Supporting Statement Part A
Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits as defined in Part 417 & 422 of 42 C.F. R.
CMS-10237, OMB 0938-0935

Background

The Balanced Budget Act of 1997 (BBA) Pub. L. 105-33, established a new "Part C" in the Medicare statute (sections 1851 through 1859 of the Social Security Act (the Act)) called Medicare+Choice (M+C). Under section 1851(a)(1) of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for most individuals with end-stage renal disease (ESRD), could elect to receive benefits either through the Original Medicare Program or an M+C plan, if one was offered where he or she lived.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Pub. L. 108-173 established the Medicare Prescription Drug Benefit Program (Part D) and made revisions to the provisions of Medicare Part C, governing what is now called the Medicare Advantage (MA) program (formerly Medicare+Choice). The MMA directed that important aspects of the new Medicare Prescription Drug Benefit Program under Part D be similar to and coordinated with regulations for the MA program. The MMA changes made managed care more accessible, efficient, and attractive to beneficiaries seeking options to meet their needs. The MA program offers several kinds of plans and health care choices which include the following:

- Coordinated Care Plans (CCPs) - Coordinated Care Plans are MA plans that offer health care through an established provider network that is approved by the Centers for Medicare and Medicaid Services. There are several types of plans that are considered CCPs that include the following:
    - Health Maintenance Organizations (HMO)
    - Provider Sponsored Associations (PSO)
    - Preferred Provider Organizations (this includes both local PPOs and regional PPOs)
    - Special Needs Plans (SNPs)

- Medical Savings Account (MSAs) – a Medical Savings Account plan is a type of MA plan that combines a high-deductible health plan with a medical savings account.

- Private Fee- For-Service (PFFS) Plans- a Medicare PFFS Plan is a type of MA plan that may or may not have a network of providers. Members of a PFFS plan may see any provider who is eligible to receive payment from Medicare and agrees to accept the PFFS's terms and conditions of payment.

- Section 1876 Cost Plan - Cost contract plans are paid based on the reasonable costs incurred by delivering Medicare-covered services to plan members. Enrollees in these plans may use the cost plan's network of providers or receive their health care services through Original Medicare. CMS no longer accepts new Cost Plan

applications. However, an existing/approved Cost Plan can submit a service area expansion application (SAE) to expand its service area.

- Employer Group Waiver Plans (EGWPs) – The MMA provides employers and unions with a number of options for providing coverage to their Medicare –eligible members. The EGWPs can offer various health plan types such PFFS, CCPs, MSAs and RPPOs.

Applications for each of the plan types described above are included in this information collection.

The final rules for the MA and Part D prescription drug programs appeared in the Federal Register on January 28, 2005 (70 FR 4588 through 4741 and 70 FR 4194 through 4585, respectively). Many of the provisions relating to applications, marketing, contracts and the new bidding process for the MA program became effective on March 22, 2005, 60 days after publication of the rule, so that the requirements for both programs could be implemented by January 1, 2006. As we have gained more experience with the MA and the Part D programs, we are making revisions to both programs to clarify existing polices or codify current guidance.

This information collection includes the process for organizations wishing to provide healthcare services under MA and/or MA-PD plans must complete an application annually, file a bid, and receive final approval from CMS. The application process has two options for applicants that include (1) request for new MA product or (2) request for expanding the service area of an existing product. This collection process is the only mechanism for MA and/or MA-PD organizations to complete the required application process. CMS utilizes the application process as the means to review, assess and determine if applicants are compliant with the current requirements for participation in the Medicare Advantage program and to make a decision related to contract award.

A Justification

1. Need and Legal Basis

Collection of this information is mandated by the Code of Federal Regulations, MMA and CMS regulations at 42 CFR 422, subpart K, in "*Application Procedures and Contracts for Medicare Advantage Organizations*." In addition, the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) further amended titles XVII and XIX of the Social Security Act.

As noted above organizations wishing to provide healthcare services under MA and/or MA-PD plans must complete an application, file a bid, and receive final approval from CMS.
This clearance request is for the vital information collection process to ensure Part C applicants are in compliance with CMS requirements and the collection of data necessary to support the decision related to contract awards.

