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2006 CALENDAR - MA AND MEDICARE COST PLAN RENEWAL PROCESS
(Calendar Dates Subject To Change)

2005	
April 4	• Announcements of MA capitation rates, local area benchmarks and adjustment factors for 2006
April 8	• CY 2006 Bid Software Package (bid pricing tool and PBP), and technical instructions available for download from the Health Plan Management System (HPMS).
April 18	• Final Day to submit formularies via HPMS
April 21	• HIPPA security compliance date, small health plans
April 25	• Due date for submission of Employer group waiver supplemental application materials
April 25 1 – 3 p.m. EDST	• Conference call to discuss 2006 Call Letter
May 6	• Last day to submit provider-specific plans for an effective date of January 1, 2006
May 20	• CMS begins accepting CY 2006 Bids via HPMS.
June 6	• MA/Drug Benefits final day for MA organizations and cost plan (if applicable) to submit CY 2006 Bids via HPMS • Final date for Medicare Cost Plans to submit Part D applications. • Final date for Employer-Only plan bids offered by regional plans • Final date for Employer-only plan formulary submission
June 7	• CMS begins accepting CY 2006 marketing material for review. • MA organizations may submit 2006 Annual Notice of Change (ANOCs) and Summary of Benefits (SBs) to the Regional Offices for review.
July 1	• Final date for Employer-Only plan bids offered by local MA and MA-PD plans
July 15	• Final date for MA organizations and Medicare cost plans to submit **CY 2005** marketing materials for CMS's review and approval. Note: This date does not apply to CY 2005 file & use materials since the organization may file these materials with the Regional Office 5 calendar days prior to their use.
August 5	The 2006 Model Evidence of Coverage (EOCs) will be available to HMO/PPO plans. • Cost plans are encouraged to submit ANOCs and SBs so that these materials can be reviewed and approved prior to the posting of Medicare Personal Plan Finder.
September 15	• MA organizations are expected to submit final 2006 ANOCs and SBs to the Regional Offices for review, based on their

	CMS approved benefit bid. Note: If an organization's bid is approved earlier than 9/14 (as noted in HPMS), submit the 2006 ANOC/SB within 72 working hours of approval.
September 16-19	• MA organizations and if applicable, Medicare cost plans, preview the 2006 "Medicare Personal Plan Finder" (MPPF) plan data in HPMS prior to internet release.
October 1	• MA organizations and Medicare cost plans may begin marketing CY 2006 benefits to Medicare beneficiaries using CMS-approved marketing materials. All organizations must cease marketing CY 2005 plans through public media when they begin marketing CY 2006 benefits. • MA organizations and Medicare cost plans are required to include information in CY 2005 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2006.
October 13	• Medicare Personal Plan Finder data goes up on the web.
October 17	• Final day for Medicare cost plans to send non-model ANOCs to CMS Regional Offices. Cost plans are encouraged to submit all ANOCs to CMS in advance of this date to ensure the ANOC can be reviewed, approved, printed, and received by members by the December 1 deadline. Note: if the Medicare cost plan follows the model ANOC without modification, the final date to send the ANOCs to the CMS Regional Office is November 20.
October 31	• All organizations must cease marketing CY 2005 plans through public media.
October 31	• CY 2006 ANOCs (with SBs) are due to all MA members. MA organizations must mail the ANOCs and SBs before this date to ensure receipt by members by October 31
November 15 – May 15, 2006	• Annual Election Period. All organizations must hold open enrollment.
December 1	• CY 2006 ANOCs (with SBs) are due to all cost plan members. Medicare cost plans must mail the ANOCs and SBs before this date to ensure receipt by members by December 1.
December 16	• Final date for MA organizations and Medicare cost plans to send non-model EOCs to CMS Regional Offices. Organizations are encouraged to submit all EOCs to CMS in advance of this date to ensure the EOC can be reviewed, approved, printed, and mailed to members by the February 1, 2006 deadline. Note: if the organization follows the model EOC without modification, the final date to send the EOCs to the CMS Regional Office is January 21, 2006.

2006	
January 1	• Plan Benefit Period Begins

February 1	• Final date to mail CY 2006 EOCs to members with an effective date of 1/1/2006. Due to the Annual Election Period being extended through May 15, 2006, all subsequent members must receive their EOCs within 30 days of their enrollment effective date.

2006 CALENDAR - MEDICARE ADVANTAGE NON-RENEWAL PROCESS
(Calendar Dates Subject To Change)

2005	
April	• CMS posts final non-renewal instructions on the Call letter and on the CMS websites.
May 2	• Deadline for MA organizations to notify CMS of an intention to non-renew a county for individuals, but continue the county for employer group health plan members. • Deadline for MA organizations to submit partial county service area reduction requests.
June 6	• Deadline for MA organizations to submit a non-renewal or service area reduction notice to CMS.
June 13	• CMS issues an acknowledgement letter to all MA organizations that are non-renewing or reducing their service area.
June	• CMS will release detailed information on the 2005 non-renewals. • Press Release: Statement from CMS Administrator (tentative)
July 1	• CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS website, and sends copies of the letters to MA organizations that are non-renewing or reducing their service area.
July 15	• Optional: MA organization that are non-renewing or reducing their service area can send a CMS approved interim notification letter no later than August 1st.
September	• CMS approves MA Organizations' final notification letter. • CMS will release a Special Election Period (SEP) letter to MA organizations remaining in the non-renewed service areas. • MA organizations can begin mailing the final notification letter. The final notification letter must be personalized and dated 10/2/05. The letter must be in the beneficiaries' hands by 10/02/05
October 2	• MA organizations must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.
November	• CMS issues "close out" information/instructions to MA Organizations that are non-renewing or reducing their service area.

2006 CALENDAR - MEDICARE COST PLAN NON-RENEWAL PROCESS
(Calendar Dates Subject To Change)

2005	
March	• CMS posts the 2006 Medicare Cost Plan non-renewal instructions on the CMS website.
July 1	• CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS websites.
October 2	• Deadline for Medicare Cost Plans to submit a non-renewal or service area reduction notice to CMS.
October 11	• CMS issues an acknowledgement letter to all Medicare Cost Plans that are non-renewing or reducing their service area.
October 14	• CMS approves Medicare Cost Plans' final beneficiary letter and public notice.
October 21	• Medicare Cost Plans can begin mailing the final notification letter. The final notification letter must be personalized and dated 11/02/05, and be in the beneficiaries' hands by 11/02/05.
December 2	• Medicare Cost Plans must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.

Part I. Statutory and Regulatory Information

MA Election Periods and Effective Dates

The table below outlines MA election periods and effective dates for enrollment in 2006 (enrollment periods for Part D follow this section).

MA Election Period	Effective Date
Annual Coordinated Election Period (AEP): For 2006, the AEP is from November 15, 2005 through May 15, 2006. Each individual has one AEP election that will take effect.	January 1, 2006 for elections received before December 31, 2005. Elections made between January 1, 2006 and May 15, 2006, are effective on the 1st day of the month following the month the election was made.
Initial Coverage Election Period (ICEP): For individuals whose initial month of eligibility for Medicare is January 2006 or earlier, the ICEP is the 3 month period immediately prior to an individual's entitlement to both Medicare Part A and Part B. For individuals whose initial month of eligibility for Medicare is after January 2006, the ICEP begins 3 months prior to the month the individual is entitled to both Medicare Part A and Part B and ends on the later of: • The last day of the month preceding the month of entitlement to both Part A and B, or: • The end of the individual's Initial Enrollment Period for Part B. The Initial Enrollment Period for Part B begins 3 months prior to the month of initial Medicare eligibility, and ends on the last day of the third month following the month of initial Medicare eligibility. Example: Mrs. Jones is first eligible for Medicare on July 1, 2006. Her Part B Initial Enrollment Period is April 1, 2006 through October 31, 2006. Each individual has 1 ICEP enrollment election that will take effect.	Enrollment elections made prior to entitlement are effective on the 1st day of the month of entitlement to both Part A and B. Enrollment elections made after the month of entitlement to both Part A and B, but before the end of the individual's Initial Enrollment Period for Part B, are effective the first of the month after the month in which the election was made.
Open Enrollment Period (OEP): In 2006, the OEP is January 1, 2006 through June 30, 2006. Eligible individuals may make one election to the same type of plan with regard to Part D qualified prescription drug coverage. For example, an individual enrolled in Original Medicare and a PDP may elect an MA-PD, but may not elect an MA-only (not an MA-PD) plan. OEP NEW: In 2006, an individual who becomes MA	OEP, OEP-NEW and OEPI elections are effective on the 1st of the month following the month the election was made.

eligible during 2006 may make **one** MA OEP-NEW election during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 6th month of entitlement, or on December 31, 2006, whichever occurs first, subject to the limitations described above for the OEP. In 2007 and going forward, the OEP-NEW period begins with the month of entitlement to both Part A and Part B and ends on the last day of the 3rd month of entitlement, or on December 31st of the same year, whichever occurs first. An OEP-NEW election is separate from an OEP election. <u>Open Enrollment Period for Institutionalized Individuals (OEPI):</u> After 2005, an individual who is eligible to elect an MA plan and who is institutionalized may at any time elect an MA plan or elect to disenroll from an MA plan. As there is a corresponding SEP in Part D for such individuals, the limitations described above for the OEP and OEP-NEW do not apply.	
Special Election Periods (SEP): Special election periods are fully described in the Medicare Managed Care Manual (MMCM), Chapter 2; "Medicare Advantage Enrollment and Disenrollment," section 30	A future revision to Chapter 2 will outline effective dates.

Elections are made at the plan (i.e. PBP) level. Both enrollments and disenrollments are elections. Because an individual may only be enrolled in one MA plan at a time, when an individual enrolls in an MA plan from another MA plan with no break in coverage, the enrollment into the new plan and the "automatic disenrollment" from the first plan count as 1 election.

> Example: Mrs. Jones in enrolled in XYZ MA Organization Plan A, an MA-PD plan. She uses her OEP election to choose Plan B (also an MA-PD plan) offered by the same organization for May 1, 2006. When the organization submits the enrollment transaction for Plan B, Mrs. Jones will be automatically disenrolled from Plan A as of April 30, 2006 and enrolled in Plan B on May 1, 2006. This activity counts as Mrs. Jones' 1 OEP election.

PDP Enrollment Periods

Enrollment periods for PDPs are coordinated with the MA election periods and include:

Part D Enrollment Period	Effective Date
<u>Annual Coordinated Election Period (AEP):</u> For 2006, the AEP is from November 15, 2005 through May 15, 2006.	January 1, 2006 for elections received before December 31, 2005. Elections made between January 1, 2006 and May 15, 2006, are

<table>
<tr><td></td><td>effective on the 1st day of the month following the month the election was made.</td></tr>
<tr><td rowspan="2"><u>Initial Enrollment Period</u>:
Is November 15, 2005 – May 15, 2006 for individuals that are currently Part D eligible and those who will become Part D eligible in November or December 2005 and January 2006.

For individuals that become Part D eligible after January 2006, generally the initial enrollment period is concurrent with the initial enrollment period for Part B.

The Initial Enrollment Period for Part B begins 3 months prior to the month of initial Medicare eligibility, and ends on the last day of the third month following the month of initial Medicare eligibility. Example: Mrs. Jones is first eligible for Medicare on July 1, 2006. Her Part B Initial Enrollment Period is April 1, 2006 through October 31, 2006.

The Initial Enrollment Period for Part D applies to all PDPs.</td><td>January 1, 2006 is the effective date for elections received before December 31, 2005.

Elections made between January 1, 2006 and May 15, 2006, are effective on the 1st day of the month following the month the election was made.</td></tr>
<tr><td>Enrollments made prior to the month of initial eligibility are effective the first day of the month of eligibility.

Enrollments made during or after the first month of eligibility are effective the 1st of the month following the month the request was made.</td></tr>
</table>

Special Enrollment Periods (SEP): SEPs will be fully described in PDP enrollment and disenrollment guidance to be provided later in Spring 2005. These will include SEPs for: • Individuals dually eligible for Medicare and Medicaid • Non-dual individuals who's enrollment into a PDP was facilitated by CMS • Individuals in institutions • Individuals who involuntarily lose creditable coverage (except for loss of such coverage due to failure to pay premiums) • Individuals not adequately informed of a loss of creditable coverage or that s/he never had creditable coverage • Individual's enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal employee • Individuals who disenroll from an MA-PD plan, as permitted by §422.62(c), to the Original Medicare plan • Contract termination • Loss of eligibility because of a permanent move out of Part D plan service area • Contract violation • Exceptional circumstances, including: o Relation of employer group coverage o Other circumstances as defined by CMS	

Cost Plan Enrollment Periods

A cost plan must be open for enrollment for a period of at least 30 consecutive days as described in the Medicare Managed Care Manual, Chapter 17, Sub-chapter D. MA election periods do not apply.

A Cost plan may offer a Part D plan as an optional supplemental benefit. Individuals who want to enroll in this optional supplemental benefit must also enroll in the cost plan. Enrollment in this optional supplemental benefit must occur during a Part D plan enrollment period (see table above). Individuals enrolled in a cost plan and its optional supplemental Part D plan who disenroll from the cost plan are automatically disenrolled from the optional supplemental Part D plan. Such individuals may enroll in another Part D plan only during established Part D enrollment periods.

Optional Involuntary Disenrollment for MA Plans

Involuntary Disenrollment for Failure to Pay Plan Premiums – The required grace period for disenrollment due to the non-payment of plan premiums has been changed to a minimum of 1 month. Chapter 2 of the MMCM will be updated to provide more information about this change.

Involuntary Disenrollment for Disruptive Behavior – The process for requesting consideration of involuntary disenrollment for disruptive behavior has been revised to focus on behavior that substantially impairs the MA organization's ability to arrange or provide care to the disruptive individual or other plan members. Chapter 2 of the MMCM will be updated to provide complete information range or provide care to the disruptive individual or other plan members.

