2019 SERVICE AREA EXPANSION CAPITATED FINANCIAL ALIGNMENT APPLICATION

Department of Health and Human Services

Centers for Medicare & Medicaid Services (CMS)

Medicare-Medicaid Coordination Office (MMCO)

1. GENERAL INFORMATION

1.1. Purpose of Application

The Centers for Medicare & Medicaid Services (CMS) is seeking applications from existing Medicare-Medicaid Plans (MMPs) seeking to enter into additional counties in the current capitated financial alignment model demonstrations. Please submit your application according to the process described in Section 2.0.

This solicitation represents an abbreviated version of the Initial Capitated Financial Alignment Application that is used for organizations seeking to participate in the demonstrations for the first time. The sections below must be completed for the new service area for which your organization is seeking to offer its MMP product under its existing three-way contract. In addition, your organization may need to complete an application or plan selection process with the participating Demonstration State.

In addition to the sections below, MMPs must continue to follow the three-way contract in the new service area. Further, final approval of a service area expansion also requires plan selection by the respective State. In addition, MMPs are still required to provide to CMS formulary and plan benefit package submissions on the appropriate dates.

1.2. Schedule

APPLICATION REVIEW PROCESS	
Date	**Milestone**
November 14, 2017	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, 2017	CMS User ID form due to CMS, if needed by additional staff
January 10, 2018	Final Application posted by CMS and available in HPMS
January 27, 2018	Deadline for NOIA form submission to CMS
February 14, 2018	Applications due
February 2018	CMS releases guidance concerning updates to Parent Organization designations in HPMS

March 2018	Parent Organization Update requests from sponsors due to CMS (instructional memo to be released in February 2018)
April 2018	Release of the 2019 Plan Benefit Package (PBP) online training module
April 2018	Release of the 2019 Plan Creation Module, PBP software in HPMS
April 2018	Release of the CY 2019 Medication Therapy Management Program (MTMP) submission module in HPMS
May 2018	MTMP submissions due
May 2018	Release of HPMS Part D formulary submission module for CY 2019
Late May 2018	CMS sends contract eligibility determinations to Applicants, based on review of application.
May 2018	Formulary submission due to CMS Transition Policy Attestations and Policy due to CMS PA/ST Attestations due to CMS P&T Attestations due to CMS
June 4, 2018	Submission of proposed PBPs due to CMS
June 4, 2018	Deadline for submitting Additional Demonstration Drug file and Part D supplemental formulary files (Free First Fill file, Over-the-Counter Drug file, and Home Infusion file) through HPMS.
Early August 2018	CMS releases the 2019 Part D national average bid amount.
August 2018	MTMP reviews completed.
September 2018	CMS mails the CY 2019 *Medicare & You* handbook to Medicare beneficiaries.
September 2018	Roll-out of MA and Part D plan landscape documents, which includes details (including high-level information about benefits and cost-sharing)

	about all available Medicare health and prescription drug plans for CY 2019.
October 1, 2018	CY 2019 marketing activity begins for Medicare Advantage and Part D.
October 1, 2018	Medicare Plan Finder on www.medicare.gov goes live for CY 2019
October 15, 2018	2019 Annual Coordinated Election Period begins.
December 7, 2018	2019 Annual Coordinated Election Period ends.
January 1, 2019	Enrollment effective date.

NOTE: This timeline does not represent an all-inclusive list of key dates. CMS reserves the right to amend or cancel this application at any time.

2. INSTRUCTIONS

2.1. Overview

This application is to be completed by those organizations that intend to add coverage to an existing MMP during 2019. This additional coverage is limited to existing counties within a demonstration.

2.2. Technical Assistance

For technical assistance in the completion of this Application, contact:

Marla Rothouse by email at Marla.Rothouse@cms.hhs.gov, or by phone at 410-786-8063.

As stated in section 2.4.1, Applicants must contact the HPMS Help Desk if they are experiencing technical difficulties uploading or completing any part of this solicitation within HPMS prior to the submission deadline. Applicants requesting technical assistance with uploading or completing any part of the online HPMS application after the published CMS application deadline will not be granted technical assistance, nor the opportunity to complete their application submission.

2.3. Health Plan Management System (HPMS) Data Entry

Applicants seeking to expand coverage under an existing contract must use the associated contract ID.

Applicants will use HPMS to communicate with CMS in support of the application process, formulary submission process, plan benefit package submission process, ongoing operations of the financial alignment demonstration, and reporting and oversight activities. Applicants are required to secure access to HPMS in order to carry out these functions.

Applicants and other interested parties, whom do not have access to HPMS, can stay abreast of current HPMS memos and guidance by subscribing to available listservs. Subscribers to the CMS Plan or Industry listservs receive memos and guidance regarding Medicare Advantage, Part D prescription drug, and Medicare-Medicaid Plan programs.

If you do not have access to HPMS but would like to receive CMS guidance and memos, simply request to be added to one of the following listservs:

- PLAN listserv: Choose this listserv to get HPMS guidance and memos if you are a user that works for an MA or Part D organization but your role in the company does not require HPMS access.
- INDUSTRY listserv: Choose this listserv if you are an industry user that is not associated with any existing MA or Part D organization, but work with MA and Part D in some capacity (e.g., consultants, PBMs, doctors, pharmacists, etc).

Please email your request directly to Sara Walters at Sara.Walters@cms.hhs.gov. Please indicate in the email which listserv you wish you join. If you wish to join the PLAN listserv please provide the contract number(s) you are associated with.

2.4. Instructions and Format of Application

Applications may be submitted until February 14, 2018. Applicants must use the 2019 service area expansion Capitated Financial Alignment Application. CMS will not accept or review any submissions using other Medicare applications (e.g., MA and Part D applications for 2018 and earlier).

2.4.1. Instructions

Applicants will complete the entire application via HPMS. CMS will not accept any information in hard copy. If an Applicant submits the information via hard copy, the application will not be considered received.

CMS will communicate with all Applicants via email. The email notifications will be generated through HPMS, so organization must ensure that the Application Contact information provided through the "Notice of Intent to Apply" process is current and correct, and that there are no firewalls in place that would prevent an email from the hpms@cms.hhs.gov web address from being delivered.

Upon completion of the HPMS online application, organizations are required to click 'Final Submit,' which time and date stamps the completion of the application. No additional work on the application may be done after the Applicant clicks 'Final Submit.' Organizations will receive a confirmation number from HPMS upon clicking 'Final Submit.' Failure to obtain a confirmation number indicates that the Applicant failed to properly submit its application by the CMS-established deadline. Any entity that experiences technical difficulties during the submission process must contact the HPMS Help Desk **prior to the submission deadline**, and CMS will make case by case determinations where appropriate regarding the timeliness of the application submission.

2.4.2. Completion of Attestations

In preparing your responses to the attestations in Section 3 of this application, please mark "Yes" or "No" or "Not Applicable" in HPMS.

In many instances, Applicants are directed to affirm within HPMS that they meet particular requirements by indicating "Yes," next to a statement of a particular program requirement. By providing such attestation, an Applicant confirms that its organization complies with the relevant requirements as of the date its application is submitted to CMS, unless a different date is stated by CMS.

2.4.3. Application Review Standard

CMS will check the application for completeness shortly after its receipt. Consistent with the Medicare 2010 Call Letter (http://www.cms.gov/Medicare/Prescription-Drug-

Coverage/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf), CMS will make determinations concerning the validity of each organization's submission. Some examples of invalid submissions include but are not limited to the following:

- Applicants that fail to upload pharmacy access reports
- Applicants that fail to upload health service delivery tables
- Applicants that fail to upload completed staffing tables

CMS will notify any Applicants that are determined to have provided invalid submissions. In accordance with 42 CFR §§ 422.502, 423.502, and 423.503, Applicants must demonstrate that they meet all (not "substantially all") program requirements to qualify as a MMP sponsor in the proposed service area.

