OMB-0938-0470

APPLICATION FOR FEDERAL QUALIFICATION

Initial and Service Area Expansion

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Center for Beneficiary Choices
Division of Qualifications and Plan Management

2007

PUBLIC REPORTING BURDEN:
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0470. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CMS-901A

QUALIFICATION APPLICATION

INTRODUCTION

PREPARATION OF THE APPLICATION

This computer-assisted format is for IBM compatible personal computers using MSWord97 and Excel 97. The diskette file README.DOC contains important information such as last-minute changes and a list of files. Please see the technical instructions included within this application for working on the application.

WHO SHOULD USE THIS APPLICATION

1. A prepaid health plan seeking federal qualification as a health maintenance organization (HMO) under the Title XIII of the Public Health Service Act. An applicant may request one or more regional components in its initial application

   Each regional component must provide substantially the full range of basic health services and may establish a separate community rate for each component based on the different costs of providing health services; see 42 CFR 417.104(b) for a full definition

2. A federally qualified HMO seeking to expand its qualified service areas or to establish one or more additional regional components

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

Indicate on the cover page the appropriate approval(s) you are requesting.

REFERENCE MATERIALS

Information requested in this application is based on Title XIII of the Public Health Services Act and the applicable regulations. The applicant should be familiar with the following materials, which are available from the Healthplan Benefits Group upon request:

1. The HMO Act (Public Law 93-222) as amended in 1976, 1978, 1981, and 1988
2. Other Federal Register publications including interpretive rulings and approved exclusions.
3. Updated applicable implementing regulations at 42 CFR Part 417.1 - 417.166
4. Financial Guidelines
5. Insolvency Protection for Members

Materials needed for the financial projections are as follows:

- Financial Report Forms and Annual Statement Blanks for HMOs.
- For the instructions, call the National Association of Insurance Commissioners, Publications office, at 816-842-7259, and ask for the Annual Statement Instructions for HMOs.

GENERAL INSTRUCTIONS

To clarify any question, refer to the regulation upon which it is based; a regulatory citation is provided after each question.

A completed application includes (items with an asterisk will be performed automatically in the computerized application):

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 question copied* and brief and precise answers, divided into chapters
5. Documents part, arranged by chapters; this section should follow the Narrative. Materials such as marketing brochures and booklets should be inserted in envelopes in the appropriate places in the application. The envelope should be numbered as a single page.

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.

Note that there must be evidence of arrangements for basic health services in the requested service area at the time the application is submitted.

<u>SERVICE AREA EXPANSIONS:</u> There are specific instructions within each section about the information to be provided if the applicant is requesting an expansion of its federally qualified service area. See below if the expansion will be two or more regional components.

Please call your CMS, Central Office, Plan Manager to discuss the information to include in the application. He/she may modify the requirements depending on whether there have been recent reviews of the HMO.

<u>ESTABLISHMENT OF REGIONAL COMPONENTS:</u> A **regional component** is defined in 42 CFR 417.104(b)(4) as "....geographically distinct and separate from any other regional component ...[which] provides substantially the full range of basic health services to its members, without extensive referral between components of the organization for these services...." An HMO may establish a separate community rate for separate regional components.

If you are applying for two or more qualified regional components, you need to provide specific information for each component in the sections listed below. When the information is the same throughout all components, you may state this.

GENERAL INFORMATION: Summary Description I.; Service Area, III.A.-C.

ORGANIZATIONAL AND CONTRACTUAL: State Authority to Operate, II.B.; Provider Contracts, VII.A.-D, Subscriber Contracts,VIII; Marketing Material, IX.

MANAGEMENT: Provide any information on differences between components.

HEALTH SERVICES DELIVERY: This entire section should be given for each component.

FINANCIAL: Community Rating, VI.A.-D.; Copayment Limitations, VII.A.,B.

MARKETING: All of parts I.-III.; Staff, V.; Titles XVIII and XIX Enrollment, VIII.; Enrollment Projections, IX.

TABLES: Within the application, you will be directed to place tables in specific places within the Narrative chapters. For those using the computerized application, this will be automatic; otherwise, you may insert the tables at the end of each chapter.

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 three-ring looseleaf binders.

NUMBER OF COPIES:
Send 4 hard copies and 2 diskette copies to:

Centers for Medicare and Medicaid Services
Center for Beneficiary Choices
Division of Qualifications and Plan Management
C4-22-04
7500 Security Boulevard
Baltimore, Maryland 21244-1850

ASSISTANCE: Assistance is available to all applicants in the preparation of this application from the staff of the Division of Qualifications and Plan Management. You may call (410) 786-6451 to request assistance.

FEES

As established in 42 CFR 417.143(d), as amended (52 Federal Register 22311, June 11, 1987), application fees for qualification applications submitted after July 13, 1987 are:

1. $18,400 for an HMO
2. $18,400 for each regional component
3. $6,900 for a service area expansion that is not a regional component - this may be an expansion of a qualified HMO or regional component; there is a separate fee for each component being expanded
4. $3,100 for a federally approved Competitive Medical Plan seeking HMO qualification

Payment is due at the time of submission. The check, payable to HMO Application Fee, and a copy of the application cover sheet should be sent to:

If through U.S. Postal Service:
Centers for Medicare and Medicaid Services
Division of Accounting
P.O. Box 7520
Baltimore, Maryland 21207-0520

If through delivery service:
Centers for Medicare and Medicaid Services
Division of Accounting
C3-09-27
7500 Security Boulevard
Baltimore, MD 21244-1850

The Division of Accounting will notify the Division of Qualifications and Plan Management when your check has been received. Applications will not be reviewed until this notification is received.

TECHNICAL INSTRUCTIONS

To expedite your completion of this application, it is being provided to you as a computerized format file. Using the computer assisted format, you will need only to fill in responses in the Narrative part and the applicable tables. For the Documents part, you will need to assemble the documents as directed within the application form and General Instructions. The Documents part does not have a computer assisted format.

<u>SYSTEM REQUIREMENTS:</u> An IBM or compatible personal computer with high density floppy drive, MSWord and Excel 97 or work-alike equivalents.

The computerized application was designed Times New Roman or Arial *proportionally-spaced* fonts. Other printers may have comparable fonts such as Times Roman, Dutch 801 Roman, Charter, Switzerland, etc., and these fonts should be suitable, but may format pages slightly differently.