2. Information Users

The information will be collected and reviewed by CMS staff under the solicitation of Part C applications for the various health plan product types described in the Background section above. The application process is open to all health plans that want to participate in the Medicare Advantage program. CMS will utilize the information collected from the applicants to ensure that applicants meet CMS requirements and support the determination of contract awards.

3. Information Technology

In the application process, technology is used in the collection, processing and storage of the data. Specifically, applicants must submit the entire application and supporting documentation through CMS' Health Plan Management System (HPMS). This is the case for both the MA or MA/PDP application and SAE application.

The Part C application has several sections that require the applicants to respond to attestations based upon the application type (new MA product or expanding services area for existing MA product) and health plan type. For example, when an applicant accesses HPMS to complete the application process for a "new MA product" the applicant would be guided through the parts of the application that need to be completed by this type of applicant that would require the applicant to select health plan type (CCP, PFFS).

Additionally the application has documents referred to as " templates" that are forms that need to be downloaded from HPMS, completed by the applicant and uploaded into HPMS so the completed documents can be reviewed by CMS staff that perform the application review process. Note templates are application specific so not all applicants would need to submit all the templates in the Part C application. For example, the Exception Request template is a type of template that is only required to be completed by applicants that want to request an exception from CMS to meeting provider and/or facility network adequacy standards. Currently the file is downloaded from the electronic application, completed by the applicant and uploaded into HPMS for review. CMS aims to automate the Exception Request template in CY 2018 but cannot fully commit to that timeframe due to the time and cost related to the design of the form. In preparation for finalizing the desired prototype for the automation, CMS has elected for CY 2017 to continue with the paper version of the form and to revise the form in order to reduce/streamline the content being requested of the applicants for Exception Requests.

4. Duplication of Similar Information

The MA application that is accessed via HPMS contains information essential for the operation and implementation of the Medicare Advantage program. It is the only standardized mechanism available to record data from organizations interested in contracting with CMS for MA or MA-PDP. Where possible, we have modified the standard application to auto-populate information that is captured in prior data collection

and resides in (HPMS). Otherwise, the form does not duplicate any information currently collected.

5. Small Business

The collection of information will have a minimal impact on small businesses since applicants must possess an insurance license and be able to accept substantial financial risk. Generally, state statutory licensure requirements effectively preclude small business from being licensed to bear risk needed to serve Medicare enrollees.

6. Less Frequent Collection

This is an annual collection. If this information were collected less frequently, CMS will have no mechanism to allow new applicants an opportunity to demonstrate that applicants meet the CMS requirements and support determination of contract awards or denials.

7. Special Circumstances

Each applicant is required to enter and maintain data in the CMS Health Plan Management System (HPMS). Prompt entry and ongoing maintenance of the data in HPMS will facilitate the tracing of the applicant's application throughout the review process. If the applicant is awarded a contract after negotiation, the collection information will be used for frequent communications during implementation of the Medicare Advantage Organizations Program. Applicants are expected to ensure the accuracy of the collected information on an ongoing basis.

8. Federal Register Notice/Outside Consultation

Federal Register Notices & Comments

60 Day Notice:
Volume 80 Page number 38692 Publication date July 7, 2015
Public Comments: Comments were received and have been attached to this package along with our response.

The public comments did not impact our burden estimates. Changes made to the Exception Request template document were initiated after the 60-day notice published and resulted from internal review. The 30-day package includes the revised paper version of the form that CMS is working to automate.

9. Payment/Gift To Respondent

There are no payments or gifts associated with this collection.

10. Confidentiality

Consistent with federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, only information within a submitted application (or attachments thereto) that constitutes a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), and is clearly labeled as such by the Applicant, and which includes an explanation of how it meets one of the expectations specified n 45 CFR Part 5, will be protected from release by CMS under 5 U.S.C. §552(b)(4). Information not labeled as trade secret, privileged, or confidential or not including an explanation of why it meets one or more of the FOIA exceptions in 45 CFR Part 5 will not be withheld from release under 5 U.S. C. § 552(b)(4).

11. Sensitive Questions

Other than the labeled information noted above in section 10, there are no sensitive questions included in the information request.

