

MEDICARE ADVANTAGE APPLICATION

Guidelines

**Introduction,
General and Technical Information,
Onsite Documentation,
&
Table Instructions**

For:

CCP, PFFS, MSA, RPPO, & SAE Applications

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

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2008

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INTRODUCTION

PREPARATION OF THE MEDICARE ADVANTAGE (MA) APPLICATION:

The computer-assisted format is for compatible personal computers using Microsoft Word for Windows and Microsoft Excel. The MA application files listed on the CMS web site at <http://www.cms.hhs.gov/MedicareAdvantageApps/> contains important information and a list of files that comprise a complete application. All MA application files are in a .zip format, but when opened, the files are in either Microsoft Word or Excel, and will be named with the corresponding extension. Please see the technical instructions included within this document for more detailed guidance while working on the application.

Note for Employer/Union-Only Group Waiver Plan (“800 series”) Applicants:

All new applicants who wish to offer Employer/Union-Only Group Waiver Plans (“800 series” EGWPs) must complete the MA “800 series” EGWP application, which will be an automated application on CMS’ Health Plan Management System (HPMS). Specific application instructions for new applicants who intend to offer EGWPs *without also offering plans to individual beneficiaries* will appear in instructions posted with the final 2008 Medicare Advantage Applications Guidelines.

CMS ASSISTANCE:

Assistance is available to all applicants in the preparation of this application from the Medicare CMS Central Office and Regional Medicare Advantage staffs. You may call either Kateisha Martin in the CMS Central Office (410) 786-4651 or a Regional Office to request assistance. A list of CMS Regional Office and the contact information follows and this list can also be found at <http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/cmsregional.pdf>.

HPMS ACCESS:

MA organizations are required to use HPMS to carry out various CMS Medicare managed care contract application functions, including the application process, formulary submission process, bid submission process, ongoing operations of the MA and Part D programs, and reporting and oversight activities.

Your organization will need the following to access HPMS:

- (1) Internet **or** Medicare Data Communications Network (MDCN) connectivity,
- (2) Use of a Microsoft Internet Explorer web browser (version 5.1 or higher) with 128-bit encryption, and

- (3) A CMS-issued user ID and password with access rights to HPMS for each user within your organization who will require such access.

Applicants must access the CMS website at:

<http://www.cms.hhs.gov/AccessToDataApplication/Downloads/Access.pdf>

to obtain the latest version of the “Application for Access to CMS Computer Systems” form. In addition to completing each section of the form, as appropriate, the applicant should:

1. Check “**Mgd Care Org/Group Health Plan**” in Section 2 of the form.
2. Write **HPMS** on the first blank line in Section 3a. If your organization has been assigned a contract number for the new 2008 product, include the contract number in Section 2h. If your organization has not yet been assigned a contract number, please leave Section 2h blank.
3. You must sign and date page 2 containing the Privacy Act statement and return it along with the form. Your request cannot be processed without this signature and date.
4. The original signed form (both pages) should be placed in a separate envelope mark HPMS access form, and placed in the same mailing package as your 2008 MA application.

In order to expedite the processing of this request, CMS strongly recommends that organizations refrain from requesting any additional systems access other than HPMS on this particular form submission at this time. Combining the HPMS request with other CMS system access requests will delay the HPMS access approval.

If you have questions about completing the Application for Access to CMS Computer Systems form for HPMS access, please contact Don Freeburger (410-786-4586 or Don.Freeburger@cms.hhs.gov) or Neetu Jhagwani (410-786-2548 or Neetu.Jhagwani@cms.hhs.gov). CMS will provide you with additional technical instructions on accessing HPMS, including its website address, once your user ID has been processed.

Important Note for Current HPMS Users:

If your organization already has HPMS access for other CMS functions, such as under another MA product, you do not need to request a new CMS user IDs, unless you need to obtain HPMS access for new users at your organization. Once you receive your new pending contract number, you may contact Don Freeburger at 410-786-4586 or Don.Freeburger@cms.hhs.gov to request that your new contract number be assigned to an existing HPMS user ID.

PAYMENT INFORMATION FORM:

Please complete the Payment Information form that 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. The completed form must also be faxed to Yvonne Rice at (410) 786-0322.

ENTITIES THAT MAY USE EACH APPLICATION

A description of the various types of organizations that may use a MA application is listed below:

COORDINATED CARE APPLICATION:

Organizations that may use this type of application are: Health Maintenance Organizations (HMOs); Local Preferred Provider Organizations, (PPOs); State Licensed Provider-Sponsored Organizations (PSOs); and other State licensed risk-bearing entities eligible to offer health benefits coverage.

PRIVATE FEE-FOR-SERVICE APPLICATION:

An organization may apply to offer a Medicare Advantage Private Fee-for- Service (PFFS) agreement with the Centers for Medicare & Medicaid Services (CMS) only if it is eligible as defined in the Social Security Act. Specifically, PFFS is defined as being a Medicare Advantage organization (MAO) that:

- (1) Reimburses providers and suppliers on a fee-for-service basis without placing the provider or supplier at financial risk;
- (2) Does not vary the payment rate based on the utilization relating to such a provider/supplier; and
- (3) Does not restrict the selection of providers/suppliers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions established by the plan.

The applicant must meet the definition above to be eligible for an MA PFFS agreement.

MEDICAL SAVINGS ACCOUNT APPLICATION:

An organization may apply to enter into a MA Medicare Savings Account (MSA) contract with the Centers for Medicare and Medicaid Services (CMS) only if it is eligible as defined in the Social Security Act. Specifically, Section 1859(b)(3)(A) of the Act defines an MSA plan as an MA plan that:

- Provides reimbursement for at least all Medicare-covered (Parts A & B) items and services (except hospice services) after an enrollee incurs countable expenses equal to the amount of the plan's annual deductible.
- Counts for purposes of the annual deductible at least all amounts that would have been payable under original Medicare (Parts A & B) if the individual receiving the services in question was a Medicare beneficiary not enrolled in an MA plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.

