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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 14, 2014

TO: All Medicare Advantage Organizations and Section1876 Cost Plans

FROM: Danielle Moon, J.D., M.P.A.
Director

SUBJECT: Contract Year 2015 Medicare Advantage Bid Review and Operations Guidance

This memorandum provides the following information for Medicare Advantage Organizations (MAOs), and, where specified, Section 1876 Cost Plans, as they prepare contract year (CY) 2015 bids for CMS review: information about several specific changes to regulation and the Plan Benefit Package (PBP) software for CY 2015; clarification of existing supplemental benefit policies; and detailed operational guidance to support plans' bid development. Guidance related to Medicare Medicaid Plans (MMPs) can be found on the Medicare-Medicaid Coordination Office (MMCO) webpage http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html.

Guidance in this memorandum references the April 7, 2014 CY 2015 Final Call Letter (specifically Section II, Part C), and the PBP bid submission module in the Health Plan Management System (HPMS). Chapter 4 of the Medicare Managed Care Manual (MMCM) will be updated to reflect the changes to benefit policy made in the Final Call Letter. Therefore, we recommend that MAOs and other Medicare health plans review these resources as well as this memorandum when developing their bids for CY 2015. MAOs must also comply with the Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2015 Final Rule (CMS-4159-F) regulation, as finalized and as of its effective date.

Bid Review

Organizations need to consider the CY 2015 Final Call Letter, this HPMS memo, and the update to Chapter 4 of the Medicare Managed Care Manual (MMCM) for the 2015 contract year for the necessary guidance on service category cost sharing standards, which bid review criteria apply to specific plan types, and maximum out-of-pocket (MOOP) cost thresholds for CY 2015.

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans	Described in Call Letter or this HPMS Memo
Meaningful Difference	Yes	No	No	No	Call Letter
Total Beneficiary Cost	Yes	No	No	No	Both
Maximum Out-of – Pocket (MOOP) Limits	Yes	Yes	No	Yes	Both
PMPM Actuarial Equivalent Cost Sharing	Yes	Yes	No	Yes	Call Letter
Service Category Cost Sharing	Yes	Yes	Yes[1]	Yes	Call Letter
Optional Supplemental Benefit Value	Yes	Yes	No	No	Call Letter

[1] MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 CFR §§417.454(e) and 422.100(j)).

CMS has made changes to service category cost sharing amounts, PMPM Actuarial Equivalence factors, and Total Beneficiary Cost (TBC) limits for CY 2015 and has provided explanations of these changes in each applicable section below. Consistent with last year, requirements implemented under the Affordable Care Act, such as the medical loss ratio and health insurance provider fee, are expected to be addressed independently of our requirements for benefits bid review. Therefore, we are not making specific adjustments or allowances for these changes in our requirements for benefits bid review.

Meaningful Difference (Duplicative Plan Offerings)

MAOs offering more than one plan in a given service area must ensure that beneficiaries can easily identify the differences between plans of the same type to determine which plan provides the highest value at the lowest cost to address their needs. For CY 2015, CMS will use plan-specific per member per month (PMPM) out-of-pocket cost (OOPC) estimates to identify meaningful differences among the same plan types. Detailed information related to this requirement can be found in the CY 2015 Final Call Letter.

Total Beneficiary Cost (TBC)

As stated in the CY 2015 Final Call Letter, CMS will exercise its authority under section 1854(a)(5)(C)(ii) of the Affordable Care Act to deny MA organization bids, on a case-by-case basis, if it determines that the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next through the use of the TBC requirement. A plan's TBC is the sum of plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost-sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By limiting excessive increases in the TBC from one year to the next, CMS is able to ensure that beneficiaries who

continue enrollment in the same plan are not exposed to significant cost increases. For CY 2015, the TBC threshold is $32.00 PMPM.

To the extent that CMS increases the amount of the maximum Part B premium buy-down in the Bid Pricing Tool (BPT): we typically provide a Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2014 ($104.90) and the new amount for CY 2015. Since the CY 2014 and 2015 Part B premium buy-down amount is staying the same ($104.90), the TBC calculation will reflect an adjustment of zero dollars for this factor.

