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vided on behalf of UnitedHealthcare for the:
antage and 1876 Cost Plan Expansion Application
9/4/2012

Description of Issue/Concern	Suggested Revision/Recommended Comment
Some recruitment efforts struggle with meeting both of CMS' time and distance requirements.	Will CMS reconsider health plans as meeting criteria if at least one (time OR distance) is met? Example geographical terrain in rural areas impedes meeting criteria requirements.
Because of contracting issues (providers not willing to accept MA rates), we typically do not recruit free standing radiology centers to provide Diagnostic Radiology or Mammography. Instead these services are directed to Acute Inpatient Hospitals or received at PCP or Specialist.	Will CMS reconsider Diagnostic Radiology/Mammography as a required Facility specialty type?
Medicare.gov is our main source of truth in terms of comparison of our networks.	Will there ever be an opportunity to review providers based on specialty type in excess of a 25 mile range? Will CMS update their web site to offer searching criteria beyond 25 mile range?
Medicare.gov lists services available at an Acute Inpatient Hospital, yet the hospital operating certificate is not approved by DOH to provide those services, or the hospital confirms they do not provide those services.	How do we address a service or provider that is posted to Medicare.gov as being Medicare participating and those providers are used to judge our network adequacy/accessibility, but we find out through provider verification that they do not perform the services or are not participating? (ie outpatient cardiac catherization v. cardiac surgery)
CMS requires information that is not readily or easily available for use in an automated fashion. For instance, the number of Medicare certified beds for hospitals, SNFs, ICUs and IP Psych facilities is not readily available to MCOs. This is also true of Medicare certification numbers.	We believe that CMS's requirements for this data is administratively burdensome. Therefore, we request 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, CMS should provide a resource from which MCOs can obtain Medicare Certification #s, bed counts, etc so that this information is consistent across all health plans.

Release of HSD Tables Prior to Final Release of Application in Early January.	Release of HSD Tables Prior to Final Release of Application in Early January: While it is recognized and appreciated that CMS provides draft applications earlier iin the year, we request that the final HSD Tables be made available by November or December 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.
Not all document revisions are dated in the naming convention to know that those downloaded from HPMS are the same as those posted on CMS website.	All documents posted to this site should be dated in the naming convention: http://www.cms.gov/MedicareAdvantageApps/
For Large Metro and Metro counties that in addition to one or more urban centers also contain large rural areas where physicians are not available (forests, reservations, military bases, etc) and the number of Medicare beneficiaires is low or non-existent in these areas.	We recommend CMS consider adjusting the criteria either by using a lower level county classification or by lengthening the distance standards for certain specialists in those geographically challenged counties to better compensate for these geographical differences within a county? How do we approach this with CMS?
Medicare.gov does not provide downloadable files of providers performing these services: Cardiac Surgery, Cardiac Catheterization, Outpatient Infusion Chemo, Mammography, and Outpatient Dialysis.	How does CMS determine availability of services? What are CMS' definitions of these services?
CMS Exception form required for 2014 - DISTANCE FROM BENEFICIARIES IN THE COUNTY field.	We recommend that CMS provide clarity & direction on how they want health plans to use the Sample Beneficiary file, HSD Beneficiary Coverage by Zip Code Report, and the Part D Eligibility File, and more detailed instructions on how CMS is calculating distances.

