PART C -MEDICARE ADVANTAGE and 1876 COST PLAN EXPANSION APPLICATION

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

For all existing Medicare Cost Plan contractors seeking to expand the contract service area

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

Medicare Advantage Coordinated Care Plan (CCPs) must offer at least one Medicare Advantage plan that includes a Part D prescription drug benefit (MA-PD) in each county of its service area. Therefore, CCP Applicants 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.

1 GENERAL INFORMATION

1.1 Overview

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (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 Medicare Advantage Organizations (MAOs). The MMA changes make managed care more accessible, efficient, and attractive to beneficiaries seeking options to meet their needs. The MA program offers several kinds of plans and health care choices, including Regional Preferred Provider Organizations (RPPOs), Private Fee-For-Service (PFFS) plans, Special Needs Plans (SNPs), and Medical Savings Account (MSA) plans.

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 have more information about those choices. The Centers for Medicare & Medicaid Services (CMS) welcomes organizations that can add value to these programs, make them more accessible to Medicare beneficiaries, and meet all the contracting requirements.

1.2 Types of MA Products

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

- Coordinated Care Plans (CCPs)
  - Health Maintenance Organizations (HMOs) with or without a Point of Service (POS) benefit
  - Local Preferred Provider Organizations (LPPOs)
  - Regional Preferred Provider Organizations (RPPOs)
  - Special Needs Plans (SNPs)
- Private Fee-for-Service (PFFS) plans
- Medical Savings Account (MSA) plans
- Employer Group Waiver plans (EGWPs)

Note: For fact sheets on each of these types of product offerings, go to http://www.cms.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.

Note: The MMA requires that CCPs offer at least one MA plan that includes a Part D prescription drug benefit (MA Part D or MA-PD) in each county of its service area. To meet this requirement, the Applicant must timely complete and submit a separate Part D application in connection with this Part C Application.

PFFS plans have the option to offer the Part D drug benefit. MSA plans cannot offer the Part D drug benefit.

1.3 Important References

MA Organizations

The following are key references about the MA program:

- Social Security Act: 42 U.S.C 1395 et seq.: http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Medicare Regulations: 42 CFR 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.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
- Marketing Guidelines: http://www.cms.gov/ManagedCareMarketing/

Medicare Cost Plans

Information requested in this application is based on Section 1876 of the Social Security Act (SSA) and the applicable regulations of Title XIII of the Public Health Services Act.

Additional information can be found on the Centers for Medicare & Medicaid Services (CMS) Web site: http://www.cms.gov/MedicareCostPlans/

- SSA: 42 U.S.C. 1395mm: http://www.ssa.gov/OP_Home/ssact/title18/1876.htm
- Medicare Regulations: 42 CFR 417: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=8072f532d9936eba1bee882c805beedb&tpl=/ecfrbrowse/Title42/42cfr417_main_02.tpl
- Centers for Medicare & Medicaid Services (CMS) Web site: http://www.cms.gov

1.4 Technical Support

CMS conducts special training sessions and user group calls for new Applicants and existing contractors. All applicants are strongly encouraged to participate in these sessions, which are announced via the HPMS (see section 1.5 below) and/or the CMS main website.

CMS Central Office (CO) staff and Regional Office (RO) staff are available to provide technical support to all Applicants during the application process. While preparing the application, Applicants may email MA_Applications@cms.hhs.gov . Applicants should contact their RO to request assistance with specific issues related to their deficiency letters. Below is a list of CMS RO contacts.

This information is also available at:
https://www.cms.gov/RegionalOffices/

RO I CMS – BOSTON REGIONAL OFFICE
John F. Kennedy Federal Building, Room 2325, 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: 212-616-2353
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 and West Virginia

RO IV CMS – ATLANTA REGIONAL OFFICE
Atlanta Federal Center, 61 Forsyth Street, 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 714, 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 Street, 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 Operations
90 7th Street, Suite 5-300 (5w), San Francisco, CA 94103-6707
Telephone: 415-744-3602
States: Arizona, California, Guam, Hawaii, Nevada, American Samoa and The Commonwealth Of Northern Mariana Islands

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

For general information about this application, please email: ma_applications@cms.hhs.gov.

1.5 The Health Plan Management System (HPMS)

A. HPMS is the primary information collection vehicle through which MAOs and Medicare Cost Plan contractors will communicate with CMS during the application process, bid submission process, ongoing operations of the MA program or Medicare Cost Plan contracts, 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 must promptly enter organizational data into HPMS and keep the information up to date. These requirements ensure that CMS has current information and is able to provide guidance to the appropriate contacts within the organization. In the event that an Applicant is awarded a contract, this information will also be used for frequent communications during contract 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 MAOs and Medicare Cost Plan contractors. This information is then incorporated into the appropriate manuals. It is imperative for MAOs and Medicare Cost Plan contractors to independently check HPMS memos and incorporate the guidance as indicated in the memos.

1.6 Submitting Notice of Intent to Apply (NOIA)

MA Applicants

Organizations interested in offering a new MA product, expanding the service area of an existing product, or submitting a PFFS network transition application must complete a nonbinding NOIA by November XX, 20XX. CMS will not accept applications from organizations that fail to submit a timely NOIA. 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 a 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: https://applications.cms.hhs.gov. 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 contract number.

Medicare Cost Plans

Existing Cost contractors requesting service area expansions should not apply for a new Cost contract number.

1.7 Additional Information

1.7.A Bid Submission and Training

On or before the first Monday of June of every year, all MAOs and Medicare Cost Plan contractors offering Part D* 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. MAOs and Medicare Cost Plan contractors 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 due. Further instructions and time frames for bid submissions are provided at: http://www.cms.gov/MedicareAdvtgSpecRateStats/01_Overview.asp#TopOfPage

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 or Medicare Cost Plan benefit and the BPT software to define its bid pricing information.

Once the PBP and BPT software requirements have been completed for each plan being offered, Applicants will upload their bids into HPMS. Applicants will be able to submit bid uploads via HPMS on their PBP or BPT one or more times between May and the CY bid deadline, which is

the first Monday in June each year. CMS will use the last successful upload received for each plan as the official bid submission.

CMS will provide technical instructions and guidance upon release of HPMS bid functionality as well as the PBP and BPT software. In addition, systems training will be available at the Bid Training in spring 2013.

* Medicare Cost contractors are not required to offer Part D coverage but may elect to do so. A cost contractor that elects to offer Part D coverage is required to submit a Bid.

1.7.B System and Data Transmission Testing

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

1.7.C Protecting Confidential Information

Applicants may seek to protect their 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 FOIA Exemption 4, CMS is required by its FOIA regulation at 45 CFR 5.65(d) and by Executive Order 12600 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; (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 place. Consistent with our approach under other Medicare programs, CMS would not release information that would be considered proprietary in nature if the Applicant has shown it meets the requirements for FOIA Exemption 4.

1.7.D Payment Information Form

Please complete the Payment Information form that is located at:
http://www.cms.gov/MedicareAdvantageApps/Downloads/pmtform.pdf.
The document contains financial institution information and Medicare contractor data.

Please submit the following documents along with the Payment Information form:

- Fax cover sheet that includes the effective month and year
- Payment Information Form
- Voided Check or confirmation letter from bank
- Form must be completely filled out
- W-9 Form

If the Applicant has questions about this form, please contact Louise Matthews at (410) 786-6903. The completed form needs to be faxed to Louise Matthews at (410) 786-0322.

1.8 Due Date for Applications

MA Plans

Applications must be submitted by 11:59 P.M. EST, February XX, 2013. 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 AND BID REVIEW PROCESS *	
Date	**Milestone**
November 9, 2012	1. Submit NOIA to CMS 2. Request HPMS Access (Includes User ID and Password Request) 3. Request CMS Connectivity
December XX, 2012	CMS User ID form due to CMS
January XX, 2013	Final Applications Posted by CMS
February XX, 2013	Deadline for NOIA form submission to CMS
February XX, 2013	Completed Applications due to CMS
March XX, 2013	Release of Health Plan Management System (HPMS) formulary submissions module
April XX, 2013	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS
June 3, 2013 *First Monday in June	All bids due to CMS
September 2013	CMS completes review and approval of bid data. CMS executes MA and MA-PD contracts with organizations whose bids are approved and who otherwise meet CMS requirements.
October XX, 2013	Annual Coordinated Election Period begins for CY 2014 plans.

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

Medicare Cost Plans

Applications must be submitted by 11:59 P.M. EST, February XX, 2013. 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 Medicare Cost Plan application review process:

COST PLAN SAE APPLICATION REVIEW PROCESS *	
Date	**Milestone**
November 9, 2012	1. Submit NOIA to CMS 2. Request HPMS Access (Includes User ID and Password Request) 3. Request CMS Connectivity
December XX, 2012	CMS User ID form due to CMS
January XX, 2013	Final Medicare Cost SAE Application Posted by CMS
February XX, 2013	Deadline for NOIA form submission to CMS
February XX, 2013	Completed Medicare Cost Plan SAE Application due to CMS
March XX, 2013	Release of Health Plan Management System (HPMS) formulary submissions module
April XX, 2013	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS
June 3, 2013 *First Monday in June	All bids due to CMS
September 2013	CMS completes review and approval of bid data. CMS executes MA and MA-PD contracts with organizations whose bids are approved and who otherwise meet CMS requirements.
October XX, 2013	Annual Coordinated Election Period begins for CY 2014 plans.

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

1.9 Request to Modify a Pending Application

Applicants seeking to withdraw or reduce the service area of a pending application (i.e., one being reviewed by CMS) must submit a written request to CMS on the organization's letterhead and signed by an authorized corporate official. All requests are due to CMS no later than fifteen days after the issuance of the Notice of Intent to Deny (NOID) letter.

Applicants may submit the request using any of the following methods:

1. Email - Send the request in PDF format as an attachment to the email message to MA_Applications@cms.hhs.gov. Send a copy of the letter via e-mail to the Regional office Account Manager or Application reviewer.

2. Mail – Address the request to:

   CMS
   Attn: MCAG/DMAO
   Mail Stop: C4-22-04
   7500 Security Blvd.
   Baltimore, MD 21244

   Mail a copy of the request to the Regional Office Account Manager or Application reviewer.

3. Fax - Send faxed requests to the attention of the Part C Applications Operations Manager at (410) 786-8933. Fax a copy to the Regional Office Account Manager or Application reviewer.

The following information must be included in the request:

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

1.10 Application Determination and Appeal Rights

All Applicants

If CMS determines that the Applicant is not qualified 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 422, Subpart N. The request for a hearing must be in writing, signed by an authorized official of the Applicant organization, and received by CMS within **15 calendar** days from the date CMS notifies the MAO of its determination (see 42 CFR 422.662.) If the 15th day falls on a weekend or federal holiday, the Applicant has until the next regular business day to submit its request.

The appealing organization must receive a favorable determination resulting from the hearing or review as specified under Part 422, Subpart N prior to September XX, 2013 (tentative date) in order to qualify for a Medicare contract to begin January 1, 2014.

2 INSTRUCTIONS

2.1 Overview

Applicants must complete the 2014 MA or Medicare Cost Plan application using HPMS as instructed. CMS will only accept submissions using this current 2013 version 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 certifying that its organization complies with the relevant requirements as of the date the application is submitted to CMS, unless a different date is stated by CMS.

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 throughout the application process, as well as at any time both prior to and after the start of the contract year. Failure to meet the requirements represented in this application and to operate MA or Medicare Cost plans consistent with the applicable statutes, regulations, and the MA or Medicare Cost Plan contract, and other CMS guidance could result in the suspension of plan marketing and enrollment. If these issues are not corrected in a timely manner, the Applicant will be disqualified from participation in the MA or Medicare Cost Plan program, as applicable.

Throughout this application, Applicants are asked to provide various documents and/or tables in HPMS. There is a summary of all documents required to be submitted at the end of each attestation section.

CMS strongly encourages MA Applicants to refer to the regulations at 42 CFR 422 while Medicare Cost Plan Applicants should refer to the regulations at 42 CFR 417 to clearly understand the nature of the requirements in order to provide an appropriate submission. Nothing in this application is intended to supersede the regulations at 42 CFR 422 or 42 CFR 417. 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 or 417 of Title 42 of the CFR. Applicants must read HPMS memos and visit the CMS web site periodically to stay informed about new or revised guidance documents.

2.2 Applicants Seeking to Offer New Employer/Union-Only Group Waiver Plans (EGWPs)

Applicants who wish to offer MA or MA-PD products under Employer/Union-Only Group Waivers must complete and timely submit a separate EGWP application. Please see APPENDIX II: Employer/Union-Only Group Waiver Plans (EGWPs) MAO "800 Series" of this application for details about EGWPs.

All Applicants will be able to enter their EGWP service areas directly into HPMS during the application process (refer to HPMS User Guide). Applicants may provide coverage to employer

group members wherever they reside (i.e., nationwide). However, in order to provide coverage to retirees wherever they reside, Applicants must set their service area to include all areas where retirees reside during the plan year (i.e., national service areas).

2.3 Applicants Seeking to Offer Employer/Union Direct Contract MAO

Applicants who wish to offer an Employer/Union Direct Contract Private Fee-For Service (PFFS) MAO must complete and timely submit a separate EGWP application. Please see APPENDIX III: Employer/Union Direct Contract for MA of this application for details about the Direct Contract MAO.

In general, MAOs can cover beneficiaries only in the service areas in which they are licensed and approved by CMS to offer benefits. CMS has waived these requirements for Direct Contract MAOs. Direct Contract MAO Applicants can extend coverage to all of their Medicare-eligible active members/retirees regardless of whether they reside in one or more MAO regions in the nation. In order to provide coverage to retirees wherever they reside, Direct Contract MAO Applicants must set their service area to include all areas where retirees may reside during the plan year. CMS will not permit mid-year service area expansions.

Direct Contract MAOs that offer Part D coverage (i.e., MA-PDs) will be required to submit pharmacy access information for the entire defined service area during the application process and demonstrate sufficient access in these areas in accordance with employer group waiver pharmacy access policy.

2.4 Applicants Seeking to Offer Special Needs Plans (SNPs)

New and expanding SNPs must complete and timely submit a separate SNP proposal. Existing SNPs that require re-approval under the NCQA SNP Approval process should only submit their Model of Care written narrative and Model of Care Matrix Upload Document. These SNPs will not be required to submit any other portion of the MA application or SNP proposal, unless specifically noted (e.g., in the instructions for submission of contracts with State Medicaid Agencies). Please refer to APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals for specific instructions and details.

Existing Dual Eligible SNPs will need to submit a signed and executed State Medicaid Agency Contract in HPMS without submitting any other portion of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion.

2.5 Applicants Seeking to Offer Medicare Cost Plans

All 2014 Applicants seeking to expand the service area of an existing Medicare Cost Plan must complete and timely submit a separate Medicare Cost Plan application. Please refer to APPENDIX IV: Medicare Cost Plan Service Area Expansion Application for application instructions and details.

2.6 Applicants Seeking to Serve Partial Counties

Applicants seeking to serve less than a full county (i.e., a partial county) must enter all service area information in HPMS by the application submission deadline, February XX, 2013. Applicants cannot introduce a partial county request after the initial application submission. In other words, applicants cannot reduce a full-county request to a partial county request during the application review period.

2.7 Types of Applications

Initial Applications are for:

- Applicants who are seeking an MA contract to offer an MA product for the first time or to offer an MA product they do not already offer.
- Existing MA contractors who are seeking an MA contract to offer a type of MA product they do not currently offer.
- Existing PFFS contractors who are required to transition some or all of their service area to a network based product.

Note: An RPPO Applicant may apply as a single 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 between/among the member organizations.

Service Area Expansion Applications are for:

- Existing MAO contractors who are seeking to expand the service area of an existing contract number.

2.8 Chart of Required Attestations by Type of Applicant

This chart (Chart 1) describes the required attestations that must be completed for each type of application and Applicant. The purpose of this chart is to provide the Applicant with a summary of the attestation topics. First, the Applicant must determine if the application will be an initial or service area expansion type. Then the Applicant must select the type of MA product it will provide. The corresponding location of each attestation is provided under the column labeled "Section #," which corresponds to this application package.

Chart 1 - Required Attestations by Type of Application

Attestation Topic	Section #	Initial Applicants					Service Area Expansion			
		CCP	PFFS	RPPO	MSA		CCP	PFFS	RPPO	MSA
Experience and Organizational History	3.1	X	X	X	X					
Administrative Management	3.2	X	X	X	X					
State Licensure	3.3	X	X	X	X		X	X	X	X
Program Integrity	3.4	X	X	X	X					
Compliance Plan	3.5	X	X	X	X					
Key Management Staff	3.6	X	X	X	X					
Fiscal Soundness	3.7	X	X	X	X					
Service Area	3.8	X	X	X	X		X	X	X	X
CMS Provider Participation Contracts & Agreements	3.9	X	X	X	X		X	X	X	X
Contracts for Administrative & Management Services	3.10	X	X	X	X		X	X	X	X
Health Services Management & Delivery	3.11	X	X	X	X		X	X*	X	X*
Quality Improvement Program	3.12	X	X	X	X					
Marketing	3.13	X	X	X	X					
Eligibility, Enrollment, and Disenrollment,	3.14	X	X	X	X					
Working Aged Membership	3.15	X	X	X	X					
Claims	3.16	X	X	X	X					
Communications between MAO and CMS	3.17	X	X	X	X					
Grievances	3.18	X	X	X	X					
Appeals	3.19	X	X	X	X					
Health Insurance Portability and Accountability Act of 1996 (HIPPA)	3.20	X	X	X	X					
Continuation Area	3.21	X	X	X	X		X	X		X
Part C Application Certification	3.22	X	X	X	X		X	X	X	X
RPPO Essential Hospital	3.23			X					X	
Access to Services	3.24		X		▪			X		▪
Claims Processing	3.25		X		X			X		X
Payment Provisions	3.26		X		X			X		X
General Administration/Management	3.27				X					X

**Indicates Applicants with a network*

▪ *Indicates that Applicants are not required to complete attestations but must upload selected information, as required, in HPMS system.*

2.9 Health Services Delivery (HSD) Tables Instructions

Applicants are required to demonstrate network adequacy through the submission of HSD Tables. Detailed instructions on how to complete each of the required HSD Tables are available in a separate file along with the HSD Table templates. The HSD instructions and table templates are available in the MA Download file in HPMS.

As part of the application module in HPMS, CMS will be providing Applicants with an automated tool for submitting network information via HSD tables. The tables will then be reviewed automatically against default adequacy measures for each required provider type in each county. This process will permit Applicants to determine if they have achieved network adequacy before finalizing their application. Further, CMS will make these default values known prior to the opening of the application module. As such, Applicants will see the values (providers and facilities of each required type in each county) that CMS requires before the application module opens. Applicants who believe that CMS default values for a given provider type in a given county are not in line with local patterns of care may seek an exception, in which case the Applicant will submit required information to support the exception request(s). The HSD exception review will occur manually by a CMS reviewer as it has in the past. Applicants who submit HSD tables that 'clear' CMS's default values will still be required to submit signed contracts and other documents that demonstrate the accuracy of the HSD table submissions. Applicants may still be determined to have network deficiencies even if they 'pass' the automated review.

CMS will be providing training to Applicants on the automated system, the HSD tables, and the default values for determining network adequacy after the application module opens, and expects to annually post the default values for determining network adequacy in the Fall of each year.

Application forms and tables associated with the applications are available in separate Microsoft Word or Excel files that are available at: http://www.cms.gov/MedicareAdvantageApps/. Microsoft Word files located on the CMS web site are posted in a .zip format and can also be found in the MA Download file in HPMS.

Applicants must submit separate completed copies of each table template for each area/region or county that the Applicant is requesting. Specific instructions on how to complete and submit each table will be outlined in the 2014 HPMS User Guide for the Part C Application.

2.10 Document (Upload) Submission Instructions

MA Applicants must include their assigned H number in the file name of all submitted documents. Medicare Cost Plan Service Area Expansion Applicants should use their existing H number in the file name of all submitted documents. Applicants are encouraged to be descriptive in naming all files. If the Applicant is required to provide multiple versions of the same document, the Applicant should insert a number, letter, or even the state name at the end of each file name for easy identification (see the Application Readme.file).

2.11 MA Part D (MA-PD) Prescription Drug Benefit Instructions

The Part D Application for MA-PD Applicants 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 Part D Application for MA-PD Applicants 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 Part D Application for MA-PD Applicants can be found at: http://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage. Specific instructions to guide MA-PD Applicants in applying to offer Part D benefits during 2014 are provided in the Part D Application for MA-PD Applicants and must be followed.

Note: Failure to file the required Part D Application for MA-PD Applicants will render the MA-PD Application incomplete and could result in the denial of this application.

Failure to submit 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 (NOID) or Denial.

3 ATTESTATIONS

3.1 Experience & Organization History

The purpose of this section is to allow Applicants to submit information describing their experience and organizational history. A description of the MAO's structure of ownership, subsidiaries, and business affiliations will enable CMS to more fully understand additional factors that contribute to the management and operation of MA plans. The following attestations were developed to implement the regulations of 42 CFR 422.502(b) and 422.503(b)

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: EXPERIENCE & ORGANIZATIONAL HISTORY	YES	NO	NA
1. Is the Applicant applying to be the same type of organization as indicated on the Applicant's NOIA? The Applicant may verify its organization type by looking at the Contract Management Basic page. If the type of organization the Applicant's organization intends to offer has changed, do not complete this application. Send an email to MA_Applications@cms.hhs.gov indicating the pending contract number and the type of organization for which the Applicant is now seeking to apply.			
2. The Medicare Advantage plan(s) currently offered by the Applicant, Applicant's parent organization, or subsidiary of the Applicant's parent organization has been operational since January 1, 2011 or earlier. (If the Applicant, Applicant's parent organization, or a subsidiary of Applicant's parent organization does not have any existing contracts with CMS to operate a Medicare Advantage Plan, select "NA".)			

B. In HPMS, upload the History/Structure/Organizational Charts. This is a brief summary of the Applicant's history, structure and ownership. Include organizational charts to show the structure of ownership, subsidiaries, and business affiliations.

3.2 Administrative Management

The purpose of the administrative management attestations is to ensure that MAOs have the appropriate resources and structures available to effectively and efficiently manage administrative issues associated with Medicare beneficiaries. CMS requires that MA

plans have sufficient personnel and systems to organize, implement, control, and evaluate financial and marketing activities, oversee quality assurance, and manage the administrative aspects of the organization. The following attestations were developed to implement the regulations of 42 CFR 422.503(b)(4)(ii).

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ADMINISTRATIVE MANAGEMENT	**YES**	**NO**
1. The Applicant has non-renewed its contract with CMS within the past 2 years. • If "Yes", do not continue and contact CMS MA_Applications@cms.hhs.gov.		
2. The Applicant currently operates a CMS Cost contract under Section 1876 of the SSA in some or all of the intended service area of this application.		
3. The Applicant offers health plan products to a commercial population.		
4. The Applicant currently 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.		
5. The Applicant currently has administrative and management agreements that feature personnel systems sufficient for the organization to organize, implement, control and evaluate financial and marketing activities, quality assurance, and the administrative aspects of the organization.		
6. The Applicant currently has administrative and management agreements that feature an executive manager / chief executive officer whose appointment and removal are under the control of the policy-making body.		

3.3 State Licensure

To ensure that all MAOs operate in compliance with state and federal regulations, CMS requires MAOs to be licensed under state law. This requirement will ensure that MAOs adhere to state regulations aimed at protecting Medicare beneficiaries. The following attestations were developed based on the regulations at 42 CFR 422.400.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE	YES	NO	N/A
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 managed care product. In addition, the scope of the license or authority allows the Applicant to offer the type of managed care product that it intends to offer in the state or states. • If "Yes", upload in HPMS an executed copy of a state licensing certificate and the CMS State Certification Form for each state being requested. • Note: Applicant must meet and document all applicable licensure and certification requirements no later than the Applicant's final upload opportunity, which is in response to CMS' NOID communication.			
2. Applicant is a Joint Enterprise. • If "Yes", upload the copy of the Joint Enterprise agreement executed by the state-licensed entities.			
3. Applicant is licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits in at least one 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. 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.			

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE	YES	NO	N/A
• If "Yes", upload in HPMS an executed copy of a state licensing certificate and the CMS State Certification Form for each state being requested or the RPPO State Licensure Attestation for MA RPPOs and a complete RPPO State Licensure Table for each MA Region, if Applicant is not licensed in all states within the region. • Note: Applicant must meet and document all applicable licensure and certification requirements no later than the Applicant's final upload opportunity, which is in response to CMS' NOID communication. • Note: Joint Enterprise Applicants must submit state certification forms for each member of the enterprise.			
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 which filed the application. • If "Yes", upload in HPMS an explanation of the specific actions taken by the state licensing authority.			
5. 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", upload in HPMS a copy of the state approval for the d/b/a.			
6. For states or territories whose license(s) renew after the first Monday in June, Applicant agrees to upload into HPMS the renewed license no later than the final upload. If the renewed license is not available at that time, applicant agrees to (1) upload, in place of the license, a copy of its completed license renewal application or other			

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE	YES	NO	N/A
documentation (e.g., invoice from payment of renewal fee) to show that the renewal process is being completed in a timely manner, and (2) electronically send a copy of the renewed license to the CMS Regional Office Account Manager promptly upon issuance. • Note: If the Applicant does not have a license that renews after the first Monday in June, then the Applicant should respond "N/A".			

B. In HPMS, upload an executed copy of the State Licensing Certificate and the CMS State Certification Form for each state being requested, if Applicant answers "Yes" to the corresponding question above.

C. In HPMS, upload a copy of the Joint Enterprise agreement executed by the state-licensed entities, if Applicant answers "Yes" to the corresponding question above.

D. In HPMS, upload an executed copy of a State Licensing Certificate and the CMS State Certification Form for each state being requested, if Applicant answers "Yes" to the corresponding question above.

E. In HPMS, upload executed copy of the RPPO State Licensure Attestation for MA RPPOs and a complete RPPO State Licensure Table for each MA Region, if Applicant is not licensed in all states within the region and answers "Yes" to the corresponding question above.

F. In HPMS, upload the State Corrective Plans / State Monitoring Explanation (as applicable), if Applicant answers "Yes" to the corresponding question above.

G. In HPMS, upload the State Approval for d/b/a, if Applicant answers "Yes" to the corresponding question above.

Note: Federal Preemption Authority – The MMA amended section 1856(b)(3) of the SSA and significantly broadened the scope of Federal preemption of state law. The revised MA regulations' at 42 CFR 422.402 states that MA standards supersede state law or regulation with respect to MA plans other than licensing laws and laws relating to plan solvency.

3.4 Program 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 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 Administration exclusion lists**.** Please note that this includes any member of the board of directors and any key management or executive staff or any major stockholder.		

3.5 Compliance Plan

The purpose of a compliance plan is to ensure that the MAO, including but not limited to compliance officers, organization employees, contractors, managers and directors, abides by all federal and state regulations, standards, and guidelines. To accomplish this objective, the plan should include the following components: training/education, communication plan, disciplinary standards, internal monitoring/auditing procedures, etc. The following information was developed to implement the regulations of 42 CFR 422.503(b)(4)(vi).

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: COMPLIANCE PLAN	YES	NO
1. Applicant has a compliance plan that is ready for implementation.		

B. If you are applying as a MA-only non-network organization (i.e. PFFS or MSA), in HPMS, upload a copy of the Applicant's Medicare Part C Compliance Plan in an Adobe.pdf format.

Note: The Part C compliance plan must be developed in accordance with 42 CFR 422.503(b)(4)(vi). The compliance plan must demonstrate that all seven elements in the regulation and in Chapter 11 of the Medicare Managed Care Manual

(MMCM) are implemented and specific to the issues and challenges presented by the Part C program.

C. If you are applying as a MA-only non-network organization (i.e. PFFS or MSA) in HPMS, complete and upload the Crosswalk for Part C Compliance Plan document.

3.6 Key Management Staff

The purpose of this section is to ensure that qualified staff is available to support the MAO. An organizational chart showing the relationships of the various departments will demonstrate that the MAO meets this requirement. The following attestations were developed to implement the regulations of 42 CFR 422.503(b)(4)(ii).