<u>INSTALLATION:</u> To begin, install the electronic version of all the application files into a distinctly named folder on your computer's hard disk. Create a second folder with the complete application files to use as your working files. This technique will preserve a set of original files that you may need if problems occur as you are entering data into a working file.

<u>COMPLETION OF THE APPLICATION</u>: After installation, the next step is the completion of the application itself on the computer's hard disk within the folder with the working files. The files supplied are Word documents or Excel spreadsheets. See the FQREADME file for a description of each file.

To produce your 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 you as much space as needed.

Large tables are provided as separate files on the disk and should be filled in at their separate location. Follow the directions in the Narrative chapters about placement of these files when they are printed for submission of the application. Be sure to leave the separate files on the diskette for submission. (See Table Management below.)

Be sure to resave the document frequently as you progress.

<u>TABLE MANAGEMENT:</u> Most tables direct that a separate table be submitted for each regional component or service area. If you need copies of a table, you should create multiple blank tables within the same file, being sure to place a hard page break between each table. Identify each table by county or service area. 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.

<u>PAGINATION</u> is completely automatic within the computer-prepared sections. The user should not attempt to type in page numbers as ordinary text. There is an automatic footer on each page.

A NARRATIVE TABLE OF CONTENTS at the beginning of the application is an automatic function and will be updated every time you generate the Table of Contents (TOC). (see instructions below) You should update the TOC as the last step before actually printing the application for submission.

Note: After you have created a Narrative TOC within a document, any subsequent editing, no matter how minor, may alter the page numbering in the Table. For that reason, before you print your final version, regenerate a final TOC.

To update the Narrative TOC, first be sure your cursor is placed just to the left of the first character of the TOC, in this case, to the left of the first line that starts with GENERAL. Then, press the F9 key. You will see a box called 'Update Table of Contents' with the selection 'Update page numbers only'. Click on OK. In a few seconds the page numbers will be correctly entered into the Narrative TOC.

Pagination of the Documents Part TOC must be manually entered. Place the cursor at the end of each line and type in the page number.

PRINTING THE APPLICATION FOR SUBMISSION:

When you are ready to submit your application, copy all files from the working folder on your hard disk to an empty diskette. Be certain not to further edit any file, either on hard disk or diskette to assure that the printed copy is identical to the diskette copy.

Print the primary qualification application file and the separate tables. Insert tables into the Documents part, as directed within the Narrative chapters of the application.

Submit both the diskette and hard copies as directed in the general instructions. Please clearly label the diskette with the plan name, date, and type of software you used.

GENERAL GUIDELINES FOR SUCCESS: Throughout the application, there are references to documents which are separate files on disk. Please be sure to follow these directions to maintain the integrity of the application:

- *Do not manually combine or delete any of these documents or change their filenames.*

- *Each separate file deals with a specific topic only. Don't append material to any file that belongs elsewhere.*

- *The files supplied have MSWord codes. Don't delete any of these codes. Don't attempt to replace these files with new ones of your own creation (the codes will be lost).*

- *Pagination is automatic; do not attempt to insert page numbers as text.*

This procedure is harder to describe than to perform -- it is not as complicated as it may seem!

THE APPLICATION FORM FOLLOWS
THIS PAGE

DO NOT SUBMIT THE PREVIOUS PAGES
IN THE PRINTED COPY
OF YOUR APPLICATION

CMS - 901-a	OMB No. 0938-0470

DIVISION OF QUALIFICATIONS AND PLAN MANAGEMENT
FEDERAL QUALIFICATION APPLICATION

Mark the type of approval you are seeking with this application

INITIAL FEDERAL QUALIFICATION _____ With regional component/s? yes___ no___ If yes, number of components ____ Fee submitted: $___________	SERVICE AREA EXPANSION _____ Regional component/s yes___ no___ If yes, number of components ____ Fee submitted: $___________
NAME OF LEGAL ENTITY TRADE NAME (if different)	MAILING ADDRESS
INDIVIDUAL EXECUTING (name and title)	TELEPHONE NO.: FAX NO.: E-MAIL.:

CEO OR EXECUTIVE DIRECTOR, (if different from above individual)

NAME AND TITLE TELEPHONE NO.: FAX NO.: E-MAIL.:	MAILING ADDRESS
BOARD CHAIRMAN - NAME AND ADDRESS	FEDERAL TAX STATUS For profit____ Not for profit____
HMO MODEL ____ Staff ____ Medical Group ____ Individual Practice Association ____ Direct Contracts	TYPE OF QUALIFICATION REQUESTED ____ Operational ____ Transitional ____ Preoperational

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, Executive Director	Date
Signature, Board Chairman	Date

NARRATIVE PART
TABLE OF CONTENTS

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

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

GENERAL INFORMATION.....6
I. SUMMARY DESCRIPTION.....6
II. SUMMARY OF SECRETARIAL WAIVERS OR APPROVALS.....6
III. SERVICE AREA OF HMO.....6
ORGANIZATIONAL AND CONTRACTUAL.....6
I. LEGAL ENTITY.....6
II. STATE AUTHORITY TO OPERATE AS AN HMO.....6
III. ORGANIZATION CHARTS.....6
IV. FULL FINANCIAL RISK.....6
V. CONTRACTS FOR MANAGEMENT SERVICES.....6
VI. LEGAL ACTIONS.....6
VII. PROVIDER CONTRACTS AND AGREEMENTS.....6
VIII. SUBSCRIBER CONTRACTS AND AGREEMENTS.....6
IX. MARKETING AND ENROLLMENT MATERIAL.....6
X. TIME-PHASED PLAN FOR TRANSITIONAL HMO.....6
XI. MEMBER GRIEVANCE PROCEDURE.....6
MANAGEMENT.....6
I. POLICYMAKING BODY.....6
II. KEY MANAGEMENT STAFF.....6
HEALTH SERVICES DELIVERY.....6
I. HEALTH CARE PROVIDERS.....6
II. HMO UTILIZATION CONTROL PRACTICES.....6
III. EMERGENCY CARE.....6
IV. AVAILABILITY, ACCESSIBILITY AND CONTINUITY OF SERVICE.....6
V. CONFIDENTIALITY.....6
VI. QUALITY ASSURANCE.....6
FINANCIAL.....6
I. FISCAL SOUNDNESS.....6
II. FINANCIAL PLAN.....6
III. PROVISIONS FOR THE EVENT OF INSOLVENCY.....6
IV. ACCOUNTING FOR INCURRED BUT NOT REPORTED CLAIMS (IBNR).....6
V. COMMUNITY RATING- COMMERCIAL.....6
VI. COPAYMENT LIMITATIONS - For Basic Health services Only.....6
VII. STATE FINANCIAL REQUIREMENTS.....6
VIII. MANAGEMENT INFORMATION SYSTEM.....6
MARKETING.....6
I. ENROLLMENT HISTORY.....6
II. COMPETITION.....6
III. ENROLLMENT PROJECTION ASSUMPTIONS.....6
IV. MARKETING STRATEGY.....6
V. MARKETING STAFF.....6
VI. MANAGEMENT INFORMATION SYSTEM (MIS).....6
VII. MARKETING BUDGET.....6
VIII. ENROLLMENT PROJECTIONS.....6

