



**MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP**

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**DATE:** November 25, 2011

**TO:** All Medicare Advantage Organizations, Sections 1833 and 1876 Cost Plans

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

**SUBJECT:** Clarification of Policy Regarding Implementation of National Coverage Determinations and Updates to Medicare-covered Preventive Services

This memorandum serves to clarify our policy regarding implementation of Medicare national coverage determinations (NCDs) by Medicare Advantage Organizations (MAOs) and sections 1833 and 1876 cost plans, and to provide notice of changes to Medicare coverage for certain preventive services.

**Clarification of NCD Implementation Policy**

We have recently received questions regarding the responsibilities of Medicare Advantage Organizations and 1833 and 1876 Cost Plans (MAOs and cost plans) for implementing Medicare NCDs, particularly about recent preventive service NCDs. We therefore are clarifying our policy on NCD implementation for MAOs.

Each year, the Centers for Medicare & Medicaid Services (CMS) releases information about legislative changes and other changes in Medicare policy that, among other things, affect Medicare coverage, such as the opening of national coverage analyses (NCAs), posting of proposed and final coverage determinations, release of NCDs and accompanying instructions, etc. Generally, legislative changes to Medicare coverage rules are implemented through notice-and-comment rulemaking. If Medicare Part B coverage is affected, the changes are often included in the annual Medicare Physician Fee Schedule (MPFS) proposed and final rules. The MPFS proposed and final rules are published in the *Federal Register* every summer and fall, respectively. The corresponding Medicare manual guidance is released in either or both the Medicare Benefit Policy Manual Publication (Pub. 100-02) and Medicare Claims Processing Manual (Pub. 100-04). Implementation of coverage changes resulting from the NCD process and of all changes to original Medicare claims processing are made through Change Requests (CRs) and Transmittals (TRs) that also are used to update the Medicare National Coverage Determinations Manual (Pub. 100-03) and the Medicare Claims Processing Manual (Pub. 100-04).

The average NCD process takes 9-12 months from the opening of the NCA to the final determination posted on the CMS Coverage Website. We expect MAOs and cost plans to monitor NCD changes through the Coverage Website, which also includes changes to the NCD Manual (Pub. 100-03). The NCD process, while lengthy, is also open and transparent and information is continually updated online on the CMS Website. MAOs and cost plans are expected to stay apprised of new and/or changing Medicare coverage policies that result from either legislation or the NCD process that may affect the Part A and B benefits all MAOs and cost plans are required to offer. We provide a number of resource links, including a link to the CMS Coverage Website, below. The website includes all of the information necessary for plans to track changes to Medicare Parts A and B coverage. In addition, we have provided a link for the “coverage listserv” and we encourage MAOs and cost plans to sign up for this listserv as another tool for tracking important coverage updates.

As presented in Chapter 4 of the Medicare Managed Care Manual (MMCM), MAOs and cost plans are required to cover benefits/services that are approved through the NCD process as of the effective date stated in the final determination and NCD, or specified in the legislation, unless CMS determines that a newly-approved legislated benefit/service or NCD meets the significant cost criterion (wherein CMS often phases in such effective/implementation dates). In most cases, new benefits/services do not represent a significant cost; therefore, the effective date of the final determination is the date the item/service is covered/non-covered.

As noted above, after the release of NCDs or final rulemaking on covered/non-covered benefits, CMS releases accompanying coverage and claims processing instructions in CRs/TRs that include additional coverage guidance and original Medicare claims processing guidance, as well as shared system edits for claims processing by Medicare Administrative Contractors (MACs). The implementation date noted on the CRs/TRs is the date when all the necessary shared system edits must be in place to implement claims processing of such coverage/non-coverage in original Medicare retroactive to the effective date.

Although MAOs and cost plans have not been required to use original Medicare claims processing systems, we expect MAOs and cost plans to follow the coverage instructions in the original Medicare CRs/TRs. We also encourage plans to use claims processing guidance as a source of information that will support their implementation of the new benefit/service or other change in coverage. While a new or changed benefit/service must be available to enrolled beneficiaries as of the NCD effective date, the implementation date in the CR/TR is the latest date by which MAOs are to have payment system edits in place and coverage/non-coverage fully implemented for providers/suppliers. MAOs must ensure that the items/services are covered retroactive to the NCD effective date. Providing a more specific period of time for MAOs to establish claims processing, provider, and beneficiary education activities prior to the required provider/supplier payment implementation date allows access to the Medicare Parts A and B services for enrollees, and ensures consistency between original Medicare and MA guidance for physicians and other health care providers. CMS plans to make these instructions more explicit in Chapter 4 of the MMCM in its next annual update.