12. Burden Estimate (Total Hours & Wages)

12.1 Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). We selected the position of Compliance Officer because this position is a key contact identified by MA plans. CMS typically interacts with the Compliance Officer in matters related to the Part C application after it is submitted to CMS. In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Compliance Officers	13-1041	32.69	32.69	65.38

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

12.2 Requirements and Associated Burden Estimates

Organizations wishing to provide healthcare services under MA and/or MA-PD plans must

complete an application, file a bid, and receive final approval from CMS. Existing MA plans may request to expand their contracted service area by completing the Service Area Expansion (SAE) application.

This clearance request is for the information collection of the health plan types described in the Background section of this document. The application process is open to all health plans that want to participate in the Medicare Advantage program.

Table 1: Summary of Hours Burden by Type of Applicant and Process

CMS used the Contract Year (CY) 2016 data to estimate the number of projected applications/responses that we will receive for CY 2017. In total, CMS estimates that it will receive 500 initial and SAE applications/responses. This would amount to 18,043 total annual hours. The estimated burden hours are based on an internal assessment of application materials that are required for submission by the applicants.

The application process has two options for applicants that include (1) request for new MA product or (2) request for expanding the service area of an existing product. If an applicant is applying for new MA product then the application process would be longer because the required completion of attestations and potential templates that need to be completed will require more effort than an applicant that is requesting to expand their service area via the SAE application. The chart below describes types of MA product types (as described in the Background section) that can submit applications. The chart is identifying application options in terms of initial applications (note: no new 1876 Cost Plans can submi new applications) and service area expansion applications. The type of health plan is identified as well.

Application/ Responses	**Initial (CCP,PFFS-Network, EGWP)**	**Initial with SNP**	**PFFS (Initial-Non-network)**	**MSA (Initial)**	**SAE (CCP, PFFS-Network, EGWP)**	**SAE with SNP**	**SNP Renewal only**	**Direct EGWP**	**Cost Plan SAE**	**Summary**
Expected Applications/ Responses	66	66	6	0	192	96 *	73	0	1	500
Review Instructions (#of hours)	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	5.5
Complete Application / Proposal (# of hours)	49.0	38.0	34.5	34.5	34.5	38.5	19.5	0.5	34.5	284
Estimated # of hours per application / proposal	50	39	35	0	35	39	20.	1	35	254
Annual Burden hours	3,300	2,574	210	0	6,720	3,744	1,460	0	35	18,043

*Represents the number of expected SNP proposals

Table 2: Total Wage Burden by Application

The estimated wage burden for the MA Part C Application is $1,139,676 based on an estimate wage rate of $65.38/hr wage.

Application/ Responses	Initial (CCP, PFFS-Network, EGWP)	Initial with SNP	PFFS (Initial- Non-network)	MSA (Initial)	SAE (CCP, PFFS-Network, EGWP)	SAE with SNP	SNP Renewal only	Direct EGWP	Cost Plan SAE	Total
Annual burden Hours	3,300	2,574	210	0	6,720	3,744	1,460	0	35	18,043
Hourly Wages.	$65.38/hr	$68.38/hr	$65.38/hr	65.38/hr	$65.38/hr	$65.38/hr	$65.38/hr	$65.38/hr	$65.38/hr	$65.38/hr
Average burden cost by application type	(66) $3,269	(66) $2,549	(6) $2,288	N/A	(192) $2,288	(96) $2,549	(73) $1,340	N/A	(1) $2,288	$16,571
Total Wage burden	$215,754	$168,288	$13,730	0	$439,354	$244,782	$55,480	0	$2,288.	$1,139,676

12.3 Information Collection Attachments

12.3.1 Part C -Medicare Advantage and 1876 Cost Plan Expansion Application- 132 page document

Part C -Medicare Advantage and 1876 Cost Plan Expansion Application is submitted electronically via HPMS. CMS provides the paper version of the application in the annual Part C PRA package. The table of contents identifies the key components of the application that include:

(1) General Information – this section provides overview of the MA program, description of MA product types, description of HPMS, key due dates related to the application process;

(2) Instructions – this section provides general information on how to complete the application process , specific instructions related to certain health plan product types such as EGWPs, SNPs and Cost Plans, and a chart is provided that summarizes the various attestations that are required to be completed by the applicant based upon heath plan type;