DOCUMENTS PART
TABLE OF CONTENTS

GENERAL INFORMATION
Service area map...

ORGANIZATIONAL AND CONTRACTUAL
State approval of business name...
Articles of Incorporation...
Bylaws...
Other entity documents, as applicable..
State license or legal opinion, if applicable...
Organization charts..
Insurance arrangements (*fqinsure.doc*)...
Management services contracts..
Provider arrangements table (*fqprovid.doc*)..
Health plan contracts with Medical Groups/IPA...
Provider contracts..
Contracts between IPA/Medical Group and physicians...
Subscriber contracts/agreements...
Marketing and enrollment materials...
Grievance procedure...

MANAGEMENT
Position descriptions and resumes..

HEALTH SERVICES DELIVERY
fqhsd1.xls table, Summary of FTE Physicians by Specialty for the entire service area.......................................
fqhsd1a.xls table, Summary of FTE Physicians by Specialty, by county...
fqhsd3.xls table, Hospitals, Other Facilities...
fqhsd4.doc table, Arrangements for Basic Health Services for Members of Federally Qualified plan.........................
fqhsd5.doc table, List of Supplemental Benefits for Members of Federally Qualified plan..

FINANCIAL
Audited financial statements...
Unaudited financial statements..
Audited financial statements of guarantors/lenders...
Annual report...
Prospectus..
Financing arrangements..
Financial projections (NAIC Report formats)..
Reinsurance/insolvency policies...
Audited financial statements of insolvency guarantor...
Uncovered Expenditures Calculation Worksheet (*fqinsolv.doc*)..
State financial requirements...

To add the page numbers for the Documents table of contents, place cursor at the end of each line and type in the page number. Do not press ENTER, just place the cursor at the end of the next line for the next page entry.

GENERAL INFORMATION

I. SUMMARY DESCRIPTION Complete the summary description table.

If applying for initial determination, complete column I only. If applying for expansion, complete column I for currently approved area and column II for the requested expansion area.		
	I-Initial	II-Proposed
HEALTH SERVICES ARRANGEMENTS - ANSWER "YES" AS APPROPRIATE:		
Staff providers		
Individual Practice Association		
Medical group		
Direct contracts with plan		
PLAN'S PREPAID ENROLLMENT AS OF (DATE):		
Group		
Non-group		
Medicaid		
Medicare - risk or cost		
Medicare - other		
Total prepaid enrollment		
BREAKEVEN - ACTUAL OR PROJECTED*		
Group		
Non-group		
Medicaid		
Medicare - risk or cost		
Medicare - other		
Total enrollment at breakeven		
Date of breakeven - month/year		
Total operating deficit		
Total financing available		
Date on which operations began		

A. In no more than two pages describe the HMO in terms of its history and its present operations. Briefly 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.)

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

B. For applicants requesting one or more regional components, explain how these areas meet requirements for regional components as referenced in 42 CFR 417.104(b)(4). As described therein, a regional component is a separate, geographically distinct service area, either contiguous or noncontiguous, without extensive referral health services between components and without substantial utilization of the same health care facilities. Separate assurances for each component are required, in accordance with 42 CFR 417.142(e).

If the components are approved, the HMO may, but is not required to, establish a separate community rate for each regional component; the separate rate for each component must be based on the different costs of providing health services in the respective regions.

EXPANSION APPLICANTS: Answer A. and B. above.

II. SUMMARY OF SECRETARIAL WAIVERS OR APPROVALS

There are several requirements for qualification which may be waived or approved under certain conditions. The waiver or approval can be understood by reading the regulation cited next to each item.

Indicate whether the HMO is applying for any of the following. The detailed justification for the waiver or approval should be provided as well at the places indicated later in the application. *EXPANSION APPLICANTS:* Answer this section.

A. Time-phased plan for transitional HMO - 417.142(b)
See Item X of the Organizational and Contractual Section. Yes___; No___

B. Community rating - 417.104(c)
See Item VI of the Financial Section. Yes___; No___

C. Separate community rate for separate regional components - 417.104(b)(4)
See Item VI of the Financial Section. Yes___; No___

D. Exclusion from coverage of unusual and infrequently provided services not necessary for the protection of an individual's health - 417.101(d)(16)
See Item III of the Health Services Delivery Section. Yes___; No___

III. SERVICE AREA OF HMO - 417.106

A. Boundary Description
Describe each proposed service area in terms of geographic subdivisions such as counties, cities, and townships. If less than a full county, zip codes must be provided.

EXPANSION APPLICANTS: Indicate if the proposed area(s) are contiguous or non-contiguous to the presently qualified service area.

B. Map

Provide a detailed map (with a scale) of each service area clearly showing the service area boundaries, main traffic arteries, any physical barriers such as mountains and rivers. Show location of primary care physicians, referral physicians and hospital providers. Show on this map the mean travel time from six points on the service area boundary to the nearest ambulatory and institutional services site. Include the map in the Documents part.

EXPANSION APPLICANTS: If the requested service area is adjacent to or in the same State as the qualified area, provide a second map with the current and proposed areas clearly designated, indicating locations of major HMO providers in the current area.

C. Service Area Justification

Provide justification for the requested service area, including a discussion of the travel times to primary care delivery sites and the normal pattern for providing primary and specialty care within the area.

EXPANSION APPLICANTS: Answer this section.

