DEPARTMENT OF HEALTH & HUMAN SERVICES
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: November 7, 2014

TO: All Medicare Advantage Organizations and Employer/Union-Sponsored Group Health Plans

FROM: Kathryn A. Coleman
Acting Director

SUBJECT: Update to Chapter 4 of the Medicare Managed Care Manual

Accompanying this memorandum is the final version of the guidance that will be posted in Chapter 4 of the Medicare Managed Care Manual, titled "Benefits and Beneficiary Protections," on the CMS internet-only manual page. This attached guidance is currently available at: http://www.cms.gov/medicare/Health-Plans/HealthPlansGeneralInfo/index.html. Plans may rely on this guidance immediately; it will be published at a later date on the internet-only manual page at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

The draft update was issued for public comment on April 29, 2014. We received 153 comments on the draft from 31 external entities and carefully considered those comments as we finalized the Chapter. We also incorporated into this final version of Chapter 4 relevant guidance from the Contract Year (CY) 2015 Rate Announcement and Final Call Letter issued on April 7, 2014, the HPMS memo "CY 2015 Medicare Advantage Bid Review and Operations Guidance," released on April 14, 2014, as well as new regulatory requirements finalized in the CY 2015 Parts C and D final rule (79 FR 29844-29968) issued on May 23, 2014. In addition, because of the timing of this issuance, we also were able to include updates to some of the benefit category titles in the Chapter to mirror updates to the Plan Benefit Package that will be effective for CY 2016 bids.

Because of the many changes to the Chapter, there are no redline passages indicating change. We have summarized the major differences between the draft and final versions of the updated Chapter 4, below.

- **Hospice coverage (Section 10.4):** We have revised the language to clarify the policy.

- **Anti-Discrimination (Section 10.5.2)**: We have updated this section by adding more specific information on anti-discrimination.

- **Review for Discrimination and Steerage (Section 10.5.3):** We have revised our language to clarify MAOs' responsibilities for their downstream entities.

- **Clinical Trials (10.7):** We have clarified that an enrollee may use a provider bill as evidence of his/her qualification for reimbursement for his/her out-of-pocket spending that exceeded the plan's required cost-sharing for services received during participation in a Medicare-qualified clinical trial.

- **Designation of DME Providers/Suppliers (10.12.1):** We have clarified that MAOs that limit the DME brands and manufacturers are to attach a list of the brands and manufacturers of DME the plan will cover to the Evidence of Coverage (EOC).

- **Specifying Brands or Manufacturers of DME** (**10.12.2**): We have aligned the guidance with regulatory language.

- **Skilled Nursing Facility (SNF) Coverage (10.13):** We have clarified that an enrollee who receives advance notice and agrees with termination of SNF services earlier than 2 days hence, may waive continuation of the services.

- **Cost-sharing Standards (50.1):** We have clarified guidance related to MOOP transferability and tiering of medical benefits as reflected in the CY 2015 Call Letter.

- **Missed Appointment and Related Charges (50.5):** We have created a separate section titled, "Other Out-of-Pocket Liability."

- **Value-Added Items and Services (Section 80)**: We have clarified several statements in this section.

- **Multiple A/B MACs with Different Policies (Section 90.2.2)**: We have clarified our guidance to MAOs related to coverage policy requirements when more than one A/B Medicare Administrative Contractor has jurisdiction in a plan's service area.

- **Rewards and Incentives (Section 100):** We have created a new section to provide guidance about rewards and incentives programs consistent with the final rule published on May 23, 2014.

- **Provider Networks (Section 110.1)**: We have created two subsections, "Provider Network Standards," and "Changes to Provider Networks" to clarify CMS network standards and provide updates included in the CY 2015 Call Letter.

- **Beneficiary Protections Related to Referrals (Section 170):** We have clarified our guidance related to plan and enrollee responsibilities for items and services obtained through referral by a plan-contracted provider and note the importance of appropriate use of pre-service organization determinations and standardized denial notices (CMS-10003).

- **Explanation of Benefits (Section 200):** We have added information about the new requirement for regular issuance of EOBs to enrollees.

- **Educating Members in Medicaid and Medicare (Section 210)**: We have retained this section in the final version.

We thank the various stakeholders who submitted comments on the draft version of the Chapter update. Those comments helped improve the clarity and comprehensiveness of Chapter 4. If you have any questions about the policies articulated in this updated Chapter 4, please contact your Regional Office Account Manager.