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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

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TO: All Medicare Advantage Organizations and 1876 Cost Plans

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

SUBJECT: Contract Year 2013 Medicare Advantage Bid Review and Operations Guidance

This memorandum provides the following information for Medicare Advantage Organizations (MAOs), and, where specified, 1876 Cost Plans, as they prepare Contract Year (CY) 2013 bids for CMS review: information about several specific changes to regulation and the Plan Benefit Package (PBP) software for CY 2013; clarification of existing supplemental benefit policies; and detailed operational guidance to support plans' bid development. We also provide guidance to support development of plan bids in areas that may be affected by implementation of a Capitated Financial Alignment Demonstration.

Please note that this guidance references the final rule on display April 2, 2012, the April 2, 2012 CY 2013 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 April 2, 2012 final rule 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 2013.

Capitated Financial Alignment Demonstration Enrollment Impacts on Non-Demonstration Plans

To assist MAOs and Part D sponsors with enrollment projections for their CY 2013 bid submissions, the Medicare-Medicaid Coordination Office (MMCO) expects to post information about the target population of Medicare-Medicaid enrollees, expected demonstration service area, and estimated number of eligible enrollees for each of the States that currently expects to move forward with implementation of a capitated financial alignment demonstration in CY 2013. CMS expects the information to be posted to the MMCO's Financial Alignment webpage (http://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp) by mid-April 2012.

Provisions of the CY 2013 Final Rule

Regional Preferred Provider Organization and Local Preferred Provider Organization Deductibles

CMS regulations (42 CFR 422.101(d)(1)) require a regional preferred provider organization (RPPO) that chooses to charge a deductible to charge a single deductible that applies to all Medicare Part A and B services. However, the single deductible that applies to in- and out-of-network Medicare Part A and B service categories may be allocated so that the deductible is applied to some of the in-network service categories and not to others or so that the amount of the deductible varies from one in-network service category to another. In our final rule, we clarified the single deductible requirements for RPPOs and applied those same requirements to local preferred provider organizations (LPPO). Please refer to the final Call Letter for more guidance on applying the single deductible. The PBP has been revised to support RPPO and LPPO deductible data entry to more clearly and accurately reflect the CMS requirements. NOTE: Plans also are permitted to exclude all in-network services from the combined in- and out-of-network deductible. In order to complete the PBP to reflect such an arrangement, PPOs must select at least ONE in-network category that applies to the deductible but does not contribute to the out-of-pocket cost (OOPC) model calculation, and enter $0 for the deductible amount that applies to that service category. The resulting Summary of Benefits (SB) sentence generated by this data entry will include language telling the beneficiary to contact the plan for a list of services that apply to the combined in- and out-of-network deductible. The plan will not need to request a hard copy change to the SB sentence.

Exceptions to Policies Permitting Plans to Limit Durable Medical Equipment to Certain Brands and Manufacturers

As established in our final rule, beginning in CY 2013, plans may limit some durable medical equipment (DME) to certain brands and manufacturers as long as the plan meets specific requirements ensuring that enrollees have access to all necessary categories of DME. Limiting DME based on brand/manufacturer is permissible for categories of DME whose items are essentially interchangeable. However, items in certain categories of DME are specifically tailored to individual needs and, consequently, require full or partial coverage.

CMS will notify plans annually of categories of DME not subject to limitation based on brand/manufacturer. Generally, we intend to identify such categories of DME based on comments from the public, advice from CMS and DME MAC medical directors, and experience from the DMEPOS competitive bidding program and other Medicare programs. We will update the list as we consider new information that becomes available. If a category of DME may not be limited, then either: (1) MA plans must provide full coverage, i.e., furnish any DME brand and manufacturer in this category or (2) MA plans must provide partial coverage, i.e., the MA plans would be allowed to limit by brand and manufacturer, as long as certain subcategories of the DME are offered.

In our CY 2013 Call Letter, we identified the following five categories of DME that cannot be subject to full limitation based on brand/manufacturer: speech-generating devices; oxygen; powered mattress systems; and specific diabetic supply items. Please refer to the final rule and Call Letter for more information.

