MEDICARE ADVANTAGE INITIAL APPLICATION

For

PRIVATE FEE-FOR-SERVICE (PFFS) PLANS

PFFS applicants seeking to offer Part D Prescription Drug benefits must also timely submit a Medicare Advantage-Prescription Drug Plan Sponsor application to offer Part D Prescription Drug benefits.

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

2008

CMS Form Number: CMS-10118

OMB No. 0938-0935

CENTER FOR BENEFICIARY CHOICES
MEDICARE ADVANTAGE GROUP
MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) APPLICATION

DOES APPLICANT CURRENTLY OPERATE AN 1876 COST PLAN Yes ___, No ___

PARTIAL COUNTY (422.2(1)(ii) Yes ___, No _____
ARE YOU REQUESTING:
Open Access (Non-Network) PFFS Plan _____ or
Contracted Network PFFS Plan _____
Number of MA-PD Plans (if applicable)_____

Please check all of the following you are requesting with this application:
PFFS only_____ PFFS MA-PD _____ or PFFS with Employer Group Waiver Plan (EGWP) _____

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

NAME OF 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:
APPLICANT'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. 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.

MINIMUM ENROLLMENT WAIVER REQUEST

(See Medicare Managed Care Manual Chapters 11)

In accordance with 42 CFR 422.503 and 422.514, an applicant must have at least 5,000 enrollees or 1,500 if non-urban 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 applicant has the capability to manage a health care delivery system and 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 & 11)

I. SUMMARY ~~DESCRIPTION~~ TABLE

A. Complete the following summary ~~description~~ table.

Complete for the requested MA service area.	Initial
Applicant's Current Enrollment as of (date):_____ Group	
Non-Group	
Medicaid	
Medicare – Cost plan	
Medicare Other product lines	
Total Enrollment	

B. Briefly describe 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.) Please include the following:

1. Summary of recent financial performance including the date of achievement of break-even* and current operating experience.

2. The extent of the current Medicare population served by the applicant, if any, and the maximum number of Medicare beneficiaries that could be served as a Medicare Advantage PFFS Plan.

3. Include information about other Medicare contracts held by the applicant, (i.e., 1876, fee for service, PPO, etc.), unless described in the Legal Entity Section.

* Break-even is defined as the point of maximum cumulative deficits followed by two consecutive quarters during which operating revenues exceeded operating expenses. Break-even date shall be the first day of the first quarter.

II. HPMS ACCESS ANDand PAYMENT FORM ~~MEDICARE CONTRACT~~ INFORMATION

A. For HPMS access, please complete and submit the appropriate CMS form located at:
http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/Access.pdf

If you have questions about this form please contact Don Freeberger at (410) 786-4586.

Note: 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). Submit requests for access to other systems on a separate form.

B. Please complete the Payment Information form located at:
http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/pmtform.pdf
The document contains financial institution information and Medicare contractor data.

If you have questions about this form please contact Yvonne Rice at (410)-786-7626 applicant. The completed form needs to be faxed to Yvonne Rice at (410) 786-0322.

III. POLICYMAKING BODY - [422.503]

A. 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 applicant? If not, describe the policymaking body and its relationship to the corporate Board.

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

1. Is the applicant's management decisions ratified by the full Board?
2. How often does the applicant formally evaluate the Chief Executive Officer's (CEO) performance?
3. Does this body have authority to appoint and remove the CEO?

C. List any policymaking committees, name of the chairperson and members of each committee. Provide organizational chart(s) showing clear lines of authority, responsibility, and any delegation(s) of authority to other entities.

D. Describe the communication within the applicant's 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 below the individuals responsible for the key management functions.

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

B. In the Documents Section, provide position descriptions and resumes for the key management staff listed in the chart above.

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

NOTE: NETWORK MODEL PFFS PLANS MUST ENTER ITS REQUESTED SERVICE AREA IN HPMS.