In HPMS, complete the table below:

<table>
<tr><th>RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: KEY STAFF MANAGEMENT</th><th>YES</th><th>NO</th></tr>
<tr><td>1. Applicant attests that all staff is qualified to perform their respective duties.</td><td></td><td></td></tr>
<tr><td>2. Applicant attests that it has completed the Contact Management/Information/Data page in HPMS.

<table>
<tr><th>Contact</th><th>Name/Title</th><th>Mailing Address</th><th>Phone/Fax Numbers</th><th>Email Address</th></tr>
<tr><td>Corporate Mailing</td><td></td><td></td><td></td><td></td></tr>
<tr><td>CEO – Sr. Official for Contracting</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Chief Financial Officer</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medicare Compliance Officer</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Enrollment Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medicare Coordinator</td><td></td><td></td><td></td><td></td></tr>
<tr><td>System Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Customer Service Operations Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>General Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>User Access Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Backup User Access Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Marketing Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medical Director</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Bid Primary Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Payment Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>HIPAA Security Officer</td><td></td><td></td><td></td><td></td></tr>
<tr><td>HIPAA Privacy Officer</td><td></td><td></td><td></td><td></td></tr>
<tr><td>CEO- CMS Administrator Contact</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Quality Director</td><td></td><td></td><td></td><td></td></tr>
</table>
</td><td></td><td></td></tr>
</table>

B. In HPMS, upload organizational charts showing the relationship of various departments.

3.7 Fiscal Soundness

A. In HPMS, complete the table below:

YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: FISCAL SOUNDNESS	YES	NO
1. Applicant maintains a fiscally sound operation and maintains a positive net worth (Total Assets exceed Total Liabilities).		

B. In HPMS, upload the most recent Audited Financial Statement that are available and the most recent Quarterly NAIC Health Blank or other form of quarterly financials if the NAIC Health Blank is not required by your state. CMS reserves the right to request additional financial information as it sees fit to determine if the Applicant is maintaining a fiscally sound operation.

Note: If the Applicant was not in business in 2011, and has less than six months of operation in 2012, it must electronically upload the financial information it submitted to the state at the time the state licensure was requested. If the Applicant has a parent company, it must submit the parent's 2012 Audited Financial Statement. If the parent's 2012 Audited Financial Statement is not available at the time of the submission of the application, the Applicant must submit the parent's 2011 Audited Financial Statement and the parent's 2012 Annual NAIC Health Blank or other form of quarterly financials if the NAIC Health Blank is not required by your State.

3.8 Service Area

The purpose of the service area attestation is to clearly define which areas will be served by the MAO. A service area for local MA plans is defined as a geographic area composed of a county or multiple counties, while a service area for MA regional plans is a region approved by CMS. The following attestation was developed to implement the regulations of 42 CFR 422.2.

A. 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 MMCM and will serve the entire county.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: SERVICE AREA	YES	NO
• If "No", complete CMS' Partial County Justification document.		

Note: Applicant may only designate or request a partial county service area during the initial application submission.

B. In HPMS, on the Contract Management/Contract Service Area/Service Area Data page, enter the state and county information for the area the Applicant proposes to serve. Applicants that answered "No" to question 1 above must complete CMS' Partial County Justification document and Partial County Network Assessment Table.

3.9 CMS Provider Participation Contracts & Agreements

This section contains attestations that address the requirements of 42 CFR 422.504, which require that MAOs have oversight for contractors, subcontractors, and other entities. The intent of the regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. The MAO is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations. Beneficiaries shall be protected from payment or fees that are the obligation of the MAO. Further guidance is provided in Chapter 11 of the MMCM.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PROVIDER CONTRACTS AND AGREEMENTS	YES	NO
1. Applicant agrees to comply with all applicable provider requirements in subpart E of this part, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. 42 CFR 422.504(a)(6)		
2. Applicant agrees that all provider and supplier contracts or agreements contain the required contract provisions that are		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PROVIDER CONTRACTS AND AGREEMENTS	YES	NO
described in the CMS Provider Contract Required Provision Matrix, the Medicare Managed Care Manual, and CMS regulations at 42 CFR 422.504.		
3. Applicant has executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services throughout the requested service area.		
4. Applicant agrees to have all provider contracts and/or agreements available upon request.		
5. Applicant has executed CMS Medicare Advantage Contract Amendments with ALL of its contracted providers and facilities first tier contracts and downstream contracts at every level		
6. Applicant has executed CMS Medicare Advantage Contract Amendments with SOME of its contracted providers and facilities (first tier contracts and downstream contracts).		
7. Applicant has executed CMS Medicare Advantage Contract Amendments with NONE of its contracted providers and facilities (first tier contracts and downstream contracts).		

* NOTE: The CMS Medicare Advantage Contract Amendment is the model amendment released by CMS on September XX, 2012.

B. In HPMS, upon request, upload a completed "CMS Contract Sample Matrix," the "CMS Provider Contract Required Provision Matrix" and the provider contracts that CMS will name during the application review process. **These documents and the contract sample are not required for the initial application submission.**

   Note: As part of the application review process, Applicants will need to provide fully executed contracts for physicians/providers that CMS reviewers select based upon the CMS Provider and Facility tables that are part of the initial application submission. CMS reviewers will list the providers/facilities and specific instructions in CMS' first deficiency notice.

3.10 Contracts for Administrative & Management Services

This section describes the requirements the Applicant must demonstrate to ensure that any contracts for administrative/management services comply with the requirements of all Medicare laws, regulations, and CMS instructions in accordance with 42 CFR 422.504(i)(4)(v). Further guidance is provided in Chapter 11 of the MMCM.

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 MA operations for the MA contract.		
2. Applicant verifies that it has entered accurate information related to the delegated entities and their functions in the HPMS Delegated Business Function Table in HPMS.		
3. Applicant agrees that as it implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.		
4. Applicant agrees that all contracts for administrative and management services contain the required contract provisions that are described in the CMS Administrative Contract Required Provision Matrix, the MMCM, and the CMS contract requirements in accordance with 42 CFR 422.504.		
5. Applicant has submitted and received CMS approval for an initial or service area expansion application during at least one of the past two (2) Medicare Advantage application review cycles.		

B. In HPMS, complete the Delegated Business Function Table under the Part C Data Link.

Note: If the Applicant plans to delegate a specific function but cannot at this time name the entity with which the Applicant will contract, enter "Not Yet Determined" so that CMS is aware of the Applicant's plans to delegate that function. If the Applicant delegates a particular function to a number of different entities (e.g., claims processing to multiple medical groups), then list the five most significant entities for each delegated business function identified and in the list for the sixth, enter "Multiple Additional Entities".

C. In HPMS, upload a completed CMS Administrative Contract Required Provision Matrix.

D. In HPMS, upload executed management contracts or letters of agreement for each contractor or subcontractor (first tier, downstream, and related entities). If the Applicant has received a Part C application approval, initial or SAE, from CMS during one or both of the two most recent application review cycles (refer to Attestation #5), then no administrative contract upload is necessary.

3.11 Health Services Management & Delivery

The purpose of the Health Service Management and Delivery attestations is to ensure that all Applicants deliver timely and accessible health services for Medicare beneficiaries. CMS recognizes the importance of ensuring continuity of care and developing policies for medical necessity determinations. Therefore, MAOs will be required to select, evaluate, and credential providers that meet CMS' standards, in addition to ensuring the availability of a range of providers necessary to meet the health care needs of Medicare beneficiaries. The following attestations were developed to implement the regulations of 42 CFR 422.112, and 422.114.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: HEALTH SERVICES MANAGEMENT AND DELIVERY	YES	NO
1. Applicant agrees to establish, maintain, and monitor the performance of a comprehensive network of providers to ensure sufficient access to Medicare covered services as well as supplemental services offered by the MAO in accordance with written policies, procedures, and standards for participation established by the MAO. Participation status will be revalidated at appropriate intervals as required by CMS regulations and guidelines.		
2. Applicant has executed written agreements with providers (first tier, downstream, or other entity instruments) structured in compliance with CMS regulations and guidelines.		
3. Applicant, through its contracted or deemed participating provider network, along with other specialists outside the network, community resources or social services within the MAO's service area, agrees to provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: a. Prompt, convenient, and appropriate access to covered services by enrollees 24 hours a day, 7		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: HEALTH SERVICES MANAGEMENT AND DELIVERY	YES	NO
days a week; b. The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; c. Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care; d. Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and e. Addressing diverse patient populations in a culturally competent manner.		
4. Applicant agrees to establish policies, procedures, and standards that: a. Ensure and facilitate the availability, convenient and timely access to all Medicare covered services as well as any supplemental services offered by the MAO; b. Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; c. Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; d. Communicate and enforce compliance by providers with medical necessity determinations; and e. Do not discriminate against Medicare enrollees.		
5. Applicant has verified that contracted providers included in the MA Facility Table are Medicare certified and the Applicant certifies that it will only contract with Medicare certified providers in the future.		
6. Applicant agrees to provide all services covered by Medicare Part A and Part B and to comply with CMS national coverage determinations, general coverage guidelines included in Original Medicare manuals and instructions, and the written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic service area covered by the MAO.		

B. In HPMS, upload the following completed HSD tables:

- MA Provider Table
- MA Facility Table

3.12 Quality Improvement Program (QIP)

The purpose of this section is to ensure that all Applicants have a QIP. A QIP will ensure that MAOs have the infrastructure available to increase quality, performance, and efficiency of the program on an on-going basis, and will help identify actual or potential triggers or activities for the purpose of mitigating risk and enhancing patient safety. This process will provide MAOs an opportunity to resolve identified areas of concern. The following attestations were developed to implement the regulations of 42 CFR 422.152 and Chapter 5 of the MMCM.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: QIP	YES	NO
1. Applicant has an ongoing QIP that is ready for implementation. 42 CFR 422.152(a)		
2. Applicant agrees to provide CMS with all documents pertaining to the QIP upon request.		

B. In HPMS, upload a copy of the Applicant's QIP Plan in an Adobe.pdf format.

C. In HPMS, complete and upload the Crosswalk for Part C QIP Plan.

3.13 Marketing

The purpose of the Medicare Operations Marketing attestations is to ensure that all Applicants comply with all CMS regulations and guidance including, but not limited to, the Managed Care Manual, user guides, the annual Call Letter, and communications through HPMS. Medicare Advantage MA and Cost Plans are required to provide comprehensive information in written form and via a call center to ensure that Medicare beneficiaries understand the features of their MA plans. The following attestations were developed to implement the regulations of 42 CFR 422.2260 through 422.2276.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – MARKETING	YES	NO	N/A
1. Applicant complies with marketing guidelines and approval procedures that are contained with Chapter 3 of the Medicare Managed Care Manual and posted on the www.cms.gov/ website, including the requirements of the File and Use Certification process.			
2. Applicant agrees to make available to beneficiaries those marketing materials, notices, and other standardized letters and forms that comply with CMS marketing requirements.			
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 (Enrollment Kit-at the time of enrollment) • Beneficiary Procedural Rights • Potential for Contract Termination • Summary of Benefits (Enrollment Kit-at the time of enrollment and upon request) • Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) • Premiums • Service Area • Provider Directory • Plan ratings information • Membership ID Card (required at the time of enrollment and as needed or required by plan sponsor post-enrollment)			
4. Applicant agrees to provide general coverage information, as well as information concerning utilization, grievances, appeals, exceptions, quality assurance, and financial information to any beneficiary upon request.			
5. The Applicant agrees to verify the identity of the caller as a beneficiary or validate the authority of the caller to act on behalf of the beneficiary prior to discussing any Personal Health Information as required under HIPAA.			
6. Applicant agrees to maintain a toll-free customer service call center that provides customer telephone service to current and prospective enrollees in compliance with CMS standards. This means the Applicant complies with the following: • Call center operates during normal business hours, seven			

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – MARKETING	YES	NO	N/A
days a week from 8:00 AM to 8:00 PM for all time zones of the Applicants respective service areas. • A customer service representative is available to answer beneficiary calls directly during the annual enrollment and 45 days after the annual enrollment period. • On Saturdays, Sundays, and holidays, from February 15th until the following annual enrollment period, a customer service representative or an automated phone system may answer beneficiary calls. • If a beneficiary is required to leave a message in voice mail box due to the utilization of an automated phone system, the applicant ensures that a return call to a beneficiary is made in a timely manner, but no more than one business day after receipt of the message. • Call center must provide interpreter service to all non-English speaking, or limited English proficient (LEP) beneficiaries.			
7. Applicant agrees to provide Toll Free TTY or TDD numbers for all hearing impaired beneficiaries in conjunction with all other phone numbers utilized for call center activity.			
8. Applicant agrees to make the marketing materials specified by CMS available in any language that is the primary language of at least 5% of a plan sponsor's benefit package service area. NOTE: Plan sponsors operating in service areas that do not meet the 5% threshold are not required to produce any translated materials.			
9. The Applicant agrees to operate a toll-free call center to respond to physicians and other providers requesting exceptions, coverage determinations, prior authorizations, and beneficiary appeals. This mean the Applicant complies with the following: • The call center must be available to callers from 8:00 am to 6:00 pm, consistent with the local time zone of each of the			

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – MARKETING	YES	NO	N/A
Applicant's respective service areas, Monday through Friday, at a minimum. • An alternative technology, such as an interactive voice response system or voice mail, may be used outside of these hours, ensuring that information may be submitted for action by the Applicant 24 hours a day, 7 days a week.			
10. The Applicant agrees to comply with CMS performance requirements for all call centers including: • The average hold time for a beneficiary to reach a customer service representative is two minutes or less. • Eighty percent (80%) of all incoming calls are answered within 30 seconds. • The disconnect rate for all incoming customer calls does not exceed 5%. • Acknowledgement of all calls received via an alternative technology within one business day.			
11. Applicant agrees to guarantee that all call center staff are effectively trained to provide thorough, accurate, and specific information on all product offerings, including applicable eligibility requirements, cost sharing amount, premiums, and provider networks.			
12. Applicant agrees to implement and maintain an explicit process for handling customer complaints.			
13. Applicant agrees to develop and maintain an Internet Web site providing thorough, accurate, and specific information as specified by CMS.			
14. Applicant agrees to provide initial and renewal compensation to a broker or agent for the sale of a Medicare health plan consistent with CMS requirements.			
15. Applicant agrees that brokers and agents selling Medicare products are trained and tested, annually, on Medicare rules and regulations and the specifics of the plans they are selling, and that they pass with a minimum score as specified in CMS guidance.			

3.14 Eligibility, Enrollment, and Disenrollment

This section identifies attestations consistent with the requirements of 42 CFR 422.50 through 422.74, which address the eligibility requirements to enroll in, continue enrollment in, or disenroll from an MA plan. The intent of these regulations is to ensure that all MAOs fully comply with the requirements set forth to ensure services adhere to standard processes and meet contractual obligations, laws, regulations and CMS instructions.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – ELIGIBILITY, ENROLLMENT and DISENROLLMENT	YES	NO
1. Applicant agrees to comply with all CMS regulations and guidance pertaining to eligibility, enrollment and disenrollment for MA, including, but not limited to, the MMCM, user guides, the annual Call Letter, and interim guidance and other communications distributed via HPMS.		
2. Applicant agrees to provide required notices to beneficiaries, including pre-enrollment and post-enrollment materials, consistent with CMS rules, guidelines, and regulations, including, but not limited to, the Annual Notice of Change (ANOC) /Summary of Benefits (SB)/Evidence of Coverage (EOC), Provider Directories, Enrollment and Disenrollment notices, Coverage Denials, ID card, and other standardized and/or mandated notices.		
3. Applicant agrees to accept enrollment elections during valid election periods from all MA eligible Medicare beneficiaries who reside in the MA service area, as provided in Chapter 2 of the MMCM.		
4. Applicant agrees to accept responsibility for accurately determining the eligibility of the beneficiary for enrollment, as described in Chapter 2 of the MMCM.		
5. Applicant agrees to accept responsibility for determining that a valid election period exists, permitting the beneficiary to request enrollment in the MAO's product, and will accept voluntary disenrollments only during timeframes specified by CMS.		
6. Applicant agrees to 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.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – ELIGIBILITY, ENROLLMENT and DISENROLLMENT	YES	NO
7. Applicant agrees to ensure that enrollee coverage in the plan begins as of the effective date of enrollment in the plan, consistent with the detailed procedures described in the CMS enrollment guidance. Organizations may not delay enrollment or otherwise withhold benefits while waiting for successful (i.e., accepted) transactions to/from MARx.		
8. Applicant agrees to develop, operate and maintain viable systems, processes, and procedures for the timely, accurate, and valid enrollment and disenrollment of beneficiaries in the MAO, consistent with all CMS requirements, guidelines, and regulations.		
9. In the event of contract termination, Applicant will notify enrollees of termination and of alternatives for obtaining other MA coverage, as well as Medicare prescription drug coverage, in accordance with Part 422 and Part 423 regulations.		
10. Applicant agrees to establish business processes and communication protocols for the prompt resolution of urgent issues affecting beneficiaries, such as late changes in enrollment or co-pay status, in collaboration with CMS.		
11. Applicant acknowledges that enrollees can make enrollment changes, during election periods for which they are eligible, in the following ways: A) Electing a different MA plan by submitting an enrollment request to that MAO, B) Submitting a request for disenrollment to the MAO in the form and manner prescribed by CMS.		
12. Applicant agrees to perform the following functions upon receipt of an enrollee's request for voluntary disenrollment: • Submit a disenrollment transaction to CMS within timeframes specified by CMS. • Provide enrollee with notice to acknowledge disenrollment request in a format specified by CMS. • File and retain disenrollment requests for the period specified in CMS instructions, and • In cases where lock-in applies, include in the notice a statement explaining that o The member remains enrolled until the effective date of disenrollment o Until the effective date of disenrollment (except for urgent and/or emergent care) neither the		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICARE OPERATIONS – ELIGIBILITY, ENROLLMENT and DISENROLLMENT	YES	NO
MAO nor CMS will pay for services that have not been provided or arranged for by the MAO prior to voluntary disenrollment.		
13. Applicant will comply with all standards and requirements regarding involuntary disenrollment of an individual initiated by the MAO for any circumstances listed below: • Any monthly plan premiums are not paid on a timely basis, 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.		
14. If the Applicant disenrolls an individual for the reasons stated above, Applicant agrees to give the individual required written notice(s) 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 MAO's grievance procedure.		
15. Applicant acknowledges and commits to utilizing HPMS as the principle tool for submitting and receiving formal communications related to MAO performance, enrollee inquiries (CTM), notices and memoranda from CMS staff, routine reporting, and the fulfillment of other functional and regulatory responsibilities and requirements, including, but not limited to, the submission of marketing materials, applications, attestations, bids, contact information, and oversight activities.		
16. On a monthly basis, Applicant agrees to accurately and thoroughly process and submit the necessary information to validate enrollment in support of the monthly payment, as provided under 42 CRF 422 subpart G.		

3.15 Working Aged Membership

The purpose of these attestations is to ensure that Applicants report all working aged members to CMS, as well as to identify amounts payable, coordinate benefits to enrollees, and identify primary Medicare patients. The following attestations were developed to implement the regulations of 42 CFR 422.108.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: WORKING AGED MEMBERSHIP	YES	NO
A. Applicant agrees to identify, document, and report to CMS relevant coverage information for working aged, including: • Identify payers that are primary to Medicare • Identify the amounts payable by those payers • Coordinate the Applicant's benefits or amounts payable with the benefits or amounts payable by the primary payers.		

3.16 Claims

The purpose of these attestations is to ensure that the Applicant properly dates and processes all claims, per CMS instructions listed herein. These attestations also provide the Applicant with general guidance on how to appropriately notify beneficiaries of claim decisions. The following attestations were developed to implement the regulations of 42 CFR 422.504(c) and 42 CFR 422.520(a).

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CLAIMS	YES	NO
1. Applicant agrees to date stamp all claims as they are received, whether in paper form or via electronic submission, in a manner that is acceptable to CMS.		
2. Applicant will ensure that all claims are processed promptly and in accordance with CMS regulations and guidelines.		
3. Applicant agrees to give the beneficiary prompt notice of acceptance or denial of a claim's payment in a format consistent with the appeals and notice requirements stated in 42 CFR Part 422 Subpart M.		
4. Applicant agrees to comply with all applicable standards and requirements and establish meaningful procedures for the development and processing of all claims, including having an effective system for receiving, controlling, and		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CLAIMS	YES	NO
processing claims actions promptly and correctly.		
5. Applicant agrees to use an automated claims system that demonstrates the ability to accurately and timely pay contracted and non-contracted providers according to CMS requirements.		

3.17 Communications between MAO and CMS

CMS is committed to ensuring clear communications with MAOs. The purpose of this section is to ensure that all Applicants engage in effective and timely communications with CMS. Such communications will help improve and support administrative coordination between CMS and MAOs. The following attestations were developed to implement the regulations of 42 CFR 422.504(b).

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: COMMUNICATIONS	YES	NO
1. Applicant agrees to facilitate the provision of access to and assignment of User IDs and Passwords for CMS systems applications for all key functional, operational, and regulatory staff within the MAO to ensure the timely completion of required transactions within the CMS systems structure, including HPMS, MARx and any other online application with restricted access.		
2. Applicant acknowledges and commits to utilizing HPMS as the principle tool for submitting and receiving formal communications related to MAO performance, enrollee inquiries (CTM), notices and memoranda from CMS staff, routine reporting, and the fulfillment of other functional and regulatory responsibilities and requirements including, but not limited to, the submission of marketing materials, applications, attestations, bids, contact information, and oversight activities.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: COMMUNICATIONS	YES	NO
3. Applicant agrees to establish connectivity to CMS via the AT&T Medicare Data Communications Network (MDCN) or via the Gentran Filesaver.		
4. Applicant agrees to submit test enrollment and disenrollment transmissions.		
5. Applicant agrees to submit enrollment, disenrollment and change transactions to CMS within 7 calendar days to communicate membership information to CMS each month.		
6. Applicant agrees to reconcile MA data to CMS enrollment/payment reports within 45 days of availability.		
7. Applicant agrees to submit enrollment/payment attestation forms within 45 days of CMS report availability.		
8. Applicant agrees to ensure that enrollee coverage in the plan begins as of the effective date of enrollment in the plan, consistent with the detailed procedures described in the CMS enrollment guidance. Organizations may not delay enrollment or otherwise withhold benefits while waiting for successful (i.e. accepted) transactions to/from MARx.		

3.18 Grievances

CMS is committed to guaranteeing that Medicare beneficiaries have access to, education on, decision making authority for, and are in receipt of quality health care. To ensure that beneficiaries have the ability to express their concerns and that those concerns are acted on promptly, MAOs must have a grievance program structured in compliance with CMS regulations and guidelines. In this capacity, a grievance is defined as any complaint or dispute, other than one 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. Enrollees or their representatives 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 complaint 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.

The following attestations were developed to implement the regulations of 42 CFR 422.561and 42 CFR 422.564.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: GRIEVANCES	YES	NO
1. Applicant agrees to comply with all applicable regulations, standards, guidelines and/or requirements, establishing meaningful processes, procedures, and effectively training the relevant staff and subcontractors (first tier, downstream and related entities), to accept, identify, track, record, resolve, and report enrollee grievances within the timelines established by CMS. An accessible and auditable record of all grievances received on behalf of the MAO, both oral and written, will be maintained to include, at a minimum: the receipt date, mode of submission (i.e. fax, telephone, letter, e-mail, etc.), originator of grievance (person or entity), enrollee affected, subject, final disposition, and date of enrollee notification of the disposition.		
2. Applicant agrees to advise all MA enrollees of the definition of a grievance, their rights, the relevant processes, and the timelines associated with the submission and resolution of grievances to the MAO and its subcontractors (first tier, downstream and related entities) through the provision of information and outreach materials.		
3. Applicant agrees to accept grievances from enrollees at least by telephone and in writing (including fax).		
4. Applicant agrees to inform enrollees of the complaint process that is available to the enrollee under the Quality Improvement Organization (QIO) process.		

3.19 Appeals

CMS recognizes the importance of the appeals process for both MAOs and Medicare beneficiaries. The purpose of this section is to ensure that beneficiaries have the opportunity to submit an appeal. Accordingly, MAOs must have an appeals process structured in compliance with CMS regulations and guidelines. An appeal is defined as any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined under 422.566(b). These procedures include reconsiderations

by the MAO, and if necessary, an independent review entity, hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review. The following attestations were developed to implement the regulations of 42 CFR 422.561.

A. 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 beneficiary organizational determinations, exceptions, and appeals consistent with 42 CFR 422, subpart M.		
2. Applicant agrees to 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 agrees to ensure 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 agrees to ensure that the reconsideration policy complies with CMS requirements as to assigning the appropriate person or persons to conduct requested reconsiderations.		
5. Applicant agrees to ensure that the reconsideration policy complies with CMS timeframes for forwarding reconsideration request cases to CMS' independent review entity (IRE) where the Applicant affirms an organization determination adverse to the member or as otherwise required under CMS policy.		
6. Applicant agrees to ensure 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 agrees to make its enrollees aware of the organization determination, reconsideration, and appeals		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: APPEALS	YES	NO
process through information provided in the Evidence of Coverage and outreach materials.		
8. Applicant agrees to establish and maintain a process designed to track and address in a timely manner all organization determinations and reconsideration requests, including those transferred to the IRE, an Administrative Law Judge (ALJ) or some higher level of appeal, received both orally and in writing, that includes, at a minimum: • Date of receipt • Date of any notification • Disposition of request • Date of disposition		
9. Applicant agrees to make available to CMS, upon CMS request, organization determination and reconsideration records.		
10. Applicant agrees to not restrict the number of reconsideration requests submitted by or on behalf of a member.		

3.20 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 complies with all applicable standards, implementation specifications, and requirements in the Standards for Privacy of Individually Identifiable Health Information and Security Standards under 45 CFR Parts 160, 162, and 164.		
2. Applicant agrees to encrypt all hard drives and other electronic storage media, including all removable media, containing electronic protected health information (PHI).		
3. Applicant agrees to have policies addressing the secure handling of portable media that are accessed or used by the organization.		
4. Applicant complies 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.		
5. Applicant complies with all applicable standards, implementation specifications, operating rules, and requirements in the Standards for Electronic Transactions under 45 CFR Parts 160 and 162.		
6. 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").		
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 PHI by the last Friday in September for the upcoming contract year.		
8. Applicant agrees to not use any part of an enrollee's Social Security Number (SSN) or Medicare ID Number (i.e., Health Insurance Claim Number) on the enrollee's identification card.		

3.21 Continuation Area

The purpose of a continuation area is to ensure continuity of care for enrollees who no longer reside in the service area of a plan and who permanently move into the geographic area designated by the MAO as a continuation area. A continuation area is defined as an additional area (outside the service area) within which the MAO offering a local plan furnishes or arranges to furnish services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis and provide documentation that establishes residency, such as a driver's license or voter registration card. A continuation area does not expand the service area of any MA local plan. The following attestations were developed to implement the regulations of 42 CFR 422.54.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CONTINUATION AREA	YES	NO
1. Applicant agrees to establish a continuation area (outside the service area) within which the MAO offering a local plan furnishes or arranges to furnish services to its enrollees that initially resided in the contract service area.		
2. Applicant agrees to submit marketing materials that will describe the continuation area options.		
3. Applicant agrees to make arrangements with providers for payment of claims for Medicare covered benefits to ensure beneficiary access to services in the continuation area.		
4. Applicant agrees to 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).		

3.22 Part C Application Certification

A. In HPMS, upload a completed and signed Adobe.pdf format copy of the Part C Application Certification Form.

Note: Once the Part C application is complete, Applicants seeking to offer a Part D plan must complete the Part D application in HPMS. PFFS and Cost Plan SAE organizations have the option to offer Part D plans. MSAs are not allowed to offer Part D plans.

3.23 RPPO Essential Hospital

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: RPPO ESSENTIAL HOSPITAL	YES	NO
1. Applicant is requesting essential hospital designation for non-contracted hospitals. • If "Yes", upload in HPMS a completed CMS Essential Hospital Designation Table and Attestation.		

