MEDICARE ADVANTAGE INITIAL APPLICATION

For

Regional Preferred Provider Organizations (RPPOs)

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

Medicare Advantage Regional Preferred Provider Organizations (RPPOs) 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 RPPO application.

2007

OMB No. 0938-0935

CENTER FOR BENEFICIARY CHOICES
HEALTH PLAN BENEFITS GROUP
MEDICARE ADVANTAGE REGIONAL PPO PLAN APPLICATION

MA REGION(s): _____
NATIONAL PLAN: Yes_____ No _____
SPECIAL NEEDS PLAN REQUESTED _____ Institutional ___ Chronic ___ Dual Eligibles _____ Other ___

DOES APPLICANT CURRENTLY OPERATE AN 1876 COST PLAN? 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(s) of each Medicare Advantage Regional PPO Plan(s):
R#(s) if available:

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

TRADE NAME (IF DIFFERENT):

MAILING ADDRESS:

NAME OF CEO OR EXECUTIVE DIRECTOR AND EXACT TITLE:

MAILING ADDRESS: (If different than above)

TELEPHONE NUMBER:
E-MAIL ADDRESS:

FAX NUMBER:

ORGANIZATION'S WEBSITE URL:

NAME AND TITLE OF APPLICANT'S CONTACT PERSON:

ADDRESS:

TELEPHONE:

E-MAIL OF CONTACT PERSON:

FAX:

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

NARRATIVE TABLE OF CONTENTS

Place the table of contents for the completed application after the cover sheet. 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. 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. The applicant must fill it in manually 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.

This table addresses Applicant's current enrollment in the proposed MA Region. If applying for more than one MA Region, please complete a separate chart for each proposed Region.	
MA Region:	
Information Based on Applicant's Current Enrollment as of (Give Date): _____	
Group (Commercial)	
Non-Group (Commercial)	
Medicaid	
Medicare – Cost plans	
Medicare – Other Product Lines	
Total Enrollment	
Date when Applicant's operations began or are proposed to begin	

B. Briefly describe the MA Regional PPO Plan applicant in terms of its history and 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 was ever 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 https://63.240.208.147/Healthplans/systems/. The specific forms are as follows:

The Medicare Application for Access to CMS Computer Systems is located at http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/Access.pdf (for HPMS access and, if needed, additional system access requests) or contact Don Freeburger at (410) 786-4586. Sign pages, as indicated.

Note: Submit an HPMS request separate from the request for access to other systems. 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 necessary after application approval.

The Payment Information form is located at:
http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/pmtform.pdf 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 applicant organization's policymaking body (name, position, address, telephone number, occupation, term of office and term expiration date). Indicate whether any of the members are employees of the MA Regional PPO Plan 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 Applicant? If not, describe the policymaking body and its relationship to the corporate Board.

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

1. Who are the members of this body?

2. Are there term limits for the Board members?

3. Are Applicant's management decisions ratified by the Board?

4. How does the Board formally evaluate the Chief Executive Officer's (CEO) performance?

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

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

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

IV. KEY MANAGEMENT STAFF - 422.503

A. Indicate the individuals responsible for the key management functions of the proposed Regional PPO plan.

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			

In the Documents part, provide brief position descriptions for the individuals listed in the chart above.

V. MANAGEMENT INFORMATION SYSTEM (MIS) - 422.503

A. 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.

B. Explain how the MA Regional PPO Plan 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 - 422.504

Describe the applicant entity's capacity to communicate with CMS electronically.

END OF CHAPTER DOCUMENTATION

1. Organizational Charts showing relationships of various departments.
2. Applicant corporate structure and relationship to affiliated and other entities.

If the applicant consists of a combination of entities, the required information must be provided for each of the entities. If the arrangements are subcontracts, the lead entity must explain how the subgroups tie together.

I. LEGAL ENTITY - 422.2, 422.6

A. Provide information regarding how the applicant organization is organized under state law in each state in the Regional service area(s). If the applicant 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 part. Provide the name(s) applicant will use to market its MA Regional PPO Plan product(s).

B. If applicant consists of more than one risk bearing entity, explain how applicant will ensure that it will treat all enrolled beneficiaries consistently.

