & 15	109 - 112	It is not clear whether Section 14 or 15, or both, should be completed by applicants. If an applicant has a State Medicaid Agency contract currently in place but requiring technical changes such as an extension to cover the application year or an amendment to reflect the service area for the application year, should the applicant consider the application complete if Section #14 is completed and skip #15?	Please clarify that Section 14 is to be completed if contract negotiations are in progress or if technical amendments to the existing contract will be needed for the application year and Section 15 is to be completed if the State Medicaid Contract has already been signed. Further, please clarify that applicants need only complete section 14 or 15 as appropriate.	Clarification	**Clarification:** CMS will add the following language to Section 14 : " *Note: Complete this section if the applicant is currently in contract negotiations with the State to amend or update an existing contract for the application year.* "
27	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	14	110-111	Under the 2011 D-SNP State Medicaid Agency Contract upload document, item #7, the Note states "The description must contain language indicating that the MA SNP has written procedures for ensuring Medicaid network adequacy including access standards." The applicability of Medicaid network adequacy standards is confusing if the State Medicaid Agency Contract only provides for the coordination of Medicaid services and not the actual provision of services. If SNPs are not actually providing Medicaid services, imposing a network adequacy requirement other than what is already required by CMS is unnecessary and impractical. For example, a SNP would not contract with a home health agency for Medicaid-only personal care services if the SNP is not providing such services under its CMS and/or State contract.	Please clarify in the Note for item #7 that this item is only applicable if the State Medicaid Agency contract requires the D-SNP to provide Medicaid services.	Revision	**Clarification:** CMS will add the following clarifying language : "In order to optimally serve dual beneficiaries, applicants that provide both Medicare and Medicaid services as well as those that coordinate the Medicare and Medicaid services should be aware of the Medicaid network adequacy included access standards. Therefore, The description must contain……."
28	United Ovations	60 Day	Part C, MA Application, Appendix I, SNPs	16	113-114	The I-SNP Upload documents is not clear with reference to the following items: (1) Consistency is needed as to whether Medicaid and/or Medicare numbers of LTC or ALF facilities. As an example, in one portion of the upload document, both the Medicare and Medicaid number is requested for LTC facilities. (2) Some ALFs do not have Medicare or Medicaid provider numbers. (3) It is unclear whether the upload document is asking for a list of ALFs that the MAO intends to contact with or already has a contract. On page 96, Section 9, Items #2 and #3 indicate that the ALFs need to be under contract, but the upload document is not clear on this requirement, which is confusing.	(1) Please clarify whether the Medicaid or Medicare number is needed for LTC facilities. (2) We recommend removing or making optional, the field for Provider # since some ALFs do not have Medicaid or Medicare provider numbers. (3) We recommend revising the upload document to state "Provide a list of contracted assisted-living facilities" similar to the wording used in the form and attestation for LTCs if that is the intent.	Deletion, Revision	**Clarification:** CMS has added clarifying language to this section.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
29	United Ovations	60 Day	Part C-HSD Tables	3.9	32	Applicants are required to provide a template of provider signatures when the HSD tables already contain this required information. We believe that providing the signature page form is duplicative of information that organizations are already required to provide. We wish to avoid duplication since signature pages have been collected using existing HSD tables or data is also found on existing HSD tables.	The form used in 2011 had several fields requesting information already on the HSD tables: Name of Physician/Provider and Type (MA Provider/Facility Tables), Contract Template Type (MA Contract and Signature Index - Provide/Facilities), Contract Signature Name (MA Signature Authority Grid), and a field for Contract Signature Date when this is on the signature page itself. We recommend that the Signature Page Form requirement be eliminated.	Deletion	**Reject**: The purpose of the CMS Signature Authority Grid is to document whether physicians of a contracted provider group are employees of the medical practice.
30	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	14	CMS includes a limited exception list. As a result, there is concern that reasons other than those listed will NOT be allowed by CMS.	We recommend that the option, "Other", be included in the event that there are exception reasons that do not fit into those listed or there are multiple reasons for exceptions. Examples of exceptions not listed: providers are resistant to managed care contracting or won't accept 100% of Medicare allowable, etc.	Revision	**Reject:** CMS intentionally identified the range of circumstances for which we would allow exceptions from the standardized criteria and intentionally omitted a provider/facility's refusal to contract as one of those circumstances. CMS does not and cannot adequately assess the offered terms and circumstances surrounding MA applicants' private contracting efforts. This would be necessary to enable CMS to determine that a refusal to contract was somehow unjustified and would qualify the applicant for an exception.
31	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	4-7	CMS has required additional information on the HSD tables which is not readily available for use in an automated fashion. For instance, the number of Medicare-certified beds for hospitals and SNFs and ICUs and MH/SA facilities is not readily available to MCOs. This is also true of Medicare certification numbers.	While we understand the need for certain data to evaluate adequacy using the Automated Criteria Check we request assistance in obtaining such data. We would continue to ask that CMS provide certain information downloadable in excel or other data files that will assist plans in their automated production of HSD tables and population of these fields with accurate CMS information. For example a listing of Medicare Certified Providers with their MCNs and Certified Bed Counts would be helpful, .e.g. Hospitals, SNF, HHA, CORFs, etc. Manual lookup on medicare.gov is cumbersome and not all required data is available there.	Request	**Reject:** It is CMS' position that the provider/facility information requested should form the basis for the MA Organization's contracting efforts and therefore would be data collected during plan contracting efforts/network development.
32	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	9	HSD2A is not included in the HSD tables provided in the draft sample, but referred to in instructions.	We request clarification as to whether CMS intends to require both tables as part of the 2012 applications. If so, MCOs need to understand whether there will be any changes to these tables.	Revision	**Clarification:** HSD2a is not a valid HSD table. CMS will delete all references to the HSD2a from the HSD instructions.