Definition of MA PPO Plan Type

Overview of plan types: There are three basic types of MA plans: coordinated care plans (CCPs), private fee-for-service (PFFS) plans and Medical Savings Account (MSA) plans. The MMA created two new types of CCPs: regional PPO plans and specialized MA plans for special needs individuals. A regional PPO plan is a private health plan that operates as a PPO but that also serves an entire CMS-designated MA region. Local plans are MA plans that are not regional PPO plans, i.e., their service areas consist of counties chosen by the MA organization. Special needs plans are CCPs, and may be local or regional PPO plans.

An employer or union group health plan that is an "800-series" plan open only to group enrollment cannot be a regional PPO plan, with one exception. If the MA organization offering a regional PPO plan that is open to individual enrollment also is offering an 800-series employer group health plan in the identical service area, this EGHP plan can be considered a regional PPO plan.

An RFB (Religious Fraternal Benefit) society plan can be any of the three basic types of MA plan - CCP, PFFS, or MSA plan.

PPO plans. Section 422.4 defines an MA PPO plan as a plan that has a network of providers that has agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and, only for purposes of quality assurance requirements in §422.152(e), is offered by an organization that is not licensed under State law as an HMO. In Subpart A of the final MA rule we discuss the rationale for refining the definition of MA PPOs and in Subpart C we discuss our approach to the statutory requirement that MA PPOs (both local MA PPO plans and regional MA PPO plans) must provide reimbursement for all plan-covered benefits regardless of whether those benefits are provided within the network of contracted providers. Higher cost sharing can be imposed for receipt of covered benefits out-of-network; however beneficiary cost sharing cannot exceed 50 percent or 20 percent greater than the stated cost share if the in-network cost share is 50 percent of the total cost of the service.

On December 14, 2004, CMS provided the following question and answer to all Medicare Advantage Preferred Provider Organizations:

> **Q:** What rules may an MA PPO plan apply for enrollees who are accessing out-of-network providers? Specifically, can a PPO plan apply pre-authorization requirements as a condition for payment or for enrollee access to out-of-network providers?

A: MA PPOs may use permitted authorities and established review techniques to conduct pre-authorization activities for the following purposes:

1. To determine medical necessity. These prospective review techniques must be applied consistently on both in- and out-of-network services. We understand that the primary purpose for using prospective review is to ensure that beneficiaries seeking out-of-network care are not financially burdened by retrospective adverse medical necessity determinations. **MA PPOs are not allowed to require their beneficiaries to secure authorization prior to receiving out-of-network services for the purpose of denying services.** Should a member receive medically necessary plan-covered services from a qualified provider, in a non-network setting, but without following the established review techniques, the PPO must pay for the service. In these instances, the PPO may charge the beneficiary higher cost-sharing for this service. Any health care service that the member receives that is determined not to be medically necessary can be denied by the PPO.

2. To determine if a service is a medical service that is covered by the plan.

3. To determine if a non-network provider is qualified to provide the plan-covered services. A PPO may require that in order to be a covered service the non-network provider must meet the PPO's terms and conditions of participation and payment.

Further, MA PPOs may restrict reimbursement to the provision of such covered services by Medicare qualified providers, that is, providers who are eligible to be paid by original Medicare and meet the requirements at section 422.204(b)(3).

MA PPOs may encourage beneficiaries to use pre-authorization by offering favorable cost sharing on out-of-network services.

Note that the question and answer was clarifying that MA organizations could not require pre-authorization prior to receiving out-of-network services for the purpose of denying services. However, (see that last paragraph above) they are permitted to encourage beneficiaries to use pre-authorization by offering favorable cost sharing on out-of-network services when pre-authorization is voluntarily sought by PPO members. Therefore, MA PPO plans must first market their out-of-network cost sharing without referring to "reductions" or "rewards" that might be available if certain plan pre-notification or pre-authorization rules are voluntarily followed by plan enrollees. In other words, MA PPOs must first tell potential and current enrollees what the cost sharing will be if the member accesses covered care out-of-network without first notifying the plan. Once that baseline information is provided, MA PPOs can then explain incentives they offer to enrollees who participate in voluntary plan pre-authorization, pre-certification or pre-notification option(s). We encourage MA organizations to prominently display rewards (such as reduced cost sharing) that are available to members when accessing covered services out of network who voluntarily participate in pre-authorization procedures.

MA PPOs may not impose "penalties" (such as denying covered benefits or imposing fines or monetary penalties in addition to the normal out-of-network cost sharing) for non-participation in pre-notification or pre-authorization protocols. MA PPOs may only reward beneficiaries when/if beneficiaries voluntarily participate. Please carefully review 42 CFR 422.105(b)(4) where we provide regulatory guidance on POS-LIKE features that MA PPOs plans may contain.

The following examples illustrate the typical differences--- penalty vs. reward --- between a POS benefit in a MA Coordinated Care plan vs. a POS-LIKE benefit in an MA PPO:

Example 1: An MA HMO/POS plan that charges 20 percent coinsurance for authorized in-network provider visits may elect to offer a POS benefit that charges 30 percent coinsurance for out-of-network provider visits. The HMO is permitted to impose a penalty on members that "misuse" the POS benefit when, for instance, the member does not first receive authorization to receive an out-of-network provider service. An HMO/POS plan can thus establish rules related to its out-of-network benefits that have the effect of imposing penalties on members who do not follow those rules.

Example 2: By contrast, a PPO that charges 20 percent coinsurance for in-network provider visits may charge 30 percent coinsurance for out-of-network provider visits. Although the PPO is permitted to impose authorization rules on in-network care for the purpose of denying services. However, the PPO can only offer to reduce cost sharing to 20 percent, for instance, if a member voluntarily participates in a pre-authorization program related to out-of-network provider care.

Part D Rules

Sec. 423.104 (f)(3) says that an MA organization can offer an MA coordinated care plan in a service area – either local coordinated care or regional PPO– only if that plan, or another MA plan offered by the same organization in the same service area, includes required prescription drug coverage under Part D. This rule applies only to coordinated care plans. By law, all regional plans are PPOs and therefore are also by definition coordinated care plans. See 423.104(f)(4) and 417.440(b)(2) for rules related to cost plans offering Part D.

All Special Needs Plans, which are a type of MA coordinated care plan, are required to provide Part D prescription drug coverage. See the definition of special needs plan in CFR 422.2. This is an important beneficiary protection because special needs individuals must have access to prescription drugs to manage and control their special health care needs.

The MMA specifies that MSA plans may not offer Part D coverage and PFFS plans and cost plans have the option of offering Part D coverage. If a beneficiary enrolls in an MSA plan, a PFFS plan, or a cost plan that either does not offer Part D coverage (or, in the case of a cost plan, if the member also does not select the Part D offering of a cost plan), s/he may also enroll in a Prescription Drug Plan (PDP). Otherwise, if the beneficiary enrolls in an MA coordinated care plan, and even if that MA coordinated care plan does not offer Part D coverage, s/he cannot enroll in a PDP. Note that since cost plans must offer Part D coverage only as an optional supplemental benefit, this means that for a cost plan enrollee in a plan that offers Part D, as long as the cost member does not elect Part D from the cost plan, s/he may also enroll in a PDP at the same time s/he is enrolled in the cost plan.

Plan Type	Regional or Local MA Plan?	Must offer Part D?	Can an enrollee elect a PDP?
MA Coordinated Care Plan (CCP)			
HMO	Local	Yes. 423.104(f)(3) Rule*	no
HMO-POS	Local	Yes. 423.104(f)(3) Rule*	no
PPO	Either	Yes. 423.104(f)(3) Rule*	no
Special Needs Plan (SNP)	Either	Yes, required	no
Provider-sponsored organization (PSO)	Local	Yes. 423.104(f)(3) Rule*	no
Part B-only CCP	Local	Yes***	no
MA Private Fee-for-Service (PFFS) Plan			
PFFS plan with Part D	Local	Option = yes	no
PFFS plan without Part D	Local	Option = no	yes
MA Medical Savings Account (MSA) Plan	Local	Not allowed	yes
Sec. 1876 Cost Plans			
Cost plan offering Part D qualified prescription drug coverage	NA	No. Can only be offered as optional supp. benefit	yes
Cost plan not offering qualified Part D coverage but offering some outpatient drug coverage**	NA	Can only be offered as optional supp. benefit	yes
Cost plan not offering any outpatient prescription drug coverage	NA	NA	yes
Sec. 1833 Cost plan - HCPP	NA	HCPPs can offer Part D under 1860D-21(b) authority to the extent that a waiver under 43 CFR 423.458(c) has been granted and to the extent the HCPP is sponsored by an employer or union.	yes
Demonstration Plans			
Social HMO plans (SHMOs)	NA	Yes	No
MN Disability Health Options	NA	Yes	No
MN Senior Health Options	NA	Yes	No
MA Senior Care Organizations	NA	Yes	No
WI Partnership Program	NA	Yes	No
PACE plans	NA	Yes****	No

Table 2. Plan Types and Part D Rules

* **423.104(f)(3) Rule.** An MA organization can offer an MA coordinated care plan (CCP) in a service only if that plan, or another MA plan offered by the same organization in the same service area, includes required prescription drug coverage under Part D. This rule applies to regional plans because they are CCPs and must be offered as PPOs.

- "Required" prescription drug coverage means coverage of Part D drugs under an MA-PD plan that consists of either: (1) Basic prescription drug coverage; or (2) Enhanced alternative coverage, provided there is no MA monthly supplemental beneficiary premium due to the application of a credit against the premium of a rebate.
- Exception to 423.104(f)(3): SNPs must offer Part D, regardless of whether the SNP sponsor offers another coordinated care MA-PD plan in the same service area as the SNP.

** This option is unique to the Sec. 1876 cost plan program. This option of offering other than qualified Part D coverage is not available to MA plans.

*** Part B-only CCPs. To accommodate "grand fathered" Part B-only enrollees in CCPs, we will require MA organizations with such members to offer at least one MA-PD plan in which Part B-only members can enroll.

**** PACE organizations will no longer receive payment for prescription drugs from Medicaid on behalf of dual eligible enrollees. As a result, we anticipate that these organizations will elect to provide Part D coverage in order to receive payment for the prescription drug coverage that they are statutorily required to provide.

Guidance Regarding MA Special Needs Plans (SNPs)

1. Updated SNP guidance - For further assistance, please note that we have posted a complete **SNP Q&A document** that addresses frequently asked questions regarding the offering of MA SNPs at the following web address:

www.cms.hhs.gov/healthplans/specialneedsplans/default.asp

2. Bidding issues – There are special bidding instructions for all MA plans (including SNP's) that enroll dual-eligible beneficiaries. These bidding rules are described in this call letter under the section titled "**Bidding Rules Regarding Cost Sharing with Dual-Eligibles**". Otherwise, MA SNP's are subject to the same bidding requirements as other MA plans.

3. Passive Election of Medicaid Dual Eligible Individuals into Special Needs Plans – Under certain conditions, and with CMS approval, Medicare Advantage organizations with a current Medicaid managed care contract and a dual eligible MA Special Needs Plan (SNP) in the same service area may passively enroll members of their Medicaid plan with Original (fee-for-service) Medicare into the SNP for an effective date of January 1, 2006.

We must receive proposals to passively enroll full dual eligibles for a January 1, 2006 effective date no later than June 6, 2005. You must currently be an MA SNP or have a SNP application pending in CMS. We will review each proposal to determine if all of the criteria below are met:

- The MA SNP must mail a notice that explains the passive enrollment process and describes the plan's benefits. Beneficiaries must receive this notice by October 1, 2005 and be able to opt out until October 31, 2005. CMS will provide a model notice later in Spring 2005;

- The MA SNP cannot charge the beneficiary any premiums for Medicare Part A and B services;

- The MA SNP network must include all of the Medicaid plan providers, or the SNP must allow the providers who meet its credentialing requirements to participate in its network;

- The pharmacy benefits manager that administers the pharmacy benefit for the Medicaid plan must also administer the Part D benefit for the MA SNP. [Note: this requirement should be taken into consideration when establishing the MA-PD formulary, which is due April 18, 2005.]; and,

- The MA organization has established a transition plan that takes into account the unique needs of this population. For example, the MA organization could allow beneficiaries passively enrolled into the SNP to continue to access care from non-network providers for a defined period of time to ensure a smooth transition to the new network.

Please send two (2) hard copies to the following address:

Centers for Medicare and Medicaid Services
7500 Security Boulevard, MS C4-23-07
Baltimore, Maryland 21244-1850
ATTN.: Sandra Bastinelli

Please also submit an electronic copy via e-mail to: Sandra.bastinelli@cms.hhs.gov and two (2) hard copies to your Regional Office Plan Manager.

MA organizations that received CMS approval must submit a list of those dual eligible individuals to be enrolled via this process into the SNP with an effective date of January 1, 2006 to CMS no later than July 15, 2005. These individuals will not be included in the Part D auto-enrollment process scheduled to occur later this fall. MA organizations must also provide CMS with a list of those beneficiaries who opt out of its SNP no later than November 4, 2005. CMS will provide the format for submission of all information at a later date. These dates are critical due to systems constraints and to ensure that dual eligibles have Part D coverage effective January 1, 2006.

Please note the following:

- All MA SNPs must be MA-PDs effective January 1, 2006.
- This is a one-time only process and applies only to January 1, 2006 SNP enrollments. For those MA organizations that currently have a SNP, or will have one effective later in 2005, dual eligibles in the organization's Medicaid managed care plan in the same service area as its SNP must actively choose to join that plan.
- Dual eligibles enrolled in both an organization's Medicaid managed care plan and one of that organization's MA plans must actively choose (elect) to be in the SNP.
- Dual eligibles currently enrolled in an MA plan offered by another MA organization, will not be included in this passive enrollment process.

- Consistent with our current policy, organizations may use the short enrollment form provided in Chapter 2 of our Medicare Managed Care Manual to elect a SNP within the same MAO.
- New dually eligible beneficiaries who enroll in the MA organization's Medicaid managed care plan after July 15, 2005 may not be passively enrolled into the SNP. This is necessary because these individuals will be included in the Part D auto-enrollment process.

  MAOs must ensure that their proposal is consistent with laws governing dual eligibles in their particular state.

