CMS Medicare Manual System
Pub. 100-16 Managed Care

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

Transmittal 21 **Date: April 4, 2003**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
11	Table of Contents 20.1 140		

Red italicized font identifies new material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 4, 2003
IMPLEMENTATION DATE: April 4, 2003.

Table of Contents - Updated name for section 140 to Special Rules for Religious and Fraternal Benefit (RFB) Societies

Section 20.1 - Conditions for Entering an M+C Contract:

Third solid disc bullet - sixth open circular bullet - defined and replaced "compliance plan" more specifically by stating "commitment to compliance, integrity, and ethical values as demonstrated by" (the bulleted points that follow).

Fourth square bullet - added phrase opening communications for employees or contractors to ask questions and report potential or actual noncompliance without fear of reprisal.

Sixth square bullet - further defined internal monitoring and auditing to include a risk assessment to identify and analyze risks associated with noncompliance.

Section 140 - Special Rules for Religious and Fraternal Benefit (RFB) Societies - corrected section heading for definition of the RFB acronym to Religious and Fraternal Benefit

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Chapter 11 - Medicare Plus Choice Contract Requirements

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

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20.1 - Conditions for Entering an M+C Contract - (Rev. 21, 04-04-03)

Organizations that seek to operate as an M+C organization must enter into a contract with CMS. A single M+C contract may cover more than one M+C plan offered by the contracting M+C organization. An applicant entity, however, must meet certain requirements before CMS can consider entering into a contract with the organization.

- The applicant must document that it is authorized under State law in the requested service area (SA) to operate as a risk bearing entity that may offer health benefits. If the applicant offers a continuation area in another (host) State, then the applicant must show that it is authorized by the host State to offer health benefits. As such, before an applicant entity may apply to become a Medicare+Choice organization, it must first submit a completed Certification Form to CMS. Existing §1876 cost contractors do not have to complete this form. Please note that the revised HMO, PPO, and State Licensed Provider Sponsored Organization (PSO) application includes this form;

- The applicant entity must be licensed (or if the State does not license such entities, hold a certificate of authority/operation) as a risk-bearing entity in the

State in which it wishes to operate as an M+C organization. The law does, however, allow for a waiver of this requirement for Federally-waivered PSOs under certain circumstances.

- The applicant must meet certain minimum enrollment requirements. The applicant entity must have at least 5,000 (or 1,500 if it is a Federally-waivered PSO) individuals receiving health benefits from the organization or at least 1,500 (or 500 if it is a PSO) individuals receiving benefits in a rural area. CMS has the authority to waive the minimum enrollment requirements for the first 3 contract years;

- An M+C organization must demonstrate certain administrative and managerial capabilities. They include:

    - A policy making body that exercises oversight and control over the M+C organizations policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees;

    - Personnel and systems sufficient for the M+C organization to organize, plan, control, and evaluate financial and marketing activities, the furnishing of services, the quality assurance program, and the administrative and management aspects of the organization;

    - At a minimum, an executive manager whose appointment and removal are under the control of the policy making body;

    - A fidelity bond or bonds procured and maintained by the M+C organization, in an amount fixed by its policy making body but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds (The bond may have reasonable deductibles, based upon the financial strength of the M+C organization.)

    - Insurance policies or other arrangements, secured and maintained by the M+C organization and approved by CMS to insure the M+C organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks; and

    - A *commitment to compliance, integrity, and ethical values as demonstrated* by the following:

        - Written policies, procedures, and standards of conduct that articulate the organizations commitment to comply with all applicable Federal and State standards;

        - The designation of a compliance officer and compliance committee that are accountable to senior management;

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

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140 - Special Rules for *Religious & Fraternal Benefit* (RFB) Societies - (Rev. 21, 04-04-03)

In order to participate as an M+C organization, an RFB society may not impose any limitation on membership based on any factor related to health status and must offer in addition to the M+C RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who are not entitled to receive benefits from the Medicare program.