For CY 2015, CMS is evaluating plan-specific TBC for non-employer plans (excluding D-SNPs) and will calculate and provide factors for each plan that adjust for payment rate, quality bonus changes, coding intensity and other technical changes in the PBP software. Thus, a plan experiencing a net increase in adjustments must have an effective TBC change amount below the $32.00 per member per month (PMPM) threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $32.00 PMPM threshold. Based on this analysis, CMS will not deny a bid solely on the grounds that TBC has increased by too much from CY 2014 to CY 2015 if the increase is equal to or less than the plan-specific TBC amount. CMS reserves the right to further examine and request additional changes to a plan bid even if a plan's TBC is within the required amount. We believe this approach not only protects beneficiaries from significant increases in cost sharing or decreases in benefits, but also ensures beneficiaries have access to viable and sustainable MA plan offerings.

The following describes how the TBC evaluation will be conducted for organizations that consolidate or segment plans from one year to the next:

- Consolidating Multiple Non-segmented Plans into One Plan: The enrollment-weighted average of the CY 2014 plans will be compared to the CY 2015 plan.
- Segmenting an Existing Plan: The TBC for each CY 2015 segmented plan will be compared independently to the CY 2014 non-segmented plan.
- Consolidating Previously Segmented Plans: The enrollment-weighted average TBCs of the existing CY 2014 segmented plans will be compared to the non-segmented CY 2015 plan.

The plan-specific data elements that CMS will post on HPMS in mid/late April are shown in the following table. Should there be any changes due to the appeals process, plan sponsors will be notified of their corresponding revised TBC adjustment factors.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2014 TBC	A	OOPC value	Each of these plan-specific values will be provided by CMS through an HPMS posting
	B	Premium (net of rebates)	
	C	Total TBC	
CY 2015 TBC	D	OOPC value	Calculated using OOPC Model Tools
	E	Premium (net of rebates)	Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14
	F	Total TBC	Calculation: D plus E
Apply TBC Adjustments	G	Unadjusted TBC change	Calculation: F minus C
	H	Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2014 ($104.90) and the amount for CY 2015 ($104.90)	Value is $0.00 for all plans
	I	Impact of benchmark/bonus payment/ coding intensity change	Plan-specific value will be provided by CMS through an HPMS posting
	J	Impact of changes in OOPC Model between CY 2014 and CY 2015	Plan-specific value will be provided by CMS through an HPMS posting
	K	Adjusted TBC change	Calculation: G – H + I – J
Evaluation	L	Apply CMS requirements	Plan is likely to be accepted, if K is ≤ $32.00 PMPM

As described in the exhibit above, CMS will provide, through HPMS, CY 2015 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of Part B premium (full premium or partial as a result of a Part B premium buy-down). Based on the CMS release of SAS software files in early April, MAOs will be able to calculate their plan-specific CY 2015 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2015 (Item E). Premium (net of rebates) can be found in the Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14.

The *Unadjusted* TBC Change between CY 2014 and CY 2015 (Item G) is the difference between CY 2014 Total TBC (Item C) and CY 2015 Total TBC (Item F), i.e., G = F – C. The *Adjusted* TBC Change amount (Item K) reflects the Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2014 ($109.90) and the new amount for CY 2015 (Item H), Impact of Benchmark/Bonus Payment (based on the current star ratings)/ Coding Intensity Changes (Item I), as well as the Impact of Changes in the OOPC Model between CY 2014 and CY 2015 (Item J). It should be noted, however, that these elements impact TBC in different directions, i.e., K = G – H + I – J.

The Adjusted TBC Change amount (Item K) will be compared to the $32.00 PMPM TBC change amount threshold. Those plan bids with Adjusted TBC Change amounts higher than the $32.00 PMPM threshold will be further scrutinized and may be denied. Plan bids with Adjusted TBC Change amounts that are equal to or less than the $32.00 PMPM threshold are likely to be accepted. However, as stated above, CMS reserves the right to further examine and request additional changes to a plan bid, even if the Adjusted TBC change (Item K) is within the threshold.

