2016 Part C MA & Cost Plan Application - 60 Day								
Comment Number	Source of Comment: (Company Name)	Part C MA Application Comments 60 day	Application Section	Page number	Description of the Issue or Question	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion Deletion, or Revision)*	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
1	United Health Plan	✓	3.5	27	In section 2.3 letter B, please confirm reference to Chapter 11 of the MMCM is a typo and should reference Chapter 21 of the MMCM *App Excerpt:* Note: The Part C compliance plan must be developed in accordance with 42 CFR 422.503(b)(4)(vi). The compliance plan must demonstrate that all seven elements in the regulation and in Chapter 11 of the Medicare Managed Care Manual (MMCM) are implemented and specific to the issues and challenges presented by the Part C program.	In section 2.3 letter B, please confirm reference to Chapter 11 of the MMCM is a typo and should reference Chapter 21 of the MMCM	Revision	Accept : Section 50.1-50.7.7 of chapter 21 of the MMCM discusses the elements of an effective compliance plan. CMS will correct the application to reference Chapter 21 instead of Chapter 11.

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2	United Health Plan	✓	3.16 attestation 3	41	Applicant agrees to give beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notices 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.	Revision	Reject: The change the commenter requested was not a part of the the 2016 application package and this language has already been approved by OMB.

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3	United Health Plan	✓	State certification form	62	We recommend CMS amend the state certification form to delete question 3.	We recommend CMS amend the state certification form to delete question 3. Specifically, the nomenclature creates confusion for states that use different terminology for benefit plans. For example, a state may use the terms "closed panel" to describe products, rather than the term "HMO." From a state's perspective, an HMO is typically a type of entity license. The certification form is effective without the question in that the state's obligation is to certify that the applying entity is licensed and solvent. Alternatively, regulatory changes could be made to describe the products more broadly to improve the alignment with the terminology used by the states. We would welcome the opportunity to work with CMS on this issue and provide additional examples.	Revision	Reject: States have been able to answer this question without difficulty. The question refers to the type of application filed with CMS and not what definition the state uses. Moreover, states are able to contact CMS if they are unaware of the type of application filed.
4	Untied Health Plan	✓	N/A	N/A	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 automated reporting.	We respectfully request that CMS produce the 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.)	Insertion	Reject: CMS provides this in PDF format.

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5	United Health Plan	✓	Exceptions Request Template	N/A	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: LIST THE CONTRACTED PROVIDERS/FACILITIES THAT WILL ENSURE ACCESS (THEY MUST BE LISTED IN THE HSD TABLE UNDER THE COUNTY IN WHICH THEY ARE PROVIDING SERVICES). ALSO, LIST THE CLOSEST CONTRACTED PROVIDER/FACILITY OF THE SPECIALTY CODE TYPE.	It is suggested that the Exception form read: LIST THE CLOSEST CONTRACTED PROVIDER/FACILITY OF THE SPECIALTY CODE TYPE.	Revision	Reject: The exception template list of contracted providers/facilities requests specific information to identify, the name, address, time and distance of next closest provider/facility for each deficient zip code. This information helps support an applicant's reasonable access explanation. The HSD table does not provide this information. Exception requests require applicants to explain how they will ensure acceptable access to the particular provider or facility for the MA' plan's enrollees. Applicants completing this section may realize that there may be additional non-contracted providers located closer to the deficient zip codes than their closest contracted providers. This information may help them meet the distance requirements.

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6	Untied Health Plan	✓	N/A	N/A	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.	We believe that CMS's requirements for this data is administratively burdensome. 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. Example, CMS should provide a resource from which MCOs can obtain bed counts, by hospital location, so that this information is consistent and available to all health plans.	Insertion	Reject: CMS does not believe this requirement is burdensome and applicants are aware of the process for providing this information for its contracted providers.
7	United Health Plan	✓	N/A	N/A	Medicare.gov lists services available at an Acute Inpatient Hospital, yet the hospital operating certificate may not be approved by DOH to provide those services, or the hospital confirms they do not provide those services.	Please clarify how to address a service or provider that is posted to Medicare.gov as being Medicare participating and those providers are used to judge network adequacy/accessibility, but plans find out through provider verification that they do not perform the services or are not participating (i.e. cardiac catherization v. cardiac surgery)?	Insertion	Reject: This comment does not represent a change to the Application or HSD Facility Tables. While CMS understands that Medicare.gov is not 100 percent accurate because of changes in provider status, if the applicant finds through direct contract that the service is not provided at the facility (or visa-versa), the applicant should rely upon the facility's data rather than the website. The applicant should adequately document the facility's information in case CMS were to request it.

