MEDICARE ADVANTAGE SERVICE AREA EXPANSION APPLICATION

For

Coordinated Care Plans
(CCPs)
and
Private Fee For Service Plans
(PFFS)

Coordinated Care Plan (CCP) applicants seeking to expand the service area of their Medicare Advantage-Prescription Drug contract must timely submit both the MA SAE application and the Part D SAE application as a condition of approval. PFFS SAE applicants that currently offer Part D prescription drug benefits would need to submit both the MA SAE application as well as the Part D SAE application. PFFS SAE applicants that do not offer Part D benefits need only timely submit this MA SAE application.

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

2007

OMB No. 0938-0935

CENTER FOR BENEFICIARY CHOICES
MEDICARE ADVANTAGE GROUP
MEDICARE ADVANTAGE SERVICE AREA EXPANSION APPLICATION

H# (if applicable): _____

Check all that apply: Type of MEDICARE ADVANTAGE COORDINATED CARE PLAN

MA CCP: HMO_____ HMO POS____ PFFS _____

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):

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 WEB 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

NARRATIVE PART
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.

GENERAL INFORMATION
(See Medicare Managed Care Manual Chapter 4)

I. SUMMARY DESCRIPTION

A. Complete the summary description table.

Complete for the requested MA service area. Complete column I for currently approved service area and column II for the requested area.		
	I – Current Service Area	II – Service Area Expansion Requested
Applicant's Current Enrollment as of (date): _____ Group		
Non-Group		
Medicaid		
Medicare – cost plan		
Medicare – Other		
Total Enrollment		
Date when the Organization's operations began or are proposed to begin		

II. KEY MANAGEMENT STAFF – [422.503]
(Complete **only** if there has been changes since the initial application, last service area expansion or last monitoring visit.)

A. Indicate the individuals responsible for the key management functions.

Staff Function	Name	Title	Employed by
CEO/President			
Medical Director			
Utilization Mgmt.			
Marketing			
Medicare Sales			
Gov't Relations			
Management Information Systems			
Compliance Officer			
Quality Director			

III. SERVICE AREA – [422.2]

Clearly describe the requested service area in terms of geographic subdivisions such as counties, cities or townships. Display the area already approved in the current MA contract. Provide a detailed map (with a scale) of the complete service area clearly showing the boundaries, main traffic arteries, any physical barriers such as mountains and rivers. Show location of the organization's contracted hospitals that will serve Medicare members. Show on map mean travel time from six points on the service area boundary to the nearest primary care provider and hospital site. Place map(s) in Documents part.

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 reference by each MA plan.

If less than full counties are requested, provide justification for this request for partial counties. If not a full county, zip codes must be annotated on the map.

ORGANIZATIONAL AND CONTRACTUAL
(See Medicare Managed Care Manual Chapters 10 and 11)

I. STATE AUTHORITY TO OPERATE – [422.400]

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 part].

II. RISK SHARING
(Complete **only** if the risk sharing is different from your existing service area expansion or last monitoring visit.)

A. 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]

III. CONTRACTS FOR ADMINISTRATIVE / MANAGEMENT SERVICES [422.504]
(Complete **only** if the management contracts or agreements are different from your existing service area.)

A. Include a copy of each administrative services contract and/or agreement in the documents part of the application.

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

IV. PRIVATE FEE-FOR-SERVICE SERVICE AREA EXPANSION: NETWORK/NON-NETWORK MODEL (422.214(A)(2)

Is the applicant paying providers, for any category of service, the Original Medicare allowable payment rates under Medicare Part A or Part B (Check one response and follow instructions for each response)

( ) YES. If yes, it will be a Non-Network product. Do not complete Section V. Instead, describe the 'deeming process'[422.214(a)(2)(i)] and how providers will be paid. Include a terms and conditions of payment that will apply.

( ) If NO. It will be a network model PFFS plan. Identify and complete the remainder of Section V for those categories of service for which the applicant will be paying less than the Medicare allowable payment rates for those categories of service or a combination of the two [422.214(a)(2)(ii)].

( ) Combination [422.214(a)(2)(iii)]

V. 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 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. 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 part. 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 part.

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 part.]

C. 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 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.)

Complete the Provider Participation Contracts and /or Agreements matrix for each applicable contracted and subcontracted providers. [This matrix is a separate file matrix.1.doc; place a hard copy in the Documents part.]

D. The signature pages from contracted and subcontracted provider (i.e., PCPs, IPAs, medical groups, PHOs or similar entities and hospitals) actual contract(s) and or agreement(s) must be available on site and upon request.

