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PART C -MEDICARE ADVANTAGE APPLICATION

For all new applicants and existing Medicare Advantage contractors seeking to expand a service area -- CCP, PFFS, MSA, RPPO, and SNPs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services (CMS)
Center for Drug and Health Plan Beneficiary Choice (CPC)
Medicare Drug and Health Plan Contract Administration Group (MCAG)

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 this application.

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.

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
- 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.

Either the applicant can 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 cannot 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 Letticia Ramsey in the CMS Central Office at (410) 786-5262, or by email Letticia.Ramsey @cms.hhs.gov or a Regional Office to request assistance. A list of CMS Regional Office contacts 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 that 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 offering a new Medicare Advantage product or expanding the service area of an existing product must complete a Notice of Intent to Apply by November 18, 2008. 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 new 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. Existing MAO's requesting service area expansions do not need to apply for a new MAO number.

7. Due date For MA Application

Applications must be submitted by 11:59 P.M.EST, February 26, 2010. 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
November 18, 2008	New MA organizations: 1. Submit notice of intent to apply to CMS 2. Request HPMS Access (Includes User ID and Password Request) 3. Request CMS Connectivity
January 6, 2009	Final Applications Posted by CMS
February 26, 2009	Applications due
April 1, 2009	First round deficiency emails
April 5, 2009	First round correction due
April 24, 2009	Notices of Intent to deny
May 4, 2009	Reponses to Notice of Intent to Deny due
June 2009	All bids due.
September 2009	CMS completes review and approval of bid data. CMS executes Part C (MA program) contract to organizations that submit an acceptable bid, and otherwise meet CMS requirements.
November 2009	2009 Annual Coordinated Election Period begins for January 1, 2010 effective date for 2010 plans.

* Note: all dates listed above are subject to change.

8. General MA Application Instructions

Applicants must complete the 2010 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 being operationally compliant with the relevant requirement as of the date the Medicare contract is signed.

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 suspension 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 or Linda Anders at 410-786-0459. Specific instructions to guide MA applicants in applying to qualify to offer a Part D benefit during 2010 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, 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 2009 and the CY 2010 bid deadline, the first Monday in June 2009. 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 2009.

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.

10.5 Withdrawing a Pending Initial And Service Area Application Requests:

Prior to the June 1, 2009 MA and MA/PD bid submission date, applicant organizations seeking to withdraw an entire pending application or seeking to withdraw counties and/or zip codes from a pending application must contact CMS by email or send us this type of request. Emails should be sent to MA_Applications@cms.hhs.gov. Mail requests should be addressed to:

MCAG/DMAO/CAT
Attn: Contracting and Application Team
Mail Stop: C4-22-04
7500 Security Blvd.
Baltimore, MD 21244

The official request to withdraw the application, counties and/or zip codes must be submitted to CMS on the organization's letterhead and signed by an authorized corporate official. If an organization's request is emailed, the request itself must be in the form of an attachment in a PDF file. The following information must be included in the letter:

- Applicant Organization's Legal Entity Name
- Full and Correct Address and Point of Contact information for follow-up, if necessary
- Contract Number (H#)
- Exact Description of the Nature of the Withdrawal:
  - Withdrawal from individual Medicare market counties (keeping Medicare employer group counties, e.g., 800 series plan(s)
  - Withdrawal from employer group counties (keeping the individual Medicare market)
  - Withdrawal of the entire application.
  - Withdrawal of specifically named counties from both individual Medicare and employer group markets

10.6 Application Determination Appeal Rights

If CMS determines that the applicant is not qualified to enter into a contract with CMS under Part C of Title XVIII of the Social Security Act and denies this application, the applicant has the right to appeal this determination through a hearing before a CMS Hearing Officer. Administrative appeals of MA-PD application denials are governed by

42 CFR Part 422, Subpart N. The request for a hearing must be in writing, signed by an authorized official of applicant organization and received by CMS within **15 calendar** days from the date CMS notifies the MAO organization of its determination (See 42 CFR 422.662.) If the 15th day falls on a weekend or federal holiday, you have until the next regular business day to submit your request.

The appealing organization must receive a favorable determination resulting from the hearing or review as specified under Part 422, Subpart N prior to July 15, 2009 in order to qualify for a Medicare contract to begin January 1, 2010.

PART 2 INITIAL APPLICATIONS

The MA application must be completed using the HPMS except as indicated otherwise throughout this document. Section 1 of the application, must be completed by all applicants applying for a new contract type (e.g. CCP, PFFS, MSA, or 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, or 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: ADMINISTRATIVE MANAGEMENT	YES	NO
1. Applicant is applying to operate as a Coordinated Care Plan (HMO, Local PPO, and/or PSO).		
2. Applicant is applying to operate as a Regional Preferred Provider Organization.		
3. Applicant is applying to operate as a Private Fee-for-Service organization.		
4. Applicant is applying to operate as a Medical Savings Account plan.		
5. Applicant is applying to operate as a Medical Savings Account demonstration plan.		
6. Has the Applicant non-renewed its contract with CMS within the past 2 years?		
7. Does the applicant currently operate a CMS Cost 1876 contract in the intended service area of this application?		
8. Does the applicant currently offer health plans products to the commercial population?		
9. 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.		
10. 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.		
11. 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.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ADMINISTRATIVE MANAGEMENT	YES	NO
12. 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.		
13. Applicant has administrative and management arrangements that feature insurance policies secured and maintained by the Applicant to insure the Applicant against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks for the contract year. ▪ If "Yes", applicant must provide in HPMS a complete copy of the "CMS Insurance Coverage Table".		
14. 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. In addition, the scope of the license or authority allows the applicant to offer the type of MA plan that it intends to offer in the state or states. • 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 requested. • Note: All licensure requirements (state license and/or state certification form), and other related documents submitted to CMS through HPMS must be met by May 4, 2009.		
2. Applicant is currently under some type of supervision, corrective action plan or special monitoring by the State licensing authority in ANY State. This means that the applicant has to disclose actions in any state against the legal entity that filed this application. • 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 from the name shown on its Articles of Incorporation. • If "Yes", applicant must provide in HPMS a copy of the State approval for the dba.		
4. For states or territories whose license(s) renew after June 1, Applicant agrees to submit the new license.		

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 (first tier, downstream, and related entities), 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, key management or executive staff or 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 corporation if applicable) and its subcontractors (first tier, downstream, and related entities), including key management or executive staff, or 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; upload 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 the 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 as well as a compliance committee accountable to senior management. Note: This requirement cannot be delegated to a subcontractor (first tier, downstream, and related entities).The applicant's compliance officer must be an employee of the applicant. This position cannot be delegated to a subcontractor (first tier, downstream, or related entities).		
4. Applicant will implement a compliance plan that includes effective training and education between the compliance officer, organization employees, contractors, managers and directors and the applicant's first tier, downstream, and related entities. (Note: to the extent that certain aspects of the compliance plan are delegated, it is important to remember that the applicant's compliance officer must maintain appropriate oversight of the delegated activities).		
5. Applicant will implement a compliance plan that includes effective lines of communication between the compliance officer and organization employees, contractors, managers, director's, members of the compliance committee, and the applicant's first tier, downstream, and related entities.		
6. Applicant will implement a compliance plan that includes disciplinary standards that are well-publicized to organization employees, contractors, managers, directors, members of the compliance committee, and the applicant's first tier, downstream, and related entities..		
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. This compliance plan should include		

procedures to voluntarily self report potential fraud or misconduct related to the Part C program to CMS or its designee.		
9. Applicant will implement a compliance plan that includes a comprehensive plan with measures 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, 2010.

1.6 Key Management Staff

A. In the HPMS 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. • 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). • 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). • 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. • 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 applicant's ability to operate its Medicare Advantage contract.		
4. Applicant is in compliance with all State financial requirements and is not under any type of supervision, corrective action plan, or special monitoring by the state regulator. • 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 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. • If "No", applicant must provide in HPMS 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.

D. For each county in the requested service area, there should be four separate maps. The first map should reflect the boundaries of the county as well as main traffic arteries (highways, interstates) and any physical barriers such as mountains or rivers. This map should include contracted ambulatory (outpatient-stand alone) facilities with the mean travel times to each location. The second map should indicate all contracted hospitals, skilled nursing facilities, rehabilitation facilities and psychiatric hospitals. Each specialty type should be delineated as a separate color or symbol. The third map should contain all contracted primary care providers. The fourth map should contain all contracted specialty providers. Each speciality type should be delineated as a separate color or symbol.

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.

Note: The service area for the MSA demonstration plan can only be offered at the entire state or territory level.

1.9 Provider Contracts & Agreements

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PROVIDER CONTRACTS & AGREEMENTS	YES	NO
1. Applicant will comply with the basic rules on provider and suppliers of health care-related services agreements as stated at section 422.504 and Chapter 11 of the Medicare Managed Care Manual.		
2. Applicant agrees that all provider and supplier contracts or agreements contain the following CMS required contract provisions: • HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, records, including medical records, and documentation related to CMS' contract with the MA organization for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. 422.504(i)(2)(i) and (ii). • Contracting providers and suppliers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records. Chapter 11, Medicare Managed Care Manual.		

• 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. Chapter 11, Medicare Managed Care Manual. • 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. Chapter 11, Medicare Managed Care Manual. • A provision requiring that any services performed will be consistent and comply with the MA organization's contractual obligations. 422.504(i)(3)(iii); • The provider agrees to comply with all applicable Medicare laws, regulations, and CMS instructions. 422.504(i)(4)(v) • The agreement must specify that providers agree to comply with the MA organization's policies and procedures. Chapter 11, Medicare Managed Care Manual. • Contracts contain accountability provisions specifying the following 422.504(i)(3)(ii) a. <u>Reporting Responsibilities</u>. The contract must clearly state the delegated activities and reporting responsibilities 422.504(i)(4)(i). b. <u>Revocation</u>. The agreement provides for the revocation of the delegated activities and reporting requirements or specify other remedies in instances when CMS or the MA organization determine that such parties have not performed satisfactorily. 422.504(i)(4)(ii); . c. <u>Monitoring</u>. The agreement provides that the performance of the parties is monitored by the MA organization on an ongoing basis. 422.504(i)(4)(iii); d. <u>Credentialing</u>. The credentials of medical professionals affiliated with the party or parties will be reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization; OR the MA organization must audit the credentialing process on		

an ongoing basis. 422.504(i)(4)(iv) • Ensure contract term dates are clearly stated and the agreement has been executed 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.