- After the annual deductible is reached, provides a level of reimbursement equal to at least the lesser of actual expenses or the amount that would have been paid under original Medicare if the individual receiving the services in question was a Medicare beneficiary not enrolled in an MA plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.
- An organization may also apply to enter into an MA MSA demonstration contract with CMS. An MSA demonstration plan must meet the above qualifications but can cover preventive care services before the deductible is met and have beneficiary cost-sharing after the deductible with an out-of-pocket limit.

The applicant must be able to satisfy the provisions above to be eligible for an MA MSA contract in addition to the minimum enrollment provisions in regulations at 422.514(a).

Please note that if the organization is a separate legal entity, then it is the applicant. If the organization is a line of business of a legal entity, then the legal entity is the applicant.

REGIONAL PPO APPLICATION:

Organizations that may use this type of application are: HMOs; State Licensed Provider-Sponsored Organizations (PSOs); Preferred Provider Organizations (PPOs) and other State licensed risk-bearing entities eligible to offer health benefits coverage that wish to offer one or more Medicare Advantage Regional PPO product.

- If the applicant consists of a combination of entities, each entity must provide the information required in the application. If an entity operates using sub contractual arrangements, the lead entity must explain how the subgroups tie together.
- An MA Regional PPO is defined in the Medicare Prescription Drug Improvement and Modernization Act of 2003, Title II, Subtitle C, at Section 221 as an MA organization that:

Has a network of providers who contractually agree on reimbursement for plan-covered services and provide reimbursement for all covered benefits regardless of whether such benefits are provided within the organization's contracted network. The service area is one or more entire MA RPPO region(s).

Applicant organizations may propose to offer a Regional PPO in more than one RPPO region or in all of the RPPO regions. Applicants may also propose to offer more than one Regional PPO plan in any one RPPO region.

- A description of the states included in each Regional PPO area can be found at <http://www.cms.hhs.gov/medicarerereform>.

SERVICE AREA EXPANSION APPLICATION FOR COORDINATED CARE, PFFS & MSA APPLICANTS:

- Organizations that may use this application are HMOs; Local PPOs, State Licensed PSOs; PFFS, and MSA organizations.

INFORMATION FOR APPLICANTS

ANNUAL BIDDING SUBMISSIONS:

No bid submission is needed at the time the application is submitted. Further instructions and time frames for bid submissions will be provided at <http://www.cms.hhs.gov/MedicareAdvantageApps/> and <http://www.cms.hhs.gov/pdps>. Annual bids are due the 1st Monday in June.

MEDICARE ADVANTAGE PFFS:

Organizations have requirements similar to coordinated care organizations and are governed by the code of federal regulations: 42 CFR Part 422. Yet, PFFS requirements are a hybrid between Medicare Advantage product rules and Original Medicare fee-for-service operations. PFFS organizations choose at the time of application to offer a network or non-network product.

- Under the network model, the organization must establish contracts with a sufficient number and range of providers.
- Non-network model PFFS organizations “deem” providers to provide health care services to Medicare beneficiaries. (This is different from deeming MAO compliance under 422.156.)
- A provider or supplier is “deemed” to have a contract with a PFFS organization if the provider or supplier knows, before furnishing service that the:
 1. beneficiary is a PFFS member, and
 2. provider or supplier must know both the terms and conditions of plan payment or has reasonable access to the terms and conditions of plan payment.
- If a provider or supplier does not meet these criteria, the provider or supplier is a non-contracting provider. In both cases, the PFFS organization must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and/or Part B and agrees to provide services to the beneficiary.
- Claims System Testing: PFFS organizations must demonstrate access by paying claims at rates not less than the rates that apply under original Medicare for the provider in question. Currently initial PFFS applicants submit a reimbursement grid and must complete a claim system test to determine whether the PFFS organization is meeting the requirements in 422.114, access to services under an MA PFFS organization. See Claims section of PFFS application.

PART D PRESCRIPTION DRUG APPLICATION:

The Medicare Modernization Act requires that coordinated care plans offer at least one MA plan that includes a Part D prescription drug benefit (an MA-PD) in each county of its service area. To meet this requirement, the applicant must timely complete and submit a separate Medicare Advantage Group Prescription Drug Plan application (MA-PD application) in connection with the MA-PD. **Failure to file the required MA-PD application will result in a denial of this application and will be considered an “incomplete” MA application.**

The MA-PD application can be found at:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage or the applicant may contact Marla Rouse at 410/786-8063. Specific instructions to guide MA applicants in applying to qualify to offer a Part D benefit during 2007 are provided in the MA-PD application.

The MA-PD application is an abbreviated version of the application used by stand-alone Prescription Drug Plan (PDPs), as the regulation allows CMS to waive provisions that are duplicative of MA requirements or where a waiver would facilitate the coordination of Part C and Part D benefits. Further, the MA-PD application includes a mechanism for applicants to request CMS approval of waivers for specific Part D requirements under the authority of 42 CFR 423.458 (b)(2).

MA APPLICANTS OFFERING A SPECIAL NEEDS PLANS:

Instructions for completing a Special Needs Plan (SNP) proposal are included in the section of the Coordinated Care Plan (CCP) application, Regional Preferred Provider Application (RPPO) and Service Area Expansion (SAE) application entitled “Solicitation for Special Needs Plan Proposal” (Solicitation)

If the applicant is seeking to offer a disproportionate share SNP, the applicant should access the following websites for assistance:

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

Additionally, an applicant seeking to offer a dual eligible SNP may review information on coordination with the applicant's State Medicaid agency by accessing the documents available for downloading at the following website:

http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#TopOfPage

Of particular interest on the above website is the State Guide to Integrated Care and the "How-To" guides for enrollment, marketing, and quality.

If you require technical assistance, please contact:

Cathy Barchi 410-786-7619 or cathy.barchi@cms.hhs.gov

DEFINITIONS

Section 42 CFR 422.2 includes the following definitions:

Minimum enrollment: To be eligible for a MA contract, the applying organization must have at least 5,000 enrollees or 1,500, if non-urban, as defined under 42 CFR 412.503 and 42 CFR 422.514. The applicant must have this enrollment at the time the application is submitted; however, if it lacks this enrollment, it may be eligible for a contract if CMS grants a minimum enrollment waiver. The request for a waiver is included in this application and must be completed if applicable.

