MEDICARE ADVANTAGE INITIAL APPLICATION

For

Coordinated Care Plans (CCPs)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)
Center for Beneficiary Choices (CBC)
Medicare Advantage Group (MAG)

Medicare Advantage Coordinated Care Plans (CCPs) must offer Part D Prescription Drug Benefits and therefore must timely submit a Medicare Advantage-Prescription Drug Plan Sponsor application to offer Part D Prescription Drug benefits as a condition of approval of this CCP application.

2007

(formerly 0938-0470) OMB No. 0938-0935

CENTER FOR BENEFICIARY CHOICES
MEDICARE ADVANTAGE GROUP
MEDICARE ADVANTAGE APPLICATION

Check all that apply:

MA CCP : HMO_____ HMO-POS____ PSO_____

SPECIAL NEEDS PLAN REQUESTED _____ Institutional ___ Chronic ___ Dual Eligible _____Other ___
DOES THE APPLICANT CURRENTLY OPERATE AN 1876 COST PLAN Yes ___, No ___
PARTIAL COUNTY (422.2(1)(ii) Yes ___, No

PLEASE CHECK ALL OF THE FOLLOWING YOU ARE REQUESTING WITH THIS APPLICATION: MA _____ MA-PD _____ or MA WITH Employer Group Waiver Plan (EGWP) ____

Product Name of each Medicare Advantage Plan(s):
H#(s) if available:

APPLICANT NAME (LEGAL ENTITY ORGANIZED AND LICENSED UNDER STATE LAW AS A RISK BEARING-ENTITY):

TRADE NAME (IF DIFFERENT):

MAILING ADDRESS:

CEO OR EXECUTIVE DIRECTOR:
NAME AND TITLE: MAILING ADDRESS: (If different than above)

TELEPHONE NUMBER:
E-MAIL ADDRESS:
FAX NUMBER:
ORGANIZATION'S WEBSITE URL:

APPLICANT CONTACT PERSON:
NAME: E-Mail:

TITLE: FAX:

ADDRESS: TELEPHONE NO:

TAX STATUS For Profit __
Not For Profit __

I certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief and are made in good faith.

Signature CEO/ Executive Director Date

TABLE OF CONTENTS

The table of contents for the completed application is placed after the cover sheet.

For computerized application users: Each chapter and subsection title within the Narrative part is marked for automatic generation of the table of contents on this page. That table appears below with page numbering that reflects a "blank" application. The numbers will change when you generate the table again for the completed application. Please follow the directions in the Technical Instructions to generate the table for the Narrative Part. Note that the table of contents for the Documents Part is not generated automatically, and is to be manually filled in after the table for the Narrative.

MINIMUM ENROLLMENT WAIVER REQUEST

(See Medicare Managed Care Manual Chapter 2)

In accordance with 42 CFR 422.503 and 422.514, an organization must have at least 5,000 enrollees, or 1,500 if non-urban, in order to enter into a MA contract with CMS. However, the regulation allows CMS to grant a waiver of this minimum enrollment up to three years if CMS determines that the organization has the capability to manage a health care delivery system and ability to handle the level of risk required of a MA contractor.

Please check below the Minimum Enrollment Waiver Request:

- **Urban (at least 5,000 enrollees)**
- **Non-Urban (1,500 enrollees)**

GENERAL INFORMATION

(See Medicare Managed Care Manual Chapter 4)

I. SUMMARY DESCRIPTION

A. Complete the summary description table.

	I - Initial Request
Applicant's Current Enrollment as of (date): _____ Group	
Non-Group	
Medicaid	
Medicare cost plan	
Other Product Lines	
Total Enrollment	
Date when the Organization's operations began or are proposed to begin	

B. Briefly describe the MA applicant (the applicant in terms of its history and its present operations). Cite significant aspects of its current financial, marketing, general management and health services delivery activities. (Do not include information requested in the Legal Entity section). Indicate if the applicant has been a Medicare risk or cost-based contractor under §1876 or § 1833 of the Social Security Act.

II. MEDICARE CONTRACT INFORMATION

Please complete and submit the appropriate CMS forms located at http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/Access.pdf or contact Don Freeberger at 410/786-4586.

Specifically, the following refers to the location of the individual forms:

The Medicare Application for Access to CMS Computer Systems is located at http://www.cms.hhs.gov/mmahelp/ or contact Don Freeberger at 410/786-4586.

(for HPMS access and, if needed, additional system access requests). Sign pages as indicated.

Note: Submit a separate HPMS request. Submit requests for access to other systems on a separate form. HPMS access is needed in the early stages of the application process to enable the applicant to input application information into the HPMS application module. Combining the HPMS request with other system access requests will delay the HPMS access approval (access to other systems will be needed after application approval). Please request HPMS access as soon as possible.

The Payment Information form is located at:

http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/pmtform.pdf or contact or contact Yvonne Rice 410-786-7626. The document contains organization, financial institution information, and Medicare contractor data. Sign pages as indicated. The completed form needs to be fax to Yvonne Rice at (410) 786-0322.

Due to the implementation of the IACS system, the Plan Authorization form located at:
http://www.cms.hhs.gov/healthplans/systems/planauthfrm.pdf is no longer required.

III. POLICYMAKING BODY – [422.503]

A. List the members of the organization's policymaking body (name, position, address, telephone number, occupation, term of office and term expiration date). Indicate whether any of the member(s) are employees of the MA organization.

B. If the applicant is a line of business versus a legal entity, does the Board of Directors of the corporation serve as the policy making body of the organization? If not, describe the policymaking body and its relationship to the corporate Board.

C. Does the State regulate the composition of the policymaking body? If yes, in what way?

D. Indicate below the ways in which the policymaking body carries out its responsibilities:

1. What is the requirement for meeting frequency?

2. How many times has this body met in the last 12 months?

3. What is the required number of members of this body?

4. Are there term limits for the Board members?

5. What are the provisions for filling vacancies?

6. What are the quorum requirements?

7. Is the MA organization's management decisions ratified by the full Board?

8. How often is the CEO's performance formally evaluated?

9. Does this body have authority to appoint and remove the CEO?

10. Does this body review and approve the Quality Improvement Program? If yes, how often?

E. List any policymaking committees, the chairperson and members of each committee. Provide an organizational chart(s) showing clear lines of authority, responsibility and delegation(s) of authority.