II. SPECIAL REQUIREMENT FOR JOINT ENTERPRISE APPLICANTS

Joint Enterprise Applicants must provide as part of their application a copy of the agreement executed by the State-licensed entities describing their rights and responsibilities to each other and to CMS in the operation of a Medicare Part D benefit plan. Such an agreement must address at least the following issues:

- Termination of participation in the joint enterprise by one or more of the member organizations; and
- Allocation of CMS payments among the member organizations.

III. STATE AUTHORITY TO OPERATE - 422.400, 422.503

A. Complete the “State Licensing Status for MA Regional PPOs” Table at the end of this chapter to provide summary information as to the legal entity’s status in each state in each MA Region in which the applicant intends to offer a MA Regional PPO Plan. Complete a separate table for each MA Region. Indicate on the table if the legal entity applicant holds a state license, and if so, the type of license and the Restricted Reserve Requirements (or equivalent) that each state requires be set up in the event of insolvency.

B. Please also complete the State Licensure Attestation included at the end of this chapter.

C. The Applicant entity must provide 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 each state in the MA Region(s) (service area) for which it is requesting an MA Regional PPO Plan contract. [This form is a separate file cert.doc; place a hard copy in the Documents part].

D. List names, addresses, and telephone numbers of state regulatory officials who have authority over a Medicare Advantage Regional PPO Plan entity in the states where the applicant intends to operate its MA Regional PPO Plan. Specify the actual state analyst(s) or other officials who have or would have regulatory purview over your organization once deemed an eligible MA Regional PPO Plan.

IV. ORGANIZATIONAL AND FUNCTIONAL CHARTS

Provide the following organizational and functional charts in the documents section at the end of this chapter:

1. The applicant's current organizational chart as the organization is licensed and organized under state(s) law as a risk-bearing entity.
2. If Applicant entity is a line of business of a corporation, describe and chart the relationship and show the Medicare line(s) of business in relation to the corporation and any affiliates or parent.
3. If significant relationships exist or are projected between the applicant entity and affiliated entities or parent entities in connection with the Regional PPO Plan, provide a description of such relationships and chart(s) indicating the relationships. Be sure to show the relationship of the entity that will hold the MA Regional PPO Plan contract to any parent or subsidiary organization(s).
4. If applicable, indicate current or projected contractual relationships between the entity that will hold the MA Regional PPO Plan contract and any administrative, management and/or marketing organization.

V. RISK SHARING

A. Describe payment arrangements (Medicare FFS, discount fee schedule, capitation, etc.) with contracted health care providers (individual physicians, IPA, PHO, hospital, SNF, etc). If financial risk, either via capitation or some other means, is to be transferred to contracted providers, describe the arrangement in detail, including whether full risk or partial risk is transferred and how the MA Regional PPO organization will share the risk.

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 part.] [422.503]

VI. CONTRACTS FOR ADMINISTRATIVE / MANAGEMENT SERVICES - 422.504

A. Describe the MA Regional PPO Plan organization's relationships with related entities, contractors and sub-contractors for the provision of health and/or administrative services specific to Medicare products. List each and describe the services to be provided.

B. Describe specific health and/or administrative functions (e.g., health services management, utilization management, case management and/or administrative services) that will be delegated to medical groups, IPAs, or other intermediate provider entities. Describe how the MA organization will remain fully accountable for any functions or responsibilities that it delegates to other entities. Describe how the MA Regional PPO Plan organization will oversee and formally evaluate any delegated entities. This may be done on a state by state basis or other coherent basis, such as by type of delegated entity.

C. Include a copy of each administrative service contract in the Documents part of this section.

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 each entity,

if applicable. [This form is a separate file matrixadm.doc; place a hard copy in the Documents parts.]

VII. 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).

There should be full documentation of arrangements for health services in the requested MA Region or Regions at the time the application is submitted. Executed written agreements are considered evidence of an operational health delivery network able to provide access and availability to health services for MA Regional PPO Plan enrollees. These arrangements are executed provider contracts with medical groups, IPAs, PHOs, facilities or individual providers, but may also include employment contracts and letters of agreement. CMS will accept legally binding written arrangements. CMS does not accept letters of intent.

A. Complete Legal-2 Table, "Provider Arrangements" - For each proposed MA Regional PPO service area and for each uniquely distinctive and separately contracted delivery system(s), applicant should provide one model of each type of contract and amendments. [This table is a separate file legal-2.xls; place a hard copy in the Documents part. Instructions for this table are included in the General Application Guidelines document.]