(3) Attestations –this section has all the attestations that are utilized in the application process by both new MA product applicants and service area expansion applicants. The required attestations for a new MA product applicant is greater than the number of attestations required for a service area expansion applicant (See chart below);

(4) Document Upload Templates- this section has all the required templates that an applicant may need to complete based upon the type of application and /or health plan type. Currently there are 10 upload documents in this area of the application;

(5) Appendix 1- Solicitations for Special Needs Plan (SNP) Application – this section includes the application for applicants that want to offer a SNP. This section would be completed to reflect the type of SNP and population of beneficiaries the applicant wants to serve. Note this section also has some specific attestations and template upload documents that are required for SNP applicants;

(6) Appendix II- Employer/union – Only Group Waiver Plans (EGWPs) MAO

"800" Series – this section is specific to EGWP applicants only. As noted above for the SNP section this section also has attestations and/or upload documents that are specific to this application type;

(7) Appendix III- Employer/Union Direct Contract for MA- this section has specific requirements for this health plan type that the applicant is required to complete; and

(8) Appendix IV-Medicare Cost Plan Service Area Expansion Application- this section is required for any existing Cost plan that wants to request an expansion in the service area for the their plan. Note: no new application for Cost Plans can be submitted to CMS. The Health Plan Management System (HPMS) is the primary information collection vehicle through which Medicare Advantage Organization's (MAOs) will communicate with CMS during the application process, bid submission process, ongoing operations of the MA program or Medicare Cost Plan contracts, reporting and oversight activities.

Chart of Required Attestations by Application Type

Attestation Topic	Section #	Initial Applicants					Service Area Expansion			
		CCP	PFFS	RPPO	MSA		CCP	PFFS	RPPO	MSA
Experience and Organizational History	3.1	X	X	X	X					
Administrative Management	3.2	X	X	X	X					
State Licensure	3.3	X	X	X	X		X	X	X	X
Program Integrity	3.4	X	X	X	X					
Compliance Plan	3.5	X	X	X	X					
Key Management Staff	3.6	X	X	X	X					
Fiscal Soundness	3.7	X	X	X	X					
Service Area	3.8	X	X	X	X		X	X	X	X
CMS Provider Participation Contracts & Agreements	3.9	X	X	X	X		X	X	X	X
Contracts for Administrative & Management Services	3.10	X	X	X	X		X	X	X	X
Health Services Management & Delivery	3.11	X	X	X	X		X	X*	X	X*
Quality Improvement Program	3.12	X	X	X	X					
Marketing	3.13	X	X	X	X					
Eligibility, Enrollment, and Disenrollment,	3.14	X	X	X	X					
Working Aged Membership	3.15	X	X	X	X					
Claims	3.16	X	X	X	X					
Communications between MAO and CMS	3.17	X	X	X	X					
Grievances	3.18	X	X	X	X					
Appeals	3.19	X	X	X	X					
Health Insurance Portability and Accountability Act of 1996 (HIPPA)	3.20	X	X	X	X					
Continuation Area	3.21	X	X	X	X		X	X		X
Part C Application Certification	3.22	X	X	X	X		X	X	X	X
RPPO Essential Hospital	3.23			X					X	
Access to Services	3.24		X		.			X		.

Attestation Topic	Section #	Initial Applicants					Service Area Expansion			
		CCP	PFFS	RPPO	MSA		CCP	PFFS	RPPO	MSA
Claims Processing	3.25		X		X			X		X
Payment Provisions	3.26		X		X			X		X
General Administration/Management	3.27				X					X
Past Performance	3.28	X	X	X	X					

**Indicates applicants with a network*

- *Indicates that applicants are not required to complete attestations but must upload selected information, as required, in HPMS system.*

12.3.2 HSD Instructions for CY 2017 Applications

The Health Service Delivery (HSD) Instructions is a document designed to provide instructions/guidance to applicants on how to complete and submit required HSD tables that provide information about the network of providers (Primary care and specialists) and facilities (hospitals, home health, etc) that will be used by beneficiaries that select and become enrolled into their health plan. The document gives details about how to complete the accompanying forms, Medicare Advantage (MA) Provider HSD Table and MA Facility HSD Table.