Regional PPOs (RPPOs)

The Regional PPO option was added to the Medicare Advantage program under the Medicare Modernization Act (MMA). Congress created the RPPO program in an effort to bring managed care to a broader range of Medicare beneficiaries, including those in rural areas.

CMS announced the twenty-six Medicare Advantage Regional PPO Regions on December 6, 2004. Entities must submit a separate bid for each MA region, and the service area for this bid must be an entire MA region. The MMA states that RPPO plan service area cannot be segmented. The benefit package must be uniform across the Region. An entity may offer an RPPO in multiple MA regions. Review of the Regional PPO applications will be coordinated by staff in the CMS Central Office, with support from the appropriate Regions.

CMS will work one-on-one with applicants to overcome obstacles and will employ flexibility in collecting and assessing supporting information. Applicants must demonstrate a good faith effort in submitting materials in a timely and complete manner.

Beyond the flexibility in the review process, the MMA and implementing regulations provide flexibility in structuring the RPPO, as compared with local coordinated care plan options. For example, under certain circumstances, RPPOs may rely on non-contracted "essential hospitals" and/or out-of-network providers to meet access requirements, generally by allowing enrollees to go to out-of-network providers at in-network cost sharing levels. "Essential hospitals" also may seek additional payments from CMS where they can demonstrate on a claim by claim basis that their costs exceed fee-for-service Medicare rates.

We encourage entities considering the Regional PPO program to contact Helaine Fingold (410) 786-5014 in the Medicare Advantage Group. She is coordinating the review of RPPO applications and can work with you on any questions you have.

Changes in Risk Adjustment Implementation

The following submission calendar is for all diagnosis data submitted for all risk adjustment models. This includes data for both the Part C CMS-HCC and ESRD models and the Part D Drug risk adjuster model.

Specific changes in implementation that differ include updated risk adjustment data collection and submission dates:

CY	Dates of Service	Initial	First Payment	Final Submission

		Submission Deadline	Date	Deadline
2004	Jul 1, 2002– Jun 30, 2003	Sep 5, 2003	Jan 1, 2004	NA**
2004*	Jan 1, 2003-Dec 31, 2003	Mar 5, 2004	Jul 1, 2004	May 13, 2005
2005	Jul 1, 2003- Jun 30, 2004	Sep 3, 2004	Jan 1, 2005	NA**
2005*	Jan 1, 2004-Dec 31, 2004	Mar 4, 2005	Jul 1, 2005	May 15, 2006
2006	Jul 1, 2004- Jun 30, 2005	Sep 2, 2005	Jan 1, 2006	NA**
2006*	Jan 1, 2005- Dec 31, 2005	Mar 3, 2006	Jul 1, 2006	Jan 31, 2007
2007	Jul 1, 2005-Jun 30, 2006	Sep 8, 2006	Jan 1, 2007	NA**
2007*	Jan 1, 2006-Dec 31, 2006	Mar 2, 2007	Jul 1, 2007	Jan 31, 2008

* Denotes non-lagged schedule.

** With the elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15th through 2006 and then becomes January 31 from 2007 forward. There is no longer a September 30th deadline for reconciliation.

Change in payment methodology for 2006, including bid-based payments for Part C, the new Part D payment methodology, and the Part D risk adjustment model, are described in the February 18th, 2005, *Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage Payment Rates* and the April 4, 2005 *Announcement of Calendar Year (CY) 2005 Medicare Advantage Payment Rates, on the CMS website at* (http://cms.hhs.gov/healthplans/rates).

National Coverage Determination (NCD) and a Legislative Change in Benefits

In October of 2004, CMS issued a legislative change in benefits that met the significant cost threshold and in January 2005 issued an NCD that met the significant cost threshold described in section 1852(a)(5) of the Social Security Act and 42 CFR 422.109 of the Medicare regulations.

The legislative change in benefits, effective October 2004, was to conduct a clinical investigation of pancreatic islet cell transplantation that includes Medicare beneficiaries. Medicare will cover islet cell transplantation for patients with Type I diabetes who are participating in National Institutes of Health (NIH)-sponsored clinical trial.

The NCD further expanded the coverage of implantable cardioverter-defibrillator (ICD). It became effective January 2005.

As stated in 42 CFR 422.109(b), if CMS determines and announces that an NCD meets the significant cost criteria, an MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. Therefore, as stated in our memoranda to plans on the NCD and the legislative change, CMS will make payments on a fee-for-service basis for services directly related to the NCD and legislative change from the effective date for each through December 31, 2005.

In accordance with 42 CFR 422.109(d), MA organizations are not liable for payment for costs relating directly to the provision of this NCD service and legislative change in benefits until January 1, 2006, when payments can be appropriately adjusted to take into account the cost of this new coverage. As of January 2006, these services or benefits will be included in the MA

organizations' payments and are covered under the MA contract. MA organizations must furnish, arrange, or pay for these services and benefits and MA plan enrollees will be liable for the plan's cost sharing for these services beginning January 1, 2006.

Plan Premium Withhold Process

The MMA allows beneficiaries to have their Part C and Part D premiums withheld from their monthly benefits received from the SSA, RRB, or OPM. Beneficiaries can also continue to pay their premiums directly to the plans.

The premium withhold process relies on data reported by the plans and on an interface between SSA/RRB/OPM and CMS. Plans submit premium information for new members on the enrollment transaction and for current members on the new Change Transaction type 72. The type of information submitted includes the Part C and D premiums, the premium payment option, creditable coverage status and noncovered months. (Note that the plan should attempt to obtain creditable coverage information from the beneficiary at the time of enrollment; i.e., by asking if the beneficiary has another health insurance card. If this information cannot be obtained, the plan should indicate no creditable coverage and zero noncovered months on the enrollment transaction.)

The Part C amount reported includes premiums for any optional supplemental benefits selected by the member. The Part D amount reported is the base premium or the base plus enhanced premium, depending on the beneficiary's election.

The premium payment options are direct pay or withhold from a SSA, RRB, or OPM benefit check. In the former case, the plan receives payment directly from the member. In the latter cases, CMS reimburses the plan after receiving confirmation that a specified premium amount was deducted from the member's benefits. If SSA, RRB, or OPM are unable to deduct the full amount of the premium from the benefit check (due to insufficient funds), CMS notifies the plan to bill the member for the full premium amount due.

The plan also reports if the beneficiary had creditable coverage and the number of uncovered months. In cases where a beneficiary failed to enroll in Part D in a timely manner, a late enrollment penalty is added to their Part D premium. This penalty is reduced if the beneficiary had other creditable drug coverage. Utilizing the data reported by the plan, CMS determines the amount of the penalty and reports the late enrollment penalty amount as well as the total premium amount back to the plan.

The late enrollment penalty remains with the beneficiary through all subsequent Part D enrollment periods. While it is true that this penalty amount is retained by CMS, it is part of the premium and is to be collected as part of that premium. If the beneficiary elects to pay the premium directly to the plan, the plan collects the penalty amount as part of that premium. CMS "collects" this late enrollment penalty by offsetting against the premiums paid to the plan from those withheld by SSA, RRB, or OPM. If the beneficiary elects to have the premium withheld, CMS deducts the late enrollment penalty from the premium prior to passing it on to the plan. CMS will provide a monthly beneficiary-level premium report that will provide premium withhold information including any subsidized amounts and late enrollment penalty amounts to allow plans to track these payments.

There are two rules associated with the premium withhold process; the "all or nothing" rule and the "single payment option" rule.

The all or nothing rule is that the entire premium amount due must be able to be deducted from the beneficiary's monthly benefit. Partial deductions are not allowed. No deduction will occur even if a portion of the premium amount due could be withheld. In this situation, CMS will notify the plan to bill the member for the full premiums due and for subsequent monthly premiums.

The single payment option rule is that, when both a Part C and a Part D premium are applicable, only one payment option can be elected by the member. This rule applies to a single plan enrollment. If a beneficiary is enrolled in two plans, two payment options can be elected.

EXAMPLE:

Beneficiary enrolls in a MA-PD plan for Part C and Part D coverage. This results in a single premium and the member must elect one payment option.
Part C/D premiums – Withhold from RRB benefit

Beneficiary enrolls in a Private Fee for Service plan for Part C coverage and a PDP for Part D coverage. The member may elect one or two payment options.
Part C premium – Direct pay
Part D premium – Withhold from SSA benefit

Payments to plans for members that choose to have their premiums withheld from other benefit payments will occur in 2 steps. The amounts of the premiums that will be subsidized by CMS for low-income individuals will be included in the monthly capitated payment.
The portion of the premiums that will be withheld from benefits will be paid by the middle of the month following the capitated payment for that month.

EXAMPLE:

Plan submits enrollment on 12/15/2005 with a 1/1/2006 effective date.
Beneficiary has elected to have their premiums withheld from their SSA benefit.
CMS sends the information to SSA for deduction from the benefit check on 12/16/2005.
SSA processes the monthly benefit payments on 12/26/2005.
CMS pays the plans for January (including the premium amounts subsidized by CMS) on 1/1/2006.
SSA sends the monthly file of the results of premium processing to CMS on 1/5/2006.
Plan receives payment for the January premiums withheld on 1/15/2006.

There will be a new Premium Withhold Report that will contain the premium payment option, premium amounts withheld (including any late enrollment penalty or low-income subsidy amounts applicable), creditable coverage months, late enrollment penalty amount, low-income subsidy amount and low-income late enrollment penalty subsidy amount.

The report will contain information for plan members that have elected to have their premiums withheld from other benefit payments. It will allow plans to reconcile premium payments and deductions made to them by CMS. The premium payments will be separate from the monthly capitated payments, so it was decided not to add this information to the MMR.

Premium payments to plans will include (as applicable):
Part C/D premiums withheld from other benefit payments

Low-income portion of the Part D premium that CMS is subsidizing
Deductions for the late enrollment penalty for directly billed beneficiaries

SSA, RRB and OPM return premiums withheld from benefit payments to CMS. CMS passes these amounts on to the plans.

For members identified as being low-income, CMS subsidizes a portion or all of their Part D premiums. CMS will provide these amounts as additional payments to the plans for directly billed members, as well as for members that elect to have their premiums withheld.

CMS retains the late enrollment penalty. These amounts will be offset from the plan's aggregate monthly premium payment for directly billed members. For members who elect to have their premiums withheld from other benefits, the late enrollment penalty will be subtracted from the premium payment amounts made to plans. CMS subsidizes a portion of some low-income beneficiaries' late enrollment penalty. For these members, the amount of the late enrollment penalty will be reduced.

MA Regional Plan Stabilization Fund

Section 221 of the MMA added Section 1858(e) to the Act to create a new MA Regional Plan Stabilization Fund. The purpose of the fund is to provide financial incentives to MA organizations to offer MA regional PPO plans in each MA region, and to retain MA regional PPO plans in regions with relatively low MA market penetration. Specifically, the MMA authorizes CMS to make a one-year "national bonus payment" to an organization(s) that offers an MA regional PPO plan in each MA region in a given year (if there was no such plan offered in one or more regions in the previous year). If no national bonus payment is made in a given year, CMS may use the fund to increase payments to MA regional PPO plans offered in regions that did not have any MA regional PPO plans offered in the prior year. Finally, to encourage plans to remain in regions with relatively low MA market penetration and few MA regional PPO plans, CMS may make retention payments from the fund to MA regional PPO plans that notify CMS of their intent to exit a region.

The MA Regional Plan Stabilization Fund will initially be funded with $10 billion from the HI and SMI Trust Funds. Half of the 25 percent savings generated each year by regional PPO plans whose bids are below the benchmark is also added to the Fund. As stipulated by the MMA, these funds will be available for payments no earlier than January 1, 2007. Therefore, no payments from the Fund (either plan entry or retention) will be made in 2006. The first payments from the Fund will begin as early as January 1, 2007.

Part II. Administrative Changes and Updates

Annual Contracting (New Mid-Year Plans, SAEs, & MYBEs) in the MA Program

We are doing as much as possible to ensure a fair yet competitive bidding process. We recognize that there will be many uncertainties since this is a new program. Several payment mechanisms will reduce the uncertainty in the bidding process: risk corridor payments for regional PPOs, the geographic ISAR adjustment, and risk adjustment to pay accurately for enrollee health status.

However, the MMA structured the new bidding methodology to foster competition by: (1) establishing an annual bidding process; (2) requiring that certain benchmarks are based on an average

of plans bids; and (3) requiring that the basic A/B bid be structured in a way that allows an "apples to apples" comparison across bids (i.e., the requirement that the basic A/B bid reflect cost sharing that is actuarially equivalent to Medicare cost sharing). Allowing organizations to enter markets "outside" of the annual bidding cycle and allowing mid-year benefit enhancements (MYBEs) throughout the year would undermine the integrity of the bidding process and create an uneven playing field.

Accordingly, there are two basic criteria informing our policy on entry of new mid-year plans and mid-year service area expansions (SAEs) offered by current contractors to the individual market:

1. An MA organization may offer a new mid-year plan or SAE only if that plan's bid is <u>not</u> included in a competitive benchmark calculation required by the MMA.

    - For the original Medicare benefits, all regional PPO plan bids in a region are included in the MA regional benchmarks.
    - For the Part D benefit, most approved Part D bids are included in the national average bid.

2. An MA organization may offer a new mid-year plan or SAE only if there are no competitors in the geographic area(s) the new plan would serve.

<u>Several rules for the individual market flow from these criteria</u>:

1. <u>Regional PPO MA plans.</u> MA organizations cannot offer new mid-year regional PPO plans because all regional plan A/B bids in a region are included in the regional benchmark. This includes special needs plans (SNPs) that are regional PPO plans.

2. <u>Local MA-PD plans.</u> An MA organization may offer a new mid-year local MA-PD plan or SAE <u>if</u> the Part D bid is not included in the national average bid and <u>if</u> the plan will be offered in counties where there are no other Prescription Drug Plans (PDPs) other than fallback plans and where there are no other MA-PD plans.

    Plans whose Part D bids are not included in the national average bid are Special Needs Plans (SNPs), PFFS and cost plans not offering Part D, and PACE organizations.

