WHITE PAPER

Medicare Advantage Startup: Considerations and the Contract Application

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Background

In 2018, there were seven new insurers in the Medicare Advantage (MA) market and in 2019 there are 14 new insurers[1]. This compares to just over 200 insurers offering Medicare Advantage products meaning there is about 10% growth in issuers between 2018 and 2019 without considering insurers exiting the market (though those are fewer). Meanwhile, MA enrollment has been increasing since the early 2000s both in aggregate as well as a percentage of the total Medicare population going from around six million MA enrollees (15% of all Medicare) to exceeding 19 million MA enrollees (33% of all Medicare) in 2017[2] and now to over 22 million as of January 2019[3]. Given the new entrants into the market and the increasing number of Medicare beneficiaries moving into MA products, there are abundant opportunities for new entrants to make a splash in the MA market and bring valuable care to Medicare beneficiaries.

The purpose of this whitepaper is to provide prospective organizations with some insight into the general process and information about the application as they embark on starting a Medicare contract.

Why Start an MA Plan?

In a word: Opportunities. Each organization that starts a Medicare Advantage plan may have its own specific reasons to starting a Medicare plan but certainly they wouldn't have done it if there weren't opportunities. Revenue and profit is one such consideration as CMS pays carriers a monthly, risk-adjusted capitation to assume the risk of managing care for Medicare beneficiaries enrolled in MA. In addition to cash-flow implications, there is also booming growth in Medicare, which in turn presents opportunities for smaller carriers to come in and fulfill niche rolls within their communities. According to the Census Bureau[4], the aged population 65+ will increase from 49 million in 2016 to over 56 million in 2020 and over 65 million by 2025. With the growth in number of Medicare eligibles and an increase in the number of beneficiaries moving towards Medicare Advantage products[2], there are opportunities for Medicare Advantage

[1] Kaiser Family Foundation - https://www.kff.org/medicare/issue-brief/medicare-advantage-2019-spotlight-first-look/
[2] Kaiser Family Foundation - https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/
[3] CMS – January 2019 Medicare Advantage Penetration file
[4] US Census Bureau - https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

Organizations to enter the market with a quality product and be profitable along the way.

What types of entities might be interested in starting a Medicare contract? Existing provider groups, carriers in other health insurance businesses, or even brand new entities might be interested. For example, with the increasing number of insurers passing risk to their providers in the form of global risk contracts, many provider entities are developing the knowledge needed to understand the complexities of managing a Medicare population and the associated risk adjustment process that impacts revenue. For provider groups such as these, global risk contracts may be the first stepping stone to starting an MA contract. By fully integrating with the health plan, the provider group may even be able to offer better managed care than a traditional Health Maintenance Organization (HMO) could achieve which in turn creates additional business growth and profit opportunities.

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Another example might be one where an existing insurer is looking to enter into the Medicare Advantage market to diversify their risk while also leveraging their current expertise.

Where the opportunities are will depend on each individual organization giving consideration to questions surrounding their current experience managing the health of a population, what competition looks like, what types of plans they intend to offer, etc.

Once an entrant has determined that they are ready to move into managing a Medicare Advantage contract they can begin work on the next steps.

Where To Start?

Where a company starts likely depends on whether or not they have a license to sell insurance in the state in which they are looking to do business. Each state has its own unique set of application requirements but generally involves getting a Certificate of Authority (COA). All states currently subscribe to the Uniform COA application which makes the process easier if filing in multiple states.

Filing an application for a COA, among other things, generally involves submitting historical financial statements and a projection of profit and loss alongside an actuarial certification. As part of the COA application, organizations must also demonstrate that they meet the state's statutory minimum capital and surplus requirements. A link to each state's website listing out the application requirements can be found in Appendix A.

If an organization already has a license, then the first decision to make is what type of product to offer and then to do a feasibility study taking into account the organization's networks, contracting, expected population, etc.

What Type of Plan to Offer?

