2020 Consolidated 60-day Comments for Part C Application							
Comment Number	Source of Comment: (Company Name)	2020 MA Application 60 day or 30 day	Application Part	Application Section *(Number/ Header)*	Comments & Recommendation(s) from Source	Type of Suggestion *(Insertion, Deletion, or Revision)*	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
1	United Healthcare	60 day	Due Dates for Applications	1.8	In the first paragraph of 1.8, CMS states, "Applications must be submitted by February 14, 2019." However, the Application and Bid Review Process grid in the same section states that completed applications are due to CMS on February 13, 2019. The October 16, 2018, HPMS memo "Release of Notice of Intent to Apply for Contract Year 2020 Medicare Advantage (MA), Medicare-Medicaid Plans (MMPs), and Prescription Drug Benefit (Part D) and Related CY 2020 Application Deadlines" indicates that February 13, 2019 is the application submission deadline. We recommend that CMS ensure that the correct submission date is indicated in this section of the	Revision	Accept. Thank you. CMS revised section 1.8 of the application to update the Application Due Date to February 13, 2019.
2	United Healthcare	60 day	State Licensure	3.3	3.3.1. Applicant is licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which the applicant proposes to offer the managed care product. In addition, the scope of the license or authority allows the applicant to offer the type of managed care product that it intends to offer in the state or states. If the applicant attests "Yes," the applicant must upload an executed copy of a state license certificate and the CMS State Certification Form for each state being requested. If an SAE applicant is adding counties to an already approved MA service area in a state, then only the CMS State Certification Form for that state needs to be uploaded. Note: Applicant must meet and document all applicable licensure and certification requirements no later than the applicants final upload opportunity, in response to CMS' NOID communication. This attestation has been replaced with new language at 3.3.1, which no longer references that the applicant is licensed as a risking-entity and instead refers only to incorporation. We would like to draw CMS's attention to this change in the draft CY 2020 application in the event the previous 3.3.1 language was removed in error. UnitedHealth Group/UnitedHealthcare Medicare Advantage Application—Part C and 1876 Cost Plan Expansion Application/Solicitation for Applications for Medicare Prescription Drug Plan 2020 Contracts 10/26/18 3 of 7	Revision	Accept. First, CMS is confirming that the language associated with attestation 3.3.1 has been modified this year. For purposes of demonstrating adequate state licensure, CMS does not believe that both an attestation and upload are required. Rather, CMS will determine whether or not an initial or service area expansion applicant meets the applicable licensure requirements based on the licensure uploads described at 3.3.B. CMS has revised the language at 3.3.B to include the following clarification from the prior language under attestation 3.3.1: ***Note: Applicant must meet and document all applicable licensure and certification requirements no later than the applicant's final upload opportunity, which is in response to CMS' NOID communication.*** Second, CMS is confirming that the new language at 3.3.1 and new upload at 3.3.G is correct for initial applicants only. Initial applicants must demonstrate that they are incorporated and approved to operate as the named organization on the contract at the time of the initial application submission. CMS has revised attestation 3.3.1 and 3.3.G to clarify that
3	United Healthcare	60 day	Fiscal Soundness	3.5	Within this section, CMS accurately references the regulations at 42 CFR Section 422.504(a)(14), with one exception. Under C. SAE applicant only, the second paragraph states: 2. The most recent quarterly or annual financial statements and include an opinion (such as a letter, not a full audit) from the applicant's independent auditor confirming that the organization's most recent quarterly or annual financial statements are meeting CMS's fiscal soundness requirement by at least maintaining a positive net worth (Total Assets exceed Total Liabilities) in accordance with 42 CFR Section 422.505(a)(14). The reference to 42 CFR Section 422.505(a)(14) appears to be incorrect. Instead, we believe this should reference 42 CFR Section 422.504(a)(14). As a result, we request that CMS make this correction.	Revision	Accept. CMS has updated the regulatory reference.