V. SERVICE AREA – [422.2]

A. For your expected Medicare enrollment area, clearly describe the requested service area in terms of geographic subdivisions such as counties, cities or townships.

B. Provide a detailed map (with a scale) of the complete requested service area clearly showing the boundaries, main traffic arteries, and any physical barriers such as mountains or rivers.

i. Show the location of the applicant's contracted ambulatory and hospital providers that will serve Medicare members.

ii. Show the mean travel time from six points on the service area boundary to the nearest contracted primary care provider and hospital site.

iii. Place the map(s) in the Documents Section.

C. If applicant is proposing to offer more than one benefit 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.

D. 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. (See Medicare Managed Care Manual Chapter 4)

VI. COMMUNICATION WITH CMS and MANAGEMENT INFORMATION SYSTEMS - [422.504]

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

B. Describe the use of the management information systems (MIS) for day-to-day management as it will apply to Medicare products operations and long-term planning of the key organizational functions. Provide a list of key reports, which include a brief description of each and describe their distribution. Have MIS reports available on-site for evaluation by CMS staff.

C. Describe the organizations MIS capabilities to track and update fee for service reimbursement and payments.

VII. ~~UPGRADES OF THE~~ HEALTH INFORMATION TECHNOLOGY

~~APPLICANT MUST ATTEST 'YES' TO EACH OF THE FOLLOWING QUALIFICATIONS TO BE APPROVED FOR A PART C CONTRACT.~~ ATTEST 'YES' OR 'NO' TO ~~THE STATEMENT PEL~~EACH OF THE FOLLOWING QUALIFICATIONS BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	YES	NO
1. As the Applicant implements, acquires, or upgrades health information technology systems, it shall utilize, where available and as applicable, health information technology systems and products that meet interoperability standards recognized by the Secretary of HHS. These interoperability standards will be further defined in forthcoming guidance and may include interoperability specifications recommended by the Health Information Technology Standards Panel or specified in the Nationwide Health Information Network architecture standards, and interoperability standards recommended by the Certification Commission for Health Information Technology or other certifying bodies recognized by the Secretary.		

VIII. ~~.~~ PRIVACY, SECURITY AND ELECTRONIC TRANSACTIONS

A. Health Insurance Portability and Accountability Act (HIPAA)

~~APPLICANT MUST ATTEST 'YES' TO EACH OF THE FOLLOWING QUALIFICATIONS TO BE APPROVED FOR A PART C CONTRACT.~~ ATTEST 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	YES	NO
1. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Privacy of Individually Identifiable Health Information under 45 CFR Parts 160 and 164 subparts A and E.		
2. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Security Standards under 45 CFR Parts 160, 162 and 164		
3. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standard Unique Health Identifier for Health Care Providers under 45 CFR Parts 160 and 162.		
4. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Electronic Transactions under 45 CFR Parts 160 and 162.		
5. ~~Applicant agrees to transmit payment and remittance advice consistent with the HIPAA adopted ACS X12N 835, Version 4010/4010A1: Health Care Claim Payment and Remittance Advice Implementation Guide ("835").~~		
6. Applicant will report to CMS any unauthorized public disclosures of protected health information~~, within 48 hours of the Applicant's detection of such disclosure~~.		
7. Applicant agrees that it, and its subcontractors, shall not perform any activities under its Part C contract at a location outside of the United States without the prior written approval of CMS. In making a decision to authorize the performance of work outside of the United States, CMS will consider the following factors, including but not limited to:		

• The Applicant's/ subcontractor's compliance with, and the enforceability of, Part C program requirements concerning system security; • The Applicant's/subcontractor's compliance with and the enforceability of, Part C program requirements concerning information and data confidentiality and privacy; • The Applicant's/subcontractor's compliance with, and the enforceability of, other relevant Part C program requirements; • The Applicant's/subcontractor's compliance with, and the enforceability of, Part C corporate compliance plan requirements; • The Applicant's/subcontractor's compliance with, and enforceability of all laws and regulations applicable to work performed outside of the United States; and • The performance of the work outside of the United States is in the best interests of the United States.		

