Experience & Organization History

1. Q. In the Experience & Organization History section of the Medicare Advantage (MA) application, CMS discusses minimum enrollment requirements and the ability to waive these requirements. Can CMS provide additional information?

A. Per the instructions in the MA Application, the Centers for Medicare & Medicaid Services (CMS) recognizes that new applicants may believe they are capable of administering and managing an MA contract although they do not meet the minimum enrollment requirements. CMS also recognizes that there may be reasonable factors, such as specific populations served or geographic location, which might result in a plan having low enrollment. For example, Special Needs Plans (SNPs) may legitimately have low enrollment because of their focus on a subset of enrollees with certain medical conditions. Such organizations and new applicants may submit a request to waive enrollment requirements. For each waiver request, the applicant must provide, as an upload in the Health Plan Management System (HPMS), a statement that demonstrates to CMS’s satisfaction that the applicant is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract. Please see 42 CFR 422.514(b) for factors that CMS may consider in evaluating any waiver request. The waiver must be submitted on plan letterhead in PDF format. The applicant should upload the waiver under the Minimum Enrollment Waiver Upload Section in HPMS.
State Licensure

2. Q. Will CMS accept the certificate of authority in lieu of the MA Certification form?

A. The MA State Certification Form must be completed by a state’s Department of Insurance and uploaded in HPMS no later than the final submission for this application review cycle in HPMS. The MA State Certification Form demonstrates to CMS that the MA contract being sought by the applicant is within the scope of the license/certificate of authority of the appropriate state regulatory agency, that the organization meets solvency requirements, and that the applicant is authorized to bear risk. For additional guidance on the required MA State Certification Form, please see section 4.3 of the Application available on our website at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

3. Q. With regard to our annual state license, is a copy of our completed license renewal application or other documentation (e.g., invoice from payment of renewal fee) showing that the renewal process is being completed in a timely manner sufficient evidence of our license renewal?

A. When a State license renews and is available prior to June, the applicant must upload an executed copy of the State License Certificate.

For State license renewals that occur after June, providing documentation that clearly demonstrates that the license renewal process has commenced timely with the state will suffice, provided that an applicant also sends a copy of the renewed license to its CMS Regional Office Account Manager promptly upon issuance and no later than December 31. However, if the renewed license is received prior to the final HPMS upload for the current application review cycle, it must be uploaded.

For additional guidance on the State Licensure requirements, please refer to section 3.3 of the Application available on our website at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

4. Q. Under what situations might CMS waive State licensure requirements?

A. As established by 42 CFR 422.400(a), CMS requires that each Medicare Advantage Organization (MAO) be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (see 42 CFR 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more MA plans. The MAO is the legal entity that holds the contract with CMS. In other words, if company XYZ holds contract ID H0001, company XYZ must be licensed under State law as required by 42 CFR 422.400.

CMS considers exceptions to the State licensure for each MAO as discussed below.
- **For Provider Sponsored Organizations.** CMS may waive the State licensure requirement if the organization has applied for the most closely appropriate State license or authority to conduct business as an MA plan (see 42 CFR 422.372(a)).

- **For Direct Contract Employer/Union Sponsored Group Health Plans.** As discussed in Chapter 9, section 60.1, an employer/union applying to become an MAO solely for purposes of providing coverage to its members will not have to meet the State licensing requirements set forth at 42 CFR 422.400(a) and 42 CFR 422.503(b)(2) as a condition of being an MA organization.
Service Area

5. **Q. When should I submit an application withdrawal?**

   A. If you are requesting to remove all of the pending counties associated with an initial application or an SAE, it is considered an application withdrawal. Information on how and when to submit an application withdrawal will be provided within the Notice of Intent to Deny.

6. **Q. In what way are applicants able to modify their service area after the MA application is submitted?**

   A. For full county requests, applicants are permitted to remove full counties from a pending service area until the denial/conditional approval letter is sent to applicants. Applicants are not permitted to remove individual ZIP codes from a pending county after an application has been submitted. In other words, an applicant cannot move from a full county to a partial county following the initial application submission.

