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# MEDICARE ADVANTAGE MASTER APPLICATION

**For all new applicants and existing Medicare Advantage contractors seeking to expand a service area -- CCP, PFFS, MSA, RPPO, & SNP Proposals**

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

**Medicare Advantage Coordinated Care Plans (CCPs) must offer Part D prescription drug benefits under at least one Medicare Advantage plan in each county of its service area, and therefore must timely submit a Medicare Advantage-Prescription Drug(MA-PD) application to offer Part D prescription drug benefits as a condition of approval of this application.**

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 is 0938-0935. The time required to complete this information collection is estimated to average 32 hours per response, including the time to review instructions, search existing data resources, and 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: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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# PART 1 GENERAL INFORMATION

## 1. Overview

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) significantly revised the Medicare + Choice managed care program, now called the Medicare Advantage (MA) program, and added outpatient prescription drugs to Medicare (offered by either stand-alone prescription drug plan sponsors or MA organizations). The MMA changes make managed care more accessible, efficient, and attractive to beneficiaries seeking options to meet their needs. The MA program offers new kinds of plans and health care choices, such as regional preferred provider organization plans (RPPOs), private fee-for-service plans (PFFS), Special Needs Plans (SNPs), and Medical Savings Account plans (MSAs).

The Medicare outpatient prescription drug benefit is a landmark addition to the Medicare program. More people have prescription drug coverage and are saving money on prescription drugs than ever before. Costs to the government for the program are lower than expected, as are premiums for prescription drug plans,

People with Medicare not only have more quality health care choices than in the past but also more information about those choices. The Centers for Medicare & Medicaid Services (CMS) welcome organizations that can add value to these programs make them more accessible to Medicare beneficiaries and meet all the contracting requirements.

## 2. Types of MA Products and MA Applicants

The MA program is comprised of a variety of product types including:

- Coordinated Care Plans
  - Health Maintenance Organizations (HMOs) with/without a Point of Service(POS) benefit
  - Local Preferred Provider Organizations (LPPOs)
  - Regional Preferred Provider Organizations (RPPOs)
  - State Licensed Provider-Sponsored Organizations (PSOs)
  - Special Needs Plans (SNPs)
- Private Fee-for-Service (PFFS) plans
- Medical Savings Account plans (including Medical Savings Account Demonstration plans)

Note: For facts sheets on each of these types of product offerings go to http://www.cms.hhs.gov/HealthPlansGenInfo/

Qualifying organizations may contract with CMS to offer any of these types of products. To offer one or more of these products an application must be submitted according to the instructions in this application.

The applicant can either be “new”, meaning the applicant is seeking a new MA contract for a type of MA product they do not already offer, or “existing”, meaning the applicant is seeking a service area expansion under an existing contract.

Note: The Medicare Modernization Act requires that CCPs 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.

Note: PFFS plans have the option to offer the Part D drug benefit. MSA plans can not offer the Part D drug benefit.

Note: All applicants who wish to offer Employer/Union-Only Group Waiver Plan must complete a separate EGWP application in HPMS. There are two types of EGWP applications: MAO "800 Series" EGWP application and Employer/Union Direct Contract PFFS MAO application.

## 3. Important References

The following are key references about the MA program:

- Social Security Act -- 42 USC 1395 et seq. http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Medicare Regulations--42 CFR Part 422 http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=4b0dbb0c0250d4508a613bbc3d131961&tpl=/ecfrbrowse/Title42/42cfr422_main_02.tpl
- Medicare Managed Care Manual--http://www.cms.hhs.gov/HealthPlansGenInfo/
- Medicare Marketing Guidelines –http://www.cms.hhs.gov/ManagedCareMarketing/

## 4. Technical Support

CMS Central and Regional Office staffs are available to provide technical support to all applicants during the application process. Applicants may call Kateisha Martin in the CMS Central Office at (410) 786-4651, or a Regional Office to request assistance. A list of CMS Regional Office contacts can be found in Part 7 of this application.

For general information about this application please send an email to the following email address: PartCappComments@cms.hhs.gov

CMS also conducts special training sessions and user group calls for new applicants and existing contractors. All applicants are strongly encouraged to participate in these sessions which will be announced via HPMS and/or CMS main website.

## 5. **Health Plan Management System (HPMS)**

A. The HPMS is the primary information collection vehicle through which MA organizations will communicate with CMS in support of the application process, bid submission process, ongoing operations of the MA program, and reporting and oversight activities.

B. Applicants are required to enter contact and other information collected in HPMS in order to facilitate the application review process. Applicants are required to provide prompt entry and ongoing updates of data in HPMS. By keeping the information in HPMS current, the applicant facilitates the tracking of its application throughout the review process and ensures that CMS has the most current information for application updates, guidance and other types of correspondence. In the event that an applicant is awarded a contract, this information will also be used for frequent communications during implementation. Therefore, it is important that this information be accurate at all times.

C. HPMS is also the vehicle used to disseminate CMS guidance to MA organizations. The information is then incorporated in the appropriate manuals. It is imperative for MA organizations to independently check HPMS notices and incorporate the guidance as indicated in the notices.

## 6. **Submit Intent to Apply**

Organizations interested in applying for a Medicare Advantage product must complete a Notice of Intent to apply form by December 5, 2007. Upon submitting the completed form to CMS the organization will be assigned a pending contract number (H number) to use throughout the application and subsequent operational processes.

Once the contract number is assigned, the applicant should request a CMS User ID. An application for Access to CMS Computer Systems (for HPMS access) is required and can be found at: http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/Access.pdf . Upon approval of the CMS User ID request, the applicant will receive a CMS User ID(s) and password(s) for HPMS access.

## 7. Due date For MA Application

Applications must be submitted by 5:00 P.M.EST, March XX, 2008.   CMS will not review applications received after this date and time.  Applicants' access to application fields within HPMS will be blocked after this date and time.

Below is a tentative timeline for the Part C (MA program) application review process:

| APPLICATION REVIEW PROCESS | |
|---|---|
| Date | Milestone |
| December 2007 | New MA organizations:<br>1. Submit notice of intent to apply to CMS<br>2. Request HPMS Access (Includes User ID and Password Request)<br>3. Request CMS Connectivity |
| January  2008 | Final Applications Posted by CMS |
| March  2008 | Applications due |
| April 2008 | Plan Creation module, Plan Benefit Package (PBP) and Bid Pricing Tool (BPT) available on HPMS |
| May 2008 | PBP/BPT Upload Module available on HPMS |
| May/June 2008 | CMS mails Part C (MA program) conditional contract eligibility determination to Applicants, based on review of application. |
| June 2008 | All bids due. |
| September  2008 | CMS completes review and approval of bid data.  CMS executes Part C (MA program) contract to organizations who submit an acceptable bid, and otherwise meet CMS requirements. |
| November 2008 | 2008 Annual Coordinated Election Period begins for January 1, 2009, effective date for 2009 plans. |

## 8. General MA Application Instructions

Applicants must complete the 2009 MA application using the HPMS as instructed.  CMS will not accept any submission using prior versions of the MA application.  All documentation must contain the appropriate CMS issued contract number.

In preparing a response to the prompts throughout this application, the Applicant must mark “Yes” or “No” in sections organized with that format.  By responding “Yes”, the Applicant is committing its organization to complying with the relevant requirement as of the date the Medicare contract is signed.

All aspects of the program to which the Applicant replies “Yes” to must be ready for operation by the effective date of the signed contract.  CMS may verify an Applicant's readiness and compliance with Medicare requirements, through on-site visits at the Applicant's facilities as well as through other program monitoring techniques.  Failure to meet the requirements represented in this application and to operate MA plans consistent with the applicable statutes, regulations, and the MA contract, and other CMS guidance could result in the closure of plan marketing and enrollment.  If corrections are not made in timely manner, the Applicant will be disqualified from participation in the MA program.

Throughout this application, applicants are asked to provide various documents and/or tables in HPMS.  Part 5 of this application lays out instructions for completing some of the requested CMS forms and tables.  Part 6 of this application provides a list of all requested documents and/or tables.  The list includes the name, the

reference point within the application, the format to use when submitting the application, and a file naming nomenclature.

The legal entity that submits this application must be the same entity with which CMS enters into a MA contract.

## 9. MA Part D (MA-PD) Prescription Drug Benefit Instructions

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). The MA-PD application can be found at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage or the applicant may contact Marla Rothouse at 410-786-8063. Specific instructions to guide MA applicants in applying to qualify to offer a Part D benefit during 2009 are provided in the MA-PD application and must be followed.

Note: Failure to file the required MA-PD application will be considered an "incomplete" MA application and could result in a denial of this application.

Failure to submit application supporting documentation consistent with these instructions may delay the review by CMS and may result in the applicant receiving a Notice of Intent to Deny.

## 10. Additional Information

### 10.1 Bid Submission and Training

On or before the first Monday of June of every year, MA organizations must submit a bid, comprised of the proper benefits and pricing for each MA plan for the upcoming year based on its determination of expected revenue needs. Each bid will have 3 components, original Medicare benefits (A/B), prescription drugs under Part D (if offered under the plan), 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. No bid submission is needed at the time the application is submitted. Further instructions and time frames for bid submissions are provided at http://www.cms.hhs.gov/MedicareAdvantageApps.

In order to prepare plan bids, Applicants will use HPMS to define its plan structures and associated plan service areas and then download the Plan Benefit Package (PBP) and Bid Pricing Tool (BPT) software. For each plan being offered, Applicants will use the PBP software to describe the detailed structure of its MA benefit and the BPT software to define its bid pricing information.

Once the PBP and BPT software have been completed for each plan being offered, Applicants will upload their bids to HPMS. Applicants will be able to submit bid uploads to HPMS on its PBP or BPT one or more times between early May 2008 and the CY 2009 bid deadline, the first Monday in June 2008. CMS will use the last successful upload received for a plan as the official bid submission.

CMS will provide technical instructions and guidance upon release of the HPMS bid functionality as well as the PBP and BPT software. In addition, systems training will be available at the Bid Training in April 2008.

### 10.2 System and Data Transmission Testing

All MA organizations must submit information about its membership to CMS electronically and have the capability to download files or receive electronic information directly. Prior to the approval of a contract, MA organizations must contact the MMA Help Desk at 1-800-927-8069 for specific guidance on establishing connectivity and the electronic submission of files. Instructions are also on the MMA Help Desk web page, www.cms.hhs.gov/mmahelp, in the Plan Reference Guide for CMS Part C/D systems link. The MMA Help Desk is the primary contact for all issues related to the physical submission of transaction files to CMS.

### 10.3 Protecting Confidential Information

Applicants may seek to protect its information from disclosure under the Freedom of Information Act (FOIA) by claiming that FOIA Exemption 4 applies. The Applicant is required to label the information in question “confidential” or “proprietary”, and explain the applicability of the FOIA exemption it is claiming. When there is a request for information that is designated by the Applicant as confidential or that could reasonably be considered exempt under Exemption 4, CMS is required by its FOIA regulation at 45 CFR §5.65(d) and by Executive Order 12,600 to give the submitter notice before the information is disclosed. To decide whether the Applicant’s information is protected by Exemption 4, CMS must determine whether the Applicant has shown that— (1) disclosure of the information might impair the government's ability to obtain necessary information in the future; (2) disclosure of the information would cause substantial harm to the competitive position of the submitter; or (3) disclosure would impair other government interests, such as program effectiveness and compliance; or (4) disclosure would impair other private interests, such as an interest in controlling availability of intrinsically valuable records, which are sold in the market. Consistent with our approach under other Medicare programs, CMS would not release information that would be considered proprietary in nature.

### 10.4 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 the applicant has questions about this form please contact Yvonne Rice at 410-786-7626. The completed form needs to be faxed to Yvonne Rice at (410) 786-0322.

## PART 2 INITIAL APPLICATIONS

The MA application must be completed using the HPMS except as indicated throughout. Section 1 of the application, must be completed by all applicants applying for a new contract type (e.g. CCP, PFFS, MSA, RPPO or SNP) for which the applicant does not already have a Medicare contract. If the applicant is seeking a service area expansion or a new SNP type under an existing Medicare contract, then an initial application should not be completed; rather a Service Area Expansion Application must be completed. Applicants applying for a Regional PPO, PFFS, MSA, or Special Needs plan must also complete the section specific to that product.

CMS strongly recommends and encourages Medicare Advantage applicants to refer to the 42 CFR Part 422 regulations to clearly understand the nature of the requirement in order to provide an appropriate response. Nothing in this application is intended to supersede the regulations at 42 CFR Part 422. Failure to reference a regulatory requirement in this application does not affect the applicability of such requirement, and Applicants are required to comply with all applicable requirements of the regulations in Part 422 of 42 CFR. Applicants must read HPMS notices and visit the CMS web site periodically to stay informed about new or revised guidance documents.

## SECTION 1 ALL MA APPLICANTS (CCP, PFFS, RPPO, & MSA)

### 1.1 Experience & Organization History

In HPMS, upload a brief summary of the applicant's history, structure and ownership. Include organizational charts to show the structure of ownership, subsidiaries, and business affiliations.

### 1.2 Administrative Management

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:<br>ADMINISTRATIVE MANAGEMENT | YES | NO |
|---|---|---|
| 1. Applicant is applying to operate as a Coordinated Care Plan (HMO, Local PPO, and/or PSO). | | |
| 1. Applicant is applying to operate as a Regional Preferred Provider Organization. | | |
| 2. Applicant is applying to operate as a Private Fee-for-Service organization. | | |
| 3. Applicant is applying to operate as a Medical Savings Account plan. | | |
| 4. Applicant is applying to operate as a Medical Savings Account demonstration plan. | | |
| 5. Has the Applicant non-renewed its contract with CMS within the past 2 years? | | |
| 6. Does the applicant currently operate a CMS Cost 1876 contract in the intended service area of this application? | | |
| 7. Does the applicant currently offer health plans products to the commercial population? | | |
| 8. Applicant has administrative and management arrangements that feature a policy-making body (e.g., board of directors) exercising oversight and control over the organization's policies and personnel (e.g., human resources) to ensure that management actions are in the best interest of the organization and its enrollees. | | |
| 9. Applicant has administrative and management arrangements that feature personnel and systems sufficient for the organization to organize, implement, control and evaluate financial and marketing activities, the quality assurance, and the administrative aspects of the organization. | | |
| 10. Applicant has administrative and management arrangements that feature an executive manager/chief executive officer whose appointment and removal are under the control of the policy-making body. | | |
| 11. Applicant has administrative and management arrangements that feature a fidelity bond or bonds, procured by the Applicant, in an amount fixed by its policymaking body, but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds. | | |

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ADMINISTRATIVE MANAGEMENT | YES | NO |
|---|---|---|
| 12. Applicant has administrative and management arrangements that feature insurance policies secured and maintained by the Applicant, and approved by CMS to insure the Applicant against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.<br><br>▪ If "Yes", applicant must provide in HPMS a complete copy of the "CMS Insurance Coverage Table". | | |
| 13. Applicant maintains contracts or other legal arrangements between or among the entities combined to meet the functions identified in Provider Contract & Agreements section. | | |

## 1.3 State Licensure (For CCP, PFFS, & MSA Applicants Only)

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE | YES | NO |
|---|---|---|
| 1. Applicant is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the Applicant proposes to offer the MA product.<br><br>● If "Yes," applicant must provide in HPMS an executed copy of a state licensing certificate and/or the CMS state certification form for each state being request.<br><br>• Note: All licensure requirements (state license and/or state certification form) must be met by the first Monday in June. | | |
| 2. Applicant is currently under some type of supervision, corrective action plan or special monitoring by the State licensing authority in any State.<br><br>• If "Yes", applicant must provide in HPMS an explanation of the specific actions taken by the State license regulator. | | |
| 3. Applicant conducts business as "doing business as" (d/b/a) or uses a name different than the name shown on its Articles of Incorporation.<br><br>• If "Yes", applicant must provide in HPMS a copy of the State approval for the dba. | | |

**Note: 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.

Note: For states or territories such as Puerto Rico whose licenses renew after June 1, the applicant is required to submit the new license in order to operate as an MA or MA-PD.

## 1.4 Business Integrity

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: BUSINESS INTEGRITY | YES | NO |
|---|---|---|
| 1. Applicant, applicant staff, and its affiliated companies, subsidiaries or subcontractors, and subcontractor staff agree that they are bound by 2 CFR Part 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services**.** Please note that this includes any member of its board of directors, and any key management or executive staff or any major stockholder. | | |
| 2. Applicant agrees it does not have any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration brought involving the Applicant (and Applicant's parent firm if applicable) and its subcontractors, including any key management or executive staff, or any major shareholders by a government agency (state or federal) over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. | | |

B. If Applicant answered "No" to either question above; provide in HPMS a Business Integrity Disclosure, which contains a brief explanation of each action, including the following:

1. Legal names of the parties.
2. Circumstances.
3. Status (pending or closed)
4. If closed, provide the details concerning resolution and any monetary payments, or settlement agreements or corporate integrity agreement.

## 1.5 Compliance Plan

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: COMPLIANCE PLAN_ | YES | NO |
|---|---|---|
| 1. Applicant will implement a compliance plan in accordance with all Federal and State regulations and guidelines. | | |
| 2. Applicant will implement a compliance plan that consists of written policies, procedures, and standards of conduct articulating your organization's commitment to abide by all applicable Federal and State standards. | | |
| 3. Applicant will implement a compliance plan that designates an employee as the compliance officer and compliance committee accountable to senior management. (Note: This requirement cannot be delegated to a subcontractor.) | | |
| 4. Applicant will implement a compliance plan that includes effective training and education between the compliance officer, organization employees, contractors, agents, and directors. | | |
| 5. Applicant will implement a compliance plan that includes effective lines of communication between the compliance officer and organization employees, contractors, agents and directors and members of the compliance committee. | | |
| 6. Applicant will implement a compliance plan that includes disciplinary standards that are well-publicized. | | |
| 7. Applicant will implement a compliance plan that includes procedures for internal monitoring and auditing. | | |
| 8. Applicant will implement a compliance plan that includes procedures for ensuring prompt response to detected offenses and development of corrective action initiatives, relating to the Applicant's MA contract. | | |
| 9. Applicant will implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste and abuse. | | |

Note: All compliance plans must be implemented no later than the effective date of the pending contract. For example: January 1, 2009.