F. Describe the communication within the MA organization to assure coordination among its physicians, board, and between the Medical Director and key management personnel.

IV. KEY MANAGEMENT STAFF – [422.503]

A. Indicate the individuals responsible for key management functions.

Staff Function	Name	Title	Employed by
CEO/President			
Medical Director			
Utilization Mgmt.			
CFO			
Marketing			
Medicare Sales			

Gov't Relations			
Management Information Systems			
Compliance Officer			
Quality Director			

B. In the Documents Section, provide brief position descriptions and resumes for the individuals listed above.

C. Provide an organizational chart showing the relationships of the various departments, including the names of the managers or directors. Place the chart at the end of this chapter.

V. MANAGEMENT INFORMATION SYSTEM (MIS) – [422.503]

Describe the use of the MIS for day-to-day management as it will apply to Medicare operations and long-term planning of the key organizational functions. Provide a list of key reports (including QI/QA program), include a brief description of each, and indicate their distribution. Be prepared to have MIS reports available onsite for evaluation by CMS staff.

A. Explain how the MA organization meets or will meet the Health Insurance Portability and Accountability Act (HIPAA) for electronic transactions. [45 CFR 160,162,164]

VI. COMMUNICATION WITH CMS – [422.503]

Describe the applicant's ability to communicate with CMS electronically.

VII. SERVICE AREA – [422.2]

For your expected Medicare enrollment area, clearly describe the requested service area in terms of geographic subdivisions such as counties, cities or townships. Provide a detailed map (with a scale) of the complete service area clearly showing the boundaries, main traffic arteries, and any physical barriers such as mountains or rivers. Show location of the organization's ambulatory and hospital providers that serve Medicare members. Show on map the mean travel time from six points on the service area boundary to the nearest primary care provider and hospital site. Place the map(s) in the Documents Section.

If requesting more than one plan and the service areas or delivery systems are different, show on the map (or maps) the geographic boundaries and the providers, as described above, and referenced by each MA plan.

If less than full counties are requested, provide justification for the partial counties request. If the area is not a full county, zip codes must be annotated. (Manual Chapter 4)

END OF CHAPTER DOCUMENTATION

1. Organizational Chart showing relationships of various departments.

CONTINUATION AREA

(See Medicare Managed Care Manual Chapter 4)

An MA organization may establish a continuation area (CA) of any of the local MA plans it will offer under its Medicare contract. [§422.54] If the applicant is requesting approval of one or more CA, this chapter must be completed with information for each CA. If not requesting CA, then disregard this chapter.

If any of the information required here would be included in other parts of this application, refer to the specific section and page number. Do not repeat information.

I. DESCRIPTION

Identify each area that the organization requests as a CA for each MA plan. For each area, estimate the number of enrollees anticipated within the CA within the first year after receipt of CMS's contract.

For each partial county in the requested CA, list the zip codes for the covered area and provide detailed justification explaining why the organization is not requesting a full county.

Indicate the area(s) on the map of the service area (that is required in the General Information Chapter), or a separate map, including the location of providers who will render services to Medicare enrollees. Place the map(s) in the Documents Section.

II. STATE AUTHORIZATION – [422.400]

The applicant must provide documentation that it is authorized under State law to operate as a risk bearing entity that may offer health benefits in the requested CA(s). If the applicant offers a continuation area in another (host) state, then the application must show that it is authorized *by the host state* to offer health benefits. [This form is a separate file *cert.doc*; place a hard copy in the Documents Section].

III. MEDICARE HEALTH BENEFITS & PROVIDERS - [422.100–422.102, 422.112]

For each continuation area, list the benefits that exceed basic Medicare Parts A & B benefits to be provided to members in the CA for each continuation area.

Describe how health care services will be provided to Medicare enrollees in each CA. If the organization's CA for a plan will overlap the service area of another plan to be offered by that organization, then state whether the same health services delivery system will be used for both. If not the same, describe the variations that will apply to the CA.

If the delivery system is an established system, e.g., group, IPA, etc., then the health services delivery tables must be provided for each CA. Be sure to clearly identify the tables as CA. These tables are <u>not</u> needed if the network has been approved for another MA plan of the same or different MA organization.

1. Complete HSD-1 County/Delivery System Summary of Physicians by Specialty [Complete these tables on separate file HSD.xls. Place hard copies in the Documents Section.]

   NOTE: If the MAO uses a sub-network or has multiple delivery systems within the county, a separate HSD 1 table should be completed for each delivery system. Each HSD 1 should be representative of the aggregate numbers of providers for the delivery system. A separate HSD 1 table should be completed for each distinct delivery system to be used within each service area.

2. Complete HSD-2 Table, Provider List of Physicians and Other Practitioners by County. [Complete this table in its file HSD.xls on the electronic copy, place a hard copy in the Documents Section]

   Complete HSD-2A Table, PCP/Specialist Contract Signature Page Index [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

3. Complete HSD-3 Table, Arrangements For Medicare Required Services by County [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

   Complete HSD–3A Table, Ancillary/Hospital Contract Signature Page Index [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

4. Complete HSD-4 Table, Arrangements For Additional and Supplemental Benefits by County [Complete this table in its file HSD.xls; place a hard copy in the Documents Section.]

5. Complete HSD-5 Table, Signature Authority Grid [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

IV. CONTINUATION AREA MATERIALS

A. Provide the language describing CA(s) that will be included in plan's Disclosure Form/Evidence of Coverage, member handbooks or other plan materials. Include basic information on eligibility for enrollment and continued enrollment in CA(s), a general description of CA benefits and cost sharing, and instructions on how to obtain specific information on CA.

B. Provide copies of materials specifically developed for the CA.

   1. CA election forms for age-ins and for current plan members permanently moving to the CA.

2. Provider directory and/or other documents describing how and from whom services should be obtained.

3. CA summary of benefits or description with cost sharing information.

4. CA notices to members.

5. Any other member/marketing materials developed for CA. Marketing materials must be submitted to CMS for review and approval before use. If submitted with the application, place all copies in the Documents Section of the application.