B. In HPMS, upload a completed CMS Essential Hospital Designation Table.

3.24 Access to Services (PFFS & MSA)

The purpose of these attestations is to provide the Applicant with information regarding the offering of the various PFFS models, including a network, partial network, or non-network PFFS model to its members, as applicable. Additionally, these attestations will inform the Applicant of the documents and/or information that will need to be uploaded into HPMS. The following attestations were developed to implement the regulations of 42 CFR 422.114(a)(2)(iii).

Please note that, effective with contract year 2012, Section 1862(d) of the SSA, as amended by Section 162(a)(1) of MIPPA, requires those PFFS plans operating in "network areas" to meet the access standards described in section 1852(d)(4)(B) of the Act through contracts with providers. The list of those areas considered "network areas" for purposes of the 2013 application and contracting requirements can be found at: http://www.cms.hhs.gov/PrivateFeeforServicePlans/. CMS will not accept a non-network or partial network application that includes any of the areas identified as "network areas" in the referenced document. Furthermore, Applicants wishing to offer both network PFFS products and non-network or partial network PFFS products must do so under separate contracts.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ACCESS TO SERVICES	YES	NO

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ACCESS TO SERVICES	YES	NO
1. Applicant agrees to offer a combination PFFS Model that meets 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, the Applicant must offer a combination PFFS model. *This attestation is not applicable to MSA Applicants.		
2. Applicant agrees to 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. *This attestation is not applicable to MSA Applicants.		
3. Applicant agrees to offer a non-network PFFS model only per 42 CFR 422.114(a)(2)(i). *This attestation is not applicable to MSA Applicants.		
4. If providing a network or partial network PFFS plan, Applicant has 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. *This attestation is not applicable to MSA Applicants.		
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 mammograms)		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: ACCESS TO SERVICES	YES	NO
• 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 • Note: If Applicant selects "Other", upload in HPMS a thorough description of proposed services, including rationale for providing a contract network for the proposed service. • If Applicant proposes to furnish certain categories of service through a contracted network, upload in HPMS a narrative description of the proposed network. Please ensure that the categories are clearly defined in the narrative description. *This attestation is not applicable to MSA Applicants.		
6. Applicant agrees to post the organization's "Terms and Conditions of Payment" on its website, which describes 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. *This attestation is not applicable to MSA Applicants.		
7. Applicant agrees to provide information to its members and providers explaining the provider deeming process and the payment mechanisms for providers. *This attestation is not applicable to MSA Applicants.		

NOTE: PFFS Applicants must select the combination PFFS model, the network model or the non-network model (Attestations #1-3) as appropriate for each type of contract (and application) they seek. A single contract cannot encompass more than one of these models.

B. In HPMS, upload a description of Proposed Services for combination networks, if Applicant selects "Other" for question 5. If Applicant proposes to furnish certain categories of service through a contracted network, please ensure that the categories are clearly defined in the narrative description. This upload is required for selected PFFS Applicants.

C. In HPMS, upload a description of how the Applicant will follow CMS's national coverage decisions and written decisions of carriers and intermediaries (LMRP) throughout the United States (Refer to 42 CFR 422.101 (b)). This upload is required for PFFS and MSA Applicants.

D. In HPMS, upload a description of how the Applicant's policies ensure that health services are provided in a culturally competent manner to enrollees of different backgrounds. This upload is required for PFFS and MSA Applicants.

3.25 Claims Processing (PFFS & MSA)

The purpose of these attestations is to verify that the Applicant uses a validated claims system, properly implements the Reimbursement Grid and pays all providers according to the PFFS plan's terms and conditions of payment. Additionally, upon request, the Applicant will submit to CMS its complete and thorough Provider Dispute Resolution Policies and Procedures (P&Ps), bi-weekly reports detailing complaints, and/or bi-weekly reports detailing appeals and/or claims. The following attestations were developed to implement the regulations of 42 CFR 422.216.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CLAIMS PROCESSING	YES	NO
1. Applicant agrees to 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 upon request.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CLAIMS PROCESSING	YES	NO
3. 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. *This attestation is not applicable to MSA Plans.		
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 these P&Ps must be disclosed to providers. The Applicant must submit information on how it has integrated the P&Ps into all staff training - particularly in Provider Relations, Customer Service and Appeals/Grievances.		
5. Applicant agrees that upon request, it will submit a biweekly report to the CMS RO Account Manager that 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 that upon request, it will submit a biweekly report to the CMS RO Account Manager that outlines all beneficiary appeals and/or complaints (verbal and written) related to claims for the six months following the receipt of the first claim. This report will outline the investigation and the resolution including the completion of CMS designed worksheet.		

3.26 Payment Provisions

This section may be applicable to PFFS & MSA Plans

The purpose of these attestations is to ensure that the Applicant has an appropriate system in place to properly pay providers and to ensure that enrollees are not being overcharged. Additionally, it instructs Applicants to upload a Reimbursement Grid in HPMS. The following attestations were developed to implement the regulations of 42 CFR 422.216(c).

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PAYMENT PROVISIONS	YES	NO
1. PFFS Plans -- 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). *This attestation is not applicable to MSA Applicants.		
2. The Applicant has a system in place to ensure members are not charged more in cost sharing or balance billing than the amounts specified in the PFFS plan's terms and conditions of payment. [Refer to 42 CFR 422.216(c)]. *This attestation is not applicable to MSA Applicants		
3. Applicant agrees that information in the Payment Reimbursement Grid is true and accurate. (PFFS and MSA Applicants)		
4. Applicant agrees to ensure that members are not charged more than the Medicare-allowed charge (up to the limiting charge for non-Medicare participating providers) when they receive medical services.		
5. Applicant has a system in place to timely furnish an advance determination of coverage upon a verbal or written request by a member or provider.		
6. The Applicant has a system in place to ensure members are not charged after the deductible has been met. [Refer to 42		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PAYMENT PROVISIONS	YES	NO
CFR 422.103(c)]. *This attestation is not applicable to PFFS Applicants.		
7. Applicant agrees to allow providers to balance bill the beneficiary up to allowed amount. • Note: This only applies to Applicants that allow balance billing.		

B. In HPMS, upload a completed Payment Reimbursement grid.

Note: Organization may use any format for the Payment Reimbursement grid that best outlines the organization's rates. There is no CMS-prescribed format.

3.27 General Administration/Management

This section is applicable to MSA Applicants

The purpose of these attestations is to ensure that the Applicant is offering Medical Savings Accounts (MSA) plans that follow requirements set forth in law, regulation and CMS instructions. The Applicant may establish a relationship with a banking partner and have a system in place to receive Medicare deposits to MSA plan enrollee accounts. The following sections of 42 CFR 422 contain provisions that are specific to Medical Savings Accounts : 422.2, 422.4(a) and (c), 422.56, 422.62(d), 422.100(b)(2), 422.102(b), 422.103, 422.104, 422.111(a), 422.152, 422.252, 422.254(e), 422.256(e), 422.262(b)(2), 422.270(a)(1), 422.304(c)(2), and lastly, 422.314.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICAL SAVINGS ACCOUNTS (MSA)	YES	NO
1. Applicant is offering network MSA plans that follow the CCP network model.		
2. Applicant is offering network MSA plans that follow the PFFS network model.		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: MEDICAL SAVINGS ACCOUNTS (MSA)	YES	NO
3. Applicant currently operates a commercial Health Savings Account (HSA) plan or other type of commercial tax-favored health plan or an MA Medical Savings Account (MSA) plan.		
4. Applicant agrees to serve as the MA MSA Trustee or Custodian for receiving Medicare deposits to MSA plan enrollee accounts.		
5. Applicant agrees to 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). • If "Yes", upload the banking contract in HPMS.		
6. Applicant agrees to establish policies and procedures with its banking partner that 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.		

B. In HPMS, upload the banking contract for review by CMS and the Applicant, if Applicant answered "Yes" to question 5 above, to ensure that ALL CMS direct and/or any delegated contracting requirements are included in the contract.

C. In HPMS, upload a description of how the Applicant will track enrollee usage of information provided on the cost and quality of providers. Be sure to include how the Applicant intends to track use of health services between those enrollees who utilize transparency information and those who do not.

D. In HPMS, upload a description of how the Applicant will recover current-year deposit amounts for members who are disenrolled from the plan before the end of the calendar year.

4 Document Upload Templates

4.1 History/Structure/Organizational Charts

Note: CMS REQUESTS THAT YOU LIMIT THIS DOCUMENT TO EIGHT (8) PAGES.

Please Check:

_____***New to the MA program (initial application)***

_____***Cost Plan SAE Application***

SECTION 1: All Applicants (new and existing) must complete this section.

1. Please give a brief summary of Applicant's history.
    a. Structure:
    b. Ownership:
2. Attach a diagram of Applicant's structure of ownership.
3. Attach a diagram of the Applicant's relation to its subsidiaries, as well as its business affiliations.

SECTION II: Applicants that are new to the MA Program must complete this section.

1. Please provide the date of the company's last financial audit.
2. What were the results of that audit?
3. Briefly describe the financial status of the Applicant's company.
4. Briefly explain the Applicant's marketing philosophy.
5. Who in the Applicant's organization can appoint and remove the executive manager?

6. Please submit a brief description and/or a flow chart of the Applicant's claims processing systems and operations.

7. Please submit a brief description and/or flow chart of the Applicant's grievances process.

8. Please provide a brief description and flow chart of the Applicant's appeals process.

9. If applicable, please provide the name of the claims systems that Applicant tested to demonstrate the systems' ability to pay Medicare FFS payments.

4.2 CMS State Certification Form

INSTRUCTIONS
(MA State Certification Form)

General:
This form is required to be submitted with all MA applications. The MA Applicant is required to complete the items above the line (items 1 - 3), then forward the document to the appropriate State Agency Official who should complete those items below the line (items 4-7). After completion, the State Agency Official should return this document to the Applicant organization for submission to CMS as part of its application for a MA contract.

The questions provided must be answered completely. If additional space is needed to respond to the questions, please add pages as necessary. Provide additional information whenever you believe further explanation will clarify the response.

The MA State Certification Form demonstrates to CMS that the MA contract being sought by the Applicant organization is within the scope of the license granted by the appropriate State regulatory agency, that the organization meets state solvency requirements and that it is authorized to bear risk. A determination on the organization's MA application will be based upon the organization's entire application that was submitted to CMS, including documentation of appropriate licensure.

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

1. List the name, d/b/a (if applicable) and complete address of the organization that is seeking to enter into the MA contract with CMS.
2. Indicate the type of license (if any) the Applicant organization currently holds in the State where the Applicant organization is applying to offer an MA contract.
3. Specify the type of MA contract the Applicant organization is seeking to enter into with CMS.

New Federal Preemption Authority – The Medicare Modernization Act amended section 1856(b)(3) of the SSA to significantly broaden the scope of Federal preemption of State laws governing plans serving Medicare beneficiaries. Current law provides that the provisions of Title XVIII of the SSA supersede State laws or regulations, other than laws relating to licensure or plan solvency, with respect to MA plans.

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

4. List the reviewer's pertinent information in the event CMS needs to communicate with the individual conducting the review at the State level.
5. List the requested information regarding other State departments/agencies required to review requests for licensure.
6. A. Circle where appropriate to indicate whether the Applicant meets State financial solvency requirements.

   B. Indicate State Agency or Division, including contact name and complete address, that is responsible for assessing whether the Applicant meets State financial solvency requirements.

7. A. Circle where appropriate to indicate whether the Applicant meets State licensure requirements.

   B. Indicate State Agency or Division, including contact name and complete address, that is responsible for assessing whether the Applicant meets State licensing requirements.

MEDICARE ADVANTAGE (MA)
STATE CERTIFICATION REQUEST

MA Applicants should complete items 1-3.

1. MA Applicant Information (Organization that has applied for MA contract(s)):

   Name _____

   D/B/A (if applicable) _____

   Address _____

   City/State/Zip _____

2. Type of State license or Certificate of Authority currently held by referenced Applicant: (Circle more than one if entity holds multiple licenses)

   ● HMO ● PSO ● PPO ● Indemnity ● Other _____

   Comments:

3. Type of MA application filed by the Applicant with the Centers for Medicare & Medicaid Services (CMS): (Circle all that are appropriate)

   ● HMO ● PPO ● MSA ● PFFS ● Religious/Fraternal

   Requested Service Area:
   _____

I certify that _____'s application to CMS is for the type of MA plan(s) and the service area(s) indicated above in questions 1-3.

_____
MAO

_____ _____
Date CEO/CFO Signature

_____
Title

(An appropriate State official must complete items 4-7.)

Please note that under section 1856(b)(3) of the SSA and 42 CFR 422.402, other than laws related to State licensure or solvency requirements, the provisions of title XVIII of the SSA preempt State laws with respect to MA plans.

4. State official reviewing MA State Certification Request:

   Reviewer's Name
   _____
   State Oversight/Compliance Officer
   _____
   Agency Name
   _____
   Address
   _____
   Address
   _____
   City/State
   _____
   Telephone
   _____
   E-Mail Address
   _____

5. Name of other State agencies (if any) whose approval is required for licensure:

   Agency_____
   Contact Person_____
   Address_____
   City/State_____
   Telephone_____
   E-Mail Address _____

6. Financial Solvency:

   Does the Applicant organization named in item 1 above meet State financial solvency requirements? (Please circle the correct response)

   ● Yes ● No

   Please indicate which State Agency or Division is responsible for assessing whether the named Applicant organization meets State financial solvency requirements.

_____

7. State Licensure:

   Does the Applicant organization named in item 1 above meet State Licensure requirements? (Please circle the correct response)

   ● Yes ● No

   Please indicate which State Agency or Division is responsible for assessing whether this organization meets State licensure requirements.

   _____

State Certification

I hereby certify to the Centers for Medicare & Medicaid Services (CMS) that the above organization (doing business as (d/b/a) _____) is:

(Check one)

_____ licensed in the State of _____ as a risk bearing entity, or

_____ authorized to operate as a risk bearing entity in the State of _____

And

(Check one)

_____ is in compliance with State solvency requirements, or

_____ State solvency requirement not applicable [please explain below].

By signing the certification, the State of _____ is certifying that the organization is licensed and/or that the organization is authorized to bear the risk associated with the MA product circled in item 3 above. The State is not being asked to verify plan eligibility for the Medicare managed care products(s) or CMS contract type(s) requested by the organization, but merely to certify to the requested information based on the representation by the organization named above.

_____
Agency

_____ _____
Date Signature

_____
Title

4.3 CMS Provider Contract Required Provision Matrix

Instructions for CMS Provider Contract Required Provision Matrix

This matrix must be completed by MA Applicants and should be used to indicate the location of the Medicare requirements in each contract / agreement for the Applicant's first tier, downstream and related entity providers that CMS has identified in the contract sample and in those that link the identified provider/facility to the Applicant.

Instructions:

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

2. At the top of each column enter the name of the provider / facility that CMS has identified in the contract sample.

3. Designate if the contract uses the CMS Medicare Advantage Contract Amendment (released by CMS on [insert date], 2012) with a "(M)" next to the provider / facility name.

4. Designate if the provider / facility is a first tier contracted provider with a "(1)" next to the provider / facility name.

5. Designate downstream contracts provider(s), group(s), or other entity with a "(DS)" next to the provider/facility name.

6. For each provider, in the row listing each requirement, provide the page number where the provision that meets the regulatory requirement can be found in each of the contracts / agreements listed.

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

CMS Provider Contract Required Provision Matrix

CONTRACT #: _____

COUNTY: _____ STATE: _____

IPA/Group/Provider Name					
CMS Medicare Advantage Contract Amendment (If yes, enter "M")					
First Tier (Enter "1") or Downstream (Enter "DS")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
All Provider Contracts					
Right to Audit and Records Retention HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the MA organization) through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. 422.504(i)(2)(i) and (ii)					
Confidentiality L/W CMS and Sponsor Comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.					

• In addition to the CFR citations provided above, the following contract provisions are required in agreements between MAOs and provider and suppliers of health care as stated in Chapter 11, section 100.4, of the MMCM .

IPA/Group/Provider Name					
CMS Medicare Advantage Contract Amendment (If yes, enter "M")					
First Tier (Enter "1") or Downstream (Enter "DS")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
422.504(a)13 and 422.118					
Hold Harmless Prohibited from holding any enrollee liable for payment of any fees that are the legal obligation of the MA organization. 422.504(g)(1)(i) and 422.504(i)(3)(i)					
Hold Harmless for MAs with Enrollees Eligible for Both Medicare and Medicaid For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. May not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source." 422.504(g)(1)(iii)					
Consistent and Comply with MAO's Contractual Obligations Any services or other activity performed are consistent and comply with the MA organization's contractual obligations. 422.504(i)(3)(iii)					
Prompt Payment The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider. 422.520(b)					

IPA/Group/Provider Name					
CMS Medicare Advantage Contract Amendment (If yes, enter "M")					
First Tier (Enter "1") or Downstream (Enter "DS")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
Delegated Activities: Selection of Providers If the MAO delegates a selection of providers, written arrangements must state the MAO retains the right to approve, suspend, or terminate such arrangement. 422.504(i)(5)					
Delegated Activities – List of Delegated Activities and Reporting Responsibilities The contract must clearly state the delegated activities and reporting responsibilities. 422.504(i)(4)(i)					
Delegated Activities – Revocation Agreement provides for the revocation of the delegated activities and reporting requirements or specifies other remedies in instances when CMS or the MAO determines that such parties have not performed satisfactorily. 422.504(i)(4)(ii)					
Delegated Activities – Monitoring Agreement provides that the performance of the parties is monitored by the MAO on an ongoing basis. 422.504(i)(4)(iii)					
Delegated Activities - Credentialing The credentials of medical professionals affiliated with the party or parties will either be reviewed by the MAO OR the credentialing process will be reviewed and approved by the MAO and the MAO must audit the credentialing process on an ongoing basis. 422.504(i)(4)(iv)					

IPA/Group/Provider Name					
CMS Medicare Advantage Contract Amendment (If yes, enter "M")					
First Tier (Enter "1") or Downstream (Enter "DS")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
Compliance with Applicable Medicare Laws and Regulations Must comply with all applicable Medicare laws, regulations, and CMS instructions. 422.504(i)(4)(v)					
Effective Date of Contract (e.g., January 1, 2014 – December 31, 2014, or automatic renewal provision)					
Right to Amend Contract (e.g., unilateral or by mutual agreement)					
Signature and Date Contract Executed					

4.4 CMS Contract Sample Matrix

Instructions: The applicant must submit a completed CMS Contract Sample Matrix to accompany the sample of contracts requested by CMS. It is CMS' expectation that the applicant submit executed contracts at each level of contracting between the applicant and the actual provider where the provider is not under direct contract with the applicant. The applicant must also submit a completed CMS Provider Contract Required Provision Matrix indicating where each of the contracts contains the required contract provisions.

Contract Number:				
Organization Name:				
Date Submitted:				

	Name of Provider / Physician (IPA Medical Group)	Type of Provider / Specialty	Name of Signatory to Contract (If different from Provider Name, explain in Comments column)	Comments (e.g., Explain if no provider contract, signatory different from provider, relationship between applicant and provider, etc.)	List all contracts that link the selected provider / facility to the applicant. After the provider/facility name, indicate with an "M" any contracts that use the CMS Medicare Advantage Contract Amendment (released by CMS on [insert date], 2012)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

4.5 CMS Administrative Contracting Required Provision Matrix

Administrative Contracting Requirements for Management/Delegation of Contracts and/or Agreements
(For contracts and/or agreements that directly relate to MAO's core functions under its contract with CMS)

Instructions for CMS Administrative Contract Matrix

MA Applicants must complete this matrix to indicate (by Section/Page) on which each fully executed administrative contract complies with the required Medicare provisions as listed in the Matrix. *MA Applicants that have received CMS approval for an application during either of the two most recent application cycles do NOT need to submit any administrative contracts nor the CMS Administrative Contract Matrix for this application review.*

Instructions:

1. Develop a single matrix for each application contract number.
2. Enter the name of the administrative contractor with which the Applicant has a fully executed agreement for a core function at the top of each column.
3. Designate if the contract / agreement uses the CMS Medicare Advantage Contract Amendment (release by CMS on [insert date, 2012]. If yes, then enter "M." If not, then leave the cell blank.
4. Enter the section and/or page number within each column on which that fully executed agreement includes the required Medicare provision.

CMS Administrative /Contracting Required Provision Matrix

NAME OF CONTRACTOR (FIRST TIER, DOWNSTREAM and RELATED ENTITY)					
CMS Medicare Advantage Contract Amendment (If Yes, enter "M")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
Record Retention HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information including books, contracts, records, including medical records, and documentation related to CMS' contract with the MAO 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)					
Privacy and Accuracy of Records Providers and suppliers agree to safeguard beneficiary privacy and confidentiality and ensure the accuracy of beneficiary health records. 422.504(a)13					
Hold Harmless** Providers may not hold beneficiaries liable for payment of fees that are the legal obligation of the MAO. (Does not charge enrollees for any health care or health-care related services) 422.504(g)(1)(i); 422.504(i)(3)(i)					
Delegated Activities: Compliance with MAO's contractual obligations A provision requiring that any services performed will be consistent and					

NAME OF CONTRACTOR (FIRST TIER, DOWNSTREAM and RELATED ENTITY)					
CMS Medicare Advantage Contract Amendment (If Yes, enter "M")					

CMS REGULATIONS – 42 CFR 422•	Section/Page	Section/Page	Section/Page	Section/Page	Section/Page
comply with the MAO's contractual obligations. 422.504(i)(3)(iii)					
Delegated Activities: Selection of Providers If the MAO delegates the selection of providers, written arrangements must state the MAO retains the right to approve, suspend, or terminate such arrangement. 422.504(i)(5)					
Delegated Activities: List of Delegated Activities and Reporting Responsibilities The contract must clearly state the delegated activities and reporting responsibilities. 422.504(i)(4)(i)					
Delegated Activities: Revocation Agreement provides for the revocation of the delegated activities and reporting requirements or specifies other remedies in instances when CMS or the MAO determines that such parties have not performed satisfactorily. 422.504(i)(3)(ii); 422.504(i)(4)(ii)					
Delegated Activities: Monitoring Agreement provides that the performance of the parties is monitored by the MAO on an ongoing basis. 422.504(i)(3)(ii); 422.504(i)(4)(iii)					
Delegated Activities: Credentialing The credentials of medical professionals affiliated with the party or parties will either be reviewed by the MAO OR the credentialing process will be reviewed and approved by the MAO; and the MAO must audit the credentialing process on an ongoing basis.					

NAME OF CONTRACTOR (FIRST TIER, DOWNSTREAM and RELATED ENTITY)					
CMS Medicare Advantage Contract Amendment (If Yes, enter "M")					
CMS REGULATIONS – 42 CFR 422•	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**	**Section/Page**
422.504(i)(4)(iv)(A)(B)					
Compliance with Applicable Medicare Laws and Regulations Must comply with all applicable Medicare laws, regulations, and CMS instructions. 422.504(i)(4)(v)					
Dated and Signed					

* In addition to the CFR citations provided above, the following contract provisions are required in agreements between MAOs and provider and suppliers of health care as stated in Chapter 11, section 100.4 of the MMCM.

**This provision is not required in administrative agreements where the first tier, downstream or related entity does not charge enrollees for any health care or health-care related services.

4.6 Part C Application Certification Form

I, _____, attest to the following:
(NAME & TITLE)

1. I have read the contents of the completed application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Centers for Medicare & Medicaid Services (CMS) immediately and in writing.
2. I authorize CMS to verify the information contained herein. I agree to notify CMS in writing of any changes that may jeopardize my ability to meet the qualifications stated in this application prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in termination of the approval.
3. I agree that if my organization meets the minimum qualifications and is Medicare-approved, and my organization enters into a Part C contract with CMS, I will abide by the requirements contained in Section 3 of this Application and provide the services outlined in my application.
4. I agree that CMS may inspect any and all information necessary, including inspecting of the premises of the Applicant's organization or plan to ensure compliance with stated Federal requirements, including specific provisions for which I have attested. I further agree to immediately notify CMS if, despite these attestations, I become aware of circumstances that preclude full compliance by January 1 of the upcoming contract year with the requirements stated here in this application as well as in Part 422 of 42 CFR of the regulation.
5. I understand that in accordance with 18 U.S.C. §1001, any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to CMS to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of approval, fines, and/or imprisonment under Federal law.
6. I further certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to enter into a Part C contract with CMS.
7. I acknowledge that I am aware that there is operational policy guidance, including the forthcoming Call Letter, relevant to this application that is posted on the CMS website and that it is continually updated. Organizations submitting an application in response to this solicitation acknowledge that they will comply with such guidance should they be approved for a Part C contract.

Authorized Representative Name (printed)	Title
Authorized Representative Signature	Date (MM/DD/YYYY)

4.7 RPPO State Licensure Table

Complete a separate table for each MA Region which the Applicant proposes to serve pursuant to this application. Please make copies as necessary.

Entity Name: _____

MA Region: _____

State (Two Letter Abbrev.)	Is Applicant Licensed in State? Yes or No	If No, Give Date Application was Filed with State	Type of License Held or Requested	Does State have Restricted Reserve Requirements (or Legal Equivalent)? If Yes, Give Amount	State Regulator's Name, Address Phone #

4.8 RPPO State Licensure Attestation

By signing this attestation, I agree that the Applicant has applied to be licensed, in each state of its regional service area(s) in which it is not already licensed, sufficient to authorize Applicant to operate as a risk bearing entity that may offer health benefits, including an MA Regional Preferred Provider Organization (RPPO) product.

I understand that, in order to offer an MA RPPO plan, section 1858(d) of the SSA, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), requires an entity to be licensed in at least one state in each of the RPPO Regions it seeks to cover in order to receive a temporary licensure waiver. This temporary waiver is to allow for the timely processing, as determined by CMS, of licensure applications for other states within the requested RPPO Region.

I understand that my organization will be required to provide documentary evidence of its filing or licensure status for each state of its regional service area(s) consistent with this attestation. I further understand that CMS may contact the relevant state regulators to confirm the information provided in this attestation as well as the status of Applicant's licensure request(s).

I further agree to immediately notify CMS if, despite this attestation, I become aware of circumstances that indicate noncompliance with the requirements indicated above.

Name of Organization: _____
Printed Name of CEO: _____
Signature: _____

4.9 RPPO Essential Hospital Designation 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 SSA 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 SSA. The attestation on the following page must be completed and submitted with the completed chart.

Hospital name and address (including county)	**Contact person and phone**	**Hospital Type/Provider Number**	**Method by which offer was communicated**	**Date(s) offer refused/how refused**	**Why hospital is needed to meet RPPO's previously submitted access standards, including distance from named hospital to next closest Medicare participating contracted hospital**
Happy Care Medical Center 211 Green St., Foxdale, Delaware County, PA 21135	Any Body, CFO (215) 345-1121	Acute Care/ 210076	2 Letter Offers followed by 2 phone calls	Letter dated 8/02/05. Confirmed by phone call with CFO	Nearest Medicare participating inpatient facility with which Applicant contracts is in downtown Philadelphia, PA – 35 or more miles away from beneficiaries in Delaware County. Applicant's hospital access standard is 98% of beneficiaries in Delaware County and northern half of Chester County have access to inpatient facility within 30 miles drive.

4.10 RPPO Essential Hospital Attestation

RPPO Attestation Regarding Designation of "Essential" Hospitals

Applicant Organization named below (the Organization) attests that it made a good faith effort consistent with Section 1858(h) of the SSA and 42 CFR 422.112(c)(3), to contract with each hospital identified by the Organization in the attached chart at rates no less than current Medicare inpatient fee-for-service amounts and that, in each case, the hospital refused to enter into a contract with the Organization.

CMS is authorized to inspect any and all books or records necessary to substantiate the information in this attestation and the corresponding designation requests.

The Organization agrees to notify CMS immediately upon becoming aware of any occurrence or circumstance that would make this attestation inaccurate with respect to any of the designated hospitals. I possess the requisite authority to execute this attestation on behalf of the Organization.

