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.

2008

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:

APPLICANT'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 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 11)

I. SUMMARY TABLE

A. Complete the summary 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	

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. HPMS ACCESS AND PAYMENT FORM 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 CMS 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. 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 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. 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?

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

IV. KEY MANAGEMENT STAFF - 422.503

A. Indicate below 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			
Medicare Compliance Officer			
Quality Director			

B. In the Documents part, provide position descriptions 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.

V. COMMUNICATION WITH CMS AND MANAGEMENT INFORMATION SYSTEMS - 422.504

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

B. Describe the use of the MIS for day-to-day management as it will apply to Medicare products operations and long-term planning of the key organizational functions.

VI. HEALTH INFORMATION TECHNOLOGY

. ATTEST 'YES' OR 'NO' TO THE STATEMENT BELOW BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	YES	NO
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.		

VII. PRIVACY, SECURITY, AND ELECTRONIC TRANSACTIONS

A. Health Insurance Portability And Accountability Act (HIPAA)

ATTEST 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS BY PLACING A CHECKMARK IN THE RELEVANT COLUMN IN HPMS:	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.		
6. Applicant will report to CMS any unauthorized public disclosures of protected health information.		
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 THE STATEMENT BELOW BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	YES	NO
Applicant agrees, in accordance with forthcoming CMS guidance, it		

should contract with an 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

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

ORGANIZATIONAL AND CONTRACTUAL

(See Medicare Managed Care Manual Chapters 10 and 11)

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 & STATE AUTHORITY TO OPERATE - 422.400, 422.501, 422.503

A. Provide information regarding how the applicant entity is organized under state law in each state in the Regional service area(s). If the applicant does business as dba or uses 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. 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.

C. 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 in the event of insolvency.

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

E. 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].

F. 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 applicant once deemed an eligible MA Regional PPO Plan.

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. 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 as 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 diagram 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.

IV. RISK SHARING - 422.208, 422.503

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 applicant 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 if approved [This table is a separate file; legal 1.doc. Place a hard copy in the Documents Section]. 422.503

V. CONTRACTS FOR ADMINISTRATIVE / MANAGEMENT SERVICES - 422.504

A. Describe the MA Regional PPO Plan applicant's relationships with related entities, contractors and sub-contractors with regards to 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 applicant will remain fully accountable for any functions or responsibilities that it delegates to other entities. Describe how the applicant 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 Section].

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

NOTE: For purposes of simplicity and completing this application, the term "provider" means physician, inpatient institutions and other ancillary practitioners, including DME suppliers, etc. For this section, applicants must demonstrate that all of the contractual provisions contained in the MA contract extend to the level of provider who is 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 organization members will be served and under what terms [422.504(i)(4)(v)].

Full documentation of arrangements for health services in the requested MA Region or Regions should be in place at the time the application is submitted, and be available upon request. 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 insert the number or provider contracts and/or arrangements. 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 can be found in the MA Application Guidelines].

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.]

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.

VII. 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. 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. 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. **Yes___ or No___**

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 agrees to provide financial and organizational conflict of interest reports to CMS pursuant to instructions to be issued by CMS. **Yes___ or No___**

VIII. COMPLIANCE PLAN - 422.503

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

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 organization.

END OF CHAPTER DOCUMENTATION

1. Organizational Chart of the Applicant Entity
2. Organizational Chart Indicating Relationship between Corporation and Regional PPO Plan applicant
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, 2007 my 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 applicant offering a Regional PPO product that intends to contract with CMS starting January 1, 2008.**

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 my 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 applicant offering a Regional PPO product that intends to contract with CMS starting January 1, 2008.**

HEALTH SERVICES DELIVERY

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

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 B 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 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. 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 applicant 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 the 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 applicant 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 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 applicant ensure that the enrollee receives access to medically necessary specialty care? [422.112(a)(2)]

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

8. Explain how and under what circumstances the applicant 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 applicant 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 the 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 the 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 the 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 applicant 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 the 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 the 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 the 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'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 applicant. 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 applicant 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 applicant'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 applicant 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 applicant 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 applicant’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. Risk Adjustment Data- 422.310

1. Describe how the MA Regional PPO applicant 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.

SOLICITATION FOR SPECIAL NEEDS PLAN PROPOSAL

Under the MMA (Section 231), Congress provided an option for Medicare Advantage (MA) coordinated care plans to limit enrollment to individuals with special needs. "Special needs individuals" were identified by Congress as: 1) institutionalized beneficiaries; 2) dually eligible; and/or 3) beneficiaries with severe or disabling chronic conditions as recognized by the Secretary. Authority to offer a Special Need Plan (SNP) ends on January 1, 2009.

Organizations that intend to offer SNPs must provide a proposal to CMS that includes information as prompted below for each type of SNP the organization intends to offer. This solicitation for SNP proposals is divided into the following sections:

I. GENERAL GUIDANCE ON COMPLETING SNP PROPOSAL

The applicant must follow the step by step instructions in Section IV to propose the type of SNP the applicant intends to offer. Sections IV. A. B. and C. offer prompts for each SNP type. If the applicant is seeking approval for more than one type of SNP, then the template for the proposal should be completed for each of those types. The applicant's responses should be provided

within the Section IV template and within all applicable attachments. The responses to the template as well as the attachments and the documentation for the State and long term care contract should all be in a single Microsoft word document. Documents requested in the template, such as copies of contracts, forms and signature pages should be added to the end of the template Microsoft word document as attachments as text or scanned into the document as a picture or as text. The end result should be only one electronic file should be submitted to CMS for a SNP proposal, which contains all the required data and information.

A SNP proposal responding to this solicitation for the next contract cycle beginning January 1, 2008 WILL NOT be considered by CMS unless the solicitation is submitted by the deadline for MA applications. The application deadline is March 12, 2007. Late proposals, including additional requests when a certain SNP type (for example, any additional proposed dual eligible subsets), WILL NOT be accepted after the MA application deadline. Other associated MA and Part D applications must also be provided; see Section II for instructions on what other applications may be required.

If the applicant has questions about the SNP program or about completing this proposal, please send an e-mail to the following address: MA_Applications@cms.hhs.gov. To ensure that the applicant's question is forwarded to the appropriate CMS staff, the subject line of the e-mail must include the phrase "SNP Proposal" and must also include the applicant name and CMS contract number(s).

II. REQUIREMENTS TO SUBMIT A SNP PROPOSAL -- MA AND PART D APPLICATIONS MAY ALSO BE REQUIRED

A. Seeking New Medicare Coordinated Care Plan (CCP) Contract that Includes SNPs

Organizations that do not have a current CCP contract with CMS must complete the full Coordinated Care Plan (CCP) MA application in order to offer a Special Needs Plan (SNP). The application is posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/. In addition, an applicant must offer Part D under the SNP products, and must file the appropriate Part D application. The Part D applications are posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/ and click on "Application Guidance.

The MA application should be submitted as described in the MA application guidelines. The Part D application should be submitted per the instructions provided in the Part D application. When the MA application includes a SNP proposal(s), the applicant must make two (2) additional paper hard copies of the MA application cover page and the SNP proposal(s) in the MA application. In addition to the hard copies, the applicant must make three (3) CD electronic copies of the complete SNP proposal(s). The applicant may submit multiple SNP proposals under a given CMS contract number on a CD. All electronic copies must be submitted as Microsoft word files. The applicant must place an external label on each CD using the label format "Hxxxx_SNP", where Hxxxx is the CMS assigned contract number. The applicant must place the hard copies and CDs in a separate envelope labeled with the organization name and CMS assigned contract number. The separate envelope containing the SNP proposal(s) must be

included as part of the applicant's MA application submission which is mailed to the following address:

Mail two (2) paper hard copies and three (3) CDs for the SNP proposal(s) along with the MA application as instructed in the MA application to:

Center for Beneficiary Choices/MAG/DQPM
Mail Stop C4-22-04
7500 Security Blvd.
Baltimore, MD 21244

B. Adding SNPs under Existing Medicare CCP Contract – Service Area Unchanged

An applicant may propose offering a SNP type not already approved by CMS under an existing Medicare CCP contract, wherein the service area of that contract will be unchanged. A SNP proposal must be submitted in those circumstances. For example, if the applicant is seeking to offer a SNP to serve a specific subset of dual eligibles in coordination with a State Medicaid contract and that subset has not been previously approved by CMS, then a SNP proposal requesting such subset must be submitted to CMS. Similarly, if a dual eligible SNP has previously been approved and the applicant intends to offer a chronic or institutional SNP not previously approved, then a SNP proposal must be submitted to CMS for each SNP type for which prior CMS approval has not been granted. The applicant MUST complete the SNP portion of the MA application for each subset requested. The MA applications are posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/.

When an applicant seeks to add a SNP to its current service area under an existing MA contract, it must also offer prescription drug coverage under Part D. If the applicant already offers Part D along with its Medicare Advantage product in the current service area, it does not need to file a new Part D application. It must maintain its prescription drug coverage by submitting a formulary and bid. If Part D coverage is not part of the applicant's MA contract, the appropriate Part D application must be completed and submitted per the instructions provided in the Part D application by March 12, 2007. The Part D applications are posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/ and click on "Application Guidance.

The SNP proposal must be completed and submitted to CMS as instructed below. The applicant must submit three (3) paper hard copies of each SNP proposal, containing the cover page of the MA contract, the cover page of the CCP application and the SNP portion of the CCP application to CMS. Two (2) complete copies must be delivered to the CMS central office and one (1) complete copy must be delivered to the applicant's CMS regional office. In addition, the applicant must submit three (3) CD electronic copies of the complete hard copy SNP proposal to the CMS central office. All electronic copies must be submitted as Microsoft word files. The applicant must place an external label on each CD using the label format "Hxxxx_SNP", where Hxxx is the CMS assigned contract number. The applicant must place the hard copies and CDs in an envelope labeled with the organization name and CMS assigned contract number.