Note: As part of the application process, applicants will be instructed to provide a sample of provider contract signatures. Applicants will receive further instructions by their CMS reviewer.

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 (first tier, downstream, and related entities) 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. ▪ (Note: This question is not applicable to non network based PFFS and non-network based MSA plan applicants.)		
8. Network-model applicants will have a delegated entity to perform all or a portion of the utilization and/or quality improvement operations. Note: PFFS or MSA plans are not required to perform utilization operations.		
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)
Beneficiary Call Center(example)	ABC Limited

C. Applicant must provide in HPMS, executed delegated administrative services/management contracts or letters of agreement for each contractor or subcontractor (first tier, downstream, and related entities) identified in the chart (Section 1.10 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 (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities)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 (first tier, downstream, and related entities) will make its books and other records including medical records and documentation involving transactions related to CMS' contract with the MA organization 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. Language must be included to specify whether the applicant and the subcontractor have agreed that CMS or its designees may have direct access to the subcontractor's records (e.g. on-site access to the subcontractor).

- Contains language that the subcontractor (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities), that such activity or responsibility is in accordance to 42 CFR 504 (i) (3) and clearly indicates that any books, contracts, records, including medical records and documentation relating to the Part C program will be provided to either the contractor to provide to CMS or will be provided directly to CMS or its designees; and 2) may be revoked if CMS or the MA contractor determines the subcontractor (first tier, downstream, and related entities) has not performed satisfactorily. 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 (first tier, downstream, and related entities) 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: a. Timeliness of access to care. b. Individual medical necessity determinations. c. Plan providers are convenient to the population served, do not discriminate against Medicare enrollees, and services are available 24 hours a day, 7 days a week, when medically necessary. d. Services are provided in a culturally competent manner.		
3. Applicant will provide continuity of care and integration of services through arrangements with contracted or deemed providers that include: a. Policies that is specific to services that are coordinated and the methods for coordination. b. An offer to provide each enrollee with an ongoing source of primary care or other means. c. Coordinate care with community and social services in the MA plan service area. d. Procedures to ensure timely communication of clinical information among providers. e. Procedures to ensure that enrollees are informed of their health care needs that require follow-up, and f. Processes to address barriers to enrollee compliance with prescribed treatments or regimens.		
4. Applicant will ensure access and availability by: a. Establishing a panel of primary care providers (PCPs). 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. 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. Note: This question is not applicable to PFFS or MSA non-network model applicants.		
5. Applicant will ensure providers are credentialed including procedures for selection and evaluation of providers.		

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
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

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 on-clinical services that can be expected to have a beneficial effect on health outcomes and 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.		
11. Applicant will ensure the capacity and functions of the health information systems for the collection and reporting of Quality Improvement Program data		

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 CMS regulations, marketing guidelines and guidance that are posted on CMS website.		
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: • Enrollment Instruction Forms • Beneficiary Procedural Rights • Potential for Contract Termination • Summary of Benefits • Evidence of Coverage • Premiums • Service Area • Provider Directory • Privacy Notice		
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 standards: • 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. • 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. • After March 2nd, a customer service representative or an automated phone system may answer beneficiary calls on Saturdays, Sundays and holidays. • Eighty percent of all incoming customer calls are answered within 30 seconds. • The abandonment rate of all incoming customer calls does not exceed 5 percent. • Call center provides thorough information about the MA benefit plan, including co-payments, deductibles, and network providers. • Call center features an explicit process for handling customer complaints. • 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.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MARKETING	YES	NO
7. Applicant agrees that the Annual Notice of Change (ANOC) / Summary of Benefits (SB) / Evidence of Coverage will be received by members by the 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: • Applicant ensures that enrollee has not been medically determined to have ESRD, • Applicant verifies that enrollee resides in the service area of the MA applicant, • 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, such as: the Annual Enrollment Period, the Open Enrollment Period, the Medicare beneficiary's Initial Enrollment Period, and any Special Enrollment Periods for which a beneficiary is entitled.		
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 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: • Submit a disenrollment notice to the CMS within timeframes specified by CMS. • Provide enrollee with notice of disenrollment in a format specified by CMS. • File and Retain disenrollment requests for the period specified in CMS instructions and • In case of where lock-in applies, include in the notice a statement explaining that he or she – o Remains enrolled until the effective date of disenrollment; and 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 all standards and requirements regarding involuntary disenrollment of an individual initiated by the MA organization for any circumstances listed below: • Any monthly basic or supplementary beneficiary premiums are not paid on a timely basis is subject to the grace period for late payment. • Individual has engaged in disruptive behavior. • 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: • Be provided to the individual before submission of the disenrollment to CMS. • 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 **Working Aged Membership**

In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: WORKING AGED MEMBERSHIP	YES	NO
1. Applicant agrees to identify and report to CMS individuals that are working aged.		
2. The applicant agrees to: • Identify payers that are primary to Medicare. • Identify the amounts payable by those payers. • 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. • If "Yes", (Stop here, and go to Section 1.15).		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MINIMUM ENROLLMENT	YES	NO
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. • 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, adopt appropriate timelines, policies and procedures and train the relevant staff and subcontractors (first tier, downstream, and related entities) 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: • Date of receipt of the grievance • Mode of receipt of grievance (i.e. fax, telephone, letter, etc.) • Person or entity that filed the grievance • Subject of the grievance • Final disposition of the grievance • Date the enrollee was notified of the disposition		
5. Applicant agrees to advise MA enrollees of their right to have any grievances between the enrollee and MAO addressed and resolved by the MAO and will ensure enrollees are informed of the following • Explanation/definition of grievance • When an enrollee might want to file a grievance • Process and timeframes for resolving grievances		
6. Applicant will make enrollees aware of the complaint process that is available to the enrollee under the Quality Improvement Organization (QIO) process.		
7. Applicant will comply with all applicable standards, requirements and establish meaningful procedures to accept, identify, track and resolve enrollee grievances.		

Note: A grievance is any complaint or dispute, other than one that involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider or facility. An expedited grievance may also include a compliant that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

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. These include requests 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: Date of receipt;		

Date of any notification; Disposition of request; and Date of disposition 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 (first tier, downstream, and related entities), 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 (first tier, downstream,, and related entities) 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.		

C. 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 (if applicable) 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. 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. 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: 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. In addition, the scope of the license or authority allows the applicant to offer the type of MA plan that it intends to offer in the state(s), • 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 • Note: All licensure requirements (state license and/or state certification form) and related documents submitted to CMS through HPMS must be met by May 4, 2009.		
2. Applicant is licensed under state law as a 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 has applied for additional state licenses for the remaining states in 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 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. This means that the applicant has to disclose actions in any state against the legal entity that		

filed this application. • 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 from 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: 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: 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 b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards 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: 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 b. discussion of patterns of care and how geo-access or other		

methods of analysis were used to develop the standards 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 area 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 non-network PFFS model only per 42 CFR 422.114(a)(2)(i)		
2. Applicant will offer a network PFFS model only per 42 CFR 422.114(a)(2)(ii). (Note: If the applicant has established payment rates that are less than Original Medicare for all Medicare covered services under the MA PFFS plan, then the Applicant must offer a network PFFS model.)		
3. Applicant will offer a combination PFFS Model that meet CMS' access requirements per 42 CFR 422.114(a)(2)(iii) (Note: If the applicant has established payment rates that are less than Original Medicare for one or more categories of Medicare covered services under the MA PFFS plan, then the Applicant must offer a combination PFFS model.)		
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, to meet the access standards described in section 1852(d)(i) of the Act.		
5. If providing a combination network, Applicant is providing a direct contracted network for the following Medicare covered services. DROP DOWN BOX WITH THE FOLLOWING SERVICES: • Acute Inpatient Hospital Care • Diagnostic & Therapeutic Radiology (excluding mammogram) • DME/Prosthetic Devices • Home Health Services • Lab Services • Mental Illness – Inpatient Treatment • Mental Illness – Outpatient Treatment • Mammography • Renal Dialysis – Outpatient • SNF Services • Surgical Services (outpatient or ambulatory) • Therapy – Outpatient Occupational/Physical • Therapy – Outpatient Speech • Transplants (Heart, Heart and Lung, Intestinal, Kidney, Liver, Lung, Pancreas) • Other (Provide thorough description of proposed services, including		

rationale for providing a contract network for the proposed service) **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.** 6. 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).		
7. 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: 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/MSA claims		
3. Applicant agrees to sign an attestation to the PFFS/MSA 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.		
6. 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.		

3.3 Payment Provisions (This section may be applicable to PFFS, MSA & MSA Demo Plans)

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 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 meets 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). Note: For PFFS Plans only		
3. The Applicant has a system in place to ensure that members are not charged more in cost sharing or balance billed for more than the amounts specified in the PFFS plan's terms and conditions of payment. [Refer to 42 CFR 422.216(c)]. Note: For PFFS Plans Only		

4. Applicant agrees that information in the Payment Reimbursement Grid is true and accurate.		
5. 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.		
6. The Applicant has a system in place to timely furnish an advance determination of coverage based upon a verbal or written request by a member or provider.		
7. Applicant has a system in place that allows the applicant to obtain payment information for any Medicare approved provider throughout the nation.		
8. The Applicant has a system in place to ensure members are not charged after the deductible has been met. [Refer to 42 CFR 422.103 (c)].		

A. Provide in HPMS, a completed Payment 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 " Section 3: section three "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 under PFFS)*

4.3. Claims Systems *(See Section 3.2 under PFFS)*

4.4 Payment Provisions *(See Section 3.3 under PFFS)*

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SECTION 5 MSA DEMONSTRATION APPLICANTS ONLY

5.1 MSA Demonstration Addendum

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 except RPPO's

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. In addition the scope of the license or authority allows the applicant to offer the type of MA plan that it intends to offer in the state or states. • 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. • Note: All licensure requirements (state license and/or state certification form) and related documents submitted to CMS through HPMS must be met by May 4, 2009.		
2. Applicant is currently under supervision (i.e. corrective action plan, special monitoring, etc.) by the State licensing authority in ANY State. This means that the applicant has to disclose actions in any state against the legal entity that filed this application. • 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. • If "Yes", provide as an attachment in HPMS a copy of the State approval for the dba.		
4. For states or territories whose license(s) renew after June 1, Applicant agrees to submit the new license.		