ORGANIZATIONAL AND CONTRACTUAL

(See Medicare Managed Care Manual Chapter 11)

I. LEGAL ENTITY – [422.2 - 422.4]

A. Provide information regarding how the applicant is organized under state law. If the application does business as (d.b.a.) a name or names different from the name shown on its Articles of Incorporation, provide such name(s) and include a copy of State approval for the d.b.a.(s) in the Documents Section. Provide the name(s) the organization will use to market its Medicare product(s).

B. Include in the Documents Section a copy of the Articles of Incorporation, bylaws and other legal entity documentation. If applicable, provide the Partnership Agreement and place in the Documents Section.

Describe any changes in the basic organizational structure since Federal approval (i.e., changes in the corporate charter or bylaws). Provide appropriate documentation as applicable. Place all documentation in the Documents Section.

II. STATE AUTHORITY TO OPERATE – [422.400, 422.503]

A. The applicant must include a completed State Certification form to document that it is licensed under State law or otherwise authorized to operate as a risk bearing entity that may offer health benefits in the service area for which it is requesting a MA contract. [This form is a separate file *cert.doc*; place a hard copy in the Documents Section].

B. Describe the state's jurisdiction over the applicant's Medicare activities and the entity's current compliance status with any state-imposed requirements.

C. List names, addresses, and telephone numbers of appropriate State regulatory officials who have authority over the Medicare Advantage applicant in the state(s) where the applicant operates. Specify the actual state analyst(s) who health plan officials work with on a routine basis.

III. ORGANIZATIONAL AND FUNCTIONAL CHARTS

A. Provide the following organizational and functional charts at the end of this chapter:

1. The MA organizational chart as the organization is licensed and organized under state law as a risk-bearing entity.

2. If the MA organization is a line of business of a corporation, describe and chart the relationship and show the line of business in relation to the corporation.

3. Show the relationship of the entity that will hold the MA contract to any parent or subsidiary organization(s).

4. Contractual Relationships: If applicable, indicate current contractual relationships between the entity that will hold the MA contract and any administrative, management, and/or marketing service entities.

IV. RISK SHARING

A. Describe payment arrangements (FFS, Fee schedule, capitation, etc) with each type of health care provider (individual physicians, IPA, PHO, hospital, SNF, HHA, etc). If financial risk, either capitation or some other means, is transferred to the provider, describe the arrangement in detail, including whether full risk or partial risk is transferred and how the MA organization shares the risk, if applicable.

B. Legal-1 Table is a summary of insurance or other arrangements for major types of loss and liability. Complete the table to indicate the types of arrangements in effect, or to be in effect, for the proposed area when approved. [This table is a separate file; *legal-1.xls* Place a hard copy in the Documents Section.] [422.503]

V. CONTRACTS FOR ADMINISTRATIVE / MANAGEMENT SERVICES 422.504

A. Describe the MA organization's relationships to related entities, contractors and sub-contractors for the provision of health and/or administrative services specific to the Medicare product.

B. Describe each of the specific functions (health and/or administrative) that are now or will be delegated to medical groups, IPAs, or other intermediate entities. Describe how the MA organization will remain accountable for any functions or responsibilities that are delegated to other entities. Describe how the MA organization oversees, and formally evaluates these delegated entities.

C. Include a copy of each administrative services contract and/or agreement in the Documents Section of the application.

D. Complete the Administrative/ Management Delegated Contracting Matrix - reference the regulatory provisions of the health and/or administrative services contracts and/or agreements in the Documents section that support each delegated functions to all entities, if applicable. [This form is a separate file *matrixadm.doc*; place a hard copy in the Documents Section.]

VI. PROVIDER CONTRACTS AND AGREEMENTS - 422.504, 422.520(b)

Note: For purposes of simplicity and completing this application, the term "provider" means physician, inpatient institutions and other ancillary practitioners, including DME suppliers, etc. This definition departs from other Medicare definitions of "providers"

(hospitals and other inpatient institutions, plus home health services) and "suppliers" (physicians or other practitioner and other non-providers). [422.505(i)(3)]

There should be full documentation of arrangements for health services in the requested service area(s) at the time that the application is submitted. Executed written agreements are considered evidence of an operational health delivery network, which is able to provide access and availability to health services for Medicare enrollees. These arrangements are typically provider contracts, but may also include employment contracts and letters of agreement. Executed written agreements with providers should be submitted at the time the application is submitted to CMS. CMS will accept any legally binding written arrangements. CMS does not accept letters of intent.

A. Complete Legal-2 Table, "Provider Arrangements" - For each proposed service area or distinctive delivery system(s) applicant should provide the provider contracts and/or agreements. Contracts and/or agreements should be executed at the time the application is submitted to CMS. [This table is a separate file *legal-2.xls*; place a hard copy in the Documents Section. Instructions for this table are at the end of this chapter.]

B. Provide a sample copy of each category of provider contract(s) and/or agreement(s) between the applicant and its primary health care contractors (i.e., direct contract with physicians, medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.) Place in the Documents Section.

Complete the Provider Participation Contracts and/or Agreements matrix for each applicable primary contracted provider. [This matrix is a separate file *matrix1.doc*; Place a hard copy in the Documents Section.]

C. The signature pages from contracted and subcontracted providers (i.e., PCPs, IPAs, medical groups, PHOs, or similar entities and hospital) actual contract(s) and or agreement(s) must be available onsite and upon request.

D. For provider contracts and agreements between medical groups, IPAs, PHOs, etc., including their subcontracting providers, provide a sample copy of each applicable subcontract in the Documents Section. (Example: If the applicant contracts with an IPA, which contracts with individual physicians, then provide a sample copy of the contract and/or agreement between the IPA and physicians.)

Complete the Provider Participation Contracts and /or Agreements matrix for each applicable contracted and subcontracted provider. [This matrix is a separate file *matrix1.doc*; place a hard copy in the Documents Section.]

NOTE: For this entire section applicants must demonstrate that all contractual provisions extend to the level of provider actually rendering the service to Medicare beneficiaries and all levels of

contracts and/or agreements must meet CMS requirements. [422.505(i)(3)]

VII. BUSINESS INTEGRITY

A. Other than government actions address in paragraph C. below, give a brief explanation and status of each current and previous legal action for the past three years, if applicable, against the applicant.

B. Applicant and its affiliated companies, subsidiaries or subcontractors, subcontractor staff, any member of its board of directors, any key management or executive staff, or any major shareholder (of 5 percent or more) agree that they are bound by 45 CFR Part 76 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration.

