MEDICARE ADVANTAGE
INITIAL CONTRACT APPLICATION

For

MEDICAL SAVINGS ACCOUNT (MSA) PLANS

MSA applicants that wish to offer a product in the MSA demonstration are required to complete the Demonstration Addendum.

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

2008

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OMB No. 0938-0935

CENTER FOR BENEFICIARY CHOICES
MEDICARE ADVANTAGE GROUP
MEDICARE ADVANTAGE MEDICAL SAVINGS ACCOUNT PLAN APPLICATION

H#: (if available) DOES APPLICANT CURRENTLY OPERATE AN 1876 COST PLAN? Yes_____ No _____ PLEASE CHECK WHICH OF THE FOLLOWING YOU ARE REQUESTING WITH THIS APPLICATION: MSA ONLY _____ OR MSA WITH EMPLOYER GROUP WAIVER PLAN (EGWP) _____ NAME OF LEGAL ENTITY: TRADE NAME: (if different)	MAILING ADDRESS: ORGANIZATION WEB ADDRESS:
CEO OR EXECUTIVE DIRECTOR:	
NAME AND TITLE: TELEPHONE NUMBER: FAX NUMBER: EMAIL ADDRESS:	MAILING ADDRESS: (If different than above)
BOARD CHAIRMAN - NAME AND ADDRESS:	FEDERAL TAX STATUS: For profit____ Not for profit____
CONTACT PERSON FOR THIS APPLICATION:	
NAME AND TITLE: TELEPHONE NUMBER: FAX NUMBER: E-MAIL ADDRESS:	MAILING ADDRESS: (If different than above)
I certify that all information and statements made in this application are true, complete, and current to the best of my knowledge and belief and are made in good faith.	

Signature, CEO/ Executive Director	Date

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

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

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MINIMUM ENROLLMENT WAIVER REQUEST

(See Medicare Managed Care Manual Chapter 11)

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

I. SUMMARY DESCRIPTION

A. Briefly describe the applicant in terms of its history and its present operations. Cite significant aspects of its current financial, marketing, general management, and health services delivery activities. (Do not include information requested in the Legal Entity section.) Please include the following:

1. A summary of recent financial performance including current operating experience and trends.
2. The extent of the current Medicare population served by the applicant, if any, and in what programs the Medicare beneficiaries are enrolled.
3. A statement as to whether the applicant currently operates a commercial Health Savings Account (HSA) plan or other type of commercial tax-favored health plan or a Medicare Advantage Medical Savings Account (MSA) plan. State the number of enrollees in each plan. Also provide a description of the commercial and/or Medicare Plan.
4. State the total enrollment in each health care product offered by the applicant in any geographic area requested for an MSA Plan.

B. HPMS Access and Payment Form Information ~~Medicare Contract Information~~

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

2. The Payment Information form is located at:

http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/pmtform.pdf
The document contains financial institution information and Medicare contractor data.

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

II. POLICYMAKING BODY – [422.503]

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

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

1. Are applicant's management decisions ratified by the full Board?

2. How often does the applicant formally evaluate the CEO performance?

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

4. 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. In the Documents Section, provide an organizational chart(s) showing clear lines of authority, responsibility and any delegation(s) of authority to other entities.

D. Describe the communication within the applicant's organization to assure coordination among its physicians, board, and between the Medical Director and key management personnel.

III. KEY MANAGEMENT STAFF - [422.501(b), 422.503]

A. On the following chart, indicate the individuals responsible for the organization's key management functions.

Staff Function	Name	Title	Employed By
CEO/President			
Medical Director			
Utilization Management			
CFO			
Marketing			
Government Relations			
Management Information Systems			

B. In the Documents section, provide position descriptions and resumes, which describe how each position above will relate to the functions and management of an MA MSA Plan.

IV. COMMUNICATION WITH CMS AND MANAGEMENT INFORMATION SYSTEMS– [422.503]

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

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

V. UPGRADES OF THE HEALTH INFORMATION TECHNOLOGY

APPLICANT MUST ATTEST 'YES' TO EACH OF THE FOLLOWING QUALIFICATIONS TO BE APPROVED FOR A PART C CONTRACT. ATTEST 'YES' OR 'NO' TO THE STATEMENT BELOW EACH OF THE FOLLOWING QUALIFICATIONS 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.		

VI. PRIVACY, SECURITY, AND ELECTRONIC TRANSACTIONS

A. Health Insurance Portability And Accountability Act (HIPAA)

APPLICANT MUST ATTEST 'YES' TO EACH OF THE FOLLOWING QUALIFICATIONS TO BE APPROVED FOR A PART C CONTRACT. ATTEST 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS BY PLACING A CHECKMARK IN THE RELEVANT COLUMN:	YES	NO
1. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Privacy of Individually Identifiable Health Information under 45 CFR Parts 160 and 164 subparts A and E.		
2. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Security Standards under 45 CFR Parts 160, 162 and 164		
3. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standard Unique Health Identifier for Health Care Providers under 45 CFR Parts 160 and 162.		

4. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Electronic Transactions under 45 CFR Parts 160 and 162.		
5. ~~Applicant agrees to transmit payment and remittance advice consistent with the HIPAA-adopted ACS X12N 835, Version 4010/4010A1: Health Care Claim Payment and Remittance Advice Implementation Guide ("835").~~		
6. Applicant will report to CMS any unauthorized public disclosures of protected health information. ~~within 48 hours of the Applicant's detection of such disclosure.~~		
7. Applicant agrees that it, and its subcontractors, shall not perform any activities under its Part C contract at a location outside of the United States without the prior written approval of CMS. In making a decision to authorize the performance of work outside of the United States, CMS will consider the following factors, including but not limited to: • The Applicant's/ subcontractor's compliance with, and the enforceability of, Part C program requirements concerning system security; • The Applicant's/subcontractor's compliance with and the enforceability of, Part C program requirements concerning information and data confidentiality and privacy; • The Applicant's/subcontractor's compliance with, and the enforceability of, other relevant Part C program requirements; • The Applicant's/subcontractor's compliance with, and the enforceability of, Part C corporate compliance plan requirements; • The Applicant's/subcontractor's compliance with, and enforceability of all laws and regulations applicable to work performed outside of the United States; and • The performance of the work outside of the United States is in the best interests of the United States.		

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.		

VII. GEOGRAPHIC AREA – [422.504(f)(2)(iii)]

NOTE: THE ~~ALL~~ APPLICANT~~S~~ MUST ENTER ITS REQUESTED SERVICE AREA IN HPMS.

Complete this section if the applicant plans to limit enrollment to residents of a specific geographic area, or are licensed by a state for a specific area and may enroll only from that area or if you are requesting a capacity limit.

For your expected Medicare enrollment area, clearly describe the requested area in terms of geographic subdivisions such as states, counties, cities or townships. If not a full county, the zip codes for the requested geographic area must be provided. Place maps in the Documents section of the application.

CONTINUATION AREA

(See Medicare Managed Care Manual Chapter 4)

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

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

I. DESCRIPTION

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

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

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

II. STATE AUTHORIZATION – [422.400]

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

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

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

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

IV. CONTINUATION AREA MATERIALS

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

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

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

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

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

4. CA notices to members.

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

ORGANIZATIONAL AND CONTRACTUAL

I. LEGAL ENTITY - [422.400, 422.501]

A. 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) the organization will use to market its Medicare product.

B. In chronological order for the last five years, describe the legal history of the entity including predecessor corporations or organizations, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved.

Describe the type of legal entity of the applicant and whether it is a subsidiary of another corporation. Include in the Documents part a copy of the Articles of Incorporation, bylaws and other legal entity documentation, such as a Partnership Agreement.

If the organization is a line of business, briefly describe the company's (legal entity) other lines. If the applicant is the legal entity and operates other lines of business, briefly describe these operations.

C. State whether the applicant meets Internal Revenue Service requirements (as a bank, insurance company or other entity as set out in Treas. Reg. Secs. 1.408-2(e)(2) through (e)(5)) and will serve as MA MSA trustee or custodian for receiving Medicare deposits to MSA plan enrollee accounts. State the name of the trustee or custodian line of business. Also, note whether the applicant has or will have a contractual relationship with outside trustees or custodians.

D. If the applicant currently offers HSA plans in the commercial market or MSA plans, please describe the relationship with your banking partner. Describe the services provided by the banking partner, such as how members' access funds, how spending is tracked and applied to the deductible, how claims are processed, customer service, etc.

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

A. Use the State License table to give information about the jurisdictions in which the organization anticipates Medicare enrollment. Indicate on the table whether the applicant holds a state license, and, if so, the type of license. Also mention whether the state regulates Medicare activities. Give the amount of any state restricted reserve that the state requires in the event of insolvency. Also list names, addresses, and telephone numbers of appropriate state regulatory officials who have authority over the organization.

Complete the table *cert.doc* electronically and place the hard copy in the Documents part.

B. If the applicant is located in jurisdictions that do not require a license or certificate, describe the legal environment for the organization to operate the MA MSA Plan.