Illustrative Calculation for Item I: Impact of Benchmark/Bonus Payment/Coding Intensity Change Adjustment Factor

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table shows two examples of how the payment adjustment is calculated. The Payment Adjustment is the CY 2015 Rebate minus the 2014 Rebate. The CY 2014 Bid Amount and Benchmark are taken from the CY 2014 BPT. For purposes of this calculation the CY 2014 Bid Amount is assumed to grow by the same MA growth percentage as used in the CY 2015 ratebook development. The CY 2015 Benchmark is the weighted average of county-specific payment rates using the CY 2015 ratebook and projected enrollment from the CY 2014 BPT. The change in MA coding intensity is taken into consideration in calculating the CY 2015 Benchmark. The Rebate percentage (Rebate %) depends on the plan's Quality Bonus Payment (QBP) rating for the year. The Rebate is calculated as the Benchmark minus the Bid Amount (if the Bid Amount is less than the Benchmark the difference is multiplied by the Rebate %). The Plan 001 example in the table below shows the calculation for a plan where the Bid Amount is greater than the Benchmark. In contrast, the Plan 002 example shows the calculation for a plan where the Bid Amount is less than the Benchmark.

Bid ID	2014 Values				2015 Values				Payment Adj.
	Bid Amt.	Bench-mark	Rebate %	Rebate	Bid Amt.	Bench-mark	Rebate %	Rebate	
Plan 001	$1,000	$950	50%	$(50.00)	$959	$925	65%	$(34.00)	$16.00
Plan 002	$1,000	$1,050	50%	$25.00	$959	$1,025	65%	$42.90	$17.90

We encourage organizations to participate in User Group Calls conducted by the Office of the Actuary in April and May that will provide the opportunity to obtain responses to their technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

As codified at 42 CFR §422.100(f)(4), (5) and §422.101(d)(2) and (3), all MA plans, including employer group plans and SNPs, must establish limits on enrollee out-of-pocket spending that do not exceed the annual maximum amounts set by CMS. Although the MOOP requirement is for Parts A and B services, an MAO can include supplemental benefits as services subject to the MOOP.

For CY 2015, we continue to encourage organizations to establish the lower, voluntary MOOP thresholds. MAOs that adopt voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits.

Plans are responsible for tracking enrolled beneficiaries' out-of-pocket spending and to alert beneficiaries and plan providers when the spending limit is reached. D-SNPs also must track enrollee cost sharing but should include only those amounts the enrollee is responsible for paying net of any State responsibility or exemption from cost sharing.

The CY 2015 Final Call Letter defines MOOP requirements by plan type. The following chart identifies the required MOOP amounts by plan type that are to be reflected in the PBP for CY 2015 for all Parts A and B services.

CY 2015 PBP Options for MOOP Amount by Plan Type

Plan Type	**Required MOOP Amounts**	**Plan also may choose to enter in the PBP:**
HMO	In-network	"In-network" is only option available in the PBP
HMO with Optional Supp. POS	In-network	"In-network" is only option available in the PBP
HMO with Mandatory Supp. POS	In-network	"No" or enter amounts for "Combined" and/or "Out-of-Network" as applicable
Local PPO	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
Regional PPO	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
PFFS (full network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (partial network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (non-network)	General	"General" is the only option available in the PBP

Service Category Cost Sharing Supporting Documentation

Service category cost sharing requirements can be found in the CY 2015 Call Letter dated April 7, 2014. Please note that MAOs with benefit designs using a coinsurance or copayment amount for which there is not have an established limit (e.g., coinsurance for inpatient or copayment for durable medical equipment) must submit with their initial bid a document that clearly demonstrates how the coinsurance or copayment amount satisfies CMS service category

requirements. This document must be submitted as part of supporting documentation for the BPT as described in the 'Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2015, Appendix B-Supporting Documentation.'

