Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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	Law Offices of Mark S. Joffe	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the Exception Request Template Instructions for completing the document and Industry Training.	I believe that the administrative burden on completing the template would be reduced if CMS provided additional clarity regarding how to complete the template, the circumstances in which CMS will not grant an exception request, and the supporting information needed to justify an exception request. While CMS provides extensive application training, including information about its access review process, this training and the guidance included in the exception request template itself, does not currently provide this clarity.	Revision	Accept. CMS has revised the Exception Request template to include instructions and/or descriptions of content within the form. CMS will develop training materials specifically related to the completion and review criteria for the Exception Request Template.
2	Law Offices of Mark S. Joffe	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to CMS Databases Used to Identify the Provider and Facility Supply.	Access to CMS database identifying available providers and inclusion of places in the template to challenge the accuracy of CMS' data. At the very end of the application process this past year (April 28), CMS released a list of the databases that it uses to determine the closest providers to the deficient portion of the service area. Not having this information available to applicants precludes them from challenging the accuracy of the information in these databases. We recommend that CMS publicize this list on an ongoing basis. We also recommend that CMS add a link to the list on the Medicare Advantage Applications' webpage on its website. CMS ought to re-evaluate the use of databases that have a large number of errors. From experience during the last application review cycle, I note that the Provider of Services database includes a number of inaccuracies with regard to facility cardiac surgery and cardiac catheterization services. The template should be revised to give applicants guidance as to where it can explain why it believes the data from CMS' sources is not correct. The instructions should also include examples of the type of supporting documentation that is satisfactory or not satisfactory in supporting the applicant's position, such as that a provider no longer exists or does not provide the service at issue. I also believe that, if CMS rejects an applicant's argument, it needs to provide the applicant with enough specificity so that it knows what it would need to show, if anything, to substantiate its position.	Revision	Accept with Modification. CMS has revised the Exception Request template to include instructions and/or descriptions of content within the form and changed the file format to Excel. In addition, CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
3	Law Offices of Mark S. Joffe	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the structure of the Exception Request template.	The purpose of the exceptions process is to allow an applicant that does not meet CMS' time and distance access standards to be approved consistent with§422.112(a)(l0), which includes the general requirement that the applicant must have contract providers that are accessible "consistent with the prevailing community patterns of health care delivery in the areas where the network is offered." While not explicitly stated, I interpret the existing template to establish a two-step review process. First, if an applicant has contracted with all providers within the time and distance standards and the access requirements are still not met, the applicant can contract with the next closest provider of the type in question and would qualify for an exception. In other words, the template did not require any further documentation for approval. Second, if this circumstance is not present, the applicant has the obligation to show that the requirements are met through the prevailing patterns of care. If CMS intends to retain this structure, I recommend that the template be expanded and expressly create these two steps. With regard to the first step, I recommend that CMS further revise the template to allow the applicant to assert that it has contracted with the closest provider type at issue and, as noted above, also supplement its assertion with information that disputes the accuracy of data in CMS' source databases.	Revision	Accept with Modification. CMS has revised the Exception Request template to include instructions and/or descriptions of content within the form and changed the file format to Excel. In addition, CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
4	Law Offices of Mark S. Joffe	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to criteria for approving and not approving Exception Request.	In order to reduce administrative burden on applicants and on CMS, I recommend that CMS provide greater clarity either in the template or in separate instructions that explain what CMS will approve or not approve when there is a non-contracted provider closer than the one that is part of the applicant's network. I believe the situations that give rise to this issue occur in one of the following three circumstances: 1. Medicare beneficiaries, consistent with prevailing patterns of care, receive the services at issue from providers located in an area farther than the closest provider. To address this instance, CMS should provide guidance that explains the documentation (or gives examples of the documentation) that will support this assertion. I assume that it is insufficient to merely assert that the provider under contract is used consistent with patterns of care. If so, the guidance should convey that point. My understanding is that the applicant can substantiate its argument based on referral patterns that are acknowledged by specialty provider groups or hospitals. CMS should identify these types of circumstances as part of the guidance to applicants. 2. The CMS identified closest provider is not available to the applicant. This can occur if the provider has retired, passed away, does not provide the service in question, or has closed his/her panel. If my understanding of CMS' policies is correct, these examples should be noted in the guidance accompanying the template. In addition, the guidance should also address circumstances where the provider will not contract with any MAO or refuses to contract with the applicant. Given that CMS' policies on what is permissible have changed over the years, I recommend that these circumstances be addressed in the guidance as well. The proposed template does not address any of these issues. 3. The distance from the closest provider to the next closest provider is only marginally closer. For example, the closest provider may be 25 miles from the deficient zip code while the next closest provider with whom the applicant has contracted is 25.5 miles away. In prior years, I have been involved in circumstances where CMS has approved exception requests in these circumstances. CMS' position on the permissibility of the next closest provider when the difference is very small should also be addressed in the guidance.	Revision	Accept with Modification. CMS will develop training materials specifically related to the completion and review criteria for the Exception Request process.