III. ORGANIZATION CHARTS – [422.503]

Provide two separate charts at the end of this chapter as follows:

A. The applicant itself: Show detailed lines of authority, including the relationships among the Board of Directors, the Chief Executive Officer, the Chief Financial Officer, the Administrator of the organization, etc., and any departments that will be involved with the MA MSA Plan, including the medical/health services delivery component, if the organization has one. Include titles and names of incumbents. If the organization is a line of business of a corporation, show its relationship to the corporate structure.

B. Contractual Relationships: If applicable, indicate current contractual relationships between the organization and contractors for health services, administrative, management, and marketing services.

IV. RISK SHARING - [422.208, 422.503]

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

V. CONTRACTS FOR ADMINSTRATIVE/MANAGEMENT SERVICES - [422.504]

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

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

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

D. Complete the Administrative/Management Delegated Contracting Matrix – for each delegated entity and include it in the Documents Section. [This form is a separate file *matrixadm.doc*; place a hard copy in the Documents Section].

E. Indicate the categories of services obtained through contractual arrangements and the status of the contract(s) in the management services table.

Management Services	**Contractor**	**Contract Effective Date**	**Contract End or Auto Renewal**
Marketing			
Claims Processing			
Data Processing			
Management Services			
Administrative Services (including outside MSA trustees or custodians)			
Other			

F. Include a copy of each contract in the Documents Section. Specify whether any are specific to Medicare.

VI. BUSINESS INTEGRITY

A. Other than government actions addressed in paragraph C below, give a brief explanation and status of each current legal action and any legal actions in the past three years, if applicable, involving the applicant's legal entity. Please include the following:

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

B. The applicant and its affiliated companies, subsidiaries or subcontractors, subcontractor staff, any member of its board of directors, any key management or executive staff, or any major shareholder of 5 percent or more agree that they are bound by 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 involving the Applicant (and Applicant's parent if applicable) and its subcontractors, including any key management or executive staff, or any major shareholders (5 percent or more), by a government agency (state or federal) over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. Provide a brief explanation of each action, including the following:

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

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

VII. COMPLIANCE PLAN – [422.503]

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

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

ON SITE DOCUMENTATION

Organizations should have the following available for inspection if CMS determines a site visit is necessary:

1. Legal entity documentation
2. State license
3. Evidence of marketing licenses or approvals
4. Board and committee meeting minutes
5. Policy and procedures manuals

HEALTH SERVICES DELIVERY

I. ARRANGEMENTS FOR HEALTH CARE SERVICES – [422.112]

A. Describe how the applicant will assure that services will be provided through institutions, entities, and persons who have qualified under the appropriate requirements of Title XVIII.

II. MEDICARE HEALTH BENEFITS – [422.111, 422.103]

A. How will the applicant communicate information to enrollees on how to access health care from contracted and non-contracted providers?

B. Explain how the applicant will communicate to enrollees the coverage of services before the deductible is met and after the deductible is met.

C. Explain any differences in costs if a contracted network is or is not used.

D. Explain how the applicant will communicate the difference in cost if the contracted network is used or not used.

E. How will the applicant ensure that appropriate risk-adjustment data is collected and reported to CMS?

ON-SITE DOCUMENTATION

Have the following available for inspection at a site visit:

1. Encounter forms
2. Policy manual of procedures for health professionals – where applicable.
3. Evidence that institutional providers and other entities providing ancillary services are certified under Title XVIII of the Social Security Act
4. Authorization and referral forms for commercial and Medicare, if different, and where applicable.

MEDICARE

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

I. MARKETING STRATEGY – [422.80]

A. Describe briefly the marketing strategy for Medicare 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 strategy and promotion programs)
3. Intent to follow Medicare Marketing guidelines
4. Systems for managing inquires and servicing members
5. Marketing staffing (include, if applicable, any information on state jurisdiction over required staff licensure, certification, registration and/or compensation)
6. Marketing budget
7. Allocation of resources and efforts to accommodate and market to disabled and socially disadvantaged beneficiaries
8. Marketing representative oversight and training on CMS Medicare Guidelines
9. Plans for community education/outreach and public relations

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

C. Submit policies and procedures for informing staff on changes in provider networks.

D. Provide the MSA plan internet website address that makes basic MA plan information and materials available to interested Medicare beneficiaries and other parties.

(Note that providing this information on the website would not remove the requirement that these materials be made available to beneficiaries in print format.)

II. ENROLLMENT AND DISENROLLMENT – [422.56, 422.62(d)]

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

B. Enrollment and Disenrollment Processes:

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

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

3. Describe how the applicant will ensure that individuals enroll in your MSA plan only during their Initial Coverage Election Period (ICEP), or the Annual Coordinated Election Period (AEP).

4. Describe how the applicant will ensure that individuals disenroll from your MSA plan only during the appropriate election periods (SEP or AEP).