B. CMS Privacy And Security Requirement

ATTEST 'YES' OR 'NO' TO STATEMENT BELOW~~EACH OF THE FOLLOWING~~ BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	**YES**	**NO**
Applicant agrees, in accordance with forthcoming CMS guidance, it should contract with unrelated organization qualified to review and certify that the Applicant has developed and implemented systems, policies, and procedures sufficient to protect individual beneficiary information from unauthorized disclosure. Applicant agrees it should obtain re-certification from a qualified reviewer once every two years.		

END OF CHAPTER DOCUMENTATION

Organizational Chart of relationships of various departments

ORGANIZATIONAL AND CONTRACTUAL

(See Medicare Managed Care Manual Chapter 11)

I. LEGAL ENTITY & STATE AUTHORITY TO OPERATE - [422.400, 422.501, 422.503]

A. Provide information regarding how the applicant is organized under state law. If the applicant does business as dba 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 dba(s) in the Documents Section.

B. Provide the name the plan will use to market its Medicare product. Submit a completed State Certification form to document that the applicant entity is licensed under State law or otherwise authorized to operate as a risk bearing entity that may offer health benefits in the service area(s) for which it is requesting a MA contract. [This form is a separate file *cert.doc*; place a hard copy in the Documents Section].

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

D. List names, addresses, and telephone numbers of appropriate State regulatory officials who have authority over the applicant in the state(s) where the applicant operates. Include the actual state analyst(s) with whom the applicant works with on a routine basis.

E. Place a copy of the Articles of Incorporation, bylaws and other legal entity documentation and the Partnership Agreement in the Documents Section.

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

II. ORGANIZATIONAL AND FUNCTIONAL CHARTS

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

A. The applicant as licensed and organized under State law as a risk-bearing entity.

B. If the applicant is a line of business of a corporation, describe and diagram the relationship and show the line of business in relation to the corporation.

C. Show the relationship of the applicant’s legal entity that will hold the MA contract to the parent or subsidiary organization(s).

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

III. RISK SHARING - 422.208, 402.503

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.doc* Place a hard copy in the Documents Section]. [422.503]

IV~~VI~~. CONTRACTS FOR ADMINISTRATIVE/MANAGEMENT SERVICES - 422.504

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

B. If using a contracted network, describe each of the specific functions (health delivery and/or administrative) that are now or will be delegated to medical groups, IPAs, or other intermediate entities. Describe how the applicant will remain accountable for any functions or responsibilities that are delegated to other entities. Describe how the applicant oversee, and formally evaluate delegated functions.

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

D. Complete the administrative/management delegated contracting matrix (*matrixadm.doc)* for each delegated entity and include it in the Documents Section of the application.

V. PROVIDER CONTRACTS & AGREEMENTS - [422.114, 422.504, 422.520(b)]

A. The applicant should determine whether it will offer a Network or Non-network model PFFS plan. The applicant should also determine if it is paying providers for any category of service at the Original Medicare allowable payment rates under Medicare Part A or Part B. Please check one of the responses below and follow instructions for each response

( ) YES The applicant will be a Non-Network model PFFS product. Do not ~~complete~~ continue Section V~~I~~. Instead, describe the 'deeming process' 422.216 (f) and how providers will be paid. Include terms and conditions of payment.

( ) NO The applicant will be a network or partial network model PFFS product. Identify and complete the remainder of Section V~~I~~ 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.

Note: For purposes of simplicity in completing this application, the term "provider" means physicians, inpatient institutions and other ancillary practitioners. This definition departs from other Medicare definitions of "providers" (hospitals and other inpatient institutions, plus home health services) and "suppliers" (DME, provider, practitioners and other non-providers).