5	Law Offices of Mark S. Joffe	60 day	Health Service Delivery - Exception Request	Health Service Delivery - Exception Request Template	N/A	Comments related to the clarity of decisions related to Exception Request.	CMS' automated process can be efficient but it does not always convey clearly to the applicant the basis for the decision to deny the exception request. I recommend that CMS re-evaluate the responses it gives to applicants and revise, where necessary, the explanation if it does not convey clearly the rationale for the denial.	Revision	Accept with Modification. CMS is currently revising the communications to the applicants regarding the status of exception request with the goal of improving the information provided to the applicants regarding the exception request decision.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
6	Lewin	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the functionality of the Exception Request template.	We support the transition to an Excel-based exception request (ER) template and believe the structure of this template will clarify expectations for ERs and will increase the consistency of submissions. To that end, we recommend CMS consider the following input to further refine the ER submission and review process: 1.Clarify the instructions of Part I: Exception Information We propose updating the instructions for Part I to make clear to Medicare Advantage Organizations (MAOs) the specific sections that need to be populated and to indicate when data, such as an SSA code, is entered incorrectly. 2.Ensure the options for the Part III: Sources dropdown list include all sources commonly used by MAOs and consider the feasibility of listing all sources CMS uses to identify available providers. 3.Ensure the options for Part V: Table of Non-Contracted Providers Reason for Not Contracting dropdown list include all reasons accepted by CMS for not contracting with an available provider or for which CMS would like documentation from the MAO to substantiate the reason for not contracting. We propose this addition so that MAOs may clearly communicate their reason(s) for not contracting with a provider to CMS. CMS may want to provide guidance on allowable versus non-allowable reasons for not contracting to accompany the list of dropdowns. 4.Enable the submission of attachments for MAOs to provide supporting documentation (e.g. maps, explanations, screenshots, etc.).The current template does not allow MAOs to submit supporting documentation beyond the information required in the ER template. CMS may consider providing the MAO the ability to include attachments with the template for additional information.	Revision	Accept. CMS has revised the Exception Request template to include instructions and/or descriptions of content within the form and changed the file format to Excel. The public will be able to view the descriptions of the content in order to provide comments during the 30 day comment period.
7	Blue Cross Blue Shield Association	60 day	Health Service Delivery Instructions	Health Service Delivery Instructions	N/A	Comments related to deletion of the specialty descriptions from the HSD instructions, plans will no longer have a ready resource to reference.	BCBSA recommends that CMS retain the Specialty descriptions in the HSD instructions.	Revision	Reject. CMS has removed the specialty descriptions from the HSD instructions due to a duplication of this information in various application related source documents. CMS wants to have consistent and accurate information available to the applicants therefore centralizing this type of information will aid in facilitating the accuracy of the information. The description of the Provider and Facility types will be included in the HSD reference file.