2.4.4. Application Review Process and Cure Periods

For those Applicants with valid submissions, CMS will notify your organization of any deficiencies and afford a courtesy opportunity to amend the application. The application status emails are accessible in HPMS at the "Communications History" link in Contract Management>Basic Contract Management>Submit Application Data. CMS will only review the last submission provided during the courtesy cure period.

As with all aspects of an Applicant's operations under its contract with CMS and the respective State, we may verify a MMP sponsor's compliance with qualifications it attests it meets through on-site visits at the MMP sponsor's facilities and through other program monitoring techniques, including readiness reviews. Failure to meet the requirements attested to in this solicitation and failure to operate its plans consistent with the requirements of the applicable statutes, regulations, call letter, guidance and the three-way contract may delay an Applicant's marketing and enrollment activities or, if corrections cannot be made in a timely manner, the Applicant will be disqualified from participation.

An individual with legal authority to bind the Applicant must execute the certification found in Section 4 and the template provided in HPMS entitled "Medicare-Medicaid Plan Certification." CMS reserves the right to request clarifications or corrections to a submitted application. Failure to provide requested clarifications within the time period specified by CMS for responding could result in the Applicant not receiving a three-way contract.

This solicitation does not commit CMS to pay any cost for the preparation and submission of an application.

For purposes of the capitated financial alignment applications, CMS has waived the notice of intent to deny and application appeal provisions in 42 CFR §422.502(c)(2), §422.502(c)(3)(iii), §423.503(c)(2), and §423.503(c)(3)(iii). CMS waived these provisions to provide flexibility for interested organizations to demonstrate Medicare qualifications through the application process and allow for validation of such qualifications by CMS and the States prior to the start of marketing or enrollment by the selected plan for the demonstration in the new service area.

CMS will not review applications received after 8:00 P.M. Eastern Daylight Time on February 14, 2018. CMS will lock access to application fields within HPMS as of that time. Applicants must complete the 2019 application in order to be considered to offer a plan under the capitated financial alignment in 2019.

2.4.5. Applicant Entity Same as Contracting Entity

The legal entity that submits this application must be the same entity with which CMS and the State enter into a capitated financial alignment model demonstration contract.

2.4.6. Withdrawal of an Application

In those instances where an organization seeks to withdraw its submission of a pending application or reduce the service area of a pending application prior to the execution of the three-way contract, the organization must send an official notice to CMS. The notice should be on organization letterhead and clearly identify the pending application number. The notice should be delivered via email to MMCOcapsmodel@cms.hhs.gov, https://dmao.lmi.org (click on the MA Applications tab) and PartD_Applications@cms.hhs.gov and the subject line of the email should read "Pending application withdrawal or reduction to pending service area." The withdrawal will be considered effective as of the date of the email.

2.4.7. Technical Support

CMS conducts technical support calls, also known as User Group calls, for Applicants and existing Medicare Advantage and Prescription Drug Plan sponsors. CMS operational experts (e.g., from areas such as enrollment, information systems, marketing, bidding, formulary design, and coordination of benefits) are available to discuss and answer questions regarding the agenda items for each meeting. Organizations can register for the technical support calls and join the list serve to get updates on CMS guidance at www.mscginc.com/Registration/.

CMS provides two user manuals to assist applicants with the technical requirements of submitting the application through the Health Plan Management System[1] (HPMS). The *Basic Contract Management User's Manual* provides information on completing and maintaining basic information required in Contract Management. The *Online Application User's Manual* provides detailed instructions on completing the various online applications. Both manuals can be found in HPMS by clicking on Contract Management>Basic Contract Management>Documentation.

[1] HPMS is a system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about provider networks, plan benefit packages, formularies, and other information via HPMS.

2.4.8. References

References to CMS guidance is provided throughout the application. Links to specific manual chapters are included in the application to further assist Applicants.

Applicants can also link to the Medicare Managed Care Manual table of contents at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html and the Prescription Drug Benefit Manual table of contents at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html. In many instances, existing manual chapters may be updated to address criteria specific to the capitated financial alignment model demonstrations and MMPs.

Guidance is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Applicants should also familiarize themselves with the CMS Advance Notice and Call Letters that can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

Applicants can access CMS issued guidance documents by following the path in HPMS: HPMS>In the News>Archived In the News.

Applicants should further familiarize themselves with the applicable three-way contracts that are currently in effect for the respective demonstration. The current three-way contracts can be found within each State link at the following website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html.

Note, that absence of any CMS issued guidance in this application does not preclude the applicability of such requirements.

2.5. Submission Software Training

Applicants use HPMS during the application, formulary, and plan benefit package processes.

Applicants are required to upload their plan formularies to HPMS using a pre-defined file format and record layout. The formulary upload functionality will be available in May 2018. Guidance will be issued with the deadline for new formulary submissions to CMS. CMS will use the last successful upload received for an Applicant as the official formulary submission.

Interested organizations will also submit a plan benefit package that details the Medicare, Medicaid and supplemental benefits they will offer for CY 2019. In order to prepare plan benefit packages, Applicants will use HPMS to define their plan structures and associated plan service areas and then download the Plan Benefit Package (PBP) software. For each plan being offered, Applicants will use the PBP software to describe the detailed structure of their Medicare, Medicaid and supplemental benefits. Each PBP

must be consistent with minimum requirements for coverage for Medicare Parts A and B benefits, as well as Part D prescription drug benefits and MMP-specific Medicaid and demonstration benefits. Therefore, the formulary must accurately crosswalk to the PBP for review purposes. In addition, States will review the PBP to ensure it is consistent with their Medicaid coverage requirements, as well as capitated financial alignment plan-specific requirements (for example, inclusion of specific supplemental benefits not currently covered under Medicare Parts A and B, or under Medicaid).

CMS will provide technical instructions and guidance upon release of the HPMS formulary functionality as well as the PBP software.

2.6. Health Service Delivery (HSD) Tables Instructions

Applicants are required to demonstrate Medicare network adequacy of the **pending** counties through the submission of HSD Tables for the Medicare medical services at the time of the application submission.

As part of the application module in HPMS, CMS will be providing Applicants with an automated tool for submitting network information via HSD tables. The tables will then be reviewed automatically against network adequacy criteria for each required provider type in each county. Further, CMS has made these network adequacy criteria available on https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html webpage. As such, Applicants will see the network adequacy criteria (providers and facilities of each required type in each county) that CMS requires before the module opens.

Applicants who do not believe that CMS default values for a given provider type in a given county are not in line with local patterns of care may seek an exception, in which case the Applicant will submit required information to support the exception(s) request.

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

2.7. Pharmacy Access

An integral component of this Application concerns the pharmacy access standards established under section 1860D-4(b)(1)(C) of the Social Security Act. The standards require in part that each Applicant must secure the participation in their pharmacy networks of a sufficient number of pharmacies to dispense drugs directly to patients (other than by mail order) to ensure convenient access to covered Part D drugs by plan enrollees. Furthermore, Applicants must provide adequate access to home infusion and convenient access to long-term care, and Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U) pharmacies in accordance with 42 CFR § 423.120 and related CMS instructions and guidance.

2.7.1. Retail Pharmacy Access

Applicants must ensure that their retail pharmacy network meets the criteria established under 42 CFR § 423.120. CMS rules require that Applicants establish retail pharmacy networks in which:

- In urban areas, at least 90 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 2 miles of a retail pharmacy participating in the Applicant's network;
- In suburban areas, at least 90 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 5 miles of a retail pharmacy participating in the Applicant's network; and
- In rural areas, at least 70 percent of Medicare beneficiaries in the Applicant's service area, on average, live within 15 miles of a retail pharmacy participating in the Applicant's network.

Applicants may count I/T/U pharmacies and pharmacies operated by Federally Qualified Health Centers and Rural Health Centers towards the standards of convenient access to retail pharmacy networks.

Applicants may use their contracted pharmacy benefit manager's (PBM) existing 2018 Part D network to demonstrate compliance with pharmacy access standards. If an Applicant is creating a new Part D network, the submission must be based on executed contracts for Year 2019. If the Applicant's retail pharmacy network is segmented (i.e., the Applicant has developed multiple networks for use in the same service area), the Applicant must submit the most restrictive (or, least accessible) network based on its executed contracts for 2019.