C. List any known past or pending investigations, legal actions, or matters subject to arbitration brought involving the Applicant (and Applicant's parent firm if applicable) and its subcontractors, including any key management or executive staff, or any major shareholders (5 percent or more), by a government agency (state or federal) over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. Provide a brief explanation of each action, including the following:

1. legal names of the parties;
2. circumstances;
3. status (pending or closed); and
4. if closed, provide the details concerning resolution and any monetary payments, or settlement agreements or corporate integrity agreement.

D. Applicant organization will be required to provide financial and organizational conflict of interest reports to CMS, pursuant to instructions to be issued by CMS.

VIII. COMPLIANCE PLAN – [422.503]

A. Describe the MA organization's internal compliance plan. Submit a copy of the MA Organization’s compliance plan by placing in the Documents Section.

B. Describe the reporting relationship of the compliance officer to the MA organization’s senior management. Describe how the compliance officer and compliance committee is accountable to senior management. List all members of the compliance committee and their positions within the MA organization.

END OF CHAPTER DOCUMENTATION

1. Organizational Chart of Organization

2. Organizational Chart between Corporation and MA organization
3. Organizational Chart of MA organization and parent/subsidiary
4. Compliance Plan
5. Chart of Contractual Relationship with other entities

STATE LICENSED PROVIDER SPONSORED ORGANIZATIONS

All MA applicants choosing to apply as an MA State Licensed Provider Sponsored Organization (PSO) must meet the applications requirements of a Coordinated Care Plan listed at 422.501.

HEALTH SERVICES DELIVERY

(See Medicare Managed Care Manual Chapters 4, 5, 6, and 7)

I. MEDICARE HEALTH BENEFITS AND PROVIDERS – [422.100-422.102]

A. All applicants: All applicants with multiple MA plans need to submit HSD tables as follows: separate table for each county and each MA plan. However, only one HSD table is needed for different plans that have the same network and service area. (Note: Please save files on Excel and please submit all tables in hardcopy) Instructions for completing HSD tables can be located in the Guidelines document provided with this application.

1. Complete HSD-1 County Summary/Delivery System of Physicians by Specialty [Complete these tables on separate file *HSD.xls*. Place hard copies in the Documents Section.]

   NOTE: If the MAO uses a sub-network or has multiple delivery systems within the county, a separate HSD 1 table should be completed for each delivery system. Each HSD 1 should be representative of the aggregate numbers of providers for the delivery system. A separate HSD 1 table should be completed for each distinct delivery system to be used within each service area.

2. Complete HSD-2 Table, Provider List of Physicians and Other Practitioners by County. Submit Microsoft electronic Excel spreadsheet format, place hard copies in the Document part. [Complete this table in its file HSD.xls on the electronic copy]

   Complete HSD-2A Table, PCP/Specialist Contract Signature Page Index [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

3. Complete HSD-3 Table, Arrangements For Medicare Required Services by County [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

   Complete HSD–3A Table, Ancillary/Hospital Contract Signature Page Index. [Complete this table in its file HSD.xls; place a hard copy in the Documents Section]

4. Complete HSD-4 Table, Arrangements For Mandatory Supplemental Benefits by County [Complete this table in its file HSD.xls; place a hard copy in the Documents Section.]

5. CompleteHSD-5 Table, Signature Grid Authority [Complete this table in its file HSD.xls; place a hard copy in the Documents Section.]

II. QUALITY IMPROVEMENT PROGRAM – [422.152]

A. MA organizations must have contract arrangements for an ongoing Quality Improvement Program for health care services. Each Quality Improvement Program must have a Chronic Care Improvement Program. Describe the organization's Quality Improvement Program and specify how this program meets (or will meet) the following requirements:

1. Conducts performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvements in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

2. Corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

3. Measure its performance using standard measures established or adopted by CMS (for Medicare) and reports its performance to the applicable agency.

4. Achieves any minimum performance levels that may be established by CMS (for Medicare) with respect to the standard measures.

5. Ensures the capacity and functions of the health information systems for the collection and reporting of Quality Improvement Program data.

B. Describe the administration of the Quality Improvement Program, including:

1. The structure and function of the policymaking body that exercises oversight and accountability of the Quality Improvement Program.

2. The mechanism for assuring formal ongoing communication and collaboration among the policy making body that oversees the Quality Improvement programs and the other functional areas of the organization (e.g., health services, management and member services).

3. The process for formal evaluation of the effectiveness of the Quality Improvement Program strategy and making necessary changes.

C. Describe the mechanism for resolving issues raised by enrollees and for making improvements.

III. HEALTH SERVICES MANAGEMENT

A. Availability and accessibility - [422.101(a), 422.112]

1. Describe how the MA organization will provide for or arrange for all the health care services (that are covered under Part A and Part B of Medicare) for their enrollees. Also describe how the MA organization will provide for or arrange for supplemental benefits. [422.112]

2. The applicant must describe the specific health care services that are to be provided either inside or outside the requested service area as long as the health care services are accessible and available to beneficiaries. [422.112]

3. Please address whether the MA organization will use the same delivery systems of providers for each requested MA plan. If the MA organization is using identical provider arrangements for more than one MA plan, indicate such on each HSD table. If not, clearly delineate variations in the networks.

4. Explain how the MA organization will ensure that the number and type of providers will be sufficient to meet the needs of the projected enrollment and to cover all MA benefit plans. For example, state how the MA organization will identify shortages in the physicians' specialties or in-patient beds in hospitals or skilled nursing facilities. If the maintenance of a network has been delegated or subcontracted, explain how the applicant will oversee the adequacy of the network.

5. Explain how the MA organization maintains and monitors the network of contracted providers (i.e., PCP, specialists, hospitals, SNFs, Home health agencies, ambulatory clinics, etc.) to ensure that adequate access of covered services will meet the needs of the population served. [422.112(a)(1)]

6. Describe the MA organization's process for establishing PCP panels for enrollees and whether a PCP referral is needed to obtain services from a specialist. If no referral is needed by the PCP then how does the MA organization ensure that the enrollee receives access to medically necessary specialty care? [422.112(a)(2)]

7. Explain how the MA organization provides women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventative health care services.