12.3.3 2017 CMS MA Provider HSD Table

The MA HSD Provider Table is the form that captures specific information required by CMS on the physicians/provider's in the applicants contracted network. All applicants (both new MA product and SAE) are required to complete this form and upload the information into HPMS. CMS expects all applicants to fully utilize the opportunities for pre-checks and to fully review the Automated Criteria Check reports to ensure that their tables are accurate and complete.

12.3.4 CY 2017 MA Facility HSD Table

The MA HSD Facility Table is the form that captures specific information required by CMS on the list of facilities and certain service types that are contracted Medicare – certified provider in the applicants contracted network. All applicants (both new MA product and SAE) are required to complete this form and upload the information into HPMS. CMS expects all applicants to fully utilize the opportunities for pre-checks and to fully review the Automated Criteria Check reports to ensure that their tables are accurate and complete.

12.3.5 CY 2017 Medicare Advantage HSD Exception Request Template- this document was discussed previously in the Information Technology section. CMS has network adequacy standards for the time and distance and number of providers that Medicare beneficiaries should have access based upon the provider/facility type. All applicants are expected to meet the CMS network standards. In the event an applicant's HSD Automated Criteria Check report indicates the submitted network does not meet the minimum provider/bed number, time and/or distance requirements for any individual provider/facility

type in a particular county, the applicant may request an Exception for that deficiency under the limited circumstances. The applicant submits an Exception Request for CMS to review and assess to determine if the request should be approved or denied. Note the paper version of the Exception Request template in the 60 day PRA package was to be automated for CY 2017. CMS aims to automate the Exception Request template in CY 2018 but cannot fully commit to that timeframe due to the time and cost related to the design of the form. In preparation for finalizing the desired prototype for the automation, CMS has elected for CY 2017 to continue with the paper version of the form and to revise the form in order to reduce/streamline the content being requested of the applicants for Exception Requests.

13. Capital Cost (Maintenance of Capital Costs)

We do not anticipate additional capital costs. CMS requirements do not require the acquisition of new systems or the development of new technology to complete the application.

System requirements for submitting HPMS applicant information are minimal. MAOs will need the following access to HPMS: (1) Internet or Medicare Data Communications Network (MDCN) connectivity, (2) use of Microsoft Internet Explorer web browser (version 5.1 or higher) with 128-bits encryption and (3) a CMS-issued user ID and password with access rights to HPMS for each user within the MAO's organization who will require such access. CMS anticipates that all qualified applicants meet these system requirements and will not incur additional capital costs.

14. Cost to Federal Government

The average estimated cost for preparation, review, and evaluation of each MAO's application is $6,128. This estimated cost is based on the budgeted amount for application review and estimate wages of key reviewers and support staff. Note the Part C applications are submitted by various MA plans across the country. The primary review of the Part C applications is the responsibility of Regional Office staff which is usually at the GS 13 level with position type such as RO Account Managers. In addition, the Central Office staff (primarily in the Medicare Drug & Health Plan Contract Administration Group (MCAG) is also required to perform some portions of the Part C application review process which is usually of the GS 13 grade level and position type such as Health Insurance Specialist. The median hourly wage for the staff reviewing applications is $49.32. The overhead and benefits are 100% of salary so the total cost per hour is $98.64 as calculated in the chart below. Note Regional Office Supervisor is requested to confirm the RO staff review decisions. The RO Supervisor is usually at the GS14 grade level. The median hourly wage for this position is $58.28. The overhead and benefits are 100% of salary so the total cost per hour is $116.56.

Annualized cost to Federal Government

CMS Staff	Projected Hours/Hourly Rate and # Of Applications	Projected Costs
Systems staff (HPMS)	4 hours x $98.64/hr x 500Applications	$197,280
Subject Matter Expert in the Medicare Drug & Health Plan Contract Administration Group (MCAG) (MCAG)	4 hours x $98.64/hr x 500Applications	$197,280
Regional Office Account Manager**	20 hours x $98.64/hr x 500 Applications	$986,400
Regional Office Sp. Review** (HSD)	20 hours x $98.64/hr x 500Applications	$986,400
Regional Office Supervisor**	4 hours x $116.56/hr x 500Applications	$ 233,120
SNP Clinical	20 hours x $98.64/hr x 235 Applications	$ 463,608
Total		$3,064,088

**These individuals do not review SNP-only responses

The estimated approximated cost per application review is $6,128 ($3,064,088 divided by 500 applications).