CMS conducts the review of retail pharmacy access based on the service area that the Applicant has provided in HPMS by February 14, 2018. The access review is automated. Applicants are required to input their pending service area into HPMS per the instructions at section 3.1 and as explained in section 3.4.1B, Applicants must upload the retail pharmacy list in HPMS. Based on the information provided by the Applicant and the Medicare Beneficiary Count file available on the CMS application guidance website, CMS will generate access percentages for all applicants.

With limited exceptions, this information gathered from the pharmacy lists will be used by CMS to geo-code the specific street-level locations of the pharmacies to precisely determine retail pharmacy access. Exceptions to this process may include, but not be limited to, those instances where a street-level address cannot be precisely geo-coded. In those situations, CMS will utilize the ZIP code-level address information to geo-code the approximate pharmacy location.

The retail pharmacy lists may contain contracted pharmacies that are outside of the Applicant's pending service area (to account for applicants who contract for a national pharmacy network); however, CMS will only evaluate retail pharmacy access for the pending service area.

While Applicants are required to demonstrate that they meet the Part D pharmacy access requirements at the time this application is submitted to CMS, CMS expects that pharmacy network contracting will be ongoing in order to maintain compliance with our retail pharmacy access requirements.

2.7.2. Home Infusion Pharmacy Access

Applicants must demonstrate that their contracted pharmacy network provides adequate access to home infusion pharmacies. In order to demonstrate adequate access to home infusion pharmacies, Applicants must provide a list of all contracted home infusion pharmacies (see section 3.4.3). CMS uses this pharmacy listing to compare Applicants' home infusion pharmacy network against existing Part D sponsors in the same service area to ensure that Applicants have contracted with an adequate number of home infusion pharmacies. The adequate number of home infusion pharmacies is developed based on data provided by all Part D sponsors through the annual Part D Reporting Requirements. A reference file entitled "*Adequate Access to Home Infusion Pharmacies*" is provided on the CMS website, http://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.html.

2.7.3. Long-Term Care Pharmacy Access

Applicants must demonstrate that their contracted pharmacy network provides convenient access to long-term care pharmacies. In order to demonstrate convenient access to long-term care pharmacies, Applicants must provide a list of all contracted long-term care pharmacies (see section 3.4.4). CMS uses this pharmacy listing, as well as information reported as part of Applicants' reporting requirements and complaints data, to evaluate initial and ongoing compliance with the convenient access standard. To assist applicants with preparing their LTC pharmacy network, CMS provides the LTC Facilities List on the CMS website, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ApplicationGuidance.html.

2.7.4. Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U)

Applicants must demonstrate that they have offered standard contracts to all I/T/U pharmacies residing within the Applicants' service areas. In order to demonstrate convenient access to I/T/U pharmacies, Applicants must provide a list of all I/T/U pharmacies to which they have offered contracts (see section 3.4.5). CMS provides the current national list of all I/T/U pharmacies to assist Applicants in identifying the states in which I/T/U pharmacies reside. The ITU Pharmacies Reference File is located on the CMS website, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ApplicationGuidance.html.

2.8. Document (Upload) Submission Instructions

Applicants must include their assigned H number in the file name of all submitted documents. Within the Medicare-Medicaid Plan template file is a Readme File that identifies each document requested as part of the application. The file further details

the application section reference for the required documentation, which Applicants must complete the document, if a template is provided, the section the document must be uploaded to in HPMS, the file format, the naming convention to be used for the document, and other relevant notes such as naming conventions when multiple documents are required in one application section.

2.9. Protection of 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. This designation must be in writing.

When there is a request for information that is designated by the Applicant as confidential or that could reasonably be considered exempt under Exemption 4, CMS is required by its FOIA regulation at 45 CFR §5.65(d) and by Executive Order 12,600 to give the submitter notice before the information is disclosed. To decide whether the Applicant's information is protected by Exemption 4, CMS must determine whether the Applicant has shown that:

- Disclosure of the information might impair the government's ability to obtain necessary information in the future;
- Disclosure of the information would cause substantial harm to the competitive position of the submitter;
- Disclosure would impair other government interests, such as program effectiveness and compliance; or
- Disclosure would impair other private interests, such as an interest in controlling availability of intrinsically valuable records, which are sold in the market.

Consistent with our approach under the Medicare Advantage and Medicare Part D programs, we would not release information under the Medicare-Medicaid Financial Alignment Initiative that would be considered proprietary in nature.

3. APPLICATION

Nothing in this application is intended to supersede the regulations at 42 CFR Parts 422 and 423, the three-way contract for the applicable demonstration, the Medicare Managed Care Manual, the Prescription Drug Benefit Manual, or any other CMS guidance or instructions related to the operation of the Capitated Financial Alignment Model. Failure to reference a regulatory requirement or CMS instruction in this application does not affect the applicability of such requirement. In particular, the attestations in this application are intended to highlight examples of key requirements across a variety of functional and operational areas, but are in no way intended to reflect a complete or thorough description of all Medicare prescription drug or medical benefit requirements.

For most of the program requirements described in this application, CMS has issued operational policy guidance that provides more detailed instructions. Organizations submitting an application acknowledge that in making the attestations stated below, they are also representing to CMS that they have reviewed the associated guidance materials posted on the CMS web site and are in compliance with such guidance. Applicants must visit the CMS web site periodically to stay informed about new or revised guidance documents.

All uploads and templates will be accessed in HPMS through the HPMS Contract Management Module. Applicants should refer to the Contract Management – Online Application User's Guide for further instructions.

3.1. Service Area/Regions

References: *42 CFR §422.2; Medicare Managed Care Manual, Chapter 4 (http://www.cms.gov/manuals/downloads/mc86c04.pdf)*

A. In HPMS, in the Contract Management/Contract Service Area/Service Area Data page, enter the state and county information for the area the Applicant proposes to serve.

B. If serving a partial county, upload in HPMS MMP Supporting Files Service Area section the template entitled "Partial County Justification" document.

Note: CMS bases its medical provider/facility and pharmacy network analyses on the service area your organization inputs into HPMS. Please make sure that the service area information you input into HPMS corresponds to the MMP Provider Table, MMP Facility Table and the pharmacy lists that are provided as part of this application.

3.2. Management and Operations

References: *42 CFR Parts 422 and 423 Subpart K; Medicare Managed Care Manual, Chapter 11 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c11.pdf); 2014 Call Letter*

A. In HPMS, complete the table below:

Attest 'yes,' 'no,' or 'NA' to the following qualification by clicking on the appropriate response in HPMS:	Yes	No	NA
1. If Applicant, Applicant's parent organization, or any subsidiaries of Applicant's parent organization has an existing contract(s) with CMS to operate a Medicare Advantage, Prescription Drug Plan, or Medicare-Medicaid Plan, at least one of those contracts has been in effect since January 1, 2016 or earlier. (If the Applicant, Applicant's parent organization, or a subsidiary of Applicant's parent organization does not have any existing contracts with CMS to operate a Medicare Advantage, Prescription Drug Plan, or Medicare-Medicaid Plan select "NA".)			
2. Applicant maintains contracts or other legal arrangements between or among the entities combined to meet the functions identified in the Medicare-Medicaid Plan Medical Benefit and Prescription Drug Benefit First tier, Downstream, and Related entities function tables in HPMS>Contract Management>Basic Contract Management>Select Contract Number>MMP Data.			