8. Explain how the MA organization arranges for specialty care outside of the MA plans provider network when specialty providers are unavailable or inadequate to meet an enrollee's medical needs. [422.112(a)(3)]

9. If the applicant is proposing to offer a point of service (POS) benefit complete the following questions [422.105]:

    a. Are there supplemental benefits?

    b. What health care services will be covered under the POS benefit and how much will enrollees be charged for using the POS benefit?

    c. Is there an out of network lifetime maximum that the MA organization will apply? If so, describe.

    d. Briefly describe how enrollees will be educated regarding the use of the POS benefit.

    e. Describe how the MA offering a POS through a MA plan will report enrollee utilization data at the plan level by contracted and non-contracted providers. [422.105(f)]

10. How will the MA organization use CMS's national coverage decisions and written decision of carriers and intermediaries in the geographic area in which services are covered under the MA plan? [422.101(b)]

11. Describe and provide policies for ensuring that health services are provided in a culturally competent manner to enrollees of different backgrounds. [422.112(a)(8)]

12. Explain the MA organization's process for assuring availability and accessibility of services within each MA plan's service area, with reasonable promptness, and in a manner which assures continuity of care. **[**422.112 (b)] Moreover, explain the patterns of care for each service area requested and specify how geo-access maps or other methods were used to assure access and availability throughout the service area.

13. Indicate how medically necessary services are available and accessible 24 hours a day, 7 days a week.[422.112(a)(7)(ii)]

14. Describe the process for ensuring access to appropriate providers, including credentialed specialists. [422.112(a)(5)]

B. Continuity And Coordination Of Care – [422.112(b)]

1. Specify the MA organization's policies to ensure continuity and coordination of care by the enrollee's primary care provider or through some other means. [422.112(b)(1) & 422.112(b)(2)]

2. Explain how the MA organization will coordinate care with community and social services available within the MA plan service area. [422.112(b)(3)]

3. Describe the procedures for assuring timely communication of clinical information among providers. [422.112(b)(4)]

4. What are the procedures for informing enrollees of their health needs that require follow-up, training in self-care, and other health promotion measures? [422.112(b)(5)]

C. Service Authorization

1. Describe the MA organizations written policies and procedures, reflecting current standards of medical practice, for referral authorizations and processing requests for initial authorization of services, or requests for continuation of services.

2. Describe procedures for monitoring utilization, controlling costs and achieving utilization goals for Medicare members for the following:

   a. In-plan and out-of-plan physician services
   b. Laboratory services
   c. X-ray services
   d. Hospital services, including admitting practices and length of stay
   e. Out-of-area hospital services

   The applicant's utilization review protocol should be (1) based on current standards of medical practice and (2) should incorporate mechanisms to detect both under and over utilization of services. Provide the MA organizations written protocols for utilization review in the Documents Section. [422.152(e)(2)(iii)]

D. Practice Guidelines, Provider Qualification and New Technology – [422.202]

1. Describe the process for adoption and/or development of practice guidelines, including the mechanism for involving representative members of the health care team, physicians in subcontracted groups regarding medical policy, quality improvement, and medical management procedures to ensure achievement of certain standards. Also, explain the process for disseminating these guidelines to providers. [422.202(b)]

2. Describe the criteria and pathways for communicating practice guidelines to enrollees (e.g., recommended self-care guidelines for diabetic patients). [422.202(b)(2)]

3. Describe the process and policies in regard to suspending or terminating physicians in the MA organization. [422.202]

4. Describe the process for selection and retention of providers in the MA organization. Include information as to initial credentialing and re-credentialing, the policies and procedures of suspension or termination of participation of contracting physicians and the appeals process available to physicians in such instances. Describe how the MA organization ensures compliance with Federal requirements prohibiting employment or contracts with individual excluded from participation under either Medicare or Medicaid. [422.204]

5. Explain how the MA organization's policies on formal selection and retention will prevent discrimination against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions. [422.205]

6. How does the MA organization prohibit having providers indemnify the organization against any liability resulting from a civil action brought from any damage caused to the enrollee by the organization's denial of medically necessary care. [422.212]

7 Describe the written policies and procedures for evaluating new medical technologies and new uses of existing technologies. (Medicare Managed Care Manual Chapter 6)

E. Enrollee Health Records and Confidentiality – [422.118]

1. How does the MA organization ensure appropriate and confidential exchange of information among providers?

2. What are the policies and procedures for sharing enrollee information with any organization with which the enrollee may subsequently enroll?

3. How does the MA organization assure that enrollees will have timely access to records and information that pertain to them?

4. Describe the organizations record keeping system through which pertinent information relating to health care of enrollees is accumulated and is readily available to appropriate professionals.

5. Provide a copy of the tool for conducting an initial assessment of each enrollee's health care needs. Place this in the Documents Section.

F. Encounter Data – [422.257] (Medicare Managed Care Manual Chapter 7)

1. Describe how the MA organization meets (or will meet) CMS requirements on the electronic submission of encounter data regarding each of the following:

   a. Inpatient hospital care data for all discharges
   b. Physician, outpatient hospital, skilled nursing facility and home health agency data and other data deemed necessary by CMS.

2. Describe any changes that are specific to the requested area for Sections II through III.

SPECIAL NEEDS PLANS

(Organizations can view the most up-to-date guidance on Special Needs Plans at www.cms.hhs.gov/SpecialNeedsPlans/)

Guidance for an MA organization requesting a Special Needs Plan (SNP) as part of this application. If an MA organization is requesting a special needs plan (SNP) as part of this application, please follow the directions in sections II through V below. If an MA Organization is requesting a new SNP or seeking to add a SNP to an approved service area, this section of the application must also be completed.

Because the statute permits MAOs to offer special needs plans for several categories of individuals, please review the following definitions to be certain that the language in the submission is consistent with the applicable regulatory language contained in 42 CFR Part 422.

I. DEFINITIONS

A. **Specialized MA Plan for Special Needs Individuals**: Any type of MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth in Section 422.4(a)(1)(iv) and that provides Part D benefits under part 423 to all enrollees.

B. **Special needs individual**: An MA eligible individual who is institutionalized, as defined below, is entitled to medical assistance under a State plan under title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan. 42 CFR 422.2

C. **Institutionalized:** For the purpose of defining a special needs individual, an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long term care facility which is a skilled nursing facility, (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); or an inpatient psychiatric facility. For purposes of SNPs, CMS may also consider as institutionalized those individuals living in the community but requiring an equivalent level of care to that of those individuals living in a long term care facility.