ORGANIZATIONAL AND CONTRACTUAL

I. LEGAL ENTITY - 417.1

A. If the HMO does business as (d.b.a.) 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 of the d.b.a.(s) in the Documents part.

B. For new qualifications: In chronological order, describe the legal history of the HMO entity including predecessor corporations or organizations, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved.

State the type of legal entity of the applicant. Include in the Documents part a copy of the HMO's Articles of Incorporation, bylaws and other legal entity documentation. If applicable, provide the HMO's Partnership Agreement in the Documents part.

If the HMO is a line of business, briefly describe the applicant's other lines. If the HMO operates other lines of business, briefly describe these operations.

C. For expansions: Describe any changes in the legal or Federal tax status of the HMO entity since Federal qualification, including mergers, reorganizations, and changes of ownership. Be specific as to dates and parties involved, providing applicable documentation as necessary.

Describe any changes in the basic organizational structure of the HMO since Federal qualification, such as any changes in the corporate charter, the bylaws, or membership of the Board of Directors. Provide applicable documentation as necessary.

II. STATE AUTHORITY TO OPERATE AS AN HMO - 417.1

A. List names, addresses, and telephone numbers of the State regulatory officials who have authority over the HMO.

B. Include the HMO's license or certificate to operate in the proposed area in the Documents part.

If the HMO is not licensed by the State to operate in the proposed area, describe the status of the application for authority to operate, and indicate the approximate date when the license or certificate expected. If the HMO is located in a jurisdiction that does not require a license or certificate, describe the legal environment for the HMO and include in the Documents an opinion by legal counsel that the HMO meets jurisdictional legal requirements.

C. If a Certificate of Need is required, explain the status of the Certificate.

D. If the use of Section 1311 of the HMO Act to supersede State law is requested, cite applicable restrictive State laws.

E. If required by State law, indicate whether HMO marketing representatives or agents have been licensed or are regulated by the State(s) in which the proposed service area is located.

EXPANSION APPLICANTS: Answer B. in this section.

III. ORGANIZATION CHARTS - 417.124(a)

Provide two separate charts in the Documents part, as follows: [New applicants and expansions should answer.]

A. The HMO. Show detailed lines of authority, including the relationships among the policymaking body, the administrator of the plan, and the medical/health services delivery component. Include titles and names of incumbents. If the HMO is a line of business, show that relationship on the chart. For expansions, show how the organizational structure in the proposed area will relate to existing administrative structure of the HMO.

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

IV. FULL FINANCIAL RISK - 417.120(b)

State how the HMO limits or proposes to limit its financial risk.

A. Describe any risk sharing with providers or any other parties. Reference, by application page number, the applicable sections of provider contracts that is included in the Documents part of this submission.

EXPANSION APPLICANTS: Describe risk sharing for the new providers in the expanded area.

B. Describe any reinsurance coverage. Reference the applicable pages in the Documents part.

C. Fill in the table in the file *fqinsure.doc* to indicate the types of insurance arrangements in effect or to be in effect for the proposed area when qualified. [This table is placed in the Documents part.] *EXPANSION APPLICANTS:* Answer this section.

V. CONTRACTS FOR MANAGEMENT SERVICES - 417.124(a)

A. Using the management services table, indicate the categories of services obtained through contractual arrangements and the status of the contract(s).

Management Services	Contractor	Contract Status Executed/Draft	Anticipated Signing Date
Marketing			
Claims Processing			
Data Processing			
Management Services			
Administrative Services			
Other			

B. Include a copy of each contract in the Documents part.

EXPANSION APPLICANTS: Fill in the management services table; provide copies of contracts if different from the most recent qualification process.

VI. LEGAL ACTIONS - 417.120(a)

If there are, or have been, legal actions against the HMO during the last two years, give a brief explanation and status of each action.
EXPANSION APPLICANTS: Answer this section.

VII. PROVIDER CONTRACTS AND AGREEMENTS - 417.1, 417.103(a),(b)

Note: There must be evidence of arrangements for basic health services in the requested service area at the time the application is submitted.

A. Where applicable, provide the names of each IPA and/or medical group that is or will be providing services in each proposed area. State the type of legal entity of these organizations.

If a group model HMO, if the medical group does not meet the requirement that the principal professional activity (over 50% individually) of the members is the coordinated practice of their profession, then describe the time-phased plan to achieve this requirement within 48 months from the HMO's date of qualification. Also, describe the plan for the medical group to provide over 35% in the aggregate of their professional activities for the delivery of health services to HMO members.

If a staff or group model HMO has as providers over 50 percent of the physicians in an IPA, provide a rationale to show that this arrangement is consistent with the regulations.

B. Complete the file *fqprovid.doc*, "Provider Arrangements," for each proposed area to show the provider agreements in effect or to be in effect when operational and

qualified. If any agreements are not yet executed, indicate date execution is expected. [This table is placed in the Documents part.]

C. Provide in Documents part a copy of each executed contract between HMO and medical group(s) and IPA(s). If there are multiple groups or IPAs, and the agreement forms are the same for each, submit a specimen copy only and all executed signature pages. **However, if there are more than 15 signature pages, list the groups or IPAs who have signed the contracts with the dates of execution instead of sending copies of the pages.**

D. For provider contracts and agreements other than HMO-Group(s) or HMO-IPA(s), include specimen copies in the Documents part of each category of provider listed in the Provider Arrangements table. For each specimen agreement, **include a list of providers who have signed the contracts, with the dates of execution.**

Be sure to include a specimen copy of the agreement between the IPA and its providers (medical groups and physicians), the medical group and its contracting providers, or the Plan and its directly contracting physicians. (The staff or medical group employment contract with its physicians is not necessary.) For each specimen contract, **list the providers who have signed the contracts, with the dates of execution.**

EXPANSION APPLICANTS: Include A.-D. for the requested service area.

VIII. SUBSCRIBER CONTRACTS AND AGREEMENTS - 417.1, 417.101, 417.124(e)

Indicate the categories of contracts for Federally Qualified plan members that are applicable in the proposed service area; include a copy of each in the Documents part. Also provide a copy of the contract between the HMO and employer groups.

___ Group Contract presently in effect
___ Non-Group Contract presently in effect
___ Conversion Contract presently in effect
___ Group Contract not yet in effect
___ Non-Group Contract not yet in effect
___ Conversion Contract not yet in effect

EXPANSION APPLICANTS: Include the applicable contracts for the requested area.