8	Anonymous	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the Exception Request template dropdown capability and instructions for completing the template.	The Exception Request template advises there are dropdowns for Part lll: Sources. Will CMS provide the available options prior to finalizing the template and will CMS provide overall instructions on how to complete the Exception Request template.	Revision	Accept. CMS will post the revised Exception Request template to include instructions and/or descriptions of content within the form in order to permit public comment. In addition, CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
9	Anonymous	60 day	Health Service Delivery Instructions	Health Service Delivery Instructions	N/A	Comments related to content within the HSD instructions related to definitions of specialty codes, CMS pre-check process for HSD tables and determining the methodology for time and distance.	Will CMS provide definitions of specialty codes? Will CMS provide pre-checks process for the HSD table when expanding, prior to the start of through application process? On the HSD Instructions , page 14 - question #24 , CMS advises additional information is coming for determining the methodology for time and distance . When will this information be available to plan sponsors?	Revision	Clarify. CMS plans to provide additional information to MAOs in the form of HSD guidance and industry training in January.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
10	Health Care Service Corporation (HCSC)	60 day	Attestations for State Licensure	Section 3.3 State Licensure - attestation #6	25-26	Comments supports the proposed new attestation language in #6 and #7 related to State Licensure documentation.	CMS is proposing to add a new State Licensure attestation (attestation 6), which would require applicants to attest that their state licensure certificate(s) in each state in which the applicant proposes to offer the managed care product automatically renews, rather than expires without renewal. In addition, CMS is proposing to revise existing attestation 7 to require applicants to submit license renewal information for all licenses that will renew after the MA application submission deadline, rather than after the MA bid submission deadline, which is the current requirement. HCSC appreciates and supports the proposed changes, and concurs with CMS' stated expectation that the changes should reduce the number of deficiencies related to licenses that automatically renew after the applications are due.	Insertion	Accept. CMS has revised the attestation language in the Section 3.3 State Licensure to clarify the documentation and process that an applicant will follow related to confirmation of current state licensure.
11	Health Care Service Corporation (HCSC)	60 day	Health Service Delivery Instructions	Health Service Delivery Instructions	3	Comments are related to MA Provider Table Instructions.	The guidance addressing completion of MA Provider Tables directs applicants to not list contracted providers in state/county codes where the Medicare beneficiary could not reasonably access services, and that are outside the pattern of care. In addition, we note that guidance related to requesting HSD exceptions that previously was included in the HSD Instructions for CY 2017 Applications (see page 12), stated that all providers listed on the Exception request template must be listed in the HSD table in the county for which the exception is being requested. For clarity, we recommend that CMS explicitly address the interaction between these two requirements.	Revision	Accept. CMS has revised the CY 2018 Part C application - Section 2.9 Health Service Delivery Tables Instructions to clarify for applicants the submission process for HSD tables and Exception Requests. In addition CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
12	Health Care Service Corporation (HCSC)	60 day	Health Service Delivery Instructions	Health Service Delivery Instructions	N/A	Comments are related to HSD Expectation Guidance in the CY 2017 HSD Instructions.	We note that the section titled "HSD Exceptions Guidance – Requesting Exceptions," that was included on page 12 of the HSD Instructions for CY 2017 Applications, does not appear to be included in the HSD Instructions for CY 2018 Applications document. Guidance under this section provided instruction to applicants on when and how an exception may be requested. For clarity and to ensure applicants comply with CMS' requirements related to exceptions requests, we recommend that CMS continue to include these or similar instructions in the HSD guidance document for 2018 and future years, as applicable.	Revision	Accept. CMS has revised the CY 2018 Part C application - Section 2.9 Health Service Delivery Tables Instructions to clarify for applicants the submission process for HSD tables and Exception Requests. In addition CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
13	Health Care Service Corporation (HCSC)	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the functionality of the Exception Request template.	CMS is proposing to convert the HSD Exceptions Request Template to an Excel format; however, the draft template provided for review and comment is in PDF format. As a result, it is not possible to view the "drop down" menu options included in Part III: Sources and Part IV: Table of Non-Contracted Providers, and it is difficult to assess and evaluate the functionality of the revised format (e.g., if the text will wrap, if the format is suitable for this type of data reporting, etc.). To facilitate a more comprehensive review and to permit plans the best opportunity to provide meaningful feedback, we request that CMS provide the Excel version of the template during the subsequent 30-day Paperwork Reduction Act (PRA) comment opportunity.	Revision	Accept. CMS will post the revised Exception Request template to include instructions and/or descriptions of content within the form in order to permit public comment. In addition, CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
14	Health Care Service Corporation (HCSC)	60 day	Health Service Delivery - Exception Request Template	Health Service Delivery - Exception Request Template	N/A	Comments related to the data sources listed in the drop down menu for Part III: Sources on Expectation Request Template.	Under Part III: Sources, applicants will be required to utilize the drop down menus to select the sources that were used by the applicant to identify available providers/facilities. For consistency and accuracy, we recommend that CMS ensure the drop down menu options correspond with the public data sources the agency uses in their review of HSD exceptions request as specified in the "CMS Data Sources for Supply Mapping" document, which was issued by the agency via HPMS on April 28, 2016.	Revision	Accept. CMS will post the revised Exception Request template to include instructions and/or descriptions of content within the form in order to permit public comment. In addition, CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.
