

PART C -MEDICARE ADVANTAGE and 1876 COST PLAN EXPANSION APPLICATION

For all new applicants and existing Medicare Advantage organizations seeking to expand a service area: Coordinated Care Plans, Private Fee-for-Service Plans, Medicare Savings Account plans, and Employer Group Waiver Plans

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)**

In accordance with 42 CFR 422.4(c) and Chapter 4 section 10.15 of the MMCM, in order to offer a Medicare Advantage Coordinated Care Plan (CCPs) in an area, a Medicare Advantage organization must offer qualified Part D coverage meeting 42 CFR 423.104 in that plan or in another Medicare Advantage plan in the same area. Therefore, CCP applicants may need to submit a separate Part D application (in connection with this Part C Application) to offer Part D prescription drug benefits as a condition for approval of this application.

DISCLAIMER: CMS will only accept applications appropriately submitted through the Health Plan Management System. CMS does not accept paper applications.

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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. Pursuant to 42 CFR 422.4, the MA program offers several kinds of plans and health care choices, including a coordinated care plans, Medicare Savings Account (MSA) plans, or Private Fee-for-Service (PFFS) 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)

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.

The following are key references about the Medicare cost plans:

- 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/MedicareCostPlans/>

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 submit an inquiry by going to <https://dmao.lmi.org> and clicking on the MA Applications tab. Please note: this is a webpage, not an email address. Below is a list of CMS RO contacts (This information is also available at: <https://www.cms.gov/RegionalOffices/>).

1.5. The Health Plan Management System (HPMS)

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.

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. Please note that it is CMS' expectation that the MA and Medicare Cost Plan Application Contact is a direct employee of the applicant.

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 follow 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 MA product, or submitting a PFFS network transition application must complete a nonbinding NOIA. 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://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess.html>. Upon approval of the CMS User ID request, the applicant will receive a CMS User ID(s) and password(s) for HPMS access. Existing MAOs requesting service area expansions do not need to apply for a new contract number.

Medicare Cost Plans

No initial or new 1876 Cost Plan applications can be accepted by CMS during this application cycle. CMS will accept applications to expand service areas of existing 1876 Cost Plans for CY 2020 in accordance with 42 CFR 417.402. During the CMS review of these applications, the most current data will be employed to apply the Cost Plan Competition Requirements with regard to this type of application. CMS will make a determination whether an application of this type cannot be processed during this

application cycle to the extent that the expansion application is for a requested service area or portions of a service area in which at least two competing Medicare Advantage local coordinated care plans or two Medicare Advantage Regional PPO coordinated care plans meeting specified enrollment thresholds are available. If this is the case, the applicant will be informed and the application withdrawn from further processing and review.

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

1.7. Additional Information

1.7.1. 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 their 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 they intend 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 their plan structures and associated plan service areas, and then download the Plan Benefit Package (PBP) and Bid Pricing Tool (BPT) software. For each plan being offered, applicants will use the PBP software to describe the detailed structure of their MA or Medicare Cost Plan benefit and the BPT software to define their 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 2020.

* 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.

1.7.2. 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 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/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/index.html>. The MA Help Desk is the primary contact for all issues related to the physical submission of transaction files to CMS.

1.7.3. 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.

1.7.4. 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 fully completed Payment Information form and the following documents to CMS:

- Copy of a voided check or a letter from bank confirming the routing and account information.
- W-9 Form.

The completed Payment Information Form and supporting documentation must be emailed to DPO_PAYMENT_ADMINISTRATOR@cms.hhs.gov by the date the completed applications are due to CMS. The subject line of the email should be “Payment Information Form for [insert contract number]”, and the plan should specify the effective date (month and year) in the body of the email.

If the applicant has questions about this form, please contact Louise Matthews at (410) 786-6903.

1.8. Due Dates for Applications – Medicare Advantage and Medicare Cost Plans

Applications must be submitted by February 12, 2020. CMS will not review applications received after this date and time. Applicant’s 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) and Medicare Cost Plan application review process:

APPLICATION AND BID REVIEW PROCESS*

Date	Milestone
November 13, 2019	Recommended date by which applicants should submit their Notice of Intent to Apply Form to CMS to ensure access to Health Plan Management System (HPMS) by the date applications are released.
December 2, 2019	CMS User ID form due to CMS
January 8, 2020	Final Applications Posted by CMS
January 24, 2020	Deadline for NOIA form submission to CMS
February 12, 2020	Completed Applications due to CMS
April 2020	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS.
May 1, 2020	PBP/BPT Upload Module available in HPMS
May 12, 2020	Release of CY 2021 Formulary Submission Module.
June 1, 2020	Bids due to CMS.
Late August 2020	CMS completes review and approval of bid data.
September 2020	CMS executes MA and MA-PD contracts with organizations whose bids are approved and who otherwise meet CMS requirements.
Mid October 2020	Annual Coordinated Election Period begins for CY 2021 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. 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

Applicants shall submit the request in PDF format to <https://dmao.lmi.org/> under the MA Applications tab. *Please note: this is a webpage, not an email address.* Applicants should also send a copy of the letter via e-mail to the Regional office Account Manager.

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 and Cost Plan 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 1, 2020 (tentative date) in order to qualify for a Medicare contract to begin January 1, 2021.

2. INSTRUCTIONS

2.1. Overview

Applicants must complete the 2021 MA or Medicare Cost Plan Service Area Expansion application within HPMS as instructed. CMS will only accept submissions using this current 2021 version of the MA/Cost Plan application. All uploaded documentation must contain the appropriate CMS-issued contract number.

In preparing a response to the prompts throughout this application, the applicant must attest “Yes” or “No.” In some instances, applicants will have the opportunity to attest “N/A” if the attestation does not apply. Applicants are also asked to provide various upload documents 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.

CMS may verify an applicant’s readiness and compliance with Medicare requirements at any time (both prior to and after the start of the contract year) through on-site visits at the applicant’s facilities as well as through other program monitoring. Failure to meet the requirements represented in this application and to operate MA or Medicare Cost plans consistent with the applicable statutes, regulations, 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.

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 complete and upload this document into HPMS.

SNP Contract Name (as provided in HPMS)_____

SNP CMS Contract Number _____

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.

All SNPs are required to develop and implement a Model of Care per regulations at: 42 CFR §422.101(f) and 42 CFR§422.152(g).

1. Description of the SNP Population:-

Element A: Description of the Overall SNP Population: The identification and comprehensive description of the SNP-specific population is an integral component of the MODEL OF CARE because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. It must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations, if relevant to the target population served by the SNP. The description of the SNP population must include, but not be limited to, the following:

- Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.
- A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.
- Identification and description of the health conditions impacting SNP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).
- Define unique characteristics for the SNP population served:
 - C-SNP: What are the unique chronic care needs for beneficiaries enrolled in a C-SNP? Include limitations and barriers that pose potential challenges for these C-SNP beneficiaries.

D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.

I-SNP: What are the unique health needs for beneficiaries enrolled in an I-SNP? Include limitations and barriers that pose potential challenges for these I-SNP beneficiaries as well as information about the facilities and/or home and community-based services in which your beneficiaries reside.

Element B: Sub-Population: Most Vulnerable Beneficiaries

As a SNP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, "medication spending above \$4,000"). The description must differentiate between the general SNP population and that of the most vulnerable members, as well as detail additional benefits above and beyond those available to general SNP members. Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

- A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.
- A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.
- The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).

2. Care Coordination:

Regulations at **42 CFR §422.101(f)(ii)-(v)** and **42 CFR §422.152(g)(2)(vii)-(x)** require all SNPs to coordinate the delivery of care, and measure the effectiveness of the MODEL OF CARE delivery of care coordination. Care coordination helps ensure that SNP beneficiaries' healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries' caregiver(s). The following MODEL OF CARE sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNPs' care coordination activities.

A. SNP Staff Structure

- Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:
 - Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.
 - Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.
 - Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.
- Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MODEL OF CARE are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP.
- Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions.
- Describe how the SNP conducts initial and annual MODEL OF CARE training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.

- Describe how the SNP documents and maintains training records as evidence to ensure MODEL OF CARE training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, and electronic training records.
- Explain any challenges associated with the completion of MODEL OF CARE training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MODEL OF CARE training has not been completed or has been found to be deficient in some way.

B. Health Risk Assessment Tool (HRAT)

Regulations at **42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv)** require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP. The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MODEL OF CARE include the following:

- A clear and detailed description of the policies and procedures for completing the HRAT including:
 - Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MODEL OF CARE Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MODEL OF CARE Element 2D).
 - Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.
 - Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiaries and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary’s plan of care. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.

C. Individualized Care Plan (ICP)

Regulations at **42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv)** require that all SNPs must develop and implement an ICP for each individual enrolled in the SNP.

- The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary’s personal healthcare preferences; description of services specifically tailored to the beneficiary’s needs; roles of the beneficiaries’ caregiver(s); and identification of goals met or not met.
 - When the beneficiary’s goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.
- Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary’s healthcare needs change. If a stratification model is used for determining SNP beneficiaries’ health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary’s ICP.
- Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).

- Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders as necessary.

D. Interdisciplinary Care Team (ICT)

Regulations at **42 CFR §422.101(f)(iii)**; **42 CFR §422.152(g)(2)(iv)** require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP.

- Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used for determining SNP beneficiaries' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.
 - Explain how the SNP facilitates the participation of beneficiaries and their caregivers as members of the ICT.
 - Describe how the beneficiary's HRAT (MODEL OF CARE Element 2B) and ICP (MODEL OF CARE Element 2C) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual beneficiary.
 - Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary's health care needs on a continuous basis.
- Identify and explain the use of clinical managers, case managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.
- Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following:
 - Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MODEL OF CARE. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.
 - The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.
 - How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.

E. Care Transitions Protocols

Regulations at **42 CFR §422.101(f)(2)(iii-v)**; **42 CFR §422.152(g)(2)(vii-x)** require all SNPs to coordinate the delivery of care.

- Explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).
- Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MODEL OF CARE Element 2A.
- Explain how the SNP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This

must include the steps that need to take place before, during and after a transition in care has occurred.

- Describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries' personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.
- Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.
- Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.

3. SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP beneficiaries. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population as identified in MODEL OF CARE 1, and provide oversight information for all of its network types. Each SNP is responsible for ensuring their MODEL OF CARE identifies, fully describes, and implements the following for its SNP Provider Network:

A. Specialized Expertise

Regulations at **42 CFR§422.152(g)(2)(vi)** require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries.

- Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MODEL OF CARE Element 1.
- Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.
- Describe how providers collaborate with the ICT (MODEL OF CARE Element 2D) and the beneficiary, contribute to the ICP (MODEL OF CARE Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

B. Use of Clinical Practice Guidelines & Care Transitions Protocols

Regulations at **42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix)** require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols.

- Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.
- Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details

regarding how these decisions are made, incorporated into the ICP (MODEL OF CARE Element 2C), communicated with the ICT (MODEL OF CARE Element 2D) and acted upon.

- Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MODEL OF CARE Element 2E.

C. MODEL OF CARE Training for the Provider Network

Regulations at **42 CFR§422.101(f)(2)(ii)** require that SNPs conduct MODEL OF CARE training for their network of providers.

- Explain, in detail, how the SNP conducts initial and annual MODEL OF CARE training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.
- Describe how the SNP documents and maintains training records as evidence of MODEL OF CARE training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MODEL OF CARE training.
- Explain any challenges associated with the completion of MODEL OF CARE training for network providers and describe what specific actions the SNP Plan will take when the required MODEL OF CARE training has not been completed or is found to be deficient in some way.

4. MODEL OF CARE Quality Measurement & Performance Improvement:

Regulations at **42 CFR §422.152(g)** require that all SNPs conduct a quality improvement program that measures the effectiveness of its MODEL OF CARE. The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

A. MODEL OF CARE Quality Performance Improvement Plan

- Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MODEL OF CARE structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:
 - The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MODEL OF CARE by using specified data sources, performance and outcome measures. The MODEL OF CARE must also describe the frequency of these activities.
 - Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process.
 - Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MODEL OF CARE Element 4B).

- Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the re-measurement plan for goals not achieved.

B. Measureable Goals & Health Outcomes for the MODEL OF CARE

- Identify and clearly define the SNP’s measureable goals and health outcomes and describe how identified measureable goals and health outcomes are communicated throughout the SNP organization. Responses must include but not be limited to, the following:
 - Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MODEL OF CARE Element 1.
 - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.
 - Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.
 - Ensuring appropriate utilization of services for preventive health and chronic conditions.
- Identify the specific beneficiary health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used.
- Describe, in detail, how the SNP establishes methods to assess and track the MODEL OF CARE’s impact on the SNP beneficiaries’ health outcomes.
- Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.
- Explain the specific steps the SNP will take if goals are not met in the expected time frame.

C. Measuring Patient Experience of Care (SNP Member Satisfaction)

- Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP beneficiary satisfaction.
- Explain how the results of SNP member satisfaction surveys are integrated into the overall MODEL OF CARE performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.

D. Ongoing Performance Improvement Evaluation of the MODEL OF CARE

- Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MODEL OF CARE, including how quality will be continuously assessed and evaluated.
- Describe the SNP’s ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MODEL OF CARE performance evaluation process.
- Describe how the performance improvement evaluation of the MODEL OF CARE will be documented and shared with key stakeholders.

E. Dissemination of SNP Quality Performance related to the MODEL OF CARE

- Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.
- This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad hoc communication with the various stakeholders, such as: a webpage for announcements; printed newsletters; bulletins; and other announcement mechanisms.

- Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MODEL OF CARE Element 2A.

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 state 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.

Note: 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 also complete and timely submit a separate SNP Application. Existing SNPs that require re-approval under the NCQA SNP Approval process should only submit their Model of Care (MOC) written narrative and MOC Matrix Upload Document in the HPMS MOC Module. These SNPs will not be required to submit any other portion of the MA application or SNP Application, 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) Applications 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 Application unless the existing D-SNP is applying for a Service Area Expansion.

2.5. Applicants Seeking to Expand Medicare Cost Plans

All 2020 applicants seeking to expand the service area of an existing Medicare Cost Plan must complete and timely submit a Medicare Cost Plan SAE application. CMS will continue to deny applications for Medicare Cost Plans expanding into areas where two or more local or regional plans meeting minimum enrollment requirements exist in accordance with 1876(h)(5)(C) of the SSA, 42 CFR 417.402(c), and CMS guidance.

2.6. Applicants Seeking to Serve Partial Counties

Applicants may request an exception to the county integrity rule at 42 CFR 422.2 by attesting 'No' to Attestation 3.6.1 and uploading a Partial County Justification document for each requested partial county in its service area. Applicants seeking to serve a partial county must enter all service area information in HPMS by the application submission deadline. Organizations requesting partial county service areas for the first time (initial or SAE applicants) and organizations expanding a current partial county (SAE applicants) by one or more zip codes (when the resulting service area will continue to be a partial county) must submit their Partial County Justifications with their applications. 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. Similarly, applicants cannot expand a partial county request to a full-county request during the application review period. Please note that applicants expanding from a partial county to a full county do NOT need to submit a Partial County Justification."

2.7. Types of Applications

2.7.1. Initial 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 Organizations 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.

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.

2.7.2. Service Area Expansion Applications

Service Area Expansion applications are for:

- Existing MAO contractors who are seeking to expand the service area of an existing contract number.
- Existing MAO contractors who are seeking to expand the service area of an existing SNP.
- Existing Medicare Cost Plans who are seeking to expand the service area of an existing cost plan.

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.

Table 0-1: Required Attestations by Type of Application

Attestation Section Name	Section #	Initial Applicants				Service Area Expansion				
		CCP	PFFS	RPPO	MSA	CCP	PFFS	RPPO	MSA	COST
Management, Experience, and History	3.1	X	X	X	X					
Administrative Management	3.2	X	X	X	X	X	X	X	X	X
State Licensure	3.3	X	X	X	X	X	X	X	X	X
Program Integrity	3.4	X	X	X	X					
Fiscal Soundness	3.5	X	X	X	X	X	X	X	X	
Service Area	3.6	X	X*	X	X*	X	X*	X	X*	X
CMS Provider Participation Contracts & Agreements	3.7	X	X	X	X	X	X	X	X	X
Contracts for Administrative & Management Services	3.8	X	X	X	X	X	X	X	X	X
Quality Improvement Program	3.9	X	X	X	X					
Marketing	3.10	X	X	X	X					
Eligibility, Enrollment, and Disenrollment,	3.11	X	X	X	X					
Working Aged Membership	3.12	X	X	X	X					
Claims	3.13	X	X	X	X					
Communication between MAO and CMS	3.14	X	X	X	X					
Grievances	3.15	X	X	X	X					

Attestation Section Name	Section #	Initial Applicants				Service Area Expansion				
		CCP	PFFS	RPPO	MSA	CCP	PFFS	RPPO	MSA	COST
Organization Determination and Appeals	3.16	X	X	X	X					
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	3.17	X	X	X	X					
Continuation Area	3.18	X	X	X	X	X	X	X	X	
Part C Application Certification	3.19	X	X	X	X	X	X	X	X	X
Access to Services	3.20		X				X			
Claims Processing	3.21		X		X		X		X	
Payment Provisions	3.22		X		X		X		X	
General Administration/Management	3.23				X				X	
Past Performance	3.24	X	X	X	X	X	X	X	X	X

**Applies to network PFFS and MSA applicants.*

2.9. 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).

2.10. 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 2020 are provided in the Part D Application for MA-PD applicants and must be followed. Failure to submit supporting documentation consistent with these instructions may delay the review by CMS and may result in the applicant receiving a NOID or a Notice of Denial.

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.

3. ATTESTATIONS

3.1. Management, Experience, and History

The purpose of this section is to allow applicants to submit information describing their organization's experience and organizational history, and the organization's management structure. 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. This section also ensures 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. Finally, this section ensures that applicants (including but not limited to compliance officers, organization employees, contractors, managers and directors) have a compliance plan and abide by all Federal and State regulations, standards, and guidelines.

An organization must meet minimum enrollment requirements in order to hold a Medicare Advantage contract with CMS (see 42 CFR 422.514). The minimum enrollment requirement is an indicator that the organization applying for a Medicare Advantage contract is able to handle risk and capitated payments. CMS expects that an organization is able to effectively manage a health care delivery system including the enrollment and disenrollment of members and the timely payment of claims, provide quality assurances, and have systems to handle grievances and appeals. CMS recognizes that new applicants may believe they are capable of administering and managing an MA contract although they do not meet the minimum enrollment requirements. CMS also recognizes that there may be reasonable factors, such as specific populations served or geographic location that might result in a plan having low enrollment. For example, SNPs may legitimately have low enrollment because of their focus on a subset of enrollees with certain medical conditions. Such organizations and new applicants may submit a request to waive the enrollment requirements.

The following attestations were developed to implement the regulations of 42 CFR 422.502(b), 422.503(b) and 422.514.

A. In HPMS, complete the attestations and applicable uploads below:

MANAGEMENT, EXPERIENCE, AND HISTORY	YES	NO
3.1.1. Is the applicant applying to be the same type of organization as indicated on the applicants NOIA? The applicant may verify its organization type by looking at the Contract Management Basic page. If the type of organization the applicants organization intends to offer has changed, do not complete this application. Send an email by going to		

MANAGEMENT, EXPERIENCE, AND HISTORY	YES	NO
<p>https://dmao.lmi.org/ and clicking on the MA Applications tab. Please note: this is a webpage, not an email address. Please indicate the pending contract number and the type of organization for which the applicant is now seeking to apply in the email.</p>		
<p>3.1.2. The applicant attests that it has at least 5,000 individuals enrolled for the purpose of receiving health benefits from the organization; or it has at least 1,500 individuals enrolled for purposes of receiving health benefits from the organization and the organization primarily serves individuals residing outside of urbanized areas as defined in 42 CFR 412.62(f). The applicant may count members enrolled in other risk based health insurance products offered by the organization (e.g., commercial, Medicaid).</p> <p>If the applicant attests "No," the applicant must submit a Minimum Enrollment Waiver Request and any supporting documentation.</p> <p>Note: CMS will provide any Minimum Enrollment Waiver review related deficiencies to applicants in the Notice of Intent to Deny.</p>		
<p>3.1.3. Applicant attests that it has completed the Contract Management/ Information/ Data page in HPMS.</p>		
<p>3.1.4. Applicant will adhere to all compliance regulations in accordance with but not limited to 42 CFR 422.503(b)(4)(vi)</p>		
<p>3.1.5 Applicant attests that the compliance officer identified in the HPMS contacts is an employee of the applicant, applicant's parent organization, or a corporate affiliate of the applicant in accordance with 42 CFR §422.503(b)(4)(vi)(B)(1).</p>		

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 including ownership, subsidiaries, and business affiliations.

C. In HPMS, upload a Minimum Enrollment Waiver Request Upload Document and any supporting documentation if you attested “No” to question 3.1.2.

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) and 422.506(a)(4)(a).