Mail two (2) paper hard copies and three (3) CDs to:

Center for Beneficiary Choices/ MAG/DSP
Mail Stop C4-22-04
7500 Security Blvd.
Baltimore, MD 21244

Mail one (1) paper hard copy to the CMS Regional Office responsible for the applicant's contract.

C. Adding SNPs under Existing CCP Contract – Service Area Changing

An applicant may expand its service area under an existing MA contract and seek to offer a SNP in the expanded service area. To do this the applicant must complete a service area expansion (SAE) application for MA contracts. The MA applications are posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/. In addition, if the applicant does not currently offer prescription drug coverage in the service area to be covered under the contract number then, the applicant must also file the appropriate separate Part D application. The Part D applications are posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/ and click on "Application Guidance.

In addition to following the directions under the MA and Part D SAE application, if the applicant is seeking a SNP in a new service area AND intends to offer a SNP in its current service area and presently does not have CMS' approval for the type of SNP intended for the current service area, the applicant must submit the SNP proposal within the MA SAE application. The SNP proposal should include the entire service area to be served by the SNP as instructed Section IV.

The SAE application should be submitted as described in the MA application guidelines.

When the SAE application includes a SNP proposal(s), the applicant must make two (2) additional paper hard copies of the SAE application cover page and the SNP proposal(s) in the SAE application. In addition to the hard copies, the applicant must make three (3) CD electronic copies of the complete SNP proposal(s). The applicant may submit multiple SNP proposals under a given CMS contract number on a CD. All electronic copies must be formatted as Microsoft word files. The applicant must place an external label on each CD using the label format "Hxxxx_SNP", where Hxxxx is the CMS assigned contract number. The applicant must place the hard copies and CDs in a separate envelope labeled with the organization name and CMS assigned contract number. The separate envelope containing the SNP proposal(s) must be included as part of the applicant's SAE application submission which is mailed to the following address:

Mail two (2) paper hard copies and three (3) CDs for the SNP proposal(s) along with the MA application to:

Center for Beneficiary Choices/MAG/DQPM

Mail Stop C4-22-04
7500 Security Blvd.
Baltimore, MD 21244

D. Procedure for Minimizing Duplication, Including Across Multiple MA-PD Contracts

There are at least three circumstances in which there could be duplicate information in the applicant's proposal if it were required to provide an individual SNP approval request for each SNP it wishes to offer. These are listed below with instructions for how this duplication can be minimized. Only these specific instructions can be followed to minimize duplication. Any other approach will not be accepted by CMS.

1. A request is made for approval of multiple SNPs under a single contract across some combination of dual eligible, institutional and severe or disabling chronic condition SNPs.

Instruction: Each section of the template must be completed in its entirety. For multiple requests within a type of SNP follow instructions under 2. below.

2. A request is made for approval of more than one targeted population within a SNP type under the same contract. Examples include all dual, full duals only and Medicaid subset; institution and community based institutional beneficiaries in separate SNP; and different chronic diseases each in separate SNPs.

Instruction: Within Section IV. A, B, and C, follow the instructions imbedded in the template that allow certain elements not to be repeated if they are the same in other populations defined under the same Section IV. A, B, or C. To summarize, for each population, the applicant may copy the template but only provide the elements where there is a change, rather than provide complete responses for each SNP request.

3. A request is made under multiple MA-PD contracts for one or more SNPs. The applicant may follow the instructions below rather than provide multiple complete responses for every SNP request.

Instructions for Completing the SNP Solicitation for Proposals Across Multiple MA-PD Contracts

If the applicant is requesting, under multiple MA-PD contracts, a uniform SNP Model of Care for any of the three SNP types – for dual, institutional, or severe or disabling chronic condition individuals, then the applicant may submit a SNP type-specific baseline proposal to CMS and consolidate the applicant's responses on all SNP plan requests related to that baseline SNP proposal.

For the purpose of the SNP solicitation and understanding how to consolidate responses under a SNP proposal, a "plan" is a unique combination of a targeted population and Model of Care, as defined in Section III under MA contract number. For example, as instructed in Section IV, if an

organization under contract H9999 intends to offer a full dual SNP and a further subsetted dual SNP, then the applicant would be requesting two dual SNPs under H9999, and these "plans" would be labeled as follows (and as instructed in Section IV of the SNP solicitation): H9999_ A_Plan_1, and H9999_A_Plan_2, where A represents a dual eligible SNP request..

The baseline proposal must contain SNP Model of Care information common to all SNP plans of a specific type (i.e., dual, institutional, or severe or disabling chronic condition) as prompted in Section IV. In addition, the applicant must submit supplemental addendums for each requested SNP plan of the particular type (i.e., dual, institutional, or severe or disabling chronic condition) along with the baseline proposal. The addendum would contain a discussion of those elements in Section IV for which the applicant determines the complete answer deviates from the baseline proposal. For selected elements in Section IV, the applicant is required to provide complete information in the same supplemental addendum for each plan of that SNP type, regardless of whether it reflects any duplication. Finally, along with the baseline proposal the applicant must provide a table that crosswalks each contract and plan number (as numbered in Section IV) indicating with a check mark those elements in Section IV that deviate from the baseline proposal.

This consolidated response and the crosswalk must be completed separately for each SNP type (i.e., dual, institutional, or severe or disabling chronic condition). For example, if across multiple contracts the applicant requests both dual and institutional SNPs, then the applicant would provide two consolidated proposals, one for dual and one for institutional SNPs. The only alternative would be to complete a SNP proposal for each contract as Section IV directs.

The specific steps that must be followed to submit a consolidated SNP proposal across multiple contracts are:

Step 1: The baseline SNP proposal is the applicant's description of the basic Model of Care used for multiple SNPs of a selected type (i.e., dual, institutional, or severe or disabling chronic condition). Develop the baseline SNP proposal(s). This is the document that provides all the detailed information on the SNP type and Model of Care requested by CMS in the "Solicitation for Special Needs Plan Proposal" as follows:

- Dual SNP: Section IV, A.2, A.5, A.7 through A.9
- Institutional SNP: Section IV, B.2, B.2.c,B.2.d, B.4, B.6.a through B.9
- Chronic SNP: Section IV, C.2, C.4, C.6 through C.8

For those elements required by CMS for each SNP plan, the baseline proposal should reference "see supplemental addendum for specific SNP plan". Those elements include number assignments for each SNP type, relationship to State Medicaid services in the event of subsets, State contracts information if other than subsets, and service area. The specific location of these elements is as follows:

- Dual SNP: Section IV, A.1, A.3, A.4, A.6.
- Institutional SNP: Section IV, B.1, B.3 and B.5
- Chronic SNP: Section IV, C.1, C.3, C.5

Step 2: Develop a supplemental addendum for each SNP plan covered under the baseline SNP proposal. The supplemental addendum is information pertaining to the specific SNP plan. The SNP plan name should be in the following format: CMS contract number, type of SNP code (A = dual, B = institutional, and C = severe or disabling chronic condition), Plan, X (where "X" is the number of the SNP plan in the SNP proposal), with an underscore between each element (Hxxxx_X_Plan_X). An example is "H9999_A_Plan_1". Two types of information must be provided. For the following elements modify or replace information that is different from the baseline SNP proposal:

- Dual SNP: Section IV, A.2, A.5, A.7 through A.9
- Institutional SNP: Section IV, B.2, B.2.c,B.2.d, B.4, B.6.a through B.9
- Chronic SNP: Section IV, C.2, C.4, C.6 through C.8

For the following elements a complete answer must be provided for each SNP plan regardless of possible duplication:

- Dual SNP: Section IV, A.1, A.3, A.4, A.6.
- Institutional SNP: Section IV, B.1, B.3 and B.5
- Chronic SNP: Section IV, C.1, C.3, C.5

To provide this information, complete Section IV A, B or C and copy the template as many times as there are requests within a Section A, B, C. Except for required responses for each SNP plan, only elements that are different from the baseline proposal should be represented.

Step 3: Complete one crosswalk for each baseline SNP proposal (i.e., dual, institutional, or severe or disabling chronic condition), listing each contract/plan number combination associated with the baseline SNP proposal as demonstrated below. Provide the following information:

1. Applicant's contracting name (as provided in HPMS)
2. Date submitted to CMS
3. Name of the baseline SNP proposal. The baseline name should be in the following format: CMS contract number, type of SNP code (A = dual, B = institutional, and C = severe or disabling chronic condition), Baseline, X (where "X" is the number of the baseline SNP proposal), with an underscore between each element. An example is "H9999_A_baseline_1".
4. For each SNP plan covered by the baseline SNP proposal
   a) Contract number (provided by HPMS)
   b) Plan number (as required in Section IV of the SNP solicitation, for example A_Plan_2)
   c) Check all elements that deviate from or provide additional information relative to the baseline SNP proposal. All checked elements must be addressed in the supplemental addendum for the specific SNP plan. CMS requires a complete response in the addendum for those elements that are

pre-checked in the template crosswalks provided in Attachment F. The crosswalks must be used in the format and structure provided.

Step 4: *Paper Hard Copies*- The applicant must submit three (3) complete paper hard copies for each SNP baseline proposal, its related plan addendums and the plan to baseline crosswalk to CMS. A separate copy must be submitted for each SNP baseline proposal, which includes the crosswalk. A separate copy must be submitted for each plan addendum, which includes all documents relating to the specific plan. Two (2) complete copies must be delivered to the CMS central office and one (1) complete copy must be delivered to the applicant's CMS regional office.