## 1.6 Key Management Staff

A. In HPMS, in the Contract Management/Contract Information/Contract Data page provide the name/title; mailing address; phone number; fax number; and email address for the following Applicant contacts:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENT: KEY MANAGEMENT STAFF | YES | NO |
|---|---|---|
| Applicant agrees that all staff is qualified to perform duties as assigned. | | |

| Contact | Name/Title | Mailing Address | Phone/Fax Numbers | Email Address |
|---|---|---|---|---|
| Corporate Mailing | | | | |
| CEO – Sr. Official for Contracting | | | | |
| Chief Financial Officer | | | | |
| Medicare Compliance Officer | | | | |
| Enrollment Contact | | | | |
| Medicare Coordinator | | | | |
| System Contact | | | | |
| Customer Service Operations Contact | | | | |
| General Contact | | | | |
| User Access Contact | | | | |
| Backup User Access Contact | | | | |
| Marketing Contact | | | | |
| Medical Director | | | | |
| Bid Primary Contact | | | | |
| Payment Contact | | | | |

| HIPAA Security Officer | | | | |
|---|---|---|---|---|
| HIPAA Privacy Officer | | | | |
| CEO- CMS Administrator Contact | | | | |
| Quality Director | | | | |

B. Provide in HPMS, position descriptions for the key management staff and an organizational chart showing the relationships of the various departments.

## 1.7 Fiscal Soundness

In HPMS, complete the table below:

| **RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: FISCAL SOUNDNESS** | **YES** | **NO** |
|---|---|---|
| 1. Applicant will submit its most recent audited financial statements.<br><br>• If "Yes," applicant must provide in HPMS the organization's prior year audited financial statements (Note: if the Applicant has six months or more of operations (i.e., Commercial, Medicaid) in the prior year, it must provide an audited financial statement).<br><br>• If "no" and the applicant has less than six months of operations but more than four months of operations in the prior year, the applicant must provide in HPMS the financial information that was submitted at the time that the State licensure was requested (which would include the Annual NAIC Health Blank and a financial plan) (Note: All applicants with less than six months of operations must provide CMS with a financial plan (discussed in section 2. below).<br><br>• If "No" and the applicant has at least three months of operations, the applicant must provide in HPMS the Quarterly Health Blank. (Note: All applicants with three months or less of operations must provide CMS with a financial plan (discussed in section 2. below). | | |
| 2. Applicant maintains a fiscally sound organization. Specifically, a fiscally sound organization must 1) maintain a net income, 2) have sufficient cash flow and adequate liquidity to meet obligations as they become due, and 3) recent balance sheet demonstrating a reserve level that meets the State regulatory reserve minimum. | | |

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|---|---|---|
| • If “No”, applicant must provide in HPMS a financial plan acceptable to CMS, which includes descriptive assumptions, and contains a projected date of break-even (two successive quarters of net income) | | |
| 3. Applicant agrees to immediately notify CMS if it becomes fiscally unsound during the contract period. Additionally, applicant will immediately notify CMS if the State identifies any financial concerns that will impact the applicants ability to operate it’s Medicare Advantage contract. | | |
| 4. Applicant is in compliance with all State requirements and is not under any type of supervision, corrective action plan, or special monitoring by the state regulator.<br><br>• If “No” applicant must provide to CMS in writing a Financial Disclosure, which details a discussion of the State’s reasons for the increased oversight and what measures the applicant is undertaking to address the reasons for the increased oversight. | | |

## 1.8 Service Area

A. In HPMS, on the Contract Management/Contract Service Area/Service Area Data page, enter the state and county information for the area the applicant wish to serve.

B. In HPMS, complete the table below:

| **RESPOND ‘YES’ OR ‘NO’ TO EACH OF THE FOLLOWING STATEMENTS: SERVICE AREA** | **YES** | **NO** |
|---|---|---|
| 1. Applicant meets the county integrity rule as outlined in Chapter 4 of the Medicare Managed Care Manual. | | |
| 2. Applicant will serve the entire county.<br><br>▪ If “No”, applicant must provide in HPMS providing a justification for wanting to serve a partial county. | | |

C. Provide in HPMS, detailed maps of the requested service area showing the boundaries, main traffic arteries, and any physical barriers such as mountains or rivers. Maps should indicate contracted ambulatory and hospital providers, and mean travel times.

Note: RPPO applicants geographic maps should be defined by rural and urban areas (include borders) that demonstrate the locations of all contracted providers in relation to the beneficiaries in those areas.

### 1.9 Provider Contracts & Agreements

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:<br>PROVIDER CONTRACTS & AGREEMENTS | YES | NO |
|---|---|---|
| 1. Applicant will comply with the basic rules on provider and suppliers of health care-related services as stated at section 422.504. | | |
| 2. Applicant agrees that all provider and supplier contracts or agreements contain the following CMS required contract provisions:<br>• Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records.<br>• Contracts specify the prompt payment requirements, the terms and conditions of which are developed and agreed-to by the MA organization and its contracted providers and suppliers.<br>• Contracts contain hold harmless language that assures the Medicare members incur no payment or fees that are the legal obligations of the MA organization to fulfill. Such provision will apply but not be limited to insolvency of the MA organization, contract breach, and provider billing.<br>• Contracts contain accountability provisions specifying the following:<br>a. That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions, and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintained records a minimum of 10 years.<br>b. That the MA organization oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations; and<br>c. The MA organizations that choose to delegate functions must adhere to the delegation requirements – including all provider contract requirements in these delegation requirements described in the MA regulations,<br>d. Contracts must specify that providers agree to comply with the MA organization's policies and procedures<br>e. Comply with reporting requirements. | | |

| | | |
|---|---|---|
| f. Ensure contract term dates and executed signatures by all parties | | |
| 3. Applicant has executed provider and supplier contracts in place to demonstrate access and availability of the requested service area. | | |
| 4. Applicant agrees to have all provider contracts and/or agreements available upon request and onsite. | | |

B. Provide in HPMS a completed “CMS Provider Arrangements by County Table”. Applicant should insert the number of provider contracts and/or agreements for each proposed service area or distinctive system(s) applicant.

C. Provide in HPMS a sample copy of each primary provider contract(s) and agreement(s) between the applicant and its health care contractors (i.e., direct contract with physicians, medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.).

D. Provide in HPMS, a sample copy of each downstream subcontract that may exist between a Medical groups, IPAs, PHO, etc. and other providers (i.e., individual physicians). (For example: If the applicant contracts with an IPA, which contracts with individual physicians the applicant must provide in HPMS a sample copy of the contract/agreement between the IPA and physicians).

E. Provide in HPMS, a completed “CMS Provider Participation Contracts and/or Agreements Matrix”, which is a crosswalk of CMS regulations to provider contracts and/or agreements. Applicant should complete a matrix for each applicable primary contracted provider and subcontracted provider.

## 1.10 Contracts for Administrative & Management Services

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE & MANAGEMENT SERVICES | YES | NO |
|---|---|---|
| 1. Applicant has contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the Medicare Advantage operations for the MA contract | | |
| 2. Applicant will utilize an administrative/management services contract/agreement for staffing to operate all or a portion the MA program. | | |
| 3. Applicant will have a delegated entity to perform all or a portion of the systems or information technology to operate the MA program for applicant. | | |
| 4. Applicant will have a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions. | | |
| 5. Applicant will have a delegated entity to perform all or a portion of enrollment, disenrollment and membership functions. | | |
| 6. Applicant will have a delegated entity that will perform any and/or all marketing including delegated sales broker and agent functions. | | |
| 7. Applicants will have a delegated accredited entity that will perform all or a portion of the credentialing functions.<br>▪ (Note: PFFS-non-network model applicants leave blank) | | |
| 8. Network-model applicants will have a delegated entity to perform all or a portion of the utilization and/or quality improvement operations.<br>▪ (Note: PFFS non-network model applicants leave blank) | | |
| 9. Applicant will have a delegated entity to perform all or a portion of the Part C call center operations. | | |
| 10. Applicant will have a delegated entity to perform all or a portion of the financial services. | | |
| 11. Applicant will delegate all or a portion of other services that are not listed. | | |

B. In HPMS, complete the table below.

| DELEGATED BUSINESS FUNCTION | SUBCONTRACTOR(S) |
|---|---|
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C. Applicant must provide in HPMS, executed delegated administrative services/management contracts or letters of agreement for each contractor or subcontractor identified in the chart (Section 1.10B**)** above that:

- Clearly identify the parties to the contract (or letter of agreement).
- Describes each of the specific functions (health and/or administrative) that are now or will be delegated to medical groups, IPAs, or other intermediate entities.
- Describes how the applicant will remain accountable for any functions or responsibilities that are delegated to other entities.
- Describes how the applicant will oversee, and formally evaluate delegated entities.
- Describes the applicant's relationships to related entities, contractors and sub-contractors with regard to provision of health and/or administrative services specific to the Medicare product.
- Contains language clearly indicating that the delegated entity, contractor, or subcontractor has agreed to perform the health and/or administrative service, and clauses requiring their activities be consistent and comply with the Applicant’s contractual obligations.
- Are signed by a representative of each party with legal authority to bind the entity.
- Contains language obligating the contractor or subcontractor to abide by all Medicare laws, regulations, and CMS instructions in accordance with 42 CFR 422 (504)(i)(4)(v).
- Contains language obligating the subcontractor to abide by State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the regulations for this program at 42 CFR §422.504(a)(13).
- Contains language ensuring that the contractor or subcontractor will make its books and other records available in accordance with 42 CFR 422.504 (i) (2). Generally stated these regulations give HHS, the Comptroller General, or their designees the right to inspect, evaluate and audit books and other records and that these rights continue for a period of 10 years from the final date of the contract period or the date of audit completion, whichever is later.

- Contains language that the subcontractor will ensure that beneficiaries are not held liable for fees that are the responsibility of the MA contractor in accordance with 42 CFR 422.504(i)(3)(i).

- Contains language that if the Applicant, upon becoming a MA contractor, delegates an activity or responsibility to the subcontractor, that such activity or responsibility may be revoked if CMS or the MA contractor determines the subcontractor has not performed satisfactorily in accordance with 42 CFR 504(i)(5). The subcontract may include remedies in lieu of revocation to address this requirement.

- Contains language specifying that the Applicant, upon becoming a MA contractor, will monitor the performance of the subcontractor on an ongoing basis in accordance with 42 CFR 422.504 (i)(1) & (4).

D. Provide in HPMS, a completed "CMS Administrative/Management Delegated Contracting or Arrangement Matrix".

## 1.11 Health Services Management & Delivery (For All CCP Applicants including RPPOs, and for PFFS & MSA Applicants offering a network)

A. In HPMS, complete the table below.

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: HEALTH SERVICES MANAGEMENT (FOR CCP APPLICANTS, AND PFFS & MSA APPLICANTS OFFERING A NETWORK) | YES | NO |
|---|---|---|
| 1. Applicant will assure availability and accessibility of services with reasonable promptness and in a manner that assures continuity of care. | | |
| 2. Applicant will establish standards, policies and procedures to ensure the following:<br>a. Timeliness of access to care.<br>b. Individual medical necessity determinations.<br>c. Plan providers are convenient to the population served, does not discriminate against Medicare enrollees, and services are available 24 hours a day, 7 days a week, when medically necessary.<br>d. Services are provided in a culturally competent manner. | | |
| 3. Applicant will provide continuity of care and integration of services through arrangements with contracted providers that include:<br>a. Policies that is specific to services that are coordinated and the methods for coordination.<br>b. An offer to provide each enrollee with an ongoing source of primary care or other means.<br>c. Coordinate care with community and social services in the MA plan service area.<br>d. Procedures to ensure timely communication of clinical information among providers.<br>e. Procedures to ensure that enrollees are informed of their health care needs that require follow-up, and<br>f. Processes to address barriers to enrollee compliance with prescribed treatments or regimens. | | |

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: HEALTH SERVICES MANAGEMENT (FOR CCP APPLICANTS, AND PFFS & MSA APPLICANTS OFFERING A NETWORK) | YES | NO |
|---|---|---|
| 4. Applicant will ensure access and availability by:<br>a. Establishing a panel of primary care providers (PCPs).<br>b. Assigning a PCP or making other arrangements to ensure access to medically necessary specialty care, for enrollees that need a referral before receiving care.<br>c. Providing or arranging for necessary specialty care outside the MA plan's provider network when specialty providers are unavailable or inadequate to meet a member's medical needs. | | |
| 5. Applicant will ensure providers are credentialed including procedures for selection and evaluation of providers. | | |
| 6. Applicant will ensure that all Medicare covered services, including supplemental services contracted for (or on behalf of) the Medicare enrollees are available and accessible under the plan. | | |
| 7. Applicant will ensure that health care services are provided in a culturally competent manner to members of different backgrounds. | | |
| 8. Applicant will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population. | | |

B. Provide in HPMS, completed HSD tables 1 through 5. Applicants offering multiple benefit plans must submit separate tables for each county and each plan. Only one HSD table is needed for different plans that have the same network and service area.

## 1.12 Quality Improvement Program (CCP & RPPOS ONLY)

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: QUALITY IMPROVEMENT PROGRAM (CCP & RPPOS ONLY) | YES | NO |
|---|---|---|
| 1. Applicant will establish a quality improvement program for health care services. | | |
| 2. Applicant's quality improvement program will include a Chronic Care Improvement program. | | |
| 3. Applicant will conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvements in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and | | |

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| enrollee satisfaction. | | |
| 4. Applicant will correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms. | | |
| 5. Applicant will measure its performance using standard measures established or adopted by CMS (for Medicare) and report its performance to the applicable agency. | | |
| 6. Applicant will achieve any minimum performance levels that may be established by CMS (for Medicare) with respect to the standard measures. | | |
| 7. Applicant will ensure the capacity and functions of the health information systems for the collection and reporting of Quality Improvement Program data. | | |
| 8. Applicant will establish a policymaking body that exercises oversight and accountability of the Quality Improvement Program. | | |
| 9. Applicant will establish a mechanism for assuring formal ongoing communication and collaboration among the policy making body that oversees the Quality Improvement programs and the other functional areas of the applicant (e.g., health services, management and member services). | | |
| 10. Applicant will establish a mechanism for resolving issues raised by enrollees and for making improvements. | | |

## 1.13 Medicare Operations

### 1.13.1 Marketing

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MARKETING | YES | NO |
|---|---|---|
| 1. Applicant will comply with marketing guidelines and approval procedures that are posted on CMS website at http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp | | |
| 2. Applicant will make available to beneficiaries only those marketing materials that comply with CMS' marketing guidelines. | | |

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MARKETING | YES | NO |
|---|---|---|
| 3. Annually and at the time of enrollment, the Applicant agrees to provide enrollees information about the following features, as described in the marketing guidelines:<br>• Enrollment Procedures<br>• Beneficiary Procedural Rights<br>• Potential for Contract Termination<br>• Benefits<br>• Premiums<br>• Service Area<br>• Provider Directory | | |
| 4. Applicant agrees to provide general coverage information, as well as information concerning utilization, grievances, quality assurance, and financial information to any beneficiary upon request. | | |
| 5. Applicant will maintain a toll-free customer service call center that is open during usual business hours and provides customer telephone service in compliance with standard business practices. This means that the Applicant must comply with at least the following:<br>• Call center operates during normal business hours, seven days a week from 8:00 AM to 8:00 PM for all time zones in which the Applicant offers a MA plan.<br>• A customer service representative will be available to answer member calls directly during the annual enrollment period and 60 days after the annual enrollment period.<br>• After March 2nd, a customer service representative or an automated phone system may answer beneficiary calls on Saturdays, Sundays and holidays.<br>• Eighty percent of all incoming customer calls are answered within 30 seconds.<br>• The abandonment rate of all incoming customer calls does not exceed 5 percent.<br>• Call center provides thorough information about the MA benefit plan, including co-payments, deductibles, and network providers.<br>• Call center features an explicit process for handling customer complaints.<br>• Call center provides service to non-English speaking and hearing impaired beneficiaries consistent with applicable laws, regulations and established policy. | | |
| 6. Applicant will operate an Internet Web site that provides all the information listed in Item #3 of this table. | | |
| 7. Applicant agrees that the Annual Notice of Change (ANOC) / Summary of Benefits (SB) / Evidence of Coverage will be received by members by CMS established due date. | | |

### 1.13.2 Enrollment, Disenrollment, and Eligibility

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ENROLLMENT, DISENROLLMENT, AND ELIGIBILITY | YES | NO |
|---|---|---|
| 1. Applicant agrees to comply with the Enrollment and Eligibility guidelines that are posted on CMS web site at http://www.cms.hhs.gov/MedicareMangCareEligEnrol/ | | |
| 2. Applicant will permit the enrollment of all Medicare beneficiaries who are eligible for MA and reside in the MA service area during allowable enrollment periods according to CMS requirements. | | |
| 3. Applicant agrees to operate and implement all applicable enrollment and eligibility requirements for enrolling Medicare beneficiaries. Including the following:<br>• Applicant only enrolls beneficiaries that have Part A & Part B only,<br>• Applicant ensures that enrollee has not been medically determined to have ESRD,<br>• Applicant verifies that enrollee resides in the service area of the MA applicant,<br>• Applicant ensures the beneficiary completes and signs an election form or completes another CMS-approved election method offered by the applicant and provides information required for enrollment. | | |
| 4. Applicant agrees not to enroll beneficiaries except during allowable enrollment periods, including: the Annual Coordinated Enrollment Period, the Initial Enrollment Period, and any Special Enrollment Periods an individual might be eligible for. | | |
| 5. Applicant will collect and transmit data elements specified by CMS for the purposes of enrolling and disenrolling beneficiaries in accordance with the CMS Eligibility Enrollment and Disenrollment Guidance. | | |
| 6. Applicant agrees to transmit enrollment and disenrollment transactions within the timeframes provided in CMS Enrollment and Disenrollment Guidance. | | |
| 7. Applicant agrees that for enrollments, it will send individuals all required enrollment material and notices within the timeframes provided in the CMS Enrollment and Disenrollment Guidance. | | |
| 8. Applicant will develop and operate a process for enrolling Medicare beneficiaries in the MA program that includes: communicating with beneficiaries who are applying for enrollment in the MA within timeframes specified by CMS in requirements initiating appropriate follow up with beneficiaries who have incomplete enrollment applications; and making enrollments effective according to the effective date policy associated with the enrollment period in which the enrollment is | | |