B. Provide one sample copy of each type or category of provider contract(s) between the applicant entity and its health care contractors (i.e., direct contract with primary care and specialist physicians, medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.) Place in the Documents part. Include a cover page indicating what type of contract will follow.

C. For provider contracts and agreements between medical groups, IPAs, PHOs, etc., including their subcontracted providers, provide a sample copy of each applicable subcontract in the Documents part. (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.) For each sample subcontract, include a cover page indicating what type of contract will follow and an attestation that all subcontracted providers have signed a contract identical to the attached sample. A model attestation is included at the end of this chapter.

D. Complete the Provider Participation Contracts and/or Agreements matrix for each sample contract (and subcontract) provided under paragraphs B and C above. [This matrix is a separate file matrix.1.doc; place a hard copy in the Documents part.]

NOTE: For this section, applicants must demonstrate that all of the contractual provisions contained in the MA contract extend to the level of provider actually rendering the service to Medicare Regional PPO Plan enrollees and that all intermediate levels or tiers of care have contracts which meet the CMS requirements. Sub-contracts must indicate which organization’s members will be served, explain how the contracted hospital, IPA, etc., advised its subcontractors about which members are covered by sub-contractor, e.g., which MA organization members will be served and under what terms. [422.505(i)(3)]

See the Medicare Managed Care Manual (Chapter 11, Section 100.4) at: http://www.cms.hhs.gov/manuals/downloads/mc86c11.pdf for provisions that must be included in provider contracts and requirements that can be included in written policies, standards and manuals distributed to providers.

VIII. BUSINESS INTEGRITY

A. Other than government actions addressed in Paragraph C below, give a brief explanation and status of each current and prior legal action against the applicant for the past three years.

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 past or pending, if known, 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.

IX. COMPLIANCE PLAN - 422.503

A. Describe the scope of the applicant organization's internal compliance plan. Submit a copy of the organization’s compliance plan by placing it in the Documents part.

B. Describe the reporting relationship of the compliance officer to the applicant 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 applicant organization.

END OF CHAPTER DOCUMENTATION

1. Organizational Chart of the Applicant Entity
2. Organizational Chart Indicating Relationship between Corporation and Regional PPO Plan organization
3. Organizational Chart of MA Regional PPO Plan organization and parent/subsidiary, if appropriate
4. State Licensure Attestation
5. Compliance Plan for applicant entity
6. Model Attestation re: Provider Subcontracts (See VI.C above)

STATE LICENSURE ATTESTATION

By signing this attestation, I agree that by August 31, 2006, applicant organization will have filed for, in each state of its regional service area(s) in which it is not already licensed, appropriate state licensure that would authorize applicant to operate as a risk bearing entity that may offer health benefits, including offering a Medicare Advantage Regional Preferred Provider product.

I understand that, in order to offer a Medicare Regional PPO plan, section 1858(d) of the Social Security Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), requires an entity to be licensed in at least one state of each of its Regional PPO service areas.

I understand that my organization will be required to provide documentary evidence of its filing or licensure status for each state of its regional service area(s) consistent with this attestation. I further understand that CMS may contact the relevant state regulators to confirm the information provided in this attestation as well as the status of applicant's licensure request(s).

I further agree to immediately notify CMS if, despite this attestation, I become aware of circumstances which indicate noncompliance with the requirements indicated above.

Name of Organization: _____
Printed Name of CEO: _____
Signature: _____

• **This attestation form must be signed by any MA organization offering a Regional PPO product that intends to contract with CMS starting January 1, 2007.**

STATE LICENSURE STATUS FOR MA REGIONAL PPOs

Complete a separate table for each MA Region which the applicant proposes to serve pursuant to this application. Please make copies as necessary.

Entity Name: _____

MA Region: _____

State (Two Letter Abbrev.)	Is Applicant Licensed in State? Yes or No	If No, Give Date Application was Filed with State	Type of License Held or Requested	Does State have Restricted Reserve Requirements (or Legal Equivalent)? If Yes, Give Amount	State Regulator's Name, Address Phone #

MODEL PROVIDER SUBCONTRACTS ATTESTATION

By signing this attestation, I agree that the applicant Medicare Advantage Organization has contracted to serve enrolled beneficiaries of [fill in RPPO product name(s)] through subcontracts with [fill in Medical Group, IPA, PHO, etc] that have signed a contract identical to the attached, entitled _____.