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 agreements as stated at section 422.504 and Chapter 11 of Medicare Managed Care Manual.		
2. Applicant agrees that all provider and supplier contracts or agreements contain the following CMS required contract provisions: • HHS, the Comptroller General of their designee have the right to audit, evaluate, and inspect any books, contracts, records, including medical records, and documentation related to CMS' contract with the MA organization for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. 422.504(i)(2)(i) and (ii); • Contracting providers and suppliers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records. Chapter 11, Medicare Managed Care Manual. • 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. Chapter 11, Medicare Managed Care Manual. • 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. Chapter 11, Medicare Managed Care Manual. • A provision requiring that any services performed will be consistent and comply with the MA organization's contractual obligations. 422.504(i)(3)(iii).		

• The provider agrees to comply with all applicable Medicare laws, regulations, and CMS instructions. 422.504(i)(4)(v) • The agreement must specify that providers agree to comply with the MA organization's policies and procedures. Chapter 11, Medicare Managed Care Manual. • Contracts contain accountability provisions specifying the following: a. Reporting Responsibilities. The contract must clearly state the delegated activities and reporting responsibilities 422.504(i)(4)(i). b. Revocation. The agreement provides for the revocation of the delegated activities and reporting requirements or specify other remedies in instances when CMS or the MA organization determine that such parties have not performed satisfactorily. 422.504(i)(4)(ii); . c. Monitoring. The agreement provides that the performance of the parties is monitored by the MA organization on an ongoing basis. 422.504(i)(4)(iii); d. Credentialing. The credentials of medical professionals affiliated with the party or parties will be reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization; OR the MA organization must audit the credentialing process on an ongoing basis. 422.504(i)(4)(iv) • Ensure contract term dates are clearly stated and the agreement has been and executed by all parties.		
4. Applicant has executed provider and supplier contracts in place to demonstrate access and availability of the requested service area.		
5. 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.

Note: As part of the application process, applicants will be instructed to provide a sample of provider contract signatures. Applicants will receive further instructions by their CMS application reviewer.

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 (first tier, downstream, and related entities) 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. ▪ (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. ▪ (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	All SUBCONTRACTOR(S) , including downstream.

C. Provide in HPMS executed delegated administrative services/management contracts or letters of agreement for each contractor or subcontractor (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities)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 (first tier, downstream, and related entities) will make its books and other records including medical records and documentation involving transactions related to CMS' contract with the MA organization 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. Language must be included to specify whether the applicant and the subcontractor have agreed that CMS or its designees may have direct access to the subcontractor's records (e.g. on-site access to the subcontractor).

- Contains language that the subcontractor (first tier, downstream, and related entities) 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 (first tier, downstream, and related entities), that such activity or responsibility is in accordance to 42 CFR 504 (i) (3) and clearly indicates that any books, contracts, records, including medical records and documentation relating to the Part C program will be provided to either the contractor to provide to CMS or will be provided directly to CMS or its designees; and 2) may be revoked if CMS or the MA contractor determines the subcontractor (first tier, downstream, and related entities) has not performed satisfactorily. 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 (first tier, downstream, and related entities) 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: a. Timeliness of access to care. b. Individual medical necessity determinations. 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 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: a. Policies specific to services that are coordinated and the methods for coordination. b. An offer to provide each enrollee with an ongoing source of primary care or other means. c. Coordinate care with community and social services in the MA plan service area. d. Procedures to ensure timely communication of clinical information among providers. e. Procedures to ensure that enrollees are informed of their health care needs that require follow-up, and f. Processes to address barriers to enrollee compliance with prescribed treatments or regimens.		
4. Applicant will ensure access and availability by: a. Establishing a panel of primary care providers (PCPs). 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. 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.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING QUALIFICATIONS FOR HEALTH SERVICES DELIVERY	YES	NO
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. ▪ 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.

For each county in the requested service area, there should be four separate maps. The first map should reflect the boundaries of the county as well as main traffic arteries (highways, interstates) and any physical barriers such as mountains or rivers. This map should include contracted ambulatory (outpatient-stand alone) facilities with the mean travel times to each

location. The second map should indicate all contracted hospitals, skilled nursing facilities, rehabilitation facilities and psychiatric hospitals. Each facility type should be delineated as a separate color or symbol. The third map should contain all contracted primary care providers. The fourth map should contain all contracted specialty providers. Each specilaity type should be delineated as a separate color or symbol.

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.

1.7. 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).		

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. In addition, the scope of the license or authority allows the applicant to offer the type of MA plan that it intends to offer in the		

state or states. • 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 requested. • Note: All licensure requirements (state license and/or state certification form) and other related documents submitted to CMS through HPMS must be met by May 4, 2009.		
2. Applicant is licensed under state law as risk-bearing entity eligible to offer health insurance or 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. This means that the applicant has to disclose actins to any state against the same legal entity as the applicant. If "Yes", provide in HPMS and as an attachment, an explanation of the specific actions taken by the State licensure regulator.		
5. Applicant conducts business as "doing business as " (dba) or uses a name different than the name shown on it Articles of Incorporation. If "Yes", provide in HPMS and as an attachment a copy of the State approval for the dba.		

B. Provide in HMPS, a complete "CMS State Licensing Status for MA Regional PPOs 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 thank licensing laws and laws relating to plan solvency.

NOTE: For states 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:

A.

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: 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: 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 b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards 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: 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 b. discussion of patterns of care and how geo-access or other methods of analysis were used to develop the standards 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: 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

Beginning with the 2010 contract year all Medicare Advantage (MA) Special Needs Plans (SNP) must meet the requirements set forth under the Medicare Improvements for Patients and Providers Act of 2008, P.L.110-275 (MIPPA). MIPPA extended the authority for SNPs through the end of 2010 and added significant new provisions for MAs that want to apply or continue to offer SNPs. MIPPA placed a moratorium to designate other plans as SNPs, beginning January 1, 2010 and ending December 31, 2010. This precludes CMS from approving "disproportionate share" SNPs. For the 2010 MA contract year, an applicant requesting to offer a new SNP will only be approved as an exclusive SNP. The remainder of this introductory section provides an overview of the MIPPA requirements for SNPs which are effective January 1, 2010.

Specific Requirements for Dual-eligible SNPs: All applicants who want to offer a new or expand the service area of an existing dual-eligible SNP must have a contract with the State Medicaid agency covering the MA SNP contracting period. Under the contract, the MA organization must retain responsibility for providing, or arranging for benefits to be provided, for individuals entitled to receive medical assistance under Title XIX. Such benefits may include long-term care services consistent with State policy.

MA organizations with an existing dual-eligible SNP without a State Medicaid agency contract may continue to operate with out a State Medicaid agency contract through 2010, provided all other statutory requirements are met, i.e., care management and quality improvement program requirements. However, they may not expand their service area for the 2010 MA contract year. After 2010, all existing dual-eligible SNPs without a State Medicaid agency contract will be required to have a State Medicaid agency contract for the 2011 MA contract year. In addition, the statute specifically made it clear that State Medicaid agencies are not required to enter into contracts with MA organizations for dual-eligible SNPs.

Dual-eligible SNPs must provide each prospective enrollee, prior to enrollment, with a comprehensive written statement of benefits and cost-sharing protections under the SNP as compared to protections under the relevant State Medicaid plan and limits the dual-eligible SNP from imposing cost-sharing requirements on dual-eligible individuals that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the dual-eligible SNP. This requirement is to assist a prospective dual-eligible enrollee to determine if he/she will receive any value from enrolling in the dual-eligible SNP that is not already available under the State Medicaid program.

Specific Requirements for Institutional SNPs: Institutional SNPs that enroll individuals living in the community but requiring an institutional level of care are required to use the State assessment tool to determine the need for institutional level of care. The assessment must be performed by an entity other than the MA organization offering the SNP.

Specific Requirements for Severe or Disabling Chronic Condition SNPs: A severe or disabling chronic condition SNP is now defined as a special needs plan that exclusively serves an individual who has a severe or disabling chronic condition and must determine that the

individual has one or more co-morbid and medically complex chronic conditions that are substantially disabling or life-threatening, has a high risk of hospitalization or other significant adverse health outcomes, and requires specialized delivery systems across domains of care.

As directed by MIPPA, CMS is in the process of convening a clinical advisors panel to determine the conditions that meet the definition of severe and disabling chronic conditions. CMS will issue guidance after the conclusion of the panel findings.

Requirements for All (both new and existing) SNPs:

Enrollment Requirements: Both existing and new SNPs can only enroll individuals who meet the statutory definition of special needs individual for the specific SNP. Applicants should refer to the definition section below to assure that their proposal will comply with enrolling only those beneficiaries who meet the statutory definition of special needs individual for their specific type SNP.

Care Management Requirements: All SNPs are required to implement an evidence-based model of care having two explicit components. The first component is an appropriate network of providers and specialists to meet the specialized needs of the SNP target population. The second component is a battery of care management services that includes 1) a comprehensive initial assessment and annual reassessments, 2) an individualized plan of care having goals and measurable outcomes, and 3) an interdisciplinary team to manage care. Listed below are examples that illustrate a variety of ways SNPs have developed and implemented their models of care.

1. SNPs must have appropriate staff trained on the SNP model of care to coordinate and/or deliver standard and add-on services and benefits. One SNP has chosen to contract with a provider network to deliver care in community health clinics while another SNP has hired practitioners to deliver care in the home setting.

2. SNPs must coordinate the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and beneficiaries. One SNP coordinates care through a telephonic link among all stakeholders and a second SNP coordinates care through an electronic system using web-based records and electronic mail exclusively accessed by the plan, network providers, and beneficiaries.

3. SNPs must coordinate the delivery of add-on benefits and services that meet the specific needs of their most vulnerable beneficiaries. A dual-eligible SNP was required by their state contract to provide state-identified services such as transportation to physician visits while an institutional SNP chose to facilitate hospice care for its beneficiaries near the end of life.

4. SNPs must coordinate care through an interdisciplinary team. One SNP team was composed of primary care physicians, nurses, social workers, and appropriate disease management specialists while another SNP team had geriatric specialists, nurse practitioners, clinical pharmacists, and nurse educators to efficaciously meet their beneficiaries' needs.

Quality Reporting Requirements**:** All SNPs are required to collect, analyze, and report data as part of the SNP's quality improvement program to measure health outcomes and other indices of quality at the plan level with respect to the care management model of care.