Name of Organization: _____

Printed Name of CEO: _____

Signature:_____

Medicare Advantage RPPO Application/Contract Number(s):

R#_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Note: This attestation form must be signed by any organization that seeks to designate one or more hospitals as "essential."

4.11 Crosswalk for Part C Quality Improvement Project (QIP) Plan

Crosswalk for Part C QIP Plan Directions: The purpose of the Crosswalk for Part C QIP Plan is to ensure that the Applicant has a QIP plan that is ready for implementation.		
Compliance Plan Element	**Reference 42 CFR**	**Document Page Number**
SECTION I: QI Program Plan For All Plan Types		
A. Chronic Care Improvement Program that includes the following components:	422.1529(a)(1) 422.152(c)	NA
1. Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program.		
2. Mechanisms for monitoring MA enrollees that are participating in the chronic care improvement program.		
B. Narrative about quality improvement projects (QIPs) that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction, and include the following components:	422.152(a)(2) 422.152(d)	NA
1. Focus on significant aspects of clinical care and non-clinical services that includes the following:		
i. Measurement of performance		
ii. System interventions, including the establishment or alteration of practice guidelines		
iii. Improving performance		
iv. Systematic and periodic follow-up on the effect of the interventions		
2. Assessing performance under the plan using quality indicators that are:		
i. Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research		
ii. Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes		
3. Performance assessment on the selected indicators must be based on systematic ongoing collection and analysis of valid and reliable data.		
4. Interventions must achieve demonstrable improvement.		
5. The organization must report the status and results of each project to CMS as requested.		

Crosswalk for Part C QIP Plan

Directions: The purpose of the Crosswalk for Part C QIP Plan is to ensure that the Applicant has a QIP plan that is ready for implementation.

Compliance Plan Element	Reference 42 CFR	Document Page Number
C. Maintain health information system that collects, analyzes and integrates the data necessary to implement the QIP.	422.152(f)(1)(i)	
D. Mechanism to ensure that all information received from the providers of services is reliable, complete and available to CMS.	422.152(f)(1)(ii-iii)	
E. A process for formal evaluation (at least annually) of the impact and effectiveness of the QIP.	422.152(f)(2)	
F. Correction of all problems that come to its attention through internal surveillance, complaints, or other mechanisms.	422.152(f)(3)	
SECTION II: For HMOs and Local PPO (licensed or organized under state law as an HMO) (excluding RPPOs)		
G. Mechanism that encourages its providers to participate in CMS and HHS QI initiatives.	422.152(a)(3)	
H. Written policies and procedures that reflect current standards of medical practice.	422.152(b)(1)	
I. Mechanism to detect both underutilization and overutilization of services.	422.152 (b)(2)	
J. Measurement and reporting of performance must include the following components:	422.152 (b)(3)	
1. Use the measurement tools required by CMS and report performance.		
2. Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them.		
SECTION III: For Regional PPO and Local PPOs (that are not licensed or organized under state law as an HMO)		
K. Use the measurement tools required by CMS and report performance.	422.152 (e)(2)(i)	
L. Evaluate the continuity and coordination of care furnished to enrollees.	422.152 (e)(2)(ii)	
M. If using written protocols for utilization review, protocols must be based on current standards of medical practice and have a mechanism to evaluate utilization of services and to inform enrollees and providers of services of the evaluation results.	422.152(e)(2)(iii)(B)	

4.12 Crosswalk to Part C Compliance Plan

Crosswalk for Part C Compliance Plan		
Compliance Plan Element	**Reference 42 CFR**	**Document Page Number**
A. Written policies, procedures, and standards of conduct that must include the following seven components:	422.503(b)(4)(vi)(A)	NA
1. Articulate the organization's commitment to comply with all applicable Federal and State standards.		
2. Describe compliance expectations as embodied in the standards of conduct.		
3. Implement the operation of the compliance program.		
4. Provide guidance to employees and others on dealing with potential compliance issues.		
5. Identify how to communicate compliance issues to appropriate compliance personnel.		
6. Describe how potential compliance issues are investigated and resolved by the organization.		
7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.		
B. Designation of a compliance officer and a compliance committee that are accountable to senior management and include the following three components:	422.503(b)(4)(vi)(B)	NA
1. The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the MAO, parent organization or corporate affiliate. The compliance officer may not be an employee of the MAO's first tier, downstream or related entity.		
2. The compliance officer and the compliance committee must periodically report directly to the governing body of the MAO on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.		
3. The governing body of the MAO must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs.		
C. Effective training and education that must include the following two components:	422.503(b)(4)(vi)(C)	NA

Crosswalk for Part C Compliance Plan		
Compliance Plan Element	**Reference 42 CFR**	**Document Page Number**
1. Implementing an effective training and education between the compliance officer and organization employees, the MAO's chief executive or other senior administrator, managers and governing body members, and the MAO's first tier, downstream, and related entities. Such training and education must occur annually at a minimum and must be made a part of the orientation for a new employee, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member.		
2. First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.		
D. Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the MAO's employees, managers and governing body, and the MAO's first tier, downstream, and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported, including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.	422.503(b)(4)(vi)(D)	
E. Well-publicized disciplinary standards that are enforced and include the following three policies:	422.503(b)(4)(vi)(E)	
1. Articulate expectations for reporting compliance issues and assist in their resolution.		
2. Identify noncompliance or unethical behavior.		
3. Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined.		
F. Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MAO, including first tier entities' compliance with CMS requirements and the overall effectiveness of the compliance program.	422.503(b)(4)(vi)(F)	
G. Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance self-evaluations and	422.503(b)(4)(vi)(G)	

Crosswalk for Part C Compliance Plan		
Compliance Plan Element	**Reference 42 CFR**	**Document Page Number**
audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements. The procedures must include the following components:		
1. If the MAO discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.		
2. The MAO must conduct appropriate corrective actions (for example, recoupment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph T.		
3. The MAO should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.		

4.13 Partial County Justification

Instructions: MA applicants requesting service areas that include one or more partial counties must upload a completed Partial County Justification with the MA Application.

Complete and upload a Partial County Justification form for each partial county in your proposed service area. This form is appropriate for organizations (1) entering into a new partial county or (2) expanding a current partial county by one or more zip codes when the resulting service area will continue to be a partial county. In this scenario, the Justification pertains to the *proposed* zip codes versus the zip codes already approved by CMS.

MA applicants expanding from a partial county to a full county do NOT need to submit a Partial County Justification.

NOTE: CMS requests that you limit this document to 20 pages.

SECTION I: Partial County Explanation

Using just a few sentences, briefly describe why you are proposing a partial county.

SECTION II: Partial County Requirements

The Medicare Managed Care Manual Chapter 4, Section 150.3 provides guidance on partial county requirements. The following questions pertain to those requirements; refer to Section 150.3 when responding to them.

Explain how and submit documentation to show that the partial county meets all three of the following criteria:

1. **Necessary** – Check the option(s) that applies to your organization, *and provide documentation to support your selection(s)*:

   ☐ You cannot establish a provider network to make health care services available and accessible to beneficiaries residing in the excluded portion of the county.

   ☐ You cannot establish economically viable contracts with sufficient providers to serve the entire county.

   Describe the evidence that you are providing to substantiate the above statement(s) and (if applicable) attach it to this form:

2. **Non-discriminatory** – You must be able to substantiate *both* of the following statements:

☐ The racial and economic composition of the population in the portion of the county you are proposing is comparable to the excluded portion of the county.

Using U.S. census data (or data from another comparable source), compare the racial and economic composition of the included and excluded portions of the proposed county service area.

☐ The anticipated health care costs of the portion of the county you are proposing to serve is similar to the area of the county that will be excluded from the service area.

Describe the evidence that you are providing to substantiate the above statement and (if applicable) attach it to this form:

3. **In the best interest of beneficiaries** – The partial county must be in the best interest of the beneficiaries who are in the pending service area.

   Describe the evidence that you are providing to substantiate the above statement and (if applicable) attach it to this form:

SECTION III: Geography

1. Describe the geographic areas for the county, both inside and outside the proposed service area, including the major population centers, transportation arteries, significant topographic features (e.g., lakes, mountain ranges, etc.), and any other geographic factors that affected your service area designation.

SECTION IV: Provider Network Assessment

1. Provide the number of Medicare eligible beneficiaries for each significant city / town in the requested partial county service area.

2. Partial County Network Assessment Table

   CMS holds partial county applicants to the same network criteria (time and distance standards) as full-county applicants. Because HPMS cannot measure contracted providers and facilities against requirements at a level smaller than a full county, you must submit access data for your network in the partial-county service area you are requesting.

   Several weeks following your initial application submission, CMS will issue its first review/deficiency notice and, in that notice, will name six cities / towns in your proposed service area that you will use to complete the Partial County Network Assessment Table. *You should upload the table as part of your response to that first notice*, which may also name deficiencies elsewhere in your MA

application. *Do not upload the Partial County Network Assessment Table in your initial application submission.*

To complete the Partial County Network Assessment Table, you will list the CMS-selected cities / towns as the column headers and provide the time (minutes) and distance (miles) from a zip code located centrally within each of those locations to the closest contracted provider / facility of each type as listed on the Table.

Where you do not meet the CMS time and distance requirements for a particular provider / facility shown on the HSD Criteria Reference Tables (available at http://www.cms.gov/MedicareAdvantageApps/), you must submit a network justification, including your strategy for ensuring access to the applicable services and the local patterns of care for that particular service. CMS recommends that you use the HSD Exception Request Template for your justification and attach the form(s) to your Partial county Network Assessment Table. This is not an official Exception; applicants cannot request exceptions in partial county service areas. However, it serves the same purpose within the Partial County review strategy.

4.14 Partial County Network Assessment Table

Instructions: List the CMS-selected cities/towns (as identified in CMS' first deficiency notice) in the column headers and list the times and distances between a centrally-located zip code in each city/town and the closest provider of each type listed in column B. Where the time or distance do not meet the requirements listed on the HSD Criteria Reference Table, describe your strategy for ensuring access to the applicable services and the local patterns of care for that service in your Partial County Justification upload.

		City/Town #1		City/Town #2		City/Town #3		City/Town #4		City/Town #5		City/Town #6	
Code	Type	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
001	General Practice												
002	Family Practice												
003	Internal Medicine												
004	Geriatrics												
005	Primary Care - Physician Assistants												
006	Primary Care - Nurse Practitioners												
007	Allergy and Immunology												
008	Cardiology												
~~009~~	~~Cardiac Surgery~~ DO NOT USE												
010	Chiropractor												
011	Dermatology												
012	Endocrinology												
013	ENT / Otolaryngology												
014	Gastroenterology												
015	General Surgery												
016	Gynecology, OB / GYN												
017	Infectious Diseases												
018	Nephrology												
019	Neurology												
020	Neurosurgery												
021	Oncology - Medical, Surgical												

		City/Town #1		City/Town #2		City/Town #3		City/Town #4		City/Town #5		City/Town #6	
Code	Type	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
022	Oncology - Radiation / Radiation Oncology												
023	Ophthalmology												
~~024~~	~~Oral Surgery~~ DO NOT USE												
025	Orthopedic Surgery												
026	Physiatry, Rehabilitative Medicine												
027	Plastic Surgery												
028	Podiatry												
029	Psychiatry												
030	Pulmonology												
031	Rheumatology												
~~032~~	~~Thoracic Surgery~~ DO NOT USE												
033	Urology												
034	Vascular Surgery												
035	Cardiothoracic Surgery												
040	Acute Inpatient Hospitals												
041	Cardiac Surgery Program												
042	Cardiac Catheterization Services												
043	Critical Care Services/Intensive Care Units (ICU)												
044	Outpatient Dialysis												
045	Surgical Services (Outpatient or ASC)												
046	Skilled Nursing Facilities												
047	Diagnostic Radiology												
048	Mammography												
049	Physical Therapy												
050	Occupational Therapy												
051	Speech Therapy												
052	Inpatient Psychiatric Facility Services												

		City/Town #1		City/Town #2		City/Town #3		City/Town #4		City/Town #5		City/Town #6	
Code	Type	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
054	Orthotics and Prosthetics												
055	Home Health												
056	Durable Medical Equipment												
057	Outpatient Infusion / Chemotherapy												
061	Heart Transplant Program												
062	Heart / Lung Transplant Program												
064	Kidney Transplant Program												
065	Liver Transplant Program												
066	Lung Transplant Program												
067	Pancreas Transplant Program												

**For the category S03 Sum of Primary Care Providers, list the shortest time/distance among the preceding six provider types (001 through 006).

5 APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals

Solicitations for Special Needs Plan Proposals

Specific Requirements for Dual-Eligible SNPs:
All 2014 Applicants seeking to offer a dual-eligible SNP must have a contract with the State Medicaid Agency(ies) from each state in which the SNP operates. This requirement applies to all initial, service area expansion and renewal dual-eligible SNP applicants. The State Medicaid agency contract must contain at least each of the contractual terms specified in 42. C.F.R. § 422.107 (c) and listed in the "2014 D-SNP State Medicaid Agency Contract Matrix Upload Document," which is a separate document included in the application packet. This contract must specify a period of performance through at least January 1, 2014 through December 31, 2014. Additionally, under the contract the MA organization must retain responsibility for providing, or contracting for benefits to be provided, for individuals entitled to receive medical assistance under Title XIX. Please note that State Medicaid agencies are not required to enter into contracts with MA organizations for dual-eligible SNPs.

Existing Dual Eligible SNPs will need to submit a signed and executed State Medicaid Agency Contract in HPMS on July 1 without submitting any other portion of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion.

Specific Requirements for Institutional SNPs: All 2014 Applicants seeking to offer a new or expand the service area of an existing institutional SNP must specify whether the plan will target only institutionalized individuals, only institutional equivalent individuals living in the community but requiring an institutional level of care, or both subtypes of individuals. Institutional SNPs targeting institutional equivalent individuals are required to use the respective State level of care assessment tool to determine the need for institutional level of care for prospective enrollees. The eligibility assessment must be performed by an entity other than the MA organization offering the SNP.

Specific Requirements for Severe or Disabling Chronic Condition SNPs: All 2014 Applicants seeking to offer a new or expand the service area of an existing severe or disabling chronic condition SNP must exclusively serve an individual confirmed to have one of the CMS-approved chronic conditions. For the sole purpose of determining eligibility for a chronic condition SNP, CMS has identified several severe or disabling chronic conditions that meet the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) definition: 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. The list of CMS-approved chronic conditions is found in the C-SNP Proposal section of this application.

2014 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 explicit components. These components include: 1) measurable goals specific to the target special needs individuals; 2) an adequate staff structure having care management roles; 3) an interdisciplinary care team for each beneficiary; 4) a provider network having specialized expertise pertinent to the target special needs individuals; 5) training on the model of care for plan personnel and contractors; 6) comprehensive health risk assessment for each beneficiary; 7) an individualized plan of care having goals and measurable outcomes for each beneficiary; 8) a communication network that facilitates coordination of care; and 9) evaluation of the effectiveness of the model of care. The MA organization must design its model of care to accommodate the needs of the most vulnerable members of its target population, i.e., the frail, the disabled, those near the end-of-life, those having multiple or medically complex chronic conditions, and those who develop end-stage renal disease after enrollment.

Quality Reporting Requirements**:** All MA organizations are required to collect, analyze, report, and act on data through a systematic and continuous quality improvement program. As an MA plan, each SNP must implement a quality improvement program that focuses on measuring indices of quality, beneficiary health outcomes, and evaluating the effectiveness of its model of care in meeting the needs of its targeted special needs individuals.

For each SNP, MA organizations must coordinate the systematic collection of data using indicators that are objective, clearly defined, and preferably based on valid and reliable measures. 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. The MA organization should document quality improvement activities and maintain the information for CMS review upon request and during audits.

MA organizations are required to report HEDIS measures (if enrollment threshold is met), Structure & Process measures, HOS survey (if enrollment threshold is met), CAHPS survey (if enrollment threshold is met), Part C Reporting Data, and Medication Therapy Management measures for each SNP.

Definitions:

Full Benefit Dual Eligible (FBDE or 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 based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers. Medicaid does not pay towards out-of pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable. Medicaid payment of the Medicare Part A or Medicare Part B premiums may be a Medicaid benefit available to FBDE beneficiaries in certain states.

Qualified Medicare Beneficiary without other Medicaid (QMB only): An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

Qualified Medicare Beneficiary Plus (QMB+): An individual entitled to Medicare Part A, with income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid does not pay towards the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only): An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. The individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

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. These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

Qualifying Individual (QI): An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage, if applicable.

All Duals: An all-dual D-SNP has a state Medicaid agency contract to enroll beneficiaries who are MA eligible and who are entitled to medical assistance under a State/Territorial plan under Title XIX of the Act. An all-dual D-SNP must enroll all categories of dual eligible individuals (i.e., FBDE, QMB, QMB+, SLMB, SLMB+, QI and QDWI) including those with comprehensive Medicaid benefits as well as those with more limited cost-sharing such as QMBs, SLMBs, and QIs.

Full Duals: A full-dual D-SNP has a state Medicaid agency contract to enroll individuals who are eligible for: (1) Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act; or (2) Medical assistance under section 1902(a)(10)(C) of the Act (Medically Needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month. Sections 1902(a), 1902(f), 1902(p), 1905, and 1935(c)(6) of the Act describe categories of individuals who are entitled to full Medicaid benefits. This includes QMB+ individuals, SLMB+ individuals, and other FBDEs.

Medicare Zero Cost Share: A Medicare zero-cost-share D-SNP that has a State Medicaid agency contract to limit enrollment to QMBs only and QMBs with comprehensive Medicaid benefits (QMB+)—the two categories of dual eligible beneficiaries who are not financially responsible for cost-sharing for Medicare Parts A or B. Because QMB-only individuals are not entitled to full Medicaid benefits, there may be Medicaid cost-sharing required.

Fully-Integrated Dual Eligible SNPs: FIDE SNPs are CMS-approved SNPs that meet all of the following criteria, as also specified in 42 C.F.R. §422.2:
(1) Enroll special needs individuals entitled to medical assistance under a Medicaid State plan, as defined in section 1859(b)(6)(B)(ii) of the Act and 42 CFR §422.2;
(2) Provide dually eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO);
(3) Have a capitated contract with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;

(4) Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
(5) Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

The FIDE SNP definition at 42 C.F.R. §422.2 requires the plan to have a contract with the state(s) in its service area specifying that the state(s) will pay the FIDE SNP a capitation payment for primary, acute and long-term care Medicaid benefits and services in exchange for the FIDE SNP's provision of these benefits to its enrollees. In determining whether a D-SNP meets the FIDE SNP definition, CMS will allow Long Term Care benefit carve-oouts or exclusions if the plan can demonstrate that it meets the following criteria:

(1)The plan must be at risk for substantially all of the services under the capitated rate; and
(2)The plan must be at risk for nursing facility services for at least six months (or one-hundred and eighty days of the year; and
(3)The individual must not be disenrolled from the plan as a result of exhausting the service covered under the capitated rate; and
(4)the plan must remain responsible for managing all benefits, including any carved-out service benefits, notwithstanding the method of payment (e.g., fee-for-service, separate capitated rate) received by the plan.

Additionally, notwithstanding any benefit care-outs permitted under such an arrangement, D-SNPs in states that currently require capitation of long term benefits for a longer duration than this CMS minimum must maintain this level of capitation.

Dual Eligible Subset: MA organizations that offer D-SNPs may exclude specific groups of dual eligibles based on the MA organization's coordination efforts with State Medicaid agencies. CMS reviews and approves requests for coverage of dual eligible subsets on a case-by-case basis. To the extent a State Medicaid agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements, those same groups may also be excluded from enrollment in the SNP, provided that the enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program. In HPMS plans have the option to select between "Dual Eligible Subset" (which is synonomous with Dual Eligible Subset – Non-Zero Dollar Cost Share) or "Dual Eligible Subset – Zero Dollar Cost Share".

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: 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 using the respective State level of care

assessment tool and be administered 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), continuing care retirement community (CCRC), or other type of residential facility, if necessary to ensure uniform delivery of specialized care. The need for the enrollment limitation to these facilities must be demonstrated by the I-SNP, including how community resources will be organized.

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 HPMS SNP Proposal Application template and submitting all completed upload documents per HPMS User Guide instructions. A SNP proposal application must be completed for each SNP type to be offered by the MAO. The service area of the proposed SNP cannot exceed the existing or pending service area for the MA contract.

All Applicants requesting to offer a dual-eligible SNP must have a State Medicaid Agency contract or be in negotiation with the State Medicaid Agency toward that goal. A dual-eligible SNP must have a State Medicaid Agency contract in place prior to the beginning of the 2014 contract year and the contract must overlap the entire CMS 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. Other associated MA and Part D applications must also be completed and submitted. Applicants must read HPMS memos and visit the CMS web site periodically to stay informed about new or revised guidance documents.

SNP Service Area Expansion (SAE)

An MA organization currently offering a SNP that wants to expand the service area of this SNP must adhere to the same requirements for submission of an initial SNP proposal application. The service area of the proposed SNP cannot exceed the existing or pending service area for the MA contract.

Renewal SNPs that are Not Expanding their Service Area:

An MA organization currently offering a SNP that requires re-approval under the NCQA SNP Approval process should only submit its Model of Care written narrative and Model of Care Matrix Upload Document and will not be required to submit any other portion of the MA application or SNP proposal, unless specifically noted (e.g., in the instructions for submission of contracts with State Medicaid Agencies). Any SNP that received a two or three year approval will not be required to submit any other portion of the

MA application or SNP proposal unless specifically noted (e.g., to meet the requirement for contracting with a State Medicaid Agency). (Note: The Affordable Care Act amended section 1859(f) of the Social Security Act to require that all SNPs be approved by National Committee for Quality Assurance (NCQA) starting January 1, 2012, and subsequent years. 42 C.F.R. §§ 422.4(a) (iv), 422.101(f), and 422.152(g) specify that the NCQA approval process be based on evaluation and approval of the model of care (MOC), as per CMS guidance. During Contract Year 2012, all SNPs went through this NCQA SNP Approval process.)

1. C-SNP Proposal Application

Attestation	Response
SNP Proposal Applications	
1. Applicant is applying to offer a new severe or disabling chronic condition SNP.	**Yes/No**
2. How many new severe or disabling chronic condition SNPs?	**Insert number.**
3. Applicant is applying to expand an existing severe or disabling chronic condition SNP.	**Yes/No**

2. C-SNP Service Area

Attestation	Response
SNP Service Area	
1. Provide a separate service area listing (State and County name and code) for each different type of dual-eligible SNP being offered. **Note**: SNP service area **must be equal to or less than** the approved or pending MA service.	**Service Area Upload Document**
2. Applicant's service area is equal to or less than the approved or pending MA service area.	**Yes/No**
3. Applicant's service area covers more than one State. If yes, respond to question #4 in this section. If no, proceed to the next section.	**Yes/No**
4. Provide the names of the States.	**Insert text.**

3. C-SNP Attestations

Attestation	Response
Severe or Disabling Chronic Conditions	
1. Applicant will offer a chronic condition SNP (C-SNP) covering one or more of the following severe or disabling chronic conditions	**Yes/No**
2. C-SNP covering only chronic alcohol and other drug abuse	**Yes/No**
3. C-SNP covering only autoimmune disorders	**Yes/No**
4. C-SNP covering only cancer	**Yes/No**
5. C-SNP covering only cardiovascular disorders	**Yes/No**
6. C-SNP covering only chronic heart failure	**Yes/No**
7. C-SNP covering only dementia	**Yes/No**
8. C-SNP covering only diabetes mellitus	**Yes/No**
9. C-SNP covering only end-stage liver disease	**Yes/No**
10. C-SNP covering only end-stage renal disease requiring dialysis	**Yes/No**
11. C-SNP covering only severe hematologic disorders	**Yes/No**
12. C-SNP covering only HIV\AIDS	**Yes/No**
13. C-SNP covering only chronic lung disorders	**Yes/No**
14. C-SNP covering only chronic disabling mental health conditions	**Yes/No**
15. C-SNP covering only neurologic disorders	**Yes/No**

16. C-SNP covering only stroke	**Yes/No**
17. Single C-SNP covering both cardiovascular disorders and chronic heart failure (Note: Enrollees must have at least **one** of the chronic conditions in the group)	**Yes/No**
18. Single C-SNP covering both cardiovascular disorders and diabetes (Note: Enrollees must have at least **one** of the chronic conditions in the group)	**Yes/No**
19. Single C-SNP covering both chronic heart failure and diabetes (Note: Enrollees must have at least **one** of the chronic conditions in the group)	**Yes/No**
20. Single C-SNP covering three conditions - cardiovascular disorders, chronic heart failure, and diabetes (Note: Enrollees must have at least **one** of the chronic conditions in the group)	**Yes/No**
21. Single C-SNP covering both cardiovascular disorders and stroke (Note: Enrollees must have at least **one** of the chronic conditions in the group)	**Yes/No**
22. Customized grouping of CMS-approved chronic conditions (Note: Enrollees must have **all** chronic conditions in the customized group)	**Yes/No**

4. D-SNP Proposal Application

Attestation	Response
SNP Proposal Applications	
1. Applicant is applying to offer a new dual-eligible SNP.	**Yes/No**
2. How many new dual-eligible SNPs?	**Insert number.**
3. Applicant is applying to expand an existing dual-eligible SNP.	**Yes/No**

5. D-SNP Service Area

Attestation	Response
SNP Service Area	
1. Provide a separate service area listing (State and County name and code) for each different type of dual-eligible SNP being offered. **Note**: Applicant's proposed service area **must be equal to or less than** the counties included in the approved or pending State Medicaid Agency(ies) contract(s).	**D-SNP State Medicaid Agency Contract Negotiation Status Document**
2. Applicant's service area is equal to or less than the approved or pending MA service area.	**Yes/No**
3. Applicant's service area is equal to or less than the counties approved in the State Medicaid Agency(ies) contract.	**Yes/No**
4. Applicant's service area covers more than one State. If yes, respond to question #5 in this section. If no, proceed to the next section.	**Yes/No**
5. Provide the names of the States.	**Insert text.**

6. D-SNP State Medicaid Agency(ies) Contract(s)

Attestation	Response
State Medicaid Agency Contracts	

1. Applicant has a contract with the State Medicaid Agency(ies) that covers the MA application year. If **yes**, go to question **#2**. If **no**, go to question **#4**. **(Note: Applicants for dual-eligible SNPs (initial, existing, and existing/expanding) must have a signed State Medicaid Agency(ies) contract by the CMS specified deadline. If an updated contract or contract amendment will be needed for the application year, applicant should go to Question #4.)**	**Yes/No**
2.Applicant wishes the contract with the State Medicaid Agency(ies) to be revieiwed to determine if it qualifies as a fully integrated dual eligible SNP (FIDE).	**Yes/No** **If yes, Upload the completed FIDE SNP Contract Matrix**
3. Provide copy of **ALL** signed State Medicaid Agency(ies) contract(s) and, for **EACH** contract, a corresponding Contract Matrix that references where to locate the MIPPA required provisions.	**Upload executed contracts and corresponding Contract Matrix for each State Medicaid Agency contract.**
4. Applicant has contacted the State Medicaid Agency(ies), initiated contract negotiation, and will have a signed State Medicaid Agency(ies) contract for the MA application year. **Note: Applicants for dual-eligible SNPs (initial, existing, and existing/expanding) must have a signed State Medicaid Agency(ies) contract by the CMS specified deadline. CMS will not approve a SNP applicant that does not have a State Medicaid Agency(ies) contract**.	**Yes/No**
5. Download the "D-SNP State Medicaid Agency Contract Negotiation Status Document" and provide a narrative description of the status of your negotiation with the State Medicaid Agency(ies).	**Upload the completed D-SNP State Medicaid Agency Contract Negotiation Status Document.**
6. Provide the State Medicaid contract begin date.	**For each of multiple contracts, reject if < 01/01/2011**
7. Provide the State Medicaid contract end date.	**For each of multiple contracts, reject if > 12/31/2011**
8.Does the applicant want the State Medicaid Agency contract to be reviewed to determine if it qualifies as a FIDE SNP for the contract period(s) identified in numbers in 6 and 7.	**Yes/No**
Attestation	**Response**
State Medicaid Agency(ies) contract enrolled population	
1. Applicant will have an executed State Medicaid Agency(ies) contract to cover one or more of the enrollment categories listed below. Select all enrollment categories that apply. **Note**: The selected enrollment categories must match those listed in the executed State Medicaid Agency(ies) contract.	**Drop-down Menu**
a. Qualified Medicare Beneficiary Plus(QMB+) dual-eligible	
b. Specified Low-income Medicare Beneficiary Plus (SLMB+) dual-eligible	

c. Other full benefit dual-eligible also known as "Medicaid only"	
d. Qualified Medicare Beneficiary (QMB) dual-eligible	
e. Specified Low-income Medicare Beneficiary (SLMB) dual-eligible	
f. Qualifying Individual (QI) dual-eligible	
g. Qualified Disabled and Working Individual (QDWI) dual-eligible	
h. Dual-eligible who are institutionalized	
i. Dual-eligible who are institutional equivalent	
j. Medicaid Subset enrollment category other than those listed above	
2. Provide a description of **1.j.**, the Medicaid Subset for an enrollment population other than what is listed above in 1.a.-1.i.	**Insert text.**

