



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services

---

**Medicare+Choice (M+C)**  
**Plan Split Based on Provider Group**  
**(Provider-Specific Plan)**  
**Proposal**

**(Name of Organization)**

**(Contract Number)**

**(Address)**

**(Contact Person)**

**(Telephone Number)**

**(Date)**

*Note: This provider-specific plan proposal may be submitted during the renewal process (if the proposal is received on or before August 1) or when requesting a new mid-year plan that is split based on provider group.*

*Current M+C Organizations that want to offer a new M+C plan type, e.g. Private Fee-for-Service plan or PPO plan, must submit a full M+C application to CMS.*

## **I. General Information**

Recognizing that Medicare + Choice Organizations (M+COs) may incur higher costs by maintaining provider contracts with certain provider groups, CMS will allow M+COs to establish provider-specific M+C plans.

For purposes of these instructions, CMS defines a provider-specific plan as a M+C plan that limits plan members to a subset of the contracted providers located within the plan's service area. Also referred to as the M+C *plan split based on provider group*, two or more CY 2 plans may be created from one CY 1 plan with membership determined by provider choice. Examples of such arrangements include, but are not limited to:

Scenario: An M+CO contracts with medical groups A, B, and C and offers M+C Plan X.

- M+C Plan X is split into M+C Plan X (renewal plan) and M+C Plan Y (new plan) based on provider choice. Members of Plan X may access care from Medical Groups A, B, and C. Members of Plan Y may only access care from Medical Group A. *In this scenario, Plan Y is a provider-specific plan.*
- M+C Plan X is split into M+C Plan X (renewal plan) and M+C Plan Y (new plan) based on provider choice. Members of Plan X may access care from Medical Groups A, B, and C. Members of Plan Y may only access care from Medical Groups A and B. *In this scenario, Plan Y is a provider-specific plan.*
- M+C Plan X is split into M+C Plan X (renewal plan) and M+C Plan Y (new plan) based on provider choice. Members of Plan X may only access care from Medical Groups A and B. Members of Plan Y may only access care from Medical Group C. *In this scenario, both Plan X and Plan Y are provider-specific plans.*

## **II. Enrollment Procedures**

*(During the Renewal Process)*

The M+CO must offer beneficiaries not in the renewal plan passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.

**III. Beneficiary Notification**

*(During the Renewal Process)*

Beneficiaries continuing in the renewal plan receive the regular Annual Notice of Coverage (ANOC). Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.

**Note:** *The M+CO is responsible for notifying CMS of significant changes to plan networks (e.g. a provider group continues to offer services to the current plan members but now also provides services to another plan; a provider group no longer contracts with the M+CO; a provider group switches exclusively from one network to another).*

**IV. Format Requirements**

M+COs that wish to offer provider-specific plans should submit the following information as part of its proposal:

1	Narrative that Includes: a) Description of the proposed plans b) Explanation of how the limited provider networks will meet access and availability standards c) Explanation of how the organization will administer the provider limitations d) Explanation of what types of providers will serve both plans (e.g. Home Health) e) Intentions to passively enroll members from current plan to the provider-specific plan and the resulting member impact ( <b>Note: M+COs are not allowed to passively enroll members for new mid-year provider-specific plans. Members can only be passively enrolled during the renewal process.</b> ) f) Reasoning/justification for the passive enrollment proposal (if applicable)	
2	Exhibit A – Listings of providers (PCPs, Specialists, Hospitals, and SNFs), specialty, location, hospital privileges, group association, plan assignments; and breakdown of current plan membership and proposed plan membership	
3	Exhibit B – Maps showing the geographic service areas of the proposed provider-specific plans as well as the organization’s other plans that overlap or are in close proximity to the provider-specific service area	
4	Exhibit C – Maps showing the location of each provider that is included in each plan’s provider network	
5	Exhibit D – Maps showing member locations	

In addition to the above requirements, M+COs that wish to offer **new mid-year provider-specific plans** must include the following in its narrative description of the proposed plan(s): (1) the number of members assigned to providers in the current plan; (2) the number of members that will lose their PCP due to the new mid-year provider-specific plan; and (3) a description of how members will be reassigned to new PCPs.

**V. Submission Requirements**

M+COs must submit their requests to the appropriate CMS Regional Office with a copy to the CMS Central Office no later than August 1<sup>st</sup>. CMS will review these requests on a case-by-case basis and make its determination based upon information submitted as part of the proposal. Provider specific plan proposals received on or before the August 1 deadline and approved by CMS must have a January 1 effective date. Proposals received after this date and approved by CMS will have an effective date no earlier than February 1 and no later than September 1.

After CMS approves the provider-specific plan proposal, the M+CO must submit to the Regional Office the following marketing materials no later than 45 days prior to the effective date of the provider specific plan:

1	Provider Directory	
2	All Member Correspondence Relating to the Provider-Specific Plan	
3	Summary of Benefits	
4	Annual Notice of Change	
5	Evidence of Coverage	

*Questions relating to the provider specific plan proposal should be directed to the appropriate CMS Regional Office.*