A. In HPMS, complete the attestations and applicable uploads below:

ADMINISTRATIVE MANAGEMENT	YES	NO
<p>3.2.1. Applicant attests that it has a contract that non-renewed or terminated a contract within the past two years as defined under 42 CFR 422.506(a). The past two year period for this application cycle would begin if the applicant non-renewed or terminated after 12/31/2018. If the applicant only non-renewed a demonstration Medicare-Medicaid Plan contract after 12/31/2018, the applicant should attest N/A.</p> <p>If the applicant attests "Yes," the applicant must upload a Two Year Prohibition Waiver Request.</p>		
<p>3.2.2. 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 and agrees to close its Cost-Based Contract to new enrollment in any areas it is approved to operate an MA product in accordance with 42 CFR 422.503(b)(4)(vi)(G)(5). If the applicant does not currently operate a CMS Cost Contract under Section 1876 of the SSA in some or all of the intended service area of this application, the applicant should respond “N/A”.</p>		
<p>3.2.3. Applicant will adhere to all applicable Administrative Management regulatory requirements including but not limited to 42 CFR 422.503(b)(4).</p>		

B. In HPMS, upload the Two Year Prohibition Waiver Request Upload document if you attested “Yes” to question 3.2.1.

3.3. State Licensure

To ensure that all organizations operate in compliance with state and federal regulations, CMS requires MAOs to be licensed under state law. This requirement will ensure that organizations adhere to state regulations aimed at protecting Medicare beneficiaries. The following attestations were developed based on the regulations at 42 CFR 422.400 and 42 CFR 417.404.

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 state that MA standards supersede State law or regulation with respect to MA plans other than licensing laws and laws relating to plan solvency.

A. In HPMS, complete the attestations and applicable uploads below:

STATE LICENSURE	YES	NO
<p>3.3.1. Applicant attests that the organization is incorporated and recognized by the state of incorporation as of the initial application submission deadline.</p> <p>If the applicant attests "Yes," the applicant must upload proof of the organization's incorporation, such as articles of incorporation or a certificate of good standing from your state of incorporation.</p> <p>Note: The applicant must be incorporated at the time of the initial application deadline submission. Not applicable for SAE applicants</p>		
<p>3.3.2. Applicant is a Joint Enterprise.</p> <p>If "Yes", upload the copy of the Joint Enterprise agreement executed by the State-licensed entities.</p>		
<p>3.3.3. 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.</p> <p>If "Yes," upload in HPMS an executed copy of a state licensing certificate and the CMS State</p>		

STATE LICENSURE	YES	NO
<p>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.</p> <p>Note: Applicant must meet and document all applicable licensure and certification requirements no later than the applicants final upload opportunity, which is in response to CMS' NOID communication.</p> <p>Note: Joint Enterprise applicants must submit state certification forms for each member of the enterprise.</p>		
<p>3.3.4. 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.</p> <p>If “Yes,” upload in HPMS an explanation of the specific actions taken by the state licensing authority.</p>		
<p>3.3.5. Applicant conducts business as "doing business as" (d/b/a) or uses a name different than the name shown on its Articles of Incorporation.</p> <p>If “Yes,” upload in HPMS a copy of the state approval for the d/b/a.</p>		

- B. In HPMS, upload an executed copy of the State License Certificate and the CMS State Certification Form for each state being requested, if you attested "Yes" to question 3.3.1. If an SAE applicant is adding counties to an already approved MA service area in a state, then only the CMS State Certification Form for that state needs to be uploaded. The CMS State Certification Form must be current and must clearly identify the requested service area. Forms related to prior years' application will not be accepted.
- C. In HPMS, upload a copy of the Joint Enterprise agreement executed by the state-licensed entities, if you attested “Yes” to the question 3.3.2.

- D. In HPMS, upload an 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 attested "Yes" to question 3.3.3.
- E. In HPMS, upload the State Corrective Plans/State Monitoring Explanation (as applicable), if you attested "Yes" to question 3.3.4.
- F. In HPMS, upload the State Approval for d/b/a, if you attested "Yes" to question 3.3.5.
- G. In HPMS, upload proof of the organization's incorporation, such as articles of incorporation or a certificate of good standing from your state of incorporation.

3.4. Program Integrity

- A. In HPMS, complete the attestations and applicable uploads below:

PROGRAM INTEGRITY	YES	NO
3.4.1. 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. Fiscal Soundness

- A. In HPMS, complete the attestations and applicable uploads below:

FISCAL SOUNDNESS	YES	NO
3.5.1 Applicant maintains a fiscally sound operation by at least maintaining - a positive net worth (Total Assets exceed Total Liabilities) in accordance with 42 CFR 422.504(a)(14).		

- B. **Initial applicant only:** In HPMS, upload:
 1. The most recent audited annual financial statements that are available for the legal entity (applicant); and
 2. The most recent quarterly financial statements available for the legal entity (applicant).

Financial statements must include, at a minimum, a balance sheet, income statement, and statement of cash flows. CMS reserves the right to request additional information, such as a financial projections, as it sees fit to determine if the applicant is maintaining a fiscally sound operation. In addition, CMS will verify that the applicant meets State financial solvency requirements as documented on the CMS State Certification Form (uploaded under State Licensure).

Note: If the applicant was not in business in previous years, 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 organization, it must submit the parent’s most recent audited financial statements and the most recent Quarterly NAIC Health Blank or other form of quarterly financial statement if the Quarterly Health Blank is not required by your state.

- C. **SAE applicant only:** CMS will confirm the attestation response by reviewing the most recent audited annual financial statements submitted by the MAO through the Fiscal Soundness Module in HPMS. If the most recent audited annual financial statements in the HPMS fiscal soundness module do not demonstrate that the applicant is maintaining a fiscally sound operation by at least maintaining a positive net worth, the applicant must demonstrate that it is meeting fiscal soundness requirements and upload either:
1. The final audited annual financial statements for the most recent fiscal year end, demonstrating the organization is maintaining a fiscally sound operation by at least maintaining a positive net worth (Total Assets exceed Total Liabilities) in accordance with 42 CFR Section 422.504(a)(14), or
 2. The most recent quarterly or annual financial statements and include an opinion (such as a letter, not a full audit) from the applicant’s independent auditor confirming that the organization’s most recent quarterly or annual financial statements are meeting CMS’s fiscal soundness requirement by at least maintaining a positive net worth (Total Assets exceed Total Liabilities) in accordance with 42 CFR Section 422.504(a)(14).

3.6. Service Area

The purpose of the service area section is to clearly define which areas will be served by the organization and 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, organizations 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.

- A. In HPMS, complete the attestations and applicable uploads below:

SERVICE AREA	YES	NO
<p>3.6.1. Applicant meets the county integrity rule in accordance with 42 CFR 422.2 and Chapter 4 of the MMCM (i.e., the applicant has no partial counties in its service area).</p> <p>If the applicant attests "No," the applicant must upload a Partial County Justification document for each requested partial county in its service area.</p>		
<p>3.6.2. Applicant will adhere to all applicable regulatory requirements including but not limited to 42 CFR 422.112, 422.500, 417.414, and 417.416, as well as sub-regulatory guidance described in Chapter 4 of the MMCM.</p>		
<p>3.6.3. 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 applicable geographic area.</p>		
<p>3.6.4. Applicant attests that contracted providers and facilities meet state and federal licensing requirements for the specialty type.</p>		
<p>3.6.5. Applicant agrees that it will provide all medically necessary transplant services to its Medicare enrollees in full agreement with Chapter 4 of the MMCM. In addition, when providing transplant services at clinical locations outside of the plan's service area, the applicant will arrange and pay for reasonable accommodation and transportation for the enrollee/patient and a companion.</p>		
<p>3.6.6. Applicant agrees that it will provide all medically necessary durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including access to providers qualified to fit these devices, to its Medicare enrollees in full agreement with Chapter 4 of the MMCM.</p>		
<p>3.6.7. Applicant agrees that it will provide all medically necessary Home Health Services to its Medicare enrollees in full agreement with 42 CFR 422.112(a)(1)(i).</p>		

SERVICE AREA	YES	NO
3.6.8. Applicant attests that it will have a contracted network in place that meets current CMS Medicare Advantage network adequacy criteria for each county in its service area prior to the start of the upcoming applicable contract year.		
3.6.9. Applicant attests that it will monitor and maintain a contracted network that meets current CMS Medicare Advantage network adequacy criteria in accordance with 42 CFR 422.112(a)(1)		
3.6.10. Applicant is an RPPO that has established networks in those areas of the region where providers are available to contract and will only operate on a non-network basis in those areas of a region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access and availability standards (see 42 CFR 422.2 and 422.112(a)(1)(ii)).		
3.6.11. When using methods other than written contract agreements to provide enrollees with access to all covered medical services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, the RPPO applicant agrees to establish and maintain a process through which they disclose to their enrollees in non-network areas (Counties/specialties) how the enrollees can access plan-covered medically necessary health care services from non-contracted providers at in-network cost sharing rates (see 42 CFR 422.111(b)(3)(ii) and 42 CFR 422.112(a)(1)(ii)).		

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.

C. In HPMS, upload a Partial County Justification document(s) if you attested “No” to question 3.6.1.

3.7. CMS Provider Participation Contracts & Agreements

This section contains attestations that address the requirements of 42 CFR 422.504 and 42 CFR 417.472, which require that organizations 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 organization 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 organization.

A. In HPMS, complete the attestations and applicable uploads below:

CMS PROVIDER CONTRACTS AND AGREEMENTS	YES	NO
<p>3.7.1. Applicant will adhere to all applicable requirements of 42 CFR 422.504 and 42 CFR 417.472 including but not limited to the following:</p> <ul style="list-style-type: none"> • 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). • Applicant agrees that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Medicare Managed Care Manual, and CMS regulations at 42 CFR 422.504. • Applicant has or will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services, in accordance with CMS established standards throughout the requested service area. • Applicant agrees to have all provider contracts and/or agreements available upon CMS request. 		

3.8. 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) and 42 CFR 417.412. Further guidance is provided in Chapter 11.

A. In HPMS, complete the attestations and applicable uploads below:

CONTRACTS FOR ADMINISTRATIVE AND MANAGEMENT SERVICES	YES	NO
3.8.1. Applicant has contracts with related entities, contractors and subcontractors (first tier, downstream, and related entities) to perform, implement or operate any aspect of operations for the contract.		
3.8.2. 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.		
3.8.3. 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.		
3.8.4. Applicant agrees that all contracts for administrative and management services contain the required contract provisions that are described in the MMCM, and the CMS contract requirements in accordance with 42 CFR 422.504 and 42 CFR 417.412.		

B. In HPMS, enter the Delegated Business Functions 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 applicants 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".

3.9. Quality Improvement Program

The purpose of this section is to ensure that all applicants have a Quality Improvement Program (QI) Program. A QI Program 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 attestations and applicable uploads below:

MAO/PPO/RPPO/LPPO Quality Improvement Program Plan Requirements.	YES	NO
<p>3.9.1. Applicant will adhere to all applicable QI Program regulatory requirements at 42 CFR 422.152, as well as sub-regulatory guidance described in Chapter 5 of the MMCM, including but not limited to the following:</p> <ul style="list-style-type: none"> • Applicant has an ongoing QI Program that can be expected to have a favorable effect on health outcomes and enrollee satisfaction; • Applicant agrees to provide CMS with all documents pertaining to the QI Program upon request; • Applicant conducts a formal evaluation at least annually, on the impact and effectiveness of the MAOs overall quality improvement program. 		