Attestation	Response
State Medicaid Agency(ies) contact	
1. Provide the name of the contact individual at the State Medicaid Agency(ies).	**Insert Text**
2. Provide the address of the State Medicaid Agency contact person.	**Insert Text**
3. Provide the phone number of the State Medicaid Agency contact person.	**Insert number**
4. Provide the e-mail address of the State Medicaid Agency contact person.	**Insert text**

7. I-SNP Proposal Application

Attestation	Response
SNP Proposal Applications	
1. Applicant is applying to offer a new institutional SNP.	**Yes/No**
2. How many new institutional SNPs?	**Insert number.**
3. Applicant is applying to expand an existing institutional SNP.	**Yes/No**

8. I-SNP Service Area

Attestation	Response
SNP Service Area	
1. Provide a separate service area listing (State and County name and code) for each different type of dual-eligible SNP being offered. **Note**: SNP service area **must be equal to or less than** the approved or pending MA service.	**Service Area Upload Document**
2. Applicant's service area is equal to or less than the approved or pending MA service area.	**Yes/No**
3. Applicant's service area covers more than one State. If yes, respond to question #4 in this section. If no, proceed to the next section.	**Yes/No**
4. Provide the names of the States.	**Insert text.**

9. I-SNP Attestations

Attestation	Response
SNPs enrolling individuals residing in institutions	
1. Applicant will enroll individuals residing in a long term care facility under contract with or owned by the organization offering the SNP.	**Yes/No**
2. Provide a list of contracted long-term care facilities.	**Upload I-SNP Upload Document.**
3. Provide attestation for Special Needs Plans (SNP) serving institutionalized beneficiaries.	**Upload I-SNP Attestation Document.**

Attestation	Response
SNPs enrolling individuals eligible as institutional equivalent	
1. Applicant will enroll individuals who are institutional equivalents residing in the community.	**Yes/No**
2. Provide a list of assisted-living facility(ies) (ALF), continuing care retirement community(ies) (CCRC), or other type of residential facility(ies). (**respond only if Applicant is contracting with these facilities**).	**Upload document.**
3. Applicant owns or has an executed contract(s) with each of the ALFs, CCRCs, or other residential facilities on the list (**if applicable**)?	**Yes/No/NA**
4. Applicant uses the respective State level of care (LOC) assessment tool to determine eligibility for each institutional equivalent beneficiary. Note: The Applicant must use the respective State (LOC) assessment tool to determine eligibility for institutional equivalent individuals living in the community.	**Yes/No**
5. Provide a copy of the State LOC assessment tool.	**Upload document.**
6. Provide the URL for the State LOC assessment tool if accessible on the State website.	**http://xxxxxxxxxxxx.xxx**
7. Applicant uses an unrelated third party entity to perform the LOC assessment. Note: The Applicant must use an unrelated third party entity to perform the LOC assessment.	**Yes/No**
8. Provide the name of the entity(ies) performing the LOC assessment.	**Insert text.**
9. Provide the address of the entity(ies) performing the LOC assessment.	**Insert text.**
10. Provide the relevant credential (e.g., RN for registered nurse, LSW for licensed social worker, etc.) of the staff from the entity(ies) performing the LOC assessment.	**Insert text.**

10. ESRD Waiver Request

Attestation	Response
ESRD Waiver Requests	
1. Applicant requests an ESRD waiver. If yes, respond to questions 2 through 10 below. If no, proceed to the next section.	**Yes/No**
2. Provide a description of how the applicant intends to serve the unique needs of the ESRD enrollees in the ESRD Waiver Request Upload Document.	**Upload ESRD Upload Document.**
3. Provide a description of any additional service(s) provided to members with ESRD.	**Upload ESRD Upload Document.**
4. Provide a description of the interdisciplinary care team coordinator role in the assessment and delivery of services needed by members with ESRD.	**Upload ESRD Upload Document.**
5. If the applicant is delegating ESRD care, case management or care coordination, the applicant must completely describe the arrangement.	**Upload ESRD Upload Document.**
6. Provide a list of the contracted nephrologist(s)	**Upload ESRD Upload Document.**
7. Provide a list of the contracted dialysis facility(ies).	**Upload ESRD Upload Document.**
8.Describe the dialysis options available to beneficiaries (e.g., home dialysis; nocturnal dialysis).	**Upload ESRD Upload Document.**
9. Provide a list of the contracted kidney transplant facility(ies).	**Upload ESRD Upload Document.**
10. Describe beneficiary access to contracted kidney transplant facilities, including the average distance beneficiaries must travel to reach a contracted kidney transplant facility.	**Upload ESRD Upload Document.**

11. Model of Care Attestations

Attestation	Response
Written Care Management Plan	
1. Applicant has a written care management plan that describes its model of care.	**Yes/No**
2. Complete and upload the Model of Care Matrix Upload Document.	**Upload**
3. Upload a copy of the written care management plan.	**Upload**
Attestation	**Response**
Model of Care Goals	
1. Applicant has the goal to improve access to medical, mental health, and social services for its enrolled special needs individuals.	**Yes/No**
2. Applicant has the goal to improve access to care for its enrolled special needs individuals.	**Yes/No**
3. Applicant has the goal to improve coordination of care through an identified point of contact for its enrolled special needs individuals.	**Yes/No**
4. Applicant has the goal to provide seamless transitions across healthcare settings, care providers, and health services for its enrolled special needs individuals.	**Yes/No**
5. Applicant has the goal to improve access to preventive health services for	**Yes/No**

its enrolled special needs individuals.	
6. Applicant has the goal to assure appropriate utilization of services by its enrolled special needs individuals.	**Yes/No**
7. Applicant has the goal to assure cost-effective health services delivery for its enrolled special needs individuals.	**Yes/No**
8. Applicant has the goal to improve beneficiary health outcomes through reducing hospitalization and nursing facility placement for its enrolled special needs individuals.	**Yes/No**
9. Applicant has the goal to improve beneficiary health outcomes through improved independence and self-management for its enrolled special needs individuals.	**Yes/No**
10. Applicant has the goal to improve beneficiary health outcomes through improved mobility and functional status for its enrolled special needs individuals.	**Yes/No**
11. Applicant has the goal to improve beneficiary health outcomes through improved pain management for its enrolled special needs individuals.	**Yes/No**
12. Applicant has the goal to improve beneficiary health outcomes through improved quality of life as perceived by its enrolled special needs individuals.	**Yes/No**
13. Applicant has the goal to improve beneficiary health outcomes through improved satisfaction with health status and healthcare services for its enrolled special needs individuals.	**Yes/No**
14. Applicant's model of care goals are written as measurable outcomes.	**Yes/No**
15. Applicant's care management plan specifies how it will determine that model of care goals are met.	**Yes/No**
16. Applicant's care management plan specifies what action it will take if goals are not met.	**Yes/No**
Attestation	**Response**
Staff Structure and Care Management Roles	
1. Applicant has appropriate staff (employed or contracted) to perform administrative functions. Specific functions include:	**Yes/No**
2. Processes enrollment	**Yes/No**
3. Verifies eligibility of enrollees	**Yes/No**
4. Processes claims	**Yes/No**
5. Processes and facilitates resolution of consumer or provider complaints	**Yes/No**
6. Communicates telephonically and disseminates written plan information to beneficiaries, network providers	**Yes/No**
7. Applicant has appropriate staff (employed or contracted) to collect, analyze, report, and act on performance and health outcome data. Specific tasks include:	**Yes/No**
8. Conducts a quality improvement program	**Yes/No**
9. Reviews and analyzes utilization data	**Yes/No**
10. Survey beneficiaries, plan personnel and network providers, oversight agencies, and the public	**Yes/No**
11. Applicant has appropriate staff (employed or contracted) to coordinate care for beneficiaries across care settings and providers. Specific functions include:	**Yes/No**

12. Authorizes and/or facilitates access to specialists and therapies	**Yes/No**
13. Advocates, informs, educates beneficiaries on services and benefits	**Yes/No**
14. Identifies and facilitates access to community resources and social services	**Yes/No**
15. Triages beneficiaries care needs	**Yes/No**
16. Conducts risk assessment	**Yes/No**
17. Facilitates the implementation of the individualized care plan for each beneficiary	**Yes/No**
18. Schedules or facilitates scheduling appointments and follow-up services	**Yes/No**
19. Facilitates transportation services	**Yes/No**
20. Requests consultation and diagnostic reports from network specialists	**Yes/No**
21. Facilitates translation services	**Yes/No**
22. Applicant has appropriate staff (employed or contracted) to deliver medical, mental health, and social services to beneficiaries.	**Yes/No**
23. Applicant has appropriate staff (employed or contracted) to manage healthcare information related to medical, mental health, and social services delivered to beneficiaries. Specific functions include:	**Yes/No**
24. Assures maintenance and sharing of healthcare records in accordance to CMS regulations and policies	**Yes/No**
25. Assures HIPAA compliance.	**Yes/No**
26. Applicant has appropriate staff (employed or contracted) to perform administrative oversight duties. Specific administrative oversight duties include:	**Yes/No**
27. Oversees plan operations and develops policies	**Yes/No**
28. Authorizes and/or facilitates access to specialists and therapies	**Yes/No**
29. Assures current licensure and competency of providers	**Yes/No**
30. Monitors contractual services to assure contractor compliance	**Yes/No**
31. Assures statutory and regulatory compliance	**Yes/No**
32. Evaluate the effectiveness of the model of care.	**Yes/No**
33. Applicant has appropriate staff (employed or contracted) to perform clinical oversight duties. Specific clinical oversight duties include:	**Yes/No**
34. Conducts and/or observes interdisciplinary team meetings randomly	**Yes/No**
35. Assures care and pharmacotherapy are delivered as planned by the interdisciplinary team	**Yes/No**
36. Coordinates care across settings and providers	**Yes/No**
37. Assures providers adhere to nationally-recognized clinical practice guidelines in clinical care	**Yes/No**
38. Assures clinical services are appropriate and timely	**Yes/No**
39. Monitors provision of services and benefits to assure follow-up	**Yes/No**
40. Monitors provision of services to assure care is seamlessly transitioned across settings and providers	**Yes/No**
41. Conducts targeted medical chart reviews as needed	**Yes/No**
42. Conducts medication reviews.	**Yes/No**
Attestation	**Response**
Interdisciplinary Care Team	

1. 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:	**Yes/No**
2. Primary care physician	**Yes/No**
3. Nurse practitioner, physician's assistant, mid-level provider	**Yes/No**
4. Social worker, community resources specialist	**Yes/No**
5. Registered nurse	**Yes/No**
6. Restorative health specialist (physical, occupational, speech, recreation)	**Yes/No**
7. Behavioral and/or mental health specialist (psychiatrist, psychologist, drug or alcohol therapist)	**Yes/No**
8. Board-certified physician	**Yes/No**
9. Dietitian, nutritionist	**Yes/No**
10. Pharmacist, clinical pharmacist	**Yes/No**
11. Disease management specialist	**Yes/No**
12. Nurse educator	**Yes/No**
13. Pastoral specialists	**Yes/No**
14. Caregiver/family member whenever feasible	**Yes/No**
15. Preventive health/health promotion specialist	**Yes/No**
16. Applicant facilitates the participation of the beneficiary on the Interdisciplinary Care Team whenever feasible.	**Yes/No**
17. Applicant assures that the interdisciplinary care team works together to manage beneficiary care by performing care management functions. Care management functions include:	**Yes/No**
18. Develop and implement an individualized care plan with the beneficiary/caregiver	**Yes/No**
19. Conduct care coordination meetings annually	**Yes/No**
20. Conduct care coordination meetings on a regular schedule	**Yes/No**
21. Conduct face-to-face meetings	**Yes/No**
22. Maintain a web-based meeting interface	**Yes/No**
23. Maintain web-based electronic health information	**Yes/No**
24. Conduct case rounds on a regular schedule	**Yes/No**
25. Maintain a call line or other mechanism for beneficiary inquiries and input	**Yes/No**
26. Conduct conference calls among plan, providers, and beneficiaries	**Yes/No**
27. Develop and disseminate newsletters or bulletins	**Yes/No**
28. Maintain a mechanism for beneficiary complaints and grievances	**Yes/No**
29. Use e-mail, fax, and written correspondence to communicate.	**Yes/No**
Attestation	**Response**
Provider Network and Use of Clinical Practice Guidelines	
1. Applicant has a network of providers and facilities through employed, contracted, or non contracted arrangements with specialized clinical expertise pertinent to the targeted special needs population. The provider network includes:	**Yes/No**
2. Acute care facility, hospital, medical center	**Yes/No**
3. Laboratory	**Yes/No**

4. Long-term care facility, skilled nursing facility	**Yes/No**
5. Pharmacy	**Yes/No**
6. Radiography facility	**Yes/No**
7. Rehabilitative facility	**Yes/No**
8. Primary care providers	**Yes/No**
9. Nursing professionals	**Yes/No**
10. Mid-level practitioners	**Yes/No**
11. Rehabilitation/restorative therapy specialists	**Yes/No**
12. Social worker/social services specialists	**Yes/No**
13. Mental health specialists	**Yes/No**
14. Medical specialists pertinent to targeted chronic conditions and identified co-morbid conditions	**Yes/No**
15. Pharmacists and/or clinical pharmacists	**Yes/No**
16. Oral health specialists	**Yes/No**
17. Applicant gives priority to having board-certified specialists in the provider network.	**Yes/No**
18. Applicant provides access through contracted or employed relationships to a network of providers and facilities having specialized clinical expertise pertinent to the targeted special needs population. Specific services include:	**Yes/No**
19. Assess, diagnose, and treat in collaboration with the interdisciplinary care team	**Yes/No**
20. Provide 24-hour access to a clinical consultant	**Yes/No**
21. Conduct conference calls with the interdisciplinary care team as needed	**Yes/No**
22. Assist with developing and updating individualized care plans	**Yes/No**
23. Assist with conducting disease management programs	**Yes/No**
24. Provide wound management services	**Yes/No**
25. Provide pharmacotherapy consultation and/or medication management clinics	**Yes/No**
26. Conduct home visits for clinical assessment or treatment	**Yes/No**
27. Conduct home safety assessments	**Yes/No**
28. Provide home health services	**Yes/No**
29. Provide home-based end-of-life care	**Yes/No**
30. Conduct risk prevention programs such as fall prevention or wellness promotion	**Yes/No**
31. Provide telemonitoring services	**Yes/No**
32. Provide telemedicine services	**Yes/No**
33. Provide in-patient acute care services	**Yes/No**
34. Provide hospital-based or urgent care facility-based emergency services	**Yes/No**
35. Provide long-term facility care.	**Yes/No**
36. Applicant has a process to assure that its network facilities and providers have current licensure and/or certification to perform services that meet the specialized needs of special needs individuals.	**Yes/No**
37. Applicant has a credentialing review every three years to assure that its network providers are credentialed and competent to perform services that meet the specialized needs of special needs individuals.	**Yes/No**

38. Applicant has a process to coordinate the delivery of services 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:	**Yes/No**
39. Applicant contracts with providers having the clinical expertise to meet the specialized needs of the targeted SNP population	**Yes/No**
40. Applicant contracts with facilities that provide diagnostic and treatment services to meet the specialized needs of the targeted SNP population	**Yes/No**
41. Applicant's contract directs how the network providers and facilities will deliver services to beneficiaries	**Yes/No**
42. Applicant has employed or contracted administrative staff that approve all referrals to network or out-of network providers prior to the delivery of services and notifies the interdisciplinary care team	**Yes/No**
43. Applicant has the beneficiary's interdisciplinary care team approve all referrals to the network or out-of-network providers prior to the delivery of services and notifies the plan's administrative staff	**Yes/No**
44. Applicant has the beneficiary directly contact network or out-of-network providers to schedule necessary services	**Yes/No**
45. Applicant has a mechanism in place that allows beneficiaries to notify the plan/and or interdisciplinary team for assistance in obtaining necessary services.	**Yes/No**
46. Applicant tracks and analyzes services utilization to assure appropriate use of services	**Yes/No**
47. Applicant contacts beneficiaries to remind them about upcoming appointments	**Yes/No**
48. Applicant contacts beneficiaries to follow-up on missed appointments.	**Yes/No**
49. Applicant has a process to coordinate the seamless transition of care across healthcare settings and providers. The process includes:	**Yes/No**
50. Applicant has written 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	**Yes/No**
51. Applicant monitors the transition of care from setting-to-setting, provider-to-provider, provider-to-facility, and notification to the interdisciplinary care team	**Yes/No**
52. Applicant has written procedures that require notification to the interdisciplinary care team and respective providers when transitions of care occur	**Yes/No**
53. Applicant tracks and analyzes transitions of care to assure timeliness and appropriateness of services	**Yes/No**
54. Applicant disseminates the results of the transition of care analysis to the interdisciplinary care team	**Yes/No**
55. Applicant contacts beneficiaries to monitor their status after a transition of care from provider-to-provider, facility-to-facility, or provider-to-facility.	**Yes/No**
56. Applicant has a process to monitor its providers and assure they 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, http://www.guideline.gov/). The process includes some or all of the following:	**Yes/No**

57. Applicant has written procedures to assure that employed or contracted providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available	**Yes/No**
58. Applicant's contract with providers stipulates that contracted providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available	**Yes/No**
59. Applicant conducts periodic surveillance 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.	**Yes/No**
Attestation	**Response**
Model of Care Training for Personnel and Providers	
1. Applicant trains employed and contracted personnel on the model of care to coordinate and/or deliver all services. Applicant conducts training using one or more of the following methods:	**Yes/No**
2. Face-to-face training	**Yes/No**
3. Web-based interactive training	**Yes/No**
4. Self-study program (electronic media, print materials)	**Yes/No**
5. Applicant maintains documentation that model of care training was completed by employed and contracted personnel.	**Yes/No**
6. Applicant designated personnel responsible to oversee training implementation and maintain training records for review upon CMS request.	**Yes/No**
7. Applicant has a process for taking action when the required model of care training has not been completed by employed or contracted personnel.	**Yes/No**
Attestation	**Response**
Health Risk Assessment	
1. Applicant conducts a comprehensive initial health risk assessment of the medical, functional, cognitive, and psychosocial status as well as annual health risk reassessments for each beneficiary. The process for health risk assessment includes some or all of the following:	**Yes/No**
2. Initial comprehensive health risk assessment is conducted within 90 days of enrollment and results are used to develop the individualized care plan	**Yes/No**
3. Annual comprehensive health risk assessment is conducted and results are used to update the individualized care plan	**Yes/No**
4. Comprehensive initial and annual health risk assessment examines medical, psychosocial, cognitive, and functional status	**Yes/No**
5. Comprehensive health risk assessment is conducted face-to-face by the Applicant	**Yes/No**
6. Comprehensive health risk assessment is conducted telephonically by the Applicant	**Yes/No**
7. Comprehensive health risk assessment is conducted by the beneficiary completing an electronic or paper-based questionnaire.	**Yes/No**
8. Applicant develops or selects and utilizes a comprehensive risk assessment tool that will be reviewed during oversight activities. The tool consists of:	**Yes/No**
9. An existing validated health risk assessment tool	**Yes/No**
10.A plan-developed health risk assessment tool	**Yes/No**

11. An electronic health risk assessment tool	**Yes/No**
12.A paper health risk assessment tool	**Yes/No**
13. Applicant standardized the use of the health risk assessment tool for all beneficiaries	**Yes/No**
14. Applicant periodically reviews the effectiveness of the health risk assessment tool	**Yes/No**
15. Provide a copy of the comprehensive health risk assessment tool.	**Yes/No**
16. Applicant has a process to analyze identified health risks and stratify them to develop an individualized care plan that mitigates health risks. The process includes some or all of the following:	**Yes/No**
17. Comprehensive health risk analysis is conducted by a credentialed healthcare professional	**Yes/No**
18. Applicant notifies the Interdisciplinary Care Team, respective providers, and beneficiary about the results of the health risk analysis	**Yes/No**
19. Applicant uses predictive modeling software to stratify beneficiary health risks for the development of an individualized care plan	**Yes/No**
20. Applicant manually analyzes health risk data to stratify beneficiary health risks for the development of an individualized care plan	**Yes/No**
21. Applicant tracks and trends population health risk data to inform the development of specialized benefits and services.	**Yes/No**
Attestation	**Response**
Individualized Care Plan	
1. Applicant has written procedures that direct how 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:	**Yes/No**
2. Each beneficiary is assigned an interdisciplinary care team that develops the individualized care plan with beneficiary involvement when feasible	**Yes/No**
3. Results from the initial health risk assessment are used to develop the individualized care plan	**Yes/No**
4. Beneficiary's medical history is used to develop the individualized care plan	**Yes/No**
5. Beneficiary's healthcare preferences are incorporated in the individualized care plan	**Yes/No**
6. Interdisciplinary care team members update the individualized care plan as beneficiary health status changes	**Yes/No**
7. Interdisciplinary care team notifies respective providers and beneficiaries when they update care plans that result from health status changes.	**Yes/No**
8. Applicant has a written process to facilitate beneficiary/caregiver participation in care planning when feasible. The process includes some or all of the following:	**Yes/No**
9. Beneficiaries and/or caregivers participate face-to-face in care planning	**Yes/No**
10. Beneficiaries and/or caregivers participate telephonically in care planning	**Yes/No**
11. Beneficiaries and/or caregivers participate in care planning through an exchange of written correspondence with their interdisciplinary team	**Yes/No**
12. Beneficiaries and/or caregivers participate in care planning through a web-based electronic interface or virtual correspondence	**Yes/No**

13. Applicant has a written procedure for maintaining the documented care plan for each beneficiary that complies with HIPAA.	**Yes/No**
14. Applicant facilitates access to the documented care plan for the Interdisciplinary Care Team, respective providers, and beneficiaries.	**Yes/No**
Attestation	**Response**
Health Risk Assessment to Communication Systems	
1. Applicant has written procedures to coordinate the delivery of services and benefits through communication systems connecting plan personnel, providers, and beneficiaries. These systems include some or all of the following:	**Yes/No**
2. Call-line for beneficiary inquiries	**Yes/No**
3. Call-line for provider network inquiries	**Yes/No**
4. Care coordination meetings	**Yes/No**
5. Case rounds	**Yes/No**
6. Complaints and grievances documentation and system for resolution	**Yes/No**
7. Committees (standing and ad hoc)	**Yes/No**
8. Conference calls	**Yes/No**
9. E-mails, faxes, written correspondence	**Yes/No**
10. Electronic network for meetings, training, information, communication	**Yes/No**
11. Electronic records (administrative data and/or clinical care)	**Yes/No**
12. Newsletter, bulletin	**Yes/No**
13. Person-to-person direct interface.	**Yes/No**
14. Applicant has written procedures to coordinate communication among the interdisciplinary care team members and the beneficiary. The system includes some or all of the following:	**Yes/No**
15. Regularly scheduled face-to-face team meetings	**Yes/No**
16. Regularly scheduled team conference calls	**Yes/No**
17. Regularly scheduled web-based team networking	**Yes/No**
18. Team access to shared electronic health information	**Yes/No**
19. Randomly scheduled team meetings conducted when needed.	**Yes/No**
20. Applicant has written procedures describing how communication among stakeholders is documented and maintained as part of the administrative and clinical care records. Documentation includes some or all of the following:	**Yes/No**
21. Written minutes	**Yes/No**
22. Recordings	**Yes/No**
23. Transcripts from recordings	**Yes/No**
24. Newsletters, bulletins	**Yes/No**
25. Web-based database	**Yes/No**
26. Applicant's written plan identifies the personnel having oversight responsibility for its communication network.	**Yes/No**
Attestation	**Response**
Care Management for the Most Vulnerable Subpopulations	
1. Applicant has written procedures to identify the most vulnerable beneficiaries enrolled in the SNP.	**Yes/No**
2. Applicant delineated care management services it will provide for its	**Yes/No**

most vulnerable beneficiaries. These add-on services address the specialized needs of the following vulnerable special needs individuals within each target population:	
3. Frail	**Yes/No**
4. Disabled	**Yes/No**
5. Beneficiaries developing end-stage renal disease after enrollment	**Yes/No**
6. Beneficiaries near the end-of-life	**Yes/No**
7. Beneficiaries having multiple and complex chronic conditions.	**Yes/No**

Attestation	Response
Performance and Health Outcome Measurement	
1. Applicant collects, analyzes, reports, and acts on data to annually evaluate the effectiveness of its model of care. This evaluation process includes examining the effectiveness of some or all of the following model of care elements by demonstrating:	**Yes/No**
2. Improved access to medical, mental health, and social services	**Yes/No**
3. Improved access to affordable care	**Yes/No**
4. Improved coordination of care through a single point of care management	**Yes/No**
5. Improved transition of care across settings and providers	**Yes/No**
6. Improved access to preventive health services	**Yes/No**
7. Improved beneficiary health outcomes	**Yes/No**
8. Quality and/or improved service delivery and oversight of services through appropriate staffing and implementation of roles	**Yes/No**
9. Quality and/or improved coordination of care through implementation of the interdisciplinary care team	**Yes/No**
10. Quality and/or improved service delivery through a competent provider network having specialized expertise and implementing evidence-based practice guidelines	**Yes/No**
11. Quality and/or improved coordination of care through identification and stratification of health risks	**Yes/No**
12. Quality and/or improved coordination of care through implementation of a dynamic individualized care plan addressing identified health risks	**Yes/No**
13. Quality and/or improved coordination of care through effective communication networks and documentation of care	**Yes/No**
14. Quality and/or improved coordination of care for vulnerable beneficiaries through implementation of the model of care.	**Yes/No**
15. Applicant has written procedures to collect, analyze, report, and act on data using a variety of strategies. Strategies include some or all of the following:	**Yes/No**
16. Internal quality assurance specialists implementing and evaluating a performance improvement program	**Yes/No**
17. External quality assurance consultants implementing and evaluating a performance improvement program	**Yes/No**
18. Participation by plan, provider network, and beneficiaries/caregivers	**Yes/No**
19. Data collection and analysis via electronic software	**Yes/No**
20. Data collection and analysis via manual techniques.	**Yes/No**

21. Applicant takes actions to improve the model of care. Actions include some or all of the following:	**Yes/No**
22. Changes in policies or procedures	**Yes/No**
23. Changes in staffing patterns or personnel	**Yes/No**
24. Changes in provider or facility network	**Yes/No**
25. Changes in systems of operation	**Yes/No**
26. Communication of results internally and externally.	**Yes/No**
27. Applicant documents its evaluation of the effectiveness of its model of care and assures access to the documentation for all stakeholders.	**Yes/No**
28. Applicant designates personnel having oversight responsibility for the evaluation of the model of care effectiveness.	**Yes/No**
29. Applicant communicates the results of its model of care evaluation to all stakeholders as identified by the CMS and SNP.	**Yes/No**