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4	United Healthcare	60 Day	Service Area	3.6.8	3.6.8: Applicant attests that it will have a contracted network in place that meets current CMS Medicare Advantage network adequacy criteria for each county in its service area prior to marketing and enrollment efforts for the upcoming contract year. We believe this attestation serves the same purpose as, and is duplicative of, attestation 3.7.1, which reads: "Applicant has or will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services, in accordance with CMS established standards throughout the requested service area." We recommend that CMS delete attestation 3.6.8 and revise attestation 3.7.1 to read: "Applicant has or will have executed provider, facility, and supplier contracts in place prior to marketing and enrollment efforts for the upcoming contract year to demonstrate adequate access and availability of covered services, in accordance with CMS established standards throughout the requested service area." In the event that CMS intends to retain both attestation 3.6.8 under the Service Area section and 3.7.1 under the CMS Provider Participation Contracts & Agreements section, we recommend that CMS revise the language (as stated in the paragraph above) for both 3.6.8 and 3.7.1 so that the attestation language is consistent for both.	Revision	Clarify. The attestation under 3.6.8 stems from the removal of the health service delivery tables and network review from the application. As stated in our January 10 HPMS memo, while applicants no longer submit networks with the application, they must meet network adequacy by January 1, or the start of the upcoming contract year. In our memo, we stated that, in support of this expectation, CMS would review applicant networks tied to an initial or service area expansion application when the contract is active, and that initial applicants that failed to meet network adequacy during this review may be suppressed from Medicare Plan Finder for the upcoming open enrollment period. Therefore, this attestation is specific to the pending service area of the contract and the need to market a network that meets network adequacy. We have clarified this attestation as follows: **Applicant attests that it will have a contracted network in place that meets current CMS Medicare Advantage network adequacy criteria for each county in the requested service area during the entire contract year, and that this network will be ready for operations on January 1.** With this clarification, we are also revising attestation 3.7.1 to clarify the ongoing obligation to maintain access across the requested service area for the full contract term (not just the January 1 date) as follows: *Applicant has or will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services, in accordance with CMS established standards throughout the requested service area for the full term of the contract.*
5	United Healthcare	60 Day	Service Area	3.6.9	3.6.9: Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy criteria as represented in the most recent version of the Health Service Delivery Reference File. Asserting that the Health Service Delivery (HSD) Reference File is the only standard CMS will use to evaluate network adequacy is inconsistent with the regulation at 42 CFR §422.112. In particular, that regulation requires CMS to consider a non-exclusive list of five factors in assessing the adequacy of a Medicare Advantage (MA) plans' network. See 42 CFR 422.112(a)(10) ("Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed Medicare Advantage (MA) plan health care delivery network include, but are not limited to the following… ."). Given this language, the regulation constrains CMS from arbitrarily restricting the standard for network access and availability to only the HSD criteria. By asking Medicare Advantage Organizations (MAOs) to attest that their networks will meet network adequacy criteria as represented in the HSD Reference File, CMS is inappropriately narrowing the network adequacy requirement to which MAOs should be held. As a result, we respectfully ask that CMS remove the language related to the HSD Reference File, so that 3.6.9 reads, "Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy criteria as set forth in regulation as represented in the most recent version of the Health Service Delivery Reference File." This change would be consistent with the regulatory language that CMS included in the CY 2019 Medicare Advantage Readiness Checklist. In the Readiness Checklist, under Section K, Item I. Benefits and Beneficiary Protections, CMS states that MAOs must "Ensure MA and MMP provider networks meet CMS network adequacy requirements (42 C.F.R. § 422.112(a)	N/A	Reject. We do not believe that this attestation is in conflict with regulation. With this attestation, the organization agrees that it will represent their contracted network to CMS. In reviewing whether or not the contracted network represented on the HSD tables meets network adequacy standards, CMS considers other factors in regulation and provides organizations with subregulatory guidance on network adequacy. No change was made to the application based on this response.