IX. MARKETING AND ENROLLMENT MATERIAL - 417.124(b)

Provide a copy in the Documents part of all marketing literature, member handbook, and subscriber certificate or evidence of coverage (if different from subscriber agreement, above) **for members of the Federally Qualified plan**. Operational plans should provide the material which will be used when qualified. Draft copies or mark-ups of material which the plan proposes to use after qualification are acceptable.
EXPANSION APPLICANTS: Include this material in the Documents part.

X. <u>TIME-PHASED PLAN FOR TRANSITIONAL HMO - 417.142(b)</u>

If the applicant is seeking transitional qualification in the proposed area, when will all contracts meet requirements to be fully qualifiable? Describe the time-phased plan to bring each contract into full compliance with requirements.
EXPANSION APPLICANTS: Answer this section.

XI. <u>MEMBER GRIEVANCE PROCEDURE - 417.124(g)</u>

Explain the member grievance procedure. Provide a copy of this procedure in the Documents part. *EXPANSION APPLICANTS:* Include this material if different than the most recent review.

ON SITE DOCUMENTS

Have the following available for inspection at the site visit:

1. State license
2. Evidence of HMO marketing licenses or approvals
3. Insurance and other arrangements for: malpractice, general liability, casualty losses, fidelity bonds, reinsurance
4. Copy of incorporation, partnership or other State required organizational documents and bylaws of each IPA and medical group with which the HMO contracts for the delivery of services in proposed area
5. Executed physician, hospital, and other provider contracts
6. Internal Revenue Service letter for nonprofit status, if applicable

MANAGEMENT

I. POLICYMAKING BODY - 417.124(a)(1)

A. List the members of the HMO's policymaking body (name, position, address, telephone number, occupation, term of office, and term expiration date).

B. If the HMO is a line of business, does the Board of Directors of the corporation serve as the policymaking body of the HMO? If not, describe the policymaking body and its relationship to the corporate Board.

C. Does the State regulate the composition of the policymaking body? If yes, describe.

D. Indicate below how the policymaking body carries out its responsibilities:

1. What is the requirement for meeting frequency?

   How many times has this body met in the last 12 months? ____

2. What is the required number of members of this body? ____

3. What are the quorum requirements?

4. Are HMO management decisions ratified by the full Board? ____

5. How often is the Chief Executive Officer's (CEO) performance formally evaluated? ____

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

E. List any policymaking committees, identifying chairperson and members of each committee.

EXPANSION APPLICANTS: Indicate changes since the most current review.

II. KEY MANAGEMENT STAFF - 417.124(a), 17.412(b)(1)

A. Using the management staff table below, indicate the individuals responsible for the key management functions.

B. If there is a separate management staff for the expanded area, provide the chart for each and explain how the managers relate to other staff of the HMO.

C. In the Documents part provide brief position descriptions and resumes for the individuals cited in the charts, limited to education, training, and experience.

EXPANSION APPLICANTS: Answer A. and B. For C., include material only for staff that will serve only the requested area.

Staff Function	Name	Title	Employed By	Percent of Time for HMO
Executive				
Medical				
Utilization Review				
Finance				
Marketing				
Management Information Systems				
Other				

ON SITE DOCUMENTS

Have the following available for inspection at the site visit:

1. Policymaking body and committee minutes
2. Administrative policy and procedure manual

HEALTH SERVICES DELIVERY

Note: Complete the health services tables for each proposed service area. You may substitute preprinted material or computer lists if the same information is given.
EXPANSION APPLICANTS: Respond to each section of this chapter only for the requested area.

I. HEALTH CARE PROVIDERS - 417.101, 417.102, 417.103, 417.105, 417.106
Note: Place tables 1, 1a, 3, 4 and 5 in the health services section in the Documents part.

A. Describe the health care delivery system and how physician services are provided. Describe compliance with each requirement of 417.1 (definitions of staff, medical group, and IPA, as applicable).

B. Complete *fqhsd1.xls* table, Summary of FTE Physicians by Specialty for the entire service area.

C. Complete *fqhsd1a.xls* table, Summary of FTE Physicians by Specialty, by county.

D. Complete *fqhsd2.xls* table, Provider List--Practitioners. (on disk only)

E. Complete *fqhsd3.xls* table, Hospitals, Other Facilities.

F. Complete *fqhsd4.doc* table, Arrangements for Basic Health Services for Members of Federally Qualified plan. If any required health service is not available, please explain.

G. Complete *fqhsd5.doc* table, List of Supplemental Benefits for Members of Federally Qualified plan.

H. If any benefits exclusion is being requested as unusual and infrequent, list the benefit and justify the exclusion as required by 417.101(d)(16).

II. HMO UTILIZATION CONTROL PRACTICES - 417.103(b)

A. Describe procedures to monitor utilization, control cost and achieve utilization goals for the following:
1. In-plan and out-of-plan physician services
2. Laboratory and X-ray services
3. Hospital services, including admitting practices and length of stay
4. Out-of-area hospital services

B. Detail current experience and projected assumptions for hospital utilization and ambulatory visits for Federally Qualified plan enrollees each regional component. Give the current community hospitalization rate.

III. EMERGENCY CARE - 417.101(a)(3), 417.103(c)(e),(3), 417.106(b)(1)

A. How does the HMO assure that medically necessary emergency health services are available and accessible 24 hours a day, 7 days a week?

B. Describe briefly procedures all members must follow in obtaining out-of-plan emergency health services.

IV. AVAILABILITY, ACCESSIBILITY AND CONTINUITY OF SERVICE - 417.106

A. What are the hours of operation at locations where basic and supplemental services are provided?

B. Describe provisions for assuring that a health professional will be responsible for coordinating a member's overall health care.

C. Describe the medical record keeping system through which pertinent information relating to the health care of enrollees is accumulated and is readily available to appropriate professionals.

D. Describe arrangements that assure continuity of care for all health care services provided.

V. CONFIDENTIALITY - 417.106(d)

Describe the location and protection for confidentiality of members' health records.