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| received. | | |
| 9. Applicant will permit voluntary disenrollments only during allowable periods as specified in CMS requirements. | | |
| 10. Applicant will accept and process disenrollment requests from beneficiaries, communicate these requests to CMS, and make the disenrollment effective according to the effective date policy associated with the enrollment period in which the disenrollment request is received. | | |
| 11. Applicant agrees that for disenrollments, it will send individuals an acknowledgement notice within 7 calendar days if it receives the disenrollment request directly from the individual; if the applicant only learns of disenrollment from CMS confirmation (e.g. as a result of enrollment in another plan), applicant must send notice confirming disenrollment within 7 calendar days. | | |
| 12. Applicant will notify enrolled beneficiaries in the event of a contract termination of the termination and alternatives for obtaining prescription drug coverage under Part D in accordance with Part 423 regulations. | | |
| 13. Applicant will develop and implement policies and procedures (including appropriate notice and due process requirements) for optional involuntary disenrollment as permitted by CMS. | | |
| 14. Applicant will ensure that information necessary to access the plan benefit, such as an ID card, is provided according to CMS guidelines. | | |
| 15. Applicant agrees to establish business processes for quickly resolving urgent issues affecting beneficiaries, such as late changes in enrollment or co-pay status, in collaboration with CMS. | | |
| 16. Applicant recognizes that enrollees can change their election during the election periods by the following manners: (a) Electing a different MA plan by completing the appropriate elections with that MA organization. (b) Submits a request for disenrollment to the MA organization in the form and manner prescribed by CMS or through other appropriate mechanisms determined by CMS. | | |
| 17. Applicant will perform the following functions once a disenrollment request is considered to have been made and on the date the disenrollment request is received by the MA organization:<br>• Submit a disenrollment notice to the CMS within timeframes specified by CMS.<br>• Provide enrollee with notice of disenrollment in a format specified by CMS.<br>• File and Retain disenrollment requests for the period specified in CMS instructions and<br>• In case of where lock-in applies, include in the notice a statement explaining that he or she –<br>    o Remains enrolled until the effective date of disenrollment; and | | |

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| o Until that date, neither the MA organization nor CMS pays for services not provided or arranged for by the MA plan in which the enrollee is enrolled. | | |
| 18. Applicant will comply with disenrollments by any individual from an MA plan it offers for any of the following circumstances listed:<br>• Any monthly basic or supplementary beneficiary premiums are not paid on a timely basis is subject to the grace period for late payment.<br>• Individual has engaged in disruptive behavior.<br>• Individual provides fraudulent information on his or her election form or permits abuse of his or her enrollment card. | | |
| 19. If the applicant disenrolls any individuals for the reasons stated above, applicant agrees to give the individual a written notice of disenrollment with an explanation of why the MAO is planning to disenroll the individual. Notices and reason must:<br>• Be provided to the individual before submission of the disenrollment to CMS.<br>• Include an explanation of the individual's right to a hearing under the MA organization's grievance procedure. | | |
| 20. Applicant must comply with all applicable standards and requirements regarding disenrollment actions, provide appropriate disenrollments notices, follow other disenrollment mechanisms including having an effective system for receiving, controlling, and processing disenrollments actions. | | |
| 21. Applicant agrees to election period restrictions | | |

### 1.13.3 <u>Working Aged Membership</u>

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: WORKING AGED MEMBERSHIP | YES | NO |
|---|---|---|
| 1. If brought to its awareness, applicant agrees to identify and report to CMS individuals that are working aged. | | |
| 2. The applicant agrees to:<br>• Identify payers that are primary to Medicare.<br>• Identify the amounts payable by those payers.<br>• Coordinate its benefits to Medicare enrollees with the benefits of the primary payers. | | |

### 1.13.4 Claims

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CLAIMS | YES | NO |
|---|---|---|
| 1. Applicant will ensure that all claims are dated as of the day it is received and in a manner that is acceptable to CMS. | | |
| 2. Applicant will ensure that all claims are processed in chronological order, by date of receipt. | | |
| 3. Applicant will give the beneficiary prompt notice of acceptance or denial of a claims' payment in a format specified by CMS. | | |
| 4. Applicant will comply with all applicable standards, requirements and establish meaningful procedures for the development and processing of all claims including having an effective system for receiving, controlling, and processing claims actions promptly and correctly. | | |

## 1.14 Minimum Enrollment

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MINIMUM ENROLLMENT | YES | NO |
|---|---|---|
| 1. For Urban areas: Applicant currently has at least 5,000 individuals (1, 500 for PSO applicants) enrolled for the purpose of receiving health benefits from the organization.<br><br>• If "Yes", (Stop here, and go to Section 1.15). | | |
| 2. For Rural Areas: Applicant currently has at least 1,500 individuals (500 for PSO applicants) enrolled for the purpose of receiving health benefits from the applicant.<br><br>• If "Yes", (Stop here, and go to Section 1.15). | | |
| 3. If "No" to 1 or 2: Applicant's organization has the capability to manage a health delivery system and to handle the level of risk required of a MA contractor. | | |

## 1.15 Communication between Medicare Advantage Plan and CMS

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: COMMUNICATION BETWEEN MEDICARE ADVANTAGE PLAN AND CMS | YES | NO |
|---|---|---|
| 1. Applicant will use HPMS to communicate with CMS in support of the application process, bid submission process, ongoing operations of the MA program, and reporting and oversight activities. | | |
| 2. Applicant will establish connectivity to CMS via the AT&T Medicare Data Communications Network (MDCN) or via the Gentran Filesaver. | | |
| 3. Applicant will submit test enrollment and disenrollment transmissions. | | |
| 4. Applicant will submit enrollment, disenrollment and change transactions to communicate membership information to CMS each month. | | |
| 5. Applicant will reconcile MA data to CMS enrollment/payment reports within 45 days of availability. | | |
| 6. Applicant will submit enrollment/payment attestation forms within 45 days of CMS report availability. | | |

## 1.16 Grievances

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: GRIEVANCES | YES | NO |
|---|---|---|
| 1. Applicant will establish and maintain a process designed to track and address enrollees' grievances, and to assure that they will adopt appropriate timelines, policies and procedures and train the relevant staff and subcontractors on such policies and procedures in accordance with regulations. | | |
| 2. Applicant will make enrollees aware of the grievance process through information and outreach materials. | | |
| 3. Applicant will accept grievances from enrollees at least by telephone and in writing (including facsimile) | | |
| 4. Applicant will maintain, and provide upon request by CMS access to records on all grievances received both orally and in writing, that includes, at a minimum:<br>• Date of receipt of the grievance<br>• Mode of receipt of grievance (i.e. fax, telephone, letter, etc.)<br>• Person or entity that filed the grievance | | |

| | | |
|---|---|---|
| • Subject of the grievance<br>• Final disposition of the grievance<br>• Date the enrollee was notified of the disposition | | |
| 5. Applicant agrees to advise MA enrollees of their rights with respect to:<br>• Right to have grievances between the enrollee and MAO heard and resolved<br>• Right to timely organization determination.<br>• If enrollee is dissatisfied with any part of an organization determination, then they have a right to request a reconsideration of the adverse decision, right to expedited reconsideration | | |
| 6. Applicant will establish grievance procedures for addressing issues that do not involve organization determinations. | | |
| 7. Applicant will make enrollees aware of the complaint process that is available to the enrollee under the Quality Improvement Organization (QIO) process. | | |
| 8. Applicant will comply with all applicable standards, requirements and establish meaningful procedures for grievances, organization determinations and appeals mechanisms including having an effective system for receiving, controlling, and processing these actions. | | |

Note: A grievance is any complaint or dispute, other than one that involves an organization determination, expressing dissatisfaction with any aspect of a MA organization's operations, activities, or behavior, regardless of whether remedial action is requested. Examples of subjects of a grievance include, but are not limited to:

- Timeliness, appropriateness, access to, and/or setting of services provided by the MA organization
- Concerns about waiting times, demeanor of providers or customer service staff.

## 1.17 Appeals

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: APPEALS | YES | NO |
|---|---|---|
| 1. Applicant agrees to adopt policies and procedures for organization determinations and reconsiderations/appeals consistent with 42 CFR §422 subpart M. | | |
| 2. Applicant will maintain a process for completing reconsiderations that includes a written description of how its organization will provide for standard reconsideration requests, and expedited reconsideration requests, where each are applicable, and how its organization will comply with such description. Such policies and procedures will be made available to CMS on request. | | |
| 3. Applicant will assure that the reconsideration policy complies with CMS regulatory timelines for processing standard and expedited reconsideration requests, as expeditiously as the enrollee's health condition requires. | | |
| 4. Applicant will assure that the reconsideration policy complies with CMS requirements as to assigning the appropriate person or persons to conduct requested reconsiderations. | | |
| 5. Applicant will assure that the reconsideration policy complies with CMS timeframes for forwarding reconsideration request cases to CMS' independent review entity (IRE) where applicant affirms an organization determination adverse to the member or as otherwise required under CMS policy. | | |
| 6. Applicant will assure that its reconsideration policy complies with CMS required timelines regarding Applicant's effectuation through payment, service authorization or service provision in cases where the organization's determinations are reversed in whole or part (by itself, the IRE, or some higher level of appeal) in favor of the member. | | |
| 7. Applicant will make its enrollees aware of the organization determination, reconsideration, and appeals process through information provided in the Evidence of Coverage and outreach materials. | | |
| 8. Applicant will establish and maintain a process designed to track and address in a timely manner all organization determinations and reconsideration requests, including those transferred to the IRE, an Administrative Law Judge (ALJ) or some higher level of appeal, received both orally and in writing, that includes, at a minimum:<br><br>Date of receipt;<br>Date of any notification;<br>Disposition of request; and | | |

| | | |
|---|---|---|
| Date of disposition<br>9. Applicant will make available to CMS upon CMS request organization determination and reconsideration records. | | |
| 10. Applicant will not restrict the number of reconsideration requests submitted by or on behalf of a member. | | |

## 1.18 Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS issued guidance 07/23/2007 and 8/28/2007; 2008 Call Letter

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) | YES | NO |
|---|---|---|
| 1. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Privacy of Individually Identifiable Health Information under 45 CFR Parts 160 and 164 subparts A and E. | | |
| 2. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Security Standards under 45 CFR Parts 160, 162 and 164 | | |
| 3. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standard Unique Health Identifier for Health Care Providers under 45 CFR Parts 160 and 162. | | |
| 4. Applicant will comply with all applicable standards, implementation specifications, and requirements in the Standards for Electronic Transactions under 45 CFR Parts 160 and 162. | | |
| 5. Applicant agrees to accept the monthly capitation payment consistent with the HIPAA-adopted ASC X12N 820, Payroll Deducted and Other Group Premium Payment for Insurance Products ("820"). | | |
| 6. Applicant agrees that it, and its subcontractors, shall not perform any activities under its MA contract at a location outside of the United States without the prior written approval of CMS. Upon request, applicant will provide CMS information necessary to make a decision. | | |
| 7. Applicant agrees to submit the Offshore Subcontract Information and Attestation for each offshore subcontractor (including downstream offshore subcontractors) that receive, process, transfer, handle, store, or access Medicare beneficiary protected health information (PHI) by the last Friday in September for the upcoming contract year. | | |

B. In HPMS complete the table below;

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: | YES | NO |
|---|---|---|
| 1. Applicant agrees not to use an enrollee's Social Security Number (SSN) or Medicare ID Number on the enrollee's identification card. | | |

C. Provide in HPMS a complete "Data Use Attestation"

## 1.19 Continuation Area

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CONTINUATION AREA | YES | NO |
|---|---|---|
| 1. Applicant will seek to establish a continuation area (outside the service area) which the MA organization offering a local plan furnishes or arranges to furnish services to its enrollees that initially resided in the contract service area. | | |
| 2. Applicant will submit marketing materials that will describe the continuation area options. | | |
| 3. Applicant will provide assurances or arrange with providers or through direct payment of claims for Medicare covered benefits to access of services. | | |
| 4. Applicant will provide for reasonable cost sharing for services furnished in the continuation area, an enrollee's cost sharing liability is limited to the cost sharing amounts required in the MA local plan's service area (in which the enrollee no longer resides). | | |

## 1.20 Medicare Advantage Certification

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE ADVANTAGE CERTIFICATION | YES | NO |
|---|---|---|
| 1. Applicant agrees to abide by the terms of a Medicare Advantage contract and/or contract addendum. | | |
| 2. Upon CMS request, Applicant agrees to make available all Policy and Procedures, and any other document(s) concerning the Medicare operations of the organization.<br>3. Applicant attests that the information that has been submitted is true and accurate to best of the applicant's knowledge. | | |

**NOTE: Based on the type of application submission indicated by MAO once the Part C application is complete; applicant must complete a Part D application/module in HPMS. Note: PFFS organizations have the option to offer Part D plans. MSAs are not allowed to offer Part D.**

## SECTION 2 REGIONAL PREFERRED PROVIDER ORGANIZATION (RPPO) APPLICANTS ONLY

Note: A RPPO applicant may apply as a signal entity or as a joint enterprise. Joint Enterprise applicants must provide as part of their application a copy of the agreement executed by the State-licensed entities describing their rights and responsibilities to each other and to CMS in the operation of a Medicare Part D benefit plan. Such an agreement must address at least the following issues:

- Termination of participation in the joint enterprise by one or more of the member organizations; and
- Allocation of CMS payments among the member organizations.

### 2.1 State licensure RPPO

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:<br>STATE LICENSURE RPPO | YES | NO |
|---|---|---|
| 1. Applicant is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the Applicant proposes to offer the MA RPPO product.<br>• If "Yes," applicant must provide in HPMS an executed copy of a state licensing certificate and/or the CMS state certification form for each state being request<br>• Note: All licensure requirements (state license and/or state certification form) must be met by the first Monday in June. | | |
| 2. Applicant is licensed under state law as risk-bearing entity eligible to offer health insurance or health benefits in at least 1 state in the RPPO region, and if not licensed in all states the applicant is seeking additional state licenses for the RPPO regions. | | |
| 3. Applicant meets State-specified standards applicable to MA RPPO plans and is authorized by the state to accept prepaid capitation for providing and arranging or paying for comprehensive health care services to be offered under the MA contract. | | |
| 4. Applicant is currently under some type of supervision, corrective action plan or special monitoring by the State licensing authority in any State.<br>• If "Yes", provide in HPMS and as an attachment, an explanation of the specific actions taken by the State license regulator. | | |
| 5. Applicant conducts business as "doing business as" (dba) or uses a name different than the name shown on its Articles of Incorporation. | | |

| | | |
|---|---|---|
| • If "Yes", provide in HPMS and as an attachment a copy of the State approval for the dba. | | |

B. Provide in HPMS, a complete "CMS State Licensing Status for MA Regional PPO Table" for each MA Region.

C. Provide in HPMS, a signed" CMS State Licensure Attestation for MA Regional PPOs"

**Note: 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.

## 2.2 Access Standards

A. In HPMS, complete the table below:

| **RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:**<br>**ACCESS STANDARDS** | **YES** | **NO** |
|---|---|---|
| 1. Applicant has created access standard for providers in rural areas of the Regions(s) in which applicant seeks to offer a Regional PPO product that includes the following:<br>a. narrative explanations for each rural area, and the access standard to support the appropriateness of the standard for the particular regional area to which it applies<br>b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards<br>c. projected enrollment numbers | | |
| 2. Applicant has created access standard for providers in urban areas of the Regions(s) in which applicant seeks to offer a Regional PPO product that includes the following:<br>a. narrative explanations for each urban area, and the access standard to support the appropriateness of the standard for the particular regional area to which it applies<br>b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards<br>c. projected enrollment numbers | | |
| 3. Applicant agrees to inform CMS of any changes in the submitted access information that occurs after initial application submission and during the review period. | | |

B. Provide in HPMS, access standards for the following specified provider types, including the percentage of beneficiaries that will fall within the standards and stated in terms of distance and time (___% of beneficiaries fall within xx miles/xx minutes of 2 Primary Care Providers):

- Contracted Hospitals with Full Emergency Facilities
- Contracted Primary Care Providers
- Contracted Skilled Nursing Facilities
- Contracted Home Health Agencies
- Contracted Ambulatory Clinics
- Contracted Providers of End Stage Renal Disease Services
- Contracted Outpatient Laboratory and Diagnostic Services
- Contracted Specialists in the following areas:
    - General Surgery
    - Otology/Laryngology/Rhinology
    - Anesthesiology
    - Cardiology
    - Dermatology
    - Gastroenterology
    - Internal Medicine
    - Neurology
    - Obstetrics and Gynecology
    - Ophthalmology
    - Orthopedic Surgery
    - Psychiatry/Mental Health
    - Pulmonary Disease
    - Urology
    - Chiropractic
    - Optometry
    - Podiatry

C. Provide in HPMS, a chart listing all counties (or other units of analysis as relied upon by applicant in establishing standards) and indicate whether each county meets or does not meet each contracted access standard for a contracted provider type.

D. Provide in HPMS, an access plan describing the applicants proposed mechanism for ensuring beneficiary access to the identified type(s) of provider(s) for each are in which the applicant does not meet its access standards through it contracted network. Access plans may include requests for essential hospital designations, facilitating enrollee access to non-contracted providers at preferred cost sharing levels, or other proposed mechanisms as approved by CMS.

## 2.3 Essential Hospital

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ESSENTIAL HOSPITAL | YES | NO |
|---|---|---|
| 1. Applicant is requesting essential hospital designation for non-contracted hospitals. | | |

| 2. Applicant has attempted to contract with hospitals prior to seeking essential hospital designation. | | |
|---|---|---|

B. Provide in HPMS, a completed “CMS Essential Hospital Designation Table”.

C. Provide in HPMS, a completed “CMS Attestation Regarding Designation of Essential Hospitals”.

## SECTION 3 PRIVATE FEE FOR SERVICE (PFFS) APPLICANTS ONLY

### 3.1 Access to Services

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ACCESS TO SERVICES | YES | NO |
|---|---|---|
| 1. Applicant will offer a combination PFFS model that would meet CMS' access requirements per 42 CFR 422.114 (a)(2)(iii). | | |
| 2. Applicant will offer a network PFFS model only per 42 CFR 422.114(a)(2)(ii). | | |
| 3. Applicant will offer a non-network PFFS model only per 42 CFR 422.114(a)(2)(ii). | | |
| 4. If providing a network or partial network PFFS plan, Applicant will have direct contracts and agreements with a sufficient number and range of providers, for whom the Applicant has established payment rates that are less than Original Medicare, to furnish the services covered under the MA PFFS plan that meet CMS' access requirements. | | |
| If providing a combination network that includes contracted providers receiving less than the Original Medicare payment rate, Applicant is providing a direct contracted network for the following Medicare required services:<br><br>DROP DOWN BOX WITH THE FOLLOWING SERVICES:<br>• Acute Inpatient Hospital Care<br>• Diagnostic & Therapeutic Radiology (excluding mammogram)<br>• DME/Prosthetic Devices<br>• Home Health Services<br>• Lab Services<br>• Mental Illness – Inpatient Treatment<br>• Mental Illness – Outpatient Treatment<br>• Mammography<br>• Renal Dialysis – Outpatient<br>• SNF Services<br>• Surgical Services (outpatient or ambulatory)<br>• Therapy – Outpatient Occupational/Physical<br>• Therapy – Outpatient Speech<br>• Transplants (Heart, Heart and Lung, Intestinal, Kidney, Liver, Lung, Pancreas)<br>• Other (Provide thorough description of proposed services, including rationale for providing a contract network for the proposed service)<br><br>**UPLOAD: Applicants proposing to furnish certain categories of service through a contracted network are required to submit a narrative description of the proposed network through an upload in HPMS. Please ensure that the categories are clearly defined in the narrative description.** | | |

| | | |
|---|---|---|
| 5. Applicant will post the organization's "Terms and Conditions of Payment" on its website, which will describe to members and providers the plan payment rates (including member cost sharing) and provider billing procedures. (Note: Applicant can use CMS model terms and conditions of payment guidance). | | |
| 6. Applicant will provide information to its members and providers explaining the provider deeming process and the payment mechanisms for providers | | |

B. Provide in HPMS, completed HSD tables 1 through 5 for network model PFFS plans. Applicants offering multiple benefit plans must submit separate tables for each county and each plan. Only one HSD table is needed for different plans that have the same network and service area.