CMS contracts with Medicare Advantage Organizations offering a variety of product types. One of the first decisions that needs to be made is what type of plan(s) the organization wishes to offer. The following is a list of plan types that can be offered under a new Medicare contract:

- Coordinated Care Plans (CCP)
  - Health Maintenance Organizations (HMOs)
  - Local Preferred Provider Organizations (LPPOs)
  - Regional Preferred Provider Organizations (RPPOs)
- Private Fee-For-Service (PFFS) plans
- Special Needs Plans (SNPs)
- Medical Savings Account (MSA) plans
- Employer Group Waiver plans (EGWPs)

Following is a brief discussion of each of the plan types:

CCP

If offering a CCP, there are benefits and drawbacks to offering either an HMO or a PPO product. HMOs generally have richer benefits but members only have coverage at network providers. PPO plans on the other hand generally have higher cost-sharing than an HMO plan but members also have coverage (with additional cost-sharing) at non-network providers. For the MAO, an HMO product may also provide leverage for better contracting with network providers versus a PPO product.

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PFFS

PFFS plans offer the standard Medicare FFS benefit and may include some reduced cost-sharing or supplemental benefits as well. This may not be a good choice for a new MAO looking to enter the MA market as these plans generally do not have significant managed care utilization savings, offer as competitive benefits, or see as high membership growth as HMO or PPO products. These plans have all but disappeared due abnormally high costs and consumer complaints which in turn prompted regulatory pressure to offer network-based products.

SNP

Special Needs Plans (SNPs) are options that are not offered to the general public. There are three different types of SNPs: C-SNPS, I-SNPs and D-SNPs. Chronic Conditions SNPs (C-SNPs) are plans tailored to a specific population such as Medicare beneficiaries with diabetes, COPD, or CHF. Institutional SNPs (I-SNPs) are plans tailored to Medicare beneficiaries who require some form of long term care. Lastly, Dual Eligible SNPS (D-SNPs) are tailored toward members who are also eligible for Medicaid. Populations enrolled in these plans can have large amounts of revenue and profit potential if managed well but can also be high risk to the organization if poorly managed.

MSA

A Medicare Medical Savings Account plan (MSA) combines a medical savings account with a high-deductible health plan. Beneficiaries with these plans use the funds from their MSA accounts to help with health care costs until they reach their high deductible where the plan starts covering benefits as they become more catastrophic for the individual beneficiary. These plans do not offer as much opportunities for managed care as they are a type of consumer-directed health plan. They also have not experienced much membership growth compared to HMO or PPO products.

EGWP

The last option, EGWPs (Also known as Employer Group Waiver Plans), are also not offered to the general population. These plans

are offered to retiree Medicare beneficiaries through their former employer. This may be a viable option for a new MAO that also has a commercial line of business.

With the product offerings above, a new entrant must also decide whether to offer plans with only medical benefits (Part C – known as MA Only plans), only pharmacy benefits (Part D – known as PDPs) or plans with both (known as MA-PDs) in their product offerings. It's important to note though that CMS requires that at least one plan under an MA contract offer a Part D (pharmacy) benefit.

Feasibility Study

A company that is considering to start an MA product must assess in great detail their readiness as an organization. An analysis must be performed to see if the plan is viable long term. This analysis should begin around two years prior to the projected start date of the product. Some of the key considerations for this analysis are below:

- What type of plan will be offered? *Will the new product be an HMO, PPO, or some other product? Will it be a special needs plan? Will there be a product offering for employer groups? How many products will be offered?*
- Assessment of the proposed market – *What service area (counties) are being considered? Can sufficient market-share be acquired to achieve profitability? Are the Part C benchmarks favorable relative to anticipated costs?*
- Provider Network – *Does the network meet adequacy requirements? Will new partnerships need to be formed? What level of managed care can be provided with the proposed network? Are network providers knowledgeable of coding practices for Medicare risk scoring? Will network providers cooperate with initiatives to enhance star ratings?*
- Contracting Arrangements – *will contract be based on Fee-For-Service costs or will at-risk global contracts be offered to providers? In what fashion will risk be assumed?*
- Product structure – *can competitive benefits be offered while remaining profitable? How competitive do benefits need to be to achieve goals?*
- Administrative Expenses – *What will overhead costs be in the first few years? How much marketing will be required to capture market share and what costs will be associated with that? Can expenses be spread over other lines of business? Is it necessary to contract with a Third Party Administrator (TPA)? Is there a contract with a Pharmacy Benefit Manager (PBM) in the works?*

Perhaps the most critical point for a company planning to create a product is to be brutally honest with themselves concerning the results of the feasibility study.