For this entire section, applicants must demonstrate that all contractual provisions extend to the level of provider who is actually rendering the service to Medicare beneficiaries and that all levels of contracts and/or agreements meet the CMS requirements. If subcontracts do not mention which insuring organization members will be served, explain how the contracted hospital, IPA, etc., advised its subcontractors about which insuring organizations are covered by subcontractor, e.g., which MA organization memberships will be served. ***[422.504(i)(4)(v)].***

~~***Note: For purposes of simplicity in completing this application, the term "provider" means physicians, inpatient institutions and other ancillary practitioners. This definition departs from other Medicare definitions of "providers" (hospitals and other inpatient institutions, plus home health services) and "suppliers" (DME, provider, practitioners and other non-providers).***~~

B. ~~There should be~~ ~~F~~full documentation of arrangements for health services in the requested service area(s) should be in place~~-~~ at the time ~~that~~ the application is submitted, and be available upon request. 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.

~~***Note: For purposes of simplicity in completing this application, the term "provider" means physicians, inpatient institutions and other ancillary practitioners. This definition departs from other Medicare definitions of "providers" (hospitals and other inpatient institutions, plus home health services) and "suppliers" (DME, provider, practitioners and other non-providers).***~~

~~**NOTE: For this entire section, applicants must demonstrate that all contractual provisions extend to the level of provider who is actually rendering the service to Medicare beneficiaries and that all levels of contracts and/or agreements meet the CMS requirements. If subcontracts do not mention which insuring organization members will be served, explain how the contracted hospital, IPA, etc., advised its subcontractors about which insuring organizations are covered by subcontractor, e.g., which MA organization memberships will be served.**~~ ~~***[422.504(i)(4)(v)].***~~ ~~**[422.505(i)(3)]. All signature pages must be identifiable and if**~~

~~**the provider cannot be identified by the signature page, then the first page of the contract and/or agreement along with signature page should be sent.**~~

1. Complete "Provider Arrangements" Table - For each proposed service area or distinct delivery system(s) applicant should insert ~~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 in the MA Application Guidelines.]

2. 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.

3. Provide the signature pages and an alphabetical listing of contracted providers for each of the major provider(s) from actual contract(s) and /or agreement(s) with these provider entities (i.e., IPAs, medical groups, PHOs or similar entities and hospitals); place in the Documents Section.

VI. BUSINESS INTEGRITY

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

B. The 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 42 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. **Yes____ or No ___**

C. List any past or pending, if known, investigations, legal actions, or matters subject to arbitration 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. The applicant agrees ~~will be required~~ to provide financial and organizational conflict of interest reports to CMS, pursuant to instructions to be issued by CMS.
Yes___ or No_____

VII. COMPLIANCE PLAN - [422.503]

A. Describe the applicant's internal compliance plan. Submit a copy of the applicant's compliance plan by placing it in the Documents Section.

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

END OF CHAPTER DOCUMENTATION

1. Organizational and Functional chart of the applicant.
2. Organizational Chart between Corporation and Applicant
3. Compliance Plan and Compliance Program
4. Chart of Contractual Relationship with other entities
5. Terms and Conditions of Payment for Non Network Model PFFS plans
6. Organization Chart of applicant and parent/~~subsidary~~subsidiary

HEALTH SERVICES DELIVERY

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

Determine whether an applicant is a Network or Non-network model PFFS plan. The answer to the following question will determine network or non-network: 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 – This is a Non-Network model PFFS plan. Do not complete item B-D under Section I. Do not complete Sections II and III. Instead, describe the 'deeming process' (422.216 (f)) and how providers will be paid. Include a copy of the terms and conditions of payment.

( ) NO – This is a network or partial network model PFFS plan. Identify and complete for those categories of service for which the applicant will be paying less than the Medicare allowable payment rates Sections I, II and III.

