
CMS Manual System

Pub. 100-16 Medicare Managed Care

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

Transmittal 124

Date: November 10, 2016

SUBJECT: **Update of Chapter 1 of the Managed Care Manual**

I. SUMMARY OF CHANGES: The entire chapter was reorganized. Content was updated reflecting changes in policy in the last 3 years.

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 10, 2016

IMPLEMENTATION DATE: November 10, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)

(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Entire Chapter

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

*Unless otherwise specified, the effective date is the date of service.

**Medicare Managed Care Manual
Chapter 1 - General Provisions**

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(Rev.124, 11-10-16)**

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10 – Legislative History

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) established a new Part C of the Medicare program, known then as the Medicare+Choice (M+C) program, effective January 1999. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including both traditional managed care plans (such as those offered by Health Maintenance Organizations (HMOs) under §1876 of the Social Security Act) and new options that were not previously authorized. Four types of M+C plans were authorized under the new Part C of Medicare:

- Coordinated care plans (CCPs), including:
 - HMOs (with or without Point-of-Service (POS) options);
 - Provider Sponsored Organizations (PSOs); and
 - Preferred Provider Organizations (PPOs).
- Medicare Medical Savings Account (MSA) plans;
- Private Fee-for-Service (PFFS) plans; and
- Religious Fraternal Brotherhood Societies (RFB).

The Part C program of Medicare was renamed the Medicare Advantage (MA) Program pursuant to Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108-173), which was enacted on December 8, 2003. The MMA updated and improved the choice of plans for beneficiaries under MA, and changed the way benefits are established and payments are made. Under the MMA, beneficiaries may choose from additional plan options, including regional PPO (RPPO) plans and special needs plans (SNPs). Title I of the MMA further established the Medicare prescription drug benefit (Part D) program, and amended the MA program to allow, and in some cases require, MA plans to offer prescription drug coverage. More information about prescription drug requirements can be found in the Medicare Prescription Drug Benefit Manual at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html> page.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) (Public Law 110-275) was enacted, revising and amending statutory provisions governing the MA and Part D programs. Among these were provisions that established new rules for PFFS plans, SNPs, and Section 1876 cost plans.

In 2010, the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act (Public Law 111-152) were enacted and are collectively referred to as the Affordable Care Act (ACA). The ACA includes significant reforms to both the

private health insurance industry and the Medicare and Medicaid programs. Provisions in the ACA concerning the MA and Part D programs largely focus on beneficiary protections, MA payments, and simplification of MA and Part D program processes.

CMS implemented the MA and Part D provisions specified in the ACA through regulations at 42 CFR 422 and 423.

20 - Types of Medicare Advantage (MA) Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

20.1- Overview of MA Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

Terms in this chapter follow the definitions at § 422.2.

There are three basic types of MA plans: CCPs (Section 20.2); MSA plans (Section 20.3); and PFFS plans (Section 20.4).

Two other types of MA plans characterized by special enrollment are the RFB societies which are affiliated with a church and may only enroll RFB members (Section 30.1) and Part B-only plans which restrict enrollment to beneficiaries who only have Part B of original Medicare (Section 30.2).

20.2 - Coordinated Care Plans (CCPs)

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

As defined at 42 CFR 422.4(a)(1), a CCP is a plan that includes a network of providers that are under contract or arrangement with the MA organization to deliver the benefit package approved by CMS. A CCP must at least (i) furnish all Part A and Part B services (except for hospice) (42 CFR 422.101(a)); (ii) conduct quality improvement activities (42 CFR 422.152(a)–(b)); (iii) provide sufficient access, as defined by CMS, to services including continuity of care (42 CFR 422.112(a)–(b)); and (iv) disclose required information about benefits and costs to enrollees (42 CFR 422.111(b)(2)).

CCPs may use mechanisms to control enrollee utilization of services. Mechanisms may include requiring referrals from a gatekeeper (usually the enrollee's primary care provider (PCP)) or prior authorization for an enrollee to receive certain covered services (42 CFR 422.4(a)(1)(ii)).

20.2.1- Health Maintenance Organizations (HMOs)

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

HMO - An HMO is generally the most restrictive of the CCP types. HMOs may control enrollees' utilization of services by requiring enrollees to go through a gatekeeper, usually the enrollees' PCP, to obtain referrals for services the PCP does not furnish and to obtain all services from network providers (42 CFR 417.448(a)).

HMO-POS - Some HMOs offer coverage of certain specified plan-covered services outside of the plan network. Offering that out-of-network access to some covered services requires that the HMO offer a point-of-service (POS) supplemental benefit and may also require the HMO to obtain state licensure to offer an HMO-POS. The HMO-POS must specify in writing which services it offers out-of-network, maximum enrollee out-of-pocket cost sharing, and any annual limits on the benefits offered under the POS benefit.

20.2.2 - Preferred Provider Organizations (PPOs)

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

A PPO is a CCP plan that provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the plan's network of providers (42 CFR 422.4(a)(1)(v)(B); Section 1852(e)(3)(iv) of the Social Security Act). PPOs may be local or regional (42 CFR 422.4(a)(iii)(C)).