- Marketing Strategy – *What specific populations will be targeted with marketing efforts? How competitive will benefits be relative to the competition?*
- Capital Requirements – *Do we have sufficient capital to take on the risk of a Medicare contract? Are we able to potentially run at a loss for the first few years while we gain market share? Do we have a solution to raise additional capital if required?*

Perhaps the most critical point for a company planning to create a product is to be brutally honest with themselves concerning the results of the feasibility study. The assumptions baked into the analysis should be appropriately conservative, but also realistic. The company may feel the need to tweak these assumptions to make the results of the study more favorable, but in actuality they should either abandon the project or reassess the strategy (different service area, product type, etc.) if the assumptions are not realistic.

If the results of the study are favorable (and the plan has already obtained an HMO license), the next step is to start developing the network and to start the Medicare application process.

Developing Your Network

In addition to the feasibility study, MAOs should make sure that they have an adequate network in place. CMS closely monitors compliance with network adequacy requirements and a new or service area expansion application is a trigger for a review of the MAO's network by CMS. However, only an attestation is required at the time of the application submission and a full review is conducted following the Medicare bid submission in June preceding the contract year. Beginning in contract year 2019, CMS has removed language from the guidance that it would deny applications that have network deficiencies and now may instead suppress deficient plans in Medicare Plan finder until those deficiencies are resolved. In addition, compliance actions may be taken against the MAO if the network remains deficient. CMS publishes a document titled Medicare Advantage Network Adequacy Criteria Guidance that helps MAOs assess their current networks.

CMS currently measures 27 provider specialty types and 14 facility specialty types to assess adequacy in each service area (as of the 2019 Network Adequacy Guidance)

Below is some general information regarding Medicare network adequacy requirements:

- Network adequacy is assessed at the county level.
- Two main components are required – Quantity of providers and Time/Distance to providers.
- CMS currently measures 27 provider specialty types and 14 facility specialty types to assess adequacy in each service area (as of the 2019 Network Adequacy Guidance).
- MAOs must contract with enough providers and facilities depending on MA penetration and population density. The minimum ultimately varies by county.[5]
- The provider network must be structured such that 90% of beneficiaries have access to at least one provider/facility for each specialty type within published time and distance standards. Note that time and distance requirements are not bound by county or state boundaries.
- Both a provider and facility Health Service Delivery (HSD) Table must be submitted as a demonstration of network adequacy.

CMS uses a formula to determine how many of each provider type is required to meet network adequacy:

[5] An example of each county designation type is shown in Appendix C from CMS's 2018 HSD Reference File.

1. First, calculate the 95th %-ile of MA penetration percentage among CCPs and PFFS plans given the county size.
2. Apply the answer from (1) to the total MA penetration in the county to determine the expected number of beneficiaries served by the plan.
3. Multiply the answer from (2) by the provider ratio for each specialty type to determine the minimum number of providers for each specialty required in the network.
4. The calculation above is similar for inpatient facilities except that CMS considers hospital beds available as opposed to number of inpatient facilities available. MAOs otherwise are generally only required to contract with one of each of the other facility types (depending on the time/distance measure).

A sample of the calculation (taken from the guidance) is shown below in Table 1

assigned after the Notice of Intent to Apply (NOIA) is submitted.

Lastly, exceptions can be made through an exception request but these are generally limited to the following circumstances:

- The existing provider/facility landscape does not enable the MAO to meet network adequacy in a given county
- The MAO has contracted with providers/facilities that may be outside of the distance criteria but provide care consistent with or better than original Medicare.

Table 1
Provider Calculation Example

County	Baldwin, AL
County Type	Metro
Total Beneficiaries	48,607
95th %-ile (Metro)	0.127
Beneficiaries Required to Cover	(48,607*0.127) = 6,162 Beneficiaries
Specialty Type	Primary Care (PCP)
Min Provider Ratio (PCP)	1.67/1000
Min # of Providers (PCP)	(1.67/1000)*6,162 = 10.29 = 11 Providers

As an additional resource, CMS also publishes a provider and facility supply file on their website to identify all Medicare providers and facilities at the national level.