CMS generally does not release HPMS guidance about NCDs to MAOs and cost plans except on relatively rare occasions; e.g. a NCD is deemed to be a significant cost or a special circumstance,

such as the five preventive services NCDs discussed below, which have special cost-sharing implications. Therefore, it is critical that MAOs and cost plans monitor NCD changes as described above.

Several helpful resources include:

- Coverage email updates page, sorted by year - <https://www.cms.gov/CoverageGenInfo/EmailUpdates/list.asp#TopOfPage>
- Main Coverage Center page - <https://www.cms.gov/center/coverage.asp>
- Sign-up for the coverage listserv - [https://www.cms.gov/InfoExchange/03\\_listserv.asp#TopOfPage](https://www.cms.gov/InfoExchange/03_listserv.asp#TopOfPage)
- Program Transmittals page - <http://www.cms.gov/Transmittals/>

### **Newly Published Preventive Services Regulatory Changes and NCDs**

On November 1, 2011, the calendar year (CY) 2012 MPFS Final Rule (FR) was displayed in the *Federal Register* ([http://www.ofr.gov/OFRUpload/OFRData/2011-28597\\_PL.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-28597_PL.pdf)). In this final rule (section VI.E.), CMS adopts criteria for a health risk assessment (HRA) to be used as part of the Annual Wellness Visits (AWVs), for which coverage under Part B began January 1, 2011, as provided under the Affordable Care Act. The HRA is intended to support a systematic approach to patient wellness and to provide the basis for a personalized prevention plan. The MPFS FR will be published in the *Federal Register* on November 28, 2011 and will be effective January 1, 2012. MAOs are expected to incorporate this change to the AWV for CY 2012.

CMS recently released final determinations for four new preventive services that are to be offered without cost-sharing. Two services, Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse and Screening for Depression in Adults, were effective on October 14, 2011. Two additional services: (1) Screening for Sexually Transmitted Infections (STIs) and (2) High Intensity Behavioral Counseling to Prevent STIs, and Intensive Behavioral Therapy for Cardiovascular Disease were effective on November 8, 2011. CMS expects to release a final determination for one additional preventive service soon.

All of the new preventive services, including the four recently-released NCDs, as well as the additional preventive service that CMS expects to release, will be covered at zero cost-sharing under original Medicare. CMS will release corresponding coverage, coding, and claims processing instructions for each final determination in a number of CRs/TRs to update the Medicare NCD Manual (Pub. 100-03) and Medicare Claims Processing Manual (Pub.100-04). MAOs should access the Program Transmittals page provided above and should monitor the CRs/TRs, the first of which are expected to be released in December 2011.

The Affordable Care Act provided original Medicare beneficiaries the right to coverage of certain preventive services with zero cost-sharing. Under regulations published on April 15, 2011, CMS used its authority to extend that right to beneficiaries enrolled in MA and cost plans.

Thus, MAOs and cost plans are responsible for covering these preventive services with zero cost-sharing within network. 76 Fed. Reg. 21432. To the extent that new preventive services are added to those covered under original Medicare with zero cost-sharing pursuant to the Affordable Care Act, MAOs and cost plans are responsible for covering such services with zero cost-sharing within network beginning on the applicable effective date. Further, MAOs and cost plans must ensure that claims for the items/services are paid retroactive to those dates. CMS will not take enforcement actions against MAOs and cost plans for failure to comply with this requirement provided that they complete their activities to implement payment to contracted and non-contracted physicians/providers for newly-approved zero cost-sharing preventive services no later than the original Medicare implementation dates noted in the forthcoming CRs/TRs.

In addition, CMS expects that MAOs and cost plans will notify their beneficiaries of these coverage changes within 30 days of the effective date of the NCD, in accordance with the notification requirements in the MMCM, Chapter 3 (Medicare Marketing Guidelines), Section 60.8. CMS also expects that plans will notify their contracted physicians and other contracted health care providers of the changes to coverage, as well as provide instructions for appropriate processing of claims, if appropriate.

If you have questions about information or guidance in this memorandum, please contact Heather Hostetler at [heather.hostetler@cms.hhs.gov](mailto:heather.hostetler@cms.hhs.gov) or (410) 786-4515.