MA Organization (MAO) means an entity licensed by the state as a risk bearing entity that is certified by CMS as meeting MA contract requirements.

MA plan means health benefits coverage offered under a policy by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan.

A Religious Fraternal Benefit (RFB) Society is an organization that is tax exempt and is affiliated with, carries out the tenets (principles or doctrines) of and shares a religious bond with, a church, convention or association of churches, or an affiliated group of churches. A RFB Society may apply to become a Medicare Advantage Organization if it meets all of the qualifying criteria. A RFB may offer any type of a MA plan.

Mandatory Supplemental Benefits are health care services not covered by Medicare that an MA enrollee must accept or purchase as part of an MA plan. Mandatory supplemental benefits may be funded by changes in cost sharing for benefits under the original Medicare fee for service program, premiums, other cost sharing, and application of the beneficiary rebate rule, in section 1854(b)(1)(C)(ii)(I) of the Act or any of the above. **NOTE: MSAs cannot offer mandatory supplemental benefits- see 42 CFS 422.103 (a).**

Optional Supplemental Benefits are health services not covered by Medicare that are purchased at the optional of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost sharing. These services can be grouped or offered individually. **Note:** MSAs are permitted to offer optional supplemental benefits in accordance with 42 CFR 422.104.

REFERENCE MATERIALS

Information requested in this application is based on Public Law 108-173, Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The applicant should be familiar with the following materials:

1. Social Security Act, 42 USC 1395 et seq.
http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
2. 42 CFR Part 422
3. Medicare Managed Care Manual
4. Medicare Marketing Guidelines

GENERAL INSTRUCTIONS

To clarify any question, refer to the regulatory citation that is provided after most questions. CMS strongly recommends and encourages Medicare Advantage applicants to refer to the regulations to clearly understand the nature of the requirement and to provide an appropriate response.

A **completed** application includes:

Note: An Application for Access to CMS Computer Systems (for HPMS access) is required. See <http://www.cms.hhs.gov/AccessToDataApplication/Downloads/Access.pdf>

1. Cover Sheet with the appropriate signatures
2. Table of Contents for the Narrative part
3. Table of Contents for Documents part
4. Narrative part, with each application question copied and followed by brief and precise answers, divided into chapters
5. Documents part, arranged by chapters, that follows the Narrative.
6. Submission of appropriate State License by the MA applicant, which is approved by the appropriate state to provide health care services to Medicare beneficiaries.
7. On or before the first Monday of June of every year, MA organizations must submit a bid for each MA plan for the upcoming year based on their determination of monthly expected revenue needs. Each bid will have 3 components, original Medicare benefits (A/B), prescription drugs under Part D, and supplemental benefits. Bids must also reflect the amount of enrollee cost sharing. CMS will review bids and request additional information if needed. MA Organizations must submit the benefit plan or plans it intends to offer under the bids submitted. Benefit plans must be submitted on or before the first Monday in June.
8. Part D application – specifics about this application can be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage. This application is a separate document.
Note: PFFS plans have the option to offer the Part D drug benefit. MSA plans can not offer the Part D drug benefit.
9. MSA Demonstration Addendum – This is a separate document that MSA applicants are required to complete if they wish to offer a product under the MSA Demonstration. This is in addition to the MSA Initial Application or the SAE Application.

PAGINATION:

Number all pages consecutively from the Narrative through the entire Documentation Section. Use a page number when referring to any document. If pages must be inserted after numbering has been completed, additional pages may be noted by A, B, C, etc.

TABLES:

Tables that are separate files should be placed in the Documents Section of the application, organized by chapter, as directed in the Narrative section. The Tables can be found within each application at <http://www.cms.hhs.gov/MedicareAdvantageApps/>

PRINTING AND BINDING:

Both sides of the page should be used. Tabs should be inserted for each chapter of the Narrative and Documents parts. Each copy should be put in loose-leaf binders.

COPIES:

The number of copies required may differ for each application. Submit the copies as indicated under each application type.

MA Application Types and Copies to Submit										
	Number of Copies									
	Hard copies					Electronic copies				
Send copies to:	CCP	PFFS	MSA	Reg PPO	SAE	CCP	PFFS	MSA	Reg PPO	SAE
Centers for Medicare and Medicaid Services CBC/MAG C4-22-04 7500 Security Boulevard Baltimore, Maryland 21244-1850 <i>Note: If applying for a RPPO, use the Attn line below:</i> ATTN: Regional. PPO	1	1	2	2	1	2	2	1	1	2
The appropriate regional office List available at http://www.cms.hhs.gov/HealthPlansGenInfo/05_RegionalOfficeCoordinates.asp#TopOfPage	1	1	0	0	1	1	1	0	0	1

- **If the applicant is submitting a SNP Solicitation, The applicant must include the SNP solicitation in the MA application, and submit a second copy of the SNP solicitation in a separate enveloped “Mark SNP Solicitation for (insert contract number)”, and place this envelope in the front of the MA application.**

APPLICATION EMAIL:

CMS established an email address to accept all inquiries for applications. All application inquiries or clarification requests should be submitted to: **MA_Application@cms.hhs.gov**. If you are asking a question related to a specific MA application please included the application title in the subject line.