Once assigned a contract the MAO can test their networks by uploading their HSDs in the online portal Health Plan Management System (HPMS). Note that a contract number is

Medicare Application Timeline

Starting a new Medicare Advantage contract is a process that may span two years before the initial contract start date. Table 2 below shows CMS's timeline for submitting an application for a new Medicare contract for the 2020 contract year. This is largely consistent from year to year.

Table 2 Application and Bid Review Process*	
Date	**Milestone**
November 14, 2018	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 3, 2018	CMS User ID form due to CMS
January 9, 2019	Final Applications Posted by CMS
January 25, 2019	Deadline for NOIA form submission to CMS
February 13, 2019	Completed Applications due to CMS
April 2019	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS.
May 3, 2019	PBP/BPT Upload Module available in HPMS
May 14, 2019	Release of CY 2019 Formulary Submission Module.
June 3, 2019	Bids due to CMS..
Late August 2019	CMS completes review and approval of bid data.
September 2019	CMS executes MA and MA-PD contracts with organizations whose bids are approved and who otherwise meet CMS requirements.
Mid October 2019	Annual Coordinated Election Period begins for CY 2019.

*Note: All dates listed above are subject to change

As a first step in submitting the application, all organizations interested in offering a new MA product or expanding the service area of an existing product must complete a Notice of Intent to Apply (NOIA). The deadline to inform CMS of intent to apply is typically towards the end of January each year though CMS encourages the NOIA to be submitted as early as mid-November of the year prior to bidding. The NOIA is nonbinding and is not a commitment to complete a bid or execute a contract with CMS but it is required in order to bid for a new organization. At the time the NOIA is submitted, a pending contract number is provided for use throughout the application process.

The application is generally released in January and due to CMS in February. CMS states that applicants may seek to protect their information from disclosure under the Freedom of Information Act (FOIA) by claiming that that FOIA Exemption 4 applies. This should be followed-up with an explanation and a label of "confidential" or "proprietary" on the information in question.

After the application is submitted, the preparation of plan bids begins. MAOs submit bids to CMS estimating the cost to the MAO of assuming the risk of a Medicare beneficiary. The bid is the basis for which MAOs are compensated. Many plan sponsors begin this process in February and March. Once the final rate notice is released in early April, plans can begin to develop bids with actual benchmarks and other information from the announcement.

Final bids must be uploaded to HPMS by the first Monday in June. Following this bid submission, plan sponsors' bids then undergo a review process that generally concludes by the end of July. CMS releases the National Average Bid in early August at which point plan sponsors may choose to make minor changes to the bids to get back to the target premium. This process lasts a week and once these bids are submitted, there are generally no further changes.

Lastly, after the bid process is concluded, contracts are executed with CMS in September.

An organization can choose whether or not to continue with a MA contract at any point in the process prior to executing the contract with CMS. CMS publishes instructions for withdrawing or otherwise modifying a pending application. In the event that an application is denied, organizations may appeal within 15 days and have until September 1st to receive a favorable determination in order to use qualify for the a contract in the next calendar year.

Medicare Application Requirements

The Medicare application contains up to twenty-five attestations that need to be made depending on the organization's history, experience, and what type of plan that is intended to be offered. Appendix B includes a table of all of the required attestations depending on the product type being offered. Brief descriptions of a few of the higher profile attestations are presented below. Note that they are numbered according to the numbering of the attestations shown in Appendix B.

3.1 - Experience and Organization History – The purpose of this section is to describe the MAO's structure and to demonstrate whether the MAO meets the minimum enrollment requirements of 5,000 members (1,500 in rural areas). If the enrollment requirement is not met, a waiver must be requested with the application.

3.2 - Administrative Management – This attestation is to ensure that MAOs have the appropriate resources to manage administrative issues associated with Medicare Beneficiaries. The applicant agrees to adhere to all applicable Administrative requirements including but not limited to 42 CFR 422.503(b)(4).