Electronic Copies **- In addition to submitting the hard copy packages, the applicant must submit (3) complete electronic copies of each packages to CMS central office. A separate electronic file must be submitted for each SNP baseline proposal, which includes the crosswalk. A separate file must be submitted for each plan addendum, which includes all documents relating to the specific plan. All electronic copies of the baseline proposals and addenda must be in Microsoft word format.**

The filename of the SNP baseline proposal must be the same as the SNP baseline name as outlined in Step 3 above. The baseline filename should be the CMS contract number, type of SNP code (A = dual, B = institutional, and C = severe or disabling chronic condition), baseline, X (where "X" is the number of the baseline SNP proposal), with an underscore between each element. An example is "H9999_A_Baseline_1".

The filename of each plan addendum must be the same as the plan addendum name as outlined in Step 2 above. Each filename should be in the following format: CMS contract number, type of SNP code (A = dual, B = institutional, and C = severe or disabling chronic condition), Plan, X (where "X" is the number of the SNP plan), with an underscore between each element (Hxxxx_X_Plan_X). An example is "H9999_A_Plan_1".

All electronic files are to be submitted on CDs. The applicant must submit each SNP baseline proposal, including the crosswalk, and related plan addenda on a single CD. The applicant may submit multiple SNP baseline proposals and related plan addenda on the same CD provided each SNP baseline proposal and its related plan addenda are placed in sub-directories on the CD using the name of the SNP baseline proposal as the sub-directory. The CD must have an external label which at a minimum has the applicant's contracting name and SNP baseline proposal name(s).

NOTE to Applicant: CMS will not accept consolidated proposals across contracts under any other format. The only other alternative is to complete a SNP proposal for each MA-PD contract.

Mail two (2) hard copy packages of each baseline proposal and related addenda, as well as three (3) CDs for each package (unless sub-directories are used) to:

Center for Beneficiary Choices/ MAG/DSP
Mail Stop C4-22-04
7500 Security Blvd.
Baltimore, MD 21244

Mail one (1) hard copy package of each baseline proposal and related addenda to the CMS Regional Office responsible for the applicant contract.

III. KEY DEFINITIONS

The following key definitions are provided here to assist the applicant in ensuring that the SNP types proposed and populations targeted for the plan offerings represented in this proposal are allowable.

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 42 CFR 422.4(a)(1)(iv) that provides specialized care to such individuals, and that provides Part D benefits under 42 CFR Part 423 to all enrollees.

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 is an individual with a severe or disabling chronic condition recognized by the Secretary as benefiting from enrollment in a specialized MA plan. 42 CFR 422.2

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. 42 CFR 422.2. For purposes of SNPs, CMS may also consider as institutionalized those individuals living in the community but requiring an institutional level of care based on a State approved assessment.

Severe or disabling chronic condition: Examples of severe and disabling chronic conditions are: AIDS, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and chronic mental illness. (SNP proposals to serve this type of special needs individual will be evaluated on a case by case basis).

Disproportionate percentage: A SNP that enrolls a greater proportion of the target group of special needs individuals (i.e. dual eligible, institutionalized, or those with a specified severe or disabling chronic condition), than occurs 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. Please consult the following websites for additional information on determining disproportionate percentage.

- Risk Adjustment page:
  http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage

- MCBS page:
  http://www.cms.hhs.gov/MCBS/

Subsets for Dual Eligible SNPs: A SNP that targets a more narrow population then is otherwise allowed to coordinate services between Medicare and Medicaid. (Attachment A is the subsetting policy).

Frailty: Generally recognized definitions of frailty include the following from an article in the Journal of Clinical Epidemiology:

> Frailty is defined as [1] a state of reduced physiologic reserve associated with increased susceptibility to disability; and [2] defined as frail those who depend on others for the activities of daily living or who are at high risk of becoming dependent.[1]

The applicant is encouraged to use one of these or a similar definition in its discussion of the SNP Model of Care.

Full benefit duals: A Full-Benefit Dual Eligible Individual is a Medicare beneficiary who is determined eligible by the State for medical assistance for full benefits under Title XIX of the Social Security Act for the month under any eligibility category covered under the State plan, or comprehensive benefits under a demonstration under section 1115 of the Act , or medical assistance under 1902(a)(10)(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individuals was eligible for medical assistance in any part of the month.

A complete breakdown of dual eligible categories is located at the following website:

http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#TopOfPage

Zero cost sharing dual eligibles: This category includes Qualified Medicare Beneficiaries (QMB) and QMB pluses, the two categories of dual eligible beneficiaries that have Medicare cost sharing paid by Medicaid. Further information on these categories is located at the following website:

http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#TopOfPage

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[1] *How to Select a Frail Elderly Population? A Comparison of Three Working Definitions;* Paw, Dekker, Fesken, Schouten and Kromhout, Journal of Clinical Epidemiology, Volume 52, Issue 11, November 1999, pages 1015-1021

Model of Care:

Background

For the SNP program there are three broad target populations groups – dual eligibles, institutionalized individuals and individuals with severe or disabling chronic conditions. Depending on how specifically the target population is defined, the Model of Care would focus on the unique needs of the targeted population as defined by the applicant (e.g. full benefit dual eligibles, beneficiaries living in the community but requiring an institutional level of care, beneficiaries with congestive heart failure). In addition, for each targeted population, the applicant should address its approach to frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries who are at the end of life, as these subsets are likely to be more prevalent among the special needs populations. As the SNP program is intended to provide specialized services and these beneficiaries are among the most complex to treat, SNP programs are expected to include goals and objectives as well as specialized care for these categories of beneficiaries within the overall Model of Care for individuals who are dually eligible, institutionalized, or have a severe or disabling chronic condition.

Definition

The Model of Care describes the applicant's proposed approach to providing specialized care to the SNP's targeted population, including a statement of goals and specific processes and outcome objectives for the targeted population to be managed under the SNP.

The Model of Care is in essence the system of care which reflects 1) pertinent clinical expertise and the staff structures; 2) the types of benefits and; 3) processes of care (organized under protocols) that will be used to meet the goals and objectives of the SNP. The Model of Care should be specific enough to imply what process and outcome measures could be used by the applicant to determine if the structures and processes of care are having an intended effect on the target population.

Examples of pertinent clinical expertise and staff structures include clinicians with a certificate to treat individuals with mental illness for a SNP that is targeting beneficiaries with mental illness, or availability and use of nurse practitioners and case managers. Another example is an explanation of how a nursing home staff shall interact with the SNP staff to implement assessment and care management under the SNP.

Examples of types of benefits and processes of care include protocols that drive frequency and character of assessment case and care management, disease management and poly pharmacy management. Protocols are specific enough to define the beneficiary circumstances or conditions for which a set of actions should be taken.

IV. TEMPLATE FOR COMPLETING SNP PROPOSAL

Follow the step by step instructions below and insert answers directly into the template. The applicant should complete only the portions of the template that correlate to the specific SNP type the applicant intends to offer, that is Section A, B or C. If the applicant is seeking approval for more than one type of SNP, then the template for the proposal should be completed for each of those types. The responses to the template as well as the attachments and the documentation for the State and long term care contract should all be in a single Microsoft word document. Documents requested in the template, such as copies of contracts, forms and signature pages should be added to the end of the template Microsoft word document as attachments as text or scanned into the document as a picture or as text. The end result should be only one electronic file should be submitted to CMS for a SNP proposal, which contains all the required data and information.

See Section II for instructions to minimize duplication of responses and otherwise follow the instructions in this template. Any other approach to minimizing duplication will not be accepted by CMS.

The following template provides all the necessary prompts for each type of SNP – Section A dual eligible; Section B institutional; and Section C severe or disabling chronic condition SNPs.

If the applicant intends to target populations under a particular SNP type, for example a dual eligible SNP for all dually eligible beneficiaries and a dual eligible SNP for full benefit dual eligible beneficiaries only, then Section A of the template should be completed twice once for each request, Hxxxx_A_Plan_1, Hxxxx_A_Plan_ 2. It is not necessary to repeat information that is the same for each request within the dual eligible SNP. For example in H9999_A_Plan_2, the applicant must complete any portion of the dual eligible section that is different from the first one, H9999_A_ Plan_ 1. For the second requested subset the applicant must indicate that all information is the same as H9999_A_ Plan_ 1 except as provided and the applicant will list the sections that contain additional information and provide the response using the same example. These additional responses must not be embedded in the discussion for H9999_A Plan_1, but rather must follow H9999_A_ Plan_ 1, presenting clearly the applicant's specific response to H9999_A Plan_ 2, then followed by H9999_ A_ Plan_ 3, etc.

In this same example, assume the applicant is also offering an institutional SNP. All elements must be completed for the first institutional SNP request H9999_B_Plan_1.

Particular attention should be paid to the circumstance of different SNP offerings within a contract service area wherein one SNP covers only a segment of that service area and another covers a different segment. Specifically, if the applicant is seeking to offer a SNP in a limited segment of the contract service area, the applicant is not required to repeat information that will be the same for each segment. However, in any section where the information is not the same, the applicant must complete that information. For example, information about state contracts, service area and provider network could vary with every request. Include the CMS assigned

contract number and plan number (e.g. Hxxx_A_ Plan_1, Hxxxx_A_Plan_2) and the type of information contained in the file. For all files use the following nomenclature H9999_x_Plan_x_proposal; H9999_x_Plan_x_contract

A. DUAL ELIGIBLE SNP TYPE

A.1. Number Assignment for each Dual Eligible SNP Type

A.1.a. State whether the applicant is proposing a dual eligible SNP. If no, proceed to Section B.

A.1.b. State how many different dual eligible SNP types are being proposed.