    For example, if CMS approves a national PDP for a contract year, then CMS cannot approve any new mid-year MA-PD plans or any mid-year SAEs for MA-PD plans.

3. <u>MA plans without Part D benefits</u>. An MA organization may offer a new mid-year local MA plan or SAE without Part D coverage <u>if</u> the plan will be offered in counties where there are no other MA plans (either MA-PD or MA-only plans).

    This applies to PFFS plans not offering Part D and MSA plans. Similar considerations will be applied to cost plans not offering Part D coverage.

    Coordinated care plans (CCPs) would not fall under this exception because they must offer MA-PD plans in all geographic areas where they offer MA plans. SNPs are CCPs, and SNPs must always offer Part D.

4. Timing of bid submission for mid-year new plans or SAEs. MA organizations may not submit bids for new mid-year plans or SAEs until after contracts for the upcoming contract year have been signed. CMS must determine which service areas do not have MA offerings before entertaining mid-year plan proposals.

Exceptions. PACE organizations are allowed to expand service areas mid-year.
Initial contracts. In general, we will not allow mid-year entry of new MA organizations. New contracts with MA organizations for MA plans will be effective only on January 1 of each year beginning on January 1, 2006. Exception: new PACE organizations will be allowed to enter mid-year. There also may be exceptions for employer or union group health plans.

Mid-year benefit enhancement for non-drug benefits (MYBEs). We will allow one MYBE per plan to non-drug benefits only under the following circumstances:

1. A MYBE can be effective no earlier than July 1 of the contract year, and no later than September 1 of the contract year.
2. MA organizations cannot submit MYBE later than July 31 of the contract year.
3. 25 percent of the value of the MYBE will be retained by the government.

The new MYBE can only take the form of reductions in part B premiums, or an enhancement of mandatory supplemental non-drug benefits. The restricted MYBE option applies to MA plans that enroll both beneficiaries from the individual and group plan markets.

See page 4640 in the preamble for Subpart F of the Final Rule implementing the Medicare Advantage program (Final Rule) for a discussion of MYBE policy for MA plans.

Employer Group members reporting process

Beginning in July 2005, plans will begin to report the Employer Group Health Plan (EGHP) status of their new members on the enrollment transaction and beginning in January 2006, they will report the status for existing members on the new Change Transaction Type 72. (See Part II – Premium Withhold Process for an explanation of this new transaction type.) In addition, beginning in January 2006, the EGHP status will be added to the monthly membership report (MMR). (A detailed systems letter containing the record layouts for the new transaction type 72 and the revised MMR was sent to all contracting plans on March 11, 2005.) CMS needs this information to be reported in order to track individual employer group members in preparation for the open enrollment period. In addition, one of the employer group waivers mandates that premiums must be directly billed. CMS requires EGHP status information in order to enforce this waiver. Please note that notification regarding this reporting requirement has been made the last two years but never enforced. We will now begin collecting this data effective July 2005.

MMCS Update – Elimination of Risk-Equivalent Payment Computations to Cost Plans

Currently, MMCS computes a risk-equivalent payment amount for members of cost-based organizations. This is the beneficiary-level amount that would be received by these organizations if they were Medicare-Advantage (MA) plans. These risk-equivalent payment amounts are displayed on the Monthly Membership Reports and on a version of the Plan Payment Reports. The original purpose of the risk equivalent reporting was to provide risk payment information to cost plans to aid in their decisions to convert to a risk based plan.

With the implementation of the plan-specific bid-based payment methodology mandated by the Medicare Modernization Act, the risk equivalent reporting to cost plans will be discontinued. To continue this reporting would impose a significant burden on cost-based organizations as they would be required to submit the same bid information as MA organizations. As a result, cost-based organizations will see the applicable per member per month payment amounts on their Monthly Membership Reports effective January 2006.

Grievance Procedures

Pursuant to section 232(a) of the MMA, State laws pertaining to grievances are preempted. Therefore, section 422.564 of Subpart M has been amended to require MA organizations to apply new grievance procedures. Under the new MA grievance requirements, organizations will be required to notify enrollees of decisions as expeditiously as the enrollee's case requires, but no later than 30 calendar days after receiving a complaint. MA organizations may extend the timeframe by up to 14 calendar days if the enrollee requests the extension, or if the organization justifies a need for additional information and the delay is in the interest of the enrollee.

If an enrollee makes a grievance orally, the MA organization will be able to respond to it orally or in writing, unless the enrollee requests a written response. If an enrollee files a written grievance, then the MA organization will be required to respond in writing. In addition, an MA organization must provide information to enrollees on their right to request a review by a Quality Improvement Organization (QIO) if the grievance involves a quality of care issue.

Coordination of Appeal Processes

Consistent with section 422.560, and contingent upon rules that must be promulgated by the Department of Labor, CMS will provide guidance on how MA organizations should process appeals from enrollees that are entitled to benefits under both an MA plan and an employer group health plan.

Applicability of MA Grievance, Organization Determination, and Appeal Procedures to Cost Plans and HCPPs

Consistent with section 417.600(b), the same rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 will apply to organizations offering Medicare cost plans. Thus, for example, optional supplemental benefits will be subject to an appeals process as opposed to grievance procedures.

A key difference, however, will involve cost plans that employ a billing option available under section 417.532(c)(1), - so called “billing option 1” - which reduces a cost plan's financial liability for certain Part A services. Under billing option 1, hospitals and skilled nursing facilities that furnish services to cost plan members obtain direct reimbursement for these services under the original Medicare claims and appeal procedures (part 405). Therefore, if a fiscal intermediary denies coverage of a hospital, skilled nursing facility, or home health service, an enrollee follows the fee-for-service appeals procedures (Original Medicare) under Part 405. However, if an enrollee has a dispute regarding co-payment or other cost sharing responsibilities as part of one of these services, the MA procedures under Part 422 apply.

Another key difference is that cost plan enrollees may use non-plan providers for Part B services. However, if an enrollee receives services form non-plan providers that are not emergent or urgently

needed care, he or she will usually have to pay Original Medicare deductible and co-insurance amounts otherwise covered by the cost plan. Furthermore, appeals procedures (Original Medicare) under Part 405 apply.

Provider Payment Rules

Section 1853(g) of the Act establishes special payment rules for situations where a beneficiary's coverage by an MA plan begins or ends while the beneficiary is a hospital inpatient. The MMA expanded the list of hospital facilities covered under this provision to include additional facility types that have come under a Medicare prospective payment system. See CFR 422.318

Medical Education Costs

Per sections 1886(d)(11) and 1886(h)(3)(D) of the Act, hospitals with approved medical residency training programs may receive payments from their fiscal intermediaries for operating indirect medical education (IME) costs and direct graduate medical education (DGME) costs for MA enrollees. The MMA did not amend these sections of the Act. Therefore, an MA organization is not required to include IME and DGME amounts in its payments to a non-contracting hospital because the hospital receives these payments from its fiscal intermediary (see §422.214(b)). An MA organization is required to pay a non-contracting hospital no more (and no less) than what the hospital would have received under original Medicare for the MA enrollee.

Federally Qualified Health Centers

Under section 237 of the MMA, FQHCs that contract with MA organizations in accordance with requirements at 42 CFR §422.527 can get additional payment from CMS. Specifically, if an FQHC contracts with an MA organization under terms and conditions that 1) require the MA organization to pay the FQHC a similar amount to what the MA organization pays other contracted providers for similar services, and 2) the FQHC accepts this payment (including allowable member cost sharing) as payment in full for MA plan enrollees, then additional payments to the FQHC by CMS can be made, up to the amount the FQHC would have received for a similar service provided to an original Medicare member. The MA-contracting FQHC should look to its normal source of Medicare payment (the fee-for-service contractor) for the additional payment, if any is due.

Medicare Advantage Quality Improvement Requirements

<u>Chronic Care Improvement Program</u>

The regulations require that Medicare Advantage HMOs and PPOs conduct chronic care improvement programs. As part of these requirements, these plans must:

Develop criteria for a chronic care improvement program that includes:
(1) Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program; and (2) Mechanisms for monitoring MA enrollees that are participating in the chronic care improvement program. We encourage plans to look to the Chronic Care Improvement Program pilot under section 721 of the MMA for guidance on the best ways to conduct such programs.

We will require plans to submit annual reports on these programs to CMS. For 2006, we will require that these reports include information on the diseases served, the types of services offered including the scope of services and a description of the types of measures that are used to assess performance on these programs, including significant outcomes (clinical, satisfaction, costs). It should be noted that plans will not be reporting performance data, only the types of performance measures collected.

Quality Improvement Projects

As of January 1, 2006, Medicare Advantage Organizations (MAO) will not be required to continue QAPI projects begun prior to January 1, 2006. Moreover, MAOs are not required to fulfill reporting requirements on QAPI projects begun prior to January 1, 2006. This includes any previously begun QAPI project, including the 2005 project. Please note that QI projects beginning in 2006 are still required, but will be reported under new requirements and timeframes. Additional information on these new requirements will be provided in the Managed Care Manual.

Performance Assessment projects for Medicare Advantage and Cost Plans

Starting in 2006 CMS will begin to use "Performance Assessment" data for broader purposes. Since 2003, CMS has reviewed Performance Assessment data (HEDIS, CAHPS, HOS, Disenrollment and financial metrics) in order to provide benefit to high performing managed care plans, by way of exempted segments of the on-site monitoring audit. Starting in 2006, CMS will review this data in order to provide targeted review and intervention for those health plans demonstrating low Performance Assessment scores. Specific criteria will be developed during 2005.

Part III. Renewal Process for 2005

Section 1. MA Plan Renewals

Background

An MA plan is the health benefits and pricing package that an MA organization offers to beneficiaries who reside in the plan's approved service area. MA organizations can offer multiple MA plans in the same or different service areas. Each MA plan consists of basic benefits (Medicare covered benefits (Parts A and B) and any mandatory and/or optional supplemental benefits. Additionally, a MA coordinated care plan must offer qualified Part D coverage in at least one plan in the service area. As described in the MA regulations at 42 CFR 422.66, a beneficiary enrolls in a specific MA plan offered by an MA organization.

In general, CMS has determined that a MA plan with a Plan Identification Number under the M+C contract in CY 2005 is a renewal MA plan under the new MA contract in CY2006 if all or part of the MA plan's current service area remains in CY2006. During the annual MA plan renewal season, MA organizations may change the benefits of a renewal MA plan, add new MA plans, reduce the service area of a renewal MA plan, segment the service area of a renewal plan, expand the service area of a renewal MA plan or terminate a MA plan. Within the established definitions and guidelines discussed below, CMS will determine how beneficiary rights will be ensured and how beneficiary elections will be made.

MA Plan Renewal Guidelines and Operational Instructions for MA Organizations

As with past years, MA organizations will be required to complete the HPMS plan crosswalk when uploading their Contract Year 2006 bids. MA organizations use the HPMS plan crosswalk to designate the relationships between plans offered in 2005 to those being submitted for 2006.

The following chart outlines the MA plan renewal guidelines and describes the relationships that can be established between CY 2005 and 2006 plans and how each one relates to the HPMS plan crosswalk, the enrollment system actions to be performed by either the MA organization or CMS, whether and which type of enrollment application is required, and the requirements for beneficiary notifications. It is extremely important that MA organizations review this chart for guidance when determining their plan structures for CY 2006. Technical instructions for completing the HPMS plan crosswalk for each type of relationship will be provided to MA organizations separately.

HPMS Plan Crosswalk
MA Plan Renewal Guidelines and Operational Instructions for MA Organizations

Contract Year 2006 Guidance for Medicare Advantage Plan Renewals

	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
1	New Plan Added		A new 2006 plan with no link to a 2005 plan.	The MA organization must submit election transactions.	Beneficiaries are required to complete an enrollment form. Beneficiaries who are already enrolled in another plan in the same organization can complete the short enrollment form.	Beneficiaries are sent a regular ANOC.
2	Renewal Plan	If an MA organization continues to offer a CY 2005 MA plan in CY 2006 and retains all of the same service area, **it must retain the same plan ID number** in order for all currently enrolled beneficiaries to remain in the same MA plan in CY 2006.	A 2006 plan that links to a 2005 plan and retains all of its plan service area from 2005.	**The renewal plan ID must remain the same** so that beneficiaries will remain in the same plan ID. The MA organization **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
3	Consolidated Renewal Plan	If an MA organization ***combines*** two or more MA plans offered in CY 2005 into a single renewal plan so that all beneficiaries in the combined plans are offered the same benefits in CY 2006, the MA organization must designate which of the renewal plan IDs will be retained in CY 2006 after consolidation. **Note:** If an MA organization reduces a county while performing this activity, the MA organization must follow the Renewal Plan with SAR rules for handling beneficiaries in the reduced county.	Two or more 2005 plans that consolidate into one 2006 plan.	**The MA organizations designated renewal plan ID must remain the same** so that CMS can consolidate the beneficiary's election by moving them in the designated renewal plan ID. The MA organization **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
4	Renewal Plan with an SAE		A 2006 plan that links to a 2005 plan and retains all of its plan service area from 2005, but also adds one or more new counties.	**The renewal plan ID must remain the same** so that beneficiaries in the current service area will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. However, the MA organization must submit election transactions for the beneficiaries involved in the service area expansion.	Beneficiaries who wish to enroll for the new county are required to complete an enrollment form. An exception is that only the short enrollment form needs to be completed if the beneficiary is currently enrolled in another MA plan offered by the same MA organization.	Beneficiaries are sent a regular ANOC.

