Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
TECHNICAL CHANGES					
1. Edits to entire document including the addition of missing words, clarifying language, capitalization, deletion of missing spaces, and final dates.	To maintain a consistent format and provide accurate timeframes and instructions.	Entire Document	All Sections	N/A	N
SUBSTANTIVE CHANGES					
2. Added attestation #3 to section 3.1 of application: "The Applicant attests that it has at least 5,000 individuals (or 1,500 individuals if the organization is a PSO) enrolled for the purpose of receiving health benefits from the organization; or it has at least 1,500 individuals (or 500 individuals if the organization is a PSO) enrolled for purposes of receiving health benefits from the organization and the organization primarily serves individuals residing outside of	We are proposing to apply the minimum enrollment requirement to new applications in an effort to strengthen our ability to distinguish stronger applicants for Part C Program Participation. Pursuant to 42 CFR 422.514 and 423.512, an organization must meet minimum enrollment requirements in order to hold a Medicare Advantage contract with CMS. As stated in our June 26, 1998 Interim Final Rule with	Section 3 - Attestations	3.1 Experience & Organization History	60-day	I

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urbanized areas as defined in §412.62(f) (or, in the case of a PSO, the PSO meets the requirements in §422.352(c)).”	Comment, the minimum enrollment requirement is an indicator that the organization applying for a Medicare Advantage contract is able to handle risk and capitated payments. In that rule, we also stated our expectation that an organization is able to effectively manage a health care delivery system including the enrollment and disenrollment of members and the timely payment of claims, provide quality assurances, and have systems to handle grievances and appeals. Recognizing that some new organizations with no prior enrollment may apply for a contract, the regulation also provides for a transition period allowing CMS to waive the minimum enrollment requirement during an organization’s				

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All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
	first three years of operation. CMS permits organizations that initially fail to meet the minimum enrollment requirements to continue operating their Medicare Advantage contracts beyond the transition period as long as they are in compliance with other stipulated contractual requirements. CMS has seen an increase in plans that have operational difficulties, which often results in disruption of benefits or services provided to beneficiaries. We are proposing that, starting with the contract year 2015 application cycle, applicants applying for either an initial contract or a service area expansion of an existing contract submit minimum enrollment				

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All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
	information as specified in §§ 422.514 of this part. An applicant that does not meet the minimum enrollment requirement may request a waiver of this requirement. CMS may consider this information in the determining whether to approve the application request. In so doing, we believe that this will help to reduce the chances of plan failure and limit beneficiary disruption of benefits and services related to plan failure.				
3. Removed reference to Partial County Network Assessment Table.	Extending the HPMS automated network review to partial counties eliminates the need for the Partial County Network Assessment Table, which assisted the reviewer with manual review.	Section 3 - Attestations	3.8 Service Area	30 day	D

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All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
4. Referenced the CMS Medicare Advantage Contract Amendment released in HPMS on 10/5/12.	CMS encourages applicants (and current contractors) to use the CMS-developed MA contract amendment by referencing the document here in the Provider Contracting section of the application.	Section 3 – Attestations	3.9 CMS Provider Participation Contracts & Agreements	30 day	N
5. Referenced the CMS Medicare Advantage Contract Amendment released in HPMS on 10/5/12.	CMS encourages applicants (and current contractors) to use the CMS-developed MA contract amendment by referencing the document here in the Administrative Contracting section of the application.	Section 3 – Attestations	3.10 Contracts for Administrative & Management Services	30 day	N
6. Added new attestation related to admitting privileges of contracted providers at contracted facilities.	We are no longer asking the applicant to name the contracted facility at which each contracted specialist has admitting privileges on the Provider Table. Instead, we are asking the applicant to attest to the fact that contracting specialists have admitting privileges at contracted facilities.	Section 3 – Attestations	3.11 Health Services Management & Delivery	30 day	I

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All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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7. Added new Transplant Attestation.	Adding new attestation pertaining to delivery of transplant services according to CMS guidelines in place of network review of transplant facility information on Facility Table.	Section 3 – Attestations	3.11 Health Services Management & Delivery	30 day	I
8. Added the instruction for the applicant to enter the National Association of Insurance Commissioners (NAIC) number if there is one to the CMS State Certification Request form.	CMS needs to collect the organizations NAIC number to help expedite its financial review of the application.	Section 4 – Document upload templates	4.2 CMS State Certification Form	60-day	I
9. Added language clarifying that partial county network assessments are automated and the applicant must follow the Exception Request process that is available to full-county applicants.	Clarification of new process.	Section 4 – Document Upload Templates	4.13 Partial County Justification	30 day	N
10. Removed Section IV of Partial County Justification referring to Provider Network Assessment for partial counties.	This section no longer applies due to the HPMS automated review of partial county networks.	Section 4 – Document Upload Templates	4.13 Partial County Justification	30 day	D