12. Quality Improvement Program Requirements

Attestation	Response
SNP Quality Improvement Program Requirements	
1. Applicant has a written plan including policies, procedures, and a systematic methodology to conduct an overall quality improvement program that is specific to its targeted special needs individuals.	**Yes/No**
2. Applicant has a health information system to collect, analyze, and integrate valid and reliable data to conduct its overall quality improvement program.	**Yes/No**
3. Applicant has a system to maintain health information for CMS review as requested.	**Yes/No**
4. Applicant has a system to ensure that data collected, analyzed, and reported are accurate and complete.	**Yes/No**
5. Applicant conducts an annual review of the effectiveness of its quality improvement program.	**Yes/No**
6. Applicant takes action to correct problems identified through its quality improvement activities as well as complaints from beneficiaries and providers.	**Yes/No**
7. Applicant conducts one or more chronic care improvement programs to improve health outcomes for beneficiaries having chronic conditions.	**Yes/No**
8. Applicant identifies beneficiaries with multiple or severe chronic conditions that would benefit from participation in a chronic care improvement program.	**Yes/No**
9. Applicant has a mechanism to monitor beneficiaries that participate in a chronic care improvement program.	**Yes/No**
10. Applicant conducts one or more quality improvement projects on clinical or non-clinical areas.	**Yes/No**
11. For each quality improvement project, Applicant measures performance, applies interventions to improve performance, evaluates performance, and conducts periodic follow-up to ensure the effectiveness of the intervention.	**Yes/No**
12. For each quality improvement project, Applicant evaluates performance using quality indicators that are objective, clearly defined, and correspond to measurable outcomes such as changes in health status, functional status, and beneficiary satisfaction.	**Yes/No**
13. For each quality improvement project, Applicant collects, analyzes, reports,	**Yes/No**

and acts on valid and reliable data, and achieves demonstrable improvement from interventions.	
14. For each special needs plan, Applicant collects, analyzes, and reports data that measure health outcomes and indices of quality pertaining to the management of care for its targeted special needs population (i.e., dual-eligible, institutionalized, or chronic condition) at the plan level.	**Yes/No**
15. For each special needs plan, Applicant collects, analyzes, and reports data that measure access to care (e.g., service and benefit utilization rates, or timeliness of referrals or treatment).	**Yes/No**
16. For each special needs plan, Applicant collects, analyzes, and reports data that measure improvement in beneficiary health status (e.g., quality of life indicators, depression scales, or chronic disease outcomes).	**Yes/No**
17. For each special needs plan, Applicant collects, analyzes, and reports data that measure staff implementation of the SNP model of care (e.g., National Committee for Quality Assurance accreditation measures or medication reconciliation associated with care setting transitions indicators).	**Yes/No**
18. For each special needs plan, Applicant collects, analyzes, and reports data that measure comprehensive health risk assessment (e.g., accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments).	**Yes/No**
19. For each special needs plan, Applicant collects, analyzes, and reports data that measure implementation of an individualized plan of care (e.g., rate of participation by IDT members and beneficiaries in care planning).	**Yes/No**
20. For each special needs plan, Applicant collects, analyzes, and reports data that measure use and adequacy of a provider network having targeted clinical expertise (e.g., service claims, pharmacy claims, diagnostic reports, etc.)	**Yes/No**
21. For each special needs plan, 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 (frail, disabled, near the end-of-life, etc.).	**Yes/No**
22. For each special needs plan, Applicant collects, analyzes, and reports data that measure provider use of evidence-based practices and/or nationally recognized clinical protocols.	**Yes/No**
23. For each special needs plan, Applicant collects, analyzes, and reports data that measure the effectiveness of communication (e.g., call center utilization rates, rates of beneficiary involvement in care plan development, analysis of beneficiary or provider complaints, etc.).	**Yes/No**
24. For each special needs plan, 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.	**Yes/No**
25. For each special needs plan, Applicant collects, analyzes, and reports data that measure CMS-required Part C Reporting Data Elements that will enable CMS to monitor plan performance.	**Yes/No**
26. For each special needs plan, Applicant collects, analyzes, and reports CMS-required Medication Therapy Management measures that will enable CMS to monitor plan performance.	**Yes/No**
27. For each special needs plan, Applicants agrees to disseminate the results of the transitions of care analysis to the interdisciplinary care team.	**Yes/No**

28. Provide a copy of the MAO's written plan that describes its overall quality improvement program.	**Upload**
29. Provide a completed copy of the Quality Improvement Program Matrix Upload Document.	**Upload Quality Improvement Program Matrix Upload Document.**

13. C-SNP Upload Document

Please complete and upload this document into HPMS per HPMS MA Application User Guide instructions.

2014 Severe or Disabling Chronic Condition SNP Upload Document

Applicant's Contract Name (as provided in HPMS):

Enter contract name here.

CMS Contract Number:

Enter CMS contract number here.

Provide the service area (County, State name and code) for the severe or disabling chronic condition SNP being offered.

County Name	State Name	State & County Code
Enter County name here.	*Enter State 2 letter abbreviation here.*	*Enter State & County Code here.*

14. D-SNP Upload Document

Applications for a new dual-eligible SNP or a Service Area Expansion to an existing dual-eligible SNP as well as all existing D-SNPs must have a signed State Medicaid Agency(ies) contract by July 1, 2012. If an existing D-SNP, new or SAE applicant DOES NOT have an executed State Medicaid Agency contract, please complete and upload this document into HPMS per the HPMS MA Application User Guide instructions.

2014 D-SNP State Medicaid Agency Contract Negotiation Status Document

Applicant's Contract Name (as provided in HPMS):

Enter contract name here.

CMS Contract Number:

Enter CMS contract number here.

1. New and SAE applicants as well as existing D-SNPs must contact the State Medicaid Agency and initiate State Medicaid Agency contract negotiations. Enter the information for the State Medicaid Agency contact individual below.

Enter your response to #1 here.

2. Applicant's proposed SNP service *area(s) must be consistent with the State Medicaid Agency contract approved service area(s):*

a) Equal to or less than the approved or pending Medicare Advantage organization (MAO) service area

b) Equal to or less than the counties approved by the State Medicaid Agency

Enter your response to # 2 here.

3. List the service area approved by the State Medicaid Agency(ies).

NOTE: The service area specified in the State Medicaid contract cannot exceed the same service area approved or pending for the Medicare Advantage organization applicant.

County Name	State Name	State & County Code
Enter Parish name here.	Enter State 2 letter abbreviation here.	Enter State & County Code here.

4. Provide a description of your progress toward negotiating the MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits covered in the State Medicaid contract.

Note: The contract must specify the following items:

- *Describe the process by which the D-SNP provides or arranges for Medicaid benefits, including any financial obligations in the contract between the State Medicaid agency and the entity.*
- *Specify how the Medicare and Medicaid benefits are integrated and/or coordinated.*

Enter your response to #4 here.

5. Provide a full description of your progress toward negotiating the category(ies) of eligibility for dual-eligible beneficiaries enrolled under the SNP as describe in the Statute at sections 1902(a), 1902(f), 1902(p), and 1905.

All Duals: QMB, QMB+,SLMB, SLMB+,QI,QDWI, FDBE *

Full Benefit Dual Eligible: QMB+, SLMB+, and FBDE*

Medicare Zero-Dollar Cost Share: QMB, QMB+

Dual Eligible Subset D-SNPs: Targeted populations that align with those that are defined under the State Medicaid Plan or are approved on a case by case basis by CMS.** ***

* As defined under the State Medicaid plan
** All Medicaid subsets must be defined in the State Medicaid Agency Contract

***** Medicaid subset targeted populations may include: a)** *Qualified Medicare Beneficiary Plus(QMB+) dual-eligible individual; b) Specified Low-income Medicare Beneficiary Plus (SLMB+) dual-eligible individual; c) other full benefit dual-eligible individual also known as "Medicaid only"; d) Qualified Medicare Beneficiary (QMB) dual-eligible individual; e) Specified Low-income Medicare Beneficiary (SLMB) dual-eligible individual; f) Qualifying Individual (QI) dual-eligible individual; g) Qualified Disabled and Working Individual (QDWI) dual-eligible individual; h) dual-eligible individual who is institutionalized; i) dual-eligible individual who is an institutional equivalent residing in the community; and j) any Medicaid subset enrollment category other than those previously listed (applicant must specify any other State-required enrollment category).*

Enter your response to #5 here.

6. Provide a full description of your progress toward negotiating the Medicaid benefits covered in the State Medicaid contract.

Provide information on the benefit design and administration, as well as assigning plan responsibility to provide or arrange for the Medicaid benefit.

NOTE: These are the Medicaid services that the organization is obligated to provide or arrange under its State contract, not Medicare Part C or Medicare supplemental benefits that are listed at the time of your Medicare Advantage BID

Enter your response to #6 here.

7. Provide a full description of your progress toward negotiating the cost-sharing protections covered in the State Medicaid contract.

Please demonstrate how the D-SNP would enforce limits on the OOP costs for dual-eligibles. Meeting this contracting element requires that D-SNPs not impose cost-sharing requirements on specified dual-eligible individuals (i.e., FIDE individuals, QMBs, or any other population designated by the State) that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP.

NOTE: Specifically indicate that the Medicaid entity will not bill or hold the member responsible in any way for charges or deductibles for Medically Necessary Covered Services.

Enter your response to #7 here.

8. Provide a full description of your progress toward negotiating the identification and sharing of written information on Medicaid provider participation covered in the State Medicaid contract.

NOTE: The description must contain language indicating the process for the State to identify and share information on providers contracted with the State Medicaid agency for inclusion in the SNP provider directory. Although CMS does not require all providers to accept both Medicare and Medicaid, the D-SNP's Medicare and Medicaid networks should meet the needs of the dual-eligible population served and be adequate enough to serve the targeted population volume as specified.

Enter your response to #8 here.

9. Provide a full description of your progress toward negotiating the process to verify Medicaid eligibility of individuals through the State.

NOTE: The description must contain language on how the State Medicaid Agency will provide MA

organizations with access to real time information verifying eligibility of enrolled dual-eligible members. The agreed upon eligible verification process must be described in detail. The targeted group(s) must be specified in the State Medicaid Agency contract.
Enter your response to #9 here.
10. Provide a full description of your progress toward negotiating the process to coordinate Medicare and Medicaid services for dual-eligible enrollees.
Enter your response to #10 here.

15. D-SNP State Medicaid Agency Contract Matrix

Please complete and upload this document into HPMS per HPMS MA Application User Guide Instructions for completed (i.e., signed) contracts with the State Medicaid Agency. This applies to previously signed contracts that are still effective due to it being a multi-year contract or an evergreen contract.

STATE CONTRACT/SUB CONTRACT REQUIREMENTS

<organization name, plan name/area, PBP number, and date of preparation>

CMS Regulations – 42 CFR 422.107 (c)	Page Number(s)	Section Number	Comments	Reviewer Findings (For CMS Reviewer Use Only)
MA organizations responsibility, including financial obligations, to provide or arrange for Medicaid benefits *The contract must specify the following items:* • *Terms and conditions;* • *Duties of the Medicaid contract or arrangement;* • *Third party liability and coordination of benefits;* • *Compliance with Federal, State and Local Law*				
Category(ies) of eligibility for dual-eligible beneficiaries enrolled under the SNP, as described under the Statute at sections 1902(a), 1902(f), 1902(p), and 1905. • *Any enrollment limitations for Medicare beneficiaries under this SNP must parallel any enrollment limitations under the Medicaid program* **Note**: If applicable, please use State aid codes to identify category of duals being enrolled. Additional guidance can be found at the following link: http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#TopOfPage				
Medicaid benefits covered under the SNP *These are the Medicaid medical services that the organization is obligated to provide under its State contract, not the non-Medicare mandatory Part C services covered under the MA contract.*				

Please complete and upload this document into HPMS per HPMS MA Application User Guide Instructions for completed (i.e., signed) contracts with the State Medicaid Agency. This applies to previously signed contracts that are still effective due to it being a multi-year contract or an evergreen contract.				
STATE CONTRACT/SUB CONTRACT REQUIREMENTS **<organization name, plan name/area, PBP number, and date of preparation>**				
CMS Regulations – 42 CFR 422.107 (c)	**Page Number(s)**	**Section Number**	**Comments**	**Reviewer Findings (For CMS Reviewer Use Only)**
Cost-sharing protections covered under the SNP *Specifically indicate that MA organizations offering D-SNPs must enforce limits on the Out Of Pocket costs for dual-eligibles. D-SNPs must not impose cost-sharing requirements on specified dual-eligible individuals that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP..* **Note:** Covered services under Medicaid may also, depending on State law and policy, include a provider network and prior authorization component, except for emergency services.				
Identification and sharing of information on Medicare provider participation *Must contain language indicating that the MA SNP has written procedures for ensuring Medicaid network adequacy, including access standards.*				
Verification of enrollee's eligibility for both Medicare and Medicaid *The targeted group(s) must be specified in the State Medicaid agency contract.*				
Service area covered by the SNP *The service area specified in the State Medicaid contract must at a minimum, cover the same service area as the MA SNP.*				
The contract period for the SNP *The contracting period between the State Medicaid agency and the DE SNP must specify that it will continue through the contract year. (January 1-December 31 of the year following the due date) If not, the plan may indicate the evergreen clause within the contract and provide an explanation of when the State issues updated rates.*				

16. Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Contract Review Matrix

Plans should use this document to identify where each FIDE SNP element is met within their contract(s). The matrix will be used to assist the Centers for Medicare and Medicaid Services (CMS) in conducting the FIDE SNP determination reviews.

FULLY INTEGRATED DUAL ELIGIBLE (FIDE) SPECIAL NEEDS PLAN (SNP) CONTRACT REVIEW MATRIX

Plan Name: _____ Date: _____

Meeting the definition of a FIDE SNP – CMS 4144-F	Page Number(s)	Section Number	Comments
(1) Enroll special needs individuals entitled to medical assistance under a Medicaid State plan, as defined in section 1859(b)(6)(B)(ii) of the Act and § 422.2. *The contract between the MAO and the state specifies that the MCO can only enroll dual eligibles.*			
(2) Provide dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO). *There is a contract in place between the MAO and the state and CMS to offer a D-SNP.*			
(3) Have a capitated contract with a State Medicaid agency that includes coverage of specified primary, acute and long-term care benefits and services, consistent with State policy. *The contract includes for provision of a capitated payment for covered services. Coverage of primary, acute and long-term care benefits are offered and covered by a capitated arrangement.*			
(4) Coordinate the delivery of covered Medicare and Medicaid health and long term care services, using aligned care management and specialty care network methods for high-risk beneficiaries. *The MAO benefit package includes services such as assessments, care coordination, and case management to improve outcomes for a high-needs population.*			

Plans should use this document to identify where each FIDE SNP element is met within their contract(s). The matrix will be used to assist the Centers for Medicare and Medicaid Services (CMS) in conducting the FIDE SNP determination reviews.

FULLY INTEGRATED DUAL ELIGIBLE (FIDE) SPECIAL NEEDS PLAN (SNP) CONTRACT REVIEW MATRIX

Plan Name: _____ Date: _____

Meeting the definition of a FIDE SNP – CMS 4144-F	Page Number(s)	Section Number	Comments
(5) Employ policies and procedures approved by CMS and the State to coordinate or integrate member materials, including enrollment, communications, grievance and appeals, and quality assurance. *The contract requires that the MCO integrate member materials and administrative processes and meet applicable state requirements. The contract indicates that prior approval by the state and CMS is required for marketing and enrollment materials.*			

17. I-SNP Upload Document

Please complete and upload this document into HPMS per HPMS MA Application User Guide instructions.			
Applicant's Contract Name (as provided in HPMS):			
Enter contract name here.			
CMS Contract Number:			
Enter CMS contract number here.			
Specific I-SNP Population: Place an "X" to the left. **(Mark only <u>one</u>.)**			
	A. Applicant will enroll **ONLY** individuals living in an institution.		
	B. Applicant will enroll **ONLY** individuals who are institutional equivalent and living in the community.		
	C. Applicant will enroll **BOTH** institutionalized and institutional equivalent individuals.		
Applicant Enrolling ONLY Institutionalized			
1. Provide the service area (County, State name and code) for the institutional SNP being offered.			
<u>County Name</u>	**<u>State Name</u>**	**<u>State & County Code</u>**	
Enter County name here.	*Enter State 2 letter abbreviation here.*	*Enter State & County Code here.*	
2. Provide a list of <u>contracted long-term care facilities. (If Applicant is contracting with LTC facilities).</u>			
<u>Name of Contracted Long-term Care Facilities</u>	**<u>Medicaid Provider # (If applicable).</u>**	**<u>Facilities Address</u>**	
Enter name of long-term care facilities here.	*Enter Medicaid provider # here.*	*Enter facilities address here.*	

Name of Contracted Long-term Care Facilities	**Medicare Provider # (If applicable).**	**Facilities Address**

Applicant Enrolling ONLY Institutional Equivalent Individuals

1. Provide the service area (County, State name and code) for the institutional SNP being offered.

County Name	State Name	State & County Code
Enter County name here.	*Enter State 2 letter abbreviation here.*	*Enter State & County Code here.*

2. Provide the name of the entity(ies) performing the level of care (LOC) assessment for enrolling individuals living in the community.

Enter name of the entity(ies) performing the LOC assessment here.

3. Provide the address of the entity (ies) performing the LOC assessment.

Enter the address of the entity(ies) performing the LOC assessment here.

4. Provide the relevant credential (e.g., RN for registered nurse, LSW for licensed social worker, etc.) of the staff from the entity(ies) performing the LOC assessment.

Enter the relevant credential from the staff of the entity(ies) performing the LOC assessment here.

5. Provide a list of assisted-living facilities (if Applicant is contracting with ALFs)

Name of Assisted-living Facilities	Medicaid Provider #	Facilities Address
Enter Name of assisted-living facilities here.	*Enter Medicaid provider # here.*	*Enter facilities address here.*

Applicant Enrolling BOTH Institutionalized and Institutional Equivalent

1. Provide the service area (County, State name and code) for the institutional SNP being offered.

County Name	State Name	State & County Code
Enter County name here.	*Enter State 2 letter abbreviation here.*	*Enter State & County Code here.*

2. Provide a list of contracted long-term care facilities.

Name of Contracted Long-term Care Facilities	Medicare Provider #	Facilities Address
Enter name of long-term care facilities here.	*Enter Medicaid provider # here.*	*Enter facilities address here.*

3. Provide the name of the entity(ies) performing the level of care (LOC) assessment for enrolling individuals

living in the community.
Enter name of the entity(ies) performing the LOC assessment here.
4. Provide the address of the entity(ies) performing the LOC assessment.
Enter the address of the entity(ies) performing the LOC assessment here.
5. Provide the relevant credential (e.g., RN for registered nurse, LSW for licensed social worker, etc.) of the staff from the entity(ies) performing the LOC assessment.
Enter the relevant credential from the staff of the entity(ies) performing the LOC assessment here.
6. Provide a list of assisted-living facilities (if Applicant is contracting with ALFs)

Name of Assisted-living Facilities	Medicaid Provider #	Facilities Address
Enter Name of assisted-living facilities here.	*Enter Medicaid provider # here.*	*Enter facilities address here.*

18. I-SNP Attestation Upload Document

Please complete and upload this document into HPMS per HPMS MA Application User Guide instructions.

2014 Institutional SNP Attestation Upload Document

Applicant's Contract Name (as provided in HPMS):

Enter contract name here.

CMS Contract Number:

Enter contract number here.

Provide attestation for Special Needs Plans (SNP) Serving institutionalized beneficiaries.

Attestation for Special Needs Plans (SNP) Serving Institutionalized Beneficiaries

I attest that in the event the above referenced organization has a CMS approved institutional SNP, the organization will only enroll beneficiaries in the SNP who (1) reside in a Long Term Care (LTC) facility under contract with or owned by the organization offering the SNP to provide services in accordance with the institutional SNP Model of Care approved by CMS, or (2) agree to move to such a facility following enrollment. I further attest that the contract with all LTCs stipulates that the MAO has the authority to conduct on-site visits to observe care, review credentialing and competency assessment records, review beneficiary medical records, and meet with LTC personnel to assure quality and safe care of its beneficiaries.

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

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

CEO_____ Date _____

CEO_____ Date _____

19. ESRD Waiver Request Upload Document

Please complete and upload this document into HPMS per the HPMS MA Application User Guide instructions.

CY 2014 ESRD Upload Document

Applicant's Contract Name (as provided in HPMS):

Enter contract name here.

Applicant's CMS Contract Number:

Enter contract number here.

1. Provide a description of how Applicant intends to monitor and serve the unique needs of the ESRD enrollees including care coordination. Describe how/why the services you provide are relevant to ESRD enrollees. Include a clinical and social profile of ESRD beneficiaries, their most frequent co-morbidities, problems with Activities of Daily Living (ADLs), living arrangements, etc.

Enter your response to #1 here.

2.Provide a listing of any additional service(s) provided to members with ESRD. Include a description of how/why these services are relevant to ESRD enrollees. Only list benefits that are already required for a Medicare Advantage plan to the extent that the applicant offers enhancements to these benefit(s) that specifically address the needs of the ESRD membership. As examples, additional benefits to be described may include but are not limited to:

- **Transportation**
- **Support groups (e.g., beneficiary; family; caregiver)**
- **Self-care education (e.g., nutrition; wound care)**

Enter your response to #2 here.

3. Provide a description of the interdisciplinary care team's coordination role in the assessment and delivery of services needed by members with ESRD. Include specific details about the interaction of the different interdisciplinary care team members during both assessment and delivery of services, and address how the interdisciplinary care team will engage the beneficiary and his/her family and caregiver(s).

Enter your response to #3 here.

4. If the applicant is delegating the ESRD care, care management, or care coordination services in any capacity to another organization, the applicant must:

a. Name the organization(s)
b. Indicate which aspect(s) of care are delegated to each organization (health plan and delegated organization(s)), and define the areas for which each party is responsible

c. Describe the legal relationships between the applicant and the organization(s), and
d. Attach a copy of the fully executed contract between the health plan and the organization(s)

Enter your response to #4 here.

5. Provide a list of the contracted nephrologist(s). Beneficiary access to contracted nephrologists must meet the current HSD criteria.

Name of Contracted Nephrologist(s)	Medicare Provider #	Provider Address
Enter name of contracted nephrologist(s) here.	*Enter Medicare provider # here.*	*Enter provider address here.*

6. Provide a list of the contracted dialysis facility(ies). Beneficiary access to contracted dialysis facilities must meet the current HSD criteria.

Name of Contracted Dialysis Facility(ies)	Medicare Provider #	Facilities Address
Enter name of contracted dialysis facility(ies) here.	*Enter Medicare provider # here.*	*Enter facilities address here.*

7. Describe the dialysis options available to beneficiaries (e.g., home dialysis; nocturnal dialysis).

Enter your response to #7 here.

8. Provide a list of the contracted kidney transplant facility(ies).

Name of Contracted Kidney Transplant Facility(ies)	Medicare Provider #	Facilities Address
Enter Name of contracted kidney transplant facility(ies) here.	*Enter Medicare provider # here.*	*Enter facilities address here.*

9. Describe beneficiary access to contracted kidney transplant facility(ies), including the average distance beneficiaries in each county served by the applicant's SNP must travel to reach a contracted kidney transplant facility. In instances where the contracted kidney transplant facility(ies) are not within the local patterns of care for a given county, provide a justification for this deviation, and describe the transportation services and accommodations which will be made available to beneficiaries.

Enter your response to #9 here.

Please use the following table to provide distance information.

County, ST	Average Distance
Enter the service area county and state (County, ST) here.	***Enter the average distance (in miles) beneficiaries must travel here.***

20. Model of Care Matrix Upload Document

Please complete and upload this document into HPMS per HPMS MA Application User Guide instructions.
Applicant's Contract Name (as provided in HPMS)

Enter contract name here.
Applicant's CMS Contract Number
Enter contract number here.
Care Management Plan Outlining the Model of Care
In the following table, list the document, page number, and section of the corresponding description in your care management plan for each model of care element.

Model of Care Elements	Corresponding Document Page Number/Section
1. Description of the SNP-specific Target Population (e.g., Medicaid subset D-SNP, institutional equivalent individuals enrolled in I-SNP, diabetes C-SNP, or chronic heart failure/cardiovascular C-SNP)	
2. Measurable Goals a. Describe the specific goals including: • Improving access to essential services such as medical, mental health, and social services • Improving access to affordable care • Improving coordination of care through an identified point of contact (e.g., gatekeeper) • Improving seamless transitions of care across healthcare settings, providers, and health services • Improving access to preventive health services • Assuring appropriate utilization of services • Improving beneficiary health outcomes (specify MAO selected health outcome measures) b. Describe the goals as measurable outcomes and indicate how MAO will know when goals are met c. Discuss actions MAO will take if goals are not met in the expected time frame	
3. Staff Structure and Care Management Roles a. Identify the specific employed or contracted staff to perform **administrative** functions (e.g., process enrollments, verify eligibility, process claims, etc.) b. Identify the specific employed or contracted staff to perform **clinical** functions (e.g., coordinates care management, provide clinical care, educate beneficiaries on self-management techniques, consult on pharmacy issues, counsel on drug dependence rehab strategies, etc.) c. Identify the specific employed or contracted staff to perform **administrative and clinical oversight** functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.)	
4. Interdisciplinary Care Team (ICT) a. Describe the composition of the ICT and how the MAO determined the membership b. Describe how the MAO will facilitate the participation of the beneficiary whenever feasible c. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.)	
5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols a. Describe the specialized expertise in the MAO's provider network that corresponds to the target population including facilities and providers	

(e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.) b. Describe how the MAO determined that its network facilities and providers were actively licensed and competent c. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.) d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.) e. Describe how the MAO assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to MAO Medical Director for review, etc.)	
6. Model of Care Training for Personnel and Provider Network a. Describe how the MAO conducted initial and annual model of care training including training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.) b. Describe how the MAO assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.) c. Describe who the MAO identified as personnel responsible for oversight of the model of care training d. Describe what actions the MAO will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.)	
7. Health Risk Assessment a. Describe the health risk assessment tool the MAO uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial, functional, and cognitive needs, medical and mental health history, etc.) b. Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary (e.g., initial assessment within 90 days of enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary, etc.) c. Describe the personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.) d. Describe the communication mechanism the MAO institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification, secure electronic record, etc.)	
8. Individualized Care Plan a. Describe which personnel develops the individualized plan of care and how the beneficiary is involved in its development as feasible	

b. Describe the essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc) c. Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the interdisciplinary care team (ICT), beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified, etc.) d. Describe how the plan of care is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.) e. Describe how the plan of care and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers	
9. Communication Network a. Describe the MAO's structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.) b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies c. Describe how the MAO preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.) d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness	
10. Care Management for the Most Vulnerable Subpopulations a. Describe how the MAO identifies its most vulnerable beneficiaries b. Describe the add-on services and benefits the MAO delivers to its most vulnerable beneficiaries	
11. Performance and Health Outcome Measurement a. Describe how the MAO will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.) b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.) c. Describe how the MAO will use the analyzed results of the performance measures to improve the model of care (e.g., internal committee, other structured mechanism, etc.) d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.) e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.) f. Describe how the MAO will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.)	

21. Quality Improvement Program Matrix Upload Document

Please complete and upload this document into HPMS per HPMS MA Application User Guide instructions.

Applicant's Contract Name (as provided in HPMS)

Enter contract name here.

Applicant's CMS Contract Number

Enter contract number here.

Quality Improvement Program Plan

In the following table, list the document, page number, and section of the corresponding description of your quality improvement program components in your written plan.