NOTE to the applicant: This section should be completed and replicated as many times as the number reported in A.1.b. Duplication can be minimized by following the instructions in Section II and IV. 3. Consecutively label each dual eligible SNP type as dual eligible SNP Hxxxx_A_Plan_ 1, Hxxxx_ A_Plan_ 2, etc.

A.1.c. This particular dual eligible SNP type is numbered (insert Hxxx_A_ Plan_ 1, Hxxx_A_ Plan_ 2, etc.)

A.2. Type of Dual SNP

A.2.a. Identify what dual eligible population will be served by this SNP:

- ☐ All Duals: Medicare and Medicaid eligible beneficiaries
- ☐ Full Duals Only (See definition in Section III)
- ☐ Zero Cost Sharing Duals: QMB only and QMB pluses (See definition in Section III)
- ☐ Other Dual Eligible Subsets/Requires a State contract. (See Attachment B)

A.2.b. Describe the procedure the applicant will use to verify eligibility of dual eligible individuals through the State.

NOTE to applicant: The applicant must verify an individual's eligibility prior to enrollment, so the applicant must clearly demonstrate how the eligibility criteria will be verified. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used as an indicator of dual eligible status as this does not reflect the most current State status. The applicant must obtain eligibility status from the respective States.

A.3. Relationship of SNP Product to State Medicaid Services in the Event of Other Subsetting

If applicant is not requesting an "Other Dual Eligible Subset" indicate that below and proceed to Section A.4.

NOTE to applicant: If the applicant intends to offer an "Other Dual Eligible Subset" it must be allowable as explained in guidance provided in Attachment A.

Additional subsetting must be approved by CMS and a contract or agreement between the State and the applicant organization must exist and evidence provided to CMS by October 1, 2007 in order for the applicant to actually offer such subsetted dual SNPs effective on January 1, 2008.

The deadline for submission of this documentation was extended from the July 1, 2007 date proposed in the draft SNP solicitation to October 1, 2007 to allow applicants additional time to finalize their State contracts. However, an applicant should submit this documentation as soon as it becomes available so CMS can proceed with final approval as quickly as possible. Further, the applicant must submit a bid for the subset population according to existing Medicare Advantage (MA) rules and regulations which require that the bid be submitted by the first Monday in June. The bid, including its underlying assumptions about the population to be served, cannot be modified in the event the applicant fails to document entry into a contract with the State by the October 1, 2007 deadline. Final approval of the bid is in part contingent on finalizing the contract with the State and providing the necessary documentation to CMS by October 1, 2007. In addition, certain addenda to the contract will have to be signed.

The applicant should be aware that the October 1, 2007 deadline could affect whether and how the SNP product will be featured in the Medicare & You Handbook, and in the Medicare Plan Finder for at least the first month. CMS approval of marketing materials may also be delayed which could subsequently delay marketing of the new SNP product.

If the proposed subset serves the institutional population and/or those living in the community requiring an institutional level of care, the applicant MUST complete this section as well as ALL portions of Section B that are not addressed by information provided in Section A on dual eligibles. If the proposed subset serves a selected dual eligible population with chronic diseases, the applicant must complete this section as well as all portions of section C that are not addressed by information provided in Section A on dual eligibles.

A.3.a. What specific subset of the dual eligible population does the applicant intend to serve under this SNP?

A.3.b. Provide a list of the types of dual eligible enrollees the applicant does not intend to serve.

A.3.c. Explain how the applicant's subset of individuals coincides with State efforts to integrate Medicare and Medicaid services for the target population. Specifically, provide an explanation from the State for the subset that also includes a discussion of why other dual eligible categories would be excluded from the Medicaid population. For example, if a State Medicaid agency excludes potential enrollees based on age or a specific disease category, the applicant must request that the State provide the reasoning behind the included and excluded categories of dual eligible beneficiaries. The applicant must include the State's response with the SNP proposal.

A.3.d. Provide the following documentation to support the subset request and verify the applicant's relationship with the State Medicaid agency.

A.3.d.1. A signed contract with a State Medicaid agency to serve the population through the SNP. Include a copy of the title page, the page that includes the eligible Medicaid population and the signature page. If this documentation does not exist, then state this and go to A.3.d.2

A.3.d.2. If applicant's organization will have a contract with the State to provide Medicaid services to the requested subset of dual eligible individuals that will be effective by January 1, 2008, include a letter from the State that verifies that information. The letter must verify the requested Medicaid subset including a list of the types of dual eligible beneficiaries eligible for the SNP and an assurance that the applicant will have a contract or agreement with the State Medicaid agency effective on January 1, 2008 that will be signed by October 1, 2007.

A.3.d.3. Provide the name and contact information of the applicant's contact person at the State Medicaid agency. If the applicant does not have a Medicaid contract to serve any dually eligible beneficiaries, then proceed to Section A.4.d.

A.4. State Contracts Information if Other Subsetting is Not being Requested by Applicant

A.4.a. Identify any contracts between the applicant and the State to provide Medicaid services to the dual eligible population. If the applicant does not have a Medicaid contract, proceed to Section A.4.d.

A.4.b. Describe the population(s) the applicant serves under that Medicaid contract(s).

A.4.c. If the applicant has a contract(s) to serve Medicaid beneficiaries, describe how the applicant will coordinate Medicare and Medicaid services for the targeted dual eligible population.

A.4.d. If the applicant does not have a Medicaid contract indicate whether the applicant intends to work with the State Medicaid agency to assist dual eligible beneficiaries with accessing Medicaid benefits and with coordination of Medicare and Medicaid covered services. State how this will be accomplished.

A.4.e. Provide the name and contact information of the applicant's contact person at the State Medicaid agency.

A.4.f. Indicate if the applicant will allow CMS to advise the State Medicaid Director that the applicant has applied to CMS to offer a dual eligible SNP.

☐ Yes

☐ No

A.5. Exclusive versus Disproportionate Percentage Population

A.5.a. Indicate whether the SNP will exclusively enroll individuals in the target population or whether its enrollment will include a disproportionate percentage of the target population.

☐ Exclusive

☐ Disproportionate

If the applicant selected exclusive, then proceed to Section A.6.

A.5.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section III., propose the reference point to compare the applicant's targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

A.5.a.2. List the expected reasons for enrollment of beneficiaries not part of the target population. (e.g. spouses, beneficiaries who lost their dual eligible status).

A.5.a.3. State what percentage of the projected enrollment would be the target population.

A.5.a.4. State what data sources and analytic methods would be used by the applicant to track the disproportionate percentage and compare it to its proposed reference point.

A.6. Service Area to be Served by SNP

A.6.a. Complete the table found in Attachment B. List the State and each of the counties in the State to be served by the applicant's proposed SNP. Complete a separate table for each SNP proposed by the applicant. If the SNP will cover all counties in the State, then the table can list "all counties".

A.7. SNP Model of Care

NOTE to applicant: Refer to the definition of Model of Care in Section III. (clinical expertise required of the Model of Care is elicited under the provider network Section A.8.)

A.7.a. List the goals and objectives of the Model of Care that will drive service delivery under this dual eligible SNP. Address the goals and objectives specific to each of the following: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

A.7.b. Describe the specific organization of staff (e.g. employees, community service workers, nurse practitioners, case managers) who interact with dual eligible individuals to provide the specialized services available under the Model of Care.

A.7.c. Describe the respective roles of the staff as identified in A.7.b.

A.7.d. Describe the lines of communication and accountability between the SNP and the staff.

A.7.e. Describe the specific steps the SNP takes (e.g. written protocols and training) to ensure that the staff understands how the Model of Care works and to function in accordance with the Model of Care.

A.7.f. State how this Model of Care will identify and meet the needs of dual eligible beneficiaries.

A.7.g. List and explain extra benefits and services that will be provided to meet the needs of dual eligible beneficiaries.

A.7.h. State what specific processes and outcome measures the applicant will use to measure performance of the Model of Care for dual eligible beneficiaries. (See Attachment E)

A.7.i. **Meeting the Needs of Frail/Disabled Enrollees**

A.7.i.1. Provide the applicant's definition of a frail enrollee either using one of the definitions in Section III or something similar.

A.7.i.2. State whether the applicant's Model of Care specifically addresses the needs of frail beneficiaries and/or the needs of enrollees with a disability.

A.7.i.3. If serving enrollees with disabilities, specify the types of disabilities the applicant will address through the SNP.

NOTE to applicant: The response should address at least one of these categories (frail enrollees, enrollees with disabilities, or both)

A.7.i.4. Address how the Model of Care will identify and meet the needs of frail/disabled beneficiaries as defined in A.7.c.1., A.7.c.2 and A.7.c.3.

A.7.i.5. List and explain extra benefits and services that will be provided to meet the needs of frail/disabled beneficiaries as defined in A.7.c.1., A.7.c.2 and A.7.c.3.

A.7.i.6. Address what specific process and outcome measures the plan will use to measure performance of the Model of Care for frail/disabled beneficiaries. (see Attachment E).

A.7.j. **Meeting the Needs of Enrollees with Multiple Chronic Illnesses**

A.7.j.1. Address how the Model of Care will identify and meet the needs of beneficiaries with multiple chronic illnesses.

A.7.j.2. List and explain extra benefits and services that will be provided to meet the needs of individuals with multiple chronic illnesses.

A.7.j.3. Address what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries with multiple chronic illnesses. (See Attachment E)

A.7.k. **Meeting the Needs of Enrollees that are at the End of Life**

A.7.k.1. Address how the Model of Care will identify and meet the needs of beneficiaries who are at the end of life.

A.7.k.2. List and explain extra benefits and services that will be provided to meet the needs of individuals facing the end of life.

A.7.k.3. Address what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries facing the end of life. (See Attachment E)

A.8. Provider Network

A.8.a. State whether the SNP provider and pharmacy networks are different than the networks for the applicant's other Medicare coordinated care plans (CCP) plans in the same service area under this contract.