Certification number: The lists of certified providers that we receive from CMS' (downloadable files from their website) does not always show all locations of a contracted provider. Ex: Walgreens - CMS's lists show some Walgreens' locations, but not all of the locations that we have contracted.	We need clarification from CMS if not all locations are certified or if we are to assume our national and multi-location contracts are covered under the main provider's certification number.
It is redundant/duplicative to require health plans to repeat listing the contracted providers/facilities "that will ensure access" on the Exception form when they are already listed on the HSD table.	It is suggested that the exception form only require the health plan to identify the "closest contracted provider".
With the suggested change in requiring complete copies of executed Medicare contracts and any applicable downstream agreements, the standard previous turnaround time may be too short.	We would like CMS to consider lengthening the time frame in which health plans have to provide complete executed Medicare agreements (including any applicable downstream agreements). The suggested timeframe would be 15 days.
CY 2014 HSD Application Instructions reference column Q (Model Contract Amendment - Indicate if contract uses CMS Model MA Contract Amendment by entering Yes or No) in the MA Provider Table section.	Will CMS be adding a column Q to the Provider Table? Column Q appears in CY 2014 Instructions but not in Provider Table sample or the CMS summary of changes. Our HSD table needs to be built to include this or be subject to HPMS upload fail. We would also need a copy of the Model Contract Amendment to know what CMS is referencing. Where is it available?
The CMS downloadable certified Transplant facilities list is in PDF format requiring considerable manual manipulation to convert to Excel or Access so that it can be used in an automated reporting	Request that CMS produce certified transplant list in a .txt or Excel/Access, similar to the other website posted downloadable files of CMS certified providers (Hospital, Home Health, DME, etc)

Certain Orthotic & Prosthetic providers can serve a county without necessarily being located in the county, e.g. a mail order vendor supplying directly to the home. In addition, we've noticed that CMS is including retail vendors such as Walmart, CVS, etc. in the O&P category when MA plans may focus on more typical orthotic suppliers who can customize the orthotics/prosthetics, etc. or provide them through hospitals or physician offices.	Could CMS reconsider Orthotics & Prosthetics differently, for example, similar to home health?
3.7(A)(2) is duplicative of 3.3(A)(1); that is we attest to state licensing twice.	United suggests that Section 3.7(A)(2) be deleted as it appears it is duplicative of 3.3(A)(1).
As part of the application review process, Applicants will need to provide fully executed contracts for physicians/providers that CMS reviewers select based upon the CMS Provider and Facility tables that are part of the initial application submission. CMS reviewers will list the providers/facilities and specific instructions in CMS' first deficiency notice. 4.3 CMS Provider Contract Matrix Instructions for CMS Provider Contract Matrix This matrix must be completed by MA Applicants and should be used to indicate the location of the Medicare requirements in each contract / agreement for the Applicant's first tier, downstream and related entity providers that CMS has identified in the contract sample.	The new requirement requires more uploading since entire contracts are requested rather than just signature pages. It also requires provider matrices produced for each selected sample during the shorter deficiency period rather than with the initial application filing. Can CMS provide the sample size per application they expect to request, expected length of the window for uploading requested contracts and matrices, and the zip file size maximum that HPMS will accept?
Applicant agrees to provide general coverage information, as well as information concerning utilization, grievances, appeals, exceptions, quality assurance, and financial information to any beneficiary upon request.	We request clarification of specifically which materials are to be made available "upon request" as this language is not reflected in 42 CFR 422.2260 through 42 CFR 422.2276, referenced in the first paragraph of Section 3.13 of the Part C - Medicare Advantage and 1876 Cost Plan Expansion Application.

We think that the addition of the word “complete” in this attestation will more closely align with the CMS requirements and with United’s claims processing policies. For example, United does not “develop” all claims that are incomplete, such as certain claims that are missing information or have invalid coding. These claims typically involve only provider liability, so they would not affect the member. This slight change in the attestation wording would allow United to answer this attestation with a “yes” without having to qualify our response.	We believe that the addition of the word “complete” in this attestation will more closely align with CMS requirements to process complete claims promptly. We recommend that the attestation be revised by inserting the word “complete,” as follows: "Applicant will comply with all applicable standards, requirements and establish meaningful procedures for the development and processing of all complete claims including having an effective system for receiving, controlling, and processing claims actions promptly and correctly."
Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M.	CMS rules do not require that plans provide notice of claim acceptance when there is no cost share involved (except for PFFS claims). There is also no requirement to notify beneficiaries of claim denials when the claim only involves provider reimbursement (such notices would be confusing to beneficiaries). Rather, the requirement is that when a claim is denied resulting in member liability, plans must provide the member with his or her appeals rights. We suggest an addition to the attestation that explains that the notice is required in all cases where there is cost-sharing or member liability. We request that the attestation be revised as follows: Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M, *in all cases where there is a member cost-sharing or member liability*.
All beneficiaries have equal access to the various tiers proposed. Note: this is new for 2014	We request clarification of "various tiers" as this term is not reflected in 42 CFR 422.112.