5. Describe how the applicant will ensure that individuals enrolled in health benefit plans with FEHB, VA or DOD are not able to enroll in your MSA plan.

6. Describe the systems, policies and procedures for identifying Medicare working aged enrollees. Note that such individuals are excluded from enrollment in an MA MSA plan. Also note that should an MA MSA plan enrollee become working aged after enrollment, disenrollment is required.

7. Describe how the applicant will ensure that individuals who elect hospice do not enroll in your MSA plan.

8. Describe how the applicant will obtain assurances from the enrollee that he or she will reside in the United States for at least 183 days during the year for which election is effective.

9. 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 a Medicare Advantage product?

10. Describe how the applicant will incorporate the establishment of member MSA accounts into the plan's enrollment process. How will the MSA trustee validate these enrollments?

III. MEMBERSHIP

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

B. Will the applicant submit an enrollment capacity waiver? If so, describe the process for maintaining a waiting list for potential enrollees.

IV. CLAIMS

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

B. Coverage of Out-of-Network Service - Ambulance Services, Emergency and urgently-needed services; renal dialysis service and post stabilization care - Describe the work flow and who is responsible for each stage of the process 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 the 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 the applicant's ability to pay interest payment requirements on claims that are not paid on a timely manner.

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

G. Will providers be permitted to balance bill the beneficiary before and after the deductible has been met? If balance billing is permitted, describe the organizational requirements and processes. Include all communications to beneficiaries and providers. Provide Policies and Procedures and how the plan will inform the beneficiaries and providers of this requirement. Provide the Policies and Procedures in the Documents Section.

H. Once the deductible has been met, how will the applicant monitor the amount collected by contracted and non-contracted providers to ensure that these amounts do not exceed the amounts permitted to be collected under law?

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

J. Please describe how the applicant will ensure that members are not charged more than the Medicare-allowed charge (up to the limiting charge for non-Medicare participating providers), when they receive medical services. Also include a description on how providers will be able to determine how much to charge the member at point-of-service and how much to bill the plan. For example, once the member reaches his/her deductible and the plan is responsible for all covered costs, how will the provider know not to charge the member any cost-sharing?

V. MEDICARE MARKETING MATERIAL – [422.80]

Definition: [422.80(b)]

Marketing materials include any informational materials targeted to Medicare beneficiaries which (1) Promotes 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 into an 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 MA organization can market or advertise its Medicare products, the MAO must be in compliance with the statutory requirements for approval of marketing materials and election forms as outlined in Section 1851 of the Social Security Act, Section 422.80 of the CFR and the Medicare Marketing guidelines.

- Subscriber agreement/Evidence of coverage
- Member handbook
- Enrollment and disenrollment notices
- Claims payment/denial notices (coverage/denial notices), including those used by delegated providers
- Correspondence relating to grievances/appeals
- Authorization/referral forms – where applicable.

A. Member Grievance Procedure – [422.564]. Explain the member grievance procedure that will be available to Medicare MSA Plan enrollees.

B. Medicare Reconsideration Appeals-Hearings – [422.582-422.616]. Explain the Medicare reconsideration and appeals procedures, including when these

procedures will be applied in place of the member grievance procedure. Provide a copy of these procedures in the Documents part.

C. Patient Self-Determination Amendments – [422.128]. Explain the organization's process of providing information regarding advance directives at the time of a member's enrollment. Provide forms in the Documents part.

ON-SITE DOCUMENTATION

Have the following available for inspection at a site visit:

1. Any policies and procedures used to determine whether a particular Medicare beneficiary can be enrolled
2. Marketing budget

FINANCIAL

(See Medicare Managed Care Manual Chapter 7)

I. FISCAL SOUNDNESS – [422.502(f)(1)]

A. Please provide a copy of your most recent independently certified audited statements. (An applicant that does not have a state license at the time of this application, or is within its first year of operation with no audit, must 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.**

DOCUMENTS TABLE OF CONTENTS

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Medicare set-up forms
Organizational charts
Position descriptions and resumes
Maps of geographic area

ORGANIZATIONAL AND CONTRACTUAL
State approval for business name
Articles of Incorporation
Bylaws
Other entity documents, as applicable
State Certification Form *[cert.doc]*
State license table
Legal Table 1 *[legal-1.xls]*
Administrative/Management services contracts
Description of provider contracting arrangements in requested service areas
Matrix for Administrative/Management Services *[matrixadm.doc]*
Compliance Plan

MEDICARE
Medicare materials
Policies/procedures on balance billing
Medicare reconsideration and appeals procedures
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FINANCIAL
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Unaudited financial statements
Audited financial statements of guarantors/lenders
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Prospectus
Insurance table
Reinsurance/insolvency policies
Insolvency documentation
State financial requirements