3.10. 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 attestations and applicable uploads below:

MARKETING	YES	NO
<p>3.10.1. Applicant agrees to adhere to all marketing requirements in 422.2260 through 422.2276 and the Medicare Communications and Marketing Guidelines.</p>		
<p>3.10.2. Applicant agrees to provide beneficiaries with all required documents found in 422.111 and the Medicare Communications and Marketing Guidelines.</p>		

3.11. 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 attestations and applicable uploads below:

ELIGIBILITY, ENROLLMENT and DISENROLLMENT	YES	NO
3.11.1. Applicant will adhere to all applicable Marketing related regulations including but not limited to 42 CFR 422.50 through 422.74.		
3.11.2. Applicant agrees to comply with eligibility, enrollment and disenrollment procedures that are contained in Chapter 2 of the MMCM		
3.11.3. Applicant also agrees to comply with all CMS regulations and guidance pertaining to eligibility, enrollment and disenrollment for MA in MARx user guides, the annual Call Letter, interim guidance and other communications distributed via HPMS.		
3.11.4. 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.		
3.11.5. On a quarterly 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 CFR 422 subpart G.		

3.12. 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 attestations and applicable uploads below:

WORKING AGED MEMBERSHIP	YES	NO
<p>3.12.1. Applicant will adhere to all applicable regulatory requirements including but not limited to 42 CFR 422.108, including the following requirements: identify, document, and report to CMS relevant coverage information for working aged, including,</p> <p>Identify payers that are primary to Medicare;</p> <p>Identify the amounts payable by those payers;</p> <p>Coordinate the applicant’s benefits or amounts payable with the benefits or amounts payable by the primary payers.</p>		

3.13. 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), 42 CFR 422.520(a) and 42 CFR 422.566 (a).

A. In HPMS, complete the attestations and applicable uploads below:

CLAIMS	YES	NO
<p>3.13.1. Applicant will be fully compliant with 42 CFR 422.504 (c), 42 CFR 422.520 (a) and 42 CFR 422.566 (a) and agrees that upon receipt paper form or electronic submitted claims will be date stamped, and will be processed promptly in accordance with CMS regulations and guidelines including:</p> <ul style="list-style-type: none"> • Beneficiary receiving prompt denial or acceptance notice of claim’s payment in a format consistent with appeals and notice requirements stated in 42 CFR Part 422 Subpart M. • Having an effective system for receiving, controlling, and promptly correcting and processing claims • Establishing meaningful procedures to develop and process all claims to comply with all applicable standards and requirements 		

3.14. 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 attestations and applicable uploads below:

COMMUNICATIONS between MAO and CMS	YES	NO
3.14.1. 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.		
3.14.2. 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.		
3.14.3. Applicant agrees to establish connectivity to CMS via the AT&T Medicare Data Communications Network (MDCN) or via the Gentran Filesaver.		
3.14.4. Applicant agrees to submit test enrollment and disenrollment transmissions.		
3.14.5. Applicant agrees to submit enrollment, disenrollment and change transactions to CMS within 7 calendar days to communicate membership information to CMS each month.		
3.14.6. Applicant agrees to reconcile MA data to CMS enrollment/payment reports within 45 days of availability.		
3.14.7. Applicant agrees to submit enrollment/payment attestation forms within 45 days of CMS report availability.		
3.14.8. 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.		

3.15. 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 422.561 and 42 CFR 422.564.

A. In HPMS, complete the attestations and applicable uploads below:

GRIEVANCES	YES	NO
<p>3.15.1. Applicant will be fully compliant with 42 CFR 422.561 and 42 CFR 422.564 in establishing meaningful processes, procedures and effectively training relevant staff and subcontractors (first tier, downstream and related entities) to accept (by telephone and in writing (including fax)), identify, track, record, resolve and report enrollee grievances within the established CMS guidelines including:</p> <ul style="list-style-type: none"> • Having an accessible and auditable record of all oral and written grievances received on behalf of the MAO which maintain at a minimum: the receipt date, submission mode (i.e., fax, telephone, letter, e-mail etc.) the grievance originator (person or entity), affected enrollee, subject, final disposition and date of enrollee notification. • Advising all MA enrollees through the provision of information and outreach materials of the definition of a grievance, the complaint process that is available under the Quality Improvement Organization (QIO), their rights, the relevant process and associated timelines for submission and resolution of grievances to the MAO and its subcontractors (first tier, downstream and related entities). 		

3.16. Organization Determination and 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 attestations and applicable uploads below:

ORGANIZATION DETERMINATION and APPEALS	YES	NO
3.16.1. Applicant will adhere to all applicable requirements of 42 CFR 422.561 including but not limited to the following:		
Applicant agrees to adopt policies and procedures for beneficiary organizational determinations, exceptions, and appeals consistent with 42 CFR 422, subpart M.		
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.		
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.		
Applicant agrees to ensure that the reconsideration policy complies with CMS requirements as to assigning the appropriate person or persons to conduct requested reconsiderations.		
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.		

ORGANIZATION DETERMINATION and APPEALS	YES	NO
<p>Applicant agrees to ensure that its reconsideration policy complies with CMS required timelines regarding applicants effectuation through payment, service authorization or service provision in cases where the organization’s determinations are reserved in whole or part (by itself, the IRE, or some higher level of appeal) in favor of the member.</p>		
<p>Applicant agrees to make its enrollees aware of the organization determination, reconsideration, and appeals process through information provided in the Evidence of Coverage and outreach materials.</p>		
<p>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.</p> <p>Administrative Law Judge (ALJ) or some higher level of appeal, received both orally and in writing, that includes, at a minimum:</p> <ul style="list-style-type: none"> Date of receipt Date of any notification Disposition of request Date of disposition <p>Applicant agrees to make available to CMS, upon CMS request, organization determination and reconsideration records.</p> <p>Applicant agrees not to restrict the number of reconsideration requests submitted by or on behalf of a member.</p>		

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

A. In HPMS, complete the attestations and applicable uploads below:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)		YES	NO
1.	Applicant complies with the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.		
2.	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”).		
3.	Applicant agrees to submit the Offshore Subcontract Information and Attestation for each offshore subcontractor (first tier, downstream, and related entities) that receives, processes, transfers, handles, stores, or accesses Medicare beneficiary PHI by the last Friday in September for the upcoming contract year.		
4.	Applicant agrees to not use any part of an enrollee’s Social Security Number (SSN) or Medicare ID Number on the enrollee’s identification card.		

3.18. 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 attestations and applicable uploads below:

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).		

3.19. Part C Application Certification

- A. In HPMS, upload a completed and signed pdf 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.

3.20. Access to Services (PFFS)

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, 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 2021 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 PFSS products and non-network or partial network PFSS products must do so under separate contracts.

A. In HPMS, complete the attestations and applicable uploads below:

ACCESS TO SERVICES PFFS		YES	NO
1.	<p>Applicant agrees to offer a combination PFFS Model that meets CMS' access requirements per 42 CFR 422.114(a)(2)(iii).</p> <p>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.</p>		
2.	<p>Applicant agrees to offer a network PFFS model only per 42 CFR 422.114(a)(2)(ii).</p> <p>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.</p>		
3.	<p>Applicant agrees to offer a non-network PFFS model only per 42 CFR 422.114(a)(2)(i).</p>		
4.	<p>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.</p>		

ACCESS TO SERVICES PFFS		YES	NO
5.	<p>If providing a combination network, applicant is providing a direct contracted network for the following Medicare covered services:</p> <p>DROP DOWN BOX WITH THE FOLLOWING SERVICES:</p> <ul style="list-style-type: none"> • Acute Inpatient Hospital Care • Diagnostic & Therapeutic Radiology (excluding mammograms) • 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 <ul style="list-style-type: none"> • 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. 		
6.	<p>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.</p> <p>Note: Applicant can use CMS model terms and conditions of payment guidance.</p>		

ACCESS TO SERVICES PFFS		YES	NO
7.	Applicant agrees to provide information to its members and providers explaining the provider deeming process and the payment mechanisms for providers.		

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 you selected "Other" for 3.22.5.
- 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)).
- 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.

3.21. Claims Processing (PFFS and 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 attestations and applicable uploads below:

CLAIMS PROCESSING (PFFS and MSA)		YES	NO
1.	Applicant agrees to use a claims system that was <u>previously</u> 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.		
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. Note: 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.		

3.22. Payment Provisions (PFFS and MSA)

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 attestations and applicable uploads below:

PAYMENT PROVISIONS		YES	NO
1.	<p>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).</p> <p>Note: This attestation is not applicable to MSA applicants.</p>		
2.	<p>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)].</p> <p>Note: This attestation is not applicable to MSA applicants</p>		
3.	<p>Applicant agrees that information in the Payment Reimbursement Grid is true and accurate.</p>		
4.	<p>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.</p>		
5.	<p>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.</p>		
6.	<p>The applicant has a system in place to ensure members are not charged after the deductible has been met. [Refer to 42 CFR 422.103(c)].</p> <p>Note: This attestation is not applicable to PFFS applicants.</p>		
7.	<p>Applicant agrees to allow providers to balance bill the beneficiary up to allowed amount.</p> <p>Note: This only applies to applicants that allow balance billing.</p>		

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.

3.23. General Administration/Management (MSA)

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 attestations and applicable uploads below:

General Administration/Management (MSA)	YES	NO
1. Applicant is offering a non-network MSA plan.		
2. Applicant is offering network MSA plans that follow the CCP network model.		
3. Applicant is offering network MSA plans that follow the PFFS network model.		
4. 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.		
5. Applicant agrees to serve as the MA MSA Trustee or Custodian for receiving Medicare deposits to MSA plan enrollee accounts.		
6. Applicant will establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements (as a bank, insurance company or other entity) as set out in Treasury Reg. Secs. 1.408-2(e)(2) through (e)(5). Applicant will 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. If applicant attests “Yes” the applicant must upload the executed banking contract.		

- B. 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.
- C. 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.
- D. 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)).

E. 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.

3.24. Past Performance

A. In HPMS, complete the attestations and applicable uploads below:

PAST PERFORMANCE		YES	NO
1.	<p>The Medicare Advantage plan(s) currently offered by the applicant, applicants’ parent organization, or subsidiary of the applicants’ parent organization has been operational since January 1, 2020 or earlier. (If the applicant, applicants parent organization, or a subsidiary of applicants parent organization does not have any existing contracts with CMS to operate a Medicare Advantage Plan, select “NA”.)</p> <p>Note: CMS will provide any Past Performance related deficiencies to applicants in the Notice of Intent to Deny.</p>		

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)*

SECTION I: All initial applicants, whether a new or existing organization, 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 ownership structure.
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 latest audited financial statement either fiscal year or calendar year.
2. What were the results of that audit?
3. Briefly describe the financial status of the applicants company.