3.3. Medical Benefit Access

References: *42 CFR §§ 422.112, 114, and 504; Medicare Managed Care Manual, Chapter 4 (http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html); Medicare Managed Care Manual, Chapter 11 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c11.pdf)*

A. In HPMS, complete the table below:

Attest 'yes' or 'no' to the following qualification by clicking on the appropriate response in HPMS:	Yes	No
1. Applicant has reviewed, understands, and complies with requirements related to medical benefit access and contracting contained in 42 CFR §§ 422.112 and 114, Chapter 4 of the Medicare Managed Care Manual, and all related guidance.		
2. Applicant has reviewed, understands, and complies with all applicable provider requirements in 422 subpart E, 422.504 and Chapter 11 of the Medicare Managed Care Manual, and all related guidance.		
3. Applicant has reviewed, understands, and complies with requirements related to covered services contained in the applicable three-way contract located at the state pages listed at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-		

and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html		

B. In HPMS, using the instructions provided in the appendix titled "MMP Health Service Delivery Instructions, upload the following completed HSD tables for your medical provider/facility network for the pending counties only. Specifically, download the Microsoft Excel worksheet templates from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP(Download Templates)

- CMS MMP Provider Table CY 2019
- CMS MMP Facility Table 2019

The HSD submission must be based on your contracted network to provide Medicare services for your organization.

3.4. Pharmacy Access

3.4.1. Retail Pharmacy

References: *42 CFR § 423.120(a); 42 CFR § 423.859(c); Prescription Drug Benefit Manual, Chapter 5 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_09.30.11.pdf); 2016 Call Letter; 2017 Call Letter*

A. In HPMS, complete the table below:

Attest 'yes' or 'no' to the following qualification by clicking on the appropriate response in HPMS:	**Yes**	**No**
1. Applicant has reviewed, understands, and complies with all requirements related to retail pharmacy access contained in 42 CFR §§ 423.120(a) & 423.859(c), Chapter 5 of the Prescription Drug Benefit Manual, and all related guidance.		

B. Upload in HPMS the Retail Pharmacy List:

To submit retail pharmacy listings to CMS, Applicants must download the Microsoft Excel worksheet template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete the worksheet and upload the finished document back into HPMS.

3.4.2. Mail Order Pharmacy

References: *42 CFR § 423.120(a)(10); Prescription Drug Benefit Manual, Chapter 5 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5*

_09.30.11.pdf); 2014 Call Letter (http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/RateNotice.pdf); 2016 Call Letter; 2017 Call Letter

A. In HPMS, complete the table below:

Attest 'yes' or 'no' to the following qualification by clicking on the appropriate response in HPMS:	Yes	No
1. Applicant offers mail order pharmacy as part of its Medicare-Medicaid plans.		

B. Mail Order Pharmacy List

To submit mail order pharmacy listings to CMS, Applicants must download the Microsoft Excel worksheet template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete the worksheet and upload the finished document back into HPMS.

3.4.3. Home Infusion Pharmacy

References: *42 CFR § 423.120(a)(4); Prescription Drug Benefit Manual, Chapter 5 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_09.30.11.pdf)*

A. Home Infusion Pharmacy List

To submit home infusion pharmacy listings to CMS, Applicants must download the Microsoft Excel worksheet template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete the worksheet and upload the finished document back into HPMS.

3.4.4. Long -Term Care (LTC) Pharmacy

References*: 42 CFR § 423.120(a)(5); Prescription Drug Benefit Manual, Chapter 5 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_09.30.11.pdf); CMS issued guidance 04/28/09*

A. In HPMS, complete the table below:

Attest 'yes' or 'no' to the following qualification by clicking on the appropriate response in HPMS:	Yes	No
1. Applicant offers standard contracting terms and conditions to all long-term care pharmacies in its service area. These terms and		

conditions must include all the performance and service criteria for long-term care pharmacies that are cited in section 50.5.2 of Chapter 5 of the Prescription Drug Benefit Manual.		
2. Applicant has reviewed, understands, and complies with requirements related to long term care pharmacy access and contracting contained in 42 CFR § 423.120(a)5), Chapter 5 of the Prescription Drug Benefit Manual, and all related guidance.		
3. Applicant readily negotiates with States with regard to contracting with State-run and operated LTC pharmacies in facilities such as ICFs/MR, IMDs, and LTC hospitals. States may not be able to agree to certain clauses in some LTC standard contracts because of constitutional and legal restraints. Applicants should be prepared to negotiate with States to address these issues.		

B. LTC Pharmacy List

To submit LTC pharmacy listings to CMS, Applicants must download the Microsoft Excel worksheet template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete the worksheet and upload the finished document back into HPMS.

3.4.5. Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U) Pharmacy

***References**: 42 CFR § 423.120(a)(6); Prescription Drug Benefit Manual, Chapter 5 (http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_09.30.11.pdf)*

A. In HPMS, complete the table below:

Not all Part D regions have I/T/U pharmacies. If the Applicant's service area covers <u>any</u> region that includes I/T/U pharmacies, then the Applicant must attest 'yes' to each of the following qualifications to be approved for a contract. To determine if I/T/U pharmacies reside in your service area, review the I/T/U reference file located on the CMS webpage: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ApplicationGuidance.html. Attest 'yes,' 'no' or n/a to each of the following qualifications by clicking on the appropriate response in HPMS:	**Yes**	**No**	**N/A**
1. Applicant has reviewed, understands, and complies with requirements related to I/T/U access and contracting			

contained in 42 CFR § 423.120(a)(6), Chapter 5 of the Prescription Drug Benefit Manual, and all related guidance.			

B. I/T/U Pharmacy List

In order to demonstrate that an Applicant meets these requirements Applicants must submit a complete list of all I/T/U pharmacies to which it has offered contracts. CMS provides the current list of I/T/U pharmacies, including the official name, address, and provider number (when applicable). To submit I/T/U pharmacy listings to CMS, Applicants must download the Microsoft Excel worksheet template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete the worksheet and upload the finished document back into HPMS. Applicants must include all I/T/U pharmacies residing in any and all counties/states within its service area, complete the worksheet and upload the finished document back into HPMS.

3.5. Staffing

A. In HPMS, complete the table below:

Attest 'yes' or 'no' to the following qualification by clicking on the appropriate response in HPMS:	Yes	No
1. Applicant agrees to maintain staffing for care coordination, including staff whose responsibility it is to conduct initial health risk assessments, at a level that is appropriate based on projected enrollment. Such levels shall include any staffing ratios that are specified in applicable three-way contracts.		
2. Applicant agrees to increase staff as necessary for call center customer service representatives.		

C. Complete and submit the Appendix titled: Staffing Template to CMS. Applicants must download the template from HPMS that is located at: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates), complete and upload the finished document back into HPMS in the MMP Supporting Files page.

Upload in HPMS MMP Supporting Files Contracting/Experience/History, in a .pdf format, the following certification:

4. MEDICARE-MEDICAID PLAN CERTIFICATION

I, _____, attest to the following:

(NAME & TITLE)

1. I have read the contents of the completed application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Centers for Medicare & Medicaid Services (CMS) immediately and in writing.
2. I authorize CMS to verify the information contained herein. I agree to notify CMS in writing of any changes that may jeopardize my ability to meet the qualifications stated in this application prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in termination of the approval.
3. I agree that if my organization meets the minimum qualifications and is Medicare-approved, and my organization continues its three-way contract with CMS and my respective State, I will abide by the requirements contained in Sections 3 of this Application and provide the services outlined in my application.
4. I agree that CMS may inspect any and all information necessary, including inspecting of the premises of the Applicant's organization or plan to ensure compliance with stated Federal requirements, including specific provisions for which I have attested. I further agree to immediately notify CMS if, despite these attestations, I become aware of circumstances that preclude full compliance by January 1 of the upcoming contract year with the requirements stated here in this application as well as the requirements of 42 CFR Parts 422 and 423.
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 capitated financial alignment contract with CMS and the respective State.
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. My organization will comply with such guidance, as applicable, as well as its existing three-way contract.

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

5. APPENDICES

Appendix A -- Partial County Justification

Instructions: Applicants requesting service areas that include one or more partial counties must upload a Partial County Justification with this Application.

Complete and upload in HPMS in the MMP Supporting Files Service Area section, the Partial County Justification form for each partial county in your proposed service area.

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

HPMS will automatically assess the contracted provider and facility networks against the CMS MMP criteria. If the ACC report shows that a provider or facility fails the network criteria, the applicant must submit an Exception Request using the same process available to full-county applicants.