A.8.b. Using the Model of Care described in Section III as a guide, describe the pertinent clinical expertise that the applicant will use is in the applicant's network to meet the special needs of the dual eligible population. Also address the pertinent clinical expertise the applicant believes are necessary in order to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

A.8.c. If the network does not include sufficient specialists to fully meet the special needs of the target population, describe how access to non-contracted specialists will be arranged. Specifically, describe the policies and procedures that will be followed to make sure enrollees have meaningful access to all necessary providers.

NOTE to applicant: Although the applicant is required to respond to the questions in the SNP proposal regarding the provider network, separate HSD tables are not required unless requested by CMS.

A.9. Individuals with End Stage Renal Disease

A.9.a. State whether the applicant intends to enroll beneficiaries with end stage renal disease (ESRD) in its dual eligible SNP. If no, then proceed to Section A.10.

A.9.a.1. If the applicant intends to enroll individuals with ESRD in its dual eligible SNP, describe how the organization will serve the unique needs of this population.

A.9.a.2. List the contracted dialysis facilities in "Attachment G –Dialysis Facilities".

A.9.a.3. List the contracted transplant facilities in "Attachment H – Transplant Facilities".

A.9.a.4. List any additional services that will be provided to beneficiaries with ESRD.

A.9.a.5. Describe the role of the care coordinator in the assessment and delivery of services needed by beneficiaries with ESRD.

NOTE to applicant: If a SNP is approved to serve ESRD beneficiaries, the exceptions authority in 42 CFR 422.50(a)(2)(iii) would apply and a waiver pursuant to 42 CFR 422.52 (c) will be provided to the applicant. The signed waiver will be attached to the MA contract. If this is an MA organization that is adding a SNP, the waiver will be sent following final approval. In both cases the waiver must be signed and returned within 10 calendar days.

A.10. Targeting an Alternative Dual Eligible Population to the One Described Above

NOTE to applicant: If the applicant also intends to target an alternative dual eligible population to the one described above, then duplicate the dual eligible section of the template (Section A) here and continue the numbering with A Plan 2, etc. If the applicant is not intending to propose any additional dual eligible SNPS, then proceed to Section B.

B. INSTITUTIONAL SNP TYPE

B.1. Number Assignment for each Institutional SNP Type

B.1.a. State whether the applicant is proposing an institutional SNP. If no, proceed to Section C.

B.1.b. State how many different institutional SNP types the applicant is proposing to offer.

NOTE to the applicant: This section should be completed and replicated as many times as the number reported in B.1.b. Consecutively label each institutional SNP type as institutional Hxxxx_B_Plan_1; Hxxxx_B_Plan_2, etc. Duplication can be minimized by following the instructions in Section II and IV.3.

B.1.c. This particular institutional SNP type is numbered.(insert actual contract number and plan number Hxxxx_B_Plan_x)

B.2. Type of Institutional SNP

NOTE to Applicant*:* Review Attachment C, *Ensuring Delivery of Institutional SNP Model of Care*, which clarifies the requirements the applicant must meet when offering an institutional SNP, particularly concerning the contractual arrangement between the applicant and a long term care (LTC) facility, and the preparedness of the applicant to provide assessment and services in accordance with the SNP Model of Care if the beneficiary moves to a new residence.

B.2.a. Applicant must review and sign attestation in Attachment D.

B.2.b. Identify what institutional population will be targeted by this SNP:

- ☐ Institutionalized individuals residing in a long term care facility.
- ☐ Individuals that reside in specific assisted living facilities (ALF) but requiring an institutional level of care

NOTE to applicant: Refer to Attachment C, Policy clarification # 3, for discussion of targeting beneficiaries who reside in ALFs, etc.

- ☐ Individuals living in the community but requiring an institutional level of care.
- ☐ A combination of the above populations (Check all that apply).

B.2.c. **Identifying Institutionalized Beneficiaries**

B.2.c.1. Provide the procedure the applicant will utilize to verify that the enrollee meets the definition of institutionalized for enrollees residing in a long term care facility.

B.2.c.2. Provide a copy of the assessment tool the applicant will utilize to determine eligibility. Indicate who will perform the assessment.

B.2.c.3. Describe and provide documentation as to how the applicant will utilize the State assessment tool to determine if an individual meets nursing home level of care. Indicate who will perform the level of care assessment

NOTE to applicant: The applicant must use the State assessment tool to determine if a potential enrollee meets the definition of institutionalized as defined in Section III. The applicant must verify an individual's eligibility prior to enrollment, so the applicant must clearly demonstrate how the eligibility criteria will be verified. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used as an indicator of institutional status.

B.2.d. **Identifying Beneficiaries Living in the Community but Requiring an Institutional Level of Care**

B.2.d.1. If the applicant intends to limit eligibility to beneficiaries who reside or agree to reside in certain Assisted Living Facilities (ALF**),** list these facilities.

B.2.d.2. Describe and provide documentation as to how the applicant will utilize the State assessment tool to determine if an individual meets nursing home level of care. Indicate who will perform the level of care assessment (e.g. State personnel, applicant's clinical staff).

NOTE to applicant: The applicant must verify an individual's eligibility prior to enrollment. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used as an indicator of institutional status. The applicant must use the State assessment tool to determine if a potential enrollee requires a nursing home level of care.

B.3. State Contracts Information

B.3.a. Identify any contracts between the applicant and the State to provide Medicaid services to the dual eligible population. If the applicant does not have a Medicaid contract proceed to Section B.3.d.

B.3.b. Describe the population(s) the applicant serves under the applicant's existing Medicaid contract(s).

B.3.c. If the applicant has a contract(s) to serve Medicaid beneficiaries, describe how the applicant will coordinate Medicare and Medicaid services for the dually eligible institutionalized population enrolled in the SNP.

B.3.d. If the applicant does not have a Medicaid contract, indicate whether the applicant intends to work with the State Medicaid agency to assist dual eligible beneficiaries enrolled in the

applicant's institutional SNP with accessing Medicaid benefits and with coordination of Medicare and Medicaid covered services. State how this will be accomplished.

B.3.e. Provide the name and contact information of the applicant's contact person at the State Medicaid agency.

B.3.f. Indicate if the applicant will allow CMS to advise the State Medicaid Director that the applicant has applied to CMS to offer a dual eligible SNP.

☐ Yes

☐ No

B.4. Exclusive versus Disproportionate Percentage Population

B.4.a. Please indicate whether the SNP will exclusively enroll individuals in the target population or whether its enrollment will include a disproportionate percentage of the target population.

☐ Exclusive

☐ Disproportionate

If applicant selected exclusive, then proceed to Section B. 5.

B.4.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section III., propose the reference point to compare its targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

B.4.a.2. List the expected reasons for enrollment of beneficiaries not part of the target population (e.g. spouses who may be institutionalized).

B.4.a.3. State the percentage of the projected enrollment that would constitute the target population.

B.4.a.4. State the data sources and analytic methods utilized by the applicant to track the disproportionate percentage and compare it to its proposed reference point.

B.5. Service Area to be Served by SNP

B.5.a. Complete the table found in Attachment B. List the State and each of the counties in the State to be served by the applicant's proposed SNP. Complete a separate table for each SNP proposed by the applicant. If the SNP will cover all counties in the State, then the table can list "all counties".

B.6. SNP Model of Care

NOTE to applicant: Refer to the definition of Model of Care in Section III. (Clinical expertise required of the Model of Care is elicited under the provider network Section B.7.).

B.6.a. **Description of Model of Care for the Institutional Setting**

NOTE to applicant: If this SNP is not targeting institutional status beneficiaries residing in a LTC setting then proceed to Section B.6.b.

B.6.a.1. List the goals and objectives of the Model of Care that will drive service delivery under this institutional eligible SNP. Address the goals and objectives specific to each of the following: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses and beneficiaries at the end of life.

B.6.a.2. Describe how the Model of Care will be implemented in the setting as defined in B.2.c., specifically the approach to patient assessment, as well as the organization, coordination, and delivery of Medicare (and other) services.

B.6.a.3. Describe the specific organization of staff (e.g. LTC staff, employees, nurse practitioners, case managers) who interact with institutionalized individuals to provide the specialized services available under the Model of Care.

B.6.a.4. Describe the key roles and interactions between the SNP and LTC facility personnel for the Model of Care to perform as planned. List the key services provided by the SNP, and key services provided by the LTC facility. Describe lines of communication and accountability between the SNP and LTC facility.

B.6.a.5. Describe the specific steps the SNP takes (e.g., written protocols and training) to ensure that the LTC facility personnel understand how the Model of Care works and how to function in accordance with that Model of Care.

B.6.a.6. State how this Model of Care will identify and meet the needs of institutionalized beneficiaries.

B.6.a.7. List and explain extra benefits and services that will be provided to meet the needs of institutionalized beneficiaries.

B.6.a.8. State what specific processes and outcome measures the applicant will use to measure performance of the Model of Care for dual eligible beneficiaries. (See Attachment E).

B.6.b. **Description of Model of Care for Beneficiaries Living in the Community but Requiring an Institutional Level of Care**

NOTE to applicant: If this SNP is not targeting beneficiaries living in the community but requiring an institutional level of care, then proceed to Section B.6.c.

B.6.b.1. List the goals and objectives of the Model of Care that will drive service delivery under this institutional SNP. Address the goals and objectives specific to each of the following: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses and beneficiaries at the end of life.

B.6.b.2. Describe how the Model of Care will be implemented in the community setting as defined in B.2.b. and B.2.d.1., specifically the approach to patient assessment, as well as the organization, coordination, and delivery of Medicare (and other) services.

