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" which are forms that need to be downloaded from HPMS, completed by the applicant, and uploaded into HPMS. The completed documents will be reviewed by CMS staff responsible for performing 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 for 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.

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 businesses 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.

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

60-Day Federal Register Notice:
Volume: 81 Page number: 44610 Publication date: July 8, 2016

Number of Comments: The CY 2018 Part C Application and supporting documents received comments from six respondents. The comments and CMS responses have been included in the 30 day PRA package in an Excel document. The public

comments received did not impact our burden estimates for the CY 2018 MA Part C application.

Changes: CMS made some technical/clarification changes to specific portions of the 30 day package that were non- substantive in nature due to public comments received from the 60 day comment period. The changes reflected in the 30 day package include: (1) 3.11 Health Services Management Delivery –attestation #5 clarified that the requirement to be Medicare certified only applies to certain types of providers and facilities (2) 3.11 Health Services Management Delivery – attestation #9 – inserted additional regulatory cite to clarify the basis for CMS authority related to RPPO networks and (3) Exception Request template- provided revised excel template in the 30 day package that included instructions and/or descriptions of content within the form that will permit the public to review and provided comments related to the form.

The technical/clarification changes identified above are not anticipated to have any impact on the burden estimates for the CY 2018 MA application process. CMS believes the changes will assist applicants in enhancing their understanding of the application requirements and process.

30-Day Federal Register Notice:
Volume: 81 Page number: 75409 Publication date: October 31 , 2016

There were no comments for the CY2018 Part C Application and supporting documents.

9. Payment/Gift to Respondent

While there are no gifts associated with this collection, the application is required to receive a government contract.

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, confidential or does not include 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. This information collection request does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

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 2015 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	33.26	33.26	66.52

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because (1) fringe benefits and overhead costs vary significantly from employer to employer, and (2) 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 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.

We are using Contract Year (CY) 2017 data to estimate the number of projected applications/responses that we will receive for CY 2018 (see section 15 of this Supporting Statement for a discussion of changes).

Summary of Hours Burden by Type of Applicant and Process

For CY 2018, CMS estimates that it will receive **310 initial and SAE**

applications/responses. This would amount to **10,941 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 a 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 submit 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	41	43	1	0	113	51	60	0	1	**310**
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	283.5
Estimated # of hours per application / proposal	50	39	35	0	35	39	20	1	35	254
Annual Burden hours	2,050	1,677	35	0	3,955	1,989	1,200	0	35	**10,941**

Total Wage Burden by Application

The estimated wage burden for the MA Part C Application is $727,795 based on an estimate wage rate of $66.52/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	2,050	1,677	35	0	3,955	1,989	1,200	0	35	10,941
Hourly Wages.	$66.52/hr	$66.52/hr	$66.52/hr	66.52/hr	$66.52/hr	$66.52/hr	$66.52/hr	$66.52/hr	$66.52/hr	$66.52/hr

Average burden cost by application type	$3,326 (41)	$2,594 (43)	$2,328 (1)	N/A	$2,328 (113)	$2,594 (51)	$1,330 (60)	N/A	$2,328 (1)	$16, 828
Total Wage burden	$136,366	$111,554	$2,328	0	$263,087	$132,308	$79,824	0	$2,328	$727,795

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, and 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 A	X	X	X	X	X	X	X	X
Fiscal Soundness	3.7 B	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		·
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 2018 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. 2018 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 2018 CMS 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 2018 Medicare Advantage HSD Exception Request Template

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 for CY 2018 the Exception Request (ER) template was converted from Word to Excel format. The ER template was enhanced to provide improved instructions, drop down menus and narrative section to aid the applicants in providing the necessary information that CMS requires for Exception requests to be reviewed by CMS. These changes were implemented in part due to industry comments related to the CY 2017 ER template.

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

To derive average costs, we used data from the OPM's 2016 Salary Table for the Washington-Baltimore-Northern Virginia locality (https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2016/DCB_h.pdf). The following table presents the hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation	Grade/Step	Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Regional Office Account Managers/ Central Office Health Insurance Specialist	13/5	50.04	50.04	100.08
Regional Office Supervisor	14/5	59.13	59.13	118.26

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because (1) fringe benefits and overhead costs vary significantly from employer to employer, and (2) 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.

Our 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.

Regional Office Supervisor is requested to confirm the RO staff review decisions. The RO Supervisor is usually at the GS14 grade level.