3.3 - State Licensure – The MAO attests that they are licensed under state law as a risk bearing entity to offer health insurance or health coverage in each state being proposed. A full list of links for HMO applications is provided for each state in Appendix A.

3.7 - Fiscal Soundness – This attestation requires that initial applicants with prior experience upload their most recent audited financial statement. Those without prior experience must upload the financial information submitted for the state license.

3.8 - Service Area – The purpose of this section is to clearly define what counties are included in the service area, if there are any partial counties, to attest that all services covered under traditional Medicare will be covered, and to attest that the MAO will have a contracted network that meets CMS's requirements.

Note that CMS requires at least 14 months of experience to consider a service area expansion. Therefore, the service area decided on for a new applicant is locked for two years.

In regards to partial counties, while CMS encourages organizations to cover full counties, there is allowance for the possibility of partial county coverage. In order to apply for this option, plan sponsors must demonstrate the following three criteria:

- Necessary - It is not possible to have a network that serves the entire county.
- Non-Discriminatory - The population in the covered portion of the county is similar to the population in the non-covered portion.
- In the best interest of beneficiaries in the pending service area.

3.10 Contracts for Administrative and Management Services – This is to confirm whether the MAO intends to outsource any part of the operations of the contract and to confirm that any contractors comply with all Medicare laws and regulations.

3.11 Quality Improvement Program – All applicants must demonstrate that a Quality Improvement (QI) program is in place. The program is to ensure that MAOs have the infrastructure to increase quality, performance, and efficiency of the Medicare program.

3.12 Marketing – Applicant agrees to adhere to all marketing requirements in 422.2260 through 422.2276 and the Medicare Marketing Guidelines.

3.15 Claims – Applicant must properly date and process all claims per CMS instructions. This includes prompt denial/acceptance of claims and having a system to receiving and promptly processing claims.

Disclaimer – This is not intended to be a replacement of the guidance issued by CMS or the guidance and instruction in 42 CFR 422 and interested parties should refer to those sources for additional information. This section is intended to highlight some of the key filing requirements for new entrants into Medicare for a Part C benefit. Many submission requirements were not shown and are included in Appendix B. Organizations should also be aware that there are separate applications that must also be submitted for Part D as well as SNP plans.

Conclusion

The task of starting up a new contract may be somewhat daunting and prospective MAOs should start the process early to fully vet out the hurdles and challenges they may face. The discussion above is not exhaustive in terms of all the considerations and filing requirements that a plan must consider when starting a new Medicare contract.

Wakely has ample experience helping new participants navigate various parts of the process. Contact Wakely if your organization is interested in starting a Medicare contract.

Please contact Robert Lang at Robert.Lang@wakely.com with any questions or to follow up on any of the concepts presented here.