B.6.b.3. Describe the specific organization of staff (e.g. employees, ALF staff, community service workers, nurse practitioners, case managers) who interact with beneficiaries living in the community but requiring an institutional level of care to provide the specialized services available under the Model of Care.

B.6.b.4. Describe the key interfaces between the SNP and ALF staff and community service workers for the Model of Care to perform as planned. List the key services provided by the SNP, and key services provided by the ALF staff and community service workers. Describe lines of communication and accountability between the SNP and ALF staff and community service workers.

B.6.b.5. Describe the specific steps the SNP takes (e.g., written protocols and training) to ensure that the ALF staff and community service workers understand how the Model of Care works and how to function in accordance with that Model of Care.

B.6.b.6. State how this Model of Care will identify and meet the needs of beneficiaries living in the community but requiring an institutional level of care.

B.6.b.7. List and explain extra benefits and services that will be provided to meet the needs of beneficiaries living in the community but requiring an institutional level of care.

B.6.b.8. State what specific processes and outcome measures the applicant will use to measure performance of the Model of Care for beneficiaries living in the community but requiring an institutional level of care. (See Attachment E).

B.6.c. **Meeting the Needs of Frail/Disabled Enrollees**

B.6.c.1. Provide the applicant's definition of a frail enrollee either using one of the definitions in Section III or something similar.

B.6.c.2. State whether the applicant's Model of Care addresses the needs of frail beneficiaries and/or the needs of enrollees with a disability.

NOTE to applicant: The response should address at least one of these categories (frail enrollees, enrollees with disabilities or both)

B.6.c.3. If serving enrollees with disabilities, specify the types of disabilities the applicant will address through the SNP.

NOTE to applicant: The response must include at least one of these categories (frail enrollees, enrollees with disabilities or both)

B.6.c.4. Address how the Model of Care will identify and meet the needs of frail/disabled beneficiaries as defined in B.6.c.1., B.6.c.2. and B.6.c.3.

B.6.c.5. List and explain extra benefits and services that will be provided to meet the needs of frail/disabled beneficiaries as defined in B.6.c.1., B.6.c.2. and B.6.c.3.

B.6.c.6. State what specific process and outcome measures the plan use to measure performance of the Model of Care for frail/disabled beneficiaries. (see Attachment E).

B.6.d. **Meeting the Needs of Enrollees with Multiple Chronic Illnesses**

B.6.d.1. Address how the Model of Care will identify and meet the needs of beneficiaries with multiple chronic illnesses.

B.6.d.2. List and explain extra benefits and services that will be provided to meet the needs of individuals with multiple chronic illnesses.

B.6.d.3. State what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries with multiple chronic illnesses. (See Attachment E).

B.6.e. **Meeting the Needs of Enrollees that are at the End of Life**

B.6.e.1. Address how the Model of Care will identify and meet the needs of beneficiaries at the end of life.

B.6.e.2. List and explain extra benefits and services that will be provided to meet the needs of individuals at the end of life.

B.6.e.3. State what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries at the end of life. (See Attachment E).

B.7. Provider Network

B.7.a. State whether the SNP provider and pharmacy networks (if any) are different from the networks for the applicant's other Medicare coordinated care plans (CCP) in the same service area under this contract.

B.7.b. Using the Model of Care defined in Section III as a guide, specifically describe the pertinent clinical expertise the applicant will use to meet the special needs of the institutional population. Also address the pertinent clinical expertise the applicant believes are necessary to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

B.7.c. If the network does not include sufficient specialists to meet the special needs of the target population, describe how access to non-contracted specialists will be arranged. Specifically, describe the policies and procedures that will be followed to make sure enrollees have meaningful access to all necessary providers.

NOTE to applicant: Although the applicant is required to respond to the questions in the SNP proposal regarding the provider network, separate HSD tables are not required unless requested by CMS.

B.8. Long Term Care Facilities

B.8.a. List in "Attachment I – Long Term Care Facilities" all of the applicant's long term care facilities contracted to serve the institutional population under this SNP Model of Care.

B.8.b. Submit a copy of the contract the applicant will utilize when contracting with a long-term care facility. In addition to the terms listed in the Medicare Advantage Managed Care Manual, Chapter 11, Section 100.4, the applicant must adequately address the following, either in the contract with the long term care provider or in provider materials including, but not limited to, written policies and procedures and provider manuals. If the information is addressed in the provider materials, then each element listed below must be referenced in the contract in a meaningful way referring the facility to the particular part of provider materials where the details concerning the element can be found.

Facilities in a chain organization that are contracted to deliver the SNP Model of Care

- If the applicant's contract is with a chain organization, the chain organization and the applicant agree to a list of those facilities that are included to deliver the SNP Model of Care.

Facilities providing access to SNP clinical Staff

- The facility agrees to provide appropriate access to the applicant's SNP clinical staff including physicians, nurses, nurse practitioners and care coordinators, to the SNP beneficiaries residing in the applicant's contracted facilities in accordance with the SNP protocols for operation.

Providing protocols for the SNP Model of Care

- The applicant agrees to provide protocols to the facility for serving the beneficiaries enrolled in the SNP in accordance with the SNP Model of Care. These protocols must be referenced in the contract.

Delineation of services provided by the SNP staff and the LTC facilities under the SNP Model of Care

- A delineation of the specific services provided by the applicant's SNP staff and the facility staff to the SNP enrollees in accordance with the protocols and payment for the services provided by the facility.

Training plan for LTC facility staff to understand SNP Model of Care

- A training plan to ensure that the LTC facility staff understand their responsibilities in accordance with the SNP Model of Care, protocols and contract. If the training plan is a separate document it should be referenced in the contract.

Procedures for facility to maintain a list of credentialed SNP clinical staff

- Procedures that ensure cooperation between the SNP and facility in maintaining a list of credentialed SNP clinical staff in accordance with the facilities' responsibilities under Medicare conditions of participation.

Contract Year for SNP

- Contract must include the full CMS contract cycle which begins on January 1st and ends on December 31st. The applicant may also contract with additional LTC facilities throughout the CMS contract cycle.

Grounds for early termination and transition plan for beneficiaries enrolled in the SNP

- Termination clause must clearly state any grounds for early termination of the contract. The contract must include a clear plan for transitioning the beneficiary should the applicant's contract with the long term care facility terminate.

B.9. Individuals with end stage renal disease

B.9.a. State whether the applicant intend to enroll beneficiaries with end stage renal disease (ESRD) in its institutional SNP If no, proceed to Section B.10.

B.9.b. If the applicant intends to enroll individuals with ESRD in its institutional SNP, please describe how the organization will serve the unique needs of this population.

B.9.b.1. List the contracted dialysis facilities in "Attachment G –Dialysis Facilities".

B.9.b.2. List the contracted transplant facilities in "Attachment H – Transplant Facilities".

B.9.b.3. List any additional services that will be provided to beneficiaries with ESRD.

B.9.b.4. Describe the role of the care coordinator in the assessment and delivery of services needed by beneficiaries with ESRD.

NOTE to applicant: If a SNP is approved to serve ESRD beneficiaries, the exceptions authority in 42 CFR 422.50(a)(2)(iii) would apply and a waiver pursuant to 42 CFR 422.52 (c) will be provided to the applicant. The signed waiver will be attached to the MA contract. If this is a

MA organization that is adding a SNP, the waiver will be sent following final approval. In both cases the waiver must be signed and returned within 10 calendar days.

B.10 Targeting an Alternative Institutional Population to the One Described Above

NOTE to applicant: If the applicant also intends to target an alternative institutional population to the one described above, then duplicate the institutional section of the template (Section B) here and continue with Hxxxx_B_ Plan _2, etc. If the applicant is not intending to propose any additional institutional SNPS, then proceed to Section C.

C. SEVERE OR DISABLING CHRONIC CONDITION SNP TYPE

C.1. Number Assignment for each Severe or Disabling Chronic Condition SNP Type

C.1.a. State whether the applicant is proposing a SNP to serve individuals with severe or disabling chronic conditions

C.1.b. State how many different severe or disabling chronic condition SNP types are being proposed.

NOTE to the applicant: This section should be completed and replicated as many times as the number reported in C.1.b. Duplication can be minimized by following the instructions in Section II and Section IV.3. Consecutively label each severe or disabling chronic condition SNP type as Hxxxx_C_Plan_1; Hxxxx_C_Plan_2, etc.

C.1.c. This particular severe or disabling chronic condition SNP type is numbered… (Insert actual contract number and plan number)

C.2. Type of Severe or Disabling Chronic Condition SNP

C.2.a. List the disease(s) the applicant intends to target in this severe or disabling chronic condition SNP.

C.2.b. Provide the procedure the applicant will utilize to verify eligibility of the severe or disabling chronic condition(s) for enrollment in the SNP.

NOTE to applicant: The applicant must verify an individual's eligibility prior to enrollment, so the applicant must clearly demonstrate how the eligibility criteria will be verified. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used to determine if a potential enrollee meets the eligibility requirement for a chronic condition SNP. The applicant must obtain a letter from the potential enrollee's physician with verification if the enrollee's condition or request authorization from the beneficiary or his/her representative, consistent with HIPAA, to contact the enrollee's physician to verify eligibility for the SNP.

C.3. State Contracts Information

C.3.a. Identify any contracts between the applicant and the State to provide Medicaid services to the dually eligible population. If the applicant does not have a Medicaid contract, proceed to section C. 3.d.

C.3.b. Describe the population(s) the applicant serves under the applicant's existing Medicaid contract(s).

C.3.c. If the applicant has a contract(s) to serve Medicaid beneficiaries, describe how the applicant will coordinate Medicare and Medicaid services for dually eligible beneficiaries with the targeted sever or disabling chronic condition that are enrolled in the applicant's SNP

C.3.d. If the applicant does not have a Medicaid contract, indicate whether the applicant intends to work with the State Medicaid agency to assist dual eligible beneficiaries enrolled in the chronic SNP with accessing Medicaid benefits and with coordination of Medicare and Medicaid covered services. State how this will be accomplished.