SECTION I: Partial County Explanation

_____ Check here if the State where your organization will be offering a Medicare-Medicaid plan requires a service area that includes a partial county. Do not complete Sections II-III.

_____ Check here if the State where your organization will be offering a Medicare-Medicaid plan is NOT requiring a service area that includes a partial county but your organization is proposing to cover a partial county. Using just a few sentences, briefly describe why you are proposing a partial county.

SECTION II: Partial County Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION III: Geography

1. Describe the geographic areas for the county, both inside and outside the proposed service area, including the major population centers, transportation

arteries, significant topographic features (e.g., lakes, mountain ranges, etc.), and any other geographic factors that affected your service area designation.

Appendix B – MMP Health Service Delivery Instructions

General Instructions and Guidance

Applicants should include all contracted providers within and outside of the pending service area that will be available to serve the county's beneficiaries (even if those providers/facilities may be outside of the time and distance standards). After your organization submits the required MMP health service delivery (HSD) tables, CMS-generated Automated Criteria Check (ACC) reports will be created showing the provider and facility types that are meeting or failing to meet the MMP access standards. CMS will invoke rounding for the Applicant for any results of 89.5% or higher. Based on those results, your organization may submit exception(s) requests based on the process described below.

Applicants must submit HSD tables for the **pending service area** reflected in the CMS Health Plan Management System (HPMS).

SPECIALTY CODES

CMS has created specific specialty codes for each of the physician/provider and facility types. Applicant must use the codes when completing HSD tables (MMP Provider and MMP Facility tables).

Specialty Codes for the MMP Provider Table

- 001 – General Practice
- 002 – Family Practice
- 003 – Internal Medicine
- 004 – Geriatrics
- 005 – Primary Care – Physician Assistants
- 006 – Primary Care – Nurse Practitioners
- 007 – Allergy and Immunology
- 008 – Cardiology
- 010 - Chiropractor
- 011 – Dermatology
- 012 – Endocrinology
- 013 – ENT/Otolaryngology
- 014 – Gastroenterology
- 015 – General Surgery
- 016 – Gynecology, OB/GYN
- 017 – Infectious Diseases
- 018 - Nephrology

- 019 - Neurology
- 020 - Neurosurgery
- 021 - Oncology - Medical, Surgical
- 022 - Oncology - Radiation/Radiation Oncology
- 023 – Ophthalmology
- 025 - Orthopedic Surgery
- 026 - Physiatry, Rehabilitative Medicine
- 027 - Plastic Surgery
- 028 - Podiatry
- 029 - Psychiatry
- 030 - Pulmonology
- 031 - Rheumatology
- 033 - Urology
- 034 - Vascular Surgery
- 035 – Cardiothoracic Surgery

Description of MMP Provider Types

The following section contains information related to MMP Provider specialty types in order to assist the Applicant with the accurate submission of the MMP Provider HSD Table.

MMP Provider Table – Select Provider Specialty Types

Primary Care Providers – The following six specialties are reported separately on the MMP Provider Table, and the criteria, as discussed below, are published and reported under "Primary Care Providers (S03):

- General Practice (001)
- Family Practice (002)
- Internal Medicine (003)
- Geriatrics (004)
- Primary Care – Physician Assistants (005)
- Primary Care – Nurse Practitioners (006)

Applicants submit contracted providers using the appropriate individual specialty codes (001 – 006). CMS sums these providers, maps them as a single group, and evaluates the results of those submissions whose office locations are within the prescribed time and distance standards for the specialty type: Primary Care Providers. These six specialties are also summed and evaluated as a single group against the Minimum Number of Primary Care Providers criteria (note that in order to apply toward the minimum number, a provider must be within the prescribed time and distance standards, as discussed below). States may require MMPs to include pediatric providers in their tables, However, CMS does not review pediatric providers for purposes of network adequacy determinations. Therefore, physicians and specialists must not be pediatric

providers; as they do not routinely provide services to the Medicare- population. There are HSD network criteria for the specialty type: Primary Care Providers, and not for the individual specialties. The criteria and the results of the Automated Criteria Check (ACC) are reported under the specialty type: S03.

Primary Care – Physician Assistants (005) – Applicants include submissions under this specialty code **only if** the contracted individual meets the applicable state requirements governing the qualifications for assistants to primary care physicians and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Primary Care – Nurse Practitioners (006) -- Applicants include submissions under this specialty code **only if** the contracted registered professional nurse is currently licensed in the state, meets the state's requirements governing the qualifications of nurse practitioners, and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Geriatrics (004) – Submissions appropriate for this specialty code are internal medicine, family practice, and general practice physicians who have a special knowledge of the aging process and special skills and who focus upon the diagnosis, treatment, and prevention of illnesses pertinent to the elderly.

Physiatry, Rehabilitative Medicine (026) – A physiatrist, or physical medicine and rehabilitation specialist, is a medical doctor trained in the diagnosis and treatment of patients with physical, functionally limiting, and/or painful conditions. These specialists focus upon the maximal restoration of physical function through comprehensive rehabilitation and pain management therapies. Physical Therapists are NOT Physiatry/Rehabilitative Medicine physicians and are not to be included on the MMP Provider tables under this specialty type.

Psychiatry (029) -- Psychiatrists must only be licensed physicians and no other type of practitioner.

Cardiothoracic Surgery (035) – Cardiothoracic surgeons provide operative, perioperative, and surgical critical care to patients with acquired and congenital pathologic conditions within the chest. This includes the surgical repair of congenital and acquired conditions of the heart, including the pericardium, coronary arteries, valves, great vessels and myocardium. Cardiologists, including interventional

cardiologists, are not cardiothoracic surgeons, and may not be included under this specialty type.

Specialty Codes for the MMP Facility Table

- 040 – Acute Inpatient Hospitals
- 041 - Cardiac Surgery Program
- 042 - Cardiac Catheterization Services
- 043 - Critical Care Services – Intensive Care Units (ICU)
- 044 - Outpatient Dialysis
- 045 - Surgical Services (Outpatient or ASC)
- 046 - Skilled Nursing Facilities
- 047 - Diagnostic Radiology
- 048 - Mammography
- 049 - Physical Therapy
- 050 - Occupational Therapy
- 051 - Speech Therapy
- 052 - Inpatient Psychiatric Facility Services
- 057 - Outpatient Infusion/Chemotherapy

Description of MMP Medicare Facility Types
The following section contains information related to Medicare Facility specialty types in order to assist Applicants with the accurate submission of the MMP Facility HSD Table.

MMP Facility Table – Select Facility Specialty Types
Contracted facilities/beds must be Medicare-certified.

Acute Inpatient Hospital (040) – Applicants must submit at least one contracted acute inpatient hospital. MMPs may need to submit more than one acute inpatient hospital in order to satisfy the time/distance criteria. There are Minimum Number criteria for the acute inpatient hospital specialty. Applicants must demonstrate that their contracted acute inpatient hospitals have at least the minimum number of Medicare-certified hospital beds. The minimum number of Medicare-certified acute inpatient hospital beds, by county of application, can be found on the “Minimum Facility #s” tab of the HSD Reference Table.

Cardiac Surgery Program (041) – A hospital with a cardiac surgery program provides for the surgical repair of problems with the heart, traditionally called open-heart surgeries. Procedures performed in a cardiac surgery hospital program include, but are not limited to: coronary artery bypass graft (CABG), cardiac valve repair and replacement, repair of thoracic aneurysms and heart replacement, and may additionally include minimal access cardiothoracic surgeries.

Inpatient Psychiatric Facility Services (052) – Inpatient Psychiatric Facility Services may include inpatient hospital services furnished to a patient of an inpatient psychiatric facility (IPF). IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and critical access hospitals. The regulations at 42 CFR § 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR § 412.22 and 42 CFR § 412.23(a), 42 CFR § 482.60, 42 CFR § 482.61, and 42 CFR § 482.62, and units that meet the requirements specified in 42 CFR § 412.22, 42 CFR § 412.25, and 42 CFR § 412.27.