I. HEALTH CARE PROVIDERS -
Physician Services, Hospital Admitting Privileges – [422.114]

If the applicant pays providers less than the Medicare allowable payment rates:

A. Describe the health services delivery system through which the applicant will furnish covered Medicare services.

B. Complete the tables' *matrix1.doc* and place a hard copy in the Documents Section.

C. Complete HSD-1 Table, County Summary of Providers by Specialty. [Complete this table in its file and place a hard copy in the Documents Section.]

D. Please address whether the applicant will use the same delivery systems of providers for each requested MA plan. If not, clearly delineate variations in the networks.

Explain how the applicant 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 applicant 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.

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

II. LOCATIONS OF HEALTH SERVICES PROVIDERS - [422.114]

Complete HSD-2 Table, Provider List – List of Physicians and other Practitioners by County. Submit Microsoft electronic Excel spreadsheet format (electronic copy) only, not in hard copy. [Complete this table in its file on the disk.]

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.]

III. MEDICARE HEALTH BENEFITS - [422.101]

A. 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.]

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

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

D. Describe how the MA applicant 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. [422.112]

IV. PROCEDURES FOR BILLING AND PAYMENT (Reimbursement Grid)

A. Describe the billing and payment process for all categories of Medicare Part A and Medicare Part B services and any additional services offered. Please include:

Who will bill the plan and to whom will the plan make payment (e.g., the enrollee and/or the provider)?

Procedures should also address when the provider bills the plan directly versus when members will be liable to pay providers, before being reimbursed by the plan.

Provide a copy of the applicant's Reimbursement \Grid in the documents section.

Describe Provider Education Strategy for all provider types.

B. Describe the mechanism by which the applicant will notify CMS of violations of the limits on charges to plan enrollees by non-contracting or deemed providers.

C. Describe the process by which the applicant will make available the terms and conditions of plan payment to all providers in a category of service. Provide a copy of the terms and conditions for review by CMS in the documents section. (Note: The payment terms and conditions are subject to ongoing review by the Regional Office).

D. Describe the mechanism the applicant will use to enforce the limits on charges by contract providers (including deemed contractors) to plan enrollees.

E. Describe any preauthorization procedures (if applicable) or other requirements for coverage that the applicant proposes.

F. Describe the applicant's provider dispute resolution process.

V. HEALTH SERVICES MANAGEMENT

((Section A is applicable to both network and non network PFFS model plans. Sections B & C are applicable to network PFFS model plans. Section C.1 is not applicable to non-network PFFS model plans.)
~~(Areas of this section are applicable to both network and non network PFFS model unless otherwise noted)~~

A. Service Management

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

2. Describe and provide policies for ensuring that health services are provided in a culturally competent manner to enrollees of different backgrounds.

B. Service Authorization

Describe the applicants 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.

C. Practice Guidelines

1. Describe how the applicant ensures compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicare or Medicaid. [422.204]

2. Describe procedures, if any, 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 applicants written protocols for utilization review in the Documents Section. [422.152(e)(3)]

D. Enrollee Health Records and Confidentiality – [422.118]

1. How does the applicant 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 applicant assure that enrollees will have timely access to records and information that pertain to them?

4. Describe the applicant's 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.

6. Encounter Data – [422.257]

- Describe how the applicant meets (or will meet) CMS requirements on the electronic submission of encounter data regarding the following:

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

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

VI. QUALITY IMPROVEMENTS INITIATIVES

PFFS applicants are exempted from the majority of QI requirements, however, they must meet the following requirements:

- Maintain health information systems
- Ensure information from providers is reliable and complete
- Make all collected information available to CMS
- Conduct quality internal reviews
- Take corrective action for all problems that come to the applicant's attention

Describe how the applicant will meet the above quality improvement initiatives.

MEDICARE

(See Medicare Managed Care Manual Chapters, 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 Medicare product
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 persons
9. Marketing representative oversight and training on CMS Medicare Marketing guidelines
10. All open enrollment periods for each MA plan, including the initial coverage election period; the mandatory annual election period; and any special election periods
11. Standard and fast track appeal notices

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 applicant expects to begin enrolling Medicare members.