I understand that my organization may be required to provide actual signature pages consistent with this attestation from such contracts at the time of a pre-approval site visit or post-approval monitoring visit.

I agree that CMS may inspect any and all information necessary including inspections at the premises of the Medicare Advantage Organization or Plan to ensure compliance with these requirements.

I further agree to immediately notify CMS if, despite this attestation, I become aware of circumstances which indicate noncompliance with the requirements indicated above.

Name of Organization: _____
Printed Name of CEO: _____
Signature: _____
Medicare Advantage RPPO Contract Number: R#_____

- **This attestation form must be signed by any MA organization offering a Regional PPO product that intends to contract with CMS starting January 1, 2007.**

I. MEDICARE HEALTH BENEFITS AND PROVIDERS - 422.100, 422.101, 422.102, 422.112, 422.113

For each MA Region which the applicant proposes to serve and each Regional PPO plan within a MA Region, applicant must submit the following materials:

A. Access Standards for Regional Plan - Preferred Contracted Providers

Applicant must provide access standards for preferred contracted providers in both Rural and Urban areas of the Region(s) in which Applicant seeks to offer a Regional PPO product. Standards may be distinct for each of the providers/service types listed below for Rural and Urban areas and must describe access in both drive times and distance. Standards must also indicate the percentage of beneficiaries meeting the standard. For example, we would expect Applicants to present the following types of information, perhaps in a grid or model (examples are for demonstration only and are **not** comprehensive):

___ percent of beneficiaries in Rural Area BB have access to 1 or more contracted Primary Care Providers within 45 minutes/45 miles

___ percent of beneficiaries in Urban Area X have access to 2 or more contracted Primary Care Providers within 30 minutes/30 miles

___ percent of total zip codes in Urban Area DX are within 20 minutes/20 miles of a contracted hospital with a fully certified ER

___ percent of beneficiaries in Rural Area XX are within 45 minutes/45 miles of a contracted hospital with 24 hour coverage

___percent of beneficiaries in Urban Area CS are within 45 minutes/45 miles of contracted specialists in the following areas: Cardiology, Urology, Ophthalmology, General Surgery, Dermatology, Psychiatry/Mental Health, Orthopedics, Neurology, and Oncology

___ percent of beneficiaries for all Rural Areas are within 60 minutes/60 miles of at least one contracted outpatient diagnostic facility for blood and other common lab and diagnostic and radiological procedures and tests

___ percent of beneficiaries for all Urban Areas are within 30 minutes/30 miles of at least one contracted outpatient diagnostic facility for blood and other common lab and diagnostic and radiological procedures and tests

CMS expects that regional plans will have a comprehensive preferred contracted network with access standards consistent with community patterns of care.

Applicant must provide access standards for the following specified provider types, including the percentage of beneficiaries that will fall within the standards and stated in terms of distance and time (___% of beneficiaries fall within xx miles/xx minutes of 2 Primary Care Providers):

1. Contracted Hospitals with Full Emergency Facilities
2. Contracted Primary Care Providers
3. Contracted Skilled Nursing Facilities
4. Contracted Home Health Agencies
5. Contracted Ambulatory Clinics
6. Contracted Providers of End Stage Renal Disease Services
7. Contracted Outpatient Laboratory and Diagnostic Services
8. Contracted Specialists in the following areas:
    a. General Surgery
    b. Otology/Laryngology/Rhinology
    c. Anesthesiology
    d. Cardiology
    e. Dermatology
    f. Gastroenterology
    g. Internal Medicine
    h. Neurology
    i. Obstetrics and Gynecology
    j. Ophthalmology
    k. Orthopedic Surgery
    l. Psychiatry/Mental Health
    m. Pulmonary Disease
    n. Urology
    o. Chiropractic
    p. Optometry
    q. Podiatry.

B. Access Narrative and Supporting Maps

Applicant must submit narrative explanations for each Rural and Urban area and the access standard required under paragraph A above to support the appropriateness of the standard for the particular regional area to which it applies. Include a discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards. The narrative should include projected enrollment numbers.

Applicant must provide geographic maps of the regional service area by defined Rural and Urban areas (include county borders) that demonstrate the locations of all contracted providers in relation to beneficiaries in those areas.

C. Addressing Nonconformance with Contracted Access Standards

Applicant must submit a chart listing all counties (or other units of analysis as relied upon by applicant in establishing standards) and indicate whether each county meets or does not meet each contracted access standard for a contracted provider type.