33	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	11-12	The HSD-4 Table for Part C refers to outpatient drugs; however the Part D application requires information related to the Rx network. Being required to provide this information in the Part C application is duplicative of information required in the Part D application.	We recommend that this column be removed from the HSD-4 since this information is already included in the Part D application.	Deletion	**Reject:** HSD 4 is not a part of the 2012 MA application PRA collection. Some Applicants have the option to submit a Part D application, therefore CMS rejects the request to remove the "outpatient drug" column from the *CMS Additional and Supplemental Benefits table*.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
34	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	All	Historically, the final version of the HSD tables has not been released until January.	While it is recognized and appreciated that CMS has provided the draft application earlier this year, it is requested that the final HSD Tables be made available by November or December 1 rather than with the release of the Final Application in early January. This would allow organizations with a high volume of submissions additional time to train network personnel and sufficient time to upgrade HSD tools, excel formulas, etc. on any changes made to the tables.	Request	**Other:** CMS will take the recommendation under consideration. Please note: All applications materials are subject OMB approval. CMS is not allowed to release final documents with out OMB clearance.
35	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	2	Cardiology is identified with Specialty Code of 009 and Cardiac Surgery with 008. Based upon CMS network adequacy reporting, these codes are transposed as they were in 2011 Instructions.	We recommend CMS review and revise 2012 HSD Instructions to display correct specialty coding as needed. Codes used on tables and by Automated Criteria Check must be in sync. Last year, CMS corrected to show 008 for Cardiology and 009 for Cardiac Surgery.	Revision	**Accept Recommendation.**
0	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	All	Document revisions are not dated in a naming convention such that plans would know that those downloaded from HPMS are the same or are updated versions of those that were posted on CMS website.	We recommend CMS use the same naming conventions and utilize dates for files in HPMS and on the website so plans can easily identify the files that are updated.	Revision	**Accept:** CMS will add dates to all files in HPMS and on the website.
37	United Ovations	60 Day	Part C-HSD Tables	HSD Instructions	5, 8	CMS instructions are not explicit enough in the address and provider name requirements regarding use of commas, "&" signs, suite #s, etc.	We recommend CMS provide more explicit instructions/guidelines so that HPMS uploads do not result in a fail due to an address deficiency or an improper naming convention (i.e. an "&" sign).	Revision	**Clarification:** CMS has and will continue to provide explicit instructions on how to upload items in HPMS. Such information will be included in training materials and user guides.
38	AHIP	60 Day	Part C Application	General	General	See Next Column	The 2011 Part C applications included significant changes from the prior year, and we understand that CMS received a number of questions from applicants requesting clarifications to supplement the application instructions. To facilitate timely completion of the application process by affected organizations and make the process more efficient for CMS, we recommend that the agency review the questions and clarifications from the 2011 application cycle and provide detailed guidance for the 2012 applications that addresses these issues, as appropriate. We also recommend that CMS issue such guidance prior to the end of CY 2011 to provide sufficient opportunity for applicants to take the steps necessary to comply.	Request	**Other.** CMS will take the recommendations under consideration. Please note: CMS has and will continue to use feedback it receives from the industry and Regional offices to improve the application submission and review process.

CMS 2011 APPLICATION COMMENT MATRIX

Comment Number	Source of Comment: CMS Organization/Region	2011 MA Application Version #__	Application Part	Application Section *(Number/ Header)*	Application Page Number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Reject, Clarify)*
39	AHIP	60 Day	Part C Application	1.9	12-13	The draft Part C application states that an applicant seeking to reduce a pending service area must submit a written request, "no later than the tenth day after the issuance of the Notice of Intent to Deny letter."	We understand that the results of the Automated Criteria Check and formal exception feedback through the HSD Exceptions Report may be provided to applicants beyond the tenth day of the Intent to Deny period, because the application process includes an opportunity for applicants to make modifications during this period to meet with CMS review criteria. We support this additional opportunity for applicants to demonstrate that they meet CMS network adequacy requirements in recognition of the complexity of the current documentation requirements and the substantial resources invested in the application process by both applicants and CMS. To optimize the value of this opportunity, we recommend that when results of the Automated Criteria Check and/or the HSD Exceptions process are not available from CMS prior to the end of the tenth day, CMS provide applicants 24 – 48 hours following notification of the results of the agency's review to notify CMS of withdrawal decisions.	Request	**Other.** CMS will take the recommendation under consideration. It is CMS intention to make the ACC and/or HSD Eexception results available when the NOID is sent out unless the applicant did not submit sufficient information to enable CMS to make a determination.
40	AHIP	60 Day	Part C Application	HSD Exceptions Guidance – Requesting Exceptions	14	Data to support exceptions requests. The draft 2012 Part	We understand that applicants frequently identify discrepancies between the data available through Medicare.gov and their experience with provider availability in their proposed service areas. However, we also understand that application reviewers have required use of Medicare.gov rather than alternate documentation that more accurately reflects provider supply. AHIP recommends that CMS revise the HSD exceptions guidance to clearly and explicitly state that alternative sources of data are permissible and to provide examples (while indicating that the examples are not all-inclusive). In addition, we understand that the Physicianfinder.gov website listed in the HSD Exceptions Guidance is no longer a functioning website and recommend that CMS eliminate this reference.	Revision	**Accept recommendation:** CMS will work to identify alternative resources of data that is permissible and add this information to the 2012 Exception guidance. CMS hopes to release the Exception Guidance for the 2012 Part C application by mid November 2010,