Bid submission instructions for highly integrated D-SNPs that qualify for participation in the benefits flexibility initiative in CY 2013

As explained in our CY 2013 Call Letter and final rule, we are allowing certain dual-eligible SNPs (D-SNPs) that meet qualifying criteria to offer specific supplemental benefits to their members. CMS will conduct a review to determine which D-SNPs meet the criteria and will notify each plan at the end of April/beginning of May as to whether or not it qualifies, to participate in this initiative. Qualifying D-SNPs that wish to offer any of the approved additional supplemental benefit categories described in the CY 2013 Call Letter are to enter the proposed benefit(s) in section B-13g 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.

Bid Review

Please refer to the CY 2013 Call Letter for 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 2013.

Plans with Low Enrollment

Later this month, CMS will send each MAO a list of plans that have been in existence for three or more years but, as of April 2012, have fewer than 500 enrollees for non-SNP plans and fewer than 100 enrollees for SNP plans. The list will not include plans with low enrollment that CMS determines are located in service areas that do not have a sufficient number of competing options of the same plan type.

Under our authority at 42 CFR §422.506(b)(1)(iv), MAOs must confirm through return email, that each of the low enrollment plans identified by CMS will be eliminated, consolidated with another of the organization's plans for CY 2013, or provide a justification for the renewal. If CMS does not find that there is a unique or compelling reason for maintaining a plan with low enrollment, CMS will instruct the organization to eliminate or consolidate the plan. Instructions and the timeframe for submitting business cases and what information is required in those submissions will be included with the list of low enrollment plans sent to the MAO.

CMS recognizes there may be reasonable factors, such as specific populations served and geographic location, that lead to a plan's low enrollment. SNPs, for example, may legitimately have low enrollments because of their focus on a subset of enrollees with certain medical conditions. CMS will consider all such information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. MAOs are to follow the CY 2013 renewal/non-renewal guidance in the final Call Letter to determine whether a low enrollment plan may be consolidated with another plan(s).

In the final Call Letter, CMS indicated our intention to limit very low enrollment plans' (sustained enrollment of fewer than 25 enrollees) opportunities for renewal due to our concern about the plans' operational viability and the quality of care they can provide. Although such a plan may submit a justification for renewal, we do not anticipate that we would allow a plan with sustained very low enrollment to renew, nor do we expect to consider many of the extenuating

circumstances or other factors, e.g., type and number of other plans offered in the service area, as CMS has in previous years.

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 those plans in order to determine which plan provides the highest value at the lowest cost to address their needs. For CY 2013, 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.

OOPC estimates are based on a nationally representative cohort of more than 12,000 Medicare beneficiaries represented in the 2006 and 2007 Medicare Current Beneficiary Survey data and are used to provide estimated plan cost information to beneficiaries on Medicare Plan Finder. Estimated out-of-pocket costs for each plan benefit package are calculated on the basis of utilization patterns for that cohort. The calculation includes Parts A, B, and D services and certain mandatory supplemental benefits, but not optional supplemental benefits. Current enrollment and risk scores will not affect the OOPC calculation. Please note the CY 2013 OOPC model incorporates updated PBP and formulary data, as well as more precise brand and generic drug cost sharing estimates for gap coverage, which utilize Food and Drug Administration data. All documentation and instructions associated with running the OOPC model are posted on the CMS website at:
http://www.cms.gov/PrescriptionDrugCovGenIn/10_OOPCResources.asp#TopOfPage.

CMS will evaluate meaningful differences among CY 2013 non-employer and non-cost contractor plans offered by the same MAO, in the same county, as follows:

1. The MAO's non-SNP plan offerings will be separated into five plan type groups on a county basis: (1) HMO; (2) HMO POS; (3) Local PPO; (4) Regional PPO; and (5) PFFS.

2. SNP plan offerings will be further separated into groups representing the specific target populations served by the SNP. Chronic Care SNPs will be separated by the chronic disease served and Institutional SNPs will be separated into the following three categories: Institutional (Facility); Institutional Equivalent (Living in the Community); and a combination of Institutional (Facility) and Institutional Equivalent (Living in the Community). D-SNPs are excluded from the meaningful difference evaluation. Please note that using different providers or serving different ethnic populations are not considered meaningfully different characteristics between two plans of the same type.

3. Plans within each plan type group will be further divided into MA-only and MA-PD sub-groups for evaluation. That is, the presence or absence of a Part D benefit is considered a meaningful difference.

4. The combined Part C and Part D OOPC PMPM estimate will be calculated for each plan within the plan type groups. There must be a difference of at least $20.00 PMPM between the combined OOPC for each plan offered by the same MAO in the same county to be considered meaningfully different. Plan premium is not included in the meaningful difference evaluation.