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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11. Removed Section 4.14 Partial County Network Assessment Table.	This section no longer applies due to the HPMS automated review of partial county networks.	Section 4 – Document Upload Templates	4.13 Partial County Justification	30 day	D
HSD INSTRUCTIONS, TABLES AND EXCEPTION PROCESS					
1. Edits to HSD Instructions document included adding clarifying language to the MA Provider table, MA Facility table and Appendix C sections.	Instructions were unclear in the HSD instructions document.	N/A	N/A	60-day	N
2. For the MA Facility Table changed Column D from Medicare Certification Number (MCN) to CMS Certification Number.	The CCN verifies the facility is Medicare certified and for what type of service. The CCN for facilities have 6 digits. The first 2 digits identify the State in which the provider is located. The last 4 digits identify the type of facility.	N/A	N/A	60-day	N
3. MA Provider Table - Removed column (L) "Contracted Hospital Where Privileged" and (M) Hospital National Provider Identifier	Removing these columns because we are replacing with attestation regarding privileges at contracting	N/A	N/A	30-day	D

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
Number.	facilities.				
4. HSD Instructions, MA Provider Table Instructions (pg 4)- Emphasized existing guidance and added clarifying language about not listing providers that don't provide reasonable access to beneficiaries.	On the HSD provider table, some applicants continue to list thousands of extra, unnecessary providers that do not affect their network scores and inappropriately extend the HPMS report processing time.	N/A	N/A	30-day	N
5. HSD Instructions, MA Provider Table Instructions (pg 4)- Clarified some of the requirements for the providers listed on the table.	This will eliminate the practice of applicants listing inappropriate providers on the Table.	N/A	N/A	30-day	N
6. HSD Instructions, MA Provider Table Instructions (pg4) – Emphasized existing and added new language regarding applicant responsibility for ensuring listed providers meet licensing and credentialing requirements for listed specialties.	Purpose is to ensure that applicants do not list inappropriate and unqualified providers on their Provider Tables.	N/A	N/A	30-day	N
7. HSD Instructions, MA Provider Table Instructions (pg 6) – Deleted columns L and	Replacing with attestation.	N/A	N/A	30-day	D

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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M pertaining to Contracted Hospital Where Privileged.					
8. HSD Instructions, MA Facility Table Instructions (pg 7) – Emphasized existing guidance and added clarifying language about not listing facilities that don't provide reasonable access to beneficiaries.	On the HSD facility table, some applicants continue to list thousands of extra, unnecessary providers that do not affect their network scores and inappropriately extend the HPMS report processing time.	N/A	N/A	30-day	D
9. HSD Instructions, Requesting Exceptions (pg9) – Added note that partial county applicants should use the Exception process beginning with CY2015 applications.	Updating instructions to reflect automated network review for partial counties.	N/A	N/A	30-day	N
10. HSD Instructions, Appendix A – CY2015 HSD Submission Frequently Asked Questions – Amended response to #11 (pg 13) to clarify that applicants should only enter "000" for providers that are alternate providers submitted as part of an exception request.	Clarification of instructions.	N/A	N/A	30-day	N

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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11. Appendix C – Field Edits for the MA Provider and Facility Tables – (pg21) Removed edits for Contracted Hospital Where Privileged.	Matches other changes to application.	N/A	N/A	30-day	D
12. Appendix C – Field Edits for the MA Provider and Facility Tables – (pg22) removed the CCN reference to 049 Physical Therapy.	Physical Therapy facilities do not have CCNs.	N/A	N/A	30-day	D
13. Exception Request Template Q1 – added language to clarify instructions regarding listing individual physicians rather than provider groups.	Clarification of instructions.	N/A	N/A	30-day	N
14. Exception Request Template Q2 – added language to clarify how to use medicare.gov to search for available providers.	Clarification of expectations.	N/A	N/A	30-day	N
15. Exception Request Template Q5 – added language to clarify how to report time/distance between available contracted providers and deficient zip codes/cities.	Clarification of instructions.	N/A	N/A	30-day	I

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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16. Exception Request Template pg 2 – changed instructions to clarify how to report on time/distance between the available contracted providers and deficient zip codes/cities.	Clarification of instructions.	N/A	N/A	30 –day	I
APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposal					
1. Removed the D-SNP State Medicaid Agency Contract Negotiation Status Document as an upload requirement.	The D-SNP State Medicaid Agency Contract Negotiation Status Document is no longer required for the application process. For CY 2013 this document was not reviewed.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Former #14	60-day	D
2. Removed attestation #6, "Provide the State Medicaid contract begin date, under the D-SNP State Medicaid Agency Contracts Attestation section."	To be consistent with the electronic application which does not require this information.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	6. – D-SNP State Medicaid Agency Contract area attestation	60-day	D