Discriminatory Pattern Analysis

During review of CY 2015 plan bid submissions, CMS will ensure that MA plans satisfy cost sharing requirements. In addition, CMS will analyze bids to ensure that discriminatory benefit designs are identified and corrected. This could include bids that satisfy CMS requirements but have cost sharing amounts that are defined or administered in a manner that may discriminate against sicker or higher-cost patients. This analysis may also evaluate the impact of benefit design on patient health status and/or certain disease states. CMS will contact plans to discuss and correct any issues that are identified as a result of these analyses.

CY 2015 Plan Benefit Package (PBP) Changes

CMS has revised PBP sections in an effort to simplify data entry, address areas that caused confusion in the past, and better reflect MA plans' and Section 1876 cost contractors' offerings.

Updated Service Category Descriptions

We have updated some of the Medicare benefit and service category descriptions within the PBP software. CMS strongly encourages MAOs to review these descriptions as they prepare their bids in order to ensure that their understanding of the specific benefits they propose to offer to beneficiaries is consistent with CMS definitions and guidance. These service category descriptions can be viewed within the PBP software, or can be viewed in HPMS under the "Service Category Report" found in the 2015 Bid Reports section of HPMS.

Worldwide Emergency Coverage (B4c)

CMS revised the name of B4c from "Worldwide Coverage" to "Worldwide Emergency Coverage." This change occurred because Worldwide Emergency Coverage benefits may only be used for those services that are classified as emergency or urgently needed had they occurred in the United States and its territories.

In Section B4c, we have removed periodicity questions and added the following questions:

- "Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency Coverage? YES/NO."
- "Is the service-specific Maximum Plan Benefit Coverage amount unlimited? YES/NO." If "NO" is chosen, the Organization will be asked to indicate the Maximum Plan Benefit Coverage amount and will be provided with a free form number field that will accept up to $1 million

Occupational Therapy (OT), Physical Therapy (PT) and Speech-language Pathology (SP) (B7c & B7i)

As stated in the CY 2015 Final Call Letter, the copayment for Sections B7i - PT and SP Services and B7c- Occupational Therapy Services may not exceed $40. Cost sharing ranges (i.e., min/max inputs) for B7c and B7i are available to accommodate multiple cost sharing amounts for different settings. MAOs must use the notes fields to describe cost share ranges entered in the min/max fields (i.e., different amounts for the min and max amounts).

In CY 2014, CMS removed the Medicare coverage limit question for B7i - PT/ST Services. We inadvertently did not remove the Medicare coverage limit question for B7c - Occupational Therapy Services. Therefore, the following question will be removed from the Occupational Therapy Services – Base 1 screen in Section B7c – Occupational Therapy Services: "Do you apply the Medicare coverage limit?"

Over the Counter (OTC) Items/Services Changed to OTC Items (B13b)

CMS revised the name of Section B13b from "OTC Items and Services" to "OTC Items." We also updated the question on the Section B13b OTC Items - Base 2 screen from "Does this cover all of the CMS OTC list?" to "Does this cover all of the OTC List which may be found in Chapter 4 of the Medicare Managed Care Manual?"

Meal Benefit (B13c)

CMS has added the following two new questions in B13c – Meal Benefit.

- "How many weeks does your Meal Benefit last?"
- "What is the maximum number of meals the benefit provides?"

For purposes of data input, one week equals seven sequential days and the maximum number of meals is a function of weeks and the total number of meals offered each week.

Eligible Supplemental Benefits as Defined in Chapter 4 (B14c)

CMS changed the title for B14c from: "Supplemental Education/Health Management Programs" to "Eligible Supplemental Benefits as Defined in Chapter 4". Unless it is necessary to describe the benefit in greater detail than is provided in Chapter 4 of the MMCM, we will not require that information be input into the notes fields for Section B14c -Eligible Supplemental Benefits as Defined in Chapter 4 - Base 5 screen.