CMS REGIONAL COORDINATORS

List available at <http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/cmsregional.pdf>

- RO I CMS – BOSTON REGIONAL OFFICE
JOHN F. KENNEDY FEDERAL BUILDING, ROOM 2375, BOSTON, MA 02203
TELEPHONE: 617-565-1267
STATES: CONNECTICUT, MAINE, MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND, AND VERMONT
- RO II CMS – NEW YORK REGIONAL OFFICE
26 FEDERAL PLAZA, ROOM 3811, NEW YORK, NY 10278
TELEPHONE: 212-616-2358
STATES: NEW JERSEY, NEW YORK, PUERTO RICO, and VIRGIN ISLANDS
- RO III CMS – PHILADELPHIA REGIONAL OFFICE
PUBLIC LEDGER BUILDING, SUITE 216, 150 S. INDEPENDENCE MALL WEST,
PHILADELPHIA PA 19106-3499
TELEPHONE: 215-861-4224
STATES: DELAWARE, DISTRICT OF COLUMBIA, MARYLAND, PENNSYLVANIA,
VIRGINIA, WEST VIRGINIA
- RO IV CMS – ATLANTA REGIONAL OFFICE
ATLANTA FEDERAL CENTER, 61 FORSYTH ST., SW, SUITE 4T20, ATLANTA, GA 30303-8909
TELEPHONE: 404-562-7362
STATES: ALABAMA, FLORIDA, GEORGIA, KENTUCKY, MISSISSIPPI, NORTH CAROLINA, SOUTH CAROLINA, AND TENNESSEE
- RO V CMS – CHICAGO REGIONAL OFFICE
233 NORTH MICHIGAN AVENUE, SUITE 600, CHICAGO, IL 60601-5519
TELEPHONE: 312-353-3620
STATES: ILLINOIS, INDIANA, MICHIGAN, MINNESOTA, OHIO, AND WISCONSIN
- RO VI CMS – DALLAS REGIONAL OFFICE
1301 YOUNG STREET, Room 833, DALLAS, TX 75202
TELEPHONE: 214-767-4471
STATES: ARKANSAS, LOUISIANA, OKLAHOMA, NEW MEXICO, AND TEXAS
- RO VII CMS – KANSAS CITY REGIONAL OFFICE
RICHARD BOLLING FEDERAL OFFICE BUILDING, 601 EAST 12th ST., ROOM 235,
KANSAS CITY, MO, 64106
TELEPHONE: 816-426-5783
STATES: IOWA, KANSAS, MISSOURI, AND NEBRASKA
- RO VIII CMS -- DENVER REGIONAL OFFICE
1600 BROADWAY, SUITE 700, DENVER, CO 80202
TELEPHONE: 303-844-2111
STATES: COLORADO, MONTANA, NORTH DAKOTA, SOUTH DAKOTA, UTAH, AND WYOMING
- RO IX CMS – SAN FRANCISCO REGIONAL OFFICE
DIVISION OF MEDICARE HEALTH PLANS
75 HAWTHORNE STREET, 4th Floor, SAN FRANCISCO, CA 94105-3901
TELEPHONE: 415-744-3617

STATES: ARIZONA, CALIFORNIA, GUAM, HAWAII, NEVADA, AND AMERICAN SAMOA,
AND THE COMMONWEALTH OF NORTHERN MARIANA ISLAND

RO X

CMS -- SEATTLE REGIONAL OFFICE
MEDICARE MANAGED CARE BRANCH
2201 6th AVENUE, RX-47, ROOM 739, SEATTLE, WA 98121-2500
TELEPHONE: 206-615-2351
STATES: ALASKA, IDAHO, OREGON, AND WASHINGTON

TECHNICAL INSTRUCTIONS

Using the computer-assisted format, each applicant will only need to fill in responses in the Narrative part and the applicable tables. For the Documents part, assemble the documents as directed within the application form and General Instructions. The Documents part does not have a computer assisted format.

SYSTEM REQUIREMENTS:

Computers with Microsoft Word for Windows and Excel have been utilized for this application. Please **save the application files as Microsoft Word and Microsoft Excel** to be compatible with CMS.

The computerized application was designed using a Times New Roman *proportionally spaced* font.

COMPLETION OF THE APPLICATION:

After installation into a MA directory on the hard drive, you should make an electronic copy of the blank application and maintain this copy as a reference. The next step is the completion of the application itself within the directory you have selected for your working files.

The files supplied are Word documents or Excel spreadsheets. See the introduction section of these guidelines for a description of the types of entities that should use each application to ensure that you have selected the correct application for your type of organization.

NOTE:

All applicants must enter their requested service area in HPMS.

To insert the responses in the Narrative chapters, simply position the cursor at the appropriate point for answering the question and type in the answer. The rest of the application will "bump down" as you type, providing as much space as needed. If a particular item is not applicable, then enter 'Not Applicable' as your response to that item. **Do not delete the item from the template and/or renumber the subsequent items.**

Most tables are provided as separate files and should be filled in at separate locations. These are coded for small print size. (See Table Management below.) The Narrative section contains instructions on where to place hard copies.

Be sure to resave the document frequently as you progress.

TABLE MANAGEMENT:

Application forms and tables associated with the applications are available in separate Microsoft Word or Excel files that are available at <http://www.cms.hhs.gov/MedicareAdvantageApps/>. Microsoft Word files located on the CMS web site are posted in a .zip format.

Most tables require that a separate table be submitted for each area/region/county that an applicant is requesting, by Medicare geographic area. If copies of a table are needed, create multiple blank tables within the same file, being sure to place a hard page break between each table. Save the entire file, now containing two or more tables, with the original file name.

Repeat this process each time you need multiple tables within a single file.

PAGINATION is completely automatic within the Narrative part, so the user should not attempt to type in page numbers as ordinary text.

A NARRATIVE TABLE OF CONTENTS at the beginning of the application is created or updated every time the Table of Contents is generated. (See instructions below.) You should create or update the Table of Contents as the last step before actually printing the application for submission.

PRINTING THE APPLICATION FOR SUBMISSION:

Before printing the application, update the Table of Contents as the last step before actually printing the application for submission.

To update the Table of Contents:

1. Place your cursor anywhere inside the Table of Contents page text; your cursor will appear as a hand.
2. Right click while your cursor is a hand, and select Update-Field.
3. Check the Update Entire Table circle from the Update Table of Contents Box.
4. Click OK.

Save the end result as XXXXXXXX.APP, with the Xs being either the applicant's name or an abbreviated name. Note: The numbers of characters are not limited to eight.

When you are ready to submit the application, copy all files from the MA directory on your hard drive to another electronic copy, i.e., an empty diskette or Compact Disk. Be certain not to further edit any file, either on hard disk or electronic copy, to assure that the printed copy is identical to the electronic copy. **THE ELECTRONIC VERSION MUST BE AN EXACT REPLICA OF THE HARD COPY VERSION OF THE APPLICATION.**

Submit both the electronic and hard copies as directed in the general instructions. Please clearly label the electronic copy with the organization name, date of submission, and type of application.