As an MA plan, each SNP must implement a documented quality improvement program for which all information is available for submission to CMS or for review during monitoring visits. The focus of the SNP quality improvement program should be the monitoring and evaluation of the performance of its model of care. The program should be executed as a three-tier system of performance improvement.

The first tier consists of data on quality and outcomes that is collected and analyzed to enable beneficiaries to compare and select from among health coverage options. In calendar year (CY) 2008, CMS required the submission of thirteen HEDIS measures and three structure and process measures to pilot the development of comparative measures to facilitate beneficiary choice. We continue to work on this initiative and will issue guidance to SNPs on collecting comparative measures for submission using CMS required tools in CY 2009.

The second tier of the quality improvement program supplants § 422.152(b) with § 422.152(g) for SNPs based on the statutory requirement that SNPs collect, analyze, and report data that measures the performance of their plan-specific model of care. This new rule establishes CMS requirements for measuring essential components of the model of care using a variety of plan-determined methodologies such as claims data, record reviews, administrative data, clinical outcomes, and other existing valid and reliable measures (ACOVE, MDS, HEDIS, CAHPS, HOS, OASIS, etc.) at the plan level.

Specifically, SNPs should collect, analyze, and be prepared to report data for its performance on: access to care; improvement in beneficiary health status; care management through its staffing structure and processes; assessment and stratification of health risk; care management through an individualized plan of care; provision of specialized clinical expertise targeting its special needs population; the coordination and delivery of services and benefits through transitions across settings and providers; the coordination and delivery of extra services and benefits that meet the needs of the most vulnerable beneficiaries; the use of evidence-based practices and/or nationally recognized clinical protocols; and the application of integrated systems of communication.

Each SNP must coordinate the systematic collection of data using indicators that are objective, clearly defined, and based on measures having established validity and reliability. Indicators should be selected from a variety of quality and outcome measurement domains such as functional status, care transitioning, disease management, behavioral health, medication management, personal and environmental safety, beneficiary involvement and satisfaction, and family and caregiver support. SNPs must document all aspects of the quality improvement program including data collection and analysis, actions taken to improve the performance of the model of care, and the participation of the interdisciplinary team members and network providers in quality improvement activities.

CMS is developing the third tier of the quality improvement program which is the required reporting of monitoring data. The monitoring data will consist of a prescribed sample of data that SNPs will already be collecting in tier two to measure the performance of their model of care. We will draw from a pool of measures across several service delivery domains, and, whenever possible, use valid measures that SNPs have reported they currently collect. We are also soliciting comments from the public regarding the types of monitoring data CMS should require SNPs to submit. We will issue guidance on the requirement to report monitoring data and the collection methodology after reviewing the public comments and completing development of the initiative for implementation in calendar year 2010.

Definitions:

Full Benefit Dual Eligible (FBDE aka Medicaid only): An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups such as medically needy, or special income levels for institutionalized, or home and community-based waivers.

Qualified Medicare Beneficiary (QMB): An individual entitled to Medicare Part A, has income at the 100% Federal Poverty Level (FPL) or less, and resources that do not exceed twice the SSI limit. This individual is eligible for Medicaid payment of Medicare Part B premium, deductibles, co-insurance and co-pays, (except for Part D).

Qualified Medicare Beneficiary Plus (QMB+): An individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the State. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

Specified Low-Income Medicare Beneficiary (SLMB): An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less then 120% FPL, and resources do not exceed twice the SSI limit. A SLMB is eligible for Medicaid payment of the Medicare Part B premium.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): An individual who meets the standards for SLMB eligibility, but who also meets the criteria for full State Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

Qualified Disabled and Working Individual (QDWI): An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of the Part A premium.

Qualifying Individual (QI): An individual entitled to Medicare Part A, has income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of Medicare Part B premium.

All duals: A SNP that has a State Medicaid agency contract to enroll all categories of Medicaid eligible individuals, who are also Medicare entitled, e.g., FBDE, QMB, QMB+, SLMB, SLMB+, QI and QDWI.

Full duals: A SNP that has a State Medicaid agency contract to enroll Medicaid eligible individuals, who are also Medicare entitled, in the following categories: 1) FBDE, 2) QMB+ and 3) SLMB+.

Zero cost share: A SNP that has a State Medicaid agency contract to enroll Medicaid eligible individuals, who are also Medicare entitled, in the following categories: 1) QMB, 2) QMB+ and 3) any other dual eligible beneficiaries for which the State holds harmless for Part A and Part B cost sharing except Part D.

Medicaid Subset: A SNP that has a State Medicaid agency contract to enroll Medicaid eligible individuals, who are also Medicare entitled, that targets a defined population in order to coordinate services between the Medicare and Medicaid programs. Any enrollment limitations for Medicare beneficiaries under this SNP must parallel any enrollment limitations under the Medicaid program, including the structure and care delivery patterns of the Medicaid program. For example, if a State Medicaid Agency contracts with a plan for a Medicaid wraparound package for certain dual eligible (such as disabled individuals), an MA organization may establish a SNP that limits enrollment to that same subset of dual eligibles. Further, the SNP must provide documentation to CMS regarding their contract with the State Medicaid agency. If applicable, this would include verification as to whether this subset will have zero cost sharing for Medicare Parts A and B for enrolled dual eligible beneficiaries.

Institutional SNP: A SNP that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional SNP to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility/ies.

Institutional equivalent SNP – (living in the community): An institutional SNP that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed by an entity other than the organization offering the SNP. This type of SNP may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) as this may be necessary in order to ensure uniform delivery of specialized care.

SNP Proposal Applications Instructions

Initial (new) SNP

An applicant, including an existing MA contractor, offering a new SNP must submit their SNP proposal by completing the HPMS SNP Proposal Application template. A SNP proposal application must be completed for each SNP type to be offered by the MA.

All applicants requesting to offer a dual-eligible SNP must have a State Medicaid Agency contract or is working with the State Medicaid Agency toward that goal. A dual-eligible SNP must have a State Medicaid Agency contract in place prior to the contract year and the contract must cover the entire contract year to offer a MA SNP for the MA contract year.

In general, CMS recommends and encourages MA applicants to refer to 42 CFR 422 regulations to clearly understand the nature of the requirement. Nothing in this solicitation is intended to supersede the regulations at 42 CFR 422. Failure to reference a regulatory requirement does not affect the applicability of such requirement. Also, other associated MA and Part D applications must also be provided. Applicants must read HPMS notices and visit the CMS web site periodically to stay informed about new or revised guidance documents.

SNP Service Area Expansion (SAE)

An MA contractor, who wants to expand the service area of the SNP, must adhere to the same requirements for submission of an initial SNP proposal application.

A dual-eligible SNP that does not have a State Medicaid Agency contract cannot expand the service area of the existing SNP. If the MA dual-eligible SNP that does not have a State Medicaid Agency contract intends to offer the dual-eligible SNP after 2010, it should take immediate actions to initiate a contract with the State Medicaid Agency.

Existing SNP with no change

An MA contractor, who offers an existing SNP must complete the 1) "Care Management Requirements" and 2) "Quality Reporting Requirements" in the HPMS SNP Proposal Application template.

SNP Proposal Applications

In HPMS, complete the table below:

SNP Proposal Applications	Yes	No	
Applicant is applying to offer a new dual-eligible SNP.			XX
How many new dual-eligible SNPs?	XX	XX	
Applicant is applying to offer a new severe or disabling chronic condition SNP.			XX
How many new severe or disabling chronic condition SNPs?	XX	XX	
Applicant is applying to offer a new institutional SNP.			XX
How many new severe or disabling chronic condition SNPs?	XX	XX	
Applicant is applying to expand an existing dual-eligible SNP.			XX
Applicant is applying to expand an existing severe or disabling chronic condition SNP.			XX
Applicant is applying to expand an existing institutional SNP.			XX

New and Expansion of Existing Dual-eligible SNPs Proposal Applications

In HPMS, complete the table below:

New and Expansion of Existing Dual-eligible SNPs Proposal Applications			
SNP Service Area:			
Provide the service area (State and County codes) for SNP proposal.	XX	XX	XX
Service area covers more than one State. • If yes, go to the next question. • If no, skip the next question.			XX
Provide the names of the States.	XX	XX	XX
State Medicaid Agency Contracts:			
Applicant has an existing contract with the State Medicaid Agency(ies) that covers the SNP service area for the current application year. • If yes, skip the next two questions. • If no, answer the next question.			XX
Applicant has contacted the State Medicaid Agency(ies) and initiated negotiation of a contract. • If yes, go to the next question. • If no, CMS will not approve an applicant to offer a dual-eligible SNP who does not have a signed State Medicaid Agency(ies) contract by September 1 of the current application year.			XX
Applicant will have a signed State Medicaid Agency(ies) contract by September 1 of the current application year. Note: CMS will not approve an applicant to offer a dual-eligible SNP who does not have a signed State Medicaid Agency(ies) contract by September 1 of the current application year to offer a dual-eligible SNP.			XX
Provide copy of the signed State Medicaid Agency(ies) contract.	XX	XX	XX
Provide the State Medicaid contract begin date.	XX	XX	
Provide the State Medicaid Agency(ies) contract end date.	XX	XX	
Does the State Medicaid Agency(ies) contract period extend through the CMS MA contract period? • If yes, skip the next question. • If no, go to the next question.			XX
If the State Medicaid Agency(ies) contract period does not extend through the CMS MA contract period, has the applicant contacted the State Medicaid Agency(ies) and initiated negotiation of a contract extension? • If yes, go to the next question. • If no, CMS will not approve an applicant to offer a dual-eligible SNP who does not have a signed State Medicaid Agency(ies) contract covering the entire MA contract implementation year by September 1 of the current application year.			XX

Provide the State Medicaid Agency(ies) contract approved service area.	XX	XX	XX
State Medicaid Agency(ies) contract enrolled population:			
Applicant has an approved State Medicaid Agency(ies) contract to cover all dual-eligible enrollment categories (QMB, QMB+, SLMB, SLMB+, QDWI, QI, and FBDE). See definition section for the description of these categories.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "full dual-eligible" enrollment category (QMB+, SLMB+ and other full benefit dual-eligible).			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "zero cost sharing" enrollment category (QMB, QMB+ and any other dual-eligible category where the State covers all cost sharing).			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "other full benefit dual-eligible", also known as "Medicaid only," enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Qualified Medicare Beneficiary (QMB) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Qualified Medicare Beneficiary Plus(QMB+) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Specified Low-income Medicare Beneficiary (SLMB) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Specified Low-income Medicare Beneficiary Plus (SLMB+) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Qualifying Individual (QI) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "Qualified Disabled and Working Individual (QDWI) dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "dual-eligible who are institutionalized dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover the "dual-eligible who are institutional equivalent dual-eligible" enrollment category.			XX
Applicant has an approved State Medicaid Agency(ies) contract to cover a Medicaid Subset enrollment category other than those listed above. • If yes, go to the next question. • If no, skip the next question.			XX
Provide a description of the Medicaid Subset for other than what is listed above.	XX	XX	XX
Does the State Medicaid Agency(ies) contract include the Medicaid benefits covered in the SNP? • If yes, go to the next question.			