We have also added check boxes for the following supplemental benefits in section B14c – Eligible Supplemental Benefits that are defined in Chapter 4 of the MMCM:

• Bathroom Safety Devices
• Counseling Services
• In-Home Safety Assessment

• Personal Emergency Response System (PERS)
• Additional sessions of Medical Nutrition Therapy (MNT)
• Post discharge In-home Medication Reconciliation
• Re-admission Prevention
• Wigs for Hair Loss Related to Chemotherapy

Authorization/Referral (B16a/B17a/B17b)

The following items have been added to B17a - Eye Exams, B17b - Eyewear and B16a – Preventive Dental in Section B:

- "Enrollee must receive Authorization from one or more of the following:"
- "Is a referral required for <Insert Name of Service>? YES/NO."

HMOPOS Geographic/Provider Restrictions (Section C)

The following questions have been added to the end of the POS General screens in Section C:

- "Does this POS benefit service the United States and its territories? YES/NO. If no, please briefly describe geographic limitations in the following area."
- "Does this POS benefit include all practitioners who are state-licensed or state-certified to furnish the services? YES/NO If no, please briefly describe provider limitations."

Deductible Guidance for Emergency Care/Urgently Needed Services

The following questions regarding deductibles have been removed from Sections B4a - Emergency Care and B4b - Urgently Needed Care:

- "Is there an enrollee Deductible?" (B4a)
- "Does ER cost sharing count towards any plan level deductible?" (B4a)
- "Is there an enrollee Deductible?" (B4b)

Deductible Guidance for LPPOs and RPPOs

We are clarifying that cost sharing for Emergency Care and Urgently Needed Care will always apply toward plan level deductibles. As a result, Emergency Care (B4a) and Urgently Needed Care (B4b) have been removed from the differential deductible picklist on the Plan Deductible LPPO/RPPO Base 3 screen in Section D.

The following two differential deductible items have been removed from the Plan Deductible Base 4 screen in Section D:

- "Indicate Differential Deductible Amount for Emergency Care."
- "Indicate Differential Deductible Amount for Urgently Needed Services."

Rounding Premiums in Section D

All of the Optional Supplemental Premiums entered for Section 1876 Cost plans in Section D must be rounded to the nearest dime, instead of to the nearest penny. The PBP software will validate this requirement.

Definition of Deductible

For CY 2015, the definition of "Deductible" has been updated in the PBP Glossary of Terms, Bid Submission Manual, PBP Help and PBP Reference Manual to include the term, "annually" as follows:

> "Specified dollar amount to be paid annually by the enrollee for health care services or for covered Part D drugs before the plan begins to pay its share of the cost for the benefits."

Segmented Plans

If a plan is offering optional and mandatory supplemental benefits, those same benefits must be the same across all segments. However, all other elements (cost sharing, number of visits, etc.) may be different between the segments. The PBP software will validate this requirement.

CY 2015 Part C Benefit Policy Updates

CMS strives to ensure that all beneficiaries receive high quality, effective health care services, and we therefore encourage plans to offer supplemental benefits to enrollees that are of value and based on sound medical practice. Below, we clarify our existing guidance regarding certain supplemental benefits that have generated questions in the past.

Multiple Supplemental Benefits with a Single Cost Sharing Limit

Some MAOs offer multiple supplemental benefits with one maximum cost sharing limit which combines two to three benefits and offers them as a package. The beneficiary can choose which supplemental benefits they would like to use up to the maximum cost sharing limit. In order to accurately complete the PBP, the MAO must enter the maximum cost sharing limit in each service category in addition to a note clarifying that the benefit is part of the multiple benefit package.

Health Education and Websites

Organizations are reminded that supplemental health education benefits may incorporate interactive web- and/or telephone-based coaching to reinforce what an enrollee learned in a group or individual session, but are not permitted to provide only a website as a Health Education benefit. Websites that are offered as part of these programs must also meet the requirements for a supplemental benefit. We provide more guidance on this issue in section 30.3 in Chapter 4.

Case Management

MAOs may not offer case management as a stand-alone supplemental benefit, as it is part of the contractual obligation of the MAO to provide care coordination to its enrollees.

Weight Loss Programs

MAOs may offer access to a weight loss program as part of their plan bid, but may not offer meals as part of that program. If a weight loss program is mentioned by brand name, the MAO must clarify in the corresponding note that no meals will be covered as part of that program.