C. Provide in HPMS, a description on how the applicant will follow CMS's national coverage decisions and written decision of carriers and intermediaries (LMRP) throughout the United States. [Refer to 42 CFR 422.101 (b)].

D. Provide in HPMS, a description on how applicant's policies will ensure that health services are provided in culturally competent manner to enrollees of different backgrounds.

### 3.2 Claims Processing

In HPMS, complete the table below:

| **RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:**<br>**CLAIMS PROCESSING** | **YES** | **NO** |
|---|---|---|
| 1. Applicant will use a claims system that was previously tested and demonstrates the ability to accurately and timely pay Medicare FFS payments. | | |
| 2. If using a claims system that was not previously validated, Applicant agrees to provide documentation that substantiates the process used to test the claims system that will be paying PFFS claims | | |
| 3. Applicant agrees to sign an attestation to the PFFS Contract indicating that Applicant has in place the necessary operational claims systems, staffing, processes, functions etc., to properly institute the Reimbursement Grid and pay all providers according to the PFFS plan's terms and conditions of payment. | | |
| 4. Applicant agrees that upon request, it will submit its complete and thorough Provider Dispute Resolution Policies and Procedures (P&Ps) to address any written or verbal provider dispute/complaints, particularly regarding the amount reimbursed. The availability of this P&P must be disclosed to providers in the PFFS plan's terms and conditions of payment. The applicant must submit how it has integrated the P&P into all staff training – particularly in Provider Relations, Customer Service and in Appeals/Grievances. | | |
| 5. Applicant agrees that upon request, it will submit a biweekly report, to the CMS Regional Office plan manager, data which outlines all provider complaints (verbal and | | |

| | | |
|---|---|---|
| written), particularly where providers or beneficiaries question the amount paid for six months following the receipt of the first claim. This report will outline the investigation and the resolution including the completion of a CMS designed worksheet. | | |

### 3.3 Payment Provisions

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:<br>PAYMENT PROVISIONS | YES | NO |
|---|---|---|
| 1. Applicant will reimburse providers at a rate equal to or greater than the Original Medicare rates for one or more services. | | |
| 2. Applicant has a system in place that allows the applicant to correctly pay providers who furnish services to its members the correct payment rate according to the PFFS plan's terms and conditions of payment (e.g., if the PFFS plan CMS' access requirements by paying providers at Original Medicare payment rates, then it will have a system in place to correctly pay at those rates throughout the United States. | | |
| 3. The Applicant has a system in place to ensure that members are not charged more in cost sharing or balance billing than the amounts specified in the PFFS plan's terms and conditions of payment. [Refer to 42 CFR 422.216(c)]. | | |
| 4. Applicant will ensure that members are not charged more than the Medicare-allowed charge (up to the limiting charge for non-Medicare participating providers) when they receive medical services. | | |
| 5. Applicant agrees that information in the Payment Reimbursement Grid is true and accurate. | | |
| 6. The Applicant has a system in place to timely furnish an advance determination of coverage upon a verbal or written request by a member or provider. | | |

C. Provide in HPMS, a completed Reimbursement grid. (Note: Applicant can use CMS model payment guidance)

## SECTION 4 MEDICAL SAVINGS ACCOUNTS (MSA) & MSA DEMO APPLICANTS ONLY

Note: MSA applicants must complete section four, in addition the applicant may have to complete questions in the "Private Fee for Service" section of this application depending upon the type of delivery system that the applicant will offer under the MSA product.

Note: MSA plans cannot offer the Part D drug benefit.

Note: MSA Demonstration Addendum – If the applicant intends to participate in the MSA Demonstration, the Applicant must complete both sections 4 & 5.

## 4.1 General Administration/ Management

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: GENERAL ADMINISTRATION/MANAGEMENT | YES | NO |
|---|---|---|
| 1.Applicant currently operates a commercial Health Savings Account (HSA) plan or other type of commercial tax-favored health plan or a Medicare Advantage Medical Savings Account (MSA) plan. | | |
| 2. Applicant will establish policies and procedures with its banking partner which will include the services provided by the banking partner, including how members' access funds, how spending is tracked and applied to the deductible, and how claims are processed. | | |
| 3. Applicant will establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements (as a bank, insurance company or other entity as set out in Treasury. Reg. Secs. 1.408-2(e)(2) through (e)(5). | | |
| 4. Applicant will serve as MA MSA Trustee or Custodian for receiving Medicare deposits to MSA plan enrollee accounts, or have a contractual relationship with a trustee or custodian. | | |

## 4.2 Access to Services *(See Section 3.1 if Using the PFFS Model)*

## 4.3. Claims Systems

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:_CLAIMS SYSTEMS & PAYMENT | YES | NO |
|---|---|---|
| 1. Applicant will use a claims system that was previously tested and demonstrates the ability to accurately and timely pay Medicare FFS payments. | | |
| 2. Applicant agrees to have an operational claims system, staffing, processes, and functions in place to properly institute the Reimbursement Grid and pay all providers of Medicare services an amount not less than Original Medicare. | | |

## 4.4 Payment Provisions

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PAYMENT PROVISIONS | YES | NO |
|---|---|---|
| 1. Applicant will reimburse providers at a rate equal to or greater than the Original Medicare rates for one or more services. | | |
| 2. Applicant has a system in place that allows the applicant to obtain payment information for any Medicare approved provider throughout the nation. | | |
| 3. Applicant will allow providers to balance bill the beneficiary up to allowed amount. **Note: This only applies to applicants that allow balance billing.** | | |
| 4. Applicant has a process and systems in place to inform the beneficiaries and providers of the balance billing requirement. | | |
| 5. Applicant agrees that information in Reimbursement Grid is true and accurate. | | |
| 6. Applicant will ensure that members are not charged more than the Medicare-allowed charge (up to the limiting charge for non-Medicare participating providers) when they receive medical services. | | |

B. Provide in HPMS, a completed Reimbursement grid. (Note: Applicant can use CMS model payment guidance)

## SECTION 5 MSA DEMONSTRATION APPLICANTS ONLY

### 5.1 <u>MSA Demonstration Addendum</u>

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MSA DEMONSTRATION ADDENDUM | YES | NO |
|---|---|---|
| 1. Applicant will determine the deductible and separate out-of-pocket (OOP) limit it would offer under the demonstration. | | |
| 2. Applicant will offer non-Medicare covered preventive services through an optional supplemental benefit. | | |
| 3. Applicant will offer a network product. | | |
| 4. Applicant will offer a non-network product. | | |
| 5. Applicant will offer more than one benefit option in each service area. | | |
| 6. Applicant will offer coverage of non-Medicare covered preventive services | | |
| 7. Applicant will propose periodic deposits into the beneficiary accounts. | | |
| 8. Applicant will provide enrollee a description of any cost sharing before and after the deductible. | | |

B. Provide in HPMS, the following:

**1.** Description of any differential in cost-sharing for supplemental benefits from the standard Medicare A/B benefits and for in-network and out-of-network services.

**2.** Description of the preventive services that will have full or partial coverage before the deductible is met.

**3.** Figures on projected enrollment and the characteristics of beneficiaries who are most likely to enroll in the applicant's plans (for example, what type of Medicare coverage do they currently have?).

**4.** Description of non-Medicare covered preventive services and whether or not any cost-sharing for these services will apply to the plan deductible.

**5.** Description of the frequency of periodic deposits and how the applicant will address cases where the enrollee incurs high health costs early in the year.

**6.** Description on how the applicant will track enrollee usage of information provided on the cost and quality of providers. Be sure to include how you intend to track use of health services between those enrollees who utilize transparency information with those who do not.

**7.** Description on how the applicant will recover current-year deposit amounts for members who are disenrolled from the plan before the end of the calendar year.

## PART 3 SERVICE AREA EXPANSION APPLICATIONS

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

## SECTION 1 ALL MA APPLICANTS (CCP, RPPO, PFFS, & MSA)

### 1.1 Contract Number in HPMS

Enter contract number in HPMS under the Contract/Management Module.

### 1.2 State Licensure (CCP, PFFS, & MSA Applicants Only)

In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS. | YES | NO |
|---|---|---|
| 1. Applicant is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the Applicant proposes to offer the MA product.<br>• If "Yes," applicant must provide in HPMS an executed copy of a state licensing certificate and/or the CMS state certification form for each state being request.<br>• Note: All licensure requirements (state license and/or state certification form) must be met by the first Monday in June. | | |
| 2. Applicant is currently under supervision (i.e. corrective action plan, special monitoring, etc..) by the State licensing authority in any State.<br>• If "Yes", provide as an attachment in HPMS, an explanation of the specific actions taken by the State license regulator. | | |
| 3. Applicant conducts business as "doing business as" (d/b/a) or uses a name different than the name shown on its Articles of Incorporation.<br>• If "Yes", provide as an attachment in HPMS a copy of the State approval for the dba. | | |

**Note: 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.

## 1.3 Provider Contracts & Agreements

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS FOR PROVIDER CONTRACTS & AGREEMENTS | YES | NO |
|---|---|---|
| 1. Applicant will comply with the basic rules on provider and suppliers of health care-related services as stated at section 422.504. | | |
| 2. Applicant agrees that all provider and supplier contracts or agreements contain the following CMS required contract provisions:<br>• Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records.<br>• Contracts specify the prompt payment requirements, the terms and conditions of which are developed and agreed-to by the MA organization and its contracted providers and suppliers.<br>• Contracts contain hold harmless language that assures the Medicare members incur no payment or fees that are the legal obligations of the MA organization to fulfill. Such provision will apply but not be limited to insolvency of the MA organization, contract breach, and provider billing.<br>• Contracts contain accountability provisions specifying the following:<br>a. That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions, and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintained records a minimum of 10 years.<br>b. That the MA organization oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations; and<br>c. The MA organizations that choose to delegate functions must adhere to the delegation requirements – including all provider contract requirements in these delegation requirements described in the MA regulations,<br>d. Contracts must specify that providers agree to comply with the MA organization's policies and procedures, Provide as an attachment a sample copy of each category of provider contract(s) and agreement(s) between the applicant and its primary health care contractors<br>e. Comply with reporting requirements. | | |

| | | |
|---|---|---|
| f. Ensure contract term dates and executed signatures by all parties | | |
| 3. Applicant has executed provider and supplier contracts in place to demonstrate access and availability of the requested service area. | | |
| 4. Applicant agrees to make contracts and/or agreements available for CMS upon request. | | |

B. Provide in HPMS a completed "CMS Provider Arrangements by County Table". Applicant should insert the number of provider contract and/or agreements for each proposed service area or distinctive system(s) applicant.

C. Provide in HPMS a sample copy of each category of provider contract(s) and agreement(s) between the applicant and its primary health care contractors.

D. Provide in HPMS a sample copy of each subcontract between Medical groups, IPAs, PHO, etc. including their subcontracting providers.

E. Provide in HPMS a completed, "Provider Participation Contracts and/or Agreements", a crosswalk of CMS regulations to provider contracts and/or agreements. Prepare a table for each contracted and subcontracted provider.

## 1.4 Contracts for Administrative & Management Services

A. In HPMS, complete the table below:

| **RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE & MANAGEMENT SERVICES** | **YES** | **NO** |
|---|---|---|
| 1. Applicant has contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the Medicare Advantage operations for the MA contract | | |
| 2. Applicant will utilize an administrative/management services contract/agreement for staffing to operate the MA program. | | |
| 3. Applicant will have a delegated entity to perform systems or information technology to operate the MA program for applicant. | | |
| 4. Applicant will have a delegated entity to perform claims administration, processing and/or adjudication | | |
| 5. Applicant will have a delegated entity to perform enrollment, disenrollment and membership functions. | | |
| 6. Applicant will have a delegated entity that will perform any and/or all marketing including delegated sales broker and agent functions. | | |
| 7. Applicants will have a delegated accredited entity that will perform credentialing functions.<br><br>▪ (Note: PFFS-non-network model applicants leave blank) | | |
| 8. Network-model applicants will have a delegated entity to | | |

| | | |
|---|---|---|
| perform utilization and/or quality improvement operations.<br><br>▪ (Note: PFFS non-network model applicants leave blank) | | |
| 9. Applicant will have a delegated entity to perform Part C call center operations. | | |
| 10. Applicant will have a delegated entity to perform financial services. | | |
| 11. Applicant will delegate other services that are not listed. | | |

B. In HPMS, complete the table below.

| DELEGATED BUSINESS FUNCTION | SUBCONTRACTOR(S) |
|---|---|
| | |
| | |
| | |
| | |
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| | |
| | |
| | |
| | |

C. Applicant must provide in HPMS, executed delegated administrative services/management contracts or letters of agreement for each contractor or subcontractor identified in the chart (Section 1.4.B**)** above that:

- Clearly identify the parties to the contract (or letter of agreement).
- Describes each of the specific functions (health and/or administrative) that are now or will be delegated to medical groups, IPAs, or other intermediate entities.
- Describes how the applicant will remain accountable for any functions or responsibilities that are delegated to other entities.
- Describes how the applicant will oversee, and formally evaluate delegated entities.
- Describes the applicant's relationships to related entities, contractors and sub-contractors with regard to provision of health and/or administrative services specific to the Medicare product.
- Contains language clearly indicating that the delegated entity, contractor, or subcontractor has agreed to perform the health and/or administrative service, and clauses requiring their activities be consistent and comply with the Applicant’s contractual obligations.
- Are signed by a representative of each party with legal authority to bind the entity.
- Contains language obligating the contractor or subcontractor to abide by all Medicare laws, regulations, and CMS instructions in accordance with 42 CFR 422 (504)(i)(4)(v).

- Contains language obligating the subcontractor to abide by State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the regulations for this program at 42 CFR §422.504(a)(13).

- Contains language ensuring that the contractor or subcontractor will make its books and other records available in accordance with 42 CFR 422.504(i) (2). Generally stated these regulations give HHS, the Comptroller General, or their designees the right to inspect, evaluate and audit books and other records and that these rights continue for a period of 10 years from the final date of the contract period or the date of audit completion, whichever is later.

- Contains language that the subcontractor will ensure that beneficiaries are not held liable for fees that are the responsibility of the MA contractor in accordance with 42 CFR 422.504(i)(3)(i).

- Contains language that if the Applicant, upon becoming a MA contractor, delegates an activity or responsibility to the subcontractor, that such activity or responsibility may be revoked if CMS or the MA contractor determines the subcontractor has not performed satisfactorily in accordance with 42 CFR 504(i)(5). The subcontract may include remedies in lieu of revocation to address this requirement.

- Contains language specifying that the Applicant, upon becoming a MA contractor, will monitor the performance of the subcontractor on an ongoing basis in accordance with 42 CFR 422.504 (i)(1) & (4).

D. Provide in HPMS, a completed "CMS Administrative/Management Delegated Contracting or Arrangement Matrix".

## 1.5 Health Services Delivery (HSD)

A. In HPMS, complete the table below.

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS FOR HEALTH SERVICES DELIVERY | YES | NO |
|---|---|---|
| 1. Applicant will assure availability and accessibility of services with reasonable promptness and in a manner that assures continuity of care. | | |
| 2. Applicant will establish standards, policies and procedures to ensure the following:<br>a. Timeliness of access to care.<br>b. Individual medical necessity determinations.<br>c. Plan providers are convenient to the population served, does not discriminate against Medicare enrollees, and services are available 24 hours a day, 7 days a week, when medically necessary<br>d. Services are provided in a culturally competent manner. | | |

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS FOR HEALTH SERVICES DELIVERY | YES | NO |
|---|---|---|
| 3. Applicant will provide continuity of care and integration of services through arrangements with contracted providers that include:<br>a. Policies specific to services that are coordinated and the methods for coordination.<br>b. An offer to provide each enrollee with an ongoing source of primary care or other means.<br>c. Coordinate care with community and social services in the MA plan service area.<br>d. Procedures to ensure timely communication of clinical information among providers.<br>e. Procedures to ensure that enrollees are informed of their health care needs that require follow-up, and<br>f. Processes to address barriers to enrollee compliance with prescribed treatments or regimens. | | |
| 4. Applicant will ensure access and availability by:<br>a. Establishing a panel of primary care providers (PCPs).<br>b. Assigning a PCP or making other arrangements to ensure access to medically necessary specialty care, for enrollees that need a referral before receiving care.<br>c. Providing or arranging for necessary specialty care outside the MA plan's provider network when specialty providers are unavailable or inadequate to meet a member's medial needs. | | |
| 5. Applicant will ensure providers are credentialed including procedures for selection and evaluation of providers. | | |
| 6. Applicant will ensure that all Medicare covered services, including supplemental services contracted for (or on behalf of) the Medicare enrollees are available and accessible under the plan. | | |
| 7. Applicant will ensure that health care services are provided in a culturally competent manner to members of different backgrounds. | | |
| 8. Applicant will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population. | | |

B. Provide in HPMS and as appendices, HSD tables 1 through 5. Applicants offering multiple benefit plans must submit separate tables for each county and each plan. Only one HSD table is needed for different plans that have the same network and service area.

### 1.6 Service Area

A. In HPMS, on the Contract Management/Contract Service Area/Service Area Data page, enter the state and county information for the area you plan to serve.

B. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS FOR SERVICE AREA. | YES | NO |
|---|---|---|
| 1. Applicant meets the county integrity rule as outlined in Chapter 4 of the Medicare Managed Care Manual. | | |
| 2. Applicant will serve the entire county.<br>▪ If "No", applicant must submit a partial county request in HPMS, providing a justification for serving a partial county. | | |

C. Provide as an attachment detailed maps of the requested service area showing the boundaries, main traffic arteries, and any physical barriers such as mountains or rivers. Maps should indicate contracted ambulatory and hospital providers, and mean travel times.

Note: RPPO applicants geographic maps should be defined by rural and urban areas (include borders) that demonstrate the locations of all contracted providers in relation to the beneficiaries in those areas.

## SECTION 2 SERVICE AREA EXPANSIONS FOR RPPO APPLICANTS ONLY

### 2.1 State licensure RPPO

A. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE RPPO | YES | NO |
|---|---|---|
| 1. Applicant is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the Applicant proposes to offer the MA RPPO product.<br>• If "Yes," applicant must provide in HPMS an executed copy of a state licensing certificate and/or the CMS state certification form for each state being request<br>• Note: All licensure requirements (state license and/or state certification form) must be met by the first Monday in June. | | |
| 2. Applicant is licensed under state law as risk-bearing entity eligible to offer health insurance or health benefits in at least 1 state in the SAE RPPO region, and if not licensed in all states the applicant is seeking additional state licenses for the SAE RPPO | | |

| | | |
|---|---|---|
| regions. | | |
| 3. Applicant meets State-specified standards applicable to MA RPPO plans and is authorized by the state to accept prepaid capitation for providing and arranging or paying for comprehensive health care services to be offered under the MA contract. | | |
| 4. Applicant is currently under some type of supervision (i.e., corrective action plan, special monitoring, etc…) by the State licensing authority in any State.<br><br>• If "Yes", provide in HPMS and as an attachment, an explanation of the specific actions taken by the State license regulator. | | |
| 5. Applicant conducts business as "doing business as" (dba) or uses a name different than the name shown on its Articles of Incorporation.<br><br>• If "Yes", provide in HPMS and as an attachment a copy of the State approval for the dba. | | |

B. Provide in HPMS, a complete "CMS State Licensing Status for MA Regional PPO Table" for the SAE MA Region.

C. Provide in HPMS, a signed" CMS State Licensure Attestation for MA Regional PPOs"

**Note: 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.

**Note:** For states or territories such as Puerto Rico whose licenses renew after June 1, the applicant is required to submit the new license in order to operate as an MA or MA-PD.

## 2.2 Access Standards

A. In HPMS, complete the table below:

| **RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:**<br>**ACCESS STANDARDS** | **YES** | **NO** |
|---|---|---|
| 1. Applicant has created access standard for providers in rural areas of the SAE Regions(s) in which applicant seeks to offer a Regional PPO product that includes the following:<br>a. narrative explanations for each rural area, and the access standard to support the appropriateness of the standard for the particular regional area to which it applies<br>b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards<br>c. projected enrollment numbers | | |
| 2. Applicant has created access standard for providers in urban areas of the SAE Regions(s) in which applicant seeks to offer a Regional | | |

| | | |
|---|---|---|
| PPO product that includes the following:<br>a. narrative explanations for each urban area, and the access standard to support the appropriateness of the standard for the particular regional area to which it applies<br>b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards<br>c. projected enrollment numbers | | |
| 3. Applicant agrees to inform CMS of any changes in the submitted access information that occurs after SAE application submission and during the review period. | | |

B. Provide in HPMS, access standards for the following specified provider types, including the percentage of beneficiaries that will fall within the standards and stated in terms of distance and time (___% of beneficiaries fall within xx miles/xx minutes of 2 Primary Care Providers):

- Contracted Hospitals with Full Emergency Facilities
- Contracted Primary Care Providers
- Contracted Skilled Nursing Facilities
- Contracted Home Health Agencies
- Contracted Ambulatory Clinics
- Contracted Providers of End Stage Renal Disease Services
- Contracted Outpatient Laboratory and Diagnostic Services
- Contracted Specialists in the following areas:
  - General Surgery
  - Otology/Laryngology/Rhinology
  - Anesthesiology
  - Cardiology
  - Dermatology
  - Gastroenterology
  - Internal Medicine
  - Neurology
  - Obstetrics and Gynecology
  - Ophthalmology
  - Orthopedic Surgery
  - Psychiatry/Mental Health
  - Pulmonary Disease
  - Urology
  - Chiropractic
  - Optometry
  - Podiatry

C. Provide in HPMS, a chart listing all counties (or other units of analysis as relied upon by applicant in establishing standards) and indicate whether each county meets or does not meet each contracted access standard for a contracted provider type.

D. Provide in HPMS, an access plan describing the applicants proposed mechanism for ensuring beneficiary access to the identified type(s) of provider(s) for each are in which the applicant does not meet its access standards through it contracted network. Access plans may include requests for essential hospital

designations, facilitating enrollee access to non-contracted providers at preferred cost sharing levels, or other proposed mechanisms as approved by CMS.

### 2.3 Essential Hospital

D. In HPMS, complete the table below:

| RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS:<br>ESSENTIAL HOSPITAL | YES | NO |
|---|---|---|
| 3. Applicant is requesting essential hospital designation for non-contracted hospitals. | | |
| 4. Applicant has attempted to contract with hospitals prior to seeking essential hospital designation. | | |

E. Provide in HPMS, a completed "CMS Essential Hospital Designation Table".

F. Provide in HPMS, a completed "CMS Attestation Regarding Designation of Essential Hospitals".

## PART 4 SOLICITATIONS FOR SPECIAL NEEDS PLAN PROPOSAL PLAN

Under the MMA (Section 231), Congress provided an option for Medicare Advantage (MA) coordinated care plans to limit enrollment to individuals with special needs. "Special needs individuals" were identified by Congress as: 1) institutionalized beneficiaries; 2) dual eligible (entitled to medical assistance under a State plan under Title XIX); and/or 3) beneficiaries with severe or disabling chronic conditions as recognized by the Secretary.

Current SNP authority will expire at the end of 2008 unless legislation reauthorizing it is passed. In anticipation that SNPs may be extended, a SNP proposal(s) must be filed by the MA application due date, March 10, 2008, in order for CMS to consider an organization to initially offer or expand an existing SNP(s) in 2009.

MA applicants and contracting MAs, intending to initially offer or expand an existing SNP(s), must complete and submit a SNP proposal(s) to CMS that includes required information as prompted below for each type of SNP the organization expect to offer. This solicitation for SNP proposals is divided into the following sections:

**1. General Guidance on Completing SNP Proposal**
**2. Requirements to Submit a SNP Proposal -- MA and Part D Applications May Also Be Required**
- **A. Seeking New Medicare Coordinated Care Plan (CCP) Contract that Includes SNPs**
- **B. Adding SNPs under Existing Medicare CCP Contract – Service Area Unchanged**
- **C. Adding SNPs under Existing CCP Contract – Service Area Changing**
- **D. Procedure for Minimizing Duplication, Including Across Multiple MA-PD Contracts**

**3. Key Definitions**
**4. Template for Completing SNP Proposal**
- **A. Dual Eligible SNP Type**
- **B. Institutional SNP Type**
- **C. Severe or Disabling Chronic Condition SNP Type**

**Attachments:**
- **A: Subsets for Dual Eligible SNPs**
- **B: SNP Service Area Table**
- **C: Ensuring Delivery of Institutional SNP Model of Care**
- **D: Attestation for Special Needs Plans (SNP) Serving Institutionalized Beneficiaries**
- **E: Quality Measurements for Special Needs Plans**
- **F: Crosswalks for Consolidating SNP Proposals for Multiple Contracts**
- **G: Dialysis Facilities Table**
- **H: Transplant Facilities Table**
- **I: Long Term Care Facilities Table**
- **J: Additional Option for Pre-enrollment Verification of Chronic Condition for Chronic Condition Special Needs Plans**
- **K. Severe or Disabling Chronic Conditions List – 2008-2009 Crosswalk**

### 1. GENERAL GUIDANCE ON COMPLETING SNP PROPOSAL

The SNP proposal must follow the step by step instructions in Section 4 to propose the type of SNP the applicant intends to offer. Sections 4. A, B, and C. offer prompts for each SNP type, and 4.D. contains the consolidated Model of Care with certain stipulations for additional information on specific SNP types. If the applicant is seeking approval for more than one type of SNP, the template for the proposal should be

completed for each of those types. The applicant's responses must be provided within the Section 4 template except as instructed in the template to provide an attachment. Do not provide narrative or other information as an attachment unless instructed to do so. The responses to the template as well as the attachments and the documentation for the State and long term care contract should all be in a single Microsoft word file. The applicant must complete and submit the SNP proposal, as an upload zip file, to the HPMS. See the HPMS Part C Application User guide for step by step upload instructions. The end result should be only one electronic zip file uploaded to the HPMS, which contains all the required data and information, for each SNP type, i.e. dual, chronic or institutional.

A SNP proposal responding to this solicitation for the next contract cycle beginning January 1, 2009 will not be considered by CMS unless the solicitation is submitted by the deadline for MA applications. The application deadline is March 10, 2008. Late proposals, including additional requests for a certain SNP type (for example, any additional proposed dual eligible subsets), will not be accepted after the MA application deadline. Other associated MA and Part D applications must also be provided; see Section 2 for instructions on what other applications may be required.

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

## 2. REQUIREMENTS TO SUBMIT A SNP PROPOSAL

A. Applicants seeking initial Medicare Coordinated Care Plan (CCP) contract that include a SNP(s)

An applicant that does not have a current CCP MA contract with CMS must complete and submit the following applications:

1. Complete and submit to CMS the full Coordinated Care Plan (CCP) MA application and SNP proposal. The MA application is posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/ and should be submitted as described in the MA application. The SNP proposal is contained within the MA application. The completed SNP proposal is an upload to the HPMS as a zip file for each SNP type, i.e. dual, chronic or institutional.. See the HPMS Part C Application User guide for step by step instructions.
2. The appropriate Part D application. The Part D applications are posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/ and click on "Application Guidance. The Part D application should be submitted per the instructions provided in the Part D application.

B. Contracting MA adding or expanding a SNP(s) with no change in the MA's existing service area

A contracting MA who wants to offer a SNP(s) or expand an existing SNP(s) in an approved existing service area must complete and submit a SNP proposal to CMS. The SNP proposal is contained within the MA application which is posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/. The completed SNP proposal is an upload to the HPMS as a zip file for each SNP type, i.e. dual, chronic or institutional. See the HPMS Part C Application User guide for step by step instructions.

The SNP proposal must include the required information for each SNP type, including subset(s), being offered by the MA. For example, if the MA is seeking to offer a dual eligible SNP to serve a specific Medicaid population in coordination with a State Medicaid contract and that subset has not been

previously approved by CMS, then the MA must submit a SNP proposal for a Medicaid subset to CMS. Similarly, if a dual eligible SNP has previously been approved and the applicant intends to offer a different dual eligible subset type, chronic or institutional SNP, not previously approved, then the SNP proposal must include the required information for each SNP type for which prior CMS approval has not been granted.

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

C. Contracting MA adding a SNP(s) or expanding an existing SNP service area to a MA Service Area Expansion (SAE)

A contracting MA, who wants to offer a SNP or expand an existing SNP service area in a MA service area expansion (SAE) must complete and submit to CMS a SAE application for MA contracts and a SNP proposal. The SNP proposal is contained within the MA application which is posted at: http://www.cms.hhs.gov/MedicareAdvantageApps/. The completed SNP proposal is an upload to the HPMS as a zip file for each SNP type, i.e. dual, chronic or institutional. See the HPMS Part C Application User guide for step by step instructions.

The MA SAE application should be submitted as described in the MA application. If the MA does not currently offer prescription drug coverage in the service area to be covered under the MA contract number, the applicant must file the appropriate Part D application. The Part D applications are posted at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/ Click on "Application Guidance".

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

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

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

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

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

   Instruction: Within Section 4. A, B, and C, and D follow the instructions embedded in the template that allow certain elements not to be repeated if they are the same in other populations defined under

the same Section 4. A, B, C, or D. To summarize, for each population the applicant may copy the template but only provide the elements where there is a change, rather than provide complete responses for each SNP request.

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

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

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

For the purpose of the SNP solicitation and understanding how to consolidate responses under a SNP proposal, a "plan" is a unique combination of a targeted population and Model of Care, as defined in Section 3 under MA contract number. For example, as instructed in Section 4, if an organization under contract H9999 intends to offer a full dual SNP and a further subset dual SNP, the applicant would request two dual SNPs under H9999, and these "plans" would be labeled as follows (and as instructed in Section 4 of the SNP solicitation): H9999_ A_Plan_1, and H9999_A_Plan_2, where A represents a dual eligible SNP request..

The baseline proposal must contain SNP Model of Care information common to all SNP plans of a specific type (i.e., dual, institutional, or severe or disabling chronic condition) as prompted in Section 4.D. In addition, the applicant must submit supplemental addendums for each requested SNP plan of the particular type (i.e., dual, institutional, or severe or disabling chronic condition) along with the baseline proposal. The addendum would contain a discussion of those elements in Section 4 for which the applicant determines the complete answer deviates from the baseline proposal. For selected elements in Section 4, the applicant is required to provide complete information in the same supplemental addendum for each plan of that SNP type, regardless of whether it reflects any duplication. Finally, along with the baseline proposal the applicant must provide a table that crosswalks each contract and plan number (as numbered in Section 4) indicating with a check mark those elements in Section 4 that deviate from the baseline proposal.

This consolidated response and the crosswalk must be completed separately for each SNP type (i.e., dual, institutional, or severe or disabling chronic condition). For example, if across multiple contracts the applicant requests both dual and institutional SNPs, then the applicant would provide two consolidated proposals, one for dual and one for institutional SNPs. The only alternative would be to complete a SNP proposal for each contract as Section 4 directs.

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

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

- Dual SNP: Section 4, A.2, A.5
- Institutional SNP: Section 4, B.2, B.2.c,B.2.d, B.4
- Chronic SNP: Section 4, C.2, C.4

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

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

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

- Dual SNP: Section 4, A.2, A.5.
- Institutional SNP: Section 4, B.2, B.2.c,B.2.d, B.4.
- Chronic SNP: Section 4, C.2, C.4.

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

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

To provide this information, complete Section 4 A, B or C and copy the template as many times as there are requests within a Section A, B, C. Except for required responses for each SNP plan, only elements that are different from the baseline proposal should be represented.

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

1. Applicant's contracting name (as provided in HPMS)
2. Date submitted to CMS
3. Name of the baseline SNP proposal. The baseline name should be in the following format: CMS contract number, type of SNP code (A = dual, B = institutional and C = severe or disabling chronic condition), Baseline, X (where "X" is the number of the baseline SNP proposal), with an underscore between each element. An example is "H9999_A_baseline_1".

4. For each SNP plan covered by the baseline SNP proposal

a) Contract number (provided by HPMS)
b) Plan number (as required in Section 4 of the SNP solicitation, for example A_Plan_2)
c) Check all elements that deviate from or provide additional information relative to the baseline SNP proposal. All checked elements must be addressed in the supplemental addendum for the specific SNP plan. CMS requires a complete response in the addendum for those elements that are pre-checked in the template crosswalks provided in Attachment F. The crosswalks must be used in the format and structure provided.

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

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

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

## 3. KEY DEFINITIONS

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

*<u>Specialized MA plan for special needs individuals:</u>* Any type of MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth in 42 CFR 422.4(a)(1)(iv) that provides specialized care to such individuals, and that provides Part D benefits under 42 CFR Part 423 to all enrollees.

*<u>Special needs individual:</u>* An MA eligible individual who is institutionalized, as defined below, is entitled to medical assistance under a State plan under title XIX, or is an individual with a severe or disabling chronic condition recognized by the Secretary as benefiting from enrollment in a specialized MA plan. 42 CFR 422.2

*<u>Institutionalized:</u>* For the purpose of defining a special needs individual, an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long term care facility which is a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); or an inpatient psychiatric facility. (42 CFR 422.2). For purposes of SNPs, CMS may also consider as institutionalized those individuals living in the community but requiring an institutional level of care based on a State approved assessment.

*<u>Severe or disabling chronic condition:</u>* CMS, in collaboration with industry experts, has identified several conditions for which beneficiaries could experience chronically severe or disabling symptoms or disease

progression. Examples include: AIDS, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and chronic mental illness. A list of severe or disabling chronic conditions currently used by approved SNP plans is found in Attachment K and on the HPMS website.

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

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

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

*Disproportionate percentage:* A SNP that enrolls a greater proportion of the target group of special needs individuals (i.e. dual eligible, institutionalized, or those with a specified severe or disabling chronic condition) than occurs nationally in the Medicare population. This percentage will be based on data acceptable to CMS, including self-reported conditions from the Medicare Current Beneficiary Survey (MCBS) and other data sources. Please consult the following websites for additional information on determining disproportionate percentage.

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

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

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

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

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

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

*Zero cost sharing dual eligibles:* This category includes Qualified Medicare Beneficiaries (QMB) and QMB pluses, the two categories of dual eligible beneficiaries that have Medicare A and B cost sharing paid by Medicaid and may include other Medicaid beneficiaries for which the State holds the beneficiary harmless for Medicare A and B cost sharing. Further information on these categories is located at the following website:

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

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

*Model of Care:*

*Background*

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

*Definition*

The Model of Care describes the applicant's proposed approach to providing specialized care to the SNP's targeted population, including a statement of goals and specific processes and outcome objectives for the targeted population to be managed under the SNP, and differentiates how this plan has added value for special needs populations when compared to other MA plans. An inclusive Model of Care would demonstrate goals and objectives, comprehensive risk assessment, care coordination and case management based on risk stratification, a provider network having specialized experts and a service delivery system pertinent to the target population, a communication network, SNP training for network providers, and a performance measurement and improvement program that evaluates the impact of care on the special needs population.

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

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

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

## 4. TEMPLATE FOR COMPLETING SNP PROPOSAL

Follow the step by step instructions below and insert answers directly into the template. The applicant should complete only the portion(s) of the template that correlate to the specific SNP type the applicant intends to offer, i.e. Section A, B or C. If the applicant is seeking approval for more than one type of SNP, then the template for the proposal should be completed for each of those types. The responses to the template as well as

the attachments and the documentation for the State and long term care contract should all be in a single Microsoft word document. All documents requested in the template must be provided in the zip file uploaded to HPMS. The final submission to CMS for a SNP proposal should be only one electronic file which contains all the required Data and information.