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6	United Healthcare	60 Day	Service Area	3.6.10	3.6.10: Applicant is an RPPO that has established networks in those areas of the region where providers are available to contract and will only operate 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 (see 42 CFR 422.2 and 422.112(a)(1)(ii)). The language in Attestation 3.6.10 for regional preferred provider organizations (RPPOs) is not supported by the applicable regulations and we recommend its deletion. MA regulations allow RPPOs an exception to the standard network access criteria. Attestation 3.6.10, however, sets forth access requirements that fail to take into account this RPPO-specific regulatory exception. In developing the exception for MA regional plans set forth in 42 CFR 422.112(a)(1)(ii), CMS recognized that the exception "is essential to foster the growth of the MA regional plan program, a goal consistent with the Congressional intent in creating the program," and particularly to "encourage MA organizations to offer MA regional plans covering rural areas." 70 FR 4588, 4626 (January 28, 2008); 69 FR 46866, 46882 (August 3, 2004). The RPPO exception supports these goals by allowing MA regional plans to use methods other than written agreements with providers to establish that access requirements are met. CMS explained how access requirements differed for MA regional plans: Unlike local coordinated care plans, such as MA local HMOs and MA local PPOs, where we have historically required comprehensive contracted networks of providers as a condition for meeting our access requirements, we will allow MA regional plans to contract with CMS with less robust networks of contracted providers. As long as an entity proposing to offer an MA regional plan pays non-contracted providers at the Medicare FFS rate, and as long as they can guarantee access through such payment to non-contracting providers, and as long as they limit enrollee cost sharing liability to in-network levels, then we will contract with such an entity for an MA regional plan as long as other non-access requirements are met. 70 FR 4588, 4628 (emphasis added). Since 42 CFR 422.112(a)(1)(ii) creates a "special access requirement" for MA regional plans, the regulation reflects a "relaxation of comprehensive network adequacy requirements." 70 FR 4588, 4625. Attestation 3.6.10, however, fails to recognize this relaxation of network adequacy requirements for MA regional plans. It requires MA regional plans to establish networks "where providers are	ERT	Reject. CMS will maintain the current language at 3.6.10, which 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.
7	United Healthcare	60 Day	Eligibility, Enrollment, and Disenrollment	3.11	3.11.1: Applicant will adhere to all applicable Marketing related regulations including but not limited to 42 CFR 422.50 through 422.74. The reference to "Marketing" in this attestation is inaccurate and we ask that it be changed to the previous language, "Eligibility, Enrollment, and Disenrollment". This section of the application is related to Eligibility, Enrollment, and Disenrollment and the regulations referenced (42 CFR 422.50 through 422.74) are specifically related to Eligibility, Enrollment, and Disenrollment. Therefore, this change should be made in order for this attestation to be accurate.	Revision	Accept. CMS concurs with this comment and has revised 3.11.1 to state: *Applicant will adhere to all applicable Eligibility, Enrollment, and Disenrollment related regulations including but not limited to 42 CFR 422.50 through 422.74.*
8	United Healthcare	60 Day	D-SNP State Medicaid Agency	5.4	In this section, the 2018 SMAC documents deadline is noted rather than the updated 2019 deadline. In addition, the dates are not consistent throughout this section. Under the instructions, one date is stated (July 2, 2018) while under Attestations 1 and 2, CMS references a later date (July 5, 2018). It is our understanding that the SMAC documents are due the first Monday in July, which will be July 1, 2019.	Revision	Accept. Thank you. CMS has revised section 5.4 of the application to update the SMAC Due Date to the first Monday in July which is July 1, 2019.

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9	United Healthcare	60 Day	Network Adequacy Review and Release of CMS Network Submission Guidance	N/A	We support CMS's decision to eliminate the network adequacy review from the Initial and SAE application process that was first effective for the CY2019 application cycle. We believe it is more appropriate, effective, and efficient for CMS to monitor MAO network adequacy through the new proposed three-year network adequacy review process rather than through the application process. Eliminating the requirement for network adequacy review in the application process helps to reduce the overall annual burden on CMS and MAOs. Historically, CMS has released network submission guidance annually as part of the application process. With the changes that CMS has introduced to the CY 2019 Part C application process, we recommend that CMS release HSD Instructions, Provider HSD Table, Facility HSD Table, Exception Request Template, and MA Network Adequacy Criteria Guidance in draft form for comment before they are released in final form and that MAOs be given 90 days after the release of these documents in final form before they must meet these new requirements. In addition, CMS has historically released the HSD Reference file in conjunction with the annual CMS application process. We recommend that CMS release any changes to the HSD Reference File at least 90 days before they become effective to allow MAOs to adjust to these updates.	N/A	Reject. As indicated in this comment, the review of Health Service Delivery tables is not part of the Part C or 1876 Cost Plan application. CMS recommends that the commenter submit their specific questions and recommendations to the CMS mailbox, located at: https://dpap.lmi.org.
10	Amy Cowell	60 Day	SMAC	N/A	Is it possible to have separate upload sections for the required SMAC uploads, such as A. State Contract B. SMAC/FIDE Matrix C. Letter of Good Standing	Revision	Reject. CMS will consider this revision during future applications. Thank you.

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