CMS expects MAOs to submit CY 2013 plan bids that meet the meaningful difference requirements, but will not prescribe how the MAOs should redesign benefit packages to achieve the differences. CMS may choose not to allow MAOs to revise their bid submissions if a plan's initial bid does not comply with meaningful difference requirements because MAOs have access to the necessary tools to calculate OOPC estimates for each plan prior to bid submission. Ultimately, CMS will not approve plan bids that do not meet these requirements. MAOs must follow the CY 2013 renewal/non-renewal guidance in the final Call Letter to determine if their plans may be consolidated with other plans.

Total Beneficiary Cost

CMS will again 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 total beneficiary cost (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. Note: To the extent that CMS increases the amount of the maximum Part B premium buy-down in the Bid Pricing Tool (BPT), we will provide a Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2012 ($96.40) and the new amount for CY 2013.

For CY 2013, CMS is evaluating TBC for non-employer plans (excluding D-SNPs) and will calculate and provide to each plan an amount that reflects the effect of MA payment changes and any quality bonus payments for which the plan is eligible, as well as year-to-year changes in the OOPC model. Thus, plans experiencing a net increase in benchmarks/bonus payments will have an effective TBC change amount below the $36.00 per member per month (PMPM requirement. Conversely, plans experiencing a net decrease in benchmark and/or bonus payments will have an effective TBC change amount above the $36.00 PMPM requirement. Based on this analysis, CMS will not deny a bid solely on the grounds that TBC has increased by too much from CY 2012 to CY 2013 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, if we find it is in the best interest of the MA program. 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. For plans that consolidate multiple CY 2012 plans into a single CY 2013 plan, CMS will use the enrollment-weighted average of the CY 2012 plan values to calculate the TBC. Otherwise, these plans will be treated as any other plan for the purpose of enforcing the TBC requirement.

The plan-specific data that CMS will post on HPMS in mid-April is shown in the following table. Note: Item I was determined based on the current star ratings. 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 2012 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 2013 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 2012 ($96.40) and the new amount for CY 2013	Value is $3.50 for all plans
	I	Impact of benchmark and/or bonus payment change	Plan-specific value will be provided by CMS through an HPMS posting
	J	Impact of changes in OOPC Model between CY 2012 and CY 2013	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 ≤ $36.00 pmpm

As described in the exhibit above, CMS will provide, through HPMS, CY 2012 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 2013 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2013 (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 2012 and CY 2013 (Item G) is the difference between CY 2012 Total TBC (Item C) and CY 2013 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 2012 ($96.40) and the new amount for CY 2013 (Item H), Impact of Benchmark and/or Bonus Payment Changes (Item I), as well as the Impact of Changes in the OOPC Model between CY 2012 and CY 2013 (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 $36.00 PMPM TBC change amount threshold. For those plans that are higher than the $36.00 PMPM threshold, the plan will be further scrutinized and may be denied. Plans that are equal to, or less than, the $36.00 PMPM threshold, are likely to be accepted. However, we note that 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, if we find it is in the best interest of the MA program.

Maximum Out-of-Pocket Limits

CMS strives to ensure that MAOs develop more transparent plan benefit designs so that beneficiaries are better able to predict their out-of-pocket costs and are protected from excessively high or unexpected cost sharing. As codified at 42 CFR 422.100(f)(4) and (5), all local MA plans (employer and non-employer), including HMOs, HMOPOS, local PPO (LPPO) plans, SNPs (including D-SNPs), and PFFS plans must establish an annual maximum out-of-pocket (MOOP) limit on total enrollee cost sharing liability for Parts A and B services, the dollar amount of which will be set annually by CMS. In addition, LPPO and RPPO (as codified at 42 CFR 422.101(d)(3)) plans, are required to have a "catastrophic" limit inclusive of both in- and out-of-network cost sharing for all Parts A and B services, the dollar amount of which also will be set annually by CMS.

For CY 2013, we continue to encourage organizations to establish lower voluntary MOOP thresholds. Therefore, 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 them 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 following chart identifies where MOOP amounts should be placed in the PBP for CY 2013 for all Parts A and B services.