VI. QUALITY ASSURANCE - 417.106(a)

A. Describe the HMO's quality assurance program for outpatient and inpatient services including:

1. The goals of the program and the organizational arrangements to carry out the program.

2. The methodology for ongoing monitoring and evaluating the quality of its health services, including:
   (a) written procedures for appropriate remedial action whenever inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished
   (b) written guidelines for assessing the effectiveness of remedial action procedures as well as the effectiveness of the corrective actions themselves
   (c) use of systematic data collection of performance and patient results, and provision to providers of interpretation of data

3. For the first year of operations as a qualified HMO, the objectives of the program and a timetable for implementation.

B. *FOR EXPANSIONS*: Discuss briefly the HMO's quality assurance program in its qualified operations. Include: organizational arrangements and specific program activities; results over the last year; and the relationship between the expanded area and the HMO.

ON-SITE DOCUMENTS

Have the following available for inspection at the site visit:

1. Authorization/Referral forms
2. Encounter forms
3. Policy manual of procedures for health professionals
4. Minutes of Utilization Review and Quality Assurance Committees for the proposed area and currently qualified area, if applicable
5. Evidence that institutional providers are certified under Titles XVIII or XIX of the Social Security Act
6. Quality assurance plan for the HMO

Instructions for the Health Services Delivery Tables

fqhsd1.xls SERVICE AREA SUMMARY OF PHYSICIANS BY SPECIALTY TABLE, FOR THE ENTIRE SERVICE AREA:

Instructions:

- Providers should only be counted once on this table.
- A mid-level practitioner is defined as a nurse practitioner, physician assistant or nurse mid-wife.

Column Explanations:

1. Specialty - Self-explanatory.
2. Total Providers: Staff Physicians, Members of Group, IPA, Direct w/Plan, or PHO - List the number for each provider type.
3. Total Number for Federally Qualified plan - List the total number for all doctors who have agreed to serve Federally Qualified plan members.
4. Total Number Accepting New Federally Qualified plan Patients - List the total number of doctors in column #3 who are accepting new Federally Qualified patients.

fqhsd1a.xls SUMMARY OF PHYSICIANS BY SPECIALTY TABLE, BY COUNTY:

Instructions:

- Provide a separate table for each county or partial county. Providers should only be counted once per county on this table even if the providers have more than one location in the county.
- A mid-level practitioner is defined as a nurse practitioner, physician assistant or nurse mid-wife.

Column Explanations: Same as 1-5 above.

fqhsd2.xls PROVIDER LIST - List of Physicians and Other Practitioners TABLE

Instructions:

- Provide a separate table for each county or partial county.
- Array providers alphabetically by type of provider (Group, IPA, PHO, Direct w/Plan and Staff) and location.
- Provide only on a spreadsheet format on diskette; do not include hard copy in the application.

Column Explanations:

1. Name of Physician or Mid-Level Practitioner (physician assistants, nurse practitioners and nurse mid-wives).
2. Specialty - Self-explanatory.
3. S=Staff; G=Group; I=IPA; P=PHO; D=Direct - Self-explanatory.
4. Service Location - Specify the city, zip code, where the provider serves patients. Providers should be listed alphabetically first by Group, IPA, PHO, Direct w/Plan and Staff. If a provider sees patients at more than one location, list each location separately. However, the provider should only be counted once on *fqhsd1.xls*.
5. Contracted Hospital(s) Where Privileged - Identify hospital(s) in the geographic area where the provider has admitting privileges, other than courtesy privileges.
6. Serves Federally Qualified enrollees? - Provide 'Yes' or 'No' response
7. Accepts New Federally Qualified Patients? – Provide 'Yes' or 'No' response

fqhsd3.xls HOSPITALS AND OTHER CONTRACTING PROVIDERS
Skilled Nursing Facilities, Psychiatric Hospitals, Home Health, Surgical Centers, Labs etc.
Instructions:
- Provide a separate table for each county or partial county.
- For radiologists/anesthesiologists/pathologists: list only those that are employees or subcontracted by the hospital/clinic, or employed by a medical group or groups.
- If the hospital provides multiple services (skilled nursing facility services, home health services or end-stage renal disease services) list each service in a separate column.

Row Explanations:
1. Name of Provider - Enter name and type of contracted entity. List first all Hospitals then SNFs, Psychiatric Hospitals, Home Health Agencies, Surgical Centers, Labs, Rehab Facilities, and Rural Health Clinics etc.
   SNF = Skilled Nursing — PH=Psychiatric Hospital
   RF= Rehab Facility — RHC= Rural Health Clinic
   SC= Surgical Center — L=Lab
   HH= Home Health — ESRD
2. Location - Enter street/city/state/zip code.
3 Title 18 Certification # or Provider # - Self-explanatory.
4. Services Provided -
   In Outpatient categories enter 'Yes' for all services provided. (Leave blank if not applicable)
   In Inpatient categories enter actual bed count for each breakdown listed; if none, enter zero (0).
   (If Surgery or Coronary Care Unit bed counts are listed in previous entries, so state in box, i.e., (include above).
5. Serves Federally Qualified enrollees? - Provide 'Yes' or 'No' response.

fqhsd4.doc ARRANGEMENTS FOR BASIC HEALTH SERVICES FOR MEMBERS OF FEDERALLY QUALIFIED PLAN - Other than Physician and Hospital
Instructions:
- Provide a separate table for each county or partial county.

Column Explanations:
1. Required Basic Health Services - Self-explanatory
2. Name of Providers for Federally Qualified Enrollees - Indicate if the services will be provided by staff of the HMO, contracted medical groups/IPAs, or direct contract with the HMO. If any other provider, give the name of the entity. If any of these required services are provided through arrangements with subcontractors indicate name of entity in the 'other' column. If provided by more than one source, state all sources.

fqhsd5.doc SUPPLEMENTAL BENEFITS FOR MEMBERS OF FEDERALLY QUALIFIED PLAN
Instructions:
- Provide a separate table for each county or partial county.
- Check which benefit type is being offered and add any additional benefits.

Column Explanations:

1. Supplemental Benefits - Self-explanatory.
2. Included as a Prepaid Service? - Indicate the supplemental services that are included in the benefit package.
3. Agreement Status - Indicate the status of the agreement with the provider.
4. Name of Provider - Enter provider name and address where services are provided. If provider is Group, IPA, Direct w/Plan or Staff indicate name of entity; if provided by more than one source, state all sources. If the service is provided by a subcontractor indicate the name of the entity.