Other Benefit Policy Issues

PBP Notes

As previously noted, when offering benefits in accordance with Chapter 4, no note is necessary; however, if a note is required, the following should be considered. A quality note in the PBP contains only information applicable to the service category in which the note section is located and provides clear, relevant information that reviewers need for bid evaluation. Furthermore, a quality note:

- Is consistent with the data entry in the corresponding section of the PBP.
- As appropriate, provides a brief description of the different cost sharing levels included in ranges in the data field. For example, minimum, maximum and cost sharing amounts that fall in between for some highly utilized services (if applicable).
- Is consistent with guidance in Chapter 4 of the MMCM:
    - If PBP notes are required in Chapter 4 guidance (e.g., Nutritional/Dietary Benefit, and Gym/Fitness Benefit), the note must provide the required description.
    - If a plan is offering more extensive services for a particular supplemental benefit, the note will describe only those services over and above what is defined in Chapter 4.
    - If there is no description in Chapter 4 for a supplemental benefit being offered, the note must describe the benefit and be entered in the Other (13d, 13e and 13f) category of the PBP.

A quality note does not contain the following:

- Detailed CPT codes or exhaustive lists of every procedure covered by the benefit.
- Bid Pricing Tool explanations.
- Terms such as "etc., or misc." in the notes field.
- Restatement of the PBP questions.
- The term "pre-certification." Plans should use appropriate terminology such as "authorization" or "referral" as defined in the current Chapter 4 section 110.1.
- Reference of Medicaid benefits.
- Linking of Supplemental Benefits to Model of Care (MOC) Requirements.

Medicare-Covered Zero Cost Sharing Preventive Services ($0 CSPS)

The list of $0 CSPS may change periodically and plans are responsible for monitoring changes to this list and must offer all services identified as a Medicare-Covered $0 CSPS throughout the year. Plans are encouraged to view the complete list of Medicare-Covered $0 CSPS, at:

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

Note: Not all preventive services are covered at $0 cost sharing by Medicare (e.g., annual glaucoma screening tests for beneficiaries who are at high risk of developing glaucoma and digital rectal exams to screen for prostate cancer) and are therefore not required to be covered at $0 cost sharing by MA plans.

Observation Costs

A plan may not charge separate cost sharing for observation services. Observation services are among the many services that a patient may receive in the outpatient department of a hospital and as such, the cost sharing for observation services is included in the cost sharing for hospital outpatient services entered at 9a.

Part B Premium Buy-down

In accordance with section 1854(a)(1)(B) of the Social Security Act and regulations at 42 CFR §422.266(b), MAOs that have rebate dollars available may allocate those dollars to the provision of supplemental benefits, prescription drug coverage premium or payment toward the Part B premium. We encourage MAOs with rebate dollars to prioritize elimination or reduction of the MA and Part D premiums prior to reducing the Part B premium, as this facilitates transparency for beneficiaries in choosing MA plans.

Cost Sharing for Special Needs Plans Serving Dual–Eligibles (D-SNPs)

CMS expects MA organizations to communicate Medicare Advantage and State Medicaid benefits to dual eligible beneficiaries in a comprehensive and transparent manner. For purposes of submitting bids to CMS, D- SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. A D-SNP may

not include any Medicaid benefits in the PBP. For example, if a plan contains a preventive dental benefit for which it receives revenue from the State Medicaid agency to provide, that benefit must not be included in the PBP.

MA organizations are required to attest in the PBP that any supplemental benefit(s) that the SNP proposes to offer do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, and, if appropriate, Part D Medicare services, through the local jurisdiction in which they reside. This segregation of Medicare-only benefits in the PBP is necessary so that CMS can appropriately account for the Medicare benefit package and costs to the Medicare program. Please note: D-SNPs must furnish their enrollees with a description of the Medicaid benefits and cost sharing that are available to them in marketing materials (see 42 CFR §422.111(b)(2)(iii)). In addition, benefits separately purchased by an employer or union that wrap around the Medicare benefit package may not be included in the PBP.

