CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 83 **Date: APRIL 25, 2007**

SUBJECT: Chapter 11, Medicare Advantage Application Procedures and Contract Requirements

I. SUMMARY OF CHANGES: Includes primarily technical and clarifying changes to the application/contract procedures for MAO plans to Chapter 11 of the Managed Care Manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 25, 2007
IMPLEMENTATION DATE: April 25, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	11/,20/20.1/Application Procedures and Conditions for Entering an MA Contract
N	11/60/ 60.1/MA Contracts are Automatically Renewed
R	11/70/70.1/Nonrenewal of MA Organization Initiated
R	11/100/MA Contract Provisions

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual
Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements

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This Chapter Last Updated - *(Rev. 83, 04-25-07)*

NOTE: This chapter addresses Medicare Advantage contract requirements only, and does not address Medicare cost-based managed care contract requirements. Information on Medicare cost-based contract requirements can be found in Chapter 17.

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20.1 - Application Procedures and Conditions for Entering an MA Contract

(Rev. 83; Issued: 04-25-07; Effective/Implementation Dates: 04-25-07)

Organizations that seek to offer an MA or MA-PD plan must enter into a contract with CMS. A single MA contract may cover more than one MA plan offered by the contracting MA organization. An applicant entity, however, must meet certain requirements before CMS can consider entering into a contract with the organization. In addition, an applicant entity must have an acceptable bid before it may enter into a contract to offer an MA or MA-PD plan (see Subpart F at 42 CFR Part 422 for information on the bidding process). *Information on the applications process and the MA program in general can be found at http://www.cms.hhs.gov/HealthPlansGenInfo.*

- The applicant must document that it is authorized under State law in the requested service area (SA) to operate as a risk bearing entity that may offer health benefits. If the applicant offers a continuation area in another State, then the applicant must show that it is authorized by the State to offer health benefits. As such, before an applicant entity may apply to become a Medicare Advantage organization, it must first submit a completed MA State Certification Form to CMS. This form, which is available on our Web site, must be provided by the MA organization to the State. The State, in turn, will certify that the organization is authorized to bear risk associated with the plan(s) it is offering in the State. Existing §1876 cost contractors do not have to complete this form. Please note that the revised coordinated care plan (CCP), regional preferred provider organization (PPO),

private fee-for-service (PFFS), medical savings account (MSA), and service area expansion (SAE) applications include this form.

- Except in the case of a provider sponsored organization granted a waiver under 422.370 of Part 422 of the CFR the applicant entity must be licensed (or if the State does not license such entities, hold a certificate of authority/operation) as a risk-bearing entity in the State in which it wishes to operate as an MA organization.
- The applicant must meet certain minimum enrollment requirements. The applicant entity must have at least 5,000 (or 1,500 if it is a PSO) individuals receiving health benefits from the organization or at least 1,500 (or 500 if it is a PSO) individuals receiving benefits in a rural area. CMS has the authority to waive the minimum enrollment requirements for the first 3 contract years;
- An MA organization must demonstrate certain administrative and managerial capabilities. They include:
    - A policy making body that exercises oversight and control over the MA organizations policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees;
    - Personnel and systems sufficient for the MA organization to organize, plan, control, and evaluate financial and marketing activities, the furnishing of services, the quality improvement program, and the administrative and management aspects of the organization (to include systems/capabilities to provide data and/or reports to CMS, in the manner and formats requested);
    - At a minimum, an executive manager whose appointment and removal are under the control of the policy making body;
    - A fidelity bond or bonds procured and maintained by the MA organization, in an amount fixed by its policy making body, but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds. (The bond may have reasonable deductibles, based upon the financial strength of the MA organization.);
    - Insurance policies or other arrangements, secured and maintained by the MA organization and approved by CMS to insure the MA organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks; and
    - A commitment to compliance, integrity, and ethical values as demonstrated by the following:
        - Written policies, procedures, and standards of conduct that articulate the organizations commitment to comply with all applicable Federal and State standards;

- The designation of a compliance officer and compliance committee that are accountable to senior management;
- Effective training and education between the compliance officer and organization employees;
- Effective lines of communication between the compliance officer, the organization's employees, and MA-related contractors that at a minimum, includes a mechanism for employees or contractors to ask questions, seek clarification, and report potential or actual noncompliance without fear of retaliation;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Provision for internal monitoring and auditing that includes a risk assessment process to identify and analyze risks associated with failure to comply with all applicable Medicare Advantage compliance standards; and
- Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's MA contract.

***NOTE*:** --MA organizations offering a prescription drug benefit under Part D must also follow the fraud, waste and abuse requirements at 42 CFR Part 423. Please see 42 CFR 423.504(b)(4)(vi)(H) for a description of these requirements.

Also please note that MA plans offered to employer/union members may not be subject to some of the rules discussed above. Employers/unions may directly contract with CMS to become an MA-only or MA-PD plan, or may contract with an existing MA plan for customized coverage for its members. These plans are referred to as employer/union-only group waiver plans (EGWPs). Information on the application process for EGWPs can be found at http://www.cms.hhs.gov/EmpGrpWaivers/.

60.1 - MA Contracts are Automatically Renewed

(Rev. 83; Issued: 04-25-07; Effective/Implementation Dates: 04-25-07)

The MA contracts are automatically renewed from term-to-term unless either CMS or the MAO provides notice of the intent to non-renew or terminate the contract at the end of the current term. Renewal of a contract is dependent on CMS and the MAO reaching agreement on the bid submitted by the MAO. Additional contract provisions or changes for subsequent years will be incorporated via an addendum to the original contract, as necessary.

CMS will notify each MA organization of its decision whether to authorize the renewal of its MA contract, along with applicable appeal rights, by May 1 of the current contract year.

NOTE: CMS annually issues a call letter specifying information concerning the contract renewal process. For information for *2007* contracts, view our call letter at http://www.cms.hhs.gov/HealthPlansGenInfo. The call letter includes the HPMS plan crosswalk which specifies MA plan renewal guidelines and operational instructions by designating the relationships between plans offered in *2006* to those being offered in *2007*.

70.1 - Nonrenewal of MA Contract: MA Organization-Initiated

(Rev. 83; Issued: 04-25-07; Effective/Implementation Dates: 04-25-07)

An MA organization may elect not to renew its contract with CMS at the end the contract for any reason provided it meets specified time frames for doing so. If an MA organization does not intend to renew its contract, it must notify:

- CMS in writing by the first Monday of June of the year in which the contract would end, or a later date specified by CMS as described below;
- Each Medicare enrollee at least 90 days before the date on which the nonrenewal is effective. The CMS approved-notice to the enrollee must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA plans, Medigap options, and Original Medicare; and
- The general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community located in the MA organization's service area. This notice must be pre-approved by CMS;

CMS may accept a nonrenewal notice submitted after the first Monday in June if:

- The MA organization notifies its Medicare enrollees and the public as specified above; and

- Acceptance of the delayed non-renewal notice would not be inconsistent with the effective and efficient administration of the Medicare program.

NOTE: For more information concerning non-renewals view *the non-renewal section* at http://www.cms.hhs.gov/HealthPlansGenInfo.

100 - MA Contract Provisions

(Rev. 83; Issued: 04-25-07; Effective/Implementation Dates: 04-25-07)

NOTE: *The MA organizations offering a Part D benefit to enrollees should review the Part D Application Procedures and Contract Requirements guidance on the CMS Web site for information on the Part D Addendum to their MA plan contracts.*