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, 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?

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

5. Describe the process for receiving and acting upon membership notifications from CMS.

6. Retroactive payment adjustments

III. CLAIMS

Note: PFFS plans must demonstrate compliance with 422.114 - Access to services under an MA PFFS plan. In non-network PFFS models, the access requirement is met, when a PFFS plan chooses to pay each a particular category of health care providers' payment rates that is not less than the rates that apply under original Medicare for the provider in question. To demonstrate the ability to pay claims on a Fee-For-Service (FFS) basis, all PFFS applicants submit a reimbursement grid for approval by CMS and must validate a claims system that pays FFS rates accurately and on a timely basis.

A. Reimbursement Grid

All PFFS applicants must submit an electronic and hard copy of the Reimbursement Grid to CMS for approval. Applicants must provide in the Documents Section a grid that outlines how the applicant will be paying each category of health care provider for Medicare benefits. A link to the CMS MA payment document is: http://www.cms.hhs.gov/healthplans/rates/out-of-network/default.asp or contact Mervyn John at (410) 786-1141.

B. Claims System - Validation

The applicant can validate the claims systems in the following ways:

1. Maintain a current claims system that has been previously tested by CMS and has demonstrated the ability to pay Medicare FFS payments (for example, using a third party claims administrator that CMS has tested previously); or

2. Utilize a claims system that has been CMS approved for a PFFS product; or

23. Validate the applicant's claims system – Provide in the Documents section reports and/or narrative that clearly substantiates the process used by the applicant to test the claims system that will be paying PFFS claims. This documentation must demonstrate the ability to accurately pay providers of all Medicare services an amount not less than the amount the providers would

receive under Original Medicare. In addition, the PFFS applicant must agree to:

a. Sign an Attestation to the PFFS Contract indicating that applicant has in place the necessary operational claims systems, staffing, processes, functions etc. to properly institute the Reimbursement Grid and pay all providers of Medicare services an amount not less than Original Medicare; (See copy at the end of this chapter) and

b. Upon request the applicant will submit complete and thorough Provider Dispute Resolution Policies and Procedures (P&Ps) with the application to address any written or verbal provider dispute/complaints, particularly regarding the amount reimbursed. This P&P must be extremely clear in all provider materials. The applicant must submit how it is integrated into all staff training – particularly in Provider Relations, Customer Service and in Appeals/Grievances; and

c. Upon request the applicant will submit a biweekly report, to the CMS Regional Office plan manager, data which outlines all provider complaints (verbal and written), particularly where providers or beneficiaries question the amount paid for six months following the receipt of the first claim. This report will outline the investigation and the resolution including the completion a CMS designed worksheet; and

d. Upon request the applicant will submit a biweekly report to the CMS Regional Office plan manager, data which outlines all beneficiary appeals and/or complaints (verbal and written) related to claims for the six months following the receipt of the first claim. This report will outline the investigation and the resolution including the completion ofa CMS designed worksheet.

NOTE: Should the data indicate that the MA applicant offering the PFFS plan is not meeting the access requirements as outlined above, CMS may institute a Claims Payment test, a Corrective Action Plan requiring the MAO to come into compliance and/or move to the initiation of Enforcement Actions as provided in 422.752.

All PFFS applicants must answer the following sections regardless of which option is chosen for Validation of Meeting Access Standards.

C. Describe the claims processing workflow and who is responsible for each stage of the process. Include a flow chart and all Policies and Procedures of this process and place at the end of this chapter.

D. Provide a list of 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 applicant's ability to document interest payment requirements on claims, which are not paid on a timely manner.

Answers to the following questions are needed if the applicant is paying providers payment rates that are equal to or greater than the rates that apply under Original Medicare (Non-network PFFS plan and network plans):

1. Describe in detail the system in place that allows the applicant to obtain payment information for any Medicare approved provider throughout the nation.