Outpatient Infusion/Chemotherapy (057) – Appropriate submissions for this specialty include freestanding infusion / cancer clinics and hospital outpatient infusion departments. While some physician practices are equipped to provide this type of service within the practice office, Applicants should only list a contracted office-based infusion service if access is made available to all members and is not limited only to those who are patients of the physician practice.

HSD Table Instructions

The tables should reflect the Applicant's executed contracted network on the date of submission. CMS considers a contract fully executed when both parties have signed. Applicants should only list providers with whom they have a fully executed updated contract. These contracts should be executed on or prior to the submission deadline. In order for the automated network review tool to appropriately process this information, your organization must submit Provider and Facility names and addresses exactly the same way each time they are entered, including spelling, abbreviations, etc. Any errors will result in problems with processing of submitted data and may result in findings of network deficiencies. CMS expects all organizations to fully utilize the functionality in the CMS HPMS Network Management Module (NMM) to conduct organization-initiated checks prior to the February due date to ensure that their HSD tables are accurate and complete. For instructions on the organization-initiated NMM uploads, please refer to HPMS>Monitoring>Network Management>Documentation>User Guide.

The MMP Provider Table Template can be found in HPMS using the following path:

HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates). This table captures information on the specific physicians/providers in the MMP's contracted network. If a provider serves beneficiaries residing in multiple counties in the service area, list the provider multiple times with the appropriate state/county code to account for each county served. Do NOT list contracted providers in the state/county codes where the beneficiary could not reasonably access services and that are outside the pattern of care. Such extraneous listing of providers affects CMS' ability to quickly and efficiently assess provider networks against network criteria. You must ensure that the providers listed must not have opted out of Medicare.

The Applicant is responsible for ensuring contracted providers (physicians and other health care practitioners) meet state and Federal licensing requirements and your credentialing requirements for the specialty type prior to including them on the MMP Provider Table. Verification of credentialing documentation may be requested at any time. Including physicians or other health care practitioners that are not qualified to provide the full range of specialty services listed in the MMP Provider Table will result in inaccurate ACC measurements that may result in your MMP Medicare network submission being found deficient. Explanations for each of the columns in the MMP Provider Table can be found in Appendix B.1.

MMP Facility Table Template

The MMP Facility Table Template can be found in HPMS using the following path: HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates). Only list the providers that are Medicare certified providers. Please do not list any additional providers or services except those included in the list of facility specialty codes. Additionally, do not list contracted facilities in state/county codes where the Medicare-Medicaid beneficiary could not reasonably access services and that are outside the pattern of care. Such extraneous listing of facilities affects CMS' ability to quickly and efficiently assess facility networks against network criteria.

If a facility offers more than one of the defined services and/or provides services in multiple counties, the facility should be listed multiple times with the appropriate "SSA State/County Code" and "Specialty Code" for each service.

Exception Requests:

As MMPs will submit networks annually, any approved exceptions will be in place until the next annual MMP Medicare network submission. CMS, in collaboration with each respective state, will consider requests for exceptions to the required minimum number of providers and/or maximum time/distance criteria under limited circumstances. Each exception request must be supported by information and documentation as specified in the exception request template attached to these instructions. If your organization believes that it will not meet the time/distance or minimum number MMP standards based on your contracted network, wants to request an exception(s), and already has additional contracted providers outside of the time and distance to serve beneficiaries, then you must include those other contracted providers on the MMP HSD tables in the MMP SAE application submission.

Exception Process Timing

Following the submission for the MMP SAE application, organizations must review the ACC report. This report identifies the providers and/or facilities passing and failing to meet the MMP Medicare network standards. For those providers and/or facilities that are not meeting the MMP Medicare network standards, your organization may submit an exception request.

Exceptions are only permitted to be requested and uploaded between specific timeframes identified in the initial deficiency notice your organization will receive during the application review process.

Completing the Exception Request Template

MMPs must submit distinct exception requests per contract ID, county, and specialty code. Each request should be tailored to the provider/facility type and the specific county using the MMP exception template (see Appendix B.3). CMS will not accept

exception request submissions using the Medicare Advantage application template or the MMP template from the 2016 annual MMP network submission.

Justification for Exception: The MMP SAE Applicant Exception Request template provides the basis for any MMP exception requests.

The exception request template has been revised since last year to provide more clear instructions related to the delivery of care. This includes in-home delivery of services, the use of mobile health clinic, and the use of telehealth. The expanded elements have been added to the exception template in response to plan feedback and allow CMS to better assess how organizations are using other methods to provide adequate access to beneficiaries, including those beneficiaries in underserved or rural areas.

Telehealth: A telehealth provider is a board-certified physician or advanced practitioner that provides virtual medical advice, treatment options and referrals to a provider if needed for non-life-threatening medical conditions from a distant site[2]. These electronic services must include an interactive 2-way telecommunications system (with at a minimum real-time audio and video equipment) which is used by both the provider and the enrollee receiving the service. Such telehealth providers must be contracted to provide services to the entire enrollee population within the specified service area. Applicants that utilize telehealth providers to provide adequate access can receive consideration in the exceptions process by completing questions Table 2 (a-h) below.

Mobile Health Clinics: Any mobile health clinics that are contracted to provide services to the entire enrollee population within the specified service area. A mobile health clinic may be a specially outfitted truck or van that provides examination rooms, laboratory services, and special medical tests to those who may be in remote areas or who have little to no access to medical facilities, and to patients who do not have the resources to travel for care. Applicants that utilize mobile health clinics to provide adequate access can receive consideration in the exceptions process by completing questions Table 2 (a-c and i-m) below.

In-Home Medical Services: Applicants can receive consideration in the exceptions process by completing Table 2 (a-c and n-q) below where contracted providers deliver medical services in the beneficiary's home in lieu of an office where the office location may be outside of the established time and or distance standards.

CMS reserves the right to follow up for any additional information that may be need as a result of the exception request review which could include an attestation from the provider outlining their service area/counties, and may also include the number of enrollees served by each provider type (telehealth, mobile health clinics and in-home service providers) within the designated service areas/counties. CMS will also work

[2] Distant site – site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

with your state of operation to verify laws pertaining to telehealth and mobile health clinics.

Rational for why Exception is Necessary:

- Questions 1-3 must be answered Yes and/or No
- Question 4 must be answered by completing Table 1 in the template for each provider/facility identified.
- If the basis for the exception request is based on telehealth, mobile health clinics, or in-home delivery of medical services, complete Table 2.
- If the basis for the exception request is based on low utilization of the provider/facility type for the demonstration population, your organization must complete Table 3.

Appendix B.1 – MMP Provider Table Column Explanations

A. SSA State/County Code – Enter the SSA State/County code of the county which the listed physician/provider will serve. The state/county code is a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes you should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.

B. **Name of Physician or Mid-Level Practitioner** – Self-explanatory. Up to 150 characters.

C. **National Provider Identifier (NPI) Number –** The provider's assigned NPI number must be included in this column. Enter the provider's individual NPI number whether the provider is part of a medical group or not. The NPI is a ten digit numeric field. Include leading zeros.

D. Specialty – Name of specialty of listed physician/provider. This should be copied directly off of the HSD Criteria Reference Table.

E. **Specialty Code –** Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001-034).

F. **Contract Type –** Enter the type of contract the MMP holds with listed provider. Use "DC" for direct contract between the MMP and the provider and "DS" for downstream (define DS) contract.

- A "DC" – direct contract provider requires the MMP to complete Column K – Medical Group Affiliation with a "DC" and Column L – Employment Status should be marked as "N/A".
- A "DS" – downstream contract is between the first tier entity and other providers (such as individual physicians).
- Where the MMP has a contract with an Independent Practice Association (IPA) with downstream contracts with physicians, MMP must complete Column F – Contract Type with a "DS", Column K – Medical Group Affiliation must be completed by entering the IPA Name.
- Where the MMP has a contract with a Medical Group with downstream contracted physicians, the MMP must complete Column F – Contract Type

with a “DS”, Column K – Medical Group Affiliation must be completed by entering the name of the Medical Group.