Local PPOs - A local PPO has a service area that is specified by the organization offering the plan and approved by CMS. Its service area typically will consist of one or multiple counties. However, as noted in Chapter 4 of the Medicare Managed Care Manual, Section 140, CMS may allow service areas to contain partial counties if the plan can demonstrate that this is necessary, non-discriminatory and in the best interests of the plan enrollees (See also 42 CFR 422.2 (definition of service area)).

Regional PPOs (RPPOs) - The MMA introduced the RPPO option in an effort to expand access to MA managed care to include Medicare beneficiaries living in rural areas. RPPOs may be offered only in one or several, but not in parts, of the 26 MA regions established by CMS for RPPOs. See <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/MAPDRegions.pdf> for the location of the MA regions; each MA region consists of one or more states. RPPOs must offer a uniform benefit package across the service area, must establish a 'catastrophic' maximum enrollee out-of-pocket cost sharing limit, and must establish a provider network approved by CMS. In those portions of its service area where it is possible, RPPOs should meet network adequacy criteria for original Medicare services by having written contracts with a full network of providers. In more rural areas, RPPOs may request an exception to CMS's requirement that the RPPO have written contracts in order to meet network adequacy criteria (42 CFR 422.112(a)(1)(ii)).

RPPO plans offered by MA organizations must be licensed or otherwise authorized under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers one or more MA plans.

See Chapter 4 of the Medicare Managed Care Manual for information on deductibles as well as catastrophic limits on cost sharing for RPPOs. Annually, CMS issues information about deductibles and cost sharing for the following contract year in the Call Letter. Current and past Call Letters may be accessed at:

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>

20.2.3 - Special Needs Plans (SNPs)

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

A SNP may be offered as any of the CCP types and must satisfy CMS' SNP requirements. SNPs must exclusively enroll special needs individuals as appropriate to the SNP type (42 CFR 422.4(a)(1)(iv)).

The MMA designated three specific segments of the Medicare population as special needs individuals: (1) institutionalized individuals; (2) those entitled to Medical Assistance under a State Plan under Title XIX (Medicaid) (i.e., dual eligibles); or (3) those who have “a severe or disabling chronic condition” who would “benefit from enrollment in a specialized MA plan (Section 1859 of the Act and 42 CFR 422.2). Corresponding to these segments of the Medicare population there are three types of SNPs: I-SNPs for institutionalized individuals, D-SNPs for dual eligible individuals and C-SNPs for chronic-condition individuals.

See chapter 16b for more details on these requirements.

20.3 - Medical Savings Account (MSA) Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

The BBA authorized MSA plans on a demonstration basis when it created the M+C program. The MMA of 2003 made Medicare MSAs a permanent type of MA plan option and extended the beneficiary protection from balance billing by non-contracting providers to include MSA enrollees (42 U.S.C. § 1395w-28(b)(3)(A); 42 CFR 422.4(a)).

An MSA has two parts: 1) A high deductible MA plan and 2) a Medical Savings account.(42 CFR 422.4(a)(2)).

1. In a high deductible MA plan:

- a. Enrollees pay no premiums to the MSA plan except as required to cover supplemental benefits (42 CFR 422.262(b)(2));
- b. Enrollees pay out of pocket for all services until they reach the deductible amount (42 CFR 422.103(a); 42 U.S.C. § 1395w-28(b)(3)(A)(i)); and
- c. The MSA plan pays for all Medicare covered services, after the high-plan deductible is met (42 CFR 422.103(c); 42 U.S.C. § 1395w-28(b)(3)(A)(iii)).

2. Medical Savings Account: The organization offering the MSA plan deposits money into a special savings account at the beginning of each calendar year. Only the plan can make deposits into the MSA account; plan enrollees cannot deposit their own money. The amount of deposit can change each year and may also earn interest. Any money left in the account at the end of the year will remain in the account and will be added to the new deposit the following year if the enrollee chooses to continue enrollment.

Enrollees are responsible for handling the money in their account, including deciding whether to pay for health care services using medical savings account funds or other funds.

An MSA plan:

- Must, after the enrollee has met the plan deductible, cover in full all original Medicare Part A and B services subject to the requirements at 42 CFR 422.101 and section 1852(a)(1). (See also section 1859(b)(3) of the Act and 42 CFR 422.103(a));
- May offer supplemental benefits but may not apply the patient portion of the cost of those services to the patient's deductible (Section 1859(a)(3)(B)(ii)); and
- May not offer a Part D benefit. However, plan enrollees may choose to simultaneously enroll in a Prescription Drug Plan (PDP) (42 CFR 422.4(c)(1)–(2)).

MSA plans must meet all other requirements of MA plans.