• If no, skip the next question.			
Provide a description of the Medicaid benefits covered in the State Medicaid contract.	XX	XX	XX
Does the State Medicaid Agency(ies) contract includes the cost-sharing protections covered in the SNP? • If yes, go to the next question. • If no, skip the next question.			
Provide a description of the cost-sharing protections covered in the State Medicaid contract.	XX	XX	XX
Does the State Medicaid Agency(ies) contract includes the identification and sharing of information on Medicaid provider participation? • If yes, go to the next question. • If no, skip the next question.			
Provide a description of the identification and sharing of information on Medicaid provider participation covered in the State Medicaid contract.	XX	XX	XX
Does the State Medicaid Agency(ies) contract includes the MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits? • If yes, go to the next question. • If no, skip the next question.			
Provide a description of the MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits covered in the State Medicaid contract.	XX	XX	XX
Provide the name of the contact individual at the State Medicaid Agency(ies).	XX	XX	XX
Provide the address of the State Medicaid Agency contact person.	XX	XX	XX
Provide the phone number of the State Medicaid Agency contact person.	XX	XX	XX
Provide the e-mail address of the State Medicaid Agency contact person.	XX	XX	XX
Does the applicant have a process to verify Medicaid eligibility of individuals through the State?			XX
Provide a description of the process to verify Medicaid eligibility of individuals through the State.	XX	XX	XX
Does the applicant have a process to coordinate Medicare and Medicaid services for dual-eligible individuals?			
Provide a description of the process.	XX	XX	XX

New and Expansion of Existing Severe or Disabling Chronic Condition SNPs Proposal Applications

In HPMS, complete the table below:

New and Expansion of Existing Severe or Disabling Chronic Condition SNPs Proposal Applications			
SNP Service Area:			
Provide the service area (State and County codes) for SNP proposal.	XX	XX	XX
Does the service area cover more than one State? • If yes, go to the next question. • If no, skip the next question.			XX
Provide the names of the States.	XX	XX	XX
Severe or disabling chronic conditions:			
Applicant will offer a chronic condition SNP covering one or more of the following severe or disabling chronic conditions: • Chronic condition #1 (To be determined)			XX
• Chronic condition #2 (To be determined)			XX
• Chronic condition #3 (To be determined)			XX
• Chronic condition # etc. (To be determined)			XX

New and Expansion of Existing Institutional SNPs Proposal Applications

In HPMS, complete the table below:

New and Expansion of Existing Institutional SNPs Proposal Applications			
SNP Service Area:			
Provide the service area (State and County codes) for SNP proposal.	XX	XX	XX
Does the service area cover more than one State? • If yes, go to the next question. • If no, skip the next question.			XX
Provide the names of the States.	XX	XX	XX
Will the applicant/SNP only enroll individuals residing in institutions?			XX
Will the applicant/SNP only enroll individuals who are institutional equivalents residing in the community?			XX
Will the applicant/SNP enroll individuals residing in institutions and institutional equivalents living in the community?			XX
SNPs enrolling individuals residing in institutions			
Will the applicant/SNP enroll only individuals residing in a long term care facility (SNF) under contract with or owned by the organization offering the SNP?			XX
Provide a list of contracted long-term care facilities.	XX	XX	XX
Is the applicant/SNPs enrolling individuals who are institutional equivalents residing in the community			XX
Provide a list of assisted-living facilities (if applicant/SNP is contracting with ALFs)	XX	XX	XX
Does the applicant/SNP own or have executed contracts with each of the ALFs on the list?			XX
Does the applicant/SNP use the State assessment tool to assess level of care (LOC) for each institutional equivalent beneficiary?			XX
Provide the State LOC assessment tool.	XX	XX	XX
Provide the url for the State LOC assessment tool if accessible on the State website.	XX	XX	XX
Does the SNP use an unrelated third party entity to perform the LOC assessment?			XX
Provide the name of the entity(ies) performing the LOC assessment.	XX	XX	XX
Provide the address of the entity(ies) performing the LOC assessment.	XX	XX	XX

ESRD Waiver Requests

In HPMS, complete the table below:

ESRD Waiver Requests			
Is the applicant requesting an ESRD waiver requests?			XX
Provide a description of how it intends to serve the unique needs of the ESRD enrollees.	XX	XX	XX
Provide a list of the contracted dialysis facility(ies).	XX	XX	XX
Provide a list of the contracted transplant facility(ies).	XX	XX	XX
Provide a description of any additional service(s) provided to members with ESRD.	XX	XX	XX
Provide a description of the interdisciplinary care team coordinator role in the assessment and delivery of services needed by members with ESRD.	XX	XX	XX

SNP Care Management Requirements

In HPMS, complete the table below:

SNP Care Management Requirements (All) **Respond "Yes" or "No" to the following statements:**			
Targeted Special Needs Individuals	**Yes**	**No**	
Applicant has a model of care to manage the delivery of specialized services and benefits to **dual-eligible** special needs individuals.			XX
Applicant has a model of care to manage the delivery of specialized services and benefits to **institutionalized or institutional equivalent** special needs individuals.			XX
Applicant has a model of care to manage the delivery of specialized services and benefits to special needs individuals having **medically complex or multiple chronic conditions**.			XX
Applicant has a model of care to manage the delivery of specialized services and benefits to special needs individuals having **end-stage renal disease**.			XX
Applicant's model of care manages the delivery of specialized services and benefits to vulnerable special needs individuals who are **frail, disabled, or near the end-of-life**.			XX
Goals			
Applicant has written care management policies, procedures, and systems to assure access to **medical services**.			XX
Applicant has written care management policies, procedures, and systems to assure access to **mental health services**.			XX
Applicant has written care management policies, procedures, and systems to assure access to **social services**.			XX
Applicant has written care management policies, procedures, and systems to assure access to **affordable quality care**.			XX
Applicant has written care management policies, procedures, and systems to assure **coordination of care through a central point of contact**.			XX
Applicant has written care management policies, procedures, and systems to assure **seamless transitions across healthcare settings, care providers, and health services**.			XX
Applicant has written care management policies, procedures, and systems to assure access to **preventive health services**.			XX
Applicant has written care management policies, procedures, and systems to assure **appropriate utilization of services**.			XX
Applicant has written care management policies, procedures, and systems to assure **access to continuous care across the life cycle**.			XX
Applicant has written care management policies, procedures, and systems to assure **cost-effective health services delivery**.			XX
Applicant has written care management policies, procedures, and systems **to reduce hospitalization and nursing facility placement**.			XX
Applicant has written care management policies, procedures, and systems to improve beneficiary health status through improved **independence and self-management**.			XX

Applicant has written care management policies, procedures, and systems to improve beneficiary health status through improved **mobility and functional status**.			XX
Applicant has written care management policies, procedures, and systems to improve beneficiary health status through improved **pain management**.			XX
Applicant has written care management policies, procedures, and systems to improve beneficiary health status through improved **quality of life perception**.			XX
Applicant has written care management policies, procedures, and systems to improve beneficiary health status through improved **satisfaction with health status and healthcare services**.			XX
Staff Structure and Roles			
Applicant has appropriate staff to coordinate benefits, plan information, and data collection and analysis for beneficiaries, network providers, and the public. Staff include some or all of the following: • Benefit coordinator, account liaison, plan representative			XX
• Data analyst			XX
• Utilization coordinator			XX
• Quality improvement specialist			XX
• HIPAA compliance officer			XX
• Government compliance officer			XX
• Trainer			XX
Applicant assures that staff coordinates benefits, plan information, and data collection and analysis for beneficiaries, network providers, and the public by performing tasks including some or all of the following: • Oversees plan operations and develops policies			XX
• Authorizes and/or facilitates access to specialists and therapies			XX
• Advocates, informs, educates beneficiaries on services and benefits			XX
• Develops and updates individualized care plan for beneficiaries			XX
• Manages care and pharmacotherapy through an interdisciplinary team			XX
• Coordinates care across settings and providers			XX
• Conducts medical chart reviews			XX
• Identifies and facilitates access to community resources and social services			XX
• Monitors provision of services and benefits to ensure follow-up			XX
• Conducts medication reviews			XX
• Conducts a quality improvement program			XX
• Processes claims			XX
• Assures statutory and regulatory compliance			XX
• Triages beneficiaries care needs			XX
• Reviews and analyzes utilization data			XX
• Conducts risk assessment			XX
Applicant has appropriate staff to perform care management and coordination of services and benefits. These staff include some or all of the following: • Care manager or coordinator			XX
• Durable medical equipment coordinator			XX
• Utilization review coordinator			XX
• Discharge planning specialist			XX

• Nurse manager or coordinator			XX
• Health information specialist			XX
Applicant assures that care management staff performs duties including some or all of the following: • Maintains a call center for 24-hour telephonic care management			XX
• Maintains a call center for business hours telephonic care management			XX
• Facilitates the implementation of the individualized care plan for each beneficiary			XX
• Maintains a website for beneficiary educational material and plan information			XX
• Schedules or facilitates scheduling appointments and follow-up services.			XX
• Facilitates transportation services			XX
• Maintains the electronic health information database			XX
• Requests consultation and diagnostic reports from network specialists			XX
• Facilitates translation services			XX
Applicant has appropriate staff to perform administrative and clinical oversight duties. These staff include some or all of the following: • Medical Director			XX
• Medical advisory panel			XX
• Board of Directors, Governing Body			XX
• Administrator, director, executive staff			XX
Applicant assures that staff effectively performs administrative and clinical oversight duties. These duties include some or all of the following: • Observe care being rendered			XX
• Review medical charts			XX
• Conduct performance assessments			XX
• Conduct and/or observe interdisciplinary team meetings			XX
• Survey beneficiaries, plan personnel and network providers			XX
• Evaluate the effectiveness of the model of care			XX
Interdisciplinary Care Team			
Applicant assigns each beneficiary to an interdisciplinary care team composed of primary, ancillary, and specialty care providers. Members of the interdisciplinary care team include some or all of the following: • Primary care physician			XX
• Nurse practitioner, physician's assistant, mid-level provider			XX
• Social worker, community resources specialist			XX
• Registered nurse			XX
• Restorative health specialist (physical, occupational, speech, recreation)			XX
• Behavioral and/or mental health specialist (psychiatrist, psychologist, drug or alcohol therapist)			XX
• Board-certified physician			XX
• Dietitian, nutritionist			XX
• Pharmacist, clinical pharmacist			XX
• Disease management specialist			XX
• Nurse educator			XX
• Pastoral specialists			XX