C.3.e. Provide the name and contact information of the applicant's contact person at the State Medicaid agency.

C.3.f. Indicate if the applicant will allow CMS to advise the State Medicaid Director that the applicant has applied to CMS to offer a dual eligible SNP.

☐ Yes

☐ No

C.4. Exclusive versus Disproportionate Percentage Population

C.4.a. Indicate whether the SNP will exclusively enroll individuals in the target population or whether its enrollment will include a disproportionate percentage of the target population.

☐ Exclusive

☐ Disproportionate

If applicant selected exclusive, then proceed to Section C.5.

C.4.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section III., propose the reference point to compare its targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

C.4.a.2. List the expected reasons for enrollment of beneficiaries that are not part of the target population (e.g., spouses of beneficiary with chronic condition).

C.4.a.3. State what percentage of the projected enrollment would be the target population.

C.4.a.4. State what data sources and analytic methods would be used by the applicant to track the disproportionate percentage and compare it to its proposed reference point.

C.5. Service Area to be Served by SNP

C.5.a. Complete the table found in Attachment B. List the State and each of the counties in the State to be served by the applicant's proposed SNP. Complete a separate table for each SNP proposed by the applicant. If the SNP will cover all counties in the State, then the table can list "all counties".

C.6. SNP Model of Care

NOTE to applicant: Refer to the definition of Model of Care in Section III. (Clinical expertise required of the Model of Care is elicited under the provider network Section C.7.)

C.6.a. List the goals and objectives of the Model of Care that will drive service delivery under this SNP serving individuals with severe or disabling chronic conditions. Address the goals and objectives specific to each of the following: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

C.6.b. Describe the specific organization of staff (e.g. employees, community service workers, nurse practitioners, case managers) who interact with individuals with sever or disabling chronic conditions to provide the specialized services available under the Model of Care.

C.6.c. Describe the respective roles of the staff as identified in C.6.b.

C.6.d. Describe the lines of communication and accountability between the SNP and the staff.

C.6.e. Describe the specific steps the SNP takes (e.g. written protocols and training) to ensure that the staff understands how the Model of Care works and to function in accordance with the Model of Care.

C.6.f. State how this Model of Care will identify and meet the needs of beneficiaries with severe or disabling chronic conditions.

C.6.g. List and explain extra benefits and services that will be provided to meet the needs of beneficiaries with severe or disabling chronic conditions.

C.6.h. State what specific process and outcome measures the applicant will use to measure performance of the Model of Care for individuals with severe or disabling chronic conditions.(See Attachment E)

C.6.i. **Meeting the Needs of Frail/Disabled Enrollees**

C.6.i.1. Provide the applicant's definition of a frail enrollee either using one of the definitions in Section III or something similar.

C.6.i.2. State whether this Model of Care specifically addresses the needs of frail beneficiaries, and/or the needs of enrollees with a disability.

C.6.i.3. If serving enrollees with disabilities, specify the types of disabilities the applicant will address through the SNP.

NOTE to applicant: The response should address at least one of these categories (frail enrollees, enrollees with disabilities or both)

C.6.i.4. Address how the Model of Care will identify and meet the needs of frail/disabled beneficiaries as defined in C.6.i.1., C.6.i.2 and C.6.i.3.

C.6.i.5. List and explain extra benefits and services that will be provided to meet the needs of frail/disabled beneficiaries as defined in C.6.i.1., C.6.i.2 and C.6.i.3.

C.6.i.6. Address what specific process and outcome measures the plan use to measure performance of the Model of Care for frail/disabled beneficiaries. (see Attachment E)

C.6.j. **Meeting the Needs of Enrollees with Multiple Chronic Illnesses**

C.6.j.1. Address how the Model of Care will identify and meet the needs of beneficiaries with multiple chronic illnesses.

C.6.j.2. List and explain extra benefits and services that will be provided to meet the needs of individuals with multiple chronic illnesses.

C.6.j.3. Address what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries with multiple chronic illnesses. (See Attachment E).

C.6.k. **Meeting the Needs of Enrollees that are at the End of Life**

C.6.k.1. State how this Model of Care will identify and meet the needs of beneficiaries who are at the end of life.

C.6.k.2. List and explain extra benefits and services that will be provided to meet the needs of beneficiaries facing the end of life.

C.6.k.3. State what specific process and outcome measures the plan will use to measure performance of the Model of Care for beneficiaries facing the end of life. (See Attachment E)

C.7. Provider Network

C.7.a. State whether the SNP provider and pharmacy networks are different than the networks for the applicant's other Medicare coordinated care plans (CCP) in the same service area.

C.7.b. Using the Model of Care described in Section III as a guide, describe the pertinent clinical expertise that the applicant will use to meet the special needs of individuals with severe or disabling conditions served through this SNP. Also address the pertinent clinical expertise the applicant believes are necessary to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries at the end of life.

C.7.c. If the network does not include sufficient specialists to fully meet the special needs of the target population, describe how access to non-contracted specialists will be arranged. Specifically, describe the policies and procedures that will be followed to make sure enrollees have meaningful access to all necessary providers.

NOTE to applicant: Although the applicant is required to answer fully the questions in the SNP proposal regarding the provider network, separate HSD tables are not required as part of the SNP proposal unless requested by CMS.

C.8. Individuals with End Stage Renal Disease

C.8.a. State whether the applicant intends to enroll beneficiaries with end stage renal disease (ESRD) in its chronic SNP. If no, then proceed to Section C.9.

C.8.a.1. If the applicant intends to enroll individuals with ESRD in its severe or disabling chronic condition SNP, describe how the organization will serve the unique needs of this population.

C.8.a.2. List the contracted dialysis facilities in "Attachment G –Dialysis Facilities".

C.8.a.3. List the contracted transplant facilities in "Attachment H – Transplant Facilities".

C.8.a.4. List any additional services that will be provided to beneficiaries with ESRD.

C.8.a.5. Describe the role of the care coordinator in the assessment and delivery of services needed by beneficiaries with ESRD.

NOTE to applicant: If a SNP is approved to serve ESRD beneficiaries, the exceptions authority in 42 CFR 422.50(a)(2)(iii) would apply and a waiver pursuant to 42 CFR 422.52 (c) will be provided to the applicant. The signed waiver will be attached to the MA contract. If this is a MA organization that is adding a SNP, the waiver will be sent following final approval. In both cases the waiver must be signed and returned within 10 calendar days.

C. 9. Targeting an Alternative Chronic Disease SNP to the One Described Above

NOTE to applicant: If the applicant also intends to target an alternative population with a severe or disabling chronic condition to the one described above, then duplicate the Chronic SNP section (Section C) of the template here and continue with Hxxxx_C_ Plan_ 2, etc.

ATTACHMENT A

Subsets for Dual Eligible SNPs

- Medicare Advantage Organizations (MAO) that offer Dual Eligible SNPs will be able to exclude specific groups of dual eligibles based on the MAO's coordination efforts with State Medicaid agencies. Requests for dual eligible subsets will be reviewed and approved by CMS on a case by case basis.

- To the extent a State Medicaid agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements, those same groups may also be excluded from enrollment in the SNP

    - For example, if an MAO offering a Dual Eligible SNP has a Medicaid managed care contract with a State Medicaid agency for all dual eligibles except for those who are medically needy with a spend down, the MAO may also exclude those dual eligibles from enrollment in the SNP.

- Those dual eligible groups which are included in the SNP request are those in which the MAO offering a SNP coordinates its Medicare related efforts in an integrated way with the State's Medicaid coverage and administration.

    - For example, a targeted group could be aged dual eligibles for which the SNP and State provide coordinated care.

- MAOs may limit enrollment to dual eligible beneficiaries through a dual eligible SNP without State Medicaid agency coordination (other than to be in compliance with applicable State licensing laws or laws relating to plan solvency), if enrollment is limited to one of the following three categories of dual eligible beneficiaries: 1) all dual eligibles; 2) full benefit dual eligibles or 3) Zero cost sharing duals (QMBs and QMB pluses). (Refer to definitions in Section III).

ATTACHMENT B

<u>SNP Service Area</u>

Date Submitted to CMS: ____________________
Applicant's Contracting Name (as provided in HPMS): __________________________
Plan #: _____________

State	**County**

ATTACHMENT C

Ensuring Delivery of Institutional SNP Model of Care

The following clarifies CMS expectations concerning the existence of an appropriate SNP Model of Care and enrollment will be limited to settings where it can be ensured that appropriate care can be delivered.

Background

The Medicare Modernization Act (MMA), Section 231**,** provided an option for Medicare Advantage (MA) coordinated care plans to limit enrollment to individuals with special needs. "Special needs individuals" were identified by Congress as: 1) institutionalized beneficiaries; 2) dual eligible beneficiaries; and/or 3) beneficiaries with severe or disabling chronic conditions as recognized by the Secretary.

An institutionalized individual was defined by regulation in 42 CFR 422.2 as an individual who continuously resides or is expected to continuously reside for 90 days or longer in a long term care (LTC) facility which is a skilled nursing facility (SNF), nursing facility (NF), intermediate care facility for the mentally retarded (ICF/MR); or inpatient psychiatric facility.

The preamble to the new regulations stated that CMS would also consider an institutional Special Needs Plan (SNP) to serve individuals living in the community but requiring an institutional level of care, although this was not included in the regulatory definition. (Many beneficiaries who would qualify for institutional status in the community reside in some type of assisted living facility (ALF).)