For each of the areas in which Applicant does not meet its access standards through its contracted network, Applicant must provide an access plan describing its Proposed mechanism for ensuring beneficiary access to the identified type(s) of provider(s).

Access plans may include requests for essential hospital designations, facilitating enrollee access to non-contracted providers at preferred cost sharing levels, or other proposed mechanisms as approved by CMS.

If the applicant requests designation of non-contracted hospitals as essentials hospitals, the applicant must complete the Essential Hospital Designation Table included in the documents section of the application and its accompanying attestation.

In this table and any accompanying documentation and text, applicant entity must:

i. Identify the name and address (including county) of each hospital that it seeks to designate as an essential hospital
ii. Explain why the hospital is needed to enable applicant to meet access requirements
iii. Demonstrate that the hospital refused to contract with applicant entity to join the Regional PPO network despite applicant's "good faith" effort to contract with this hospital. A "good faith" effort to contract is demonstrated to the extent that the applicant entity can show it has offered the hospital a contract providing for payment of rates in an amount no less than the amount the hospital would have received had payment been made under section 1886(d) of the Act. Documentation may include copies of offer/rejection letters, e-mails, returned delivery receipts, etc.. .
iv. Indicate the name, address and distance to the next closest Medicare participating hospitals in the area to which MA Regional PPO enrollees could reasonably be referred for inpatient hospital services. Distance should be measured from the nearest Medicare participating hospital that has agreed to contract with the applicant entity for purposes of offering the Regional PPO. Applicant may provide additional distance information, such as the distance from the nearest Medicare participating hospital that has agreed to contract with the applicant to various points in the relevant counties.

NOTE: Designation as an essential hospital renders the hospital eligible to seek additional payment from CMS for inpatient hospital services provided to the Regional PPO's enrollees above the amounts payable under section 1886 and in accordance with section 1858(h).

NOTE: Applicant is required to inform CMS of any changes in the submitted access information that occurs after initial application submission and during the review period.

II. QUALITY IMPROVEMENT PROGRAM - 422.152

Applicant must explain how it meets the requirements of 42 CFR 422 Subpart D.

III. HEALTH SERVICES MANAGEMENT

A. Availability and accessibility - 422.101(a) 422.112. In responding to this section, Applicant should provide cross reference to materials or discussions in other sections of the application, e.g., Access Narrative – Health Services Delivery, Section I.B. above.

1. Describe how the MA Regional PPO 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 Applicant will provide for or arrange for additional and mandatory supplemental benefits. [422.112]

2. Describe the specific health care services that are to be provided outside the requested service area of requested MA Region or Regions and how such health care service locations and clinical practice sites are accessible and available to beneficiaries. [422.112]

3. Please address whether the MA Regional PPO organization will use the same delivery systems of providers for each requested Regional PPO. If not, clearly delineate variations in the networks. [Please refer to the benefit plans with the number that identifies them on the Benefits table.]

4. Explain how Applicant has determined that the number and type of providers with whom it has contracted will be sufficient to meet the needs of the projected Medicare enrollment and to cover all MA Regional PPO benefit plans. For example, state how the organization will identify shortages in physician specialties or in-patient beds in contracted hospitals or skilled nursing facilities. If the maintenance of a network(s) has been delegated or subcontracted, explain how the applicant will oversee the adequacy of these network(s).

5. Explain how the applicant organization will maintain and monitor its networks of contracted providers (i.e., PCP, specialists, hospitals, SNFs, home health agencies, ambulatory practices, clinics, etc.) to ensure that adequate access of covered services will meet the needs of the population served at in-network cost sharing. [422.112(a)(1)]

6. Describe Applicant's process to establish PCP panels and whether a PCP referral is needed to obtain services from specialists. If no referral is needed from the PCP, how does the organization ensure that the enrollee receives access to medically necessary specialty care? [422.112(a)(2)]

7. Explain how Applicant will provide female enrollees the option of direct access to women's health

8. Explain how and under what circumstances the applicant organization will arrange for specialty care outside of the contracted network(s) when specialty providers are unavailable or inadequate to meet an enrollee's medical needs. [422.112(a)(3)]

9. Explain how the organization will apply CMS's national coverage decisions and written decision of carriers and intermediaries to its Medicare enrollees in the MA Regions in which services are covered under its Regional PPO Plans. [422.101(b)] If the applicant entity chooses to apply a uniform local coverage determination from any part of the Region to the entire Region, please specify this and identify the local coverage determination that it will so apply.