GENERAL GUIDELINES FOR SUCCESS:

Throughout the application there are references to documents that are separate files. Most of these files should be printed and placed in the appropriate part of the hard copy application as directed,

usually in a Documents chapter. However, simply leave the files as individual files on the electronic copy. Do not integrate the files into the application file on the electronic copy.

- Each file deals with a specific topic only. Do not append material to any file that belongs elsewhere.
- Edit each file under its own file name.
- The files supplied have both visible and invisible Word codes. Do not delete any of these codes. Do not attempt to replace these files with new ones of your own creation (the codes will be lost).
- Pagination is automatic in the Narrative part; do not attempt to insert page numbers as text.

INSTRUCTIONS FOR TABLES

INSTRUCTIONS FOR STATE CERTIFICATION FORM

The applicant is required to complete items 1 – 3 and then forward the form to the appropriate State Agency Official for completion of items 4 – 7. Upon completion of items 4 – 7, the State agency Official will return the form to the applicant. The applicant must include the completed form in the Organizational and Contractual section under the Legal Entity subsection in the application when it is submitted to CMS for review.

All questions must be fully answered. Sufficient space has been provided, however, if additional space is required; please add pages to provide a more detailed response. Additional information can be provided if the Applicant feels it will further clarify the response.

The State Certification form demonstrates that the contract being sought by the applicant with CMS is within the scope of the license granted by the appropriate State regulatory agency and is authorized to bear financial risk.

Items 1 - 3 (to be completed by the Applicant):

1. List the name and complete address of the organization that will enter into the MA contract with CMS.
2. The Applicant should list the type of license (if any) currently being held in the State where an MA contract is being sought.
3. Applicants must specify the type of MA contract being requested from CMS. CMS wants to verify that any MA plans being offered by the MA organization in the State meet State licensure and solvency requirements applicable to a Federal health plan.

New Federal Preemption Authority – The Medicare Modernization Act amended section 1856(b)(3) of the Social Security Act and significantly broadened the scope of Federal preemption of State law. The revised MA regulations at Sec. 422.402 state that MA standards supersede State law or regulation with respect to MA plans other than licensing laws and laws relating to plan solvency.

Items 4 - 7 (to be completed by State Official):

4. List the reviewer's pertinent information in case CMS needs to communicate with the individual conducting the review at the State level.
5. Some States require several departments/agencies to review licensure requests. CMS wants to know about other departments/agencies involved in such review/approval.
6. Check the appropriate box to indicate whether the applicant meets State financial solvency requirements.
7. Indicate State Agency or Division, including contact name and complete address, which is responsible for assessing whether the applicant meets State financial solvency requirements.
8. Check the appropriate box to indicate whether the applicant meets State licensure requirements.
9. Indicate State Agency or Division, including contact name and complete address, which is responsible for assessing whether the applicant meets State licensing requirements.

State Certification Section: Enter the following information:

- Name of the Applicant (organization)
- State in which the Applicant is licensed
- Name of the certifying State Agency
- Signature of State Official
- Title of State Official
- Date of State Certification

INSTRUCTIONS FOR LEGAL TABLE – 1

Legal-1.doc: Applicant’s Insurance Coverage

Instructions

- Complete Legal Table-1 by providing a summary of Applicant’s insurance coverage or other arrangements for major types of loss and liability and place a hard copy in the Documents section of the application.

Column Explanations:

1. Type - Identifies the various types of insurance.
2. Carrier - Enter the name of the insurance carrier for each insurance type identified by the Applicant.
3. Entity covered - Enter the name of the entity (organization) that is covered by this insurance.
4. Description: Deductibles, Co-insurance, Minimum & Maximum Benefits
5. Premiums - Enter the amount of the premiums.
6. Period Policies are in effect - Enter the periods that the policies are in effect.
7. Other Arrangements to Cover These Risks - Enter any other insurance arrangements to cover the Applicant’s risks.

INSTRUCTIONS FOR LEGAL TABLE-2

Legal-2.xls - Provider Arrangements by County

Instructions

- Provide a separate table for each county, partial county, or delivery system.

Column Explanations:

1. **Category - Staff/Group/ IPA/PHO/Direct:**
Member Physicians - Licensed Medical Doctors (M.D.) and Doctors of Osteopathic Medicine (O.D.) who are members and/or employees of the entity that contracts with the MA organization.
Member Non-Physicians - Midwives, nurse practitioners, or chiropractors, etc., who are members and/or employees of the entity that contracts with the MA organization.
Non-Member Physicians - Licensed M.D. and D.O. who are contracted and/or subcontracted to provide services on behalf of the entity but are not members and/or employees of the entity.
Non-Member, Non-Physician - Mid-wives, nurse practitioners, or chiropractors, etc., who are subcontracted to provide services to the entity but are not members and/or employees of the entity.
Direct Contract HMO-Physicians - Licensed M.D. and D.O. who have entered into a direct contract with the HMO.
2. **Type of Contract and/or Agreement** - Only contracts or Letters of Agreement (LOA) are acceptable. *Letters of intent, Memorandums of Understanding and Memorandums of Agreement are not acceptable. CMS will accept any legally binding written arrangement.*
3. **Number of Contracts and/or Agreements** - List the total number of signed contracts and/or agreements.
4. **Automatic Renewal of Contracts and/or Agreements** - Provide "Yes" or "No" response.
5. **Date Executed** - Enter the date all contracts and/or agreements were finalized for the particular category.
6. **Page Number in Contract and/or Agreement** - List the page number(s) where the contracts and/or agreement(s) can be located in the application package.

INSTRUCTIONS FOR PROVIDER MATRIX– 1

(To be used for first tier and downstream contracts and/or agreements with the MA organization)

Matrix1.doc - Provider Participation Contracts and/or Agreements

Instructions:

1. Provide a separate matrix for each county or partial county.
2. Enter name of the provider(s)/group(s) or entity that the MA organization will be contracting with to provide services to Medicare enrollees. Each matrix will need to be filled out for all first tier and downstream providers.
3. Designate if provider is first tier contracted provider with a "(1)" next to the name of that provider(s)/group(s) or other entity.
4. Designate downstream contracted provider(s), group, or other entity with a "(DS)".
5. Under each column list the page number where the provision that meets the regulatory requirement can be found in each of the contracts and/or agreements for that particular provider(s), group(s) and other contracted entities.