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

Revision/Clarification	Purpose of the Revision/Clarification	2014 Part C Application	Application Section	Category of Comment	Level of Applicant Burden I = Increases burden D – Decreases burden N – No Change
3. Removed attestation #7, "Provide the State Medicaid contract end date, under the D-SNP State Medicaid Agency Contracts Attestation section."	To be consistent with the electronic application which does not require this information.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	6. – D-SNP State Medicaid Agency Contract area attestation	60-day	D
4. Removed attestation #8, "Does the applicant want the State Medicaid Agency Contract to be reviewed to determine if it qualifies as a FIDE SNP for the contract period(s) identified in numbers 6 and 7."	This is a redundant attestation for this section of the SNP proposal. It was similar to Attestation #2 which says, "Applicant wishes the contract with the State Medicaid Agency(ies) to be reviewed to determine if it qualifies as a fully integrated dual eligible SNP (FIDE)."	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	6. – D-SNP State Medicaid Agency Contract area attestation	60-day	D
5. Deleted approximately 240 Model of Care attestation questions from application. One attestation and 2 uploads remain under Model of Care. The attestation remaining is "Applicant has submitted a written description of its Model of Care as defined	This information duplicates information collected in another document, the Model of Care (OMB control number 0938-0936).	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	11. Model of Care Attestations	60 day	D

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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in the Model of Care Matrix upload document."					
6. Revisions to the CY2015 Model of Care Matrix Upload Document.	CMS revised CY2015 Model of Care Matrix Upload Document to clarify and accept comments received from 60 day comments period.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	18. Model of Care Matrix Upload Document	30 day	N
7. Replaced 2014 D-SNP State Medicaid Agency Contract Matrix with 2015 D-SNP State Medicaid Agency Contract Matrix.	Updated D-SNP State Medicaid Agency Contract matrix in application to reflect the CY2015 D-SNP State Medicaid Agency Contract matrix changes.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	14. D-SNP State Medicaid Agency Contract Matrix	30 day	N
8. Replaced 2014 Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Contract Review Matrix with 2015 Fully Integrated Dual Eligible (FIDE) Special	Updated the Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Contract Review matrix in application to reflect the CY2015	APPENDIX I: Solicitations for Special Needs Plan	15. Fully Integrated Dual Eligible (FIDE) Special Needs Plan	30 day	N

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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Needs Plan (SNP) Contract Review Matrix.	Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Contract Review matrix changes.	(SNP) Proposals	(SNP) Contract Review Matrix		
9. Replaced 2014 I-SNP Upload Documents with 2015 I-SNP Upload Documents.	Updated the I-SNP Upload Documents in application to reflect the CY2015 I-SNP Upload Documents changes.		16. I-SNP Upload Documents	30 day	N
10. Deleted I-SNP attestation upload document.	Inserted the attestation that was in the I-SNP attestation upload document within the I-SNP upload documents.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	Former #18	30 day	N
11. Replaced 2014 ESRD Waiver Request Upload Document version with 2015 ESRD Waiver Request Upload Document.	Updated the ESRD Waiver Request Upload Document in application to reflect the CY2015 ESRD Waiver Request Upload Document changes.	APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals	17. ESRD Waiver Request Upload Document	30 day	N

Summary of Substantive and Technical Changes for
All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
30 day PRA Package

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APPENDIX IV: Medicare Cost Plan Service Area Expansion Application					
1. Removed reference to Partial County Network Assessment Table.	This section no longer applies due to the HPMS automated review of partial county networks.	APPENDIX IV: Medicare Cost Plan Service Area Expansion Application	8.2 Service Area	30 day	D
2. Added new attestation related to admitting privileges of contracted providers at contracted facilities.	We are no longer asking the applicant to name the contracted facility at which each contracted specialist has admitting privileges on the Provider Table. Instead, we are asking the applicant to attest to the fact that contracting specialists have admitting privileges at contracted facilities.	APPENDIX IV: Medicare Cost Plan Service Area Expansion Application	8.5 Health Services Management & Delivery	30 day	D
3. Added new Transplant Attestation.	Adding new attestation pertaining to delivery of transplant services according to CMS guidelines in place of network review of transplant	APPENDIX IV: Medicare Cost Plan Service Area	8.5 Health Services Management & Delivery	30 day	I

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All Part C Application Revisions from 2014 Version of Part C Application to 2015 Version
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	facility information on Facility Table.	Expansion Application			