   For partial county requests, the applicant’s initial service area submission cannot be modified following the application submission. Therefore, after the application submission, applicants are not permitted to add or remove individual ZIP codes from a pending partial county. Applicants are also not permitted to move from a partial county to a full county following the initial application submission. However, the applicant may choose to drop the entire pending partial county.

7. **Q. Following the submission of an application, are applicants able to convert counties from full to partial or vice versa, or reduce or add ZIP codes to a partial county application during that same application cycle?**

   A. As discussed in question 6 above, applicants are not permitted to drop ZIP codes from pending partial or full counties after they hit final submit. Applicants are permitted to request that CMS remove pending counties (partial or full) from an application after submission, but not ZIP codes.

Comment [MS1]: Add language for county withdrawal requests
8. Q. CMS requires that “specific terms and conditions be incorporated into the Agreement between an MAO or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions.” What additional provisions are required beyond those in the CMS provider contract required provisions matrix and in the CMS administrative contract required provisions matrix?

A. The contracts must include the provisions noted in Chapter 11, section 100 of the Medicare Managed Care Manual. CMS expects that a provider agreement would also include items such as provider appeal process, specific payment arrangements, etc. CMS provides a Model Contract Amendment that applicants may use that contains the required CMS provisions for use with Administrative/Management Contracts and First Tier or Downstream Entity-Provider Contracts. This Model Contract Amendment is available under the Downloads section of the Applications page on the CMS website at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

9. Q. If we have downstream contracts, to what degree do the contracts have to be compliant per the MA Contract Amendment?

A. The required provisions must be in every level of contracts between the health plan and the individual provider offering services to the plan members, regardless of how many “layers” of contracts separate the two. Applicants should review provider contracts at every level of contracting to ensure that the contracts include the MA required contract provisions. Until an applicant is sure of a contract’s compliance, the applicant should not list that provider, or providers, on the Provider or Facility Table.

10. Q. Can you clarify whether the provider contract matrix and the contract sample matrix will be required if we are no longer required to submit the fully executed contracts?

A. CMS is not requesting a sample of provider contracts (and, therefore, the provider contract matrix) for the current application review.
Contracts for Administrative & Management Services

11. Q. Do we need to submit administrative contracts or associated matrices if we received CMS approval for a Part C initial or SAE application in the last two application cycles?

A. Applicants are not required to upload executed copies of administrative and management contracts (see section 3.9 of the CY 2016 Application Instructions available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/medicareadvantageapps/).
Application Process and Other Considerations

12. Q. If we receive an application denial and appeal that denial, should we include the affected counties in our bid?
   A. If your appeal is pending, you are required to submit a bid reflecting the counties/application under appeal.

13. Q. If we did not receive a deficiency notice/NOID, are there any additional actions that we must make?
   A. No action is needed if you do not receive a deficiency notice/NOID.

14. Q. Our MAO would like to combine two contracts into one contract. What actions need to be taken to complete this?
   A. If the two contracts are held by the same legal entity for the same product type (e.g., HMO/HMOPOS, PPO, etc.), the MAO should submit a consolidation request to CMS by April 15, 2015. CMS issued guidance on consolidation requests in an HPMS memo on February 6, 2015. This memo is titled “CMS Guidance to Medicare Advantage Organizations (MAOs) Requesting Contract Consolidations for the Same Product Types in Contract Year (CY) 2016.”

   Please note, CMS only permits the consolidation of contracts that are under the same legal entity. If the MAO seeks to combine/consolidate two contracts for the same product type that are held by separate legal entities, then the MAO should contact CMS about the change of ownership/novation process prior to requesting a contract consolidation. For more information about the change of ownership/novation process, please see Chapter 12 of the Medicare Managed Care Manual.

15. Q. If an MAO modifies a network at any point during the year, must the MAO alert CMS?
   A. MAOs who plan to make network changes that the MAO deems significant must notify CMS of the planned changes. Additionally, if an MAO has determined that a network will no longer meet published HSD standards as a result of the network changes, the MAO should notify CMS.