- Where the MMP has a contract with a Medical Group with employed providers, the MMP must complete Column F – Contract Type with a “DS”, Column K – Medical Group Affiliation must be completed by entering the name of the Medical Group.

Provider Service Address Columns- Enter the address (i.e., street, city, state and zip code) of the location at which the provider sees patients. **Do not list P.O. Box, house, apartment, building or suite numbers, or street intersections.**

G. **Provider Service Address: Street Address** – up to 250 characters

H. **Provider Service Address: City** – up to 150 characters

I. **Provider Service Address: State** – 2 characters

J. **Provider Service Address: Zip Code** – up to 10 characters

K. **Medical Group Affiliation –** Provide name of affiliated Medical Group/Individual Practice Association MG/IPA) or if MMP has direct contract with provider enter “DC”.

Appendix B.2 – MMP Facility Table Column Explanations

A. SSA State/County Code – Enter the SSA State/County code of the county for which the listed facility will serve. The county code should be a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes that MMP should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.

B. **Facility or Service Type** – Name of facility/service type of listed facility. This should be copied directly off of the HSD Criteria Reference Table.

C. **Specialty Code** – Specialty codes are unique 3 digit numeric codes assigned by CMS to process data. Enter the Specialty Code that best describes the services offered by each facility or service. Include leading zeros.

D. **National Provider Identifier (NPI) Number** – Enter the provider's assigned NPI number in this column. The NPI is a ten digit numeric field. Include leading zeros.

E. **Number of Staffed, Medicare Certified Beds** – For Acute Inpatient Hospitals (040), Critical Care Services – Intensive Care Units (ICUs) (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility Services (052), your organization must enter the number of Medicare certified beds for which it has contracted access for enrollees. This number should not include Neo-Natal Intensive Care Unit (NICU) beds.

F. **Facility Name** – Enter the name of the facility. Field Length is 150 characters.

Provider Service Address Columns- Enter the address (i.e., street, city, state and zip code) from which the provider serves patients. **Do not list P.O. Box, house, apartment, building or suite numbers, or street intersections.** For Home Health and Durable Medical Equipment, indicate the business address where one can contact these vendors.

G. **Provider Service Address: Street Address** – up to 250 characters

H. **Provider Service Address: City** – up to 150 characters

I. **Provider Service Address: State** – 2 characters

J. **Provider Service Address: Zip Code** – up to 10 characters

Appendix B.3 – MMP SAE Applicant Exception Request Template

Applicants are required to use the exception request template below to submit all exception requests. CMS will not accept any request submitted on the Medicare Advantage template. Applicants can access the template by going to HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>MMP (Download Templates)

(File naming convention: Contract ID_County Code_Specialty Code) – 15 characters

CONTRACT ID:	
COUNTY CODE:	
SPECIALTY CODE:	

JUSTIFICATION FOR EXCEPTION- Other Factors in accordance with 42 CFR § 422.112 a (10)(v)that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area.

Select the one most relevant justification for your exception request by checking the appropriate box.

☐ An insufficient number of providers are available within CMS's current time and distance criteria to meet the HSD network adequacy standards for this county and provider/facility type as specified in the current Medicare-Medicaid Plan (MMP) HSD Reference File. However, our contracted provider network, which may include services provided by telehealth providers, mobile health clinics, or in-home delivery of medical services, is consistent with the current pattern of care and provides enrollee access to covered services that is equal to or better than the prevailing Original Medicare pattern of care. **(Complete Tables 1 and 2)**

RATIONALE FOR WHY EXCEPTION IS NECESSARY

Skip this section if requesting an exception based on low utilization

Question 1. Does the Applicant attest that it has reviewed publicly available databases and other sources to determine availability of providers with respect to the exception being requested?

☐ Yes

☐ No

Question 2. If the Applicant responded “yes” to Question 1, did the Applicant’s review identify providers within CMS’ MMP current time and distance criteria, and with which the Applicant has not contracted?

☐ Yes

☐ No

Question 3.a. Did the Applicant contract with providers who are outside CMS’ Applicant current time and distance criteria?

☐ Yes

☐ No

Question 3.b. Are there other non-contracted providers outside CMS’ MMP current time and distance criteria who are located closer to Applicant’s enrollees?

☐ Yes

☐ No

Question 3.c. Are there geographic boundaries that preclude otherwise meeting the CMS MMP time and distance standard for the provider/facility type in the county?

☐ Yes

☐ No

Question 3.d. Does your organization contract with telehealth providers that do not meet the CMS MMP time and distance standard for the provider/facility type in the county? If you answer yes, please complete table 3.

☐ Yes

☐ No

Note: If your organization answered Question 3.d as ‘Yes’ then **i**n table 2 below, **l**ist

the providers/facilities, NPIs, and additional information requested for the provider. Please provide detailed information. CMS may follow up for any additional information need, including but not limited to the verification of the state laws pertaining to telehealth and mobile health clinics.

Question 3.e. Does your organization contract with mobile health clinics that do not meet the CMS MMP time and distance standard for the provider/facility type in the county? If you answer yes, please complete table 2.

☐ Yes

☐ No

Note: If your organization answered Question 3.e as 'Yes' then **i**n table 2 below, **l**ist the providers/facilities, NPIs, and additional information requested for the provider. Please provide detailed information. CMS may follow up for any additional information need, including but not limited to the verification of the state laws pertaining to telehealth and mobile health clinics.

Question 3.f. Does your organization contract with providers that provide in-home medical services whose office location does not meet the CMS MMP time and distance standard for the provider/facility type in the county? If you answer yes, please complete table 2.

☐ Yes

☐ No

Note: If your organization answered Question 3.f as 'Yes' then **i**n table 2 below, **l**ist the providers/facilities, NPIs, and additional information requested for the provider. Please provide detailed information. CMS may follow up for any additional information need, including but not limited to the verification of the state laws pertaining to telehealth and mobile health clinics.

Question 4. If your organization answered Question 2 as 'Yes' then **i**n table 1 below, list the providers/facilities that were identified, the reason(s) they were not contracted, and the source of evidence supporting the reason(s) for which the identified provider/facilities were not contracted.

For <u>each</u> provider/facility identified, use table 1 below to provide this information.

If the sources of information used (and listed in the table below) are proprietary or otherwise not publically available, the Applicant must describe how the information supports the reason for not contracting with a provider and provide evidence of the data source information (e.g., screenshots).

TABLE 1 **(complete if answer to question 2 is Yes)**	
a. PROVIDER/FACILITY NAME:	
b. PROVIDER NPI:	
c. ADDRESS (street, city, state, ZIP code, and telephone number):	

TABLE 1 (complete if answer to question 2 is Yes)	
d. REASON FOR NOT CONTRACTING WITH PROVIDER (CHECK ALL THAT APPLY):	__ Provider is no longer practicing (e.g., deceased, retired, etc.) __ Provider does not provide services at the office/facility address listed in database __ Provider does not provide services in the specialty type listed in the database and for which this exception is being requested __ Provider has opted out of Medicare __ Provider does not contract with Medicare-Medicaid Plans __ Sanctioned provider on List of Excluded Individuals and Entities __ Provider/Facility type better than prevailing Original Medicare pattern of care __Contract offered to provider/facility but declined/rejected __ Provider is at capacity and is not accepting new patients __ Geographic limitations, explain below __ Other

TABLE 1 (complete if answer to question 2 is Yes)	
e. PROVIDE EXPLANATION FOR SELECTED REASON(S) ABOVE:	
f. PROVIDE SOURCE(S) OF INFORMATION:	__ Physician Compare __ Hospital Compare __ Nursing Home Compare __ Dialysis Compare __ NPI File/NPPES __Provider of Services (POS) File __ Direct Outreach to provider __ Provider website

TABLE 1 (complete if answer to question 2 is Yes)	
g. PROVIDE EXPLANATION OF OTHER SOURCE SELECTED ABOVE:	

TABLE 2	
(complete a, b, and c below if answer to question 3 d, e, and/or f above are "Yes")	
a. PROVIDER/FACILITY NAME:	
b. PROVIDER NPI:	
c. ADDRESS (street, city, state, ZIP code, and telephone number):	
JUSTIFICATION FOR TELEHEALTH PROVIDERS *Answer Table 2d- 2h if answer to 3d was "Yes"*	

TABLE 2	
d. HOW DOES THE TELEHEALTH PROVIDER PROVIDE SERVICES FOR THE ENTIRE POPULATION IN THE SERVICE AREA?	
e. WHAT ARE THE REQUIREMENTS FOR A BENEFICIARY TO BE ELIGIBLE TO PARTICIPATE IN TELEHEALTH?	
f. HOW DOES THE BENEFICIARY ACCESS TELEHEALTH SERVICES?	
g. HOW DOES YOUR ORGANIZATION PROVIDE ACCESS TO A PROVIDER WHEN AN IN-PERSON VISIT IS DEEMED NECESSARY FOLLOWING A TELEHEALTH VISIT?	