4.2. Minimum Enrollment Waiver Request Upload Document

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

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

Applicant's CMS Contract Number: _____

1. a) Does the contract applicant (organization) have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in 42 CFR §422.514? (yes/no).

b) If response in 1(a) is yes, please describe the extent of this experience.
2. a) Does the contract applicant's parent organization have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in 42 CFR §422.514? (yes/no).

b) If response in 2(a) is yes, please describe the extent of this experience.
3. a) Does the contract applicant's management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in 42 CFR §422.514? (yes/no).

b) If response in 3(a) is yes, please describe the extent of this experience.
4. a) Does the applicant have stop-loss insurance? (yes/no)

b) If response in 4(a) is yes, please provide evidence of this stop-loss insurance.
5. Please describe any factors, such as specific populations your organization intends to serve or geographic locations, which may result in low enrollment?
6. Please describe how your organization is able to establish a marketing and enrollment process that allows your organization to meet the applicable minimum enrollment requirements specified in 42 CFR §422.514.

4.3. Two Year Prohibition Waiver Request Upload Document

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

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

Applicant's CMS Contract Number: _____

Date of Contract Non-Renewal: _____

Under 42 CFR 422.506(a)(4)(a) CMS will not enter into a contract with a Medicare Advantage (MA) Organization for 2 years unless there are special circumstances that warrant special consideration as determined by CMS. If organization attests "yes" to attestation #1 under Administrative Management the MA Organization is required to submit the Two Year Prohibition Waiver Request Upload Document for review and consideration by CMS. The MA organization should provide a description of the circumstance that warrant special consideration related to the non-renewal of your MA contract. The past 2 year period for this application cycle would begin if the MAO non-renewed or terminated after 12/31/2018.

4.4. 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 - 4), then forward the document to the appropriate State Agency Official who should complete those items below the line (items 5-8). 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. The completed form must be current and must include the requested service area. Forms submitted for prior years' applications will not be accepted. 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.

Note: The NAIC number must be populated within the Contract Management Module in HPMS.

Items 1 - 4 (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.
4. Enter the National Association of Insurance Commissioners (NAIC) number if there is one.

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 5 - 8 (to be completed by State Official):

5. List the reviewer's pertinent information in the event CMS needs to communicate with the individual conducting the review at the State level.
6. List the requested information regarding other State departments/agencies required to review requests for licensure.
7. 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.
8. 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 1-4.

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:

4. National Association of Insurance Commissioners (NAIC) number:

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 5-8)

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.

5. State official reviewing MA State Certification Request:

Reviewer's Name

State Oversight/Compliance Officer

Agency Name

Address

Address

City/State

Telephone

E-Mail Address

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

Agency _____

Contact Person _____

Address _____

City/State _____

Telephone _____

E-Mail Address _____

7. 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.

8. 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

4.5.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, 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 applicants 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 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 applicants 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: _____

4.8. Partial County Justification

Instructions: Organizations requesting service areas that include one or more partial counties must upload a completed Partial County Justification

Complete and upload a Partial County Justification form for each partial county in your service area.

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

If an organization would like to request a Network Exception Request for a partial county, the organization must do so during its network adequacy review in the Network Management Module and must use the same process available to organizations operating in the full county.

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

SECTION I: Partial County Explanation

Using just a few sentences, briefly describe the reason for your partial county, and complete the following to reflect your situation:

- Request for new partial county: Zip Code(s) _____
- Request to expand current partial county by 1+ zip code(s): Zip Code(s) _____
- Previously approved/current partial county
Year Approved _____ Zip Code(s) _____

SECTION II: Partial County Requirements

The Medicare Managed Care Manual Chapter 4, Section 140.3 provides guidance on partial county requirements. The following questions pertain to those requirements; refer to Section 140.3 when responding to them.

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

1. **Necessary** – It is not possible to establish a network of providers to serve the entire county.

Describe the evidence that you are providing to substantiate the above statement that it is not possible to establish a network to serve the entire county 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.

5. APPENDIX I: Special Needs Plan (SNP) Application

5.1 Overview

The Bipartisan Budget Act of 2018 (BBA of 2018) permanently authorized special needs plans (SNPs), including dual eligible special needs plans (D-SNPs), chronic condition SNPs (C-SNP), and institutional SNPs (I-SNP). 42 CFR 422.2 defines special needs individuals and SNPs for special needs individuals.

The BBA of 2018 also requires the establishment of new standards for integration of Medicare and Medicaid benefits provided to enrollees in D-SNPs, as well as the development unified appeals and grievance processes for D-SNPs, beginning in CY 2021. CMS-4185-F, “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published in the Federal Register on April 16, 2019, modified and amended 42 CFR 422 to codify integration criteria for all D-SNPs and unified appeals and grievance processes for some D-SNPs (those defined as “applicable integrated plans”) beginning in CY 2021.

SNPs are required to follow existing MA and Prescription Drug Benefit program rules. . An applicant intending to offer a SNP must be qualified under the MA and Part D application in all counties of the SNP type service area. Therefore, an applicant may need to submit an MA and Part D application in conjunction with its SNP application. The timeline for submitting a SNP application is the same as the MA application timeline. Please see the section below for more information.

Applicants must complete the 2021 SNP application within HPMS as instructed. CMS will only accept submissions using this current 2021 version of the SNP application. All uploaded documentation must contain the appropriate CMS-issued contract number.

In preparing a response to the prompts throughout this application, the applicant must attest “Yes” or “No.” In some instances, applicants will have the opportunity to attest “N/A” if the attestation does not apply. Applicants must upload various documents in HPMS. SNP application upload documents are described throughout the SNP attestation sections. The applicant should read the sections carefully in order to provide the information as requested.

CMS strongly encourages SNP 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. Applicants should read HPMS memos and visit the CMS web site periodically to stay informed about new or revised guidance documents.

For further guidance regarding SNPs, refer to Chapter 16b: Special Needs Plans of the MMCM.

5.2 SNP Application Types

All applicants must submit their SNP Application by completing the HPMS SNP Application template and submitting all completed upload documents per the HPMS User Guide instructions. A SNP application must be completed for each SNP type to be offered by the MA organization.

A D-SNP must have a State Medicaid Agency Contract in place prior to the beginning of the 2021 contract year, which aligns with the entire 2021 SNP contract term.

5.2.1 Initial (New) SNP Applications

Initial (new) SNP applications are for:

- New applicants or existing MA organizations seeking to offer a SNP for the first time. **Note: An initial applicant seeking to offer a SNP must submit an MA and Part D application in conjunction with the SNP Application.**
- Existing MA organizations seeking to offer a new SNP type that they do not currently offer. **Note: The applicant or the existing MA organization must be qualified under the MA and Part D application in all counties of the SNP type service area.**

Note: If the MA service area is not approved due to unresolved deficiencies, the new SNP or SNP SAE Application will not be approved.

5.2.2. SNP Service Area Expansion Applications

SNP Service Area Expansion Applications are for:

- An MA organization currently offering a SNP that wants to expand the service area of the SNP. Even if the SNP is the only plan benefit package in a contract, the MA organization must complete in HPMS the MA-PD SAE (to trigger the SNP SAE) *and* the SNP SAE for the overall MA contract.
- **Note: For contract year 2021, all D-SNPs, including D-SNPs seeking to expand their service area, must submit a new State Medicaid Agency Contract or a current (evergreen) contract with amendments and submit the applicable D-SNP attestations and required uploads in order to meet the new D-SNP requirements as a result of the BBA of 2018 which amended section 1859 of the Social Security Act and updated requirements in 42 CFR 422. For contract year 2021 only, evergreen contracts with letters of good standing will not be accepted for purposes of the D-SNP State Medicaid**

Agency Contract review. A State Medicaid Agency Contract that reflects requirements effective CY 2021 is required.

- **Note: The service area of the proposed SNP cannot exceed the existing or pending service area for the MA contract.**

Note: If the MA service area is not approved due to unresolved deficiencies, the new SNP or SNP SAE Application will not be approved.

Note: The MOC Matrix Upload Document and the MOC Narrative are not required with the SAE application.

5.3

Renewal SNPs that are Not Expanding their Service Area:

An MA organization currently offering a SNP that requires re-approval under the National Committee for Quality Assurance (NCQA) SNP Approval process should submit its MOC written narrative and MOC Matrix Upload Document in the HPMS MOC Module, and will not be required to submit any other portion of the MA application or SNP Application, 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 Application unless specifically noted (e.g., to meet the requirement for contracting with a State Medicaid Agency).

Note: For contract year 2021, all D-SNPs, including renewal D-SNPs that are not expanding their service area, must submit a new State Medicaid Agency Contract or a current (evergreen) contract with amendments and submit the applicable D-SNP attestations and required uploads in order to meet the new D-SNP requirements as a result of the BBA of 2018, which amended section 1859 of the Social Security Act and resulted in updated requirements in 42 CFR 422. For contract year 2021 only, evergreen contracts with letters of good standing will not be accepted for purposes of the D-SNP State Medicaid Agency Contract review.

The Affordable Care Act amended section 1859(f) of the Social Security Act to require that all SNPs be approved by NCQA starting January 1, 2012, and subsequent years. 42 CFR §§ 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 MOC as per CMS guidance.

5.4 D-SNP State Medicaid Agency(ies) Contract(s): Attestation and Uploads

State Medicaid Agency Contracts- Note that these attestations and uploads should not be submitted with the Part C Application in February 2020. CMS will send HPMS memo indicating when the SMAC module will be available for uploads. The SMAC documents will be due by July 6, 2020.