Contract Year 2006 Guidance for Medicare Advantage Plan Renewals

	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
5	Renewal Plan with a SAR.	If an MA organization ***reduces the service area*** of a CY 2006 MA plan and makes the reduced area part of a new or renewal MA plan service area in CY 2006, the MA organization must offer passive elections in CY 2006 to all of the current enrollees who reside in the reduced service area. ***Note:** When the SAR county(ies) is not contained in another MA plan (contract SAR), the MA organization must submit transactions to disenroll the beneficiaries from the plan. Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights. To enroll in a different MA plan, these beneficiaries must complete an enrollment form. The model modified ANOC will be available on the CMS website at: http://www.cms.hhs.gov/healthplans/ by April 15, 2005.	A 2006 plan that links to a 2005 plan and retains only a portion of its plan service area.	**The renewal plan ID must remain the same** so that beneficiaries in the renewal portion of the service area will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. When the SAR county(ies) is contained in another plan, the MA organization **must submit transactions** to passively enroll the beneficiaries into another plan.	Beneficiaries in the renewal portion need do nothing. Beneficiaries impacted by the plan SAR **must be offered passive elections into another plan offered by the organization.**	Beneficiaries continuing in the same plan that were not impacted by the SAR are sent a regular ANOC. Beneficiaries impacted by the plan SAR (passively enrolled) are sent a modified ANOC and receive guaranteed issue Medigap rights.
6	Renewal Plan Split Based on Provider Groups	If one CY 2005 MA Plan splits into two or more CY 2006 MA plans in order to reflect the beneficiary's provider group choice, both CY 2006 MA plans must have the same service area. The CY 2005 MA plan ID must be designated as the renewal plan in CY 2006. **Provider-specific plan splits require prior approval from CMS.** MA organizations wishing to offer provider-specific plans effective January 1, 2006 must submit their formal requests to their CMS Regional Office plan managers with a CC to their Central Office plan manager no later than **May 6, 2005**. CMS will review such requests on a case-by-case basis and make its determination based upon information that the MA organization submits as part of its proposal. For further information and format requirements, refer to the CMS website at: http://www.cms.hhs.gov/healthplans/.	Two or more 2006 plans that are created from one 2005 plan with membership determined by provider choice.	If the beneficiary's appropriate plan based on provider group choice is the renewal plan ID, beneficiaries remain in the same plan ID. The MA organization **does not** submit any transactions for these members. Otherwise, the MA organization **must submit transactions** to passively enroll beneficiaries into the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.

Contract Year 2006 Guidance for Medicare Advantage Plan Renewals

	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary N
7	Renewal Plan Split by Optional Supplemental Benefit Choice	If one CY 2005 MA plan splits into two or more CY 2006 MA plans because one or more MA plans has a mandatory benefit based on last year's optional supplemental benefit, and therefore a different monthly premium, the CY 2006 MA plans must have the same service area and basic benefit cost-sharing amounts. The CY 2005 MA plan ID must be designated as the renewal plan in CY 2006. **Requires prior approval from CMS.** MA organizations wishing to offer the Renewal Plan Split by Optional Supplemental Benefit Choice effective January 1, 2006 must submit their written requests to the Regional Office plan managers with a CC to CMS Central Office plan manager no later than May 6, 2005.	A CY 2005 plan that has an optional supplemental benefit(s) is split into 2 or more CY 2006 plans; 1 with only basic benefits and 1 (or more) with the same basic benefits and the former optional supplemental(s) as a mandatory benefit(s).	If the beneficiary's appropriate plan based on benefit choice is the renewal plan ID, beneficiaries will remain in the same plan ID. The MA organization **does not** submit any transactions for these members. Otherwise, the MA organization **must submit transactions** to passively enroll beneficiaries to the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.
8	Renewal Plan Split by Premium and/or Cost-sharing Based on Segmented Service Areas	The MA organization splits an existing CY 2005 MA plan service area into plan segments in CY 2006, and the only difference between the resulting MA plan segments is premium and/or cost-sharing. A segment cannot be smaller than a payment area (e.g., county). The MA organization must submit a separate bid/PBP for each plan segment.	A 2005 plan that is split into two or more 2006 plan segments that share identical benefit packages with the exception of premium and/or cost-sharing. A segment ID is added to the PBP identifier.	The MA organization must submit transaction type 72 Change transactions to move the members to the appropriate segments based on their county of residence	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
9	Terminated Plan		A 2005 plan that is no longer offered in 2006.	If the beneficiary elects to enroll in another plan with the same organization, the MA organization **must submit transactions** to enroll the beneficiary in another plan with the organization; CMS disenrolls beneficiaries to FFS who do not elect another plan with the same MA organization or a different MA organization.	Beneficiaries are required to complete an enrollment election if they choose to enroll in another plan. Beneficiaries who elect to enroll in another plan with the same organization can complete the short enrollment form.	Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights.

* Note: See the non-renewal instructions for a contract non-renewal or service area reduction.

Transition to 2006

Through the renewal process and using the MA plan cross walk, individuals enrolled in MA plans on December 31, 2005, will transition into the new 2006 plan structure as follows:

Generally, individuals enrolled in an MA plan in 2005 remain enrolled in that MA plan in 2006. However, individuals enrolled in an MA plan on December 31, 2005, that offers any prescription drug coverage (including those individuals who have selected an optional supplemental benefit that includes any prescription drug benefit) will be deemed to have elected an MA-PD plan on January 1, 2006. If the plan such an individual is enrolled in will be an MA-PD plan in 2006, all enrollees of one CY 2005 plan being transitioned in this way must be transitioned to the same C"Y 2006 MA-PD plan. The MA organization will have to submit transactions to accomplish this transition.

Summary Table

Plan in 2005	**Plan in 2006**
MA plan with any drug benefit	MA-PD plan
Any MA plan that becomes an MA-PD in 2006	MA-PD plan
MA plan with no drug benefit (that renews as an MA plan with no drug benefit)	MA- only plan
PACE plan	PACE plan and PACE plan's Part D benefit
Cost plans: Individuals who selected drug coverage in 2005 Individuals who do not have drug coverage in 2005	 Cost plan and Part D supplemental (if offered) Cost plan only - individual would have to choose Part D supplemental benefit (if offered)

These transition rules apply to all plan enrollees, including individuals with ESRD, individuals who are dually eligible for Medicare and Medicaid and members who are currently grand fathered for any reason. They also apply to full-benefit dual eligible individuals enrolled in demonstrations that deliver Medicaid and Medicare benefits through a single, capitated entity. This is true even though, through the end of 2005, prescription drug benefits are funded by Medicaid.

When transitioning Medicaid beneficiaries in 2005, MA plans must assure that the MA-PD plans into which beneficiaries are deemed have the capacity to accept them. In other words, should a capacity limit be proposed for an MA-PD into which beneficiaries are transitioned, it must be set high enough to ensure all beneficiaries may be transitioned.

The model Annual Notice of Change in the fall of 2005 includes notice of these transitions, and makes it clear that the beneficiaries transitioned into MA-PD plans as above will receive Part D benefits without any further action on their part. Some beneficiaries will be eligible for the low-income premium subsidy. It may be that the MA-PD plan into which these beneficiaries are transitioned has a Part D premium that exceeds the low-income premium subsidy amount. To ensure these beneficiaries can make a fully informed choice about obtaining Part D benefits. The Annual Notice of Change should include information on the MA-PD plans' Part D premium, and whether it is covered by the low-income premium subsidy amount for the MA-PD plans. Since MA plans will

not know in advance who will be eligible for the low-income subsidy in 2006, this information should be included on all letters.

Special Enrollment Rule for Full Benefit Dual Eligible Individuals

For full-benefit dual eligible individuals who would be deemed as described above into an MA-only (non MA-PD) plan, CMS will facilitate their enrollment into an MA-PD plan offered by the same MA organization in that service area with a Part D premium at or below the low-income premium subsidy amount. If all the MA-PD plans in the organization have Part D premiums that exceed the low-income premium subsidy amount, CMS will facilitate enrollment into the MA-PD plan with the lowest Part D premium. For those who are full-benefit dual eligible individuals in 2005, the effective date will be January 1, 2006. Prospectively, the effective date will be the first day of Part D eligibility. CMS intends to delegate this facilitated enrollment to MA organizations, who will create the new enrollment transaction to facilitate the enrollment of the person into an MA-PD plan, ensuring no coverage gap between the end of the Medicaid prescription drug coverage December 31, 2005, and the beginning of Part D enrollment January 1, 2006. CMS will issue further guidance about these enrollment procedures.

MA Election Mechanisms

Chapter 2 of the Medicare Managed Care Manual describes election mechanism formats allowed by CMS. These include paper enrollment and disenrollment forms, Internet disenrollment processes and alternate mechanisms for Employer Group Health Plans (EGHP).

In a forthcoming update to Chapter 2, CMS will include 2 new MA enrollment election mechanism options:

1. An Internet enrollment election mechanism format for individuals enrolling in MA plans and
2. An enrollment election by telephone limited to current MA enrollees of the MA organization electing another MA plan offered by that organization.

Note: These election mechanisms apply to MA plan elections. Cost plans must follow the instructions provided in the Medicare Managed Care Manual, Chapter 17-D.

MA Plan Seamless Conversion Enrollment Option for Newly Medicare Eligible Individuals

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly Medicare eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare. CMS will review an organization's proposal and must approve it before use. Any such proposal must be sent to the MA organization's Regional Office plan manager with a copy to the Central Office plan manager and must include the following conditions:

- A description of the MA organizations process to identify individuals currently enrolled in a health plan offered by the organization. Such process must be able to identify these individuals no later than 120 days prior to the date of initial Medicare eligibility (the conversion date).

- A description of the outreach activity associated with the seamless conversion process including a written notice provided to each individual at least 90 days prior to the date of conversion. The notice must include clear information instructing the individual on how to opt-out, or decline, the seamless conversion enrollment.

- The process to opt-out or decline the seamless conversion enrollment must include both the opportunity to contact the MA organization in writing or by telephone to a toll-free number. The MA organization is prohibited from discouraging declination.

- Enrollment transactions submitted to CMS for these cases must always use the first day of an individual's Initial Enrollment Period as the application date in the transaction record. Doing so ensures that any subsequent action taken by the individual will take precedence.

An update to Chapter 2 of the Medicare Managed Care Manual will include this information as well as any additional information as necessary about this process.

Higher Premium Charges for Late Enrollment

A Part D eligible individual who was not enrolled in Part D and who did not have creditable drug coverage for any period of 63 days or longer after the end of his or her Part D initial enrollment period will pay a higher premium for Part D. Creditable coverage is coverage provided through certain entities that meets or exceeds an actuarial test to determine if it is at least as good as coverage under Part D. Whether or not an individual has or had creditable coverage will be important in determining if any higher premium charge might apply. The amount of the premium increase will be calculated by counting full months within the period described above.

Example: Mrs. Jones' Part D initial enrollment period is March 1, 2006 – September 30, 2006. She does not enroll in Part D during this period and she does not have any creditable coverage at this time. She does enroll in a PDP during the AEP with an effective date of January 1, 2007. The period subject to the calculation of the higher premium is October 1, 2006 – December 31, 2006. This period meets the test of being 63 days or longer, therefore we count the full months during this time (October, November, and December) and determine that her higher premium will be based on 3 full months.

Section 2. Guidance for Bid/PBP submissions

Overview of Bidding Methodology for A/B Benefits

One purpose of bidding by MA organizations is to base payment for Medicare Part A and B benefits on an organization's monthly expected revenue needs for covering those benefits, rather than solely on an administratively set amount. The bidding process also determines how much (if anything) a Medicare enrollee would have to pay for Part A and B benefits, and how much an enrollee would receive in rebates or benefits in addition to A and B benefits. On the first Monday of June in each year beginning in 2005, MA organizations will submit a bid for the upcoming year based on their determinations of their monthly expected revenue needs, i.e. their medical and administrative costs, including profit. The Instructions for Completing the Medicare Advantage Plan Bid Form for Contract Year 2006 will describe the bidding method and policies in detail.

1. Bids. An MA organization's combined bid for its service area, for both local and regional organizations (and service area segment, in the case of a local organization), will have three parts:

   - An amount for the provision of Medicare Parts A and B medical benefits – (This is the standardized A/B bid. It is exclusive of an amount actuarially equivalent to Medicare cost sharing.);
   - An amount for basic coverage of Medicare prescription drug benefits (if any);
   - Amounts for the provision of supplemental medical (if any); and
   - Amounts for the provision of prescription drug benefits (if any).

   Note that for bidding purposes only, supplemental benefits will be divided into those related to prescription drug coverage and all other supplemental benefits. This treatment for bidding purposes does not affect how the benefits are offered to enrollees or the premium charged. That is, supplemental benefits include both medical and prescription drug benefits (if offered) and are offered for a single supplemental benefits premium.

2. Actuarially equivalent cost sharing. The plan A/B bid must reflect cost sharing as required under original Medicare, or an actuarially equivalent amount. As discussed in the preamble for Subpart F of the Final Rule implementing the Medicare Advantage program (Final Rule), which was published in the *Federal Register*, January 28, 2005 (70 FR 4588), plan-specific actuarially equivalent cost sharing will be determined based on cost sharing proportions in original Medicare that are applied to projected plan allowed costs for Medicare benefits. The actuarially equivalent amount will be determined using service-specific proportions (e.g., proportions for inpatient facility, SNF facility, home health outpatient facility, and all other Part B services) that may vary by geographic area. The fee-for-service actuarial equivalence cost sharing factors can be found on the CMS website at http://www.cms.hhs.gov/healthplans/rates/default.asp

   In the bid pricing tool, a single enrollment-weighted proportion across all counties in the organization's service area (or service area segment) for each of these five service categories will be used. Each service category proportion is multiplied by the appropriate allowed costs for that category, and then these amounts are summed to generate the cost sharing amount that is considered to be actuarially equivalent to average FFS cost sharing. The total actuarially equivalent cost sharing amount is then subtracted from the allowable costs to determine the plan A/B bid.

3. Benchmarks. For both local and regional MA plans, the plan A/B benchmark, when compared against a plan A/B bid, determines whether a plan will have savings and offer rebates or additional benefits, or whether the MA organization will have to charge a basic premium for the plan's coverage of Part A and B benefits.

   For local plans, the plan A/B benchmark is determined according to formulas established in the MMA. For a single-county plan (or segment), the plan A/B benchmark is the capitation rate for that county, adjusted to reflect the plan's projected risk profile to allow comparison to the plan A/B bid. For local plans serving more than one county, the plan A/B benchmark is the enrollment-weighted average of all the county capitation rates in the plan's service area (or segment), adjusted by the projected risk profile of the plan. (In determining the enrollment-

weighted average, the weights are based on the plan's projected enrollment in each county of its service area.)