Appendix A	
State	**Certificate of Authority/Company Licensing Information**
Alabama,AL	https://www.alabamapublichealth.gov/mcc/hmo-requirements.html
Alaska,AK	https://www.commerce.alaska.gov/web/portals/11/pub/Companies/Forms/08-251HMO.pdf
Arizona,AZ	https://insurance.az.gov/insurers/licensingregistration/insurer
Arkansas,AR	https://www.insurance.arkansas.gov/pages/industry-regulation/finance/health-maintenance-organizations/
California,CA	http://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/certificate-of-authority/index.cfm
Colorado,CO	https://www.colorado.gov/pacific/dora/apply-insurance-line-business-colorado
Connecticut,CT	https://www.ct.gov/cid/cwp/view.asp?a=1261&Q=421768
Delaware,DE	https://insurance.delaware.gov/divisions/berg/ucaa/
Florida,FL	https://www.floir.com/siteDocuments/Applications/HMO.pdf
Georgia,GA	https://www.oci.ga.gov/Insurers/Application%20Process.aspx
Hawaii,HI	http://cca.hawaii.gov/ins/insurers/insurance_company_license/certificate_of_authority/
Idaho,ID	https://doi.idaho.gov/Company/Admissions/default
Illinois,IL	http://insurance.illinois.gov/Company/CompanyMain.html#collapse03
Indiana,IN	https://www.in.gov/idoi/2405.htm
Iowa,IA	https://iid.iowa.gov/insurers-entering-the-iowa-market
Kansas,KS	https://www.ksinsurance.org/company/company-licensing.php
Kentucky,KY	http://insurance.ky.gov/static_info.aspx?static_id=3&Div_id=6
Louisiana,LA	https://www.ldi.la.gov/docs/default-source/documents/licensing/companies/hmo-application.pdf?sfvrsn=1d77152_15
Maine,ME	https://www.maine.gov/pfr/insurance/regulated/insurance_companies/insurer/index.html
Maryland,MD	http://www.mdinsurance.state.md.us/Insurer/Pages/HealthMaintenanceOrganizations.aspx
Massachusetts,MA	https://www.mass.gov/service-details/instructions-to-apply-for-authority-to-transact-insurance-business-in-massachusetts
Michigan,MI	https://www.michigan.gov/documents/cis_ofis_hmo_app_24381_7.pdf
Minnesota,MN	https://mn.gov/elicense/a-z/?id=1083-230877#/list/appId//filterType//filterValue//page/1/sort//order/
Mississippi,MS	https://www.mid.ms.gov/companies/company-licensing.aspx
Missouri,MO	https://insurance.mo.gov/industry/filings/admissions/index.php
Montana,MT	https://csimt.gov/insurance/examinations/
Nebraska,NE	https://doi.nebraska.gov/insurers/company-admissionslicensingregistration
Nevada,NV	(Search for Health Maintenance Org) http://doi.nv.gov/Insurers/Company-Admissions/
New Hampshire,NH	https://www.nh.gov/insurance/companies/applications/foreign.htm
New Jersey,NJ	https://www.nj.gov/dobi/division_insurance/managedcare/mcapps.htm#hmo

Appendix A (continued)	
State	**Certificate of Authority/Company Licensing Information**
New Mexico,NM	https://www.osi.state.nm.us/CompanyLicensing/index.aspx
New York,NY	https://www.dfs.ny.gov/insurance/insure_app.htm
North Carolina,NC	http://www.ncdoi.com/LH/Licensing,_Renewals_and_Other_-_HMO.aspx#Certificate
North Dakota,ND	https://www.nd.gov/ndins/Companies/companylicensing/uniformapplicationUCAA/
Ohio,OH	https://www.insurance.ohio.gov/Company/pages/CAA_COA.aspx
Oklahoma,OK	https://www.ok.gov/oid/Regulated_Entities/Financial/Forms.html
Oregon,OR	https://dfr.oregon.gov/business/reg/insurer/Pages/forms-apps.aspx
Pennsylvania,PA	https://www.insurance.pa.gov/Companies/DoingBusiness/Pages/HMO.aspx
Rhode Island,RI	http://www.dbr.ri.gov/documents/divisions/insurance/foreign/Application-LHorPC(Rev).pdf
South Carolina,SC	https://doi.sc.gov/534/Health-Maintenance-Organization-HMO
South Dakota,SD	https://dlr.sd.gov/insurance/companies/company_licensing.aspx
Tennessee,TN	https://www.tn.gov/commerce/insurance/types-of-insurance-companies/health-insurance-company.html
Texas,TX	https://www.tdi.texas.gov/insurer/clhmo.html
Utah,UT	https://insurance.utah.gov/licensee/insurers/company-licensing/new-applications
Vermont,VT	http://www.dfr.vermont.gov/sites/default/files/HMO_Information.pdf
Virginia,VA	https://www.scc.virginia.gov/PublicForms/561/hmo.pdf
Washington,WA	https://www.insurance.wa.gov/health-carrier-admissions
West Virginia,WV	https://www.wvinsurance.gov/company/Forms/Health-Maintenance-Organization
Wisconsin,WI	(Search for Health Maintenance Organizations) https://oci.wi.gov/Pages/Companies/AppPackets.aspx
Wyoming,WY	https://sites.google.com/a/wyo.gov/doi/industry/health-insurers/company-licensing-information