D. **Disproportionate percentage:** A SNP that enrolls a greater proportion of the target group (dually eligible, institutionalized, or those with a specified chronic illness or disability) of special needs individuals than occur nationally in the Medicare population. This percentage will be based on data acceptable to CMS, including self-reported conditions from the Medicare Current Beneficiary Survey (MCBS) and other data sources.

E. **Severe and disabling chronic condition:** SNP proposals to serve this type of special needs individual will be evaluated on a case by case basis. The requirements for submitting such a proposal are set forth under Section V below.

II. GENERAL REQUIREMENTS FOR ALL SPECIAL NEEDS PLANS (SNPs)

Please address the following for all SNP requests:

A. A description of the SNP, to include at a minimum:

Overview of the key components of the SNP: marketing, enrollment, clinical expertise and experience, benefits that are unique to the SNP population including an explanation of why those benefits were chosen and how the specified benefits are meaningful to the target population;

B. A description of the target population (i.e., beneficiaries who are dually eligible or institutionalized, or who have chronic or disabling conditions) to include at a minimum:

How the target population will be identified;

The criteria that will be used to identify potential enrollees;

How the organization will determine if the beneficiary meets the enrollment criteria;

C. Please indicate whether the SNP will enroll only individuals in the target population, or whether its enrollment will include a disproportionate percentage of the target population. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in section I. D., please describe the data sources used to determine the disproportionate percentage of special needs individuals it is proposing to include in the SNP.

SNP final guidance will be posted on the CMS website and will provide additional information on disproportionate percentage SNPs.

D. An explanation of how the contracted provider network will meet access and availability standards, if the SNP network is different from the network for the MA Organization's other plans. Include an explanation of what specific types of providers/facilities will participate to serve the unique needs of the target population;

E. A description of how the SNP will market to its target population (with the understanding that any actual marketing materials will be subject to the review process described in 42 CFR 422.80 and the marketing guidelines).

If the SNP intends to enroll beneficiaries with end stage renal disease (ESRD) in any type of SNP, please describe how the organization will serve the unique needs of this

population. For a SNP serving ESRD beneficiaries, the exceptions authority in 42 CFR 422.50(a)(2)(iii) would apply and a waiver must be requested as defined in 42 CFR 422.52 (c).

III. SPECIFIC REQUIREMENTS FOR SNPS SERVING DUAL ELIGIBLE BENEFICIARIES

If the applicant is requesting a SNP to serve the dual eligible population, please address the following additional issues:

a. Identify any contracts between the applicant and the State to provide Medicaid services;
b. If the applicant organization has a contract to serve Medicaid beneficiaries, indicate whether the contract excludes any subset(s) of beneficiaries;

IV. SPECIFIC REQUIREMENTS FOR SNPS SERVING INSTITUTIONALIZED INDIVIDUALS AND/OR THOSE LIVING IN THE COMMUNITY REQUIRING AN EQUIVALENT LEVEL OF CARE, AS DETERMINED BY THE STATE AGENCY

If the applicant is requesting a SNP to serve institutionalized individuals or those requiring an equivalent level of care, please address the following additional issues:

a. Identify any contracts between the applicant and the State to provide Medicaid services;
b. Indicate whether the SNP will be serving individuals living in the community but requiring an equivalent level of care;
c. Indicate who will perform the level of care assessment.

V. SPECIFIC REQUIREMENTS FOR SNPS SERVING INDIVIDUALS WITH SEVERE OR DISABLING CONDITIONS

If the applicant is requesting a SNP to serve individuals with severe or disabling chronic conditions, please address the following additional issues:

a. Delineate the specific disease management and/or clinical protocols to be used to enhance care and care outcomes;
b. Describe how the provider/facility network configuration and intervention strategies will benefit the population;
c. Describe how the benefit structure serves the needs of the target population (e.g. for a diabetes chronic disease SNP, coverage of nutritionists, insulin delivery system supplies, and blood sugar testing materials and equipment);
d. Indicate what distinguishes the SNP from a Coordinated Care Plan in terms of benefit design, disease management strategies, health delivery system

configuration, and any other unique aspects of the program related to the specific conditions/diseases targeted..

e. Specify what clinical interventions, if any, (e.g. individual nutritional plan for diabetic enrollees) will be developed to serve the targeted population.

VI. SPECIFIC REQUIREMENTS FOR SNPS SERVING SUBSETS OF SPECIAL NEEDS INDIVIDUALS

An MA organization may offer a SNP to appropriate subsets of the population in a service area, including subsets within a SNP population. CMS will consider requests for SNPs to serve certain subsets of dual eligibles and institutionalized individuals on a case-by-case basis. CMS will not consider subsets of individuals for a SNP targeted to individuals with chronic and disabling conditions.

Please describe the nature of any proposed subsets and how they were derived. For example, provide an explanation of characteristics of the subset(s), such as a specific network of participating facilities, and/or categories of Medicaid eligibility.

Please note that the SNP final guidance will be posted on the CMS website and will provide additional information on subsets for SNPs.

MEDICARE

(See Medicare Managed Care Manual Chapters 2, 4, 13, and 14 and the Medicare Marketing Guidelines)

I. MARKETING

A. Marketing strategy – [422.6, 422.64, 422.80(e), 422.100(f)] -- Describe the applicant's Medicare marketing strategy, including:

1. Overall marketing approach in the marketplace including communication materials and how materials will be developed and used to market the program
2. Sales approach and channels that will be used to enroll (e.g. internet, advertising and promotion programs)
3. Intent to follow Medicare Marketing guidelines
4. Plans for community education /outreach and public relations
5. Systems for managing inquiries and servicing members
6. Marketing staff (include, if applicable, any information on state jurisdiction over required staff licensure, certification, registration, and/or compensation)
7. Marketing budget
8. Allocation of resources and efforts to accommodate and market to disabled and socially disadvantaged beneficiaries.
9. Marketing representative oversight and training on CMS Medicare guidelines
10. ALL open enrollment periods for each MA plan, including the initial coverage election period; the mandatory November annual election period; and any special election periods

B. Provide a general narrative describing the compensation and bonus structures in place for sales representatives.

C. Submit policies and procedures for informing sales staff and members regarding changes in provider and pharmacy network.