Local plan A/B benchmarks are plan-specific, because the MA organization selects which counties to include in a plan's service area, and each plan's benchmark is weighted by the plan's projected enrollment. Regional plan A/B benchmarks are based on a different statutory formula that results in a single (standardized) benchmark amount for each region applicable to all regional plans in that region. The CMS will determine a standardized A/B benchmark annually for each of the 26 MA regions, and a MA regional plan will adjust the standardized benchmark to reflect the plan's projected risk profile.

The standardized benchmark for each MA region is a blend of two components: a statutory component consisting of the weighted average of the county capitation rates across the region; and a competitive component consisting of the weighted average of all of the standardized A/B bids for regional plans in the region. The weighting for the statutory component is based on MA eligible individuals in the region. The weighting for the competitive component (which includes each regional plan's bid) is based on the projected enrollment of the regional plans competing in the region. The blend of the two components will reflect the market share of traditional Medicare (for the statutory component) and the market share of all MA organizations (for the competitive component) in the Medicare population nationally.

The statutory components of the 26 regional standardized A/B benchmarks can be found on the CMS website at http://www.cms.hhs.gov/healthplans/rates/default.asp. For the annual June bid submission, an MA organization will estimate the regional plan benchmark by weighting together the appropriate statutory component published by CMS with the regional plan's standardized A/B bid as a proxy for the competitive component of the benchmark. In early August each year, CMS will publish the final MA regional standardized A/B benchmarks which will reflect the average bid component and the statutory component. Regional plans will adjust the standardized regional benchmark by their plan projected risk profile to arrive at the regional plan A/B benchmark, which is used for the savings calculation. (Note on the weighting used for the competitive component of regional benchmarks: If an MA region has approved bids for regional plans only open to a specific subgroup of Medicare beneficiaries (e.g., special needs plans for institutionalized beneficiaries), the Office of the Actuary (OACT) will consider assigning one weight to standard plans and a different weight to plans enrolling a specific subgroup of beneficiaries.)

4. Computation of benchmarks based on transition payment blends. The schedule for the transition from demographic to fully risk adjusted payments requires that, for 2006, 75 percent of payments for A/B benefits will be based on the CMS-HCC risk adjustment model, and 25 percent of payments will be based on the demographic-only model. This means that, under the bidding methodology, the savings calculation must be done using a blended benchmark. This type of blending should be distinguished from the statutory requirement for calculation of regional MA benchmarks, which combines competitive and statutory components, as described above under item (3). For 2006, the Bid Pricing Tool will calculate a blended benchmark that combines aged and disabled demographic benchmarks with risk benchmarks. As a result, the savings and rebate amounts (if any) will be determined by subtracting a blended plan A/B bid from a blended A/B benchmark. The beneficiary premium amount (if any) will also be determined by using a blended benchmark (in this case the standardized A/B benchmark). However, the demographic and risk adjusted payment amounts are determined separately, as discussed in the next section.

Partial County Service Areas

An MA organization that offers a plan with a partial county service area in 2005 may continue to do the same in 2006 as a local MA plan. (Regional MA plans are required to serve an entire MA region, so could not have partial county service areas.)

Organizations must submit bids June 6, 2005 for MA plans they intend to offer in 2006. A plan's bid represents the expected revenue requirements for the plan's service area. Accordingly, for a partial county, the bid would reflect the MA organization's expected costs for projected enrollees living in the subset of the county's zip codes ("partial county") included in the plan's service area.

Local plans have plan-specific benchmarks based on county MA capitation rates. A local MA plan's benchmark is the enrollment-weighted average of county capitation rates in the plan's service area, with the plan's projected enrollment in each county as weights. An MA organization would use for the projected enrollment in the zip codes that constitute the partial county area for that county's enrollment weight. The benchmark is used to determine whether a plan has a rebate or must charge a basic beneficiary premium for original Medicare benefits.

Medical Savings Account Plans. A Medicare MSA plan combines a high-deductible insurance policy with a MSA for health care expenses. The maximum annual MSA plan deductible is set by law. The Medicare program pays premiums for the high deductible insurance policies and makes a contribution to the beneficiaries' MSAs. The beneficiaries use the money in their MSAs to pay for their health care before the high deductible is reached. Once the deductible is met, the MA organization offering the MSA plan is responsible for payment of 100 percent of the expenses related to Medicare-covered services. In both cases, whether it is the enrollee or the MSA that assumes responsibility for payment, providers and other entities are required to accept the amount that the Medicare FFS would have paid as payment in full.

MMA did not amend section 1853(e)(1), which governs the calculation of the CMS deposit into an enrollee's MSA. However, we have interpreted the existing language referencing capitation rates "applied under this section for the area" as incorporating the new MMA bidding and payment methodology that now applies to MA plans under section 1853. An MSA organization offering an MSA plan will submit the "MSA premium" for benefits under original Medicare, called the MSA plan A/B bid in this Advance Notice. The MSA plan may include optional supplemental benefits, and the MA organization would submit a bid amount for these supplemental benefits. The MSA premium (MSA plan A/B bid) reflects the expected risk profile of plan enrollees, so in this sense is risk adjusted at the plan level. (The requirement at Section 1854(a)(6)(A) that MA organizations submit a standardized A/B bid does not apply to MSA plans.)

The MA organization offering an MSA plan also will submit an expected plan average risk score. The plan A/B benchmark is then calculated using the same formula as for other local MA organizations: the plan-level risk score is multiplied by the standardized A/B benchmark. For 2006, the transition blend would also apply to MSA plan benchmarks. A blended standardized A/B benchmark reflecting the 25 percent demographic rates/75 percent risk rates transition blend will be calculated in same manner as the blended standardized A/B benchmark is calculated in the bid pricing tool for CCP and PFFS plans (see Section A, item 4).

MSA enrollee deposit and payment to plan. The deposit into each MSA enrollee's account is calculated at the service area or service area segment level as the plan A/B benchmark minus the plan A/B bid. The deposit is uniform for each enrollee in the service area or service area segment. The payment to an MSA plan for an MSA plan enrollee is determined according to the following formula: the standardized A/B benchmark, adjusted by the enrollee's risk factor, minus the MSA deposit. Thus, while the MSA deposit is uniform, the monthly payments that CMS will make to the MSA plans will vary based on the risk characteristics of the enrollee. The ISAR adjustment does not apply to MSA plans. The transition payment blend discussed below in Section F- Changes to the Risk Adjustment Method for MA Organizations also applies to MSAs.

Part-B only Plans and Enrollees

MA plans covering Part B-only enrollees are separate from MA plans serving enrollees eligible for both Part A and Part B of Medicare. Organizations must generally file separate bid forms for any MA plan(s) covering Part B-only Medicare enrollees. An MA organization will have Part B-only enrollees if it was a Section 1876 contractor on December 31, 1998, and if it had Medicare enrollees who had Medicare coverage only under Part B and who did not terminate their membership before January 1, 1999.

CMS encourages MA organizations to submit as few plans as possible for its Part B-only members, rather than duplicating each of its A/B plans for them. However, MA organizations with Part B-only members will be required to offer at least one MA-PD plan in which Part B-only members can enroll. [Note that MA organizations can continue to meet this requirement by permitting Part B-only members to enroll in A/B plans - as long as they do not change an additional premium for Part A coverage.] This is a requirement because in the absence of such an MA-PD plan offering, such CCP members would be forced to disenroll from the MA organization as a condition of securing Part D coverage. You can get additional information about Part B-only plans on the Internet in section 50.1 - Rules for Coordinated Care Plans - and 70.2 - Standard Method – in Chapter 8 – Premiums and Cost Sharing – of the Medicare Managed Care Manual.

Clarification of segments of the service area of an MA local plan

No changes are being made in our policy related to segments. We provide the following discussion and guidance in response to inquiries we have had related to segments of an MA plan's service area. Segments were introduced in statute by section 515 of the BBRA (November 1999) which added a new subsection (h) to section 1854 of the Act. The statute allowed MA organizations to segment service areas for contract years beginning on or after January 1, 2001.

Segments are composed of "one or more MA payment areas" – see section 1854(h) of the Act – and an MA organization must submit a separate ACR/bid for each segment – see section 1854(a)(1)(A) of the Act. Note that section 1858(a)(1) prohibits segmentation of a regional plan's service area. This means that segments are, in effect, composed of one or more "MA local areas" (counties) in a local MA plan's service area, as defined at section 1853(d)(2) of the Act.

Beneficiaries must live in the service area of a segment of a plan, in order to enroll in that segment. The restriction on enrollment in section 1851(b)(1)(A) of the Act (that a beneficiary reside in the service area of an MA plan in order to be eligible to enroll in that MA plan) applies at the MA plan segment level.

Segments must be mutually exclusive – they may not overlap. In other words, a county may not be included in more than one segment in a plan's service area. Segments generally permit an MA organization to offer the "same" local plan (but with different cost sharing and/or premiums for A/B and non-drug supplemental benefits) in different areas. Since no segments are allowed in Part D, no elements (formulary or cost sharing) of the Part D benefit design may vary throughout the service area of a local MA-PD plan's service area. – including from segment to segment, if the MA portion of an MA-PD plan is segmented. Although premiums and cost sharing for non-Part D benefits may vary between different segments of the same plan, the actual benefits offered in different segments of an MA plan cannot vary.

Example 1 – **permitted** MA plan segmentation:

Segment 1 has an annual eyewear benefit ($100 copay for 1 pair of glasses) and unlimited inpatient hospital days ($100 copay for days 1 – 5).

Segment 2 has an annual eyewear benefit ($150 copay for 1 paid of glasses) and unlimited inpatient hospital days ($100 copay for days 1 – 10).

Example 2 – **impermissible** MA plan segmentation:

Segment 1 has an annual eyewear benefit ($100 copay for 1 pair of glasses) and unlimited inpatient hospital days ($100 copay for days 1 – 5).

Segment 2 has an annual hearing benefit ($100 copay) and up to 200 days of inpatient hospital care per benefit period ($100 copay for days 1 – 5).

In Example 2, *Segment 2* has different benefits than *segment 1* and therefore is not a segment of the same MA plan. The MA organization could offer the benefit packages in Example 2 as different MA plans, but not as segments of the same MA plan.

The primary advantage of segments to MA organizations is in marketing. An MA organization is permitted to market segments of the same plan under an identical plan name. Since CMS permits MA organizations to offer multiple MA plans, there is little additional advantage to be gained in segmenting the service area of an MA plan. See 42 CFR 422.4(b).

Changes to the Plan Benefit Package (PBP) & Summary of Benefits (SB) Software

CMS has implemented the following enhancements to the PBP/SB software in support of the CY 2006 bid season:

- Local MA plans may submit their PBP at the plan/segment level. Regional MA plans cannot create plan segments.

- In accordance with MMA, enhanced (Non-Medicare) benefits may no longer be defined as "Additional." Enhanced benefits must be specified as "Mandatory Supplemental" or "Optional Supplemental" benefits.

- PBP service category B-15 (prescription drugs) only includes information for the Medicare Part B benefit. The Medicare Part D prescription drug coverage will be collected in a separate Medicare Prescription Drug (Rx) section.

- Five additional groups were added in Section C to enable a plan to describe its Out-of-Network benefits cost shares, making the total number of groups available for data entry equal to 10.

- The new Medicare Prescription Drug Section is enabled if a plan indicates in the Plan Creation portion of HPMS that a Medicare Part D benefit is offered.

- New SB sentences have been created to describe the Medicare Part D benefit.

- Each MA-PD plan must indicate the type of Part D coverage offered (only one selected per plan):

    - Defined Standard
    - Actuarially Equivalent Standard
    - Basic Alternative
    - Enhanced Alternative

- For each type of Part D coverage, there is a standard set of data entry fields that must be completed. These include:

    - location(s) where drugs can be obtained (in-network preferred pharmacy, in-network non-preferred pharmacy, out-of-network pharmacy, and mail order)
    - quantity amounts associated with each location (one month, three months, and/or Other [specify number of days])
    - coinsurance amounts associated with each quantity, by location
    - copayment amounts associated with each quantity, by location
    - if there are additional costs to the beneficiary for selecting higher priced drugs when lower priced drugs are available
    - if there are additional costs to the beneficiary for obtaining drugs out of network
    - if there are maximum quantity amounts for certain drugs
    - if prior authorization is required for certain prescription drugs

This list is not intended to represent the entire set of modifications made to the 2006 PBP/SB software. CMS implemented these software changes in response to MMA and the numerous comments and suggestions made by MA plans and other entities during the 2006 PBP industry review period.

Using HPMS to Submit Bids and Formularies

MA organizations will use HPMS to electronically upload plan formularies and bids to CMS. 1876 cost organizations will be required to use HPMS to electronically upload plan formularies and bids if they are offering the Medicare Part D benefit to their members. As with past years, 1876 cost organizations may also voluntarily submit Plan Benefit Packages (PBP) if they wish to have their plan benefits displayed in the Medicare & You handbook and on Medicare Personal Plan Finder (MPPF).

MA and 1876 cost organizations will upload their plan formularies to HPMS using a pre-defined file format and record layout. HPMS began accepting plan formulary uploads on March 28, 2005. Organizations may upload their formularies one or more times between March 28, 2005 and the formulary deadline of **5:00 p.m. EST on April 18, 2005**. CMS will accept the last successful upload of each formulary received by this deadline as the official submission.

In order to prepare plan bids, organizations will use HPMS to define their plan structures and associated plan service areas and then download the PBP and Bid Pricing Tool (BPT) software. For each plan being offered, organizations will use the PBP software to describe the detailed structure of their benefit packages and the BPT software to define their bid pricing information. Each formulary submitted by April 18, 2005 must accurately crosswalk to a plan (or set of plans) defined during the bid process. The combination of the PBP and BPT for a plan comprises a bid.