• Caregiver/family member			XX
• Preventive health/health promotion specialist			XX
Applicant assures that the interdisciplinary care team works together to manage beneficiary care by performing duties including some or all of the following: • Develop and implement an individualized care plan with the beneficiary/caregiver			XX
• Conduct care coordination meetings on a regular schedule			XX
• Conduct face-to-face meetings			XX
• Maintain a web-based meeting interface			XX
• Maintain web-based electronic health information			XX
• Conduct case rounds on a regular schedule			XX
• Maintain a call line or other mechanism for beneficiary inquiries and input			XX
• Conduct conference calls among plan, providers, and beneficiaries			XX
• Develop and disseminate newsletters or bulletins			XX
• Maintain a mechanism for beneficiary complaints and grievances			XX
• Use e-mail, fax, and written correspondence to communicate			XX
Provider Network			
Applicant has a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. The provider and facility network delivers services beyond the scope of the interdisciplinary team including some or all of the following: • Acute care facility, hospital, medical center			XX
• Laboratory			XX
• Long-term care facility, skilled nursing facility			XX
• Pharmacy			XX
• Radiography facility			XX
• Rehabilitative facility			XX
• Advanced degree social workers			XX
• Board-certified cardiology specialists			XX
• Board-certified chiropractic specialists			XX
• Board-certified dentists			XX
• Board-certified dermatology specialists			XX
• Board-certified ear, nose, & throat (ENT) specialists			XX
• Board-certified endocrinology specialists			XX
• Board-certified family practice specialists			XX
• Board-certified gastroenterology specialists			XX
• Board-certified general practice specialists			XX
• Board-certified general surgery specialists			XX
• Board-certified geriatric specialists			XX
• Board-certified gynecology specialists			XX
• Board-certified infectious disease specialists			XX
• Board-certified internal medicine specialists			XX
• Board-certified nephrology specialists			XX
• Board-certified neurology specialists			XX
• Board-certified oncology specialists			XX

• Board-certified ophthalmology specialists			XX
• Board-certified oral surgery specialists			XX
• Board-certified orthopedic specialists			XX
• Board-certified pathology specialists			XX
• Board-certified podiatry specialists			XX
• Board-certified psychiatrists			XX
• Board-certified pulmonology specialists			XX
• Board-certified radiology specialists			XX
• Board-certified rheumatology specialists			XX
• Board-certified surgery specialists			XX
• Board-certified urology specialists			XX
• Board-certified vascular surgery specialists			XX
• Mental health specialists			XX
• Mid-level practitioners (nurse practitioner, physician assistant)			XX
• Registered nurses and other nursing professionals			XX
• Registered pharmacists			XX
• Registered physical and occupational therapists			XX
• Registered respiratory therapists			XX
• Registered speech therapists			XX
Applicant assures that the provider and facility network having specialized clinical expertise pertinent to the targeted special needs population delivers services beyond the scope of the interdisciplinary team. Specialized clinical experts' duties include some or all of the following: • Assess, diagnose, and treat in collaboration with the interdisciplinary team			XX
• Provide 24-hour access to a clinical consultant			XX
• Conduct conference calls with the interdisciplinary team on a regular basis			XX
• Assist with developing and updating individualized care plans			XX
• Conduct disease management programs			XX
• Provide wound management services			XX
• Provide pharmacotherapy consultation and management clinics			XX
• Conduct home visits for clinical assessment or treatment			XX
• Conduct home safety assessments			XX
• Conduct risk prevention programs such as fall prevention or wellness promotion			XX
• Provide telemonitoring services			XX
• Provide telemedicine services			XX
• Provide in-patient acute care services			XX
• Provide hospital-based or urgent care facility-based emergency services			XX
• Provide long-term facility care			XX
• Provide home-based palliative or end-of-life care			XX
• Provide home health services			XX
Applicant has a process to coordinate the delivery of standard services and benefits through a provider and facility network having clinical expertise pertinent to the targeted special needs population. The process includes some or all of the following: • The plan contracts with providers having the clinical expertise to meet the			XX

specialized needs of the targeted SNP population			
• The plan contracts with facilities that provide diagnostic and treatment services to meet the specialized needs of the targeted SNP population			XX
• The plan has policies and procedures that direct how the network providers and facilities will deliver services to beneficiaries			XX
• The plan's administrative staff, acting as gatekeeper, approves all referrals to the provider network prior to the delivery of services and notifies the interdisciplinary care team			XX
• The beneficiary's interdisciplinary care team, acting as gatekeeper, approves all referrals to the provider network prior to the delivery of services and notifies the plan's administrative staff			XX
• The beneficiary directly contacts providers within the plan's network to schedule necessary services and notifies the plan and/or interdisciplinary team			XX
• The plan's administrative staff, acting as gatekeeper, determine whether beneficiaries require services outside the existing provider network and approve services prior to delivery and notifies the interdisciplinary care team			XX
• The beneficiary's interdisciplinary care team, acting as gatekeeper, determines whether beneficiaries require services outside the existing provider network and approve services prior to delivery and notifies the plan's administrative staff			XX
• The beneficiary directly contacts providers outside the plan's network to schedule necessary services and notifies the plan and/or interdisciplinary team			XX
• The plan has a specialist to track and analyze services and benefits utilization			XX
• The plan disseminates the results of the utilization analysis to the interdisciplinary care team			XX
• The plan contacts beneficiaries to remind them about upcoming appointments			XX
• The plan contacts beneficiaries to follow-up on missed appointments			XX
Applicant has policies, procedures, and a system to coordinate the delivery of care across all healthcare settings, providers, and services to assure continuity of care. The system includes some or all of the following: • The plan has policies and procedures that direct how the network providers and facilities will deliver services to beneficiaries including transition of care from setting-to-setting, provider-to-provider, and provider-to-facility			XX
• The plan's administrative staff, acting as gatekeeper, coordinates the delivery of services to beneficiaries including transition of care from setting-to-setting, provider-to-provider, provider-to-facility, and notification to the interdisciplinary care team			XX
• The beneficiary's interdisciplinary care team, acting as gatekeeper, coordinates the delivery of services to beneficiaries including transition of care from setting-to-setting, provider-to-provider, provider-to-facility, and notification to the plan's administrative staff			XX
• The beneficiary directly contacts providers within the plan's network to schedule necessary services and notifies the plan and/or interdisciplinary team			XX
• The beneficiary directly contacts providers outside the plan's network to schedule necessary services and notifies the plan and/or interdisciplinary team			XX
• The plan has a specialist to track and analyze transitions of care to assure timeliness and appropriateness of services and benefits			XX

• The plan disseminates the results of the transition of care analysis to the interdisciplinary care team			XX
• The plan contacts beneficiaries to monitor their status after a transition of care from provider-to-provider, facility-to-facility, or provider-to-facility			XX
Applicant assures its providers deliver evidence-based services in accordance with nationally recognized clinical protocols and guidelines when available (see the Agency for Healthcare Research and Quality's National Guideline Clearinghouse at http://www.guideline.gov/). Assurance includes some or all of the following: • The plan has a written policy and procedures to assure that employed providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available			XX
• The plan has a written contract that stipulates contracted providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available			XX
• The plan conducts periodic monitoring of employed and contracted providers to assure that nationally recognized clinical protocols and guidelines are used when available and maintains monitoring data for review during CMS monitoring visits			XX
Applicant has policies, procedures, and a system to coordinate the delivery of add-on benefits and services that meet the specialized needs of the most vulnerable including frail/disabled beneficiaries and beneficiaries near the end of life. The system includes some or all of the following: • The plan contracts with providers having the clinical expertise to meet the specialized needs of frail/disabled beneficiaries and beneficiaries near the end of life			XX
• The plan contracts with facilities that provide diagnostic and treatment services to meet the specialized needs of frail/disabled beneficiaries and beneficiaries near the end of life			XX
• The plan has policies and procedures that direct how the network providers and facilities will deliver services to frail/disabled beneficiaries and beneficiaries near the end of life			XX
• The plan's interdisciplinary care team uses health risk assessment findings, medical history, and current clinical diagnostics and assessments to develop individualized care plans that identify standard and add-on benefits and services required by frail/disabled beneficiaries and beneficiaries near the end of life			XX
• The plan's administrative staff, acting as gatekeeper, approves all referrals for frail/disabled beneficiaries and beneficiaries near the end of life to the appropriate specialized providers prior to the delivery of services, and notifies the interdisciplinary care team			XX
• The beneficiary's interdisciplinary care team, acting as gatekeeper, approves all referrals for frail/disabled beneficiaries and beneficiaries near the end of life to the appropriate specialized providers prior to the delivery of services, and notifies the interdisciplinary care team			XX
• The beneficiary directly contacts providers within the plan's network to schedule necessary services and notifies the plan and/or interdisciplinary team			XX
• The beneficiary directly contacts providers outside the plan's network to			XX