15	United Healthcare	60 day	N/A	N/A	N/A	Comments related to CMS listening sessions to discuss the most recent application cycle.	In the past, CMS has held listening sessions to discuss industry feedback and opportunities for improvement based on the most recent application cycle. These listening sessions were helpful in improving the application process. Therefore, UnitedHealthcare respectfully requests that CMS schedule another listening session to discuss feedback on the 2017 application process as soon as possible.	Insertion	Clarify. CMS is reviewing the public comments and feedback received from the CY 2017 application. CMS is committed to improving the application process and will identify the best method(s) for process improvements.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
16	United Healthcare	60 day	Timeline for Release of Final CY 2018 Application Instructions and Forms	N/A	N/A	Comments related to the release of final CY 2018 application and supporting documents.	In 2016, the final 2017 CMS Application, forms, and Health Services Delivery (HSD) table instructions were issued in January with applications due February. This timeline is problematic for large organizations that submit high volumes of HSD tables. In order to develop HSD Tables by the CMS deadline, UnitedHealthcare begins to build them well in advance of the CMS deadline, several weeks before the date that final application information is made available by UnitedHealth Group/UnitedHealthcare Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits 9/6/16 3 of 10 CMS. As a result, this requires revising/repeating work and could also require programming changes that are difficult to accomplish in advance of the CMS application deadline. We respectfully ask that CMS provide HSD criteria and final instruction/forms earlier, with an October timetable being optimal, so that organizations have sufficient time to review and ask questions before they begin implementing changes.	Revision	Reject. The application schedule has been established in order to account for the PRA process and other significant timelines.
17	United Healthcare	60 day	CMS Certification Form	4.4 CMS	65	Comments regarding content of the Certification form and suggested deletion of 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. The current language will be maintained in the CMS State Certification form.
18	United Healthcare	60 day	Health Service Delivery Section	3.11 Health Service Delivery	34	Comments related to revising language in attestation #5.	There are some types of providers that are on the list of types of providers to include in the MA Facility Table that are not required to be Medicare certified, such as Speech Therapy. We recommend the insertion of “if applicable” in this attestation, as follows: Applicant has verified that contracted providers included in the MA Facility Table are Medicare certified, if applicable, and the applicant certifies that it will only contract with Medicare certified providers in the future, if applicable.	Revision	Accept. CMS revised attestation #5 in section 3.11 Health Service Delivery to reflect that Medicare certified applies to applicable providers and/or facilities that need to be Medicare certified.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
19	United Healthcare	60 day	Health Service Delivery Section	3.11 Health Service Delivery	34	Comments related to revising language in attestation #9.	We recommend a revision to Attestation 9, which relates to regional preferred provider organization (RPPO) applicants. We are proposing these revisions to make the attestation consistent with the governing regulation that is cited as the basis for this attestation. Specifically, we advise removing the language relating to the Applicant "only operate[ing] on a non-network basis in those areas of a region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access and availability standards" and instead using the language set forth in 42 CFR 422.2. Although this draft language purportedly relies on 42 CFR 422.2, that regulation does not in fact contain these additional requirements for operating on a non-network basis (nor does the applicable section of the Social Security Act; see 42 U.S.C. 1395w–28(b)(4)). Importantly, this draft Attestation 9 language is also inconsistent with what the Social Security Act and regulations allow: RPPOs may use methods other than written agreements to establish that access requirements are met. (See 42 U.S.C. 1395w–22(d)(5)(c)(ii); 42 CFR 422.112(a)(1)(ii).) We suggest the following language for Attestation 9 as it more closely tracks what 42 CFR 422.2 requires: "Applicant is an RPPO that has established a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and will pay for all covered services whether provided in or out of the network (see 42 CFR 422.2)."	Revision	Reject. CMS will maintain the current language in the attestation #9. The current language contained in Attestation 9 is consistent with CMS's expectation that RPPOs will establish networks in those areas of the region where providers are available to secure contracts with. In the January 28, 2005, Final Rule, CMS provided for an exception to network adequacy specific to RPPOs, allowing RPPOs to use methods other than written agreements to provide access to covered health care services. CMS clarified that this flexibility in the network adequacy requirements, which was subject to CMS approval, would apply in certain situations, such as the RPPO's inability to secure contracts with an adequate number of a specific type of provider or providers to satisfy our comprehensive network adequacy requirements. Consistent with 42 CFR 422.112(a)(1)(ii) and the definition of RPPOs under 42 CFR 422.2, CMS expects that an RPPO will establish networks in those areas of the region it is being offered in where providers are available to contract with. Therefore, the RPPO will only operate on a non-network basis in those areas of the region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access and availability standards. CMS has revised the language in Attestation 9 to reference both 42 CFR 422.2 and 422.112(a)(1)(ii).