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8	United Health Plan	✓	General Information Section 1.8	12	Last year, health plans received final CMS instructions and forms on January 13, 2014 for a February 18, 2014 deliverable. CMS time/distance Criteria Guidance was received in late December for a February deliverable. As a high volume HSD table submitter, this timeline is very problematic as UHC already has its tables largely built by the time the updated information is made available. This then requires that we go back and re-do work; and may also require programming changes that are difficult to accomplish within that timeframe.	We ask that CMS provide criteria and final instruction/forms earlier in the process. Receiving the final instructions and forms in Nov. would be optimal.	Insertion	Reject: CMS believes the current timeline is reasonable for applicants to submit required materials by the due dates.
9	United Health Plan	✓	HSD Instructions Appendix A	10	HSD Pre-Checks are allowed on Thursdays 8PM ET only.	Since ACCs are automated, we would like to see CMS create an open window for on demand Pre-Checks in lieu of date/time specific limitations. This would allow table editing work to remain more fluid and timely.	Revision	Reject: CMS will consider the comment for Contract Year 2017.
10	United Health Plan	✓	HSD Instructions Appendix A	17-18	Error Reports contain a limited number of error data lines, requiring a fix of those errors and resubmitting only to learn there are additional data errors under the same H#.	We ask that CMS update their error reporting to include all errors under an H# in a single report.	Revision	Reject: This comment is not a part of the 2016 application package for comment.

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11	United Health Plan	✓	Provider and Facility Tables	N/A	Provider & Facility tables each have a required data element of "Are you using the CMS amendment, Y or N?" This is answered the same for every provider listed in HSD.	This is already addressed as an attestation. We feel this is redundant and should be removed from the HSD tables.	Deletion	Accepts: CMS maintains the right to collect contracts for review. Therefore, CMS does not believe that deleting this requirement will significantly hamper our review.
12	United Health Plan	✓	N/A	N/A	The required data element "Employment Status" seems unnecessary, since all downstream providers are subject to the terms of our agreements whether they are employees or subcontractors.	We recommend that this be deleted as a data element.	Deletion	Reject: CMS agrees with the commenter that contracted and employed providers are subject to the same requirements and terms. However, CMS requests employment status to assist reviewers in selecting only contracted (not employed) providers. While CMS is no longer requesting provider contracts as part of the standard review, CMS maintains the right to include a contract review and would need to know if the provider was employed or contracted in order to select the appropriate sample.

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13	United Health Plan	✓	Section 3.11 Attestation 7		Attestation Statement #7: Applicant agrees that each of its contracted physicians/providers listed in the Provider Table has admitting privileges (other than courtesy privileges) at a contracted facility. All of the physicians/providers listed in the Provider Table have admitting privileges *if required* to have admitting privileges. However, some of the physician/providers listed in the provider table, e.g., Chiropractor, Podiatry - do not normally require admitting privileges or may have arrangements with another participating physician to admit on their behalf. The attestation of admitting privileges for these providers is not relevant.	We ask that CMS revise the attestation regarding admitting privileges since plans cannot attest to a provider that is not required to have admitting privileges (e.g., chiropractor, podiatry). For example, the attestation could read: Applicant agrees that each of its contracted physicians/providers that is required to have admitting privileges and is listed in the Provider Table has admitting privileges (other than courtesy privileges) at a contracted facility.	Revision	Reject: CMS has changed this attestation to state "applicable" physicians/providers for contract year 2016

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