All SNP proposals are required to provide a description of the SNP Model of Care that the Medicare Advantage Organization (MAO) has designed and must implement specifically to serve the special population in the MAO's SNP. The word "specialized" in the statute clearly contemplates that the SNP product provides for "specialized" benefits that are targeted to meet the needs of the SNP population. Some aspects of the Model of Care concept described in Section III of the SNP solicitation, as well as how it would be implemented, will vary depending on the site of care LTC facility or in the community, based on, for example the availability of and need for staff and community services. Refer to the Model of Care definition in Section III of the SNP solicitation.

Institutional SNPs can be restricted to enrollment of those individuals residing in long term care facilities or to individuals living in the community , or both can be included under an institutional SNP

Policy Clarification #1

MAOs offering an institutional SNP to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the LTC facility to deliver its SNP Model of Care. The contracted/owned approach provides assurances that beneficiaries will be assessed and receive services as required under the SNP Model of Care. The institutional setting is complex and requires coordination between the SNP and facility providers and administrative staff, which can not be attained without a strong, well articulated MAO/facility relationship. Without a contractual or ownership arrangement, the MAO can not ensure the complex interface will function appropriately and care will be delivered in accordance with the Model of Care. Furthermore, this approach to limiting enrollment to contracted LTC facilities assures the delivery of uniform benefits

Policy Clarification #2

MAO marketing materials and outreach for new enrollment must make clear that enrollment is limited to the CMS approved targeted population and to those beneficiaries who live in, or are willing to move to, contracted LTC facilities. If the MAO's institutional SNP enrollee changes residence, the MAO must have appropriate documentation that it is prepared to implement the SNP Model of Care at the beneficiary's new residence. Appropriate documentation includes that the MAO has a contract with the LTC facility to provide the SNP Model of Care, and written documentation of the necessary arrangements in the community setting to ensure beneficiaries will be assessed and receive services as required under the SNP Model of Care.

Policy Clarification # 3

An institutional SNP serving individuals living in the community but requiring an institutional level of care may restrict access to enrollment to those individuals that reside in, or agree to reside in, a contracted Assisted Living Facility (ALF) as this is necessary in order to ensure uniform delivery of specialized care.

a. If a community based institutional SNP is limited to specific assisted living facilities, a potential enrollee must either reside or agree to reside in the MAOs contracted ALF to enroll in the SNP.

b. Proposals for this type of institutional SNP will be reviewed on a case by case basis for approval and the applicant must demonstrate the need for the limitation, including how community resources will be organized and provided.

ATTACHMENT D

NOTE to applicant: If consolidating SNP proposals across multiple contracts, include all the contract numbers in this consolidated proposal.

Attestation for Special Needs Plans (SNP) Serving Institutionalized Beneficiaries

(Name of Organization)
(H number)

I attest that in the event the above referenced organization has a CMS approved institutional SNP, the organization will only enroll beneficiaries in the SNP who (1) reside in a Long Term Care (LTC) facility under contract with or owned by the organization offering the SNP to provide services in accordance with the institutional SNP Model of Care approved by CMS, or (2) agree to move to such a facility following enrollment.

I attest that in the event the above referenced organization has a CMS approved institutional SNP to provide services to community dwelling beneficiaries who otherwise meet the institutional status as determined by the State, the SNP will ensure that the necessary arrangements with the community are in place to ensure beneficiaries will be assessed and receive services as specified by the SNP Model of Care.

I attest that if a SNP enrollee changes residence, the SNP will have appropriate documentation that it is prepared to implement the SNP Model of Care at the beneficiary's new residence, or disenroll the resident in accordance with CMS enrollment/disenrollment policies and procedures. Appropriate documentation includes that the SNP has a contract with the LTC facility to provide the SNP Model of Care, and written documentation of the necessary arrangements in the community setting to ensure beneficiaries will be assessed and receive services as required under the SNP Model of Care.

_____ _____

CEO **DATE**

_____ _____

CFO **DATE**

ATTACHMENT E

Quality Measurement For Special Needs Plans

CMS is currently working on developing a set of standard quality measures tailored to the special need populations served in the SNP program. Those measures are in development and are not yet available. Each applicant that offers or is seeking to offer a SNP should develop internal process and outcome measures that can be used by the organization to determine if the Model of Care is having its intended effect on the targeted SNP population.

An applicant should determine how its organization will record and report these measures for the specific population served by the SNP and how this information will be used to drive quality improvement.

ATTACHMENT F

Crosswalk Consolidating Proposals for Dual Eligible SNPs

Applicant's Contracting Name (as provided in HPMS): _<u>MAO SNP Example</u>________________ Date Submitted to CMS: _______________

Name of the baseline SNP proposal: **<u>Dual Baseline 1____</u>** **Summary of Addendums for Dual Eligible SNP**		**Number assignment for each dual eligible SNP type**	**Type of Dual SNP**	**Relationship of SNP product to State Medicaid services in the event of other subsetting**	**State contracts information if other subsetting is not being requested by applicant**	**Exclusive versus disproportionate percentage population**	**Service area to be served by SNP**	**SNP Model of Care**	**Meeting the needs of frail/disabled enrollees**	**Meeting the needs of enrollees with multiple chronic illnesses**	**Meeting the needs of enrollees that are at the end of life**	**Provider Network**	**Individuals with end stage renal disease**
<u>Contract #</u>	**<u>Plan #</u>**	**<u>A.1</u>**	**<u>A.2</u>**	**<u>A.3</u>**	**<u>A.4</u>**	**<u>A.5</u>**	**<u>A.6</u>**	**<u>A.7</u>**	**<u>A.7.i</u>**	**<u>A.7.j</u>**	**<u>A.7.k</u>**	**<u>A.8</u>**	**<u>A.9</u>**
H9999	H9999_A_Plan_1	✓		✓	✓		✓						
(Example)		✓		✓	✓		✓						
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ATTACHMENT F

Crosswalk Consolidating Proposals for Institutional SNPs

Applicant's Contracting Name (as provided in HPMS): ___MAO SNP Example____________ Date Submitted to CMS: ____________________

Name of the baseline SNP proposal: Institutional Baseline 1 **Summary of Addendums for Institutional SNP**		**Number assignment for each institutional SNP type**	**Type of institutional SNP**	**Identifying institutionalized beneficiaries**	**Identifying beneficiaries living in the community but requiring an institutional level of care**	**State contracts information**	**Exclusive versus disproportionate percentage population**	**Service area to be served by SNP**	**SNP Model of Care for the institutional setting**	**Description of Model of Care for beneficiaries living in the community but requiring an institutional level of care**	**Meeting the needs of frail/ disabled enrollees**	**Meeting the needs of enrollees with multiple chronic illnesses**	**Meeting the needs of enrollees that are at the end of life**	**Provider Network**	**Long term care facility**	**Individuals with end stage renal disease**
Contract #	**Plan #**	**B.1**	**B.2**	**B.2.c**	**B.2.d**	**B.3**	**B.4**	**B.5**	**B.6.a**	**B.6.b**	**B.6.c**	**B.6.d**	**B.6.e**	**B.7**	**B.8**	**B.9**
H9999	H9999_B_Plan_1	✓				✓		✓								
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ATTACHMENT F

Crosswalk Consolidating Proposals for Severe or Disabling Chronic Condition SNPs

Applicant's Contracting Name (as provided in HPMS): __MAO SNP Example___________ Date Submitted to CMS: ________________

Name of the baseline SNP proposal: **Chronic Baseline 1____** **Summary of Addendums for Severe or Disabling Chronic Condition SNP**		**Number assignment for each severe or disabling chronic condition SNP type**	**Type of chronic condition SNP**	**State contracts information**	**Exclusive versus disproportionate percentage population**	**Service area to be served by SNP**	**SNP Model of Care**	**Meeting the needs of frail/ disabled enrollees**	**Meeting the needs of enrollees with multiple chronic illnesses**	**Meeting the needs of enrollees that are at the end of life**	**Provider network**	**Individuals with end stage renal disease**
Contract #	**Plan #**	**C.1**	**C.2**	**C.3**	**C.4**	**C.5**	**C.6**	**C.6.i**	**C.6.j**	**C.6.k**	**C.7**	**C.8**
H9999	H9999_C_Plan_1	✓		✓		✓						
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ATTACHMENT G – Dialysis Facilities Table

Dialysis Facilities

Date Submitted to CMS: _____
Applicant's Contracting Name (as provided in HPMS): _____
Contract #/Plan #: H9999_A_Plan_1 (example)___

Name of Dialysis Facilities	Medicare Provider #	Facilities Address

ATTACHMENT H –Transplant Facilities Table

Transplant Facilities

Date Submitted to CMS: _____
Applicant's Contracting Name (as provided in HPMS): _____
Contract #/Plan #: H9999_A_Plan_1 (example)___

Name of Transplant Facilities	Medicare Provider #	Facilities Address

ATTACHMENT I – Long Term Care Facilities Table

Long Term Care Facilities

Date Submitted to CMS: _____
Applicant's Contracting Name (as provided in HPMS): _____
Contract #/Plan #: H9999_B_Plan _1 (example)___

Name of Long Term Care Facilities	Medicare Provider #	Facilities Address

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

IV. CLAIMS

A. Describe applicant's 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 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 applicant 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, provide the diagnostic/procedure codes for the requested service(s) 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 applicant or any MA 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 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 applicant 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
8. Diagnostic and/procedure codes for Moral and Religious Exception

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 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 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.

PART D PRESCRIPTION DRUG BENEFIT - 422.252

I. PART D PRESCRIPTION DRUG BENEFIT

The Medicare Modernization Act requires that coordinated care plans offer at least one MA plan that includes a Part D prescription drug benefit (an MA-PD) in each county of its service area. To meet this requirement, 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 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 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).

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