Note: Matrix contains brief description of MA regulatory requirements; please refer to full regulatory citations for an appropriate response.

**INSTRUCTIONS FOR ADMINISTRATIVE / MANAGEMENT SERVICES AGREEMENT
MATRIX (Not required for non-network PFFS)**

(To be used for first tier and downstream contracts and/or agreements with the MA organization)

**Matrixadm.doc - Administrative Contracting Requirements for
Management/Delegations Services for Contracts and/or Agreements
(Including MSA arrangements with entities offering MA MSA accounts
in accordance with §1853(e)(2) of the Act)**

Instructions:

1. Enter name of entity or entities that the MA organization has contracted with to provide administrative services to Medicare enrollees.
2. Matrix will need to be completed for the entire administrative first tier and downstream contracted entities that will be providing administrative services to the MA organization.
3. Designate if the contracted entity is a first tier administrative provider with a "**(1)**" next to the name of the provider(s), group or other entity.
4. Designate any downstream contracted entities for administrative services with "**(DS)**" next to the name of the entity.
5. Under each column list the page number where the regulation can be found in each of the administrative services contracts and/or agreements for that particular contracted entity.

Note: Matrix contains brief description of MA regulatory requirements; please refer to full regulatory citations for an appropriate response.

INSTRUCTIONS FOR PROVIDER CONTRACT REQUIREMENTS THROUGH POLICIES, PROCEDURES, STANDARDS AND MANUAL (Not required for non-network PFFS)

Matrix2.doc - Contracting requirements through policies, standards, and manual

Instructions:

Matrix2.doc is to ensure that the MA organization has met the MA provider contracting requirements through inclusion of the provisions in one of the several materials such as policies, procedures, standards or manuals as appropriate and Chapter 11.

Note: Statements on matrix are condensed. Please refer to the regulatory citations listed to ensure that applicant is fully complying with the regulatory requirements.

1. Enter the name of each documented MA organization's policies, procedures, standards and manual for the Medicare product in each column.
2. Under each column list the page number where the provision that meets the regulatory requirements can be found in each of the particular policies, standards, procedures or manuals. Do not make reference to the provision location within your provider contracts.

Must have this documentation available for on-site review as well as the listed policies, procedures, standards, and manuals.

GENERAL INSTRUCTIONS FOR HSD TABLES 1, 2, 2A, 3, 3A, 4, 5

(Not required for non-network PFFS)

Reviewers use the following information to help with the specific review of HSD tables. You may be asked to provide information included in these tables.

If any plan has a network exclusive to that plan, submit the four separate HSD tables for each plan. List the plan or plans to which a table applies at the top of each table. If the table applies to all plans, state *All*.

Enter the date that the tables were constructed after *date prepared*. The tables should reflect the contracted network providers and facilities on this date.

Only providers contracted to serve Medicare patients should be listed on these tables.

If a type of provider or facility is not available in a county but the pattern of care is to obtain those medical services from another county listed on an HSD table, please provide a narrative of this exception/these exceptions on a separate Word document and list the providers in your HSD tables.. Submit the word document with your HSD tables. The Word document should be separated by county and then by HSD table, within each county. In the rarity that non-contracted providers must be used to provide services to members, please explain within the document how the applicant will ensure that members are not balance-billed for these services.

Submit these tables as Excel documents in both paper and electronic copies. Paper submission is required so that reviewers will have a printed record of the tables. Electronic submission is required so that reviewers will be able to analyze the tables using various Excel techniques.

NOTE: RPPPO applicants are not required to complete HSD tables but should follow instructions in the HSD section of the RPPPO application.

TABLE: HSD-1: COUNTY/DELIVERY SYSTEM SUMMARY OF PROVIDERS BY SPECIALTY

Instructions:

Providers should be counted only once per county on this table even if the provider has more than one location in a county.

If the MAO uses a subnetwork or has multiple delivery systems within the county, a separate HSD 1 table should be completed for each delivery system. Each HSD 1 table should be representative of the aggregate numbers of providers for the delivery system being described.

A separate HSD 1 table should be completed for each distinct delivery system to be used within each service area.

If there are other specialties that are not listed, add lines under "vascular surgery" to cover these specialists.

Arrange all entries alphabetically by county. Please do not change provider specialty order as listed on HSD-1.

Column Explanations:

1. Specialty - Self-explanatory. Note: For radiology, chiropractic, and podiatry list only those providers who are contracted directly with the MAO or downstream entity.

2 & 3. Medicare Provider Breakdown - List the number of contracted providers by type of contract (direct with MAO or downstream arrangement).

4. Total # of Providers - Add up the total number of providers per specialty listed in columns 2 & 3.

5. May Providers Serve as PCPs? - Enter "Y" if providers may serve as a member's Primary Care Physician. Enter "N" if providers may not serve as a member's Primary Care Physician.

6. Total # of PCPs Accepting New Patients - If "Y" was entered in column 5, list the total number of providers who are accepting new Medicare patients. New patients are defined as patients who were not previously seen by the physician. If "N" was entered in column 5, please leave the cell blank.

7. Total # of PCPs Accepting only Established Patients - If "Y" was entered in column 5, list the total number of providers who are accepting only established patients. Established patients are defined as patients who are already patients of the physician's practice, either under original Medicare, another Medicare managed care organization, or through an age-in arrangement. If "N" was entered in column 5, please leave cell blank.

8. County - County in which the provider is located.

TABLE: HSD-2: PROVIDER LIST - LIST OF PHYSICIANS AND OTHER PRACTITIONERS BY COUNTY

Instructions:

Arrange providers alphabetically by county, then alphabetically by specialty, and finally numerically by zip code.

If a provider sees patients at more than one location, list each location separately.

All providers that compose the total counts on HSD-1 must be listed on HSD-2.