Once the PBP and BPT software has been completed for each plan being offered, organizations will upload their bids to HPMS. CMS anticipates releasing the PBP and BPT bid upload functionality, including the new Bid Validation Tool (BPT) software, on **May 20, 2005**. Organizations may upload their plan bids one or more times between May 20, 2005, and the CY 2006 bid deadline of **12:00 p.m. PST on June 6, 2005**. CMS will accept the last successful bid upload received for a plan by this deadline as the official bid submission for that plan.

CMS will provide detailed technical instructions upon release of the HPMS formulary and bid functionality as well as the PBP and BPT software.

HPMS Modifications for CY 2006

CMS has implemented the following HPMS changes in support of the CY 2006 MA renewal season:

- Plan Segments – HPMS will enable local MA organizations to segment plans for CY 2006. Each segment of a local MA or MA-PD plan must retain the same benefit structure, but the premium and cost sharing for those segments may vary. A separate bid (PBP/BPT) submission is still required for each plan segment.

- MA-PD Indicator – HPMS will enable each local, regional, and 1876 cost organizations to indicate in which plan(s) they are offering the Medicare Part D benefit.

- Bid Substantiation - HPMS will allow organizations to electronically upload bid substantiation during the bid submission process.

- Formulary Crosswalk – HPMS will enable organizations to crosswalk each already-uploaded formulary to a plan, or set of plans, during the bid upload process.

Additional changes will be described in the Bid Technical User's Manual for CY 2006 (formerly known as the ACRP Technical User's Manual).

Instructions for Obtaining HPMS Access

MA and cost organizations have three alternatives for accessing HPMS:

- Internet access via a Secure Socket Layer Virtual Private Network (SSL VPN) using your corporate Internet Service Provider (ISP);
- T-1 lease line access via AT&T Global Network Services (AGNS); or
- Dial-up access via AGNS.

Internet users will access HPMS at https://gateway.cms.hhs.gov, whereas AGNS users will use http://32.91.239.68. All three methods require the use of a Microsoft Internet Explorer web browser version 5.1 or higher and a CMS-issued user ID and password with access to HPMS.

If your organization requires assistance with establishing connectivity to HPMS, please contact Don Freeburger at either 410-786-4586 or DFreeburger@cms.hhs.gov. In order to obtain a CMS-issued user ID and password for HPMS access, please contact Neetu Jhagwani at either 410-786-2548 or NJhagwani@cms.hhs.gov

Submitting Part C/D Premium Information for Current MA Plan Members

There is a need to obtain premium information for a plan's current members. The premium payment option and the premium amounts are required in order to compute plan payments. Plans receive their premiums from CMS for beneficiaries that elect to have them withheld from benefits as well as a portion of the premiums for low-income beneficiaries.

A new transaction type 72 Change Transaction has been developed to report premium information to CMS. These transactions must be submitted between the October and December 2005 Medicare Managed Care System (MMCS) plan data due dates. There is a priority order of submission that should be followed if at all possible.

1. Members that elect to have their premiums withheld from benefits.
2. Members that are low-income*.
3. Members subject to a late enrollment penalty.
4. Members that elect to pay their premiums directly to the plan.

* CMS realizes that plans may lack sufficient information regarding the low-income status of a beneficiary.

If this order can be followed, it will allow CMS to immediately submit premium withhold information to SSA, RRB and OPM so that timely payments to the plans can occur.

A systems letter with detailed record layouts for the Change Transaction Type 72, MMR and Premium Withhold Report will be forthcoming.

Cost Sharing Guidance

In the last two years CMS included cost-sharing guidance in the annual call letter to assist MA organizations in the preparation of their bids. This guidance had been developed in response to the high cost-sharing features of many ACRPs that had been submitted in previous years. Of particular concern prior to **2003** were the substantial increases in beneficiary cost-sharing that were experienced for dialysis and chemotherapy drugs. These services are still of particular concern. In addition, for the **2003** benefit year CMS noted further substantial cost-sharing increases in other medical categories such as inpatient stays; outpatient facilities; and ambulatory surgical centers. For the 2006 benefit year CMS will continue to focus on high cost sharing for Medicare-covered benefits in reviewing bids. We will not approve any bid that we find would have the effect of discriminating based on health status. We plan to pay greater attention to plans that have high co-insurance percentages in addition to those with high copayments. We will apply similar scrutiny to cost-based plans.

Medicare Advantage regulatory requirements specify that organizations may not design benefit packages that discriminate, discourage enrollment or hasten disenrollment of severely ill or chronically ill beneficiaries - 42 CFR 422.100(g) and 42 CFR 422.752(a)(4).

CMS will use the following factors in reviewing proposed 2006 MA organizations cost-sharing amounts:

1. Plans that set a total annual cost-sharing cap on member liability at an appropriate level will have great latitude in establishing cost-sharing amounts for individual services. CMS will review caps to verify that they are within actuarial standards. Working with the CMS Office of Actuary, we have determined that a total annual cap of $2,960 for out-of-pocket expenses for Medicare-covered services, excluding monthly basic premium would be an appropriate level for this purpose. We reached this conclusion by considering the method of setting out of pocket caps in the Federally-qualified HMO program, enrollee costs under Medigap, and continuance tables of out-of-pocket costs for Medicare services.

   With acceptable justification, we will also give some latitude to those plans with out-of-pocket (OOP) caps above $2,960 that impose higher copay amounts as long as the cost sharing is spread across widely used health care services. We will not approve plans with higher caps that concentrate cost-sharing on specific services, such as dialysis and chemotherapy drugs.

2. CMS will carefully examine plans that do not have an annual cap on member liability that meets the level identified above. This is to ensure that the proposed cost-sharing structure does not discriminate against “sicker” beneficiaries, or that the proposed cost-sharing structure does not inappropriately encourage disenrollment or discourage enrollment. We are particularly concerned with the cost-sharing levels for dialysis and chemotherapy drugs.

3. CMS will review all cost-sharing to ensure that out-of-pocket costs on specific items and services are not significantly higher than cost-sharing imposed on services in general, e.g., durable medical equipment.

4. We also will pay attention to high cost-sharing levels that are charged for each admission to an inpatient setting or skilled nursing facility. We encourage MA organizations to consider

cost-sharing levels to be based on benefit periods as administered under Original Medicare. In Original Medicare, a benefit period begins the day a Medicare beneficiary enters the hospital, or skilled nursing facility, and ends when the member has received no additional hospital or SNF services for a period of 60 days in a row. A Medicare beneficiary is charged the hospital or SNF deductible only once during this benefit period regardless of the number of admissions. CMS will allow some latitude for organizations that incorporate benefit periods into their benefit designs.

5. No dollar limits can be placed on the provision of drugs covered under original Medicare. CMS will carefully review cost-sharing related to Medicare-covered Part B drugs to ensure that individuals with a specific disease or condition are not being discriminated against or encouraged to disenroll.

In reviewing bids, CMS will consider that broad-based but reasonable deductibles are more equitable ways to spread costs than copays and coinsurance, since such deductibles spread costs more broadly among enrollees. We plan to provide feedback to plans as soon as possible after the bids are submitted on any concerns with regard to their proposed cost-sharing amounts.

Guidance of cost sharing for out-of-area dialysis services

We are providing the following general guidance for all MA plans. Section 1852(d)(1)(C) describes three specific types of health care services for which all MA organizations must provide reimbursement in all of MA plans they offer. They are:

- Urgently needed services which are medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it is not reasonable given the circumstances to obtain the services through the organization's network providers;
- Renal dialysis services provided other than through the organization's network providers because the individual enrollee was temporarily out of the plan's service area; and
- Maintenance and post-stabilization care covered under 42 CFR 422.113(c).

Urgently needed services are further defined in regulation at 42 CFR 422.113(b)(1)(iii), while the requirement to cover renal dialysis services while MA enrollees are traveling can be found at 42 CFR 422.100(b)(1)(iv). Mandatory coverage and reimbursement for these services, under specific conditions and even when provided by non-network providers, is in addition to an MA organization's requirement to cover and reimburse for emergency services.

In 42 CFR 422.113(b)(2)(v) the regulations limit the cost sharing that can be imposed on MA plan enrollees for receipt of emergency department services to $50 or the amount the MA plan would charge for in-network emergency department services, whichever is less. In 42 CFR 422.113(c)(2)(iv) the regulations limit the cost sharing that can be imposed on MA plan enrollees for receipt of maintenance and post-stabilization care services to an amount no greater than what the organization would charge an enrollee if he or she had obtained the services through the MA organization's network providers.

Although the regulations do not stipulate a specific limit on enrollee cost sharing related to urgently needed or renal dialysis services obtained from non-network providers, our policy is that when urgently needed services are provided by non-network providers within the service area (or continuation area) due to the temporary unavailability of appropriate network providers, then the cost sharing cannot exceed the amounts that would have applied had network providers been available.

For out-of-area dialysis services, CMS will carefully review cost-sharing levels and will consider cost sharing for these services in relationship to cost sharing for other services in making a determination of whether the cost sharing related to dialysis services is excessive and therefore discriminatory.

Cost sharing guidance for Regional MA plans

The following guidance is directed to Regional MA plans. Special beneficiary cost sharing rules and requirements apply to Regional MA plans, which must be offered as MA PPOs and which plans must be offered in an entire MA Region. Note that MA Regional plans may not segment their service areas. See section 1858(a)(1) of the Act.

MA Regional plans, like all MA PPOs, are required to provide reimbursement for all plan-covered benefits regardless of whether such benefits are provided within the network of contracted providers. In addition, MA Regional plans are required to have:

- Only one deductible related to combined Medicare Part A and Part B services, to the extent they have any deductible at all. See §422.101(d)(1).

- A catastrophic limit on beneficiary out-of-pocket expenses for in-network benefits under the original fee-for-service Medicare program. See §422.101(d)(2). This catastrophic limit is equivalent of the "total annual cap" described elsewhere in this Cost Sharing Guidance which is derived from consideration of amounts computed under the federally-qualified HMO program, enrollee costs under Medigap, and continuance tables of out-of-pocket costs for Medicare services. In 2006 the amount is $2,960. Similar consideration will be applied to MA regional plans related to this catastrophic cap as we have applied to local MA plans. In other words, to the extent a Regional MA plan limits the value of the cap described in §422.101(d)(2) to $2,960 in 2006, we will provide more latitude for that plan in establishing cost-sharing amounts for individual services. With acceptable justification, we will also give some latitude to those Regional plans with §422.101(d)(2) caps above $2,960 as long as the cost sharing is spread across widely used health care services. We will not approve plans with higher §422.101(d)(2) caps that concentrate cost-sharing on specific services, such as dialysis and chemotherapy drugs. This is consistent to the approach we have taken related to caps in local plans.

- A total catastrophic limit on beneficiary expenditures for in-network and out-of-network benefits under the original fee-for-service Medicare program. This catastrophic limit may be higher than the in-network limit, but may not increase it. CMS will not apply the "total annual cap" test to this catastrophic cap. See §422.101(d)(3).

- MA Regional plans must have a system for tracking and reporting the deductible (if any) and catastrophic limit accruals as they occur for members during the course of a contract year. See §422.101(d)(4).

Guidance on deductibles

- As we have explained in more detail in another section of this Call Letter, an MA regional plan, to the extent it has a deductible, may have only a single (or combined) deductible related to Medicare Part A and Part B services.

- While CMS supports the creation of "high deductible" MSA MA plans for Medicare beneficiaries in accordance with applicable statutory and regulatory requirements, CMS does not necessarily believe that "high" deductibles are appropriate in other types of MA plans (such as HMOs or PPOs) as they tend to discriminate against low-income individuals and to inappropriately attract non-utilizers. Therefore, when we review 2006 MA plan submissions we will examine the total deductible amount proposed, if any, and will more carefully scrutinize plans with relatively "high" deductibles (deductibles in excess of $1,000). We will also examine plans with greater scrutiny where deductibles apply only to specific services or to types of services that are more commonly used by individuals in specific disease groups or classes. We will provide greater latitude to plans that limit (or cap) beneficiary cost sharing to $2,960.

Finally, the overall limit on the actuarial value of cost sharing related to original Medicare benefits continues to apply in all MA coordinated care and private fee-for-service plans.

ESRD Bidding Policy

For 2006, ESRD enrollees will not be included in the plan A/B bid. MA organizations will have the option to adjust a plan's supplemental benefit premium by an ESRD factor, based on an organization's estimate of higher supplemental benefit costs for ESRD enrollees in the plan. See the Instructions for the Bid Pricing Tool for information on how to separate these costs from aged/disabled costs and information on the ESRD factor for pricing supplemental benefits.

Submission of Bids by Demonstration Plans

In 2006, the S/HMO, MSHO/MnDHO, WPP, and SCO demonstration plans will submit bids for Medicare covered, mandatory supplemental, prescription drug, and other benefits. The Wisconsin Partnership Program (WPP) demonstration plans will submit bids for prescription drugs and other benefits in 2006. These bids will be submitted in a manner that appropriately reflects the unique features of the demonstrations.

Bidding Rules Regarding Cost Sharing for Plans with Dual-Eligibles

As noted in Section 2: OACT Bid Process, each MA plan's bid must reflect cost sharing that is actuarially equivalent to the cost sharing charged under original Medicare. That is, in developing its A/B bid, the plan must reduce its estimate of projected required revenue by the amount of revenue that would be generated if beneficiaries were charged cost sharing that is actuarially equivalent to original Medicare. If the plan does not want to charge this level of cost sharing, the plan may charge a supplemental premium or, if their bid is below the benchmark, the plan may use beneficiary rebate dollars to buy down some or all of the enrollees' cost sharing obligation.

Under Federal Medicaid law, however, full-benefit dual eligible individuals and Qualified Medicare Beneficiaries (QMBs) are not required to pay Medicare cost sharing. State Medicaid agencies must pay Medicare cost sharing on behalf of these individuals. The Medicaid statute, however, allows States in many instances to pay less than the full value of Medicare cost sharing. Under the standard MA bidding rules, MA plans that serve these dual eligible individuals would be required to subtract cost-sharing revenue from their total revenue requirements based on a non-dual eligible population.