TABLE 2	
h. PROVIDE ANY ADDITIONAL DETAILS FOR CONSIDERATION THAT SUPPORT YOUR ORGANIZATION'S OPTIONS TO UTILIZE THESE TYPES OF PROVIDERS OVER PROVIDERS IN A PHYSICAL LOCATION.	
JUSTIFICATION FOR MOBILE HEALTH CLINICS ***Answer Table 2i – 2m if answer to 3e was "Yes"***	
i. EXPLAIN THE MEDICAL SERVICES PROVIDED BY THE MOBILE HEALTH CLINIC(S).	
j. HOW DOES THE BENEFICIARY ACCESS MOBILE HEALTH CLINIC SERVICES?	

TABLE 2	
k. **IS THE MOBILE HEALTH CLINIC CONTRACTED DIRECTLY WITH YOUR ORGANIZAITON OR IS THE MOBILE HEALTH CLINIC ASSOCIATED WITH A FACILITY OR PROVIDER GROUP CONTRACTED WITH YOUR ORGANIZATION?**	
l. **PROVIDE THE MOBILE HEALTH CLINIC'S FIXED SCHEDUTE THAT SPECIFIES THE DATE(S) AND LOCATION(S) FOR SERVICES?**	
m. **PROVIDE ANY ADDITIONAL DETAIL FOR CONSIDERATION THAT SUPPORT YOUR ORGANIZATION'S OPTION TO UTILIZE THESE TYPES OF PROVIDERS OVER PROVIDERS IN A STANDARD PHYSICAL BUILDING LOCATION.**	
JUSTIFICATION FOR IN-HOME MEDICAL SERVICES ***Answer Table 2n – 2r if answer to 3f was "Yes"***	

TABLE 2	
n. EXPLAIN THE MEDICAL SERVICES PROVIDED IN THE BENEFICIARY'S HOME?	
o. HOW DOES THE BENEFICIARY ACCESS IN-HOME MEDICAL SERVICES? ARE THERE SPECIFIC REQUIREMENTS THE BENEFICIARY HAS TO FULFILL TO QUALIFY FOR IN-HOME VISITS?	
p. EXPLAIN THE TIMEFRAME FOR WHEN A BENEFICIARY REQUESTS THE IN-HOME MEDICAL SERVICE TO WHEN THE IN-HOME MEDICAL SERVICE IS PROVIDED.	
q. HOW DOES YOUR ORGANIZATION PROVIDE ACCESS TO A PROVIDER WHEN AN IN-PERSON VISIT IS DEEMED NECESSARY FOLLOWING AN IN-HOME VISIT?	
r. PROVIDE ANY ADDITIONAL DETAILS FOR CONSIDERATION THAT SUPPORT YOUR ORGANIZATION'S	

TABLE 2	
OPTION TO UTILIZE THESE TYPES OF PROVIDERS OVER PROVIDERS IN A STANDARD PHYSICAL BUILDING LOCATION.	

Appendix B.4 – CMS Public Data Source for HSD Exception Request

The following table listed below provides a list of acceptable CMS data sources used for review of HSD Exception Request. **Note:** The Medicare Advantage Provider Supply File is not used as a data source for purposes of the Applicant's Medicare Network Review.

HSD Specialty Type	Data Source
Allergy and Immunology Cardiology Chiropractor Dermatology Endocrinology ENT/Otolaryngology Gastroenterology General Surgery Gynecology, OB/GYN Infectious Diseases Nephrology Neurology Neurosurgery Oncology – Medical, Surgical Oncology – Radiation/Radiation Oncology Ophthalmology Orthopedic Surgery Physiatry, Rehabilitative Medicine Plastic Surgery Podiatry Primary Care Providers Psychiatry Pulmonology Rheumatology Urology	Physician Compare – Data available at: https://data.medicare.gov/data/physician-compare
HSD Specialty Type	**Data Source**
Vascular Surgery Cardiothoracic Surgery	
Acute Inpatient Hospitals Cardiac Surgery Program Cardiac Catheterization Services Critical Care Services – Intensive Care Units (ICU) Surgical Services (Outpatient or ASC) Inpatient Psychiatric Facility Services	Provider of Services – Data available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/
Outpatient Dialysis	Dialysis Facility Compare – Data available at: https://data.medicare.gov/data/dialysis-facility-compare

HSD Specialty Type	Data Source
Physical Therapy Speech Therapy Occupational Therapy	Physician Compare – Data available at: https://data.medicare.gov/data/physician-compare and National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html
Skilled Nursing Facilities	Nursing Home Compare – Data available at: https://data.medicare.gov/data/nursing-home-compare
HSD Specialty Type	Data Source
Mammography	Hospital Compare – Data available at: https://data.medicare.gov/data/hospital-compare and National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html
Orthotics & Prosthetics	Medicare Outpatient claims data, extracted from Data Extract System (DESY) – Data not available by hyperlink
Diagnostic Radiology Outpatient Infusion/Chemotherapy	National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html
HSD Specialty Type	Data Source
	and Provider of Services – Data available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/

Appendix C --Staffing Template

Complete and upload in HPMS in the MMP Supporting Files Service Area section, the Staffing Template.

Part I -- Enrollment Assumptions

1. Applicant enrollment assumptions **for pending counties only**:

Date	**Number of Enrollees Expected from pending counties**
Estimated enrollment as of January 1, 2019	
Estimated enrollment as of April 1, 2019	
Estimated enrollment as of July 1, 2019	
Estimated enrollment as of October 1, 2019	

2. In the table below, provide Applicant's enrollment case mix for current counties.

Acuity Level	**Percent of total current enrollment**

3. Does the Applicant anticipate a different case mix for the pending county (ies) from what is reported in #2 above?
   _____Yes _____No

4. If the Applicant answered question 3 as ‘YES’ please provide anticipated case mix in the table below for pending counties.

Acuity Level	Percent of projected enrollment for pending counties

Part II -- Care Management/Care Coordination Staffing

5. In the table below, provide Applicant’s existing care management/care coordination ratios.

Acuity Level	Ratio (provide ratios for overall current service area)

6. Will the existing care management/care coordination ratios be maintained for the pending counties?

   _____Yes

   _____No

7. If Applicant answered question 6 as ‘NO’, provide as part of the zip file with this completed template, a pdf document that indicates the expected care management/care coordination ratio in the pending counties and why it is different than the existing care management/care coordination ratio.

8. Will Applicant delegate any care management/care coordination staffing for the pending counties to a First Tier, Downstream, or Related Entity (FDR)?
_____Yes _____No

9. If ‘Yes’, provide the name of First Tier, Downstream, Related Entity

_____

10. Consistent with the acuity levels provided in Question 5, provide in the table below the Applicant’s expected care management/care coordination staffing **for the pending county(ies) only:**

Date	**Staffing Category by Acuity Level**	**Number of Staff Expected**
January 1, 2019	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____

Date	Staffing Category by Acuity Level	Number of Staff Expected
April 1, 2019	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
July 1, 2019	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____
	Acuity Level: _____	# FDR staff: _____ # Applicant staff: _____ # total: _____