Column Explanations:

1. Name of Physician (including chiropractors and podiatrists) or Mid-Level Practitioner (nurse practitioners and physician assistants).
2. Specialty - Self-explanatory.
3. Contract Type - Indicate type of contract with provider. D=Direct and W=Downstream.
- 4-8. Service Address - Specify the address (street, city, state, zip code, county) where the provider serves patients. If a provider sees patients at more than one location, list each location separately.
9. Provider Previously Listed? - Enter "Y" if the same provider is previously listed in the rows above. Enter "N" if a provider is not previously listed in the rows above (e.g., the first time a provider listed on the worksheet, a "N" should be entered.)
10. Contracted Hospital Where Privileged - Identify one contracted hospital in the service area where the provider has admitting privileges, other than courtesy privileges. If the provider does not have admitting privileges, please leave cell blank.
11. Will Provider Serve as PCP? - Enter "Y" if provider will serve as a member's Primary Care Physician. Enter "N" if provider will not serve as a member's Primary Care Physician.
12. If PCP, Accepts New Patients? - If "Y" was entered in column 11, indicate if provider accepts new patients by entering a "Y" or "N" response. If "N" was entered in column 11, please leave cell blank.
13. If PCP, Accepts Only Established Patients? - If "Y" was entered in column 11, indicate if provider accepts only established patients by entering a "Y" or "N" response. If "N" was entered in column 11, please leave cell blank.

14. Does MCO Delegate Credentialing?- Enter "Y" if MAO delegates the credentialing of the physician. Enter "N" if MAO does not delegate credentialing of the physician. If credentialing is not required, please leave cell blank.

15. If Credentialing is Delegated, List Entity- If credentialing is not performed by the MAO, enter the name of the entity that does the credentialing. The name entered should match one of the entities listed on the "Entity Listing in Preparation for Monitoring Review " document that was previously provided to the RO.

16. Medical Group Affiliation - For each provider reflected on the table indicate the medical group/IPA affiliation for that provider. This data is necessary so that CMS may sort the table to assess provider network adequacy without requiring that a separate HSD 2 table be completed for each medical group/IPA that comprises a distinct health service delivery network. Note: Leave this column blank if the provider is not affiliated with a medical group/IPA. For example if you have a provider with a direct contract that is affiliated with a "XYZ" medical group/IPA you must input "DC" in column number 3 and the name of "XYZ" medical group/IPA in column 16. If you provider has a direct contract but is not affiliated with a medical group/IPA then you must input "DC" in column 3 and leave column 16 blank.

17. Employment Status - Indicate whether the provider is an employee of a medical group/IPA or whether a downstream contract is in place for that provider. Insert "E" if the provider is an employee. Insert "DC" if a downstream contract is in place for the provider.

TABLE HSD-2A: PCP/Specialist Contract Signature Page Index

The purpose of this index is to map contracted PCPs and specialty physicians listed in HSD2 to the tab indicating the template contract used to make official the relationship between the MAO and the provider. The grid will also document whether any of the MAO's current providers will be part of the network available in the expansion area. If so, the provider should be reflected in the index to 1) establish the provider as a part of the contracted network for the expansion area, and 2) to provide the template contract used to formalize the arrangements. However, since these providers are already established as providers for the MAO, signature pages will not be requested to further support the existence of written arrangements. It is assumed that these arrangements were in place prior to the filing of the service area expansion.

PCP/Specialist - Enter the contract name as indicated in HSD2 for all PCPs and specialist contracts.

Contract Template/Tabs - Documentation to support the types of contracts executed should be submitted as part of this application. Enter the tab title/section to where the documentation supporting the arrangements between the physician and the MAO can be found. Then indicate the specific contract used for each physician reflected in the PCP/Specialist column.

Existing Network – Indicate whether the provider was previously established as a network provider in the MAO's existing service area. (Not applicable for new MAO applicants)

TABLE HSD-3: ARRANGEMENTS FOR MEDICARE REQUIRED SERVICES BY COUNTY

Instructions:

Arrange contracted entities alphabetically by county and then alphabetically by type of provider. All direct and downstream providers of services should be listed.

Only list the providers who provide the Medicare required services that are listed in columns 9-28. Please do not list any additional providers or services.

If any providers listed on HSD-2 provide the services reviewed on HSD-3, list them as follows:

If all of the providers listed on HSD-2 provide one or more of the services listed in columns 9-28, enter "all providers listed on HSD-2" in the "Name of Provider" column; enter "Other" for the "Type of Provider" column; leave columns 3-8 blank; and place an "X" in column(s) that represent the services provided by all of the providers listed on HSD-2.

If all providers of a certain specialty listed on HSD-2 provide one or more of the services listed in columns 9-28, enter "all providers listed on HSD-2 with specialty (enter specialty) " in the "Name of Provider" column; enter "Other" for the "Type of Provider" column; leave columns 3-8 blank; and place an "X" in column(s) that represent the services provided by the providers of a certain specialty as listed on HSD-2.

If all providers who may serve as a "PCP" as listed on HSD-2 provide one or more of the services listed in columns 9-28, enter "all providers listed on HSD-2 who may serve as a PCP " in the "Name of Provider" column; enter "Other" for the "Type of Provider" column; leave columns 3-8 blank; and place an "X" in column(s) that represent the services provided by the providers that may serve as PCPs as listed on HSD-2.

Column Explanations:

1. Name of Provider - Enter name of contracted provider.
2. Type of Provider - Enter type of contracted provider.

ASC = Ambulatory Surgical Center
OPT = Outpatient physical therapy, occupational therapy, or speech pathology facility
CMHC = Community Mental Health Center
PH = Psychiatric Hospital
CORF = Comprehensive Outpatient Rehabilitation Facility
RAD = Radiology Therapeutic & Diagnostic
ESRD = Outpatient Dialysis Center
RH = Rehabilitation Hospital
FQHC = Federally Qualified Health Center
RHC = Rural Health Clinic
HHA = Home Health Agency

RNHC - Religious Nonmedical Health Care Institutions

HOSP = Acute Care Hospital

SNF = Skilled Nursing Facility

Lab = Laboratory

OTHER = Any provider not listed above, such as durable medical equipment suppliers, transplant facilities, etc.