Attestation	Response
<p>1. Applicant has an existing, executed contract(s) with the State Medicaid Agency in the state(s) in which the applicant seeks to operate for the MA application year by July 6, 2020.</p> <p>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. A current (evergreen) contract with amendments, or future contract, must be uploaded each application cycle or year. For contract year 2021, submission of only evergreen contracts with letters of good standing will not be accepted.</p> <p>Note: This attestation and upload should be completed in the SMAC module at the time of the SMAC submission.</p>	<p>Yes/No</p>
<p>2. Applicant’s contract with the State Medicaid Agency(ies) qualifies as a highly integrated dual eligible SNP (HIDE SNP). Note: Please refer to Section 5.12 to help make this determination.</p> <p>If the applicant attests “Yes,” upload the completed D-SNP State Medicaid Agency Contract Matrix and SNP Status Contract Matrix with your SMAC before July 6, 2020.</p> <p>NOTE: This attestation and upload should be completed in the SMAC module at the time of the SMAC submission.</p>	<p>Yes/No</p>
<p>3. Applicant’s contract with the State Medicaid Agency(ies) qualifies as a fully integrated dual eligible SNP (FIDE SNP). Note: Please refer to Section 5.12 to help make this determination.</p> <p>If the applicant attests "Yes," upload the completed D-SNP State Medicaid Agency Contract Matrix and SNP Status Contract Matrix with your State Medicaid Agency Contract before July 6, 2020.</p>	<p>Yes/No</p>

Attestation	Response
<p>Note: This attestation and upload should be completed in the SMAC module at the time of the SMAC submission.</p>	
<p>4. Applicant has a contract with the State Medicaid Agency(ies) that stipulates that the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid Agency and/or its designee(s) of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals identified by the State Medicaid Agency.</p> <p>If the applicant attests “Yes,” upload the completed D-SNP State Medicaid Agency Contract Matrix (see Section 5.11) before July 6, 2020</p> <p>NOTE: This attestation and upload should be completed in the SMAC module at the time of the SMAC submission.</p> <p>NOTE: If Applicant attested “No” to attestations 2 and 3 in this table, it must attest “Yes” to this attestation.</p>	<p>Yes/No</p>
<p>5. Consistent with the definition of a SNP with exclusively aligned enrollment at 422.2, Applicant is a SNP that <i>exclusively</i> enrolls full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and the SNP’s MA organization, the SNP’s parent organization, or another entity that is owned and controlled by the D-SNP’s parent organization.</p> <p>NOTE: If the applicant attests “Yes,” and is a FIDE SNP or HIDE SNP, per the responses to attestations 3 and 4 of this section, then the applicant agrees to use the unified appeals and grievance procedures under 422.629 through 422.634, 438.210, 438.400 and 438.402 and must complete the SNP Status Contract Matrix elements 1 and 2.</p>	<p>Yes/No</p>

5.5. I-SNP: Attestations and Uploads

Attestation	Response
I-SNP Individuals Residing ONLY in Institutions	
<p>1. Applicant will only enroll institutionalized individuals residing in a long-term care (LTC) facility under contract with or owned and operated by the SNP.</p> <p>Corresponding Upload Document: I-SNP residing Only in Institutions.</p>	Yes/No
Attestation	Response
I-SNP Individuals Residing ONLY in the Community	
<p>1. Applicant will enroll only individuals who are institutional equivalents residing in the community.</p> <p>Corresponding Upload Documents:</p> <ul style="list-style-type: none"> • I-SNP residing Only in Community, and • A Copy of the respective State’s Level of Care (LOC) assessment tool to determine eligibility for each institutional equivalent beneficiary. 	Yes/No
Attestation	Response
I-SNP Individuals Residing in BOTH Institutions and the Community	
<p>1. Applicant will enroll individuals who are both institutionalized and institutionalized equivalents residing in the community.</p> <p>Corresponding Upload Documents:</p> <ul style="list-style-type: none"> • SNP Individuals Residing in Both Institutions and the Community, and • A Copy of the respective State’s Level of Care (LOC) assessment tool to determine eligibility for each institutional equivalent beneficiary. 	Yes/No

5.6. C-SNP, D-SNP and I-SNP ESRD Waiver Request: Attestation and Upload

Attestation	Response
<p>1. Applicant is applying to offer a new SNP targeting individuals having ESRD.</p> <p>If applicant answered "Yes," download the SNP ESRD Waiver Request Upload Document, fully complete it, and upload the completed document.</p>	<p>Yes/No</p>

5.7. MOC: Attestation and Uploads

Attestation	Response
<p>1. Applicant has submitted a written description of its MOC as defined in the MOC Matrix upload document.</p> <p>Upload a copy of the written MOC AND Download the MOC Matrix Upload Document, fully complete it, and upload the completed document</p>	<p>Yes/No</p>

5.8 Health Risk Assessment: Attestations

Attestation	Response
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 which includes some or all of the following:	
a. conduct an initial comprehensive health risk assessment within 90 days of enrollment and use the results to develop the individualized care plan for each beneficiary	Yes/No
b. conduct annual comprehensive health risk assessment and the results are used to update the individualized care plan for each beneficiary	Yes/No
c. comprehensive initial and annual health risk assessment examines covers medical, psychosocial, cognitive, and functional status	Yes/No
d. comprehensive health risk assessment is conducted face-to-face by the applicant	Yes/No
e. comprehensive health risk assessment is conducted telephonically by the applicant	Yes/No
f. comprehensive health risk assessment is conducted by having the beneficiary complete an electronic or paper-based questionnaire	Yes/No
2. Applicant develops or selects and utilizes a comprehensive risk assessment tool that will be reviewed during oversight activities and consists of:	
a. an existing validated health risk assessment tool	Yes/No
b. a plan-developed health risk assessment tool	Yes/No
c. an electronic health risk assessment tool	Yes/No
d. a paper health risk assessment tool	Yes/No
e. uses a standardized health risk assessment tool for all beneficiaries	Yes/No
f. periodically reviews the effectiveness of the health risk assessment tool	Yes/No
3. Applicant has a process to conduct authoritative health risk assessment, analyze identified health risks, and stratify them to develop an individualized care plan that mitigates health risks through some of the following methods:	
a. Comprehensive health risk analysis is conducted by a credentialed healthcare professional	Yes/No
b. Applicant notifies the Interdisciplinary Care Team, respective providers, and beneficiary about the results of the health risk analysis	Yes/No

Attestation	Response
c. Applicant tracks and trends population health risk data to inform the development of specialized benefits and services	Yes/No
d. Applicant uses predictive modeling or other software to stratify beneficiary health risks for the development of an individualized care plan	Yes/No
e. Applicant manually analyzes health risk data to stratify beneficiary health risks for the development of an individualized care plan	Yes/No

5.9. SNP Quality Improvement Program: Attestations

Attestation	Response
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. 42 CFR §152(g)	Yes/No
2. Applicant conducts an annual review of the effectiveness of its quality improvement program.	Yes/No
3. 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
4. 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
5. 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
6. For each special needs plan, applicant collects, analyzes, and reports data that measure staff implementation of the SNP MOC (e.g., National Committee for Quality Assurance accreditation measures or medication reconciliation associated with care setting transitions indicators).	Yes/No
7. 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
8. For each special needs plan, applicant collects, analyze, 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
9. 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
10. 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	Yes/No

Attestation	Response
vulnerable beneficiaries (frail, disabled, near the end-of-life, etc.).	
11. 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
12. 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
13. 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
14. 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
15. 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
16. For each special needs plan, applicant can demonstrate it has a provider network having targeted clinical expertise as evidenced by measures from medication management, disease management, or behavioral health domains.	Yes/No
17. For each special needs plan, applicants agrees to disseminate the results of the transitions of care analysis to the interdisciplinary care team.	Yes/No
18. Applicant can provide CMS with documentation on policies and procedures that will enable CMS to monitor the plans MOC performance.	Yes/No

5.10. Past Performance Attestation

Attestation	Response
<p>1. 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, 2020 or earlier. (If the applicant, applicants parent organization, or a subsidiary of applicants parent organization does not have any existing contracts with CMS to operate a Medicare Advantage Plan, select “NA”.)</p>	<p>Yes/No</p>

5.11 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 items that may have been part of previously signed contracts that are still effective due to it being a multi-year contract, in addition to any items below that are part of a new amendment. When designating the page numbers and sections below, please note if the page numbers and sections are in an amendment to the SMAC. If an element is not applicable, please indicate that in the not applicable column.

STATE CONTRACT REQUIREMENTS

Plan Name: _____

PBP: _____

Date: _____

State: _____

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>1. How the SNP coordinates the delivery of Medicaid benefits for individuals who are eligible for such services. This includes Medicaid services covered under Medicaid fee-for-service, by the SNP’s MA organization, the SNP itself (or a Medicaid plan offered by the SNP’s parent organization or another entity owned and controlled by its parent organization), or by other Medicaid plans available in the state. (422.107(c)(1)(i))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>2. If applicable, how the SNP provides coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services. (422.107(c)(1)(ii))</p> <p>NOTE: Page number and section number should be completed by applicable D-SNPs; however, if</p>			

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>not applicable, D-SNP should indicate that in the not applicable column.</p>			
<p>3. The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP, including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act. (422.107(c)(2))</p> <p>NOTE: If applicable, please use State aid codes to identify category of duals being enrolled. Page number and section number must be completed by all D-SNPs.</p>			
<p>4. Medicaid benefits covered under a capitated contract between the State Medicaid Agency and the MA organization offering the SNP, the SNP’s parent organization, or another entity that is owned and controlled by the SNP’s parent organization. (422.107(c)(3))</p> <p>NOTE: Page number and section number should be completed by applicable D-SNPs; however, if not applicable please indicate that in the not applicable column.</p> <p>Please provide specific page numbers and section numbers for:</p> <ul style="list-style-type: none"> • Medicaid behavioral health services, • Medicaid long-term supports and services, • Medicaid payment of Medicare cost sharing, and • Other Medicaid benefits <p>For the bulleted items above, if D-SNPs are not capitated to provide the specific Medicaid service they should indicate that in the not applicable column.</p>			
<p>5. Language that identifies the entity (your MA organization, parent organization, or other organization owned and controlled by your parent organization) that holds the capitated contract with the</p>			

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>State Medicaid Agency for the Medicaid benefits covered. (422.107(c)(3))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs. However, if not applicable please enter that in the not applicable column.</p>			
<p>6. Cost-sharing protections covered under the SNP. (422.107(c)(4))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>7. Identification and sharing of information on Medicaid provider participation. (422.107(c)(5))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>8. Verification of enrollee’s eligibility for both Medicare and Medicaid. (422.107(c)(6))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>9. Service area covered by the SNP. (422.107(c)(7))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>10. The contract period for the SNP. (422.107(c)(8))</p> <p>NOTE: Page number and section number must be completed by all D-SNPs.</p>			
<p>If you answered “Yes” to attestation 4 in section 5.4, or if your SNP is seeking HIDE or FIDE designations and meets some or all of the following provisions, please also identify the page number and section number for those provisions if the information is in the SMAC. Otherwise, if it is not applicable please indicate that in the not applicable column.</p>			
<p>11. Criteria for identification of the group of high-risk full-benefit dual eligible individuals identified by the State Medicaid Agency for which notification of hospital and skilled nursing facility admissions will apply. (422.107(d))</p>			

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>12. Language that indicates the entity (your organization or the type of entity or entities) responsible for providing the notification of hospital or skilled nursing facility admissions. (422.107(d))</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>13. Language that indicates the entity or entities (the State Medicaid Agency, or the State’s designee(s)) responsible for receiving notifications of hospital and skilled nursing facility admissions. (422.107(d))</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is 			

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column.</p>			
<p>14. If your organization designates another entity(ies) to provide the notification on your behalf, language that indicates that your organization retains responsibility for complying with the notification requirement. (422.107(d))</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>15. The timeframe that your organization or your designee has to provide notification of hospital and skilled nursing facility admissions to the State Medicaid Agency or its designee(s). (422.107(d))</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>16. The method(s) your organization or your designee uses to provide notification of hospital and skilled nursing facility admissions to the State Medicaid Agency or its designee(s). (422.107(d))</p>			

Contract Provision	Page Number(s)	Section Number	Not Applicable
<p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must be completed for organizations that answered “Yes” to attestation 4 in section 5.4. • Organizations seeking HIDE or FIDE SNP designation should complete the page number and section number if language is included in SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			

5.12 Special Needs Plan (SNP) Contract Status Review Matrix

Plans should use this document to identify where each SNP element is met within their contract(s). The matrix will be used to assist the Centers for Medicare & Medicaid Services (CMS) in conducting the HIDE and FIDE SNP determination reviews. If an element is not applicable, please indicate that in the not applicable column.