CY 2013 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

Per Member Per Month Actuarial Equivalent Cost Sharing Maximums

Total MA cost sharing for Parts A and B services must not exceed cost sharing for those services in Original Medicare on an actuarially equivalent basis. CMS will also apply this requirement separately to the following service categories for CY 2013: Inpatient Facility, Skilled Nursing Facility (SNF), Home Health, Durable Medical Equipment (DME), and Part B drugs.

Whether in the aggregate, or on a service-specific basis, excess cost sharing is identified by comparing two values found in Worksheet 4 of the Bid Pricing Tool (BPT). Specifically, a plan's per member per month (PMPM) cost sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) is compared to Original Medicare actuarially equivalent cost sharing (BPT Worksheet 4, Section IIA, column n). For inpatient facility and SNF services, the Actuarial Equivalent (AE) Original Medicare cost sharing values, unlike plan cost sharing values, do not include Part B cost sharing; therefore, an adjustment factor is applied to these AE Original Medicare values to incorporate Part B cost sharing and to make the comparison valid.

Once the comparison amounts have been determined, excess cost sharing can be identified. Excess cost sharing is the difference (if positive) between the plan cost sharing amount (column #1) and the comparison amount (column #5). The chart below uses illustrative values to demonstrate the mechanics of this determination.

Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing

	#1	#2	#3	#4	#5	#6	#7
BPT Benefit Category	PMPM Plan Cost Sharing (Parts A&B) *(BPT Col. l)*	Original Medicare Allowed *(BPT Col. m)*	Original Medicare AE Cost sharing (Part A only) *(BPT Col. n)*	Part B Adjustment. Factor to Incorporate Part B Cost Sharing (Based on FFS data)	Comparison Amount *(#3 × #4)*	Excess Cost Sharing (#1 − #5)	Pass/Fail
Inpatient	$33.49	$331.06	$25.30	1.366	$34.56	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.073	$10.61	$0.22	Fail
Home Health*	$0.01	$0.30	$0.00	0.150	$0.05	$0.00	Pass
DME	$3.00	$11.37	$2.65	1.000	$2.65	$0.35	Fail
Part B-Rx	$0.06	$1.42	$0.33	1.00	$0.33	$0.00	Pass

*Home health has no cost sharing under Original Medicare, so the comparison amount (#5) is calculated by multiplying the Medicare allowed amount (#2) by the Part B Adjustment Factor (#4).

Discriminatory Pattern Analysis

During review of CY 2013 plan bid submissions, CMS will ensure that MA plans conform to the cost sharing requirements. In addition, CMS will analyze bids to ensure that discriminatory benefit designs are identified and corrected. This could include bids that meet standards but have cost sharing amounts that are distributed in a manner that may discriminate against sicker, 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 these analyses.

CY 2013 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 1876 cost contractors' offerings. We have also updated the Medicare benefit and service category descriptions within the PBP software. MAOs are encouraged to review these descriptions as they complete 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.

Copayment and Coinsurance for the Same Service

To enable us to better understand the rationale for a plan's cost sharing where both a copayment and coinsurance are entered in a service category, the revised PBP requires the plan to provide an explanation of its rationale in the notes field. We continue to encourage plans to enter cost sharing that is easy to understand and transparent to beneficiaries. We recognize that plans need the flexibility to contract with different service settings (i.e., freestanding imaging centers,

hospital outpatient departments) to furnish services within a service category and that varying cost sharing arrangements may result.

As always, plans must make the differences in cost sharing transparent to beneficiaries through the Annual Notice of Change, Evidence of Coverage, Summary of Benefit sentences and in their marketing materials and ensure beneficiaries are not charged twice for the same service.

Character Limits on Notes Fields throughout the PBP

In efforts to update the PBP and improve the quality of information provided in the notes fields, our analysis of CY 2012 PBPs showed only a small number of plans entered notes that were more than 3,000 characters. Based on that finding, we have decreased the amount of space that will be available in the PBP notes fields for CY 2013 bids and have established the limit at 3,000 characters.

Prior to the bid submission deadline, we will contact the plans that submitted notes in their CY 2012 bids that were in excess of 3,000 characters to ensure they are prepared for the reduction in characters for the CY 2013 bid submissions.

Inpatient Hospital - Sections B1a and 1b

Several MAOs offer benefit structures with tiered cost sharing for inpatient hospital services, consistent with CMS guidance in Chapter 4 of the MMCM. For CY 2013, CMS revised the PBP to enable data entry for tiered inpatient hospital cost sharing to ensure benefit and cost sharing transparency for beneficiaries. The revised PBP will include data entry fields for up to three tiers of cost sharing for inpatient acute and inpatient mental health service categories.