See Section 2 for instructions to minimize duplication of responses and otherwise follow the instructions in this template. Any other approach to minimizing duplication will not be accepted by CMS.

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

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

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

Particular attention should be paid to the circumstance of different SNP offerings within a contract service area wherein one SNP covers only a segment of that service area and another covers a different segment. Specifically, if the applicant is seeking to offer a SNP in a limited segment of the contract service area, the applicant is not required to repeat information that will be the same for each segment. However, in any section where the information is not the same, the applicant must complete that information. For example, information about state contracts, service area and provider network could vary with every request. Include the CMS assigned contract number and plan number (e.g. Hxxx_A_ Plan_1, Hxxxx_A_Plan_2) and the type of information contained in the file. For all files use the following nomenclature H9999_x_Plan_x_proposal; H9999_x_Plan_x_contract

## DUAL ELIGIBLE SNP TYPE

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

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

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

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

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

### A.2.Type of Dual SNP

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

- ☐ All Duals: Medicare and Medicaid eligible beneficiaries
- ☐ Full Duals Only (See definition in Section 3)
- ☐ Zero Cost Sharing Duals: QMB only and QMB pluses (See definition in Section 3)
- ☐ Other Dual Eligibles Subset/Requires a State contract. If the State contract is limited to only those beneficiaries the state holds harmless from Medicare Part A and B cost sharing, check the Zero Cost Sharing Duals box as well. (See Attachment A)

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

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

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

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

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

Additional subsetting must be approved by CMS and a contract or agreement between the State and the applicant organization must exist and evidence must be provided to CMS by October 1, 2008 in order for the applicant to actually offer such subsetted dual SNPs effective on January 1, 2009.

The deadline for submission of this documentation was extended from the July 1, 2008 date proposed in the draft SNP solicitation to October 1, 2008 to allow applicants additional time to finalize their State contracts. However, an applicant should submit this documentation as soon as it becomes available so CMS can proceed with final approval as quickly as possible. Further, the applicant must submit a bid for the subset population

according to existing Medicare Advantage (MA) and Part D prescription drug plan rules and regulations which require that the bid be submitted by the first Monday in June. The bid, including its underlying assumptions about the population to be served, cannot be modified in the event the applicant fails to document entry into a contract with the State by the October 1, 2008 deadline. Final approval of the bid is in part contingent on finalizing the contract with the State and providing the necessary documentation to CMS by October 1, 2008. In addition, certain addenda to the contract will have to be signed.

The applicant should be aware that the October 1, 2008 deadline could affect whether and how the SNP product will be featured in the Medicare & You Handbook, and in the Medicare Plan Finder for at least the first month. CMS approval of marketing materials may also be delayed which could subsequently delay marketing of the new SNP product.

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

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

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

A.3.c. Explain how the applicant's subset of individuals coincides with State efforts to integrate Medicare and Medicaid services for the target population. Specifically, provide an explanation from the State for the subset that also includes a discussion of the Medicaid population that will be served by the SNP. The applicant must include the State's response with the SNP proposal.

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

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

A.3.d.2. If applicant's organization will have a contract with the State to provide Medicaid services to the requested subset of dual eligible individuals that will be effective by January 1, 2009, include a letter from the State that verifies that information. The letter must verify the requested Medicaid subset including a list of the types of dual eligible beneficiaries eligible for the SNP and an assurance that the applicant will have a contract or agreement with the State Medicaid agency effective on January 1, 2009 that will be signed by October 1, 2008.

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

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

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

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

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

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

A.4.e. Provide the name, phone number, e-mail address and mailing address (contact information) of the applicant's contact person at the State Medicaid agency. If the proposed SNP serves more than one State, provide the contact information for each State.

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

☐ Yes

☐ No

**A.5. Exclusive versus Disproportionate Percentage Population**

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

☐ Exclusive

☐ Disproportionate

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

A.5.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section 3., propose the reference point to compare the applicant's targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

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

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

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

**A.6. Service Area to be Served by SNP**

A.6.a. The applicant can submit a SNP proposal in **only** counties approved or pending approval in the MA contract. The SNP service area can be a subset of the county level approved MA service area. The SNP service area cannot be a subset below the county level approved MA service area. If the approved MA service area is for selected zip codes of a county, the SNP service area must be equal to all the zip codes approved for the MA service area for the county. An exception is a SNP that also includes a Medicaid contract for a geographic area smaller than a county.

A.6.b. Complete a separate Attachment B for each SNP proposal. List the State(s) and County(ies) to be served by the SNP proposal. If the SNP proposal will serve all counties in the State, then Attachment B can list "All Counties" instead of listing the individual counties.

## B. INSTITUTIONAL SNP TYPE

### B.1. Number Assignment for each Institutional SNP Type

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

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

***NOTE to the applicant:*** This section should be completed and replicated as many times as the number reported in B.1.b. Consecutively label each institutional SNP type as institutional Hxxxx_B_Plan_1; Hxxxx_B_Plan_2, etc. Duplication can be minimized by following the instructions in Section 2 and IV.3.

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

### B.2. Type of Institutional SNP

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

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

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

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

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

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

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

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

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

B.2.c.3. Describe how the assessment tool will be utilized to determine if the enrollee meets the definition of institutionalized contained in Section 3 of this solicitation. Indicate who will perform the level of care assessment

***NOTE to applicant:*** The applicant must use a CMS approved assessment tool to determine if a potential enrollee meets the definition of institutionalized as defined in Section 3. The Minimum Data Set (MDS) form is an acceptable assessment tool for determining institutional status and may be utilized. The applicant must verify an individual's eligibility prior to enrollment, so the applicant must clearly demonstrate how the eligibility criteria will be verified. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used as an indicator of institutional status.

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

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

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

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

### B.3. State Contracts Information

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

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

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

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

B.3.e. Provide the name, phone number, e-mail address and mailing address(contact information) of the applicant's contact person at the State Medicaid agency. If the proposed SNP serves more than one State, provide the contact information for each State.

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

☐ Yes

☐ No

## B.4. Exclusive versus Disproportionate Percentage Population

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

☐ Exclusive

☐ Disproportionate

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

B.4.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section 3., propose the reference point to compare its targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

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

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

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

## B.5. Service Area to be Served by SNP

B.5.a. The applicant can submit a SNP proposal in **only** counties approved or pending approval in the MA contract. The SNP service area can be a subset of the county level approved MA service area. The SNP service area cannot be a subset below the county level approved MA service area. If the approved MA service area is for selected zip codes of a county, the SNP service area must be equal to all the zip codes approved for the MA service area for the county. An exception is a SNP which includes a Medicaid contract for a geographic smaller area than a county.

B.5.b. Complete a separate Attachment B for each SNP proposal. List the State(s) and County(ies) to be served by the SNP proposal. If the SNP proposal will serve all counties in the State, then Attachment B can list "All Counties" instead of listing the individual counties.

## C. SEVERE OR DISABLING CHRONIC CONDITION SNP TYPE

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

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

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

***NOTE to the applicant:*** This section should be completed and replicated as many times as the number reported in C.1.b. Duplication can be minimized by following the instructions in Section 2 and Section 4.3. Consecutively label each severe or disabling chronic condition SNP type as Hxxxx_C_Plan_1; Hxxxx_C_Plan_2, etc.

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

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

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

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

***NOTE to applicant:*** The applicant must verify an individual's eligibility prior to enrollment, so the applicant must clearly demonstrate how the eligibility criteria will be verified. There are no CMS files related to Medicare health plan enrollment that can accomplish the task of determining eligibility for a SNP. The values in existing CMS data files may not be used to determine if a potential enrollee meets the eligibility requirement for a chronic condition SNP. The applicant may obtain a letter from the potential enrollee's physician with verification if the enrollee's condition or request authorization from the beneficiary or his/her representative, consistent with HIPAA, to contact the enrollee's physician to verify eligibility for the SNP. In addition, an applicant may be approved to use a Pre-enrollment Qualification Assessment tool as an alternative to the existing pre-enrollment verification processes. The applicant must review Attachment J and follow all of the instructions contained in Attachment J if the applicant is seeking approval to utilize the Pre-enrollment Qualification Assessment tool to verify eligibility in a chronic SNP. A request to utilize this alternative chronic SNP verification process must be submitted as part of the applicant's SNP proposal.

### C.3. State Contracts Information

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

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

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

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

C.3.e. Provide the name, phone number, e-mail address and mailing address (contact information) of the applicant's contact person at the State Medicaid agency. If the proposed SNP serves more than one State, provide the contact information for each State.

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

☐ Yes

☐ No

**C.4. Exclusive versus Disproportionate Percentage Population**

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

☐ Exclusive

☐ Disproportionate

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

C.4.a.1. If the organization is requesting that its SNP cover a disproportionate percentage of special needs individuals as defined in Section 3, propose the reference point to compare its targeted enrollment percentage to the incidence of that type of beneficiary in the Medicare population.

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

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

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

**C.5. Service Area to be Served by SNP**

C.5.a. The applicant can submit a SNP proposal in **only** counties approved or pending approval in the MA contract. The SNP service area can be a subset of the county level approved MA service area. The SNP service area cannot be a subset below the county level approved MA service area. If the approved MA service area is for selected zip codes of a county, the SNP service area must be equal to all the zip codes approved for the MA service area for the county. An exception is a SNP which includes a Medicaid contract for a geographic smaller area than a county.

C.5.b. Complete a separate Attachment B for each SNP proposal. List the State(s) and County(ies) to be served by the SNP proposal. If the SNP proposal will serve all counties in the State, then Attachment B can list "All Counties" instead of listing the individual counties.

## D. MODEL OF CARE

All SNP applicants, regardless of the proposed type of SNP plan, must complete Section D., Model of Care. Unless otherwise noted, all elements under each topical heading should be addressed.

### D.1. Goals and objectives

D.1.a. Delineate the goals and objectives that will drive service delivery for the SNP-targeted population.

D.1.b. Explain how the goals and objectives apply to the following vulnerable sub-populations likely to exist within the SNP-targeted population:
D.1.b.1. frail/disabled beneficiaries
D.1.b.2. beneficiaries with multiple chronic illnesses
D.1.b.3. beneficiaries near the end of life
D.1.b.4. beneficiaries with end-stage renal disease (ESRD) **if the applicant intends to enroll them**

***NOTE to <u>all</u> applicants:*** In the description of subsequent Model of Care components (D.2. through D.8) and for **each** SNP type, include a discussion thread that explicitly addresses how the model applies to beneficiaries who are frail/disabled, have multiple chronic illnesses, and/or are near the end of life. You will not be further prompted to continue this thread; however, your application will be evaluated on how your Model of Care incorporates these vulnerable groups.

***NOTE to <u>applicants intending to enroll ESRD beneficiaries</u>***: If a SNP is approved to serve ESRD beneficiaries, the exceptions authority in 42 CFR 422.50 (a) (2) (iii) would apply and a waiver pursuant to 42 CFR 422.52 (c) will be provided to the applicant. The signed waiver will be attached to the MA contract. If this is an MA organization that is adding a SNP, the waiver will be sent following final approval and the waiver must be signed and returned within 10 calendar days. Further, the applicant may accept a copy of the CMS form 2728, "ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration" as a verification of ESRD status prior to enrollment.

### D.2. Comprehensive Risk Assessment

D.2.a. Describe the process for initial and periodic comprehensive health risk assessments addressing each of the following elements. Indicate a time frame for initial assessment that expedites care planning and case management. Specify the risk stratification that will be used to drive the level of benefits and services assigned to beneficiaries in each risk category for the SNP-targeted population.
D.2.a.1. physical and mental health assessments
D.2.a.2. activities of daily living (ADLs)
D.2.a.3. social and physical environment
D.2.a.4. caregiver availability and capacity (e.g., frail/disabled beneficiary in any SNP plan; beneficiary having dementia in a chronic condition SNP plan; any SNP plan beneficiary assessed as a high risk category)
D.2.a.5. protocol for initially assessing and transitioning beneficiary from current treatment regimens (e.g., chemotherapy, acute hospitalization, nursing home stay, etc.) into SNP plan provider network

D.2.b. Include the risk assessment tool as a document attachment in the electronic file.

### D.3. Specialized Provider Network

D.3.a. Describe the mix of healthcare providers and health facilities in the plan's network that have specialized expertise to deliver services to the SNP-targeted population addressing each of the following elements:

D.3.a.1. specialty and primary care providers and their care roles within the network (e.g., cardiology consultant for a beneficiary with chronic heart failure in a chronic condition SNP; registered nurse responsible for the immunization schedule of a frail/disabled beneficiary who is institutionalized)

D.3.a.2. pharmacy network if different from the applicant's other Medicare coordinated care plans

D.3.a.3. case managers and their care role (e.g., coordination of benefits for dual eligibles)

D.3.a.4. acute care and rehabilitation facilities (e.g., hospitalization of a beneficiary with multiple chronic conditions who suffers an acute diabetic emergency; rehabilitation services for the post-stroke beneficiary having residual cognitive and functional deficits in a chronic condition SNP plan)

D.3.a.5. facilities with specialized services (e.g., dialysis facility for a beneficiary with end-stage renal disease; assisted living facility for beneficiaries living in the community but requiring an institutional level of care)

D.3.a.6. long-term facilities (e.g., skilled nursing facility for a beneficiary near the end of life)

***NOTE to <u>all</u> applicants***: Although the applicant is required to respond to the above-listed elements in explaining the provider network, separate HSD tables are not required unless requested by CMS.

***NOTE to <u>applicants intending to enroll ESRD beneficiaries</u>***: Complete "Attachment G – Dialysis Facilities" and "Attachment H – Transplant Facilities" by listing ***all*** contracted dialysis and transplant facilities.

***NOTE to <u>applicants intending to implement a SNP plan for institutionalized beneficiaries</u>***: Complete "Attachment I – Long Term Care Facilities" by listing ***all*** contracted long term care facilities. In addition, submit a copy of the contract the applicant will utilize when contracting with a long-term care facility. Over and above the terms listed in the Medicare Advantage Managed Care Manual, Chapter 11, Section 100.4, the applicant must adequately address the following, either in the contract with the long term care provider or in provider materials including, but not limited to, written policies and procedures and provider manuals. If the information is addressed in the provider materials, then each element listed below must be referenced in the contract in a meaningful way referring the facility to the particular part of provider materials where the details concerning the element can be found.

*<u>Facilities in a chain organization that are contracted to deliver the SNP Model of Care</u>*

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

*<u>Facilities providing access to SNP clinical Staff</u>*

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

*<u>Providing protocols for the SNP Model of Care</u>*

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

*<u>Delineation of services provided by the SNP staff and the LTC facilities under the SNP Model of Care</u>*

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

*<u>Training plan for LTC facility staff to understand SNP Model of Care</u>*

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

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

- Procedures that ensure cooperation between the SNP and facility in maintaining a list of credentialed SNP clinical staff.

*Contract Year for SNP*

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

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

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

**D.4. Coordinated Care and Case Management**

D.4.a. Describe how the risk assessment stratification will determine the types of benefits and services needed by the beneficiaries in the SNP-targeted population, and how care will be coordinated across the provider network. In addition, explain explicitly how case management will be applied to assure:

D.4.a.1. coordination of care across healthcare and community settings (e.g., the chronic care SNP beneficiary having a coronary artery stent post-angioplasty, emphysema, and diabetic retinopathy who needs periodic cardiology, pulmonary, and ophthalmology consults within and/or out-of-network)

D.4.a.2. continuity of care during transitions (e.g., enrollments/disenrollments; changes in a provider network)

D.4.a.3. involvement of the caregiver in developing and implementing the care plan (e.g., caregiver role in developing advance directives for beneficiaries near the end of life)

**D.5. Healthcare Delivery System**

D.5.a. Describe the delivery of specialized care appropriate to the SNP-targeted population addressing each of the following elements:

D.5.a.1. use of evidenced-based disease management protocols (e.g., using protocols recommended in the ATP III Cholesterol guidelines, JNC 7 Hypertension guidelines, Asthma, Expert Panel Report 3, or similar evidence-based clinical practice guidelines to manage beneficiaries having multiple chronic conditions)

D.5.a.2. process for using out-of-network providers when necessary

D.5.a.3. extra benefits and services that differentiate this model of care from other MA CCP plan types

**D.6. Communication and Accountability**

D.6.a. Describe the system of communication among healthcare providers that assures that specialized needs of the SNP-targeted population will be met and healthcare providers will be accountable for service delivery addressing each the following elements:

D.6.a.1. communication across the provider network

D.6.a.2. communication with caregivers

D.6.a.3. communication with participants that accounts for health literacy levels and cultural issues

D.6.a.4. communication with federal, state, and community agencies as appropriate (e.g., CMS and state reporting requirements, reportable communicable diseases, etc.)

**D.7. SNP Training and Competency Assurance**

D.7.a. Describe the process for training and assuring competency among the specialized experts needed to deliver focused health services to the SNP-targeted population addressing each of the following elements:

D.7.a.1. compliance with SNP regulations
D.7.a.2. knowing and implementing the SNP-specific model of care
D.7.a.3. knowledge and experience with the SNP-targeted population
D.7.a.4. procedures for assuring credentials verification and periodic competency review across the provider network

**D.8. Performance Measurement and Improvement**

D.8.a. Describe the process and outcome measures that will be used to measure performance in implementing the model of care for the SNP-targeted population addressing each of the following elements:

D.8.a.1. specific measures used for data collection
D.8.a.2. methodology for collection and analysis of data
D.8.a.3. process for performance improvement based on data analysis
D.8.a.4. dissemination of analysis results across the provider network
D.8.a.5. required plan level reporting to CMS and state
D.8.a.6. inclusion of measures that evaluate the model of care for applicable sub-populations:

- **D.8.a.6.1.** frail/disabled beneficiaries
- **D.8.a.6.2.** beneficiaries with multiple chronic illnesses
- **D.8.a.6.3.** beneficiaries near the end of life

## ATTACHMENT A

### Subsets for Dual Eligible SNPs

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

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

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

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

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

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

## ATTACHMENT B

**<u>SNP Service Area</u>**

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

| **State** | **County** |
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**ATTACHMENT C**

## Ensuring Delivery of Institutional SNP Model of Care

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

Background

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

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

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

All SNP proposals are required to provide a description of the SNP Model of Care that the Medicare Advantage Organization (MAO) has designed and must implement specifically to serve the special population in the MAO's SNP. The word "specialized" in the statute clearly contemplates that the SNP product provides for "specialized" benefits that are targeted to meet the needs of the SNP population. Some aspects of the Model of Care concept described in Section 3 of the SNP solicitation, as well as how it would be implemented, will vary depending on the site of care LTC facility or in the community, based on, for example the availability of and need for staff and community services. Refer to the Model of Care definition in Section 3 of the SNP solicitation.