NOTE: To be designated as a HIDE SNP, a D-SNP must identify contract language for provision 3 and provisions 5 or 6. To be designated as a FIDE SNP, a D-SNP must provide contract language for provisions 3-9. Please answer all questions. If an element is not applicable please indicate that in the not applicable column.

If the applicant is seeking HIDE or FIDE designation, then the following matrix must be completed.

It is optional for organizations that answered “Yes” to attestation 4 in section 5.4, stipulating that the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid Agency and/or its designee(s) of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals identified by the State Medicaid Agency, to complete this table.

SPECIAL NEEDS PLAN (SNP) CONTRACT STATUS REVIEW MATRIX

Plan Name: _____

PBP: _____

Date: _____

State: _____

Coverage: LTC _____ BH _____ Both _____

	Page Number(s)	Section Number	Not Applicable
<p>1. If applicable based on state policy, language that indicates your organization has exclusively aligned enrollment, meaning that it only enrolls full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Social Security Act between the applicable State and your organization, parent organization or another entity that is owned and controlled by your organization’s parent organization. (422.2)</p> <p>NOTE: All D-SNPs completing this table must complete this row. The page number and section number must be completed for organizations that answered “Yes” to attestation 5 in section 5.4. Otherwise if not applicable please indicate that in the not applicable column.</p>			
<p>2. If applicable based on exclusively aligned enrollment attestation above, language that describes how your organization uses the unified appeals and grievance procedures under 422.629 through 422.634, 438.210, 438.400 and 438.402. (422.107(c)(9))</p> <p>NOTE: All D-SNPs completing this table must complete this row. The page number and section number must be completed for organizations that answered “Yes” to attestation 5 in section 5.4. Otherwise if not applicable please indicate that in the not applicable column.</p>			
<p>3. Language that identifies the entity (your MA organization, parent organization or other organization owned and controlled by your parent organization) that holds the capitated contract with the State Medicaid Agency. (422.2)</p> <p>NOTE: Page number and section number must be completed for organizations seeking HIDE or FIDE SNP designations.</p> <ul style="list-style-type: none"> • For FIDE SNP status only, the same legal entity must hold both the MA contract with CMS and the Medicaid managed care organization (as 			

<p>defined in 438.2) contract with the applicable state.</p> <ul style="list-style-type: none"> • For HIDE SNP status, the legal entity that holds the MA contract with CMS and the legal entity that holds the Medicaid managed care contract can be the MA organization, the parent organization, or other organization owned and controlled by your parent organization. 			
<p>4. Language that indicates that your organization has a capitated contract with the State Medicaid Agency that provides coverage, consistent with State policy, of primary and acute care. (422.2)</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must only be completed for organizations seeking a FIDE SNP designation. • Other organizations should complete the page number and section number if language is included in the SMAC. Otherwise if it is not applicable please indicate this in the not applicable column. 			
<p>5. Language that indicates that your organization has a capitated contract with the State Medicaid Agency that provides coverage, consistent with State policy, of behavioral health services. (422.2)</p> <p>NOTE: Page number and section number must be completed for organizations seeking HIDE or FIDE SNP designations.</p> <ul style="list-style-type: none"> • For HIDE SNPs, element 5 OR element 6 must be completed. • For FIDE SNP status, coverage of behavioral health services is not required when it is not consistent with state policy (i.e., Medicaid behavioral health is covered by the State through Medicaid Fee-for-service). 			
<p>6. Language that indicates that your organization has a capitated contract with the State Medicaid Agency that provides coverage, consistent with State policy, of long-term services and supports, including in community-based settings. (422.2)</p> <p>NOTE: Page number and section number must be completed for organizations seeking HIDE or FIDE SNP designations.</p>			

<ul style="list-style-type: none"> • For HIDE SNP status, element 5 OR element 6 must be completed. 			
<p>7. Language that indicates that your organization has a capitated contract with the State Medicaid Agency that provides coverage, consistent with State policy, of nursing facility services for a period of at least 180 days during the plan year. (422.2)</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must only be completed for FIDE SNP designation. • Other organizations should complete the page number and section number if language is included in the SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>8. Language that describes how your organization coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries. (422.2)</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must only be completed for FIDE SNP designation. • Other organizations should complete the page number and section number if language is included in the SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			
<p>9. Language that indicates that your organization employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement. (422.2)</p> <p>NOTE:</p> <ul style="list-style-type: none"> • Page number and section number must only be completed for FIDE SNP designation. • Other organizations should complete the page number and section number if language is included in the SMAC. Otherwise if it is not applicable please indicate that in the not applicable column. 			

5.13 I-SNP Upload Documents

5.13.1 I-SNP Individuals Residing Only in Institutions

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

I-SNP Individuals Residing Only in Institutions Upload Document

Applicants Contract Name (as provided in HPMS):_____

CMS Contract Number:_____

1. Provide a list of contracted long-term care facilities. (Provide the Names and addresses of the Contracted Long-term Care facilities)

2. 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 and operated 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.

Authorized Representative Name (Print): _____

Authorized Representative Signature: _____

Title: _____

Date: _____

5.13.2. I-SNP Individuals Residing Only in the Community

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

I-SNP Individuals Residing Only in the Community Upload Document

Applicants Contract Name (as provided in HPMS): _____

CMS Contract Number: _____

1. **Provide the name of the entity(ies) performing the level of care (LOC) assessment for enrolling individuals living in the community.**
2. **Provide the address of the entity(ies) performing the LOC assessment.**
3. **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.**
4. **Provide a list of assisted-living facilities (if applicant is contracting with ALFs at the time of application)**
5. **Provide attestation for I-SNP serving individuals residing ONLY in the Community. (Provide the names and addresses of the assisted living facilities)**

Attestation for Institutional Equivalent SNP's

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

I attest that if an I-SNP enrollee changes residence, the I-SNP will have appropriate documentation that it is prepared to implement the I-SNP Model of Care at the enrollee's new residence, or disenroll the individual according to CMS enrollment/disenrollment policies and procedures. Appropriate documentation includes any executed organization contract with the LTC facility to provide the I-SNP Model of Care, and written documentation of the necessary

arrangements in the community setting to ensure enrollees will be assessed and receive services as required under the I-SNP Model of Care."

Authorized Representative Name (Print): _____

Authorized Representative Signature: _____

Title: _____

Date: _____

5.13.3. I-SNP Individuals Residing in Both Institutions and the Community

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

I-SNP Individuals Residing in Both Institutions and the Community Upload Document

Applicants Contract Name (as provided in HPMS): _____

CMS Contract Number: _____

- 1. For institutionalized individuals, provide a list of contracted long-term care facilities. (Provide the names and addresses of the long-term care facilities)**
- 2. For institutionalized individuals, provide the following attestation by the authorized signatory.**

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.

Authorized Representative Name (Print): _____

Authorized Representative Signature: _____

Title: _____
Date: _____

3. For institutional equivalent individuals residing in the community, provide the name, address, and relevant professional credential (e.g., RN for registered nurse, LSW for licensed social worker, etc.) of the entity(ies) performing the mandatory level of care (LOC) assessment for enrolling eligible individuals.

Name: _____

Address: _____

Professional Credential: _____

4. For institutional equivalent individuals residing in the community, provide a list of applicable assisted living facilities or other residential facilities, e.g., continuing care communities. (Note: The use of Assisted Living Facilities or other residential facilities is optional for I-SNPs that serve institutional equivalent individuals in the community.)

a. Applicant is contracting with assisted-living facilities or other residential facilities at the time of application. Yes No

b. If applicant is contracting with assisted-living facilities or other residential facilities, enter the requested information below. (Provide the names and addresses of the assisted living or other residential facilities)

5.14. ESRD Waiver Request Upload Document

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

Applicants Contract Name (as provided in HPMS): _____

Applicants CMS Contract Number: _____

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 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.

2. Provide a description 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)**

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).

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)**

5. Provide a list of the contracted nephrologist(s). Beneficiary access to CONTRACTED (DO NOT LIST NON-CONTRACTED PROVIDERS) nephrologists must meet the current HSD criteria. (Provide the names, medicare provider numbers and addresses of the contracted Nephrologist(s))

6. Provide a list of the contracted dialysis facility(ies). Beneficiary access to CONTRACTED (DO NOT LIST NON-CONTRACTED FACILITIES)dialysis facilities must meet the current HSD criteria. (Provide the names, medicare provider numbers and addresses of the contracted Dialysis Facility(ies))

7. List and describe (include relevant characteristics, details and/or qualities) the dialysis options available to beneficiaries (e.g., home dialysis; nocturnal dialysis).

8. Provide a list of the CONTRACTED kidney transplant facility(ies). (Provide the names, medicare provider numbers and addresses of the contracted kidney transplant facility(ies))

9. Describe beneficiary access to contracted kidney transplant facility(ies), including the average distance beneficiaries in each county served by the applicants 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.

5.15. MOC Matrix Upload Document for Initial Application and Renewal

Please complete and upload this document into HPMS.

SNP Contract Name (as provided in HPMS)_____

SNP CMS Contract Number_____

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.

All SNPs are required to develop and implement a Model of Care per regulations at: 42 CFR §422.101(f) and 42 CFR§422.152(g).

2. Description of the SNP Population:-

Element A: Description of the Overall SNP Population: The identification and comprehensive description of the SNP-specific population is an integral component of the MODEL OF CARE because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. It must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations, if relevant to the target population served by the SNP. The description of the SNP population must include, but not be limited to, the following:

- Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.
- A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.
- Identification and description of the health conditions impacting SNP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).
- Define unique characteristics for the SNP population served:
C-SNP: What are the unique chronic care needs for beneficiaries enrolled in a C-SNP? Include limitations and barriers that pose potential challenges for these C-SNP beneficiaries.

D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.

I-SNP: What are the unique health needs for beneficiaries enrolled in an I-SNP? Include limitations and barriers that pose potential challenges for these I-SNP beneficiaries as well as information about the facilities and/or home and community-based services in which your beneficiaries reside.

Element B: Sub-Population: Most Vulnerable Beneficiaries

As a SNP, you must include a complete description of the specially-tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, “medication spending above \$4,000”). The description must differentiate between the general SNP population and that of the most vulnerable members, as well as detail additional benefits above and beyond those available to general SNP members. Other information specific to the description of the most vulnerable beneficiaries must include, but not be limited to, the following:

- A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.
- A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.
- The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).