MAOs must continue to ensure their tiered cost sharing is not discriminatory and provides beneficiaries with equal access to quality hospitals. The additional data entry fields will decrease the need for notes entry explaining inpatient hospital tiers and enable generation of accurate and meaningful summary of benefit sentences, thus ensuring the benefit is transparent to beneficiaries.

Urgently Needed Care – Sections B4b and B7a

For CY 2013, we revised the PBP to remove the data entry field for urgently needed care from section B7a, Primary Care Physician. That data entry was duplicative of the data entry at B4b, Urgently Needed Care. The on-screen description of urgently needed care has been removed and the service category descriptions for B4b and B7a have been revised. The PBP revisions will result in better beneficiary understanding of the cost sharing for urgent care services offered by plans.

Outpatient Diagnostic Procedures and Tests and Lab Services- Section B8a and Outpatient Diagnostic and Therapeutic Radiological Services-Section B8b

We revised the PBP to provide greater separation of the cost sharing information in these service categories. Previously there were separate data entry fields in sections B8a and 8b, but there was also a single notes section in each service category, and that limitation resulted in plans entering lengthy and sometimes confusing information in an attempt to clarify all of the possible cost sharing amounts for these services.

In the CY 2013 PBP, section B8a will have two notes fields: one for Medicare-covered Diagnostic Procedures/Tests and another for Medicare-covered Lab Services. Similarly, section B8b will have three notes fields: one each for Medicare-covered X-Ray Services, Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc), and Medicare-covered Therapeutic Radiological Services.

Medicare-Covered Zero Cost Sharing Preventive Services ($0 CSPS) - Section B14a

CMS has made several revisions to section B14a of the PBP to address MAO requests as well as changes to the list of Medicare-covered $0 CSPS that MAOs are required to offer. We have added revisions to authorization and referral questions and a notes field, which will enable plans to identify the $0 CSPS that require prior authorization from the plan or a referral by a physician or other qualified health provider.

Through the national coverage determination (NCD) process, CMS approved five new preventive services under Original Medicare. CMS determined that the new services would be covered under Original Medicare without cost sharing and thus, as codified at 42 CFR 417.454(d) and 422.100(k), all MA plans and 1876 cost contractors also must provide them without charging enrollee cost sharing.

The effective dates for coverage of the new services are based on the issue date for the relevant NCD. Plans should refer to the November 25, 2011, HPMS memo entitled "***Clarification of Policy Regarding Implementation of National Coverage Determinations and Updates to Medicare-covered Preventive Services***" regarding plans' responsibilities to monitor NCD issuances and implement NCDs and updates to Medicare-covered services. The memo provides helpful resource links to monitor coverage changes that result from the NCD process.

As the list of $0 CSPS may change periodically, we revised the related attestation statement in the PBP and no longer list $0 CSPS. The attestation statement does not refer to a discrete list of services in the PBP, but rather to all preventive services that must be covered by all MAOs and 1876 cost contractors without cost sharing. The revised attestation states: "I attest that there is no coinsurance, copayment, or deductible for all preventive services that are offered at zero dollar cost sharing under Original Medicare."

As we explained above, although we cannot provide a definite list of preventive services that must be provided without cost sharing that will apply for all of CY 2013, below is the most current listing of those services.

- Initial Preventive Physical Examination (IPPE)
- Annual Wellness Visit (AWV)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
- Cardiovascular Disease Screening
- Diabetes Screening Test
- Medical Nutrition Therapy (MNT)
- Screening Pap Tests/ Pelvic Exam
- Screening Mammography
- Bone Mass Measurements
- Colorectal Cancer screening

- Prostate Cancer Screening (PSA)
- Seasonal Influenza Virus Vaccine
- Pneumococcal Vaccine
- Hepatitis B (HBV) Vaccine
- Tobacco Use Cessation Counseling
- Human Immunodeficiency Virus (HIV) Screening
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse;
- Screening for depression in adults
- Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs
- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity

Important Note: MAOs can refer to the link below for the most updated list of the Medicare-covered preventive services:
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

Annual Physical Exam – Section B14b

We revised section B14b of the PBP by renaming the section "Annual Physical Exam." This field is to be used by plans that choose to offer as a supplemental benefit, an exam that complements and in no way, duplicates, the services and activities included in the required Annual Wellness Visit, to enter cost sharing and any needed notes related to that service offering. A full description of the proposed physical exam supplemental benefit must be included in the notes field for this PBP item for CMS review.