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

Policy Clarification #1

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

Policy Clarification #2

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

Policy Clarification # 3

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

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

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

## ATTACHMENT D

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

**Attestation for Special Needs Plans (SNP) Serving Institutionalized Beneficiaries**

(Name of Organization)
(H number)

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

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

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

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| **CEO** | **DATE** |

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| **CFO** | **DATE** |

## ATTACHMENT E

### Quality Measurement for Special Needs Plans

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

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

## ATTACHMENT F

**Crosswalk Consolidating Proposals for Dual Eligible SNPs**

**Applicant's contracting Name (As provided in HPMS):** **<u>MAP SNP Example</u>**

**Date submitted to CMS:___________________________**

| **Name of the baseline SNP proposal:**<br>**<u>Dual Baseline 1____</u>**<br><br>**Summary of Addendums for Dual Eligible SNP** | | **Number assignment for each dual eligible SNP type** | **Type of Dual SNP** | **Relationship of SNP product to State Medicaid services in the event of other subsetting** | **State contracts information if other subsetting is not being requested by applicant** | **Exclusive versus disproportionate percentage population** | **Service area to be served by SNP** | **SNP Mod** |
|---|---|---|---|---|---|---|---|---|
| **<u>Contract #</u>** | **<u>Plan #</u>** | **<u>A.1</u>** | **<u>A.2</u>** | **<u>A.3</u>** | **<u>A.4</u>** | **<u>A.5</u>** | **<u>A.6</u>** | **<u>I</u>** |
| H9999 | H9999_A_Plan_1 | ✓ | | ✓ | ✓ | | ✓ | |
| (Example) | | ✓ | | ✓ | ✓ | | ✓ | |
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## ATTACHMENT F

| Crosswalk Consolidating Proposals for Dual Eligible SNPs<br><br>Applicant's contracting Name (As provided in HPMS): <u>MAP SNP Example</u><br><br>Date submitted to CMS:_____________________________ | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Name of the baseline SNP proposal: <u>Institutional Baseline 1</u><br><br>Summary of Addendums for Institutional SNP | | Number assignment for each institutional SNP type | Type of institu-tional SNP | Identifying institu-tionalized benefici-aries | Identifying beneficiaries living in the community but requiring an institutional level of care | State contracts infor-mation | Exclusive versus dispropor-tionate percentage population | Service area to be served by SNP | SNP Mo |
| Contract # | **<u>Plan #</u>** | **<u>B.1</u>** | **<u>B.2</u>** | **<u>B.2.c</u>** | **<u>B.2.d</u>** | **<u>B.3</u>** | **<u>B.4</u>** | **<u>B.5</u>** | **<u>I</u>** |
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## ATTACHMENT F

**Crosswalk Consolidating Proposals for Severe or Disabling Chronic Condition SNPs**

**Applicant's Contracting Name (as provided in HPMS): __MAO SNP Example___________**

**Date Submitted to CMS: _________________**

| Name of the baseline SNP proposal: Chronic Baseline 1____<br><br>Summary of Addendums for Severe or Disabling Chronic Condition SNP | | Number assignment for each severe or disabling chronic condition SNP type | Type of chronic condition SNP | State contracts information | Exclusive versus disproportionate percentage population | Service area to be served by SNP | SNP Mod |
|---|---|---|---|---|---|---|---|
| Contract # | Plan # | C.1 | C.2 | C.3 | C.4 | C.5 | I |
| H9999 | H9999_C_Plan_1 | ✓ | | ✓ | | ✓ | |
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**ATTACHMENT G – Dialysis Facilities Table**

**Dialysis Facilities**

**Date Submitted to CMS: ____________________**

**Applicant's Contracting Name (as provided in HPMS): __________________________**

**Contract #/Plan #: H9999_A_Plan _1 (example)___**

| Name of Dialysis Facilities | Medicare Provider # | Facilities Address |
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## ATTACHMENT H –Transplant Facilities Table

**Transplant Facilities**

**Date Submitted to CMS: ____________________**

**Applicant's Contracting Name (as provided in HPMS): __________________________**

**Contract #/Plan #: H9999_A_Plan _1 (example)___**

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## ATTACHMENT I – Long Term Care Facilities Table

**Long Term Care Facilities**

**Date Submitted to CMS: ____________________**

**Applicant’s Contracting Name (as provided in HPMS): __________________________**

**Contract #/Plan #: H9999_B_Plan _1 (example)___**

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## ATTACHMENT J-Pre-enrollment Verification

### Additional Option for Pre-enrollment Verification of Chronic Condition for Chronic Condition Special Needs Plans

This policy provides an additional option for pre-enrollment verification of a chronic condition to determine eligibility for enrollment in a chronic care special needs plan (SNP).

CMS requires that SNPs serving beneficiaries with severe or disabling chronic conditions verify with a provider or the provider's office that a potential enrollee has the condition for which the chronic care SNP is targeted. SNPs have reported that some providers or their office staff may not be readily accessible to obtain verification in a timely manner. Therefore, effective May 31, 2007, a Medicare Advantage Organization (MAO) may be approved to use a Pre-enrollment Qualification Assessment tool as an alternative to the existing pre-enrollment verification processes.

CMS will approve the use of a Pre-enrollment Qualification Assessment tool under the following conditions:

1) h The Pre-enrollment Qualification tool provides for each applicable condition a clinically appropriate set of questions relevant to the specific condition(s) that cover the potential enrollee's past medical history, current signs and/or symptoms, and medication regimen that provides a reliable indicator that the beneficiary has the condition. An example of a pre-qualification questionnaire is attached. CMS is working with the industry to develop model pre-qualification questionnaires that may be used by organizations seeking approval for this alternative verification process.

1 2) The MAO maintains a record of the results of the Qualification Tool, such as documentation of a phone call. This record must include a date and time that establishes the verification occurred in accordance with the timeframes for completing an MA enrollment request, pursuant to CMS' Enrollment and Disenrollment Guidance for Medicare Advantage Organizations.

2

3 3) The MAO conducts a post-enrollment confirmation of each enrollee's information and eligibility based on medical information provided by the enrollee's physician or other provider.

4

5 4) The MAO ensures that for all enrollments conducted by an agent or broker, if applicable, any commission or payment associated with that enrollment will be forfeited in the event the condition cannot be confirmed post-enrollment.

6 5) If the enrollee is accepted into the SNP, but is later determined to not have had the targeted condition, the enrollee will remain in the SNP until the end of the calendar year and will be disenrolled at that time. The MAO must notify the enrollee of this disenrollment by October 1 of each year. The beneficiary will have a Special Enrollment Period (SEP) that begins on October 1 and ends on March 31 of the following year.

7 6) The MAO tracks the total number enrollees and the number and percent by condition whose post enrollment verification matches the pre-enrollment verification. These data and the supporting documentation will be made available upon request by CMS and will be audited.

8 7) All information gathered in the pre-enrollment Qualification Tool will be held confidential and in accordance with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). This requirement applies to plan employees as well as the plan's business associates.

The applicant must submit a request for approval to use a Pre-Enrollment Qualification Assessment Tool (Assessment) as part of the SNP proposal. The Assessment must be tailored to the specific disease(s) to be targeted through the SNP. This attachment contains a number of samples that may be utilized by the applicant in preparing the Assessment.

The request to utilize an Assessment for verification of chronic condition(s) must include an attestation that states the MAO agrees to implement the policy provided in items 1 through 7 above.

## Sample Pre-qualification Assessment Tools

### Pre-Qualification Assessment for Stroke/TIA

*“Yes” to 1 or 2 pre-qualify the candidate. “Yes” to 3 or 4 only require further verification.*

1. Have you ever been told by a doctor or clinic that you have had a blood clot in your brain, a stroke or a near stroke?
2. Have you had episodes of mental confusion, dizziness, paralysis or loss of consciousness that a doctor has told you were due to poor circulation to the brain?
3. Have you experienced loss of any of the following:
   - speech
   - swallowing
   - vision,
   - the use or control of muscles in any part of your body (i.e. loss of control, numbness on one side)
   - sensation in any part of your body
   - bowel or bladder control
   - emotional control
   - thinking and reasoning ability?

4. Have you been prescribed or are you taking medication to improve or protect the circulation to the brain such as blood thinners (for example, Coumadin, Lovenox) or platelet clot preventers (for example, aspirin, Plavix, Ticlid or Persantine)?

### Pre-Qualification Assessment for Peripheral Vascular Disease

*“Yes” to 1, 2, 3 or 4 pre-qualify the candidate. “Yes” to 5 only, requires further verification.*

1. Have your ever been told by a doctor or clinic that you have poor circulation in your arms or legs due to hardening of the arteries or poor veins?
2. Have you ever had an imaging test (arteriogram, venogram or ultrasound”) that showed decreased circulation in your arms or legs?
3. Have you ever had an operation to improve the circulation in your arms or legs (not in your heart) such as angioplasty or bypass graft?
4. Have you ever had a slow healing leg ulcer (sore) or have had an amputation of part of a foot or leg due to poor circulation?
5. Have you been prescribed or are you taking medication to improve circulation in your arms or legs such as blood thinners (for example, Coumadin, Lovenox) or platelet clot preventers (for example, aspirin, Plavix, Ticlid or Persantine)?

### Pre-Qualification Assessment for ESRD

*“Yes” to 1, 2 or 3 pre-qualifies beneficiary.*

1. Have you ever been told by a doctor or clinic that you have End Stage Renal Disease/ESRD or kidney failure?
2. Are you currently on dialysis?
3. Have you had or are you on a waiting list for an organ transplant? Was/is it for a kidney transplant?

**Pre-Qualification Assessment for Chronic Heart Failure**

*"Yes" to question 1 or questions 2 and 3 pre-qualifies the candidate. Yes to question 2 or 3 only requires further verification.*

1. Have you ever been told by a doctor or clinic that you have heart failure (weak heart)?
2. Have you had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem?
3. During the past 12 months, have you been counseled or educated about weighing yourself daily due to a heart problem?

**Pre-Qualification Assessment for Coronary Artery Disease**

*"Yes" to any one of questions 1-5, pre-qualifies candidates. Yes to 6 only requires further verification.*

1. Have you ever been told by a doctor or clinic that you have Coronary Artery Disease?
2. Have you ever had a heart attack?
3. Have you ever had an admission to the hospital for angina (chest pain)?
4. Have you ever had cardiac bypass surgery (open heart surgery)?
5. Have you ever had an angioplasty or stent in your heart?
6. Have you ever experienced chest pain (angina) and was told by your doctor it was heart related?

**Pre-Qualification Assessment for COPD**

*"Yes" to 1, 2, 3 or 4 pre-qualify the candidate.*

1. Have you ever been told by a doctor or clinic that you have COPD (chronic), chronic Bronchitis, emphysema and/or chronic asthma?
2. Do you suffer from chronic coughing or shortness of breath for which you have been prescribed or are taking medicine?
3. Have you smoked for 20 years or more and, if so, do you have a chronic cough or shortness of breath?
4. Have you been prescribed or are you taking a medication or oxygen for any chronic lung disease such as COPD (chronic obstructive pulmonary disease), chronic Bronchitis, emphysema and/or chronic asthma?

**Pre-Qualification Assessment for Hypertension**

*“Yes” to 1 and pre-qualify the candidate.*

1. Have you been told by a doctor or clinic you have hypertension or high blood pressure?
2. Have you been prescribed or are you taking medication for high blood pressure?

**Pre-Qualification Assessment for Depression**

*“Yes” to 1, 2 or 3 pre-qualifies candidate*

1. Have you been told by a doctor or clinic that you have depression?
2. Have you been treated for depression with any of the following?
    a. With medication
    b. With therapy
    c. With ECT (shock treatments)
3. Have you ever been hospitalized for depression?

**Pre-Qualification Assessment for Dementia**

“*Yes” to1 or 2 pre-qualifies the candidate.  “Yes” to 3 only requires further verification...*

1. Does the applicant have memory loss that interferes with daily activities?
2. Has the applicant been told by a doctor or clinic that they have any form of dementia or Alzheimer’s disease?
3. Is the applicant taking either Namenda or Aricept for Alzheimer’s disease?

## Pre-Qualification Assessment for Diabetes

*"Yes" to 1 or 2 pre-qualifies the candidate.*

1. Have you ever been told by a doctor or clinic that you have diabetes (too much sugar in the blood or urine)?
2. Have you been prescribed or are you taking insulin or an oral medication that is supposed to lower the sugar in your blood?

## Pre-Qualification Assessment for Chronic Renal Disease

*"Yes" to 1, 2, 3 or 4 pre-qualify the candidate. "Yes" to 5, 6 or 7 only require further verification.*

1. Have you ever been told by a doctor or clinic you had chronic renal disease?
2. Have you ever been told by a doctor or clinic your kidney function is abnormal?
3. Have you ever been told by a doctor or clinic you had a high creatinine level?
4. Have you been told by a doctor of a problem with your kidneys other than stones or infection?
5. Have you ever had to collect your urine for 24 hours to measure your kidney function?
6. Have you been told by a doctor or clinic that you had protein or blood in your urine?
7. Have you been told by a doctor or clinic to decrease protein in your diet?

## ATTACHMENT K

List of Severe or Disabling Chronic Conditions – 2008-2009 HPMS Crosswalk

| 2008 Chronic Condition List | 2009 Chronic Condition List |
| --- | --- |
| Chronic cardiomyopathy | CVD: Chronic Heart Failure |
| Coronary artery disease | CVD: Coronary Artery Disease |
| Hypertension | CVD: Hypetension |
| Asthma | COPD: Asthma |
| Chronic obstructive pulmonary disease | COPD: Asthma |
| Chronic obstructive pulmonary disease | COPD: Chronic bronchitis |
| Chronic obstructive pulmonary disease | COPD: Emphysema |
| Diabetes | Endocrine/Metabolic: Diabetes |
| Hypercholesteremia | Endocrine/Metabolic: Dyslipidemia |
| Obesity | Endocrine/Metabolic: Obesity |
| HIV | Immune Disorders: HIV infection |
| Arthritis | Joint Disorders: Osteoarthritis |
| Ischemic Stroke | Neurologic Disorders: Ischemic stroke |
| Dementia | Neurologic Disorders: Dementia |
| Chronic kidney disease | Renal Disorders: Chronic renal failure |
| Renal failure | Renal Disorders: Chronic renal failure |
| Renal failure (pre-End Stage Renal Disease) | Renal Disorders: Chronic renal failure |
| End-stage renal disease | Renal Disorders: End-stage renal disease (ESRD) |
| Post-kidney transplant | Status-post Organ Transplantation |
| Other | Other |
| Cardiovascular disease | CVD: Cardiac Arrhythmia |
| Cardiovascular disease | CVD: Chronic Heart Failure |
| Cardiovascular disease | CVD: Coronary Artery Disease |
| Cardiovascular disease | CVD: Hypetension |
| Cardiovascular disease | CVD: Peripheral Vascular Disease |
| Heart Disease | CVD: Cardiac Arrhythmia |
| Heart Disease | CVD: Chronic Heart Failure |
| Heart Disease | CVD: Coronary Artery Disease |
| Heart Disease | CVD: Hypetension |
| Heart Disease | CVD: Peripheral Vascular Disease |
| Mental illness | Psychiatric Disorders: Alcoholism |
| Mental illness | Psychiatric Disorders: Bipolar disorder |
| Mental illness | Psychiatric Disorders: Drug dependency |
| Mental illness | Psychiatric Disorders: Major depression |
| Mental illness | Psychiatric Disorders: Schizophrenia |
| Neurological condition | Neurologic Disorders: Dementia |
| Neurological condition | Neurologic Disorders: Hemorrhagic stroke |
| Neurological condition | Neurologic Disorders: Ischemic stroke |
| Psychiatric disorders | Psychiatric Disorders: Alcoholism |
| Psychiatric disorders | Psychiatric Disorders: Bipolar disorder |
| Psychiatric disorders | Psychiatric Disorders: Drug dependency |
| Psychiatric disorders | Psychiatric Disorders: Major depression |
| Psychiatric disorders | Psychiatric Disorders: Schizophrenia |

**Key**

CVD is cardiovascular disease.

COPD is chronic obstructive pulmonary disease.

**New**

Immune Disorders: Rheumatoid Arthritis
Liver Disease: Chronic liver failure
Liver Disease: End-stage liver disease (ESLD)

# PART 5 INSTRUCTIONS FOR COMPLETING CMS FORMS

## 2.1. Form and 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.

Please note that all documents submitted to HPMS with the application must include file names as specified in Part 6.

## 2.2 Instructions for CMS Insurance Coverage Table

**Instructions**

- Complete the table by inserting the amount of insurance coverage or other arrangements the applicant has for major types of loss and liability and place a hard copy in the Documents section of the application.
- Provide in HPMS, a completed copy of this table in PDF format.

**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.

## 2.3. Instructions for CMS State Certification Form

The applicant should 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 provide in HPMS a copy of this executed form using a PDF format.

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.

**Note: 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.

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

## 2.4. Instructions for CMS Provider Arrangements by County Table

**Instructions:**

- Provide in HPMS, 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 (D.O.) 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 –** Insert number of contracts, or Letter of Agreements (LOA).
   - Note: 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 Agreement**s **–** Insert number of contracts/and or Agreements that are automatically renewed.

5. **Date Executed** - Enter the date or date range (in which all contracts and/or agreements were finalized for the particular category.

6. **Contract and/or Agreement Template name** - List the template name (i.e., Template A or Templates A- C) for each category.

## 2.5. Instructions for CMS Provider Participation Contracts and/or Agreements Matrix

This matrix should be completed by MA applicants and should be use to reflect the applicants first tier and downstream contracts and/or agreements.

**Instructions:**

1. Provide in HPMS using a PDF format, a separate matrix for each county or partial county.

2. Enter name of the provider(s)/group(s) or entity that the MA organization contracts 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 templates for that particular provider(s), group(s) and other contracted entities.

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

## 2.6. Instructions for CMS Administrative/Management Delegated Contracting or Arrangement Matrix

This matrix should be completed by network model MA applicants and should be use to reflect the applicants first tier and downstream contracts and/or agreements.