2. Care Coordination:

Regulations at **42 CFR §422.101(f)(ii)-(v)** and **42 CFR §422.152(g)(2)(vii)-(x)** require all SNPs to coordinate the delivery of care, and measure the effectiveness of the MODEL OF CARE delivery of care coordination. Care coordination helps ensure that SNP beneficiaries’ healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP’s provider network as well as the care coordination roles and responsibilities overseen by the beneficiaries’ caregiver(s). The following MODEL OF CARE sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNPs’ care coordination activities.

F. SNP Staff Structure

- Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:
 - Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.

- Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.
- Employed and/or contracted staff that performs administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use appropriate clinical practice guidelines and integrate care transitions protocols.
- Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MODEL OF CARE are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP.
- Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions.
- Describe how the SNP conducts initial and annual MODEL OF CARE training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing.
- Describe how the SNP documents and maintains training records as evidence to ensure MODEL OF CARE training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, and electronic training records.
- Explain any challenges associated with the completion of MODEL OF CARE training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MODEL OF CARE training has not been completed or has been found to be deficient in some way.

G. Health Risk Assessment Tool (HRAT)

Regulations at **42 CFR §422.101(f)(i)**; **42 CFR §422.152(g)(2)(iv)** require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP. The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan and ongoing coordination of Interdisciplinary Care Team activities; therefore, it is imperative that the MODEL OF CARE include the following:

- A clear and detailed description of the policies and procedures for completing the HRAT including:
 - Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MODEL OF CARE Element 2C) for each beneficiary and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MODEL OF CARE Element 2D).
 - Detailed explanation for how the initial HRAT and annual reassessment are conducted for each beneficiary.
 - Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, beneficiaries and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary's plan of care. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.

H. Individualized Care Plan (ICP)

Regulations at **42 CFR §422.101(f)(ii)**; **42 CFR §422.152(g)(2)(iv)** require that all SNPs must develop and implement an ICP for each individual enrolled in the SNP.

- The ICP components must include, but are not limited to: beneficiary self-management goals and objectives; the beneficiary’s personal healthcare preferences; description of services specifically tailored to the beneficiary’s needs; roles of the beneficiaries’ caregiver(s); and identification of goals met or not met.
 - When the beneficiary’s goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.
- Explain the process and which SNP personnel are responsible for the development of the ICP, how the beneficiary and/or his/her caregiver(s) or representative(s) is involved in its development and how often the ICP is reviewed and modified as the beneficiary’s healthcare needs change. If a stratification model is used for determining SNP beneficiaries’ health care needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each beneficiary’s ICP.
- Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).
- Explain how updates and/or modifications to the ICP are communicated to the beneficiary and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel and other stakeholders as necessary.

I. Interdisciplinary Care Team (ICT)

Regulations at **42 CFR §422.101(f)(iii)**; **42 CFR §422.152(g)(2)(iv)** require all SNPs to use an ICT in the management of care for each individual enrolled in the SNP.

- Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise and capabilities of the ICT members align with the identified clinical and social needs of the SNP beneficiaries, and how the ICT members contribute to improving the health status of SNP beneficiaries. If a stratification model is used for determining SNP beneficiaries’ health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT.
 - Explain how the SNP facilitates the participation of beneficiaries and their caregivers as members of the ICT.
 - Describe how the beneficiary’s HRAT (MODEL OF CARE Element 2B) and ICP (MODEL OF CARE Element 2C) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual beneficiary.
 - Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the beneficiary’s health care needs on a continuous basis.
- Identify and explain the use of clinical managers, case managers or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted.
- Provide a clear and comprehensive description of the SNP’s communication plan that ensures exchanges of beneficiary information is occurring regularly within the ICT, including not be limited to, the following:
 - Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MODEL OF CARE. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.

- The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.
- How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.

J. Care Transitions Protocols

Regulations at **42 CFR §422.101(f)(2)(iii-v)**; **42 CFR §422.152(g)(2)(vii-x)** require all SNPs to coordinate the delivery of care.

- Explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).
- Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MODEL OF CARE Element 2A.
- Explain how the SNP ensures elements of the beneficiary’s ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.
- Describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries’ personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.
- Describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.
- Describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.

3. SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP beneficiaries. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population as identified in MODEL OF CARE 1, and provide oversight information for all of its network types. Each SNP is responsible for ensuring their MODEL OF CARE identifies, fully describes, and implements the following for its SNP Provider Network:

D. Specialized Expertise

Regulations at **42 CFR§422.152(g)(2)(vi)** require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries.

- Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MODEL OF CARE Element 1.
- Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.
- Describe how providers collaborate with the ICT (MODEL OF CARE Element 2D) and the beneficiary, contribute to the ICP (MODEL OF CARE Element 2C) and ensure the

delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

E. Use of Clinical Practice Guidelines & Care Transitions Protocols

Regulations at **42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix)**require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols.

- Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation.
- Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MODEL OF CARE Element 2C), communicated with the ICT (MODEL OF CARE Element 2D) and acted upon.
- Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MODEL OF CARE Element 2E.

F. MODEL OF CARE Training for the Provider Network

Regulations at **42 CFR§422.101(f)(2)(ii)** require that SNPs conduct MODEL OF CARE training for their network of providers.

- Explain, in detail, how the SNP conducts initial and annual MODEL OF CARE training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.
- Describe how the SNP documents and maintains training records as evidence of MODEL OF CARE training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MODEL OF CARE training.
- Explain any challenges associated with the completion of MODEL OF CARE training for network providers and describe what specific actions the SNP Plan will take when the required MODEL OF CARE training has not been completed or is found to be deficient in some way.

4. MODEL OF CARE Quality Measurement & Performance Improvement:

Regulations at **42 CFR §422.152(g)** require that all SNPs conduct a quality improvement program that measures the effectiveness of its MODEL OF CARE. The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

C. MODEL OF CARE Quality Performance Improvement Plan

- Explain, in detail, the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MODEL OF CARE structure effectively accommodates beneficiaries' unique healthcare needs. The description must include, but is not limited to, the following:
 - The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MODEL OF CARE by using specified data sources, performance and outcome measures. The MODEL OF CARE must also describe the frequency of these activities.
 - Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process.
 - Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MODEL OF CARE Element 4B).
 - Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the re-measurement plan for goals not achieved.

D. Measureable Goals & Health Outcomes for the MODEL OF CARE

- Identify and clearly define the SNP's measureable goals and health outcomes and describe how identified measureable goals and health outcomes are communicated throughout the SNP organization. Responses must include but not be limited to, the following:
 - Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MODEL OF CARE Element 1.
 - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.
 - Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.
 - Ensuring appropriate utilization of services for preventive health and chronic conditions.
- Identify the specific beneficiary health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used.
- Describe, in detail, how the SNP establishes methods to assess and track the MODEL OF CARE's impact on the SNP beneficiaries' health outcomes.
- Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.
- Explain the specific steps the SNP will take if goals are not met in the expected time frame.

C. Measuring Patient Experience of Care (SNP Member Satisfaction)

- Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP beneficiary satisfaction.
- Explain how the results of SNP member satisfaction surveys are integrated into the overall MODEL OF CARE performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.

D. Ongoing Performance Improvement Evaluation of the MODEL OF CARE

- Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MODEL OF CARE, including how quality will be continuously assessed and evaluated.

- Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MODEL OF CARE performance evaluation process.
- Describe how the performance improvement evaluation of the MODEL OF CARE will be documented and shared with key stakeholders.

E. Dissemination of SNP Quality Performance related to the MODEL OF CARE

- Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP beneficiaries and caregivers, the general public, and regulatory agencies on a routine basis.
- This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad hoc communication with the various stakeholders, such as: a webpage for announcements; printed newsletters; bulletins; and other announcement mechanisms.
- Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MODEL OF CARE Element 2A.

6. **APPENDIX II: Employer/Union-Only Group Waiver Plans (EGWPs) MAO “800 Series”**

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 and MAOs 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.

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 *2021 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors*. The *2021 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 2021. Together these documents will comprise a completed application for new MAOs. Failure to complete, if applicable, the 2021 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.

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.

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 2021 MA Applications and the 2021 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 2021 MA Application and the 2021 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 2021 Part D bid (i.e., bid pricing tool) in order to offer its EGWPs. (Section 2.7 of the 2021 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 applicants' 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 applicants network is sufficient to meet the needs of its employer group population. (See the 2021 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 2021 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"). Applicants EGWPs. (Sections 3.6.A10 and 3.24.A2-A4 of the 2021 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 2021 Solicitation for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors)
 - 10) Applicant understands that its EGWPs are 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 2021 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 2021 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 2021 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 2021 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

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.

Instructions

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

- (1) The 2021 MA Application. This portion of the appendix is submitted electronically through the HPMS.
- (2) The 2021 Part C Financial Solvency & Capital Adequacy Documentation Direct Contract MA Application. This portion of the appendix is submitted electronically through HPMS.
- (3) The 2021 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 2021 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).

Note: 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 2021 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors and the 2021 Solicitation for Applications for New Employer/Union Direct Contract Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors.

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.

Attestations

Direct Contract MA Attestations

1.SERVICE AREA REQUIREMENTS

In general, MAOs can cover beneficiaries only in the service areas in which they are state 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 2021 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 2021 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 2021 MA Application in addition to this *2021 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 2021 Solicitation for Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors and the 2021 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 2021 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 2021 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 2021 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 2021 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 2021 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 2021 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 2021 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 2021 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.}

Part C Financial Solvency & Capital Adequacy Documentation For Direct Contract MAO applicants

1. 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.

IDENTIFY YOUR ORGANIZATION BY PROVIDING THE FOLLOWING INFORMATION:	
Type of DIRECT CONTRACT MEDICARE ADVANTAGE PLAN requested (Check all that apply): Coordinated Care Plan : <input type="checkbox"/> HMO/POS <input type="checkbox"/> LPPO Open Access (Non-Network) PFFS Plan <input type="checkbox"/> Contracted Network PFFS Plan <input type="checkbox"/>	
Organization’s Full Legal Name:	
Full Address Of Your Organization’s Headquarters (<i>Street, City, State, Zip</i>):	
Tax Status: For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/>	Is Applicant Subject To ERISA? Yes <input type="checkbox"/> No <input type="checkbox"/>
Type Of Entity (Check All That Apply) : Employer <input type="checkbox"/> Labor Union <input type="checkbox"/> Fund Established by One or More Employers or Labor Organizations <input type="checkbox"/> Government <input type="checkbox"/> Church Group <input type="checkbox"/> Publicly-Traded Corporation <input type="checkbox"/> Privately-Held Corporation <input type="checkbox"/> 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 applicants 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 applicants 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 applicants 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 applicants 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 applicants 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 applicants 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 MAOs.

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.