Quality Improvement Program Components	Corresponding Document Page Number/Section
1. Description of the SNP-specific Target Population a. Identify the SNP-specific target population (e.g., Medicaid subset D-SNP, institutional equivalent individuals enrolled in I-SNP, diabetes C-SNP, or chronic heart failure/cardiovascular C-SNP) b. Describe the purpose of the quality improvement program in relation to the target population c. Describe how the MAO identifies and monitors the most vulnerable members of the population (i.e., frail, disabled, near the end-of-life, multiple or complex chronic conditions, or developing ESRD after enrollment) and the quality improvement activities designed for these individuals. d. Outline the components of the overall quality improvement program including the MAO's internal activities and the following CMS required activities: • Health information system to collect, analyze, and report accurate and complete data • MAO-determined internal quality improvement activities • Chronic care improvement program (one or more) • Quality improvement project (one or more) • Measurement of the effectiveness of the SNP model of care, indices of quality, and beneficiary health outcomes • Collection and reporting of HEDIS measures (NCQA) • Collection and reporting of Structure and Process measures (NCQA) • Participation in HOS survey if enrollment meets threshold • Participation in CAPHS survey if enrollment meets threshold (Wilkerson & Associates) • Collection and reporting of Part C Reporting Elements (HPMS) • Collection and Reporting of Part D Medication Therapy Management data	
2. Health Information System a. Describe the health information system and how the system enables the MAO to: • Collect, analyze, and integrate data to conduct the quality improvement program • Ensure that data is accurate and complete • Maintain health information for CMS review as requested • Conduct annual review of the MAO's overall quality improvement program • Take action to correct problems revealed through complaints and quality improvement activities b. Describe how the MAO manages the health information system	

to comply with HIPAA and privacy laws, and professional standards of health information management	
3. MAO-determined Internal Quality Improvement Activities a. Describe the quality improvement activities the MAO has designed that address the target population and are not specifically required by CMS. b. Describe how the MAO maintains documentation on internal quality improvement activities and makes it available to CMS if requested.	
4. Chronic Care Improvement Program (CCIP) a. Describe the chronic care improvement program(s) and how CCIP(s) relate to the SNP target population b. Describe how the MAO identifies SNP beneficiaries who would benefit from participation in the CCIP(s) c. Describe how the MAO monitors the beneficiaries who participate in the CCIP(s), and how it evaluates the health outcomes, quality indices, and/or improved operational systems post-intervention.	
5. Quality Improvement Projects (QIP) a. Describe the quality improvement project(s) and how QIP(s) relate to the SNP target population including: • Clearly defined objectives • Interventions for SNP target population • Quality indices and health outcomes written as measureable outcomes b. Describe how the MAO identifies SNP beneficiaries who would benefit from participation in the QIP(s) c. Describe how the MAO monitors the beneficiaries who participate in the QIP(s) d. Describe how it evaluates the health outcomes, quality indices, and/or improved operational systems post-intervention, and achieves demonstrable improvement e. Describe how the MAO conducts systematic and periodic follow-up to assure improvements are sustained	
6. SNP-specific Care Management Measurement a. Describe how the MAO will evaluate the effectiveness of its model of care including: • Methodology • Specific measurable performance outcomes that demonstrate improvements (e.g., access to care, beneficiary health status, staff structure and performance of roles, health risk assessment and stratification of identified needs, implementation of care plans, adequacy of provider network, use of clinical practice guidelines by providers, adequacy of the provider network, etc.) b. Describe how the MAO maintains documentation on model of care evaluation and makes it available to CMS as requested and during onsite audits. c. Describe how the MAO determines what actions to take based on the results of its model of care evaluation.	
7. HEDIS and Structure & Process Measures (NCQA) a. Describe how the MAO collects and reports the required HEDIS measures and Structure & Process measures to NCQA (Note: SNPs having 30 or more enrolled members are required to report these measures)	

b. Describe how the MAO assures accuracy of HEDIS and Structure & Process measures. c. Describe how the MAO determines what actions to take based on the results of HEDIS data and Structure & Process measurement.	
8. Health Outcomes Survey - HOS a. Describe how the MAO participates in reporting HOS (Note: MAOs having 500 or more enrolled members are required to report HOS information) b. Describe how the MAO determines what actions to take based on the HOS survey results.	
9. Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey (Wilkerson & Associates) a. Describe how the MAO participates in reporting CAHPS (Note: MAOs having 600 or more enrolled members are required to report CAPHS information) b. Describe how the MAO determines what actions to take based on the CAHPS survey results.	
10. Part C Reporting Elements a. Describe how the MAO collects, analyzes, and reports Part C reporting data elements to CMS. b. Describe how the MAO assures accuracy of Part C reporting data elements. c. Describe how the MAO determines what actions to take based on the results of Part C reporting data elements.	
11. Part D Medication Therapy Management Reporting a. Describe how the MAO collects, analyzes, and reports Medication Therapy Management measures to CMS. b. Describe how the MAO assures accuracy of Medication Therapy Management measures. c. Describe how the MAO determines what actions to take based on the results of Medication Therapy Management measurement.	
12. Communication on Quality Improvement Program with Stakeholders a. Describe how the MAO will facilitate the participation of providers, the interdisciplinary care team, and beneficiaries/caregivers in its overall quality improvement program. b. Describe how the MAO will communicate improvements in care management resulting from its overall quality improvement program to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.) c. Describe how the MAO maintains documentation on its overall quality improvement program and makes it available to CMS as requested and during onsite audits.	

6 APPENDIX II: Employer/Union-Only Group Waiver Plans (EGWPs) MAO "800 Series"

6.1 Background

The MMA provides employers and unions with a number of options for providing coverage to their Medicare-eligible members. Under the MMA, these options include purchasing benefits from sponsors of prescription drug-only plans (PDPs), making special arrangements with Medicare Advantage Organizations (MAOs) and Section 1876 Cost Plans to purchase customized benefits, including drug benefits, for their members, and directly contracting with CMS to become Part D or MAO plan sponsors themselves. Each of these approaches involves the use of CMS waivers authorized under Sections 1857(i) or 1860D-22(b) of the SSA. Under this authority, CMS may waive or modify requirements that "hinder the design of, the offering of, or the enrollment in" employer-sponsored group plans. CMS may exercise its waiver authority for PDPs, MAOs and Cost Plan Sponsors that offer employer/union-only group waiver plans (EGWPs). EGWPs are also known as "800 series" plans because of the way they are enumerated in CMS systems.

Which Applicants Should Complete this Appendix?

This appendix is to be used by MAOs seeking to offer the following new "800 series" EGWPs: Private Fee-For-Service (PFFS) Plans, Local Coordinated Care Plans (CCPs), Regional Preferred Provider Organization Plans (RPPOs), and Regular Medical Savings Accounts (MSAs). CMS issues separate contract numbers for each type of offering and thus a separate application is required for each corresponding contract. However, Applicants may submit one application to be eligible to offer new MA-only and new MA-PD EGWPs under the same contract number. All applications are required to be submitted electronically in the HPMS. Please follow the application instructions below and submit the required material in support of your application to offer new "800 series" EGWPs.

For waiver guidance and rules on Part C and Part D Employer contracts, see Chapter 9 of the MMCM and Chapter 12 of the Prescription Drug Benefit Manual.

6.2 Instructions

- New MAO applicants seeking to offer new "800 series" EGWPs are Applicants that have not previously applied to offer plans to individual beneficiaries or "800 series" EGWPs.

  Note: All new MAOs intending to offer Part D EGWPs (i.e., MA-PDs) must also complete the *2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors*. The *2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD)*

Sponsors must also be submitted electronically through HPMS. These requirements are also applicable to new MAOs applying to offer "800 series" Regular MSA or Demonstration MSA plans that do not intend to offer plans to individual beneficiaries in 2012. Together these documents will comprise a completed application for new MAOs. Failure to complete, if applicable, the *2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors*, may result in a denial of the EGWP application.

- Existing MAOs that currently offer plans to individual beneficiaries under an existing contract but have not previously applied to offer EGWPs (MA-only or MA-PD) under this same contract.

  Note: Existing MAOs are only required to complete this appendix.

Separate Applications Required For Each Contract Number

A separate application must be submitted for *each contract number* under which the MAO Applicant is applying to offer new "800 series" EGWPs.

6.3 Request for Additional Waivers/Modification of Requirements (Optional)

As a part of the application process, Applicants may submit individual waiver/modification requests to CMS. The Applicant should submit this additional waiver/modification request as an upload via HPMS to the Attestation Waiver Request in the appropriate MA or Part D supplemental upload pages.

These requests must be identified as requests for additional waivers/modifications and must fully address the following items:

- Specific provisions of existing statutory, regulatory, and/or CMS policy requirement(s) the entity is requesting to be waived/modified (please identify the specific requirement (e.g., "42 CFR § 422.66," or "Section 40.4 of Chapter 2 of the MMCM and whether you are requesting a waiver or a modification of these requirements);
- How the particular requirements hinder the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Detailed description of the waiver/modification requested, including how the waiver/modification will remedy the impediment (i.e., hindrance) to the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Other details specific to the particular waiver/modification that would assist CMS in the evaluation of the request; and
- Contact information (contract number, name, position, phone, fax and email address) of the person who is available to answer inquiries about the waiver/modification request.

6.4 Attestations

EGWP Attestation for Contract _____

1. MSA Applicants:

- If Applicant is seeking to offer MSA "800 series" EGWPs, Applicant may designate national service areas and provide coverage to employer group members wherever they reside (i.e., nationwide). Note that CMS has not issued any waiver permitting MAOs to offer non-calendar year MSA plans. Therefore, MAOs may only offer calendar year MSA plans.

Network PFFS Applicants:

- If Applicant is seeking to offer individual plans in any part of a state, Applicant may designate statewide service areas for its "800-series" plan of the same type (i.e. HMO, PPO or PFFS) and provide coverage to employer group members residing anywhere in the entire state. Note that all employer PFFS plans must be network based.

For Local CCP Applicants:

- If Applicant is seeking to offer individual plans in any part of a state, the Applicant may designate statewide service areas and provide coverage to employer group members residing anywhere in the entire state.

However, to enable employers and unions to offer CCPs to all their Medicare eligible retirees wherever they reside, an MAO offering a local CCP in a given service area (i.e., a state) can extend coverage to an employer's or union sponsor's beneficiaries residing outside of that service area when the MAO, either by itself or through partnerships with other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries. Applicants who are eligible for this waiver at the time of application or who may become eligible at any time during the contract year are strongly encouraged to designate their service area broadly (e.g., multiple states, national) to allow for the possibility of enrolling members during the contract year if adequate networks are in place. **No mid-year service area expansions will be permitted.** Applicants offering both individual and "800 series" plans will be required to have Part C or D networks in place for those designated EGWP service areas outside of their individual plan service areas.

RPPO Applicants:

- Applicants offering individual plans in any region may provide coverage to employer group members residing throughout the entire region (i.e., RPPOs must have the same service area for its EGWPs as for its individual plans).

☐ I certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to offer EGWPs in association with my organization's MA contract with CMS. I have read,

understand, and agree to comply with the above statement about service areas. If I need further information, I will contact one of the individuals listed in the instructions for this appendix.

{Entity MUST complete to be considered a complete application.}

2. CERTIFICATION

Note: Any specific certifications below that reference Part D are not applicable to MAO Applicants applying to offer an MSA product because these entities cannot offer Part D under these contracts. Entities can offer Part D benefits through a separate standalone Prescription Drug Plan (PDP); however, a separate application is required to offer "800 series" PDPs.

All provisions of the 2014 MA Applications and the 2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors apply to all employer/union-group waiver plan benefit packages offered by MAOs except where the provisions are specifically modified and/or superseded by particular employer/union-only group waiver guidance, including those waivers/modifications set forth below.

For existing MAOs, this appendix comprises the entire "800 series" EGWP application for MAOs.

I, the undersigned, certify to the following:

1) Applicant is applying to offer new employer/union-only group waiver ("800 series") plans and agrees to be subject to and comply with all CMS employer/union-only group waiver guidance.

2) New MAO Applicants seeking to offer an EGWP ("800 series" plan) must submit and complete the entire EGWP application for MAOs which consists of: this appendix, along with the 2014 MA Application and the 2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors (if applicable).

3) Applicant agrees to restrict enrollment in its EGWPs to those Medicare eligible individuals eligible for the employer's/union's employment-based group coverage. (See 42 CFR section 422.106(d)(2))

4) Applicant understands and agrees that it is not required to submit a 2014 Part D bid (i.e., bid pricing tool) in order to offer its EGWPs. (Section 2.7 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

5) In order to be eligible for the CMS retail pharmacy access waiver of 42 CFR § 423.120(a)(1), Applicant attests that its retail pharmacy network is sufficient to

meet the needs of its enrollees throughout the employer/union-only group waiver service area, including situations involving emergency access, as determined by CMS. Applicant acknowledges and understands that CMS reviews the adequacy of the Applicant's pharmacy networks and may potentially require expanded access in the event of beneficiary complaints or for other reasons it determines in order to ensure that the Applicant's network is sufficient to meet the needs of its employer group population. (See the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

6) MAO Applicant understands and agrees that as a part of the underlying application, it submits a Part D retail pharmacy network list, and other pharmacy access submissions (mail order, home infusion, long-term care, I/T/U) in the 2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors for its designated EGWP service area at the time of application.

7) Applicant understands that its EGWPs are not included in the processes for auto-enrollment (for full-dual eligible beneficiaries) or facilitated enrollment (for other low income subsidy eligible beneficiaries).

8) Applicant understands that CMS has waived the requirement that the EGWPs must provide beneficiaries the option to pay their premiums through Social Security withholding. Thus, the premium withhold option will not be available for enrollees in 42 CFR § 422.64 and 42 CFR § 423.48 to submit information to CMS, including the requirement to submit information (e.g., pricing and pharmacy network information) to be publicly reported on www.medicare.gov, Medicare Plan Finder ("MPF"). Applicant's EGWPs. (Sections 3.6.A10 and 3.24.A2-A4 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

9) Applicant understands that dissemination/disclosure materials for its EGWPs are not subject to the requirements contained in 42 CFR § 422.2262 or 42 CFR § 423.2262 to be submitted for review and approval by CMS prior to use. However, Applicant agrees to submit these materials to CMS at the time of use in accordance with the procedures outlined in Chapter 9 of the MMCM. Applicant also understands CMS reserves the right to review these materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan. (See the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

10) Applicant understands that its EGWPs is not subject to the requirements regarding the timing for issuance of certain disclosure materials, such as the Annual Notice of Change/ Evidence of Coverage (ANOC/EOC), Summary of Benefits (SB), Formulary, and LIS rider when an employer's or union's open enrollment period does not correspond to Medicare's Annual Coordinated Election Period. For these

employers and unions, the timing for issuance of the above disclosure materials should be appropriately based on the employer/union sponsor's open enrollment period. For example, the Annual Notice of Change/Evidence of Coverage (ANOC/EOC), Summary of Benefits (SB), LIS rider, and Formulary are required to be received by beneficiaries no later than 15 days before the beginning of the employer/union group health plan's open enrollment period. The timing for other disclosure materials that are based on the start of the Medicare plan (i.e., calendar) year should be appropriately based on the employer/union sponsor's plan year. (Section 3.14.A.11 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

11) Applicant understands that the dissemination/disclosure requirements set forth in 42 CFR § 422.111 and 42 CFR § 423.128 do not apply to its EGWPs when the employer/union sponsor is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and complies with such alternative requirements. Applicant complies with the requirements for this waiver contained in employer/union-only group waiver guidance, including those requirements contained in Chapter 9 of the MMCM. (Sections 3.14.A.1-2, 9 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

12) Applicant understands that its EGWPs are not subject to the Part D beneficiary customer service call center hours and call center performance requirements. Applicant has a sufficient mechanism is available to respond to beneficiary inquiries and provides customer service call center services to these members during normal business hours. However, CMS may review the adequacy of these call center hours and potentially require expanded beneficiary customer service call center hours in the event of beneficiary complaints or for other reasons in order to ensure that the entity's customer service call center hours are sufficient to meet the needs of its enrollee population. (Section 3.14.A.6 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

13) Applicant understands that its EGWPs are not subject to the requirements contained in 42 CFR § 422.64 and 42 CFR § 423.48 to submit information to CMS, including the requirements to submit information (e.g., pricing and pharmacy network information) to be publicly reported on www.medicare.gov, Medicare Plan Finder ("MPF"). (Sections 3.8.A and 3.17.A.14 of the 2014 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)

14) In order to be eligible for the CMS service area waiver for Local CCPs that allows an MAO to extend coverage to employer group members outside of its individual plan service area, Applicant attests it has at the time of application or will have at the time of enrollment, Part C networks adequate to meet CMS requirements and is able to provide consistent benefits to those beneficiaries, either by itself or

through partnerships with other MAOs. If Applicant is also applying to offer Part D, Applicant attests that such expanded service areas will have convenient Part D pharmacy access sufficient to meet the needs of these enrollees.

15) MSA employer/union-only group waiver plan Applicants understand that they will be permitted to enroll members through a Special Election Period (SEP) as specified in Chapter 2, Section 30.4.4.1, of the MMCM.

16) This Certification is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

17) I have read the contents of the completed application and certify that the information contained herein is true, correct, and complete. If I become aware that any information in this appendix is not true, correct, or complete, I agree to notify CMS immediately and in writing.

18) I authorize CMS to verify the information contained herein. I agree to notify CMS in writing of any changes that may jeopardize my ability to meet the qualifications stated in this appendix prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in revocation of the approval.

19) I understand that in accordance with 18 U.S.C.§. 1001, any omission, misrepresentation or falsification of any information contained in this appendix or contained in any communication supplying information to CMS to complete or clarify this appendix may be punishable by criminal, civil, or other administrative actions including revocation of approval, fines, and/or imprisonment under Federal law.

20) I acknowledge that I am aware that there is operational policy guidance, including the forthcoming Call Letter, relevant to this appendix that is posted on the CMS website and that it is continually updated. Organizations submitting an application in response to this solicitation acknowledge that they will comply with such guidance at the time of application submission.

☐ I certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to offer EGWPs in association with my organization's MA contract with CMS. I have read and agree to comply with the above certifications.

{Entity MUST check box to be considered a complete application.}

{Entity MUST create 800-series PBPs during plan creation and designate EGWP service areas.}

7 APPENDIX III: Employer/Union Direct Contract for MA

7.1 Background

The MMA provides employers and unions with a number of options for providing medical and prescription drug coverage to their Medicare-eligible employees, members, and retirees. Under the MMA, these options include making special arrangements with MAOs and Section 1876 Cost Plans to purchase customized benefits, including drug benefits, for their members; purchasing benefits from sponsors of standalone prescription drug plans (PDPs); and directly contracting with CMS to become a Direct Contract MA, MA-PD or PDP sponsor themselves. Each of these approaches involves the use of CMS waivers authorized under Section 1857(i) or 1860D-22(b) of the SSA. Under this authority, CMS may waive or modify requirements that "hinder the design of, the offering of, or the enrollment in" employer or union-sponsored group plans.

Which Applicants Should Complete This Appendix?

This appendix is to be used by employers or unions seeking to contract directly with CMS to become a Direct Contract MAO for its Medicare-eligible active employees and/or retirees. A Direct Contract MAO can be a:

i. Coordinated Care Plan (CCP) or

ii. Private Fee-For-Service (PFFS) Plan.

Please follow the application instructions below and submit the required material in support of your application.

7.2 Instructions

All Direct Contract MA Applicants must complete and submit the following:

(1) The 2014 MA Application. This portion of the appendix is submitted electronically through the HPMS.

(2) The 2014 Part C Financial Solvency & Capital Adequacy Documentation Direct Contract MA Application. This portion of the appendix is submitted electronically through HPMS.

(3) The 2014 Direct Contract MA Attestations. This portion of the appendix is submitted electronically through HPMS. A copy of these attestations is included with this appendix.

(4) The 2014 Request for Additional Waivers/Modification of Requirements (Optional). This portion of the application is submitted electronically through HPMS. This submission is optional and should be submitted only if the Direct Contract MA Applicant is seeking new waivers or modifications of CMS requirements.

All of the above enumerated submissions will comprise a completed application for new Direct Contract MA Applicants. Failure to complete and submit item numbers 1 through 3 above will result in a denial of the Direct Contract MA application (item number 4 is optional, as noted above).

Please note that in addition to this Appendix, all Direct Contract MA Applicants seeking to contract directly with CMS to offer Part D coverage must also complete the *2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors* and the *2014 Solicitation for Applications for New Employer/Union Direct Contract Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors*.

7.3 Request for Additional Waivers/Modification of Requirements (Optional)

Applicants may submit individual waiver/modification requests to CMS. The Applicant should submit these additional waiver/modifications via hard copy in accordance with the instructions above.

These requests must be identified as requests for additional waivers/modifications and must fully address the following items:

- Specific provisions of existing statutory, regulatory, and/or CMS policy requirement(s) the entity is requesting to be waived/modified (please identify the specific requirement (e.g., "42 CFR § 422.66," or "Section 40.4 of Chapter 2 of the MMCM) and whether you are requesting a waiver or a modification of these requirements);
- How the particular requirements hinder the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Detailed description of the waiver/modification requested including how the waiver/modification will remedy the impediment (i.e., hindrance) to the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Other details specific to the particular waiver/modification that would assist CMS in the evaluation of the request; and
- Contact information (contract number, name, position, phone, fax and email address) of the person who is available to answer inquiries about the waiver/modification request.

7.4 **Attestations**

Direct Contract MA Attestations

1. SERVICE AREA REQUIREMENTS

In general, MAOs can cover beneficiaries only in the service areas in which they are licensed and approved by CMS to offer benefits. CMS has waived these requirements for Direct Contract MA Applicants (Direct Contract CCP and/or Direct Contract PFFS MAOs). Applicants can extend coverage to all of their Medicare-eligible employees/retirees, regardless of whether they reside in one or more other MAO regions in the nation. In order to provide coverage to retirees wherever they reside, Direct Contract MA Applicants must set their service area to include all areas where retirees may reside during the plan year (**no mid-year service area expansions will be permitted**).

Direct Contract MA Applicants that offer Part D (i.e., MA-PDs) will be required to submit pharmacy access information for the entire defined service area during the application process and demonstrate sufficient access in these areas in accordance with employer group waiver pharmacy access policy.

☐ I certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to offer a Direct Contract MA plan. I have read, understand, and agree to comply with the above statement about service areas. If I need further information, I will contact one of the individuals listed in the instructions for this appendix.
{Entity MUST check box for their application to be considered complete.}

2. CERTIFICATION

All provisions of the 2014 MA Application apply to all plan benefit packages offered by Direct Contract MAO except where the provisions are specifically modified and/or superseded by particular employer/union-only group waiver guidance, including those waivers/modifications set forth below (specific sections of the 2014 MA Application that have been waived or modified for new Direct Contract MAOs are noted in parentheses).

I, the undersigned, certify to the following:

1) Applicant is applying to offer new employer/union Direct Contract MA plans and agrees to be subject to and comply with all CMS employer/union-only group waiver guidance.

2) Applicant understands and agrees that it must complete and submit the 2014 MA Application in addition to this *2014 Initial Application for Employer/Union Direct Contract MAOs* application in its entirety, and the Part C Financial Solvency & Capital Adequacy Documentation for Direct Contract Applicants).

Note: Applicant understands and agrees that to offer prescription drug benefits, it must also submit the 2014 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors and the 2014 Solicitation for Applications for New Employer/Union Direct Contract Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors.

3) In general, an MAO must be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers coverage (42 CFR § 422.400). However, CMS has waived the state licensing requirement for all Direct Contract MAOs. As a condition of this waiver, Applicant understands that CMS will require such entities to meet the financial solvency and capital adequacy standards contained in this appendix. (See State Licensure Section of the 2014 MA Application)

4) Applicant agrees to restrict enrollment in its Direct Contract MA plans to those Medicare-eligible individuals eligible for the employer's/union's employment-based group coverage.

5) In general, MAOs must meet minimum enrollment standards as set forth in 42 CFR § 422.514(a). Applicant understands that it will not be subject to the minimum enrollment requirements set forth in 42 CFR § 422.514(a).

6) Applicant understands that dissemination/disclosure materials for its Direct Contract MAO plans are not subject to the requirements contained in 42 CFR § 422.2262 to be submitted for review and approval by CMS prior to use. However, Applicant agrees to submit these materials to CMS at the time of use in accordance with the procedures outlined in Chapter 9 of the MMCM. Applicant also understands that CMS reserves the right to review these materials in the event of beneficiary complaints, or for any other reason it determines, to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan. (See Medicare Operations Section of the 2014 MA Application)

7) Applicant understands that its Direct Contract MA plans will not be subject to the requirements regarding the timing for issuance of certain disclosure materials, such as the Annual Notice of Change/ Evidence of Coverage (ANOC/EOC), Summary of Benefits (SB), Formulary, and LIS rider when an employer's or union's open enrollment period does not correspond to Medicare's Annual Coordinated Election Period. For these employers and unions, the timing for issuance of the above disclosure materials should be appropriately based on the employer/union sponsor's open enrollment period. For example, the Annual Notice of Change/Evidence of Coverage (ANOC/EOC), Summary of Benefits (SB), LIS rider, and Formulary are required to be received by beneficiaries no later than 15 days before the beginning of the employer/union group health plan's open enrollment period. The timing for other disclosure materials that are based on the start of the Medicare plan (i.e., calendar) year should be appropriately based on the employer/union sponsor's plan year. (See Medicare Operations Section of the 2014 MA Application)

8) Applicant understands that the dissemination/disclosure requirements set forth in 42 CFR § 422.111 will not apply to its Direct Contract MA plans when the employer/union sponsor is subject to alternative disclosure requirements (e.g., ERISA) and complies with such alternative requirements. Applicant agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance, including those requirements contained in Chapter 9 of the MMCM. (See Medicare Operations Section 3.13 of the 2014 MA Application)

9) Applicant understands that its Direct Contract MA plans are not subject to the MA beneficiary customer service call center hours and call center performance requirements. Applicant has a sufficient mechanism available to respond to beneficiary inquiries and will provide customer service call center services to these members during normal business hours. However, CMS may review the adequacy of these call center hours and potentially require expanded beneficiary customer service call center hours in the event of beneficiary complaints or for other reasons in order to ensure that the entity's customer service call center hours are sufficient to meet the needs of its enrollee population. (See Medicare Operations Section of the 2014 MA Application)

10) Applicant understands that its Direct Contract MA plans are not subject to the requirements contained in 42 CFR § 422.64 to submit information to CMS, including the requirements to submit information (e.g., pricing and provider network information) to be publicly reported on http://www.medicare.gov (Medicare Options Compare).

11) Applicant understands that the management and operations requirements of 42 CFR § 422.503(b)(4)(i)-(iii) are waived if the employer or union (or to the extent applicable, the business associate with which it contracts for benefit services) is subject to ERISA fiduciary requirements or similar state or federal law standards. However, such entities (or their business associates) are not relieved from the record retention standards applicable to other MAOs set forth in 42 CFR 422.504(d). (See Fiscal Soundness Section of the 2014 MA Application)

12) In general, MAOs must report certain information to CMS, to their enrollees, and to the general public (such as the cost of their operations and financial statements) under 42 CFR § 422.516(a). Applicant understands that in order to avoid imposing additional and possibly conflicting public disclosure obligations that would hinder the offering of employer sponsored group plans, CMS modifies these reporting requirements for Direct Contract MAOs to allow information to be reported to enrollees and to the general public to the extent required by other laws (including ERISA or securities laws) or by contract.

13) In general, MAOs are not permitted to enroll beneficiaries who do not meet the MA eligibility requirements of 42 CFR § 422.50(a), which include the requirement to be entitled to Medicare Part A. (42 CFR § 422.50(a)(1)). Applicant understands that under certain circumstances, as outlined in section 30.1.4 of Chapter 9 of the MMCM, Direct Contract MAOs are permitted to enroll beneficiaries who are not entitled to Medicare

Part A into Part B-only plan benefit packages. (See Medicare Operations Section of the 2014 MA Application)

14) In general, MAOs are not permitted to enroll beneficiaries who have end-stage renal disease (ESRD). Applicant understands that under certain circumstances, as outlined in section 20.2.3 of Chapter 2 of the MMCM, Direct Contract MAOs are permitted to enroll beneficiaries who have ESRD. (See Medicare Operations Section of the 2014 MA Application)

15) This Certification is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

16) I have read the contents of the completed application and the information contained herein is true, correct, and complete. If I become aware that any information in this appendix is not true, correct, or complete, I agree to notify CMS immediately and in writing.

17) I authorize CMS to verify the information contained herein. I agree to notify CMS in writing of any changes that may jeopardize my ability to meet the qualifications stated in this appendix prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in revocation of the approval.