FINANCIAL

I. FISCAL SOUNDNESS - 417.120(a)(1)

A. Provide independently certified audited financial statements in the Documents part.

Preoperational applicants should provide statements for the most recent fiscal year. All other applicants must provide audited statements for the three most recent fiscal year periods or, if operational for a shorter period of time, for each of those fiscal years. If the HMO is a line of business of the applicant, it should provide audited statements relating to the legal entity. Audits are to include:

1. Opinion of a certified public accountant
2. Statement of revenues and expenses
3. Balance sheet
4. Statement of cash flows
5. Explanatory notes
6. Management letters
7. Statements of Changes in Net Worth

B. Provide in the Documents part a copy of the most recent unaudited financial statements of the entity.

C. If applicable, provide in the Documents part independently certified audited financial statements of guarantors, and lenders (organizations providing loans, letters of credit or other similar financing arrangements, excluding banks).

D. If the entity is a public corporation or subsidiary of a public corporation, provide the most recent Annual Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934, Form 10-K in the Documents part.

E. If the entity has raised capital through public offerings within the last 3 years or anticipates a public offering, provide a copy of the prospectus in the Documents part.

II. FINANCIAL PLAN - 417.120(a)

A. Special exception: **Applicants who meet the special conditions below need not provide financial projections. All other parts of the financial section are required.**

An applicant must meet all five of the following conditions:

a. Has operated as a prepaid health services plan for at least 3 years
b. Has a positive net worth as established by generally accepted accounting principles
c. Has earned a net operating surplus or profit (after taxes) during the HMO's most recent fiscal year period
d. Has sustained a cumulative net operating surplus at the end of the 3 most recent fiscal years
e. Demonstrated with audited financial statements that conditions b. through d. are met.

B. FINANCIAL PROJECTIONS

If the entity does not meet the exception in Part A, provide projections which evidence how fiscal soundness will be achieved or maintained.

Describe financing arrangements and include all documents supporting these arrangements for any projected deficits in the Documents part. **Note: there must be evidence of financing arrangements for the projected deficit.**

Operational HMOs should provide actual data (but not necessarily audited statements) from the date of the latest annual audit. Preoperational HMOs should provide projections from the date of the anticipated start of operations.

The plan must provide projections for a minimum of one year from the date of the latest submitted financial statement. Give projections from this date through one year beyond breakeven; if plan has reached breakeven, provide projections from this date until one year from anticipated date of qualification.

Financial projections should be prepared using the accrual method of accounting in conformity with generally accepted accounting principles. Prepare projections using the pro-forma financial statement methodology. *For a line of business, assumptions need only be submitted to support the projections of the line.*

Projections are to be part of the Financial Documents part and must include the following:

1. Quarterly balance sheets for the applicant, using the National Association of Insurance Commissioners (NAIC) Financial Report #1 format.

2. Quarterly statements of revenues and expenses for the legal entity, using NAIC Financial Report #2 format. *In cases where the plan is a line of business, the applicant should also complete a statement of revenue and expenses for the line-of-business.* Give projections in gross dollars as well as on a per member per month basis. Quarters should be consistent with standard calendar year quarters. Include year end totals. If an organization has a category of revenue and/or expense that is not included in the present definitions, provide an explanation.

3. Quarterly Statements of Cash Flows, using the NAIC Financial Report #3 format.

4. Statement and Justification of Assumptions

   For the proposed service area or each regional component, if applicable, state major assumptions separately for Medicare, Medicaid and Federally Qualified members in sufficient detail to allow an independent financial analyst to reconstruct projected figures using only the stated assumptions. Include operating and capital budget breakdowns.

   Stated assumptions should address all periods for which projections are made and include inflation assumptions. Details of minor assumptions will be verified on site. Justify

assumptions to the extent that a knowledgeable reviewer would be convinced that they are reasonable. Base justification on such factors as the applicant's experience, the experience of other HMOs and others. Describe hospital and health professional costs and utilization in detail.

For a line of business, financial assumptions need only be submitted to support the projections of the line.

Note: If an organization has a category of revenue and/or expense that is not included in the present definitions, provide an explanation.

III. PROVISIONS FOR THE EVENT OF INSOLVENCY - 417.122(a), 417.122(b)

A. Describe provisions or planned provisions in the event of insolvency:
   1. To pay for services for the duration of the contract period for which payment has been made.
   2. To pay for continuation of services until the time of discharge for members confined in an inpatient facility.
   3. To protect members from incurring liability for services provided before the HMO's insolvency.

B. Provide all documents supporting these arrangements in the Documents part, including reinsurance/insolvency policies and any other proposed arrangements to cover uncovered expenditures. If applicable, include independently certified audited statements of any guarantor.

   On the Uncovered Expenditures Calculation Work Sheet (*fqinsolv.doc*) calculate the HMO's uncovered health care expenses for a two month period, averaged for the year following anticipated qualification. Insert the work sheet in the Financial Documents part.

   Note 1: If provisions for A or B are in the Documents part, reference, by application page number, the applicable sections of such documents.
   Note 2: Refer to the Program Information Letter on insolvency protection.

IV. ACCOUNTING FOR INCURRED BUT NOT REPORTED CLAIMS (IBNR)

Describe the method of accounting for claims incurred, but for which bills have not been received at the end of accounting periods.

V. COMMUNITY RATING- FEDERALLY QUALIFIED PLAN - 417.104, 417.105(b)

A. If the HMO claims the 4-year exemption from community rating under 417.104(c) for the proposed service area, explain how the HMO meets exemption requirements?

   In order to qualify for an exemption from community rating, the HMO must have no less than 2,500 members and must have provided comprehensive health services for 6 months at the time of application submission. For multiple components, each region can claim the 4 year exemption from community rating.

B. State the community rate for the proposed service area or each component. Describe the method and formula for arriving at your community rates, if applicable. Include the projected mix of contracts, the average contract size, the family size, and the required revenue yield.

C. If you wish to use community rating by class, submit: (1) a list of factors and classes to be used in the determination of the rate by class; and (2) sufficient rationale to substantiate by reference or with submitted statistical data that the factors and classes reasonably predict differences in the use of HMO services by the individuals and families in the class (Section 1302(8)(C) of the Public Health Service Act as amended).

D. If you wish to set separate prospective rates for specific groups, describe the method and formula for arriving at your rates.

NOTE: For groups of 100 or less, rates may not be set higher than 110 percent of the community rate.