For further information on MSA plans including special tax requirements see:

<https://www.medicare.gov/Pubs/pdf/11206.pdf>

20.4 - Private Fee-for-Service (PFFS) Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

All PFFS plans must cover all Part A and Part B original Medicare services whether or not the PFFS plan has a full network of contracted providers. If the PFFS plan is not in a network area, and does not have a full network of contracted providers, it must pay for covered services furnished to enrollees by providers with whom they do not have written contracts by paying at least the original Medicare rate (Section 1852(d)(4) of the Act and 42 CFR 422.114(a)(2)).

PFFS plans may differ in their network requirements. For a given contract year, a network area is any area that the Secretary determines to have “at least 2 network-based plans” (Section 1852(d)(5)(B) of the Act). CMS annually announces which counties are network areas in the Advance Notice. Effective 2011, a PFFS plan operating in a network area must meet Medicare Advantage network adequacy criteria consistent with the CMS network management module by having a full network. This means the PFFS plan must have written contracts with a sufficient number and range of providers to provide coverage for all Part A and Part B original Medicare services. Similarly, a PFFS employer/union plan that has waivers under section 1857(i) of the Act must operate as a full network plan (irrespective of its service area) (42 CFR 422.114(a)(3) and (4)).

PFFS plans operating in non-network areas may choose to meet network adequacy criteria for original Medicare services by having full networks, or they may choose to meet network adequacy criteria by stating in their terms and conditions of payment that they will pay providers with whom the plan does not have a written contract at least the original Medicare rate.

PFFS plans may offer qualified Part D. If the PFFS plan chooses not to cover Part D, the PFFS plan enrollees may simultaneously enroll in a PDP (42 CFR 422.4(c)(1), (3)).

PFFS plans are further discussed in chapter 16a.

30 - Other MA plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

30.1 – Religious Fraternal Society (RFB) Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

RFB plans are MA plans that are offered by an RFB society; the RFB society must limit enrollment exclusively to members of the RFB society (42 CFR 422.57) and may be approved to offer any MA plan type (e.g., HMO, PPO, PFFS).

An RFB society is an organization that is described in §501(c)(8) of the Internal Revenue Code of 1986, is exempt from taxation under §501(a) of that code and is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches. *See* section 1859(e)(3)(A) of the Act; 42 CFR 422.2.

30.2 – Part B only Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

An MA Part B only plan is a plan offered to individuals eligible for Part B who do not have Part A coverage. Part B only plans are required to cover the Medicare benefits that are covered under Part B and any supplemental benefits the plan may offer. Regulations at 42 CFR 422.50 prohibit creating new Part B only plans except for EGWPs that are granted a waiver. Non-EGWP Part B only plans created before the MMA may continue operating as long as they have membership and provided they do not enroll new Part B only members. For a complete discussion of Part B only plans offered by Employer Group Waiver Plans (EGWPs), see chapter 9 of this manual.

For information on Part B only beneficiaries enrolling in Medicare cost plans under section 1876 of the Social Security Act, see Section 40.

40 - Medicare Cost Plans and Health Care Prepayment Plans (HCPP)

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

Medicare cost plans and HCPP plans are not MA plans because they are authorized under a different section of the Social Security Act than MA plans.

40.1 - Medicare Cost Plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

Medicare cost plans are operated by a legal entity licensed as an HMO in accordance with a cost reimbursement contract under Section 1876 of the Social Security Act and Title 42, Part 417 of the Code of Federal Regulations. Medicare payment to the HMO is based on the reasonable costs of providing services to their enrollees.

Medicare cost plans may enroll both Part A/B as well as Part B only beneficiaries (Section 1876(d) of the Social Security Act). Medicare cost plan enrollees are not restricted to the HMO network for receipt of covered Medicare services (i.e., covered Part A and Part B services may be received through non-HMO plan sources and are reimbursed separately by original Medicare).

Cost plans may offer either Part D or non-qualified prescription drug coverage but may not offer both (42 CFR 417.440(b)). Plan enrollees not electing Part D coverage from the plan, either because the plan does not offer it or because they did not elect it, may enroll in a PDP.

Under Section 1876 (h)(5) of the Social Security Act, no new cost plan contracts are accepted by CMS. CMS will, however, accept and review applications to modify cost plan contracts in order to expand service areas (42 CFR 417.402(b)).

Section 1876(h)(5)(C) of the Social Security Act requires that beginning CY 2016, CMS non-renew cost plans in service areas or portions of service areas in which at least two competing MA local or two MA regional coordinated care plans that meet specified enrollment thresholds are available. Because a full year's enrollment data of competing plans must be assessed and affected cost plans non-renewed, cost contractors will not be able to operate in impacted service areas beginning in contract year 2017.

For further information on Medicare Cost plans see chapter 17 of this manual.

40.2 – HCPP plans

(Rev.124, Issued: 11-10-16; Effective: 11-10-16; Implementation: 11-10-16)

An HCPP operates like a Medicare cost plan but exclusively enrolls Part B only beneficiaries and only provides Part B benefits (42 CFR 417.800(a)(1)(B), (d)(1)).