20	United Healthcare	60 day	Service Area	3.11 Health Service Delivery	N/A	Comments related to the accuracy of service area data/reports.	Our CMS contract H0543 includes Los Angeles County, California in its service area. Los Angeles (LA) County is comprised of two state and county codes (SCCs); 05210, which has four zip codes (although it shows in our HPMS service area as a full county), and 05200, which has dozens of zip codes, but not the four in 05210. The 05210 zip codes are in the middle of the county and it is not clear why they comprise an SCC separate from the 05200 zip codes. Historically, when our organization has operated in only parts of LA County, 05200 would show as a partial county. As a result, we have filed bids with both 05210/full county and 05200/partial county included. While our bids were initially filed as full county for 2017, the bids still included both SCCs; both showed as "Full" LA County. Having two SCCs with different zip codes associated with this single county makes it difficult for our organization, as well as other health plans that operate in LA County, to interpret the ACC report results used to evaluate network adequacy. We do not believe that health plans are required to meet network adequacy requirements in the four 05210 zip codes separately from the rest of the county. Instead, it is our understanding that health plans are required to meet the requirements in the county as a whole with all zips included. However, the reports are not produced that way. We are unclear as to why LA County has two county codes associated with it and respectfully request that CMS collapse the two county codes into one. Having the LA County service area listed as a single county code would greatly simplify internal monitoring, reporting, and tracking associated with this county. Alternately, we request that CMS explain why they are separate and provide further detail around how to interpret the ACC reports for these two ACCs, CMS' expectations, and any difference in exception request rules if the expectation is that we meet network adequacy in the four 05210 zip codes independently in addition to meeting adequacy in the rest of the county zip codes.	Revision	Reject. The zip codes associated with Los Angeles County, California have been in place for several application cycles and several MAOs are operational within Los Angles County ,California.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
21	United Healthcare	60 day	Inaccurate and Outdated Sources of Data on Providers and Facility Services	HSD Instructions and MA Provider and Facility Tables	N/A	Related to the accuracy of the data sources used to identify providers and facilities in relation to network adequacy.	The provider and facility data sources CMS is relying on to determine if there are deficiencies in an MAO's network are inaccurate and outdated. Every one of the provider and facility data sources listed by CMS in the April 28, 2016 document titled, "CMS Data Sources for Supply Mapping" has issues with inaccurate addresses, provider specialties and facility services, providers that are retired, deceased or moved out of the area, or facilities that are out of business, changed their name or merged with another entity. For example, we have noticed that the Medicare.gov website often lists services available at an acute inpatient hospital even though the hospital operating certificate may not be approved by Department of Health to provide those services. Additionally, it appears a hospital can remain on these lists even after CMS is notified that it does not actually provide those services. Due to these significant concerns related to the accuracy of the data sources used by CMS, we respectfully request that CMS consider ways to ensure that all provider data sources used are accurate, up-to-date and publicly available. UnitedHealthcare believes it would be beneficial for all MAOs if CMS released one centralized and updated source of providers / facilities / suppliers (e.g., enhancing or improving Medicare.gov) rather than multiple data sources. This may make it easier for CMS to maintain accurate and updated provider data. A future, centralized data source should include processes to remove providers who are no longer practicing the specialties listed, who are no longer accepting Medicare, whose office locations are no longer correct, or who are otherwise not available.	Revision	Clarify. CMS plans to provide additional information to MAOs in the form of HSD guidance and industry training in January.
22	United Healthcare	60 day	Health Service Delivery Instructions	HSD Exception Request Template	N/A	Comments related to the draft CY 2018 HSD Instruction document that do not reference the Exception Request template.	The draft HSD instructions and exception request template for 2018 that CMS released for comment do not include instructions for completing exception requests or the criteria CMS will use to approve or deny exception requests. UnitedHealthcare respectfully requests that CMS issue revised exception request instructions and template as well as provide MAOs a review and comment period to ensure the revised instructions and template are clear, correct, and internally consistent. It is critical that MAOs have an opportunity to review and comment on these components of the application materials and process because for the last application cycle, CMS made numerous changes to the instructions, exception request template, and process that were unclear, incomplete, and inconsistent with the regulations.	Revision	Accept. CMS has revised the CY 2018 Part C application - Section 2.9 Health Service Delivery Tables Instructions to clarify for applicants the submission process for HSD tables and Exception Requests. CMS will post the revised Exception Request template to include instructions and/or descriptions of content within the form in order to permit public comment.