VI. COPAYMENT LIMITATIONS - For Basic Health services Only - 417.104(a)(4)

For the proposed service area or for each component having a separate rate, provide the following information using this format if the HMO requires a copayment for any basic health service for Federally Qualified members. Specify the copayments required below.

A. 20 Percent Aggregate Limit
   1. Total projected copayments (to all HMO providers) _____________ -
   2. Total projected costs of all basic health service _____________
   3. Ratio (Line 1) - (2) x (100) _____________ -

B. 50 Percent of Single Service Cost Limit

Service	Copayment	Cost of Service to HMO

C. Annual Premium Limit

If the HMO has copayments, describe how subscribers will be notified, at least annually, of the specific annual maximum copayment amount to which they are subject. Describe the procedures to demonstrate to the HMO when the limit has been reached.

VII. STATE FINANCIAL REQUIREMENTS - 417.120(a)

Describe the reserve requirements and other financial requirements set by the State in which the HMO does or will operate and how the HMO meets these requirements. Include any supporting documentation in the Documents part.

VIII. MANAGEMENT INFORMATION SYSTEM - 417.124(a)

Describe the use of the MIS for day-to-day management of key plan functions as well as long term planning and for the National Data Reporting Requirements. Provide a list of key reports which includes a brief description of each and indicates their distribution. Expansion applicants should explain the interface between the requested service area and existing systems.

EXPANSION APPLICANTS: Answer all the sections in this chapter.

ON SITE DOCUMENTS

Have the following available for inspection at the site visit:

1. Management information system reports.
2. The most recent financial statements to update those submitted with the application, using the same format.
3. Actuarial analysis prepared by independent actuaries if used in developing the financial assumptions.

MARKETING

If you are exempt from submitting financial projections under Financial II, you are not required to submit the Marketing chapter. If you are not exempt from submitting financial projections, complete the Marketing chapter.

I. ENROLLMENT HISTORY - 417.120(a)

Describe your enrollment history since the start of prepaid care. Discuss attainment of breakeven, if applicable. Include comparisons of actual enrollment to projected enrollment.

II. COMPETITION - 417.120(a)

A. Describe existing health benefit coverage in the service area for commercial plans. Identify major competitors by name, current benefit and premium levels, and respective market share.

B. Identify the HMO's projected premium inflation rates and compare with expected trends within the competition.

III. ENROLLMENT PROJECTION ASSUMPTIONS - 417.120(a)

Describe the following assumptions underlying the enrollment projections for the proposed service area or each component:

1. Number of eligible residing within the service area
2. Penetration assumptions and rationale for initial enrollments and reenrollment

Complete chart for the year after anticipated qualification:

Contract Distribution	Single_____ Double_____ Family_____
Average Family Size	
Average Contract Size	
PMPM Federally Qualified Premium Revenue Yield	

IV. MARKETING STRATEGY - 417.120(a)

Describe briefly the marketing strategy for each major category of enrollment (e.g., group, non-group), including:

1. Criteria for selection of primary and secondary targets
2. Use of underwriting guidelines
3. Sales approach
4. Account development
5. Contingency strategies
6. Advertising/promotion strategy

V. MARKETING STAFF - 417.120(a)

Describe the number, organization and training of marketing staff. Discuss staff requirements over the time and any incentive programs for staff. Explain internal systems used to evaluate the performance of marketing staff.

VI. MANAGEMENT INFORMATION SYSTEM (MIS) - 417.124(a)

Describe how the MIS monitors contract distribution and size for assessing revenue yield.

VII. MARKETING BUDGET - 417.120(a)

Submit a detailed marketing budget which reflects the program objectives stated in the strategy discussion. Include as many years of information as are required in the financial section of this application. Include items such as: compensation, local and out-of-town travel, equipment, printing and postage, advertising and public relations, expense accounts, meeting costs and publications, if applicable.

VIII. ENROLLMENT PROJECTIONS - 417.120(a)

To assure the most current enrollment projections, prepare projections in accordance with the instructions below and have them available at the time of the site visit.

EXPANSION APPLICANTS: Answer all the sections in this chapter only for the requested area.

ON SITE DOCUMENTS

Have the following available for inspection at the site visit:

1. Underwriting guidelines
2. Account files for groups included in the enrollment projections
3. A list of contact persons and telephone numbers for projected groups
4. Comparison of the HMO's benefits and premiums versus its competitor(s) for accounts enrolled/reenrolled within the 90 days prior to the site visit and any accounts scheduled for enrollment/reenrollment subsequent to the site visit, where available
5. Enrollment projections for the proposed service area for each component. Use the Enrollment Projections Worksheet to detail quarterly enrollment projections with account-specific information. Projections should begin with actual enrollment as of the date of the site visit or the start of operations (if preoperational) through one year beyond anticipated qualification.

   Provide account-specific information for new groups; membership through reenrollment may be aggregated on a single line for each quarter. For non-group, Medicare and Medicaid projections, complete the appropriate columns as shown.

   Note: The file named *fqenroll.doc* should be filled out and a hard copy and disk copy should be available at the site visit.

DOCUMENTS PART

THE FOLLOWING DOCUMENTS ARE SEPARATE FILES --
HARD COPIES BELONG IN THIS PART OF THE APPLICATION

Chapter	File Name	Description
ORGANIZATIONAL & CONTRACTUAL	fqinsure.doc	Insurance Coverage
	fqprovid.doc	Provider Arrangements
HEALTH SERVICES DELIVERY	fqhsd1.xls	Physicians, by Specialty, entire service area
	fqhsd1a.xls	Physicians, by Specialty, by county
	fqhsd3.xls	Hospitals, other facilities
	fqhsd4.doc	Basic Health Services
	fqhsd5.doc	Supplemental Health Services
FINANCIAL	fqinsolv.doc	Uncovered Expenditures

Please be sure to:

- INCLUDE EACH COMPLETED FILE ON THE DISKETTE SUBMITTED TO CMS.
- INSERT COMPLETED DOCUMENTS INTO THE DOCUMENTS PART, BY CHAPTER, WHEN PREPARING THE HARD COPY OF APPLICATION; USE TABS TO SEPARATE CHAPTERS.
- NUMBER EACH PAGE (OR DOCUMENT) IN THE DOCUMENTATION PART.
- FILL IN THE NUMBERS ON THE DOCUMENTS TABLE OF CONTENTS.