2. Provide an electronic and hard copy of the PFFS applicant's Terms and Conditions in the Documents Section that will be made available to potential providers.

3. Describe how providers will be able to access the terms and conditions.

4. Will providers be allowed to balance bill the beneficiary? If balance billing is allowed, describe the organizational requirements and processes. Include all communications to beneficiaries and providers. Provide Policies and Procedures and how the plan will inform the beneficiaries and providers of this requirement. Provide the Policies and Procedures in the Documents Section.

5. How will the applicant monitor the amount collected by non-contracted providers to ensure that these amounts do not exceed the amounts permitted to be collected under law?

6. How will the applicant provide to enrollees an appropriate explanation of benefits for each claim filed by the enrollee or provider? The explanation must include a clear statement of the enrollee's liability for deductibles, coinsurance, co-payment and balance billing. Describe and attach a copy.

7. Describe the provider payment appeal process. Provide a flow chart, Policies and Procedures, education materials, etc., of this process.

IV. ENROLLEE RIGHTS AND RESPONSIBILITIES

(Areas of this section may be applicable to both network and non-network PFFS model)

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

B. Explain how the applicant will handle Medicare reconsideration and appeals procedures, including expedited determinations and expedited reconsideration.

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

C. Provide the applicant's policies and explain projected procedures for implementing those 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 the 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 the applicant will ensure the following:

1. The applicant will handle Medicare enrollees' privacy with regards to each enrollee being treated with respect and dignity including the protection of any information that identifies a particular enrollee.

2. The applicant will ensure the confidentiality of health and medical records enrollees. [422.118(a)]

3. The applicant 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 applicant 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)(9)]

5. The applicant will ensure that enrollees participate in decision-making regarding their health care and if unable to do so, the applicant will provide information to the enrollees' representative to facilitate care or treatment decision when the enrollee is unable to do so. [422.206(b), 422.128(a), 422.128(b)]

6. The applicant will ensure that the enrollee will receive information on available treatment options (including the option of no treatment) or alternative sources of care. The 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)]

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

8. The applicant will ensure prompt resolution of issues raised by the enrollee, including complaints or grievances and issues relating to authorization, coverage or payment for services. [422.118(d)]

D. Describe how the applicant will ensure that the following enrollee information is received at the time of enrollment and at least annually thereafter, a written statement including 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 applicant 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 applicant will ensure that all enrollee information 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 applicant 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 applicant 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)]

5. The applicant will ensure the right to access emergency health care services is consistent with the determination of the need for services by a prudent layperson. [422.113]

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

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

8. The applicant will provide for enrollees' disenrollment rights and responsibilities. Explain how the applicant will provide to the enrollee upon request any disclosures. [422.111(b)(10), 422.111(c)(1-5)]

E. For each of the following describe the applicant'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), 422.152(c), 422.562(a)(I), 422.562(a)(ii)]

Explain how the applicant will ensure the following:

1. The applicant will ensure that it follows its own written procedures for processing all issues raised by enrollees.

2. The applicant will implement procedures (with clearly explained steps and time limits for each step) for the resolutions of a compliant or grievance by enrollees. [422.564(a)(1), 422.564(a)(2), 422.564(b)(1)]

3. The applicant will implement procedures, (That clearly explain steps and time limits for each step) for reviewing coverage and payment requests for reconsideration of initial decisions that the applicant chooses not to provide or pay for a particular service. [422.564(b)(4), 422.564(b)(iii)]

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

F. Patient self-determination Act - Explain the applicant'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 applicant interference with health professional advice to enrollees regarding enrollees' care and treatment options.

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

V. MORAL OR RELIGIOUS EXCEPTION - [422.206(b)]

If the applicant is requesting an exception to covering a particular counseling or referral service due to moral or religious grounds, provide the diagnostic/procedure codes for the requested service(s)~~state the service,~~ and explain the reasons for the request.