Appendix B					
Attestation Section Name	Section #	Initial Applicants			
		CCP	PFFS	RPPO	MSA
Experience and Organizational History	3.1	X	X	X	X
Administrative Management	3.2	X	X	X	X
State Licensure	3.3	X	X	X	X
Program Integrity	3.4	X	X	X	X
Compliance Plan	3.5	X	X	X	X
Key Management Staff	3.6	X	X	X	X
Fiscal Soundness	3.7	X	X	X	X
Service Area	3.8	X	X	X	X
CMS Provider Participation Contracts and Agreements	3.9	X	X	X	X
Contracts for Administrative and Management Services	3.1	X	X	X	X
Quality Improvement Program	3.11	X	X	X	X
Marketing	3.12	X	X	X	X
Eligibility, Enrollment, and Disenrollment	3.13	X	X	X	X
Working Aged Membership	3.14	X	X	X	X
Claims	3.15	X	X	X	X
Communication between MAO and CMS	3.16	X	X	X	X
Grievances	3.17	X	X	X	X
Organization Determination and Appeals	3.18	X	X	X	X
Health Insurance Portability and Accountability Act of 1966 (HIPAA)	3.19	X	X	X	X
Continuation Area	3.20	X	X	X	X
Part C Application Certification	3.21	X	X	X	X
Access to Services	3.22		X		
Claims Processing	3.23		X		X
Payment Provisions	3.24		X		X
General Administration/Management	3.25				X
Past Performance	3.26	X	X	X	X

Appendix C1 Minimum Number of Providers Required Examples					
City, State	Calhoun, AR	Bradley, AR	Autauga, AL	Baldwin, AL	Miami-Dade, FL
County Designation	CEAC	Rural	Micro	Metro	Large Metro
Total Beneficiaries	1,225	2,553	10,529	48,607	449,425
Beneficiaries Required to Cover	187	325	1,247	6,162	33,047
Primary Care (see Notes)	1	1	2	11	56
Allergy and Immunology	1	1	1	1	2
Cardiology	1	1	1	2	9
Chiropractor	1	1	1	1	4
Dermatology	1	1	1	1	6
Endocrinology	1	1	1	1	2
ENT/Otolaryngology	1	1	1	1	2
Gastroenterology	1	1	1	1	4
General Surgery	1	1	1	2	10
Gynecology, OB/GYN	1	1	1	1	2
Infectious Diseases	1	1	1	1	1
Nephrology	1	1	1	1	3
Neurology	1	1	1	1	4
Neurosurgery	1	1	1	1	1
Oncology - Medical, Surgical	1	1	1	2	7
Oncology - Radiation/ Radiation Oncology	1	1	1	1	2
Ophthalmology	1	1	1	2	8
Orthopedic Surgery	1	1	1	2	7
Physiatry, Rehabilitative Medicine (see Notes)	1	1	1	1	2
Plastic Surgery	1	1	1	1	1
Podiatry	1	1	1	2	7
Psychiatry	1	1	1	1	5
Pulmonology	1	1	1	1	5
Rheumatology	1	1	1	1	3
Urology	1	1	1	1	4
Vascular Surgery	1	1	1	1	1
Cardiothoracic Surgery (see Notes)	1	1	1	1	1

Appendix C2 Minimum Number of Facilities Required Examples					
City, State	Calhoun, AR	Bradley, AR	Autauga, AL	Baldwin, AL	Miami-Dade, FL
County Designation	CEAC	Rural	Micro	Metro	Large Metro
Total Beneficiaries	1,225	2,553	10,529	48,607	449,425
Beneficiaries Required to Cover	187	325	1,247	6,162	33,047
Acute Inpatient Hospital Beds	3	4	16	76	404
Cardiac Surgery Program	1	1	1	1	1
Cardiac Catheterization Services	1	1	1	1	1
Critical Care Services/Intensive Care Units	1	1	1	1	1
Outpatient Dialysis	1	1	1	1	1
Surgical Services (Outpatient or ASC)	1	1	1	1	1
Skilled Nursing Facilities	1	1	1	1	1
Diagnostic Radiology	1	1	1	1	1
Mammography	1	1	1	1	1
Physical Therapy (See Notes)	1	1	1	1	1
Occupational Therapy (See Notes)	1	1	1	1	1
Speech Therapy (See Notes)	1	1	1	1	1
Inpatient Psychiatric Facility Services	1	1	1	1	1
Outpatient Infusion/Chemotherapy	1	1	1	1	1