II. ENROLLMENT and DISENROLLMENT

A. By product line, describe your enrollment history for the last 3 years.

B. Enrollment and Disenrollment Processes:

1. Describe how the applicant will enroll Medicare beneficiaries in accordance with CMS requirements. Include the date the MA organization expects to begin enrolling Medicare members.

2. Describe the MA organization's process for receiving and processing enrollments and disenrollments, including beneficiary notification. Include a flow chart that shows each stage of the process for your MA organization, including the responsible entity.

3. Does the MA organization currently offer a Medicare "wrap around" or supplement? If so, how will the MA organization ensure that there is no health screening of members transferring from a wrap around product to Medicare Advantage product?

III. MEMBERSHIP

A. Describe the systems, policies and procedures for identifying and reporting Medicare working aged enrollees.

B. Describe your process for receiving and acting upon membership notifications from CMS.

IV. CLAIMS

A. Describe the claims processing workflow and who is responsible for each stage of the process for the MA organization. Include a flow chart of this process and place at the end of this chapter.

B. Coverage of Out-of-Network Service - *Ambulance Services, Emergency and urgently-needed services; renal dialysis service and post stabilization care* - Describe the work flow and who is responsible for each stage of the process for your organization regarding procedures for honoring, processing and paying claims for services provided to Medicare members for out-of-plan emergency and out-of-area urgently needed care, renal dialysis services and post stabilization care services. Specify how coverage will be provided for emergency services, without regard to either prior authorization or whether the provider is a participating provider. [422.100(b)(1), 422.112(a)(10), 422.113, 422.2]

C. Medicare Secondary Payer - Describe the systems/procedures the MA organization will implement (1) under the Medicare Secondary Payer provisions and (2) to avoid duplicate payment of health care services . [422.108]

D. Provide a list of: 1) All claim denial codes and reasons for denial used in the Medicare contract (do not include commercial); and 2) All procedure codes for services that are not allowed and /or automatically denied in the Medicare contract (identify the procedure code and the service, do not include commercial).

E. Describe the MA organization's ability to pay interest payment requirements on claims that are not paid on a timely manner.

F. Describe the applicant's reimbursement process on claims that are received for certain covered benefits which are not required to be obtained by a network provider, such as eyeglasses, hearing aids, etc.

V. ENROLLEE RIGHTS AND RESPONSIBILITIES

A. Explain the MA organization's member complaints and grievance procedures and how this will be available to Medicare enrollees. Provide a flow chart of the MA organization's Medicare enrollee complaint and grievance procedures. [422.564]

B. Explain how the MA organization will handle Medicare reconsideration and appeals procedures, including expedited determinations and expedited reconsideration. Provide a flow chart of the MA organization's Medicare reconsideration and appeals procedures (including expedited determinations). Describe how the organization will respond to reversals of Medicare reconsideration determinations by the Independent Review Entity. [422.566, 422.618(b)]

C. Provide the MA organization's policies and explain projected procedures for implementing those policies with respect to enrollee rights in the areas listed below. This includes detailing mechanisms for communicating policies to enrollees at the time of enrollment, and thereafter on a yearly basis, how the organization will ensure its compliance with Federal and state laws affecting the rights of Medicare enrollees. [422.112(a)(8), 422.112(a)(8)(I), 422.112(a)(10)(I), 422.100(g)]

Describe how:

1. The MA organization will handle Medicare enrollee’s privacy with regards to each enrollee being treated with respect, dignity including the protection of any information that identifies a particular enrollee.

2. The MA organization will ensure the confidentiality of health and medical records of other information about enrollees. [422.118(a)]

3. The MA organization will ensure that enrollees are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, and mental or physical disability. [422.110(a)]

4. The MA organization will allow enrollees to be able to choose providers from among those affiliated with the organization. [422.112(a) 422.111(b)(5)]

5. The MA organization will ensure that all services both clinical and non-clinical are accessible to all including those with limited English

proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. [422.112(a)(8)]

6. The MA organization will ensure the right to access emergency health care services is consistent with an enrollee's determination of the need for services as a prudent layperson. [422.113(2)(iii)]

7. The MA organization will ensure that enrollees participate in decision-making regarding the enrollee's health care and if unable to do so, the MA provides for the enrollee's representative to facilitate care or treatment decision when the enrollee is unable to do so. [422.206(a), 422.128(a), 422.128(b)(10(iii)(d)]

8. The MA organization will ensure that the enrollee will receive information on available treatment options (including the option of no treatment) or alternative sources of care. The MA organization must ensure that information provided by health care professionals regarding treatment options are in a language that the enrollee understands. [422.206(a)(i), 422.206(a)(2)]

9. The MA organization will ensure enrollees will have access to one's medical records in accordance with applicable Federal and State laws. [422.118(a), 422.118(d)]

10. The MA organization will ensure prompt resolution of enrollee concerns, (i.e., complaints, grievances, issues relating to authorization, coverage or payment for services). [422.118(d)]

D. Describe how (for the areas listed below) the MA organization will ensure that the following enrollee information is received at the time of enrollment (and at least annually thereafter). Include a written statement with information that is readable and easily understood for each area, refer to regulations at: [422.111 (a)(1-3), (422.111(b)(1)-(10))]

1. The MA organization will ensure that enrollees are provided information on the MA plan's service area and any enrollment of continuation area(s), if applicable. [422.111(b)(1)]

2. The MA organization will ensure that all enrollee information provided on benefits and services including mandatory and supplemental benefits will be provided in an appropriate manner. [422.111(b)(2), 422.111(b)(6)]

3. The MA organization will ensure that enrollees have information on the number, mix and distribution of providers including out-of-network coverage, point-of-service etc. [422.111(b)(3)]

4. The MA organization will ensure that out-of-area coverage provided will be communicated to enrollees. [422.111(b)(4)]

5. The MA organization will ensure that enrollees are provided information on emergency coverage, including, the appropriate use of emergency services, and policies and procedures**. [**422.111(b)(5)(I-IV)]

6. The MA organization will ensure that enrollees are informed of prior authorizations and review rules. [422.111(b)(7)]

7. The MA organization will ensure that all enrollee's rights have been provided on the grievance and appeals procedures. [422.111(b)(8)]

8. The MA organization will ensure that enrollees are informed of the organization's quality improvement program. [422.111(b)(9)]

9. The MA organization will provide for enrollees disenrollment rights and responsibilities. Including (upon request of an individual) any disclosure upon requests. [422.111(b)(10), 422.111(c)(1-5)]

E. For each of the following describe the MA organization's system for resolution of enrollee issues which are raised by enrollees, including complaints and grievances, issues related to authorization of, coverage of, or payment of services; and issues related to discontinuation of service [Note: references to an enrollee in these standards include reference to an enrollee's representative]. [422.564(a)(2), 422.562(a)(I), 422.562(a)(ii)]

Describe how:

1. The MA organization will ensure that it follows its own written procedures for the receipt an initial processing of all issues raised by enrollees.