schedule necessary services and notifies the plan and/or interdisciplinary team			
• The plan has a specialist to track and analyze services and benefits utilization			XX
• The plan disseminates the results of the utilization analysis to the interdisciplinary care team			XX
• The plan contacts beneficiaries to remind them about upcoming appointments			XX
• The plan contacts beneficiaries to follow-up on missed appointments			XX
• The plan offers transportation to facilitate access to services for frail/disabled beneficiaries and beneficiaries near the end of life			XX
Model of Care Training			
Applicant has appropriate staff (employed, contracted, or non-contracted) trained on the model of care to coordinate and/or deliver all services and benefits including some or all of the following: • All SNP employees having initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations			XX
• All SNP contractors having initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations			XX
• All network providers having initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations			XX
• All temporary non-contracted staff having initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations			XX
Applicant has a training strategy that uses a variety of methods including some or all of the following: • Face-to-face training			XX
• Web-based interactive training			XX
• Self-study program (electronic media, print materials)			XX
Health Risk Assessment			
Applicant has written policies, procedures, and a system to coordinate a comprehensive initial health risk assessment of the medical, functional, cognitive, and psychosocial status as well as annual health risk reassessments of each beneficiary. The system includes some or all of the following: • Face-to-face comprehensive health risk assessment			XX
• Telephonic comprehensive health risk assessment			XX
• Initial comprehensive health risk assessment conducted within 90 days of enrollment and results used as basis for individualized care plan			XX
• Annual comprehensive health risk assessment conducted and results used to update individualized care plan			XX
• Comprehensive initial health risk assessment addresses medical, psychosocial, cognitive, and functional status			XX
• Comprehensive annual health risk assessment addresses medical, psychosocial, cognitive, and functional status			XX
• Comprehensive health risk assessment is conducted by a credentialed healthcare professional			XX
• Results of the comprehensive health risk assessment are communicated to all members of the interdisciplinary care team and beneficiary			XX
Applicant has a process to develop or select and utilize a comprehensive risk assessment tool that will be reviewed during oversight activities. The process includes			XX

some or all of the following: • Use of an existing validated health risk assessment tool			
• Use of a plan-developed health risk assessment tool			XX
• Standardized use of a health risk assessment tool for all beneficiaries			XX
• Use of an electronic health risk assessment tool			XX
• Use of a paper health risk assessment tool			XX
• Periodic review of the effectiveness of the health risk assessment tool			XX
Provide a copy of the comprehensive health risk assessment tool.	XX	XX	XX
Applicant has a process to stratify health risks and develop a care management plan that mitigates those risks. The process includes some or all of the following: • Use of predictive modeling software to stratify beneficiary health risks for the development of an individualized care plan			XX
• Manual analysis of health risk data to stratify beneficiary health risks for the development of an individualized care plan			XX
• Trending of population health risk data to inform the development of specialized benefits and services			XX
Individualized Care Plan			
Applicant has written policies, procedures, and a system to assure that the interdisciplinary care team develops and implements a comprehensive individualized plan of care for each beneficiary. The system includes some or all of the following: • Results from the initial health risk assessment are used to develop the individualized care plan			XX
• Beneficiary's medical history is used to develop the individualized care plan			XX
• Beneficiary's healthcare preferences are incorporated in the individualized care plan			XX
• Each beneficiary is assigned an interdisciplinary care team that develops the individualized care plan with beneficiary involvement when feasible			XX
• Interdisciplinary team members update the individualized care plan as beneficiary health status changes			XX
• Initial and annual assessments are analyzed to determine the need for add-on services and benefits, and these needs are incorporated into the individualized care plan for each beneficiary.			XX
Applicant has a written process to facilitate beneficiary/caregiver participation in care planning when feasible. The process includes some or all of the following: • Beneficiaries and/or caregivers participate face-to-face in care planning			XX
• Beneficiaries and/or caregivers participate telephonically in care planning			XX
• Beneficiaries and/or caregivers participate in care planning through an exchange of written correspondence with their interdisciplinary team			XX
• Beneficiaries and/or caregivers participate in care planning through a web-based electronic interface or virtual correspondence			XX
Communication			
Applicant has written policies and procedures to coordinate the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and beneficiaries. These systems include some or all of the following: • Call-line for beneficiary and provider network inquiries			XX
• Care coordination meetings			XX

• Case rounds			XX
• Complaints and grievances documentation and system for resolution			XX
• Committees (standing and ad hoc)			XX
• Conference calls			XX
• E-mails, faxes, written correspondence			XX
• Electronic network for meetings, training, information, communication			XX
• Electronic records			XX
• Newsletter, bulletin			XX
• Person-to-person direct interface			XX
Applicant has written policies, procedures, and a system to coordinate communication among the interdisciplinary care team. The system includes some or all of the following: • Regularly scheduled face-to-face team meetings			XX
• Regularly scheduled team conference calls			XX
• Regularly scheduled web-based team networking			XX
• Team access to shared electronic health information			XX
• Team meetings conducted when needed without a set schedule			XX
Performance and Health Outcomes Measurement			
Applicant has written policies, procedures, and a system to collect and analyze data to evaluate the effectiveness of its model of care.			XX
Applicant collects data from a variety of sources including some or all of the following: • Beneficiary demographics			XX
• Administrative			XX
• Claims			XX
• Encounters			XX
• Medical record reviews			XX
• Health outcomes			XX
• Diagnostics (labs, pathology, radiography)			XX
• Pharmacy			XX
• Utilization			XX
• Risk assessments			XX
• Surveys			XX
• HEDIS data			XX
• HOS data			XX
• CAHPS data			XX
Applicant collects data using a variety or methodologies including some or all of the following: • Internal quality assurance specialists implementing a performance improvement program			XX
• External quality assurance consultants implementing a performance improvement program			XX
• Participation by plan, provider network, and beneficiaries/caregivers			XX
Applicant analyzes health indicators and performance data using a variety of mechanisms including some or all of the following: • Electronic software			XX

• Manual analysis techniques			XX
• External quality improvement consultants			XX
Applicant takes actions to improve the model of care including some or all of the following: • Changes in policies or procedures			XX
• Changes in staffing patterns or personnel			XX
• Changes in provider or facility network			XX
• Changes in systems of operation			XX
• Communication of results internally and externally			XX
Applicant collects and analyzes data that demonstrates beneficiaries have access to eligible services and benefits, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data that demonstrates beneficiaries have improved health status, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data on service delivery processes and outcomes, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data on chronic condition management using evidence-based guidelines, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data on the utilization of evidence-based guidelines by the interdisciplinary team and provider network, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data demonstrating the participation of beneficiaries and interdisciplinary care team members in care planning, and acts to improve deficiencies that are identified. The data includes some or all of the following: • Written summaries of care planning meetings list attendees including team members, beneficiaries, and caregivers			XX
• Interdisciplinary team members maintain attendance logs for all care planning meetings			XX
• Perpetual audits of meeting summaries are conducted to assure participation of team members and beneficiaries			XX
• Perpetual audits of care planning attendance lists summaries are conducted to assure participation of team members and beneficiaries			XX
• Beneficiaries are surveyed to determine the level of their own and their interdisciplinary team's participation in care planning meetings			XX
• Perpetual audits of complaint and grievance summaries are conducted to assure beneficiaries and team members participate in care planning			XX
Applicant collects and analyzes data related to add-on services and benefits including beneficiary utilization and/or satisfaction with such services and benefits, and acts to improve deficiencies that are identified.			XX
Applicant collects and analyzes data on beneficiary utilization of communication mechanisms (e.g., call centers, complaint logs, etc.), and acts to improve deficiencies that are identified.			XX
Applicant has written policies, procedures, and a system to submit required public reporting data that inform stakeholders about the plan's performance as requested by CMS. These data include some or all of the following: • HEDIS data			XX
• Structure and process measures data			XX

• HOS data			XX
• CAHPS data			XX
Applicant has written policies, procedures, and a system to submit required reporting data that monitors the plan's performance as requested by CMS. These data include some or all of the following: • Audits of health information for accuracy and appropriateness			XX
• Beneficiary/caregiver education for frequency and appropriateness			XX
• Clinical outcomes			XX
• Behavioral health/psychiatric services utilization rates			XX
• Community services access/utilizations rates			XX
• Complaints, grievances, services and benefits denials			XX
• Disease management indicators			XX
• Disease management referrals for timeliness and appropriateness			XX
• Emergency room utilization rates			XX
• Enrollment/disenrollment rates			XX
• Evidence-based clinical guidelines or protocols utilization rates			XX
• Fall and injury occurrences			XX
• Facilitation of beneficiary developing advance directives/health proxy			XX
• Functional/ADLs status/deficits			XX
• Home meal delivery service utilization rates			XX
• Hospice referral and utilization rates			XX
• Hospital admissions/readmissions			XX
• Hospital discharge outreach and follow-up rates			XX
• Immunization rates			XX
• Infection risk rates			XX
• Medication compliance/utilization rates			XX
• Medication errors/adverse drug events			XX
• Medication therapy management effectiveness			XX
• Mortality reviews			XX
• Pain and symptoms management effectiveness			XX
• Policies and procedures for effectiveness and staff compliance			XX
• Preventive programs utilization rates (e.g., smoking cessation)			XX
• Preventive screening rates			XX
• Primary care visit utilization rates			XX
• Satisfaction surveys for beneficiaries/caregivers			XX
• Satisfaction surveys for provider network			XX
• Screening for depression and drug/alcohol abuse			XX
• Screening for elder/physical/sexual abuse			XX
• Skilled nursing facility placement/readmission rates			XX
• Skilled nursing facility level of care beneficiaries living in the community having admissions/readmissions to skilled nursing facilities			XX
• Urinary incontinence rates			XX
• Wellness program utilization rates			XX

SNP Quality Improvement Program Requirements

In HPMS, complete the table below:

SNP Quality Improvement Program Requirements			
Applicant has policies, procedures, and a system for conducting a quality improvement program?			XX
Provide a written description of the quality improvement program.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure health outcomes and indices of quality pertaining to its targeted special needs population (i.e., dual-eligible, institutionalized, or chronic condition) at the plan level?			XX
Provide a description and examples of the types of data collected, analyzed, and reported that measure health outcomes and indices of quality pertaining to the SNP targeted special needs population (i.e., dual-eligible, institutionalized, or chronic condition) at the plan level.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure access to care as evidenced by measures from the care coordination domain (e.g., service and benefit utilization rates, or timeliness of referrals or treatment).			XX
Provide a description and examples of data collected, analyzed, and reported that measure access to care.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure improvement in beneficiary health status as evidenced by measures from functional, psychosocial, or clinical domains (e.g., quality of life indicators, depression scales, or chronic disease outcomes).			XX
Provide a description and examples of data collected, analyzed, and reported that measure improvement in beneficiary health status.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure staff implementation of the SNP model of care as evidenced by measures of care structure and process from the continuity of care domain (e.g., National Committee for Quality Assurance accreditation measures or medication reconciliation associated with care setting transitions indicators).			XX
Provide a description and examples of data collected, analyzed, and reported that measure staff implementation of the SNP model of care.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure comprehensive health risk assessment as evidenced by measures from the care coordination domain (e.g., accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments).			XX
Provide a description and examples of data collected, analyzed, and reported that measure comprehensive health risk assessment.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure implementation of an individualized plan of care as evidenced by measures from functional, psychosocial, or clinical domains (e.g., rate of participation by IDT members and beneficiaries in care planning).			XX
Provide a description and examples of data collected, analyzed, and reported that measure implementation of an individualized plan of care.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure use of a provider network			XX

having targeted clinical expertise as evidenced by measures from medication management, disease management, or behavioral health domains.			
Provide a description and examples of data collected, analyzed, and reported that measure use of a provider network having targeted clinical expertise.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure delivery of services across the continuum of care.			XX
Provide a description and examples of data collected, analyzed, and reported that measure delivery of services across the continuum of care.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure delivery of add-on services and benefits that meet the specialized needs of the most vulnerable beneficiaries as evidenced by measures from the psychosocial, functional, and end-of-life domains.			XX
Provide a description and examples of data collected, analyzed, and reported that measure delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure use of evidence-based practices and/or nationally recognized clinical protocols.			XX
Provide a description and examples of data collected, analyzed, and reported that measure use of evidence-based practices and/or nationally recognized clinical protocols.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure the use of integrated systems of communication as evidenced by measures from the care coordination domain (e.g., call center utilization rates, rates of beneficiary involvement in care plan development, etc.).			XX
Provide a description and examples of data collected, analyzed, and reported that measure the use of integrated systems of communication.	XX	XX	XX
Applicant collects, analyzes, and reports data that measure CMS-required data on quality and outcomes measures that will enable beneficiaries to compare health coverage options. These data include HEDIS, HOS, and/or CAHPS data.			XX

								✓	

								✓	
								✓	
								✓	
								✓	
								✓	
								✓	

Uploads Requested in the 2010 SNP Proposal Included in the MA Application

New and Expansion of Existing Dual-eligible SNPs Proposal Applications

1) **SNP Service Area**
   - Service area (State and County codes)
   - Names of States
2) **State Medicaid Agency Contracts**
   - Copy of signed State Medicaid Agency(ies) contract
   - State Medicaid Agency(ies) contract approved service area
3) **State Medicaid Agency Contract Enrolled Population**
   - Description of the Medicaid subset for other than what is listed as Y/N response
   - Description of the Medicaid benefits covered in the State Medicaid contract
   - Description of the cost-sharing protections covered in the State Medicaid contract
   - Description of the identification and sharing information on Medicaid provider participation covered in the State Medicaid contract
   - Description of the MAO's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits covered in the State Medicaid contract
   - Name of the contact individual at the State Medicaid Agency(ies)
   - Address of the State Medicaid agency(ies) contact person
   - Phone number of the State Medicaid agency(ies) contact person
   - E-mail address of the State Medicaid agency(ies) contact person
   - Description of the process to verify Medicaid eligibility of individuals through the State
   - Description of the process to coordinate Medicare and Medicaid services for dual-eligible individuals

New and Expansion of Existing Severe or Disabling Chronic Condition SNPs Proposal Applications

1) **SNP Service Area**
   - Service area (State and County codes)

- Names of States

New and Expansion of Existing Institutional SNPs Proposal Applications

1) **SNP Service Area**
   - Service area (State and County codes)
   - Names of States
2) **SNPs Enrolling Individuals Residing in Institutions**
   - List of contracted long-term care facilities
   - List of assisted-living facilities (if applicant/SNP is contracting with ALFs)
   - Copy of the State Level of Care assessment tool
   - URL to access the State Level of Care assessment tool (if web-based)
   - Name of the entity performing the LOC assessment
   - Address of the entity

ERSD Waiver Requests

- Description of how the SNP intends to serve the unique needs of the ESRD beneficiaries
- List of the contracted dialysis facility(ies)
- List of the contract transplant facility(ies)
- Description of any additional service(s) provided to members with ESRD
- Description of the interdisciplinary care team coordinator role in the assessment and delivery of services needed by beneficiaries with ESRD

Model of Care

1) **Health Risk Assessment**
   - Copy of the comprehensive health risk assessment tool

Note: Does not include items which require a text box to input information (e.g., a date)

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.
- 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, downstream and related entity 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, downstream and related entity 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. General Instructions for CMS HSD Tables 1, 2, 2a, 3, 3a, 4, 5

(Not required for non-network Private Fee For Service PFFS,)

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

Instructions:

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 "date prepared". The tables should reflect the applicants **fully executed contracted** 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 and that the non-contracted providers are reimbursed sufficiently to provide health care services.

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

6. HSD Table format must include:

- Set print area and page set-up to ensure all columns fit within one 81\2 sheet of paper either portrait or landscape for some HSD tables, the number of rows may require additional pages.
- Set repeat rows to specify the title of the worksheet and the column headings for HSD tables that require multiple pages to be printed. For example, the CMS reviewer must be able to view subsequent pages of the HSD table with the same column headings as the first page.
- Save format settings prior to uploading into HPMS.

NOTE: RPPO applicants are 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. Physicians and specialists should be counted only once per county on this table even if the provider has more than one location in a county. Facilities such as hospitals and clinics that provide more than one service listed on HSD-3, should be counted once on HSD-1 for each service provided by the facility.

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. Initial applicants must include a numeric entry for each provider type. If the number of providers is zero, please enter a zero. Every county in your proposed service area must include an entry for every provider type

4. SAE applicants must include a numeric entry for each provider type for the counties in which expansion is to occur.

5. If there are other specialties that are not listed, applicant should add lines under "Pancreas Transplant Facilities" to cover these specialists. Please do not change provider specialty order as listed on HSD-1.

6. Applicants will need to provide the SSA State/County Code for every provider type.

7. Applicant must indicate the total number of providers in EVERY SSA State/county code in their pending service area

8. Applicant must insert the project enrollment numbers for the county.

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. **Total # of Providers** - Add up the total number of providers per specialty listed in columns 5 & 6.

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

6. **Total # of PCPs Accepting New Patients -** If "Y" was entered in column 8, 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 8, please leave the cell blank.

7. **Total # of PCPs Accepting Only Established Patients -** If "Y" was entered in column 9, 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 8, please leave cell blank.

8. **Other Counties Served -** Other counties that provider will serve.

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, podiatrists, 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, and 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, an "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. If the provider does not have admitting privileges, other than one contracted hospital, please use an abbreviation and place a footnote on the bottom of each page.

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 name of 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 “DC” 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. 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 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:

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

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

Existing Network – Indicate whether the provider was previously established as a network provider in the 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:

Name of Provider - Enter name of contracted provider.
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

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

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.)

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.)

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

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

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:

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

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

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

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

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

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

Please list all direct and downstream providers of services.

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

Column Explanations:

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).

Steps 2-5

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

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.

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 this provider provides.

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:

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

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

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

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	Yes	PDF. File	HXXX_History-1. pdf
2. CMS Insurance Table Coverage	1.2 Administrative Management	Yes	PDF. File	HXXX_Insurance-1.pd
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_UnderStateRev 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.pd
8. Position Description/Organizational Relationship Chart of Key Management Staff	1.6 Key Management Staff	No	PDF. File	Hxxxx_KeyManageme
9. (If Applicable) Audited Financial Statements	1.7 Fiscal Soundness	No	PDF. File	Hxxxx_AuditedStatem
10. (If Applicable) Annual NAIC Health Blank & Financial Plans	1.7 Fiscal Soundness	No	PDF. File	Hxxxx_ANAICFinanc
11. (If Applicable) Quarterly Health Blank.	1.7 Fiscal Soundness	No	PDF. File	Hxxxx_QuarterlyHealt
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.
13. (If Applicable) Financial Disclosure	1.7 Fiscal Soundness	No	PDF. File	Hxxxx_FinancialDiscl
14. Partial County Service area justification	1.8 Service Area	No	PDF. File	Hxxxx_PartialCountyJ
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.
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,	1.9 Provider Contracts & Agreements	No	PDF. File	Hxxxx_PContract-Ten PCP.pdf, Hxxxx_PContract-Ten

medical group, IPA, PHO, hospitals, skilled nursing facilities, etc.).				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_ DownstreamC Template 1-MG.pdf. Hxxxx_DownstreamC Template 2_MG.pdf Hxxxx_DownstreamC Template 1-IPA.pdf
19. CMS Provider Participation Contracts and/or Agreements Matrix	1.9 Provider Contracts & Agreements	Yes	PDF. File	Hxxxx_ProviderMatrix 1-MG.pdf.
20. Executed Administrative or Management Contracts, letter of agreement	1.10 Contracts for Administrative & Management Services	No	PDF. File	Hxxxx_AdminContrac version, or template).p
21. CMS Administrative/Management Delegated Contracting Matrix	1.10 Contracts for Administrative & Management Services	Yes	PDF. File	Hxxxx_AdminDelCon (number, version, or template).PDF
22. CMS HSD TABLES 1-5	1.11 Health Services Delivery (HSD)	Yes	Excel File	Hxxxx_HSD1..xls Hxxxx_HSD2..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-PFFS 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.xls Hxxxx_HSD2..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..xls Hxxxx_HSD2..xls
2. Reimbursement Grid (note: can use CMS model payment guidance)	4.4 Payment Provisions	Model Guidance	PDF. File	Hxxxx_Reimbursement Grid.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_CostsharingScr
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_PreventService
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_ProjectedEnroll
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_NonMedicareSi
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.
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_EnrollmentTrac
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_RecoverDeposi

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, 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. Hxxxx_DownstreamContract-Template 2_MG.pdf 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	1.4 Contracts for Administrative & Management	Yes	PDF. File	Hxxxx_AdminDelContractMatrix (number, version, or template).PDF

Matrix	Services			
11. CMS HSD TABLES 1-5	1.5 Health Services Delivery (HSD)	Yes	Excel File	Hxxxx_HSD1.County Name.xls 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 Rxxxx_StateLicensePA.pdf
2. CMS State Certification form	2.1 State licensure RPPO	Yes	PDF. File	Rxxxx_StateCertNY.pdf Rxxxx_StateCertGA.pdf
3. State approval of dba	2.1 State licensure RPPO	No	PDF. File	Rxxxx_StateDBA-NJ.pdf 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 7 CMS REGIONAL OFFICES

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

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

RO IX CMS – SAN FRANCISCO REGIONAL OFFICE
DIVISION OF MEDICARE HEALTH PLANS
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