Maximum Out-of-Pocket Costs (MOOP) for Dual Eligible Special Needs Plans (D-SNPs)

We note that, although it may be rare that a dual-eligible enrollee would be responsible for paying any cost sharing because the State Medicaid program is making those payments on his/her behalf, all MA plans must track enrollees' actual out-of-pocket spending, if any, for covered services in order to be able to ensure that an enrollee does not spend more than the MOOP limit established by the plan. A dual-eligible enrollee may incur responsibility for the costs of care if the plan charges cost sharing for covered services and the enrollee loses his or her Medicaid eligibility.

Currently, SNPs have the flexibility to establish $0 as the MOOP amount, thereby guaranteeing that there is no cost sharing for plan enrollees. Otherwise, if the SNP does charge cost sharing for covered services, it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

Benefits Flexibility for Certain D-SNPs

As explained in the Medicare Managed Care Manual (Chapter 16b, Section 40.4.4), we allow certain D-SNPs that meet qualifying criteria to offer specific supplemental benefits beyond those currently permitted for MA plans. Letters notifying each plan as to whether or not it qualifies to participate in this initiative are being sent the week of April 14, 2014. Qualifying D-SNPs that wish to offer any of the approved additional supplemental benefit categories described in the Medicare Managed Care Manual are to enter the proposed benefit(s) in section B13g of the PBP. CMS will review all submitted bids and will determine whether the additional supplemental benefits entered are consistent with CMS guidance. Any D-SNP that has been notified by CMS that it is not qualified to participate in the supplemental benefits flexibility initiative will not be able to enter the additional supplemental benefits in the PBP.

Tiered Cost Sharing for Medical Benefits

CMS is aware that some MA plans offer plan benefit structures that incorporate limited tiered cost sharing consistent with CMS guidance. CMS is committed both to protecting beneficiaries from discriminatory cost sharing and allowing MAOs to exercise maximum flexibility within the bounds of our beneficiary protections. Thus, for CY 2015, MAOs that choose to charge tiered cost sharing for medical benefits must notify their CMS account manager and submit a request document (provided through the CMS account manager) by April 23, 2014 of their intention to offer plans that include tiered cost sharing (e.g., for the inpatient hospital service category). MAOs will be required to provide a detailed description of proposed tiered cost sharing, including identification and descriptions of the hospitals in the plans' networks and the tiered cost sharing to be charged for each entity. As part of the request document, MAOs intending to tier a particular benefit within a plan must explicitly address the following in order for CMS to determine whether the proposed approach is acceptable:

- Demonstrate that enrollees will have equal access to all of the specified tiers for services offered by the MA plan and that the tiers are transparent to prospective and actively enrolled beneficiaries and plan providers. A basic principal of plan design is that prospective and current enrollees are able to anticipate what their costs will be in a given MA plan. The MAO offering a tiered MA plan must be able to describe its tiering structure in the bid so that a reasonable person can readily comprehend it.
- Explanation of how tiering the cost of benefits affects plan enrollees. For example, is the plan introducing tiers to encourage enrollees to seek care from providers with demonstrated quality advantages?

MA Benefit Mailbox

The MA benefit mailbox at: https://MABenefitsMailbox.lmi.org/ includes links to a variety of reference materials, frequently asked questions (FAQs) and answers to questions submitted during CY 2015 bid preparation. CMS strongly encourages MAOs to review the available resources before submitting a question to ensure we have not already provided information on a specific topic.

MAOs can submit questions regarding policy, cost sharing, and supplemental benefits to this mailbox for CMS review and response. We appreciate your cooperation in this regard.

Other questions may be directed to the appropriate mailbox identified below:

- Technical HPMS questions (e.g. PBP download, plan creation, bid, upload), please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov
- Technical questions about the Out-of-Pocket Cost (OOPC) model, please submit an email to OOPC@cms.hhs.gov
- Part D policy questions about meaningful difference, please submit an email to partDbenefits@cms.hhs.gov
- Bid Pricing tool (BPT) questions, please submit an email to actuarial-bids@cms.hhs.gov