10. Describe Applicant's process for identification, diagnosis and monitoring of individuals with complex and serious medical conditions and development of a treatment plan with direct access to specialists. [422.112(a)(4)]

11. Describe and provide Applicant’s policies that assure health services are provided in a culturally competent manner to enrollees of different backgrounds. [422.112(a)(9)]

12. Explain Applicant's process by which it will assure availability and accessibility of services for enrollees within the service area of each MA Region with reasonable promptness and in a manner which assures continuity of care. [422.112 (b)]

13. Indicate how the organization intends to assure that medically necessary services are available and accessible 24 hours a day, 7 days a week. [422.112(a)(8)(ii)]

14. Describe the process for ensuring access to appropriate providers, including credentialed specialists. [422.112(a)(6)]

B. Continuity and Coordination of Care - 422.112(b)

1. Specify Applicant'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 Applicant will coordinate care with community and social services available within the MA Regions it will serve. [422.112(b)(3)]

3. Describe the procedures and policies in place to assure timely communication of clinical information among providers. [422.112(b)(4)]

4. Describe 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. Outline proposed 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 to monitor utilization, control costs and achieve utilization targets for Medicare enrollees for the following:

   a. in-network and out-of-network physician services
   b. Laboratory services
   c. X-ray and diagnostic imaging services
   d. Hospital services, including admissions, discharges and length of stay
   e. Out-of-area emergency services

D. Practice Guidelines, Provider Qualification and New Technology - 422.202

1. Describe the applicant organization’s processes 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 assurance, and medical management procedures to ensure achievement of certain standards. [422.202(b)]

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

3. Describe the process for selection and retention of providers in the MA Regional PPO Plan 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 organization ensures compliance with Federal requirements prohibiting employment or contracts with individual excluded from participation under either Medicare or Medicaid. [422.202, 422.204]

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

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

E. Enrollee Health Records and Confidentiality - 422.118

1. Explain the methods by which the organization will facilitate and monitor the appropriate and confidential exchange of information among providers.

2. Outline proposed policies and procedures for sharing enrollee information with any organization with which the enrollee may subsequently enroll.

3. Explain how Applicant will assure that its Medicare enrollees have timely access to records and information that pertain to them.

4. Describe the organization’s record keeping system through which it accumulates pertinent information relating to health care of enrollees and makes it readily available to appropriate professionals.

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

F. Encounter Data - 422.257 (Chapter 7, Medicare Managed Care Manual)

1. Describe how the MA Regional PPO 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.

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

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 - 422.62, 422.64, 422.80(e), 422.100(g) -- 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 network.

II. ENROLLMENT and DISENROLLMENT

A. By product line, describe your enrollment history for the last three (3) years or, if operating fewer than three (3) years, since the start of your operations.

B. Enrollment and Disenrollment Processes:

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.

2. Describe the Applicant'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 Applicant currently offer a Medicare "wrap around" or supplement? If so, how will the applicant 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 Applicant's the claims processing workflow and who is responsible for each stage of the process. 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 Applicant's 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 Applicant 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 Applicant's ability to pay interest payment requirements on claims that are not paid on a timely manner.

F. Describe Applicant's reimbursement process on claims that are received for any covered benefits which are not required to be obtained by a network provider, such as eyeglasses, hearing aids, etc to be covered at in-network cost-sharing, if applicable.

V. ENROLLEE RIGHTS AND RESPONSIBILITIES

A. Explain Applicant's member complaints and grievance procedures and how these will be made available to Medicare enrollees. Provide a flow chart of Applicant's Medicare enrollee complaint and grievance procedures. [422.564] Explain how Applicant will handle Medicare reconsideration and appeals procedures, including expedited determinations and expedited reconsideration. Provide a flow chart of Applicant's Medicare reconsideration and appeals procedures (including expedited determinations).

B. Describe how Applicant will respond to reversals of Medicare reconsideration determinations by the Independent Review Entity (IRE). [422.566, 422.618(b)].