15. Program or Burden Changes

We have adjusted our cost estimates by using the most recent BLS wage estimates.

Table 3: Summary of Burden Hours Comparison CY2016 to CY2017

	CY 2016 Number of Respondents	CY 2016 Estimates (hours)	CY2016 Annual Burden Hours	CY 2017 Number of Respondents	CY 2017 Estimates (hours)	CY2017 Annual Burden Hours
MA (initials)	66	47	3,102	66	50	3,300
PFFS non-Network	6	35	210	6	35	210

SAE	192	35	6,720	192	35	6,720
MSA	2	0	0	2	0	0
Initial SNP with MA	66	42	2,772	66	39	2,574
SNP with SAE	96	42	4,032	96	39	3,744
SNP Renewal Only	73	20	1,460	73	20	1,460
Direct EGWP	0	1	0	0	1	0
800 Series* Only	0	0	0	0	0	0
Cost Plan SAE	1	35	35	1	35	35
Total	**502**	**257**	**18,331**	**502**	**254**	**18,043**

*For CY2017, EGWP 800 series only are included in the CCP and SAE

The reduction of 288 hr in annual burden hours (18,331hr-18,043hr=-288hr) from CY 2016 to CY 2017 is attributed to the reduction in the estimated hours to complete both SNP with MA and SNP with SAE applications. The estimated hours for completion of a SNP application was 42 hours in CY2016 which was reduced to 39 hours in CY2017. Note the projected number of SNP applications remained unchanged from CY2016 to CY2017. The overall number of expected respondents remains the same for CY2017.

There is a 3 hr increase in burden from the MA initial application and a 3 hr decrease for the SNP Proposal for CY2017. Thus, the increase and decrease in burden hours cancel each other. Please see the specifics below regarding the changes made to the CY2017 application:

Summary of Changes for Burden Hours

Medicare Advantage Application Increased Burden Hours		
Change Impacting Burden Hours	Rationale for Change	Total Burden Hours
Service Area Expansion (SAE) applications will require HSD Tables for the entire MAO network not just the counties the plan is proposing to expand into with the SAE request.	CMS has an expectation that MAOs are routinely monitoring their networks to confirm that networks are in compliance with current network adequacy standards. Note this is not a new requirement. Therefore, the requirement to upload HSD tables for the entire network at the contract level with a SAE application submission is consistent with CMS's expectations that MAOs are	Increase burden by 2 hours.

	meeting network standards. CMS is implementing this change to SAE applicants as a monitoring tool.	
Added Two Year Prohibition Waiver Request Upload Document.in Section 4 – Upload # 4.3,of the Part C Application	The addition of the document will improve the efficiency of the application process because the applicant completes this form to request that CMS consider granting a waiver of the Two Year Prohibition.	Increased burden by 30 minutes.
Added question #5 to Minimum Enrollment Waiver Request Upload Document in Section 4-Upload #4.2 as follows: Please describe any factors, such as specific populations your organization intends to serve or geographic locations, which may result in low enrollment.	The addition of one clarifying question to the existing document is designed to aid the applicant in providing the necessary information for CMS to be able to conduct the application review.	Increased burden by 30 minutes.
Special Needs Plans Proposal Decreased Burden Hours		
Change Impacting Burden Hours	Rationale for Change	Total Burden Hours
Reduced the number of attestations for the SNP Quality Improvement Program from 28 to 18.	CMS reduced the number of attestations required for the SNP Quality Improvement section of the SNP proposal.	Decreased burden by 2 hours.
Deleted the requirement for upload of the both the Quality Improve Plan and QIP Matrix upload documents.	CMS determined this information was no longer required for the SNP proposal.	Decreased burden by 30 minutes.
Deleted requirement for submission of MOC Matrix Upload Document and the MOC Narrative for SNP applicants submitting SAE application	CMS determined this information was no longer required for the SNP proposal for SAE application.	Decreased burden by 30 minutes.

16. Publication and Tabulation Dates

This information is not published or tabulated.

17. Expiration Date

CMS is not requesting an exemption from displaying the expiration date. Note this collection request is submitted annually for the Part C application.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

There has been no statistical method employed in this collection.