18) I understand that in accordance with 18 U.S.C.§.§ 1001, any omission, misrepresentation or falsification of any information contained in this appendix or contained in any communication supplying information to CMS to complete or clarify this appendix may be punishable by criminal, civil, or other administrative actions, including revocation of approval, fines, and/or imprisonment under Federal law.

19) I acknowledge that I am aware that there is operational policy guidance, including the forthcoming Call Letter, relevant to this appendix that is posted on the CMS website and that it is continually updated. Organizations submitting an application in response to this solicitation acknowledge that they will comply with such guidance should they be approved to offer employer/union-only group waiver plans in association with the organization's MA contract with CMS.

☐ I certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to offer a Direct Contract MAO plan. I have read and agree to comply with the above certifications.

{Entity MUST check box for their application to be considered complete.}

7.5 Part C Financial Solvency & Capital Adequacy Documentation For Direct Contract MAO Applicants:

Background and Instructions

An MAO generally must be licensed by at least one state as a risk-bearing entity (42 CFR 422.400). CMS has waived the requirement for Direct Contract MAOs. Direct Contract MAOs are not required to be licensed, but must meet CMS MA Part C financial solvency and capital adequacy requirements. Each Direct Contract MAO Applicant must demonstrate that it meets the financial solvency requirements set forth in this appendix and provide all required information set forth below. CMS has the discretion to approve, on a case-by-case basis, waivers of such requirements if the Direct Contract MAO can demonstrate that its fiscal soundness is commensurate with its financial risk and that through other means the entity can ensure that claims for benefits paid for by CMS and beneficiaries will be covered. In all cases, CMS will require that the employers'/unions' contracts and sub-contracts provide beneficiary hold-harmless provisions.

The information required in this Appendix must be submitted in hardcopy in accordance with the instructions above.

I. EMPLOYER/UNION ORGANIZATIONAL INFORMATION

A. Complete the information in the table below.

INDENTIFY YOUR ORGANIZATION BY PROVIDING THE FOLLOWING INFORMATION:	
Type of DIRECT CONTRACT MEDICARE ADVANTAGE PLAN requested (Check all that apply): Coordinated Care Plan : ☐ HMO/POS ☐ LPPO Open Access (Non-Network) PFFS Plan ☐ Contracted Network PFFS Plan ☐	
Organization's Full Legal Name:	
Full Address Of Your Organization's Headquarters *(Street, City, State, Zip):*	
Tax Status: For Profit ☐ Not For Profit ☐	Is Applicant Subject To ERISA? Yes ☐ No ☐
Type Of Entity (Check All That Apply) : Employer ☐ Labor Union ☐ Fund Established by One or More Employers or Labor Organizations ☐ Government ☐ Church Group ☐ Publicly-Traded Corporation ☐ Privately-Held Corporation ☐ Other (list Type) _____	
Name of Your Organization's Parent Organization, if any:	
State in Which your Organization is Incorporated or Otherwise Organized to do Business:	

B. Summary Description

Briefly describe the organization in terms of its history and its present operations. Cite significant aspects of its current financial, general management, and health services delivery activities. Please include the following:

A. The size of the Medicare population currently served by the Applicant, and if any, the maximum number of Medicare beneficiaries that could be served by a Direct Contract MAO.
B. The manner in which benefits are currently provided to the current Medicare population served by the Applicant, and if any, the number of beneficiaries in each employer sponsored group option currently made available by the Direct Contract MAO Applicant and how these options are currently funded (i.e., self-funded or fully insured).
C. The current benefit design for each of the options described in B above, including premium contributions made by the employer and/or the retiree, deductibles, co-payments, or co-insurance, etc. (Applicant may attach a summary plan description of its benefits or other relevant materials describing these benefits.)
D. Information about other Medicare contracts held by the Applicant, (i.e., 1876, fee for service, PPO, etc.). Provide the names and contact information for all CMS personnel with whom Applicant works on their other Medicare contract(s).
E. The factors that are most important to Applicant in deciding to apply to become a Direct Contract MAO for its retirees and how becoming a Direct Contract MAO will benefit the Applicant and its retirees.

C. If the Applicant is a state agency, labor organization, or a trust established by one or more employers or labor organizations, Applicant must provide the required information listed below:

State Agencies:

If Applicant is a state agency, instrumentality or subdivision, please provide the relationship between the entity that is named as the Direct Contract MAO Applicant and the state or commonwealth with respect to which the Direct Contract MAO Applicant is an agency, instrumentality or subdivision. Also, Applicant must provide the source of Applicant's revenues, including whether Applicant receives appropriations and/or has the authority to issue debt.

Labor Organizations:

If Applicant is a labor organization, including a fund or trust, please provide the relationship (if any) between Applicant and any other related labor organizations such as regional, local or international unions, or welfare funds sponsored by such related labor

organizations. If Applicant is a jointly trusted Taft-Hartley fund, please include the names and titles of labor-appointed and management-appointed trustees.

Trusts:

If Applicant is a trust such as a voluntary employee beneficiary association under Section 501(c)(9) of the Internal Revenue Code, please provide the names of the individual trustees and the bank, trust company or other financial institution that has custody of Applicant's assets.

D. Policymaking Body (42 CFR 422.503(b)(4)(i)-(iii)

In general, an entity seeking to contract with CMS as a Direct Contract MAO must have policymaking bodies exercising oversight and control to ensure actions are in the best interest of the organization and its enrollees, appropriate personnel and systems relating to medical services, administration and management, and at a minimum an executive manager whose appointment and removal are under the control of the policymaking body.

An employer or union directly contracting with CMS as a Direct Contract MAO may be subject to other, potentially different standards governing its management and operations, such as the Employee Retirement Income Security Act of 1974 ("ERISA") fiduciary requirements, state law standards, and certain oversight standards created under the Sarbanes-Oxley Act. In most cases, they will also contract with outside vendors (i.e., business associates) to provide health benefit plan services. To reflect these issues and avoid imposing additional (and potentially conflicting) government oversight that may hinder employers and unions from considering applying to offer Direct Contract MA Plans, the management and operations requirements under 42 CFR 422.503(b)(4)(i)-(iii) are waived if the employer or union (or to the extent applicable, the business associate with which it contracts for health benefit plan services) is subject to ERISA fiduciary requirements or similar state or federal laws and standards. However, such entities (or their business associates) are not relieved from the record retention standards applicable to other MAOs.

In accordance with the terms of this waiver, please provide the following information:

A. List the members of the organization's policymaking body (name, position, address, telephone number, occupation, term of office and term expiration date). Indicate whether any of the members are employees of the Applicant.

B. If the Applicant is a line of business rather than a legal entity, does the Board of Directors of the corporation serve as the policymaking body of the organization? If not, describe the policymaking body and its relationship to the corporate board.

C. Does the Federal Government or a state regulate the composition of the policymaking body? If yes, please identify all Federal and state regulations that govern your policymaking body (e.g., ERISA).

II. FINANCIAL SOLVENCY

A. Please provide a copy of the Applicant's most recent independently certified audited statements.

B. Please submit an attestation signed by the Chairman of the Board, Chief Executive Officer and Chief Financial Officer or Trustee or other equivalent official attesting to the following:

1. The Applicant will maintain a fiscally sound operation and will notify CMS within 10 business days if it becomes fiscally unsound during the contract period.

2. The Applicant is in compliance with all applicable Federal and state requirements and is not under any type of supervision, corrective action plan, or special monitoring by the Federal or state government or a state regulator. **Note: If the Applicant cannot attest to this compliance, a written statement of the reasons must be provided.**

III. FINANCIAL DOCUMENTATION

A. **Minimum Net Worth at the Time of Application - Documentation of Minimum Net Worth**

At the time of application, the Applicant must demonstrate financial solvency through furnishing two years of independently audited financial statements to CMS. These financial statements must demonstrate a required minimum net worth at the time of application of the greater of $3.0 million or the number of expected individuals to be covered under the Direct Contract MAO Plan times (X) $800.00. Complete the following:

1. Minimum Net Worth: $_____
2. Number of expected individuals to be covered under the Direct Contract MAO Plan times (X) $800.00 = $_____.

Note: If the Direct Contract MAO Applicant is also applying to offer a Direct Contract MAO that provides Part D coverage (i.e., MA-PD), it must complete and submit the corresponding Direct Contract MA-PD application with this appendix and meet the Part D Minimum Net Worth requirements stated in the separate Direct Contract MA-PD application.

If the Applicant has not been in operation at least twelve months, it may choose to: 1) obtain independently audited financial statements for a shorter time period; or 2) demonstrate that it has the minimum net worth through presentation of un-

audited financial statements that contain sufficient detail to allow CMS to verify the validity of the financial presentation. The un-audited financial statements must be accompanied by an actuarial opinion from a qualified actuary regarding the assumptions and methods used in determining loss reserves, actuarial liabilities and related items.

A "qualified actuary" for purposes of this appendix means a member in good standing of the American Academy of Actuaries, a person recognized by the Academy as qualified for membership, or a person who has otherwise demonstrated competency in the field of actuarial science and is satisfactory to CMS.

If the Direct Contract MAO Applicant's auditor is not one of the 10 largest national accounting firms in accordance with the list of the 100 largest public accounting firms published by the CCH Public Accounting Report, the Applicant should enclose proof of the auditor's good standing from the relevant state board of accountancy.

A. Minimum Net Worth On and After Effective Date of Contract

The Applicant must have net worth as of the effective date of the contract of the **greatest** of the following financial thresholds; $3.0 Million; or, an amount equal to eight percent of annual health care expenditures, using the most recent financial statements filed with CMS; or the number of expected individuals to be covered under the Direct Contract MAO Plan times (X) $800.00.

B. Liquidity at the Time of Application ($1.5 Million)

The Applicant must have sufficient cash flow to meet its financial obligations as they become due. The amount of the minimum net worth requirement to be met by cash or cash equivalents is $1.5 Million. Cash equivalents are short-term highly liquid investments that can be readily converted to cash. To be classified as cash equivalents, investments must have a maturity date not longer than three months from the date of purchase.

Note: If the Direct Contract MAO Applicant is also applying to offer a Direct Contract MA Plan that provides Part D coverage (i.e., MA-PD), it must complete and submit the corresponding Direct Contract MA-PD application and meet the Part D Liquidity requirements stated in the separate Direct Contract MA-PD application.

C. Liquidity On and After Effective Date of Contract

After the effective date of the contract, an Applicant must maintain the **greater** of $1.5 Million **or** 40 percent of the minimum net worth requirement outlined in Section III.B above in cash or cash equivalents.

In determining the ability of an Applicant to meet the requirements of this paragraph D, CMS will consider the following:

1. The timeliness of payment;
2. The extent to which the current ratio is maintained at 1:1 or greater, or whether there is a change in the current ratio over a period of time; and
3. The availability of outside financial resources.

CMS may apply the following corresponding corrective remedies:

1. If a Direct Contract MAO fails to pay obligations as they become due, CMS will require the Direct Contract MAO to initiate corrective action to pay all overdue obligations.
2. CMS may require the Direct Contract MAO to initiate corrective action if either of the following is evident:
   (a) The current ratio declines significantly; or
   (b) There is a continued downward trend in the current ratio.
   The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding to restore the current ratio to at least 1:1.
3. If there is a change in the availability of outside resources, CMS will require the Direct Contract MAO to obtain funding from alternative financial resources.

D. Methods of Accounting

A Direct Contract MAO Applicant generally must use the standards of Generally Accepted Accounting Principles (GAAP). GAAP are those accounting principles or practices prescribed or permitted by the Financial Accounting Standards Board. However, a Direct Contract MAO whose audited financial statements are prepared using accounting principles or practices other than GAAP, such as a governmental entity that reports in accordance with the principles promulgated by the Governmental Accounting Standards Board (GASB), may utilize such alternative standard.

E. Bonding and Insurance

An Applicant may request a waiver in writing of the bonding and/or insurance requirements set forth at 42 CFR 422.503(b)(4)(iv) and (v). Relevant considerations will include demonstration that either or both of the foregoing requirements are unnecessary based on the entity's individualized circumstances, including maintenance of similar coverage pursuant to other law, such as the bonding requirement at ERISA Section 412. If the waiver request is based on the existence of alternative coverage, the Applicant must describe such alternative coverage and enclose proof of the existence of such coverage.

F. Additional Information

A Direct Contract MAO Applicant must furnish the following financial information to CMS to the extent applicable:

1. **Self-Insurance/Self Funding**- If the Direct Contract MAO Applicant's PFFS Plan(s) will be self-insured or self-funded, it must forward proof of stop-loss coverage (if any) through copies of policy declarations.
2. **Trust**- If the Direct Contract MAO Applicant maintains one or more trusts with respect to its health plan(s), a copy of the trust documents, and if the trust is intended to meet the requirements of Section 501(c)(9) of the Internal Revenue Code, the most recent IRS approval letter.
3. **Forms 5500 and M-1**- The two most recent annual reports on Forms 5500 and M-1 (to the extent applicable) for the Direct Contract MAO Applicant's health plans that cover prescription drugs for individuals who are Part D eligible.
4. **ERISA Section 411(a) Attestation**- The Direct Contract MAO (including a Direct Contract MAO that is exempt from ERISA) must provide a signed attestation that no person serves as a fiduciary, administrator, trustee, custodian, counsel, agent, employee, consultant, adviser or in any capacity that involves decision-making authority, custody, or control of the assets or property of any employee benefit plan sponsored by the Direct Contract MAO Applicant, if he or she has been convicted of, or has been imprisoned as a result of his or her conviction, of one of the felonies set forth in ERISA Section 411(a), for 13 years after such conviction or imprisonment (whichever is later).
5. **Defined Benefit Pension Plan-** If the Direct Contract MAO Applicant sponsors one or more defined benefit pension plans (within the meaning of ERISA Section 3(35)) that is subject to the requirements of Title IV of ERISA, the latest actuarial report for each such plan.
6. **Multi-Employer Pension Plan-** If the Direct Contract MAO Applicant is a contributing employer with respect to one or more multi-employer pension plans within the meaning of ERISA Section 3(37), the latest estimate of contingent withdrawal liability.
7. **Tax-Exempt Direct Contract MAOs (Only)-** a copy of the most recent IRS tax-exemption.

IV. INSOLVENCY REQUIREMENTS

A. Hold Harmless and Continuation of Coverage/Benefits.

The Direct Contract MAO shall be subject to the same hold harmless and continuation of coverage/benefit requirements as other MA contractors.

B. Deposit Requirements - Deposit at the Time of Application

A Direct Contract MAO generally must forward confirmation of its establishment and maintenance of a deposit of at least $1.0 Million to be held in accordance with CMS requirements by a qualified U.S. financial institution. A "qualified financial institution" means an institution that:

1. Is organized or (in the case of a U.S. office of a foreign banking organization) licensed, under the laws of the United States or any state thereof; and
2. Is regulated, supervised, and examined by the U.S. Federal or state authorities having regulatory authority over banks and trust companies.

The purpose of this deposit is to help ensure continuation of services, protect the interest of Medicare enrollees, and pay costs associated with any receivership or liquidation. The deposit may be used to satisfy the minimum net worth requirement set forth in Section III above.

A Direct Contract MAO may request a waiver in writing of this requirement.

Note: In addition to the requirements in this appendix, if the Direct Contract MAO is also applying to offer a Direct Contract MA Plan that provides Part D coverage (i.e., MA-PD), it must complete and submit the corresponding Direct Contract MA-PD application within this appendix and meet the Part D Deposit requirements stated in the separate Direct Contract MA-PD application.

Deposit On and After Effective Date of Contract

Based on the most recent financial statements filed with CMS, CMS will determine the adequacy of the deposit under this Section and inform the Direct Contract MAO as to the necessity for any increased deposit. Factors CMS will consider shall include the total amount of health care expenditures during the applicable period, the amount of expenditures that are uncovered, and the length of time necessary to pay claims.

Rules Concerning Deposit

1. The deposit must be held in trust and restricted for CMS' use in the event of insolvency to pay related costs and/or to help ensure continuation of services.
2. All income from the deposit are considered assets of the Direct Contract MAO and may be withdrawn from the deposit upon CMS' approval. Such approval is not to be withheld unreasonably.
3. On prior written approval from CMS, a Direct Contract MAO that has made a deposit under this Section may withdraw such deposit or any part thereof if:

   (a) a substitute deposit of cash or securities of equal amount and value is made;

(b) the fair market value of the assets held in trust exceeds the required amount for the deposit; or
(c) the required deposit is reduced or eliminated.

V. GUARANTEES (only applies to an Applicant that utilizes a Guarantor)

A. General policy

The Direct Contract PFFS MAO, or the legal entity of which the Direct Contract PFFS MAO is a component, may apply to CMS to use the financial resources of a Guarantor for the purpose of meeting the requirements of a Direct Contract MAO set forth above. CMS has the sole discretion to approve or deny the use of a Guarantor.

B. Request to Use a Guarantor

To apply to use the financial resources of a Guarantor, a Direct Contract MAO must submit to CMS:

1. Documentation that the Guarantor meets the requirements for a Guarantor under paragraph (C) of this section; and

2. The Guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the Guarantor's balance sheets, profit and loss statements, and cash flow statements.

C. Requirements for Guarantor

To serve as a Guarantor, an organization must meet the following requirements:

1. Be a legal entity authorized to conduct business within a state of the United States.

2. Not be under Federal or state bankruptcy or rehabilitation proceedings.

3. Have a net worth (not including other guarantees, intangibles and restricted reserves) equal to three times the amount of the Direct Contract PFFS MAO guarantee.

4. If a state insurance commissioner or other state official with authority for risk-bearing entities regulates the Guarantor, it must meet the net worth requirement in Section III above with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

5. If the Guarantor is not regulated by a state insurance commissioner or other similar state official, it must meet the net worth requirement in Section III above with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties (subsidiaries and affiliates) excluded from its assets.

D. Guarantee Document

If the guarantee request is approved, a Direct Contract MAO must submit to CMS a written guarantee document signed by an appropriate Guarantor. The guarantee document must:

1. State the financial obligation covered by the guarantee;
2. Agree to:
   (a) Unconditionally fulfill the financial obligation covered by the guarantee; and
   (b) Not subordinate the guarantee to any other claim on the resources of the Guarantor;
3. Declare that the Guarantor must act on a timely basis, in any case not more than five business days, to satisfy the financial obligation covered by the guarantee; and
4. Meet any other conditions as CMS may establish from time to time.

E. Ongoing Guarantee Reporting Requirements

A Direct Contract MAO must submit to CMS the current internal financial statements and annual audited financial statements of the Guarantor according to the schedule, manner, and form that CMS requires.

F. Modification, Substitution, and Termination of a Guarantee

A Direct Contract MAO cannot modify, substitute or terminate a guarantee unless the Direct Contract MAO:

1. Requests CMS' approval at least 90 days before the proposed effective date of the modification, substitution, or termination;
2. Demonstrates to CMS' satisfaction that the modification, substitution, or termination will not result in insolvency of the Direct Contract MAO; and
3. Demonstrates how the Direct Contract MAO will meet the requirements of this Section.

G. Nullification

If at any time the Guarantor or the guarantee ceases to meet the requirements of this section, CMS will notify the Direct Contract MAO that it ceases to recognize

the guarantee document. In the event of this nullification, a Direct Contract MAO must:

1. Meet the applicable requirements of this section within 15 business days; and
2. If required by CMS, meet a portion of the applicable requirements in less than the 15 business days in paragraph (G.1.) of this section.

VI. ONGOING FINANCIAL SOLVENCY/CAPITAL ADEQUACY REPORTING REQUIREMENTS

An approved Direct Contract MAO is required to update the financial information set forth in Sections III and IV above to CMS on an ongoing basis. The schedule, manner, form and type of reporting, will be in accordance with CMS requirements.

8 APPENDIX IV: Medicare Cost Plan Service Area Expansion Application

8.1 State Licensure

To ensure that all Cost Plan contractors operate in compliance with state and federal regulations, CMS requires Cost Plan contractors to be licensed under state law. This will ensure that Cost Plan contractors adhere to state regulations aimed at protecting Medicare beneficiaries. The following attestations were developed based on regulations at 42 CFR 417.404.

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE	YES	NO	N/A
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 managed care product. In addition, the scope of the license or authority allows the Applicant to offer the type of managed care product that it intends to offer in the state or states. • If "Yes", upload in HPMS an executed copy of a state licensing certificate and the CMS State Certification Form for each state being requested. • Note: Applicant must meet and document all applicable licensure and certification requirements no later than the Applicant's final upload opportunity, which is in response to CMS' NOID communication.			
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 which filed the application. • If "Yes", upload in HPMS an explanation			

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: STATE LICENSURE	YES	NO	N/A
of the specific actions taken by the State licensing authority.			
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", upload in HPMS a copy of the state approval for the d/b/a.			
4. For states or territories whose license(s) renew after the first Monday in June, Applicant agrees to submit the new license promptly upon issuance. Applicant must upload into HPMS no later than the final upload opportunity a copy of its completed license renewal application or other documentation that the State's renewal process has been followed (e.g., invoice from payment of renewal fee) to document that the renewal process is being completed in a timely manner. • Note: If the Applicant does not have a license that renews after the first Monday in June, then the Applicant should respond "N/A".			
5. Applicant has marketing representatives and/or agents who are licensed or regulated by the State in which the proposed service area is located. • If the State in which the proposed service area is located doesn't require marketing representatives/agents to be licensed, Applicant should respond "N/A".			

B. In HPMS, upload an executed copy of the State Licensing Certificate and the CMS State Certification Form for each state being requested, if Applicant answers "Yes" to the corresponding question above.

C. In HPMS, upload the State Corrective Plans / State Monitoring Explanation (as applicable), if Applicant answers "Yes" to the corresponding question above.

D. In HPMS, upload the State Approval for d/b/a, if Applicant answers "Yes" to the corresponding question above.

8.2 Service Area

The purpose of the service area attestation is to clearly define which areas will be served by the MAO. A service area for local plans is defined as a geographic area composed of a county or multiple counties, while a service area for MA regional plans is a region approved by CMS. The following attestation was developed to implement the regulations of 42 CFR 422.2.

A. 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 MMCM and will serve the entire county. • If "No", upload in HPMS a justification for wanting to serve a partial county.		

B. In HPMS, on the Contract Management/Contract Service Area/Service Area Data page, enter the state and county information for the area the Applicant proposes to serve. Applicant must also upload a justification for wanting to serve a partial county, if Applicant answered "No" to question 1 above.

8.3 CMS Provider Participation Contracts & Agreements

A. In HPMS, complete the table below:

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: PROVIDER CONTRACTS AND AGREEMENTS	YES	NO
1. Applicant has executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services throughout the requested service area.		
2. Applicant agrees to have all provider contracts and/or agreements available upon request and onsite.		

B. In HPMS, upload a template copy of each first tier provider contract(s) and/or agreement(s) between the Applicant and its health care contractors (i.e., direct contracts with physicians, medical groups, IPAs, PHOs, hospitals, skilled nursing facilities, etc.).

C. In HPMS, upload a template copy of each downstream subcontract that may exist between a Medical group(s), IPA(s), PHO(s), etc. and its downstream providers (e.g., 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 in addition to the contract between the Applicant and the IPA referenced in section B above).

D. In HPMS, upload a completed "CMS Provider Contract Template Matrix", which is a crosswalk to show where in each provider contract/agreement template the referenced CMS regulations are included. Applicant should list each contracted (including sub-contracted) provider template on the matrix.

E. In HPMS, upon request, upload a completed "Contract Signature Page Matrix", which is a document that must accompany the sample of contract signature pages that CMS will request during the application review process. This document is not required for application submission.

F. Note: As part of the application review process, Applicants will need to provide signature pages for physician and provider contracts that the CMS reviewers select based upon the CMS Provider and Facility tables that are a part of the initial application submission. CMS reviewers will include a list of providers and specific instructions in the CMS' first deficiency letter.

G. In HPMS, upload a completed "Contract and Signature Index-Providers", which is an index to link contracted primary care and specialty physicians listed in the MA Provider Table to the template contract(s) listed in the CMS Provider Contract Template and indicate which contract(s) execute the relationship between the applicant and the provider. For MA applicants requesting an SAE, the index will also serve to document whether any of the applicant's current providers will be part of the network available in the expansion area.

H. In HPMS, upload a completed "Contract and Signature Index-Facilities", which is an index to link contracted ancillary or hospital providers listed in the MA Facility Table to the template contract(s) listed in the CMS Template Provider Contract Matrix and indicate which contract(s) execute the official relationship between the applicant and the provider. For MA applicants requesting an SAE, the index will also serve to document whether any of the applicant's current providers will be part of the network relied upon in the expansion area/network.

I. In HPMS, upload a completed "MA Signature Authority Grid", which is a grid to document whether physicians/practitioners of a contracted provider group are

employees of the medical practice or under an alternate arrangement (e.g., medical practice partnership) through which another individual can sign on the provider's behalf. The grid should display the medical group, the person authorized to sign contracts on behalf of the group, and the roster of employed/partner physicians/practitioners of that group.

8.4 Contracts for Administrative & Management Services

This section describes the requirements the Applicant must demonstrate to ensure any contracts for administrative/management services comply with the requirements of all Medicare laws, regulations, and CMS instructions in accordance with 42 CFR 417.412.

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 Cost Plan operations.		
2. Applicant has administrative/management contract/agreement with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the Cost Plan.		
3. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the systems or information technology to operate the Cost Plan.		
4. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.		
5. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the enrollment, disenrollment and membership functions.		
6. Applicant has an administrative/management contract/agreement with a delegated entity to perform any and/or all marketing including delegated sales broker and agent functions.		
7. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a		

RESPOND 'YES' OR 'NO' TO EACH OF THE FOLLOWING STATEMENTS: CONTRACTS FOR ADMINISTRATIVE MANAGEMENT SERVICES	YES	NO
portion of the credentialing functions.		
8. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of call center operations.		
9. Applicant has an administrative/management contract/agreement with a delegated entity to perform all or a portion of the financial services.		
10. Applicant has an administrative/management contract/agreement with a delegated entity to delegate all or a portion of other services that are not listed.		
11. Applicant agrees that as it implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.		

B. In HPMS, complete the Delegated Business Function Table under the Part C Data Link.

Note: If the Applicant plans to delegate a specific function but cannot at this time name the entity with which the Applicant will contract, enter "Not Yet Determined" so that CMS is aware of the Applicant's plans to delegate that function. If the Applicant delegates a particular function to a number of different entities (e.g., claims processing to multiple medical groups), then list the five most significant entities for each delegated business function identified and in the list for the sixth, enter "Multiple Additional Entities".

C. In HPMS, upload executed management contracts or letters of agreement for each contractor or subcontractor (first tier, downstream, and related entities).

8.5 Health Services Management & Delivery

The purpose of the Health Service Management and Delivery attestations is to ensure that all Applicants deliver timely and accessible health services for Medicare beneficiaries. CMS recognizes the importance of ensuring continuity of care and developing policies for medical necessity determinations. In efforts to accomplish this, Cost Plan contractors will be required to select, evaluate, and credential providers that meet CMS' standards, in addition, to ensuring the availability of a range of providers necessary to meet the health

care needs of Medicare beneficiaries. The following attestations were developed to implement the regulations of 42 CFR 417.414, 417.416.

A. In HPMS, upload the following completed HSD tables:

- MA Provider Table
- MA Facility Table

8.6 Part C Application Certification

A. The Applicant does not need to complete attestations for the Part C Application Certification Form. The Applicant must follow instructions in sub-section B below.

B. In HPMS, upload a completed and signed Adobe.pdf format copy of the Part C Application Certification Form.

Note: Once the Part C application is complete, Applicants seeking to offer a Part D plan must complete the Part D application in HPMS. PFFS and Cost Plan SAE organizations have the option to offer Part D plans. MSAs are not allowed to offer Part D plans.

8.7 Full Financial Risk

A. In HPMS, upload a description of any risk sharing with providers and provide physician incentive plans (PIP) disclosure for the new providers in the expanded areas.

8.8 Budget Forecast

A. In HPMS, upload a copy of the Cost Budget for the expanded service area.

Note: The cost budget must be based on the Cost plan financial and statistical records that can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual method of accounting.