Contract Year 2013 Supplemental Benefits

CMS' interests are in ensuring that all beneficiaries receive high quality, effective health care services and are taking this opportunity to reiterate those goals and encourage plans to offer supplemental benefits to enrollees that are of value and based on sound medical practice. CMS is clarifying its existing guidance regarding certain supplemental benefits that have generated questions in the past.

Wigs for Hair Loss Related to Chemotherapy

CMS will continue to permit plans to provide wigs for hair loss that is a result of chemotherapy as a supplemental benefit.

Acupuncture, Reflexology, and Other Alternative Therapies

CMS will continue to permit plans to offer benefits alternative therapies as supplemental benefits. These alternative therapies must be provided by practitioners who are state-licensed or state-certified to furnish the services, are practicing in the state in which they are licensed or certified, and are furnishing services within the scope of practice defined by their licensing or certifying state.

Re-admission Prevention

Immediately following a beneficiary's discharge from a hospital or skilled nursing facility (SNF) inpatient stay (e.g., within the first week), plans may offer, as a supplemental benefit, non-Medicare covered services that are intended to prevent the beneficiary's readmission to a hospital or other institution.

Services included in a supplemental re-admission prevention benefit that CMS would expect to approve for CY 2013 would:

- Not duplicate Medicare-covered benefits (e.g., home health which may provide some services to homebound beneficiaries);
- Be initiated immediately after a beneficiary's discharge from an institutional setting (e.g., hospital, SNF);
- Be provided for a limited and specified period of time not to exceed four weeks; and
- Be entered with the title "Re-admission Prevention" in one of the "Other" service category fields (B13d, e, or f) in the PBP and be described in the PBP notes for that service category.

The following are examples of benefits that a plan may choose to offer as a supplemental benefit. A plan also may choose to either combine the example benefits as a complete "Re-admission Prevention" benefit or offer the benefits separately. Examples include:

Post discharge In-home Medication Reconciliation: Immediately following discharge (e.g., within the first week) from a hospital or SNF inpatient stay, a qualified healthcare provider, in cooperation with the beneficiary's physician, would review the beneficiary's complete medication regimen that was in place prior to admission and compare and reconcile with the regimen prescribed for the beneficiary at discharge to ensure new prescriptions are obtained and discontinued medications are discarded. This reconciliation of the beneficiary's medications may be provided in the home and is designed to identify and eliminate medication side effects and interactions that could result in illness or injury.

Meal Delivery as defined in Chapter 4 of the MMCM.

In-Home Safety Assessment performed by an occupational therapist or other qualified health provider. Services included in such a benefit would be provided only to beneficiaries who do not qualify for an in-home safety assessment under Original Medicare's home health benefit and the plan must ensure the following conditions apply:

- The assessment is performed by an occupational therapist or other qualified health provider;

- The assessment's focus is on the beneficiary's risk for falls and identification of how falls may be prevented; and

- The bathroom safety devices that may be installed must be appropriate for the individual beneficiary's home, determined to be necessary by the occupational therapist or other qualified health provider furnishing the safety assessment, and be approved by the beneficiary.

The assessment may include identification and/or minor modification of some home hazards outside of the bathroom, in order to reduce risk of injury. Such modifications may include removal of rugs that are not attached to the floor and rearrangement of furniture to create clear pathways.

Nutrition/Dietary Education

General nutritional education for all beneficiaries through classes and/or individual counseling may be provided as a supplemental benefit as long as the services are provided by practitioners who are practicing in the state in which s/he is licensed or certified, and are furnishing services within the scope of practice defined by their licensing or certifying state. (i.e., physician, nurse, registered dietician, or nutritionist). The number of visits, time limitations, and whether the benefit is for classes and/or individual counseling must be defined in the notes. The data entry for this supplemental benefit can be entered at section B14c of the PBP.

Gym and Fitness Benefit

Gym and fitness benefits (e.g., gym membership, exercise and yoga classes) may be offered as supplemental benefits. A supplemental gym membership benefit must include an orientation to the facility and the equipment for each beneficiary who comes to the gym. The benefit also may include development of a personalized exercise plan and a limited number of sessions with a certified trainer. Plans may not offer personal trainers or exercise coaches for in-home sessions. Plans must describe specifically what is included in the gym and fitness supplemental benefit (e.g., access to facilities, support staff, general goals of the program) in the PBP notes field at section B14c.