23	United Healthcare	60 day	Health Service Delivery Instructions	HSD Table Instructions /MA Provider Table	N/A	Comments related to removing the descriptions of both MA provider and facility in the HSD instructions.	UnitedHealthcare has concerns regarding CMS' removal of the descriptions of Primary Care provider types and MA Facility Types. Instead, in the HSD Guidance and Methodology document, CMS refers applicants to information posted on their website. Without a direct link to a currently posted document or excerpts from the applicable document included in the HSD instructions, it becomes difficult to determine whether there are proposed changes in CMS' definitions regarding these providers and facilities. Additionally, a cross-reference to another document may create additional burden or confusion for applicants if CMS alters the relevant definitions of the HSD Guidance and Methodology document at a later date without notice. We recommend that CMS include the applicable definitions and instructions related to these providers and facilities in the HSD instructions instead of providing a cross-reference to CMS' website. We continue to support CMS' inclusion of Physician Assistants and Nurse Practitioners as Primary Care Providers. While the Descriptions of the MA Provider Types section has been removed from the draft 2018 HSD instructions, we want to ensure that physician extenders (assistants and practitioners) will still be counted as Primary Care Providers in applicants' submissions in accordance with state requirements.	Revision	Clarify. CMS has removed the specialty descriptions from the HSD instructions due to a duplication of this information in various application related source documents. CMS wants to have consistent and accurate information available to the applicants therefore centralizing this type of information will aid in facilitating the accuracy of the information. The description of the Provider and Facility types will be included in the HSD reference file. CMS has revised the CY 2018 Part C application - Section 2.9 Health Service Delivery Tables Instructions to clarify for applicants the submission process for HSD tables and Exception Requests. In addition CMS will provide industry training and HPMS guidance related to the exception request process closer to the application due date.

Comment Number	Source of Comment: (Company Name)	2018 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Application 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)*
24	United Healthcare	60 day	Transplant Facilities List Format	N/A	N/A	Request for CMS to provide transplant facilities list in file format such as .txt or Excel/Access format instead of PDF file.	UnitedHealthcare appreciates CMS' inclusion of a downloadable certified transplant facilities list. However, the list is currently only available in a PDF format, which requires considerable manual manipulation to convert to Microsoft Excel or Access for automated reporting. We request that CMS produce the certified transplant list in a .txt or Excel/Access format similar to the other website posted downloadable files of CMS certified providers (e.g., Hospital, Home Health, Suppliers) in order to streamline this process and eliminate the need for manual manipulation. While the 2018 instructions list a specialty code of 062 for Heart/Lung Transplant Programs, the list of Medicare-Approved Transplant Programs on CMS' website does not include heart/lung transplant programs (only heart-only and lung-only). We request additional clarification regarding the availability of a heart/lung transplant program list or if CMS is not currently using this category.	Revision	Reject. The MAO has identified that the file is only provided in a PDF format. We are unable to confirm that another file format can be made available for this document. In addition, the HSD Reference file will provide the information needed for MAOs related to the use of provider and facility codes.
25	United Healthcare	60 day	Facility Table Services-Access to CMS Information	N/A	N/A	Request for CMS to automate data that is requested on HSD MA Facility tables such as Medicare certified beds for hospitals.	CMS often requires information regarding facilities that is not readily available to all MAOs for use in an automated fashion; for example, the number of Medicare certified beds for hospitals, skilled nursing facilities, intensive care units, and inpatient psychiatric facilities. CMS should provide a central resource from which MAOs can obtain bed counts, by hospital location, so that this information is consistent and available to all health plans. We request that CMS provide information so that it is downloadable in Excel or other downloadable data formats. This will assist plans in their automated production of HSD tables and population of these fields with accurate CMS information.	Revision	Reject: We would suggest that MAOs identify sources for obtaining and confirming this information such as facility websites. No government data base is going to be as current and up to date as the facility's own official record in the CEO or CFO's office.