VI. MEDICARE MARKETING MATERIAL - [422.80]

Definition: 422.80(b)

Marketing materials include any applicable informational materials targeted to Medicare beneficiaries which:

(1) Promotes the applicant, or any plan offered by the applicant;
(2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in an MA plan offered by the applicant;
(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 are not required to be submitted with the application or approved prior to the contract being awarded. However, before an applicant can market or advertise its Medicare products the applicant 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 Applicable Medicare Managed Care Manual Chapters.

- Subscriber agreement/Evidence of coverage
- Member handbook
- Application form
- Disenrollment form
- Membership card
- Brochures/Advertising materials
- Radio/TV scripts
- All letters, 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 applicant 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 (NODMAR); Notice of Medicare Non-Coverage (NOMNC) and 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. Reimbursement Grid and Policy and Procedures for quarterly updates to CMS.
2. Substantiation of claims system capabilities to pay claims – Flow chart of claims processing workflow with responsibility outlined
   a. Narrative on how the test process was conducted to pay all PFFS claims
   b. Provide five actual test claims as examples for each provider type with a results report for each provider type.
   c. Describe the plan's evaluation process (how did the plan determine the amount was accurate to FFS payments), discrepancies noted and corrective actions taken.
   d. Policies and Procedures on payment processes for all provider types represented in the Reimbursement Grid. Describe edits used.
   e. List of Claim denial codes and reasons
   f. List of Public Use Files accessed and loaded into the claims system.

3. Terms and Conditions of Payment for Non Network Model PFFS plans
4. Provider Dispute Resolution Policies and Procedures
5. All Provider education materials
6. Policies and Procedures for Balance Billing
7. Copies of Beneficiary and Provider notifications of payments (Explanation of Benefits and Payment Advice)
8. Diagnostic and/or Procedure codes for Moral and Religious Exception

~~8. All Marketing Materials~~

ON SITE DOCUMENTS

1. Policy and Procedure Manuals for claims processing, appeals, enrollment, provider relations, reimbursement
2. Staffing plans for all operational areas.
3. Provider appeal flowchart

FINANCIAL

I. FISCAL SOUNDNESS – [422.502 (f) (1)]

A. Please provide a copy of your most recent independently certified audited statements. (An applicant 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 applicant will maintain a fiscally sound operation and will notify CMS in writing if it becomes fiscally unsound during the contract period.

2. The applicant 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 applicant cannot attest to this compliance, a written statement of the reasons must be provided.**

ATTACHMENT D

CERTIFICATION OF CLAIMS PAYMENT SYSTEMS RELATING TO THE MEDCARE ADVANTAGE ORGANIZATION'S ABILITY TO PAY PROVIDER CLAIMS ACCURATELY ON A FEE-FOR-SERVICE BASIS

Pursuant to the contracts(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MEDICARE ADVANTAGE ORGANIZATION), hereafter referred to as the Medicare Advantage Organization (MAO), governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE),hereby makes the following certification to CMS. The MAO acknowledges that the information described below is accurate, complete and truthful and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MAO has an operational claims payment system that is duly tested, and has the ability to pay providers rates that are not less than rates that apply under original Medicare for the provider in question. For services that currently have no Medicare fee schedules, the MAO will pay providers rates that CMS has approved on the MAO's reimbursement grid.

_____

(INDICATE TITLE [CEO, CFO, or delegate])

On behalf of

_____

(INDICATE MA ORGANIZATION)

PART D PRESCRIPTION DRUG BENEFIT – [422.252]

Note: PFFS plans are not required to offer the Part D drug benefit. MSA plans may not offer the Part D drug benefit.

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, the applicant 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 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 the applicant may contact Marla Rothouse at 410/786-8063. Specific instructions to guide MA applicants 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 applicants 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.