2. The MA organization will implement procedures which clearly explain each step for the resolution of a complaint or grievance by enrollees. [422.564(a)(1), 422.564(a)(2), 422.564(b)(1)]

3. The MA organization will implement procedures (with clearly explained steps and time limits for each step) for the resolution of a compliant or grievance by enrollees. [422.564(a)(1), 422.564(b)(1)]

4. The MA organization will monitor the resolution of enrollee issues. How will the MA organization ensure that it maintain, aggregates and analyzes the resolution of enrollee issues? [422.152(f)(1)]

F. Patient self-determination Act – Explain the MA organization's process of providing information regarding advance directives to members at the time of a member's enrollment.

G. Describe how the applicant will comply with the prohibitions against MA organization interference with health professional advice to enrollees regarding enrollees' care and treatment options.

H. Describe the process for assuring a "best effort" to conduct an initial assessment of each enrollee's health care needs within 90 days of effective date of enrollment [422.112(b)(4)(i)]

I. Describe the process for discharge of an enrollee from an inpatient facility. Include a flow chart and the process for assuring that the MA organization will meet the requirements of issuing the NODMAR, NOMNC, and DENC. Place this at the end of the chapter. [422.620, 422.622]

VI. MORAL OR RELIGIOUS EXCEPTION – [422.206(b)]

If the MA organization is requesting an exception to covering a particular counseling or referral service due to moral or religious grounds, state the service and explain the reasons for the request.

VII. MEDICARE MARKETING MATERIAL – [422.80]

Definition: [422.80(b)]

Marketing materials include any informational materials targeted to Medicare beneficiaries which: (1) Promotes the MA organization, or any MA plan offered by the MA organization; (2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in an MA plan offered by the MA organization; (3) Explain the benefits of enrollment in a MA plan, or rules that apply to enrollees; (4) Explain how Medicare services are covered under an MA plan; including conditions that apply to such coverage.

Marketing materials listed below do not have to be submitted with the application or approved prior to the contract being awarded. However, before a MA Organization can market or advertise its Medicare products, the MAO must be in compliance with the statutory requirements for approval of marketing materials and election forms as outlined in Section 1851 of the Social Security Act, Section 422.80 of the CFR and the Medicare Marketing guidelines.

- Subscriber agreement/Evidence of coverage
- Member handbook
- Application form
- Disenrollment form

- Membership card
- Brochures/Advertising materials
- Radio/TV scripts
- All letters, but not limited to the following: denial of enrollment, disenrollment due to non-payment of premiums, move out of service area, working aged survey etc.
- Provider Directory
- Notice of organization determination for service, claim denial and service denial notices.
- Authorization/referral forms
- Material prepared by contracting IPAs and Groups
- Correspondence relating to grievances/appeals
- Notice of discharge and Medicare appeals rights
- Forms for patient self-determination
- Written notice to beneficiaries of termination of a contracted provider.
- Notices of a service exception due to moral or religious grounds, if applicable
- If applicable, Employer Group marketing material (refer to 422.80(f))
- All denial and Grievance letters

END OF CHAPTER DOCUMENTATION

1. Flow chart of enrollment process
2. Flow chart of disenrollment process
3. Flow chart of claims processing
4. Flow chart of complaints and grievances procedures
5. Flow chart of reconsideration and appeals
6. Flow chart of discharge of enrollees from inpatient facility

FINANCIAL

(See Medicare Managed Care Manual Chapter 7)

I. FISCAL SOUNDNESS – [422.502(f)(1)]

A. Please provide a copy of your most recent independently certified audited statements. (An MA organization that does not have a state license at the time of this application, or is within it's first year of operation with no audit, please submit a copy of the financial information that was submitted at the time the State licensure was requested).

B. Please submit an attestation signed by the Chairman of the Board, CEO and CFO attesting to the following:

1. The MA Organization will maintain a fiscally sound operation and will notify CMS if it becomes fiscally unsound during the contract period.

2. The MA organization is in compliance with all State requirements and is not under any type of supervision, corrective action plan, or special monitoring by the state regulator. **NOTE: If the MA organization cannot attest to this compliance, a written statement of the reasons must be provided.**

PART D PRESCRIPTION DRUG BENEFIT - 422.252

I. PART D PRESCRIPTION DRUG BENEFIT

The Medicare Modernization Act requires that coordinated care plans offer at least one MA plan that includes a Part D prescription drug benefit (an MA-PD) in each county of its service area. To meet this requirement, your organization must timely complete and submit a separate Medicare Advantage Group Prescription Drug Plan application (MA-PD application) in connection with the MA-PD. Failure to file the required MA-PD application will result in a denial of this application and will not be considered an "incomplete" MA application.

The MA-PD application can be found at:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage or you may contact Marla Rothouse at 410/786-8063. Specific instructions to guide MA organizations in applying to qualify to offer a Part D benefit during 2007 are provided in the MA-PD application.

The MA-PD application is an abbreviated version of the application used by stand-alone Prescription Drug Plan (PDPs), as the regulation allows CMS to waive provisions that are duplicative of MA requirements or where a waiver would facilitate the coordination of Part C and Part D benefits. Further, the MA-PD application includes a mechanism for Medicare Advantage organizations to request CMS approval of waivers for specific Part D requirements under the authority of 42 CFR 423.458 (b)(2).

DOCUMENTS TABLE OF CONTENTS

To add the page numbers for the Documents table of contents, place cursor at the end of each line (using the End key) and type in the page number. Do not press ENTER, just place the cursor at the end of the next line for the next page entry.