**Instructions:**

1. Enter name of entity or entities that the MA applicant has contracted with to provide administrative services to Medicare enrollees
   - Note: MSA applicants will enter the name of the entity that the applicant has arranged to offer MA MSA accounts in accordance with §1853(e)(2) of the Act.
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 applicants.
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 a brief description of MA regulatory requirements; please refer to full regulatory citations for an appropriate response**.

## 2.7. <u>General Instructions for CMS HSD Tables 1, 2, 2a, 3, 3a, 4, 5</u>

*(Not required for non-network PFFS)*

These tables should be completed by contracted-network MA applicants, excluding RPPO applicants.

**<u>Instructions:</u>**

1. If an MA applicant has a network exclusive to a particular plan, the applicant must provide in HPMS four separate HSD tables for each plan.

2. The applicant must list the plan or plans name to which a table applies at the top of each tables. If the table applies to all plans, state "All".

3. Enter the date that the tables were constructed next to "<u>date prepared</u>". The tables should reflect the applicants **fully executed <u>contracted</u>** network providers and facilities that are in place on the date of submission..

   Note: For CMS purposes, contracts are considered fully executed when both parties have signed.

4. 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, the applicant must
   - Provide in HPMS a narrative of this exception/these exceptions in a PDF file and list the providers in the HSD tables. This narrative 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, applicant must explain within the PDF file how the applicant will ensure that members are not balance-billed for these services.

5. Applicant must provide these tables in HPMS as Excel documents.

**NOTE:** RPPO applicants are not required to complete HSD tables but should follow instructions in Section 2 of this application.

### 2.7.1 Table: HSD-1: County/Delivery System Summary of Providers by Specialty

**Instructions:**

1. Providers should be counted only once per county on this table even if the provider has more than one location in a county.
2. If the applicant uses a subnetwork or has multiple delivery systems within the county/service area, the applicant must complete a separate HSD 1 table for each delivery system. Each HSD 1 table should be representative of the aggregate numbers of providers for the delivery system being described.
3. If there are other specialties that are not listed, applicant should add lines under "vascular surgery" to cover these specialists.
4. Applicant must arrange all entries alphabetically by county. Note: 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. Available Medicare Participating Providers in County-List the number of Medicare participating providers located in the county. Information can be obtained from the Medicare Carriers.

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

4. **Medicare Provider Breakdown** - List the number of contracted providers by type of contract (direct arrangement or downstream arrangement).

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

6. **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.

7. **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.

8. **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.

9. **County** - County in which the provider is located.

## 2.7.2 Table: HSD-2: Provider List - List of Physicians and Other Practitioners by County

**Instructions:**

1. Applicant must arrange providers alphabetically by county, then alphabetically by specialty, and finally numerically by zip code.

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

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

**Column Explanations:**

1. **Name of Physician—**Self Explanatory. Please include chiropractors and podiatrists and 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. **Step 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.

5. **Provider Previously Liste**d? - 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.)

6. **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.

7. **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.

8. **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.

9. **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.

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

11. **If Credentialing is Delegated, List Entity**- If credentialing is not performed by the applicant, 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.

12. **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 your provider has a direct contract but is not affiliated with a medical group/IPA then you must input “D” in column 3 and leave column 16 blank.

13. **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.

### 2.7.3 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 applicant and the provider. For SAE MA applicants, the grid will also document whether any of the applicant'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 applicants, 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.

**Column Explanations:**

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

2. 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 applicant can be found. Then indicate the specific contract used for each physician reflected in the PCP/Specialist column.

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

### 2.7.4 Table HSD-3: Arrangements for Medicare Required Services by County

**Instructions**:

1. Applicant must arrange contracted entities alphabetically by county and then alphabetically by type of provider. All direct and downstream providers of services should be listed.

2. 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.

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

4. 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.

5. 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.

6. 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. **Steps 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. **Steps 9-28**

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

### 2.7.5 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 applicant and the provider. The grid will also document whether any of the applicant'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 applicant, 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.

**Column Explanations:**

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

2. **Tab Name –** Indicate the Tab Name containing the template contract executed between the provider and the applicant.

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

### 2.7.6 Table HSD-4: Arrangements for Additional and Supplemental Benefits

**Instructions**:

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

2. 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.

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

4. 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.

5. 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.

6. 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.

7. All direct and downstream providers of services should be listed.

8. 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. **Steps 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. **Steps 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.

### 2.7.7 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.

**Column Explanations**:

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

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

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

## 2.8. 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.

## PART 6 LISTS OF REQUESTED DOCUMENTS

The following is a summary of the documentation that must be submitted with the Medicare Advantage application. To assist in the application review Applicant's must submit these documents using the file name provided in the table. Applicants are encouraged to use the file name format that is provided below. If the Applicant is required to provide multiple versions of the same document, the Applicant should insert a number, letter, or even the state behind the file name for easy identification.

### Part 2 Initial Applications--Section 1-- All MA Applicants

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. History/Structure/ Organizational Charts | 1.1 Experience & Organization History | No | PDF. File | HXXX_History-1. pdf |
| 2. CMS Insurance Table Coverage | 1.2 Administrative Management | Yes | PDF. File | HXXX_Insurance-1.pdf |
| 3. State Licensure | 1.3 State Licensure | No | PDF. File | Hxxxx_StateLicense-StateAbbreviation.pdf |
| 4. CMS State Certification Form | 1.3 State Licensure | Yes | PDF. File | Hxxxx_StateCert-StateAbbreviation.pdf |
| 5. State corrective action plan/State Monitoring Explanation | 1.3 State Licensure | No | PDF. File | Hxxxx_UnderStateReview-StateAbbreviation.pdf. |
| 6. State approval of dba | 1.3 State Licensure | No | PDF. File | Hxxxx_StateDBA-StateAbbreviation.pdf |
| 7. (If Applicable) Business Integrity Disclosure | 1.4 Business Integrity | No | PDF. File | Hxxxx_IntegrityDis.pdf |
| 8. Position Description/Organizational Relationship Chart of Key Management Staff | 1.6 Key Management Staff | No | PDF. File | Hxxxx_KeyManagement.pdf |
| 9. (If Applicable) Audited Financial Statements | 1.7 Fiscal Soundness | No | PDF. File | Hxxxx_AuditedStatements.pdf |
| 10. (If Applicable) Annual NAIC Health Blank & Financial Plans | 1.7 Fiscal Soundness | No | PDF. File | Hxxxx_ANAICFinancialPlan.pdf |
| 11. (If Applicable) Quarterly Health Blank. | 1.7 Fiscal Soundness | No | PDF. File | Hxxxx_QuarterlyHealthBlanK.pdf |
| 12. (If Applicable) Financial plan acceptable to CMS, which includes descriptive assumptions, and contains a projected date of break-even (two successive quarters of net income) | 1.7 Fiscal Soundness | No | PDF. File | Hxxxx_FinancialPlan.pdf |

| | | | | |
|---|---|---|---|---|
| 13. (If Applicable) Financial Disclosure | 1.7 Fiscal Soundness | No | PDF. File | Hxxxx_FinancialDisclosure.pdf |
| 14. Partial County Service area justification | 1.8 Service Area | No | PDF. File | Hxxxx_PartialCountyJust.pdf |
| 15. Service Area Geographic Description & Service Area MAPS | 1.8 Service Area | No | PDF. File | Hxxxx_County Name-GeoScrptMaps.pdf |
| 16. CMS Provider Arrangements Table. | 1.9 Provider Contracts & Agreements | Yes | PDF. File | Hxxxx_ProviderTable.pdf |
| 17. Sample copy of each primary provider contract(s) and agreement(s) between the applicant and its health care contractors (i.e., direct contract with physicians, medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.). | 1.9 Provider Contracts & Agreements | No | PDF. File | Hxxxx_PContract-Template 1-PCP.pdf,<br><br>Hxxxx_PContract-Template 2-IPA.pdf |
| 18. Sample copy of each downstream subcontract that may exist between a Medical groups, IPAs, PHO, etc. and other providers (i.e., individual physicians). (For example: If the applicant contracts with an IPA, which contracts with individual physicians the applicant must provide in HPMS a sample copy of the contract/agreement between the IPA and physicians). | 1.9 Provider Contracts & Agreements | No | PDF. File | Hxxxx_ DownstreamContract-Template 1-MG.pdf.<br><br>Hxxxx_DownstreamContract-Template 2_MG.pdf<br><br>Hxxxx_DownstreamContract-Template 1-IPA.pdf |
| 19. CMS Provider Participation Contracts and/or Agreements Matrix | 1.9 Provider Contracts & Agreements | Yes | PDF. File | Hxxxx_ProviderMatrix –Template 1-MG.pdf. |
| 20. Executed Administrative or Management Contracts, letter of agreement | 1.10 Contracts for Administrative & Management Services | No | PDF. File | Hxxxx_AdminContract (number, version, or template).pdf |
| 21. CMS Administrative/Management Delegated Contracting Matrix | 1.10 Contracts for Administrative & Management Services | Yes | PDF. File | Hxxxx_AdminDelContractMatrix (number, version, or template).PDF |
| 22. CMS HSD TABLES 1-5 | 1.11 Health Services Delivery (HSD) | Yes | Excel File | Hxxxx_HSD1.County Name.xls<br><br>Hxxxx_HSD2.County Name.xls |
| 23. Data Use Attestation | 1.18 | Yes | PDF. File | Hxxxx_DUA.pdf |

**Part 2 Initial Applications--Section 2 –RPPO Applicants**

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. State Licensure | 2.1 State licensure RPPO | No | PDF. File | Rxxxx_StateLicense-StateAbbreviation.pdf |
| 2. CMS State Certification form | 2.1 State licensure RPPO | Yes | PDF. File | Rxxxx_StateCert-StateAbbreviation.pdf |
| 3. State approval of dba | 2.1 State licensure RPPO | No | PDF. File | Rxxxx_StateDBA-StateAbbreviation.pdf |
| 4. State corrective action plan/State Monitoring Explanation | 2.1 State licensure RPPO | Yes | PDF. File | Rxxxx_UnderStateReview-StateAbbreviation.pdf. |
| 5. RPPO Access Standards | 2.2 Access Standards | No | PDF. File | Rxxxx_AccesStandards (Urban or Rural).pdf |
| 6. Access standard chart by county | 2.2 Access Standards | No | PDF. File | Rxxxx_AccessStandardsChart (State Abbreviation).pdf |
| 7. RPPO Contingency Access Standards | 2.2 Access Standards | No | PDF. File | Rxxxx_ContingenyPlanAccess.pdf |
| 8. CMS RPPO Essential Hospital Designation Table | 2.3 Essential Hospital | Yes | Excel File | Rxxxx_EssentialTable.xls |
| 9. CMS Attestation Regarding Designation of Essential Hospitals | 2.3 Essential Hospital | Yes | PDF. File | Rxxxx_EssenstialAttest(Hospital Name).pdf |

**Part 2 Initial Applications--Section 3-PPO Applicants**

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. CMS HSD Tables 1-5 | 3.1 Access to Services | Yes | Excel File. | Hxxxx_HSD1.County Name.xls<br><br>Hxxxx_HSD2.County Name.xls |
| 2. Description on how the applicant will follow CMS's national coverage decisions and written decisions and written decision of carriers and intermediaries (LMRP) throughout the United States.[Refer to 42 CFR 422.101 (b)]. | 3.1 Access to Services | No | PDF. File | Hxxxx_NationalCoverageScipt.pdf |
| 3. Description on how applicant's policies will ensure that health services are provided in culturally competent manner to enrollees of different backgrounds. | 3.1 Access to Services | No | PDF. File | Hxxxx_DiversityScrpt.pdf |
| 4. CMS Reimbursement Grid (note: can use CMS model payment guidance) | 3.3 Payment Provisions | Model Guidance | PDF. File | Hxxxx_ReimbursementGrid.pdf |

**Part 2 Initial Applications--Section 4- MSA/ MSA Demo**

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. CMS HSD Table 1-5 (Network MSA model) | 4.2 Access to Services | Yes | Excel File | Hxxxx_HSD1.County Name.xls<br><br>Hxxxx_HSD2.County Name.xls |
| 2. Reimbursement Grid (note: can use CMS model payment guidance) | 4.4 Payment Provisions | Model Guidance | PDF. File | Hxxxx_ReimbursementGrid.pdf |

**Part 2 Initial Applications--Section 5- MSA DEMO ONLY**

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. Description of the differentials in Cost Sharing for supplemental benefits in-network and out-of- network services. | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_CostsharingScript.pdf |
| 2. Description of the preventive services that will have full or partial coverage before the deductible is met. | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_PreventServices.pdf |
| 3. Figures on projected enrollment and the characteristics of beneficiaries who are most likely to enroll in the applicant's plans (for example, what type of Medicare coverage do they currently have?). | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_ProjectedEnrolllment.pdf |
| 4. Description of non-Medicare covered preventive services and whether or not any cost-sharing for these services will apply to the plan deductible | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_NonMedicareSrvcs.pdf |
| 5. Description of the frequency of periodic deposits and how the applicant will address cases where the enrollee incurs high health costs early in the year. | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_DepositsScript.pdf |
| 6. Description on how the applicant will track enrollee usage of information provided on the cost and quality of providers. Must include: how applicant intend to track use of health services between those enrollees who utilize transparency information with those who do not. | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_EnrollmentTracking.pdf |
| 7. Description on how applicant will recover current-year deposit amounts for members who are disenrolled from the plan before the end of the calendar year. | 5.1 MSA Demonstration Addendum | No | PDF. File | Hxxxx_RecoverDeposits.pdf |

## Part 3 Service Area Expansions--Section 1--All MA Applicants

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. State Licensure | 1.2 State Licensure | No | PDF. File | Hxxxx_StateLicense-StateAbbreviation.pdf |
| 2. CMS State Certification Form | 1.2 State Licensure | Yes | PDF. File | Hxxxx_StateCert-StateAbbreviation.pdf |
| 3. State corrective action plan/State Monitoring Explanation | 1.2 State Licensure | No | PDF. File | Hxxxx_UnderStateReview-StateAbbreviation.pdf. |
| 4. State approval of dba | 1.2 State Licensure | No | PDF. File | Hxxxx_StateDBA-StateAbbreviation.pdf |
| 5. CMS Provider Arrangements Table | 1.3 Provider Contracts & Agreements | Yes | PDF. File | Hxxxx_ProviderTable.pdf |
| 6. Sample copy of each primary provider contract(s) and agreement(s) between the applicant and its health care contractors (i.e., direct contract with physicians, medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.). | 1.3 Provider Contracts & Agreements | No | PDF. File | Hxxxx_PContract-Template 1-PCP.pdf,<br><br>Hxxxx_PContract-Template 2-IPA.pdf |
| 7. Sample copy of each downstream subcontract that may exist between a Medical groups, IPAs, PHO, etc. and other providers (i.e., individual physicians). (For example: If the applicant contracts with an IPA, which contracts with individual physicians the applicant must provide in HPMS a sample copy of the contract/agreement between the IPA and physicians). | 1.3 Provider Contracts & Agreements | No | PDF. File | Hxxxx_ DownstreamContract-Template 1-MG.pdf.<br><br>Hxxxx_DownstreamContract-Template 2_MG.pdf<br><br>Hxxxx_DownstreamContract-Template 1-IPA.pdf |
| 8. CMS Provider Participation Contracts and/or Agreements Matrix | 1.3 Provider Contracts & Agreements | Yes | PDF. File | Hxxxx_ProviderMatrix –Template 1-MG.pdf. |
| 9. Executed Administrative or Management Contracts, letter of agreement | 1.4 Contracts for Administrative & Management Services | No | PDF. File | Hxxxx_AdminContract (number, version, or template).pdf |
| 10. CMS Administrative/Management Delegated Contracting Matrix | 1.4 Contracts for Administrative & | Yes | PDF. File | Hxxxx_AdminDelContractMatrix (number, version, or template).PDF |

| | Management Services | | | |
|---|---|---|---|---|
| 11. CMS HSD TABLES 1-5 | 1.5 Health Services Delivery (HSD) | Yes | Excel File | Hxxxx_HSD1.County Name.xls<br><br>Hxxxx_HSD2.County Name.xls |
| 12. Partial County Service area justification using CMS guidance | 1.6 Service Area | No | PDF. File | Hxxxx_PartialCountyJust.pdf |
| 13. Service Area Geographic Description & Service Area MAPS | 1.6 Service Area | No | PDF. File | Hxxxx_County Name-GeoScrptMaps.pdf |

**Part 3 Service Area Expansion--Section 2 --RPPO Applicants**

| Document Requested | Reference within Application | Template Provided | Format | File Name |
|---|---|---|---|---|
| 1. State Licensure | 2.1 State licensure RPPO | No | PDF. File | Rxxxx_StateLicenseNJ.pdf<br><br>Rxxxx_StateLicensePA.pdf |
| 2. CMS State Certification form | 2.1 State licensure RPPO | Yes | PDF. File | Rxxxx_StateCertNY.pdf<br><br>Rxxxx_StateCertGA.pdf |
| 3. State approval of dba | 2.1 State licensure RPPO | No | PDF. File | Rxxxx_StateDBA-NJ.pdf<br><br>Rxxxx_StateDBA-NY.pdf |
| 4. State corrective action plan/State Monitoring Explanation | 2.1 State licensure RPPO | Yes | PDF. File | Rxxxx_UnderStateReview-StateAbbreviation.pdf. |
| 5. RPPO Access Standards | 2.2 Access Standards | No | PDF. File | Rxxxx_AccesStandards (Urban or Rural).pdf |
| 6. Access standard chart by county | 2.2 Access Standards | No | PDF. File | Rxxxx_AccessStandardsChart (State Abbreviation).pdf |
| 7. RPPO Contingency Access Standards | 2.2 Access Standards | No | PDF. File | Rxxxx_ContingenyPlanAccess.pdf |
| 8. CMS RPPO Essential Hospital Designation Table | 2.3 Essential Hospital | Yes | Excel File | Rxxxx_EssentialTable.xls |
| 9. CMS Attestation Regarding Designation of Essential Hospitals | 2.3 Essential Hospital | Yes | PDF. File | Rxxxx_EssenstialAttest(Hospital Name).pdf |

**Part** 4 Solicitation of Special Needs Proposals

| **Document Requested** | **Reference within Application** | **Template Provided** | **Format** | **File Name** |
|---|---|---|---|---|
| 1. Multiple Documents | See subsets within Solicitation | See Attachment Section | Following Instructions | See Solicitation Instructions |

## PART 7 CMS REGIONAL OFFICES

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

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

DIVISION OF MEDICARE HEALTH PLANS
90 7th Street Suite 5-300 (5W), SAN FRANCISCO, CA 94103-6707
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