Designate if the contract uses the CMS Model Medicare Advantage contract amendment with a "(M)" next to the provider/facility name.	We believe the "CMS Model Medicare Advantage contract amendment" document has not been released and we would like to know when it will be released.
We encourage CMS to provide flexibility with the deadlines for completing State Medicaid Agency contracts. There may be cases where state legislative activity or the start of Financial Alignment Demonstration plans may make it difficult to complete the contract by July 1st.	We recommend removal of the reference to a July 1 deadline for submitting State Medicaid Agency contracts.
Can clarification be provided on when the "Dual Eligible Subset - Zero Dollar Cost Share" designation or the "Dual Eligible Subset" designation should be used?	We request an example of when these designations should be used.
	Please clarify what material needs to be submitted for an existing D-SNP that is changing its subtype. Is the entire SNP proposal needed when changing D-SNP subtypes?
Under the "Provider Network and Use of Clinical Practice Guidelines" category, item #59 states, "Applicant conducts periodic surveillance of employed and contracted providers to assure that nationally recognized clinical protocols and guidelines are used when available and maintains monitoring data for review during CMS monitoring visits), the term "contracted providers". This statement implies that the Applicant will need to conduct surveillance of <u>all</u> providers, Therefore, this raises concerns about this applicability to the broader provider network that can be several thousand providers.	We recommend that this section be modified so that a sampling can be used in monitoring surveillance.

Under the 2011 D-SNP State Medicaid Agency Contract Upload Document, item #3, bullet #3 states, "Third party liability and coordination of benefits". We believe that clarify is needed with regard to the meaning of "third party liability."	We recommend that reference to "third party liability" be removed because CMS has not provided clear direction as to what is meant be this. As an alternative, CMS needs to clarify or provide background on "third party liability" in this context.
a. There is a significant amount of confusion for both D-SNPs and State Medicaid Agencies as to whether the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Please clarify that the provision of Medicaid benefits is not always required and that increased levels of agreed-upon coordination of Medicaid benefits is also acceptable. b. Specifically, the NOTE comment only makes reference to Medicaid services "that the organization is obligated to provide under its State contract," which is confusing without a reference to coordination of services as another alternative.	We are assuming that this section would only be included if the State Medicaid Agency contract requires the D-SNP to provide Medicaid services. Broadly, if State Medicaid Agencies and MAOs determine that increased coordination will best serve dually-eligible members, the requirements should be clarified to allow this. Specifically, in item #5 and elsewhere that references providing Medicaid benefits, clarify in these areas that agreed-upon coordination is acceptable.
The third element of the Dual SNP contract matrix provides that: Medicaid benefits covered under the SNP These are the Medicaid medical services that the organization is obligated to provide under its State contract, not the non-Medicare mandatory Part C services covered under the MA contract. There is confusion about what should be documented for this element. Further the above description makes it sound like the D-SNP is required to provide Medicaid benefits, when in fact most D-SNPs do not provide/cover Medicaid benefits, but rather help members to coordinate the services available through Medicare and Medicaid.	Flexibility should be provided to allow the Medicaid benefits to be documented in a variety of ways that will accommodate each state's unique negotiated approach. For example, due to the overlap of benefits covered by both Medicare (primary) and Medicaid (secondary), if a state wants a combined list of Medicaid and Medicare benefits outlining each program's responsibility for a category of service, that should be sufficient to meet this element and will help MAO's create a better Section IV of the Summary of Benefits.

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.	We believes that the correct citations are 42 CFR 422.2262 and 42 CFR 423.2262, respectively.