Counseling Services

Medicare Part B covers individual and group therapy services to diagnose and treat a mental illness. The Part B coverage usually requires a physician referral for mental health care and is based on a mental health diagnosis. "Counseling" services not covered by Original Medicare may be eligible as a supplemental benefit offered to all beneficiaries. These services are <u>not</u> intended to diagnose and treat a mental illness. These supplemental benefits may address general topics, such as: coping with life changes; conflict resolution; or grief counseling and be offered as individual or group sessions.

Examples of Ineligible Supplemental Benefits

We are clarifying that the following services may <u>not</u> be offered as supplemental benefits:

<u>Electronic medical records and electronic data storage devices:</u> Plans may <u>not</u> offer electronic health records, electronic data storage devices, or practice management systems (e.g., appointment making, requesting prescription refills) as supplemental benefits, because these activities are not "health benefits." But are administrative expenses integral to providing medical care under Parts A and B.

<u>Loaner DME items when the beneficiary's rented or owned DME is being repaired:</u> Plans may <u>not</u> offer as a supplemental benefit loaner DME. Loaner DME is a required Medicare Part B service. MAOs are required to "provide coverage of, by furnishing, arranging for, or making

payment for, all services that are covered by Medicare Part A and B" (see 422.101(a)). Therefore, if a beneficiary's Medicare-covered DME item needs to be repaired or replaced, the MAO is responsible for maintaining continuity of care for its beneficiary by ensuring uninterrupted access to the medically necessary covered DME item. The MAO must purchase or rent a replacement item for the beneficiary to use.

Other Benefit Policy Issues

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 (e.g., Chapter 4 of the MMCM). Because CMS is committed both to protecting beneficiaries from discriminatory cost sharing and to allowing MAOs to exercise maximum flexibility within the bounds of our beneficiary protections, for CY 2013, MAOs that choose to charge tiered cost sharing for medical benefits must notify their CMS account manager and submit a request document (provided by the CMS account manager) by April 27, 2012, 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 plans' proposed tiered cost sharing including, identification and descriptions of the hospitals in the plans' networks, the tiered cost sharing to be charged for each entity. As part of the request document provided by the CMS account manager, MAOs intending to tier a particular benefit within a plan must explicitly address the following in order for CMS to determine if 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. Demonstrate 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 their tiering structure so that a reasonable person can readily comprehend it.

- Explanation of how tiering cost sharing for benefits affects plan enrollees. For example, is the plan introducing tiers to encourage enrollees to seek care from providers with demonstrated quality advantages?

Rewards & Incentives

Rewards and incentives are not eligible supplemental benefits and CMS does not expect to see rewards or incentives in CY 2013 PBPs. Rewards and incentives are marketing tools and information related to how they may be offered and acceptable language in marketing material is provided in the CMS Marketing Guidelines (Chapter 3 of the MMCM).

Cost Sharing for SNPs Serving Dual –Eligibles

PBPs for plans serving dual-eligible enrollees must show the plans' actual charges for beneficiary cost sharing (if any) for services covered under the MA plan. For a full discussion of this issue, please refer to the CY 2013 Call Letter.

Plan Corrections for CY 2013

CMS expects that requests for MA and cost plan corrections for CY 2013 will be minimal. As required by 42 CFR §422.254, submission of the final actuarial certification and the bid attestation serves as documentation that the final bid submission has been verified and is complete and accurate at the time of submission. A request for a plan correction indicates the presence of inaccuracies and/or the incompleteness of a bid and calls into question an organization's ability to submit correct bids and the validity of the final actuarial certification and bid attestation. Please be advised that an organization requesting a plan correction will receive a corrective action warning letter. An organization that received a warning letter for CY 2012 may receive a corrective action plan if it requests a plan correction for CY 2013.

MA Benefit Mailbox

The MA benefit mailbox has a new format and now includes links to a variety of reference materials, frequently asked questions (FAQs) and answers to questions submitted during CY 2013 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 will have an opportunity to submit questions regarding policy, cost sharing, and supplemental benefits. CMS will review benefit questions and will provide appropriate responses. We appreciate your cooperation with regard to these important issues.

Please direct questions to CMS at: https://MABenefitsMailbox.lmi.org/.