LH = Long Term Hospital

3-6. Location - Enter street address/city/state/zip code.

7. County Served by Provider - List one county the provider serves from this location. (If more than one county is served, repeat information as entered in columns 1-6 and columns 9-28, changing column 7 as applicable.)

8. Provider Previously Listed? - Enter "Y" if the same provider is previously listed in the rows above. Enter "N" if a provider is not previously listed in the rows above (e.g., the first time a provider listed on the worksheet.)

9-28. Services - Mark an "X" in the box if the provider/facility provides this service

TABLE HSD-3A: ANCILLARY/HOSPITAL CONTRACT SIGNATURE PAGE INDEX

The purpose of this index is to map contracted ancillary or hospital providers listed in HSD3 to the tab indicating the template contract used to make official the relationship between the MAO and the provider. The grid will also document whether any of the MAO's current providers will be part of the network available in the expansion area. If so, the provider should be reflected in the index to 1) establish the provider as a part of the contracted network for the expansion county, and 2) to provide the template contract used to formalize the arrangements. However, since these providers are already established as providers for the MAO, signature pages will not be requested to further support the existence of written arrangements. It is assumed that these arrangements were in place prior to the filing of the service area expansion.

Ancillary/Hospital HSD3 – Enter the contract name as indicated in HSD3 for all ancillary and hospital contracts.

Tab Name – Indicate the Tab Name containing the template contract executed between the provider and the MAO.

Existing Network – Indicate whether the provider was previously established as a network provider in the MAO's existing service area. (Not applicable for new MAO applicants)

TABLE HSD-4: ARRANGEMENTS FOR ADDITIONAL AND SUPPLEMENTAL BENEFITS

Instructions:

If there are other services that are not listed, add columns to the right of the "Screening-Vision" column to cover these services.

Only list the providers who provide the additional and supplemental benefit services as listed in the "services" columns (columns 7-12). Note: if other services are added to the right of the "Screening-Vision" column (column 12), those providers should also be listed.

If any providers listed on HSD-2 provide the services reviewed on HSD-4, list them as follows:

If all of the providers listed on HSD-2 provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2" in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by all of the providers listed on HSD-2.

If all providers of a certain specialty listed on HSD-2 provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2 with specialty (enter specialty) " in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by the providers of a certain specialty as listed on HSD-2.

If all providers listed on HSD-2 will serve as "PCPs" and provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2 who may serve as a PCP " in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by the providers that may serve as PCPs as listed on HSD-2.

All direct and downstream providers of services should be listed.

Arrange benefits alphabetically by county and then numerically by zip code.

Column Explanations:

1. Name of Provider - Enter name of the contracted provider, for example – Comfort Dental Group(Dental); Comfort Eyewear Associates (Eyeglasses/Contacts); Comfort Hearing Aids Associates (Hearing Aids); XYZ Pharmacy (Prescription Drugs – outpatient); Comfort Hearing, Inc. (Screening-Hearing); Comfort Vision Specialists (Screening – Vision).

2-5. Location - Enter street address/city/state/zip code, for example – 123 Main Street, Baltimore, MD 11111

6. County Served by Provider - List one county the provider serves from this location. (If more than one county is served, repeat information as entered in columns 1-5 and columns 7-12, changing column 6 as applicable.) Examples: Canyon County, Peaks County.

7-12. Services - Mark an "X" in the box if the provider provides this service. For the providers that are listed in Column 1, please indicate which services are provided by this provider.

TABLE HSD-5: SIGNATURE AUTHORITY GRID

The purpose of this grid is to evidence whether physicians of a provider group are employees of the medical practice. The grid will display the medical group, the person authorized to sign contracts on behalf of the group and the roster of employed physicians of that group.

Practice Name – The name of the provider group for which a single signature authority exists on behalf of the group.

Signature Authority – The representative of the medical practice with authority to execute arrangements on behalf of the group

Physicians – Reflect all of the physicians in HSD2 for which the signature authority is applicable

TABLE: ESSENTIAL HOSPITAL DESIGNATION TABLE

Please complete this form with the indicated information about each hospital that applicant seeks to have designated as essential. Please note that, under Section 1858(h) of the Social Security Act (the Act) and 42 CFR 422.112(c)(3), applicant organization must have made a good faith effort to contract with each hospital that it seeks to have designated as essential. A “good faith” effort is defined as having offered the hospital a contract providing for payment rates in amounts no less than the amount the hospital would have received had payment been made under section 1886(d) of the Act. The attestation on the following page must be completed and submitted with the completed chart.

ONSITE DOCUMENTATION

Documentation Material to be available during onsite visit or upon request.

The entire application should be available for review during an onsite visit. In addition, materials listed below should be available for review. Some of the following items are a reiteration of items that are included in the application; they are listed here for reference. (The Application section headings are listed for reference.)

GENERAL INFORMATION

1. Copies of MIS reports available onsite for evaluation by CMS staff.

ORGANIZATIONAL AND CONTRACTUAL

1. Articles of Incorporation; Bylaws and other legal entity documentation
2. State license and certificate of authority
3. Evidence of marketing licenses or approvals
4. Executed physician, hospital, other provider contracts and/or agreements and sub-contracts fully amended for Medicare coverage.
5. Board and committee meeting minutes since MA or PSO incorporation.
6. Policy and procedures manuals
7. Administrative / Management Contracts and/or Agreements
8. Policies and Procedures Matrix (see instructions below)

HEALTH SERVICES DELIVERY

1. Authorization/Referral forms for commercial and Medicare product, if different.
2. Encounter Forms.
3. Policy manual of procedures for health professional
4. Minutes of Utilization Review and Quality Assurance Committees
5. Evidence that the MAO providers are certified under Titles XVIII or XIX of the Social Security Act.
6. Evidence of monitoring/assessment of performance of any functions delegated to other entities or provider groups.
7. Committee minutes of last 12 months of QAPI, Peer Review, Utilization Review committees and subcommittee meetings
8. Policies and Procedures Matrix [refer to file – *matrix2.doc*]
9. Initial Enrollee Assessment Tool
10. Evidence that a PRO contract has been entered into or initiated by the MA applicant.