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 that all levels of contracts and/or agreements meet the CMS requirements. [422.505(i)(3)]

I. MEDICARE HEALTH BENEFITS AND PROVIDERS – [422.100-422.102]
(Note: For PFFS complete only if answered NO under Organizational and Contractual section IV titled Private Fee-For- Service Expansion)

A. For each MA benefit plan, describe how health services will be arranged for or provided to the projected Medicare membership. Applicant should explain for each MA plan if all contracted providers are available to the Medicare member on normal referral from PCP or by self- referral or if there are sub-networks (e.g. based on the member's selection of a PCP) and consequently different procedures for accessing care within the sub-networks on the member and member's PCP. Also if the Medicare product in a MA plan is a gatekeeper model, all services for which the member may self-refer should be clearly identified.

B. All applicants with multiple MA plans need to submit HSD tables as follows: separate table for each county for 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 as Excel and please submit all tables in hardcopy) Instructions for completing HSD tables can be located in the Guidelines document of the application

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 apart.]

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.

1. Complete HSD-2 Table, Provider List of Physicians and Other Practitioners by County, [Complete this table in its file hsdmc1HSD.xls; place hard copies in the Document part.]

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 part]

2. 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 part]

   [Complete this table in its file hsdmc1HSD.xls; place a hard copy in the Documents part]
   Complete HSD–3A Table, Ancillary/Hospital Contract Signature Page Index

3. Complete HSD-4 Table, Arrangements For Additional and Supplemental Benefits by County [Complete this table in its file hsdmc1HSD.xls; place a hard copy in the documents part.]

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

C. Will the MA organization use the same delivery systems for the new service area? If so, how does the MA organization assure sufficient providers for projected enrollment? If not, how will services be rendered in the new area?

II. HEALTH SERVICES MANAGEMENT
Availability and accessibility – [422.101(a) 422.112]

Please indicate any variances in regulatory requirements between the current service area with regard to operations and the proposed service area expansion. For example, entity will delegate medical management responsibilities to unique delivery system in expansion, while conducting medical management in-house in current service area.

1. Describe how the MA organization will provide coverage of or arrange for all health care services (that are available to Medicare beneficiaries residing in the plan's service areas) for their enrollees. Also describe how the MA organization will provide for or arrange for additional and mandatory supplemental benefits. [422.112]

2. The applicant should delineate the specific health care services that are to be provided either inside or outside the requested expansion service area. [422.112]

3. Please address whether the MA organization will use the same delivery system of facilities and providers for each requested MA plan in the expansion area. If the MA organization will use identical provider arrangements for more than one MA plan, indicate such on each HSD table. 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 ensures that the number and types of contracted facilities and providers will be sufficient to meet the needs of the projected expansion area enrollment and to cover all MA benefit plans to be offered in the expansion area. If the operation of a network or networks in the expansion area has been delegated or subcontracted, explain how the MAO will oversee the ongoing adequacy of the network.

5. Explain how the MA organization will maintain and monitor its networks of contracted providers (i.e., PCP, specialists, hospitals, SNFs, Home health agencies, ambulatory clinics, etc.) in the expansion area(s) to ensure adequate access of covered services which 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. 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 will arrange for specialty care by non-contracting providers when specialty providers or facilities are unavailable or inadequate to meet an enrollee’s medical needs. [422.112(a)(3)]

8. If the applicant proposes to offer a new MA plan with a point of service (POS) benefit complete the following. [422.105]

    a. Is there a mandatory supplemental or optional supplemental benefit?

    b. What health care services will be covered under the POS benefit and how much will enrollees be charged in 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)]

9. Only respond if different than in existing service area:

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

10. Explain the MA organization's process for assuring availability and accessibility within each new MA plan in the expansion area with reasonable promptness, and in ways that ensure 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.

11. Indicate which medically necessary services are available and accessible 24 hours a day, 7 days a week. [422.112(a)(7)(ii)] and how the enrollee will be so informed.

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. For Coordinated Care Plans only, if an MA organization is requesting a special needs plan (SNP) as part of this SAE application, please follow the directions in sections II through V below.

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.

I. 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.

II. MEDICARE MARKETING MATERIAL – [422.80]

Definition: [422.80(b)]

Marketing materials include any applicable 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.

The 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 MAOs 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.

- Advertising Materials (related to SAE only)
- Provider Directory (template)
- Provider Marketing Materials (if applicable)
- Subscriber agreement/Evidence of coverage
- Summary of Benefits

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

HSD Table 5 *[HSD.xls]*
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MEDICARE
Marketing Marketing Materials …….

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.