C. Provide Applicant's policies and explain projected procedures for implementing policies with respect to enrollee rights. This includes detailing mechanisms for communicating policies to enrollees at the time of enrollment and thereafter on a yearly basis; how Applicant 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 Applicant will:

1. 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. Ensure the confidentiality of health and medical records and other information about enrollees. [422.118]
3. 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. Allow enrollees to be able to choose providers from among those affiliated with Applicant. [422.112(a) 422.111(b)(5)]
5. 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)(9)]
6. 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]
7. 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. [422.112(a), 422.206(b), 422.128(a), 422.128(b)]
8. Ensure that the enrollee will receive information on available treatment options (including the option of no treatment) or alternative sources of care. Applicant must ensure that information provided by health care professionals regarding treatment options are in a language that the enrollee understands. [422.206(a)(1)(i), 422.206(a)(2)]
9. 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. Ensure prompt resolution of enrollee issues, including complaints or grievances and issues relating to authorization, coverage or payment for services. [422.118(d)]

D. Describe how Applicant will ensure that it delivers the following information to an enrollee at the time of enrollment and at least annually thereafter, through written

statements that are readable and easily understood: [422.111 (a)(1-3), (422.111(b)(1)-(10))]

1. Information provided on benefits and services including mandatory and supplemental benefits. [422.111(b)(2), 422.111(b)(6)]
2. Information on the number, mix and distribution of providers, including out-of-network coverage, etc. [422.111(b)(3)]
3. Information on out-of-area coverage. [422.111(b)(4)]
4. Information on emergency coverage, including, the appropriate use of emergency services, and policies and procedures. [422.111(b)(5)(I-IV)]
5. Prior authorizations and review rules. [422.111(b)(7)]
6. Enrollee's rights on the grievance and appeals procedures. [422.111(b)(8)]
7. Applicant's quality assurance program. [422.111(b)(9)]

E. For each of the following, describe Applicant's system for resolution of enrollee issues that are raised by enrollees, including: complaints and grievances; issues related to authorization of, coverage of, or payment for 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), 422.152(c), 422.562(a)(I), 422.562(a)(ii)]

Describe how Applicant will:

1. Ensure that it follows its own written procedures for the receipt and initial processing of all issues raised by enrollees.
2. Implement procedures (with clearly explained steps and time limits) for each step for the resolutions of a complaint or grievance by enrollees. [422.564(a)(1), 422.564(a)(2), 422.564(b)(1)]
3. Implement procedures (with clearly explained steps and time limits for each step) for reviewing coverage and payment requests for reconsideration of initial decisions that Applicant chooses not to provide or pay for a particular service. [422.564(b)(4), 422.564(b)(iii)]
4. Monitor the resolution of enrollee issues. How will Applicant ensure that it maintains aggregates and analyzes the resolution of enrollee issues? [422.152(f)(1)]

F. Patient Self-Determination Act – Explain Applicant's processes for 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 organization's interference with health professional advice to enrollees regarding enrollees' care and treatment options.

H. Describe the applicant's proposed processes 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 Regional PPO Plan organization will meet the requirements of issuing the N.O.D.M.A.R. Place this at the end of the chapter. [422.620, 422.622]

VI. MORAL OR RELIGIOUS EXCEPTION – 422.206(b)

If Applicant 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 applicable informational materials targeted to Medicare beneficiaries which: (1) Promote 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 an 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 Chapter 3 of the Medicare Managed Care Manual.

Subscriber agreement/Evidence of coverage
Member handbook/Summary of Benefits
Application form/Enrollment 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/or Medical Groups
Correspondence relating to grievances/appeals
Notice of discharge and Medicare appeals rights (NODMAR)
Notice of Medicare Non-Coverage (NOMNC)
Detailed Explanation of Non-Coverage (DENC)
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))
Summary of benefits
All denial and Grievance letters

END OF CHAPTER DOCUMENTATION

1. Attestation of compliance with Quality Improvement Requirements
2. Flow chart of enrollment process
3. Flow chart of disenrollment process
4. Flow chart of claims processing
5. Flow chart of complaints and grievances procedures
6. Flow chart of reconsideration and appeals
7. Flow chart of discharge of enrollees from inpatient facility

FINANCIAL

(See Medicare Managed Care Manual Chapter 7)

I. FISCAL SOUNDNESS – [422.502]

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, Chief Executive Officer and Chief Financial Officer 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.

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

GENERAL INFORMATION

ORGANIZATIONAL AND CONTRACTUAL

HEALTH SERVICES DELIVERY

MEDICARE

FINANCIAL

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. Does not press ENTER; just place the cursor at the end of the next line for the next page entry.