Annualized cost to Federal Government

CMS Staff	Projected Hours/Hourly Rate and # Of Applications	Projected Costs
Systems staff (HPMS)	4 hours x $100.08/hr x 310 Applications	$124,099.20
Subject Matter Expert in the Medicare Drug & Health Plan Contract Administration Group (MCAG) (MCAG)	4 hours x $100.08/hr x 310 Applications	$124,099.20
Regional Office Account Manager**	20 hours x $100.08/hr x 310 Applications	$620,496
Regional Office Sp. Review** (HSD)	20 hours x $100.08/hr x 310 Applications	$620,496
Regional Office Supervisor**	4 hours x $118.26/hr x 310 Applications	$146,642.40
SNP Clinical	20 hours x $100.08/hr x 154 Applications	$308,246.4
Total		$1,944,079.20

**These individuals do not review SNP-only responses

15. Program or Burden Changes

CMS used the Contract Year (CY) 2017 data to estimate the number of projected applications/responses that we will receive for CY2018. While we acknowledge there was a decrease in the estimated number for Initial applications, there were no significant burden or program changes that would have attributed to this decrease. The projected figures for the CY2018 estimates were based on actual data received from CY2017. While CY2017 estimates were based on data received from CY2016.

The estimated numbers for SAE applications decreased due to the data received from the CY2017 application cycle. Based on CY2017 data, CMS noted an approximate 41% decrease in the SAE applications when compared with CY2016 estimates (193-114 = 79/193 = 0.409 * 100 = 40.9%). There was a policy change which required SAE applicants to submit Health Service Delivery (HSD) tables for the entire provider network (both active and pending counties) that the plan was proposing to expand into with the SAE request. Previously SAE applicants were only required to submit HSD tables for the pending/proposed service areas. Although the policy change was presented in the CY2017

Industry Training, as well as the CY2017 PRA notice, we believe the decrease in SAE applications was attributed to this change. The policy change may have caused a 1-year blip while plans became familiar with the new policy. Therefore our estimate for SAE applications reflects the decrease in SAE applications presented in CY2017 data, however as plans familiarize with the new policy we expect to see an increase in SAE applications. In addition, CMS noted an approximate 48% decrease in the number of SNP applications submitted based on CY2017 data when compared to CY 2016 estimates (299-154 = 145/299 = 0.484 * 100 = 48.4%). We believe the reduction in the SNP applications in CY2017 was attributed to the policy change to remove the requirement for D-SNPs to submit applications based upon their subtypes. Therefore our estimate for SNP applications reflects the decrease in SNP applications presented in CY2017 data.

Additionally, we made some technical/clarification changes to specific portions of the 30 day package that were non- substantive in nature due to public comments received from the 60 day comment period. The changes reflected in the 30 day package include: (1) 3.11 Health Services Management Delivery –attestation #5 clarified that the requirement to be Medicare certified only applies to certain types of providers and facilities (2) 3.11 Health Services Management Delivery – attestation #9 – inserted additional regulatory cite to clarify the basis for CMS authority related to RPPO networks and (3) Exception Request template- provided revised excel template in the 30 day package that included instructions and/or descriptions of content within the form that will permit the public to review and provided comments related to the form.

The technical/clarification changes identified above are not anticipated to have any impact on the burden estimates for the CY 2018 MA application process. CMS believes the changes will assist applicants in enhancing their understanding of the application requirements and process.

As such, there are no significant changes in the application content from CY2017 to CY 2018 therefore the burden is expected to remain constant for the applicant as reflected below in Table 3.

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

Table 3: Summary of Burden Hours Comparison CY2017 to CY2018

	CY 2017 Number of Respondents	**CY 2017 Estimates (hours)**	**CY2017 Annual Burden Hours**	**CY2018 Number of Respondents**	**CY 2018 Estimates (hours)**	**CY2018 Annual Burden Hours**
MA (initials)	66	50	3,300	41	50	2,050
PFFS non-Network	6	35	210	1	35	35
SAE	192	35	6,720	113	35	3,955
MSA	2	0	0	0	0	0
Initial SNP with MA	239	39	9,321	43	39	1,677
SNP with SAE	60	39	2,340	51	39	1,989
SNP Renewal Only	0	20	0	60	20	1,200

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	**566**	**254**	**21,926**	**310**	**254**	**10,941**

*For CY2018, EGWP 800 series only are included in the CCP and SAE

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.