CMS is developing a modification to the MA bidding rules in which we will consider Medicaid payments for cost sharing for original Medicare benefits that are made on behalf of full-benefit dual eligibles and QMBs enrolled in an eligible MA plan as fully meeting the cost sharing obligation of these individuals. This change will give MA plans greater flexibility in the allocation of beneficiary rebate dollars. This bidding modification will be optional for any MA plan that serves full-benefit dual eligibles and/or QMBs, including Special Needs Plans. Additional information on this bidding modification will be made available through CMS Bid Pricing Tool user calls. Information on how to participate in these calls will be available at http://www.cms.hhs.gov/healthplans/training.

2006 Capacity Limits

The HPMS Capacity Limit module is being modified to incorporate new functions and to reflect the requirements and implementing regulations of the Medicare Modernization Act (MMA). Information about the details regarding the capacity limit policy and revised instructions for the Capacity Limit module will be issued in the near future.

As in the past, Medicare Advantage (MA) organizations must submit requests for capacity limits through the HPMS Capacity Limit Module. This procedure must be followed even if the capacity limit information is included in the bid submittal.

Employer/Union Group Guidance

Application of Existing Part C Waivers to Employer/Union Group Plans

The following Part C employer/union group waivers contained in Chapter 11, Section 150, of the Medicare Managed Care Manual will apply to Medicare Advantage organizations offering MA-only and MA-PD plans in 2006:

- Actuarial Swapping (Section 150.1.1)
- Actuarial Equivalence (Section 150.1.2)
- Employer/Union-only Plans (Section 150.1.3)
- Part B-only Plans (Section 150.1.4)
- General Considerations (Marketing/Beneficiary Communications) (Section 150.4)

Service Area Rules for Employer/Union Group Local and Regional MA Plans

Local MA Plans:

The service area rules for employer/union group MA plans prior to passage of the MMA will continue to apply to employer/union group Local MA-only plans and to Local MA-PD plans. If a Local MA-only or Local MA-PD provides MA-only or MA-PD coverage to individuals in any part of a State, it can offer employer/union group coverage for an employer or union throughout that State.

Regional MA Plans:

For Regional MA-only and MA-PD plans, the plan can provide employer/union group coverage in any area within or throughout the MA region in which it provides coverage to individuals. CMS may, on a case-by-case basis, grant a waiver to permit a regional MA-only or MA-PD providing coverage under an employer or union-sponsored retiree plan to extend coverage to employer or union retirees living outside such region.

Bidding Requirements For Employer/Union Group Local and Regional MA Plans

Bid Submission Deadlines:

June 6, 2005: For Regional MA-only or MA-PD plans

July 1, 2005: For Local MA-only or Local MA-PD plans

Bid Submission:

All MA organizations offering employer/union group MA-only and MA-PD plans will submit bids for this coverage in a manner similar to the flexible methods offered to MA organizations in the past. Under this approach, CMS will require plan sponsors to submit bids for employer/union sponsored plans only for the basic Part C or Part D benefit. These organizations will not submit separate bids in 2006 for each employer/union benefit design variation. Any supplemental coverage will be provided separately pursuant to a private agreement between the plan sponsor and the employer/union. (*See* Part D Waiver Guidance, April 6, 2005 at: http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp).

Formularies for Employer/Union Group Plans

MA organizations are required to submit formularies for employer/union group prescription drug plans (Regional and Local MA-PDs) by June 6, 2006. MA organizations may enhance these employer/union group formularies subsequent to submission without further review by CMS if the MA organization is adding new drugs or changing the cost sharing to lower cost sharing. However, these formularies may not be modified after submission to add restrictions or limitations. CMS will require that these MA organizations sign a letter certifying that the employer/union group formularies used comply with these guidelines.

Employer/Union Group Non-Calendar Year Plans

All employer group MA-only and MA-PD plans will be allowed to operate on a non-calendar year basis. These plans are permitted to determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis. However, bids and other submissions to CMS, along with CMS payments, will be determined on a calendar year basis. (*See* Part D Waiver Guidance, April 6, 2005 at: http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp). MA organizations that intend to offer employer/union calendar year and non-calendar year employer/union group plans (MA-only and MA-PD plans) must submit a bid for the non-calendar plan offering, and a separate bid for the calendar year plan offering.

Application Process for Employer/Union Group Offerings

MA organizations that wish to offer an employer/union group prescription drug plan (MA-PD) must follow the waiver application instructions issued on April 6, 2005. (*See* Part D Waiver Application Instructions, April 6, 2005 at: http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp). In accordance with these instructions, MA organizations must provide supplemental waiver application materials for these employer/union group Part D plans.

MA organizations that offer employer group plans do not have to comply with these instructions with respect to the equivalent Part C A/B benefits (i.e., MA-only plans or the MA portion of the MA-PD). However, MA-only and MA-PD employer group plans (employer-only or "800 series plans") must notify CMS by April 25, 2005 of the service areas(s) in which they intend to offer employer/union group coverage (for Regional MA-only and MA-PDs please identify the regions; for Local MA-only and MA-PDs please identify the states and counties). Please note that for current MA plans, no submission is necessary if no changes to the current service area(s) will be made. Also please note that service area information does not need to be employer-specific. Include with this submission the assigned current or pending "H" or "R" number. Please mail a hard copy of this information to the following address with a cc: to the local Regional Office contact:

Gloria Parker, Director
Division of Plan Management
Medicare Advantage Group/Center for Beneficiary Choices
Centers for Medicare & Medicaid Services
Mail Stop C4-23-07
7500 Security Boulevard
Baltimore, MD 21244-1850

For more information on employer group waivers, contact the Employer Policy & Operations Group (EPOG) at employerwaivers@cms.hhs.gov.

Section 3. Marketing

Retrospective Review of Marketing Materials

Plan Submission and CMS Review of Marketing Materials

For the past few years, CMS has allowed MA organizations to use a streamlined marketing review process, in which the organization could use marketing materials prior to CMS approval of the ACRP as long as the materials contained a "pending Federal approval" disclaimer. For 2006 plan year materials and until CMS indicates otherwise for any materials for future plan years, organizations **must not** use this streamlined review process. Given that the bidding process is new and we anticipate benefits changing from initial submission to bid approval, and given that the enrollment lock-in begins on January 1, 2006, the streamlined review process would pose too much risk to CMS, MA organizations, and Medicare beneficiaries. As a result, beginning with marketing materials for plan year 2006, organizations may only use marketing materials that contain CMS-approved bid (benefit) information.

MA Organizations may begin submitting 2006 marketing materials (i.e. SB and ANOC) on June 7, 2005. The Regional Office will review the materials and either disapprove or conditionally approve

the materials. MA Organizations that do not yet have a final contract approval will receive a "conditional approval' as applicable on marketing materials. If the materials are conditionally approved, CMS is indicating to the MAO that the materials are approvable based on the current, not yet approved bid. The organization may not use conditionally approved marketing materials in the market. If the materials are disapproved, the organization must revise the materials and continue to work with the RO until it receives a conditional approval on the materials.

After CMS approves the MAO's bid the organization must submit a revised SB and ANOC, based on the CMS-approved bid/PBP. The organization must clearly annotate (such as in red-line) anything in the conditionally approved material that has changed since the material was conditionally approved. This step will help ensure an expedited review of the final materials.

In order for an MA organization to be able to market its plans, it is essential that it follow the review process. If an organization fails to submit materials timely or to clearly annotate changes in the submitted materials, then it is at risk of not being able to market timely.

Note: If there is no change in the bid or marketing materials from when the materials received the conditional approval, the organization need not resubmit the marketing materials. Instead, all marketing materials with a status of "conditional approval" will be changed to an "approved status" as of September 30, 2005.

Marketing CY 2005 and CY 2006 Benefits

Marketing of CY 2005 Plans

All MA organizations and Medicare cost plans must cease using public media to market CY 2005 plans beginning October 30, 2005. If the organization begins marketing its CY 2006 plans any time between October 1 and October 30, it must cease using public media to market the CY 2005 plans on the day it begins marketing the CY 2006 plans. "Public media" includes billboards, radio, TV, print advertisements and direct mail.

Renewing plans may continue to send and orally present CY 2005 plan information to individuals who specifically ask for it and to employer group members, and may continue to enroll individuals for effective dates before January 2006, based on an individual's election period and on other requirements of the law, regulations, and previously issued guidance. If a prospective enrollee inquires about the 2005 plan, the organization should provide the individual with both 2005 and 2006 plan information so that the individual is fully informed about changes that will take place on January 1.

In general, MA organizations and Medicare cost plans must submit all remaining CY 2005 marketing materials to CMS by no later than June 30. This deadline will allow CMS to begin focusing resources on the review of CY 2006 marketing materials. In some unique circumstances an organization may need to have CY 2005 marketing materials reviewed after June 30. In those cases, the organization should contact its Regional Office to arrange for review of these materials.

Effective October 1, all MA organizations and Medicare cost plans must include disclaimers in CY 2005 marketing materials whenever they advertise a CY 2005 benefit, premium, or copayment that may or will change effective January 1, 2006, or whenever it accepts an election form for an

effective date in 2005 on or after November 1. (The disclaimer is not required if the organization knows that benefits will not change in 2006). The disclaimer must be in the form of an attachment or an addendum to all marketing materials, including advertisements and election forms, and must alert potential members that changes will occur on January 1.

The following model disclaimer may be used by organizations with benefit changes in 2006. Additional RO review and approval is not required if this disclaimer is used verbatim, but is required if it is modified.

> [Insert any or all of the following, whichever is appropriate: Benefits, premiums and/or copayments][insert whichever is appropriate: "may" or "will"] change on January 1, 2006. Please contact [insert organization name] for details.

Marketing of CY 2006 Plans

Beginning October 1, all MA organizations and Medicare cost plans may begin using approved CY 2006 marketing materials. MA organizations must have an approved bid prior to marketing CY 2006 plans. All organizations must begin using approved CY 2006 marketing materials no later than October 31.

All marketing presentations and all mailings to Medicare beneficiaries concerning CY 2006 enrollment (annual election period) must include a Summary of Benefits (SB) describing CY 2006 benefit package information.

H Number on Marketing Materials and Enrollment Card

In order to facilitate processing of beneficiary inquiries and complaints to CMS and its contractors, all organizations will now be required to print their CMS contract number on marketing materials and enrollment card. CMS will provide further guidance on this requirement, but, at a minimum, the H number will need to be printed on the front page of Summaries of Benefits and Explanations of Coverage, as well as on enrollment card.

CY 2006 Annual Notice of Change (ANOC)

The ANOC highlights the specific changes in Medicare and plan benefits, plan premiums and plan rules effective January 1, 2006. While a model ANOC for MA organizations and Medicare cost plans is contained in Section 40.1.3 of Chapter 3 of the Medicare Managed Care Manual, organizations should not use that model for the CY 2006 ANOC. A revised ANOC model that introduces the Medicare Part D benefit and the Open Enrollment Period limitations will be completed and distributed soon. The SB must be included with the mailing of the ANOC.

All MA organizations and demonstrations must ensure that members receive the ANOC (with the SB) by October 31, 2005. All Medicare cost plans must ensure that members receive the ANOC (with the SB) by December 1, 2005.

Please refer to the "Calendar for 2006 MA and Medicare Cost Plan Renewal Process" for the time frames for sending SBs into the Regional Offices for review. The time frames were established to ensure that organizations submit ANOCs and SBs in time to have them reviewed, approved, printed,

and received by members by the October 31 (for MA organizations) and December 1 (for Medicare cost plans) deadlines.

CY 2006 Summary of Benefits (SB)

All MA organizations and demonstrations must send a standardized SB to individual members with the ANOC. MA organizations and demonstrations must also send a SB to employer group members with the ANOC; however, they are not required to use the standardized SB for these members.

All Medicare cost plans must send a SB to all members with the ANOC. They are not required to use the standardized SB. However, if a Medicare cost plan intends to have its plan appear in Medicare Personal Plan Finder, it must complete the Plan Benefit Package (PBP) and create a standardized SB.

General instructions for the SB are included in Section 40.5 of Chapter 3 of the Medicare Managed Care Manual. Please remember that Section 3 of the SB is intended to describe special features of the plan beyond information contained in Sections 1 and 2 of the SB, to further describe mandatory and optional supplemental benefits that appear in the Section 2, and to describe non-Medicare endorsed drug discount programs (if appropriate and at the option of the organization). Section 3 is not intended to include a description of every plan benefit not included in Section 2 that has cost sharing associated with it.

Please refer to the "Calendar for 2006 MA and Medicare Cost Plan Renewal Process" for the time frames for sending SBs into the Regional Offices for review. The time frames were established to ensure that organizations submit ANOCs and SBs in time to have them reviewed, approved, printed, and received by members by the October 31 (for MA organizations) and December 1 (for Medicare cost plans) deadlines.

Under unique circumstances, an organization may need to make a hard copy change to its standardized SB. Chapter 3 Section 40.5.3 of the Managed Care Manual outlines the process for requesting such changes.

The organization is required to provide each contract number (i.e., H1234 or P1234) and Plan Id in the SB hard copy change request. However, if the request applies to multiple plan Ids within one contract number, then list the all plan Id numbers in the request. The CMS approval would apply to all plan ids that were submitted in the request.

Any changes to organization and plan information (i.e., Customer service number, plan name, or other plan information) can be changed through HPMS by the organization/plan.

If an organization submits the standardized SB without section 3, plan specific features, it will be treated as a model so the 10 day timeframe will apply. The full three sections standardized SB is reviewed in the 45 days timeframe.

Questions about the SB and requests for hard copy changes should be sent to SummaryofBenefits@cms.hhs.gov.

CY 2006 Evidence of Coverage (EOC)

All MA organizations and Medicare cost plans must mail CY 2006 EOCs to all plan members no later than February 1, 2006. After these organizations have mailed the CY 2006 EOC to all members, they must mail CY 2006 EOCs to new members no later than when they notify the member of acceptance (confirmation) of enrollment (the time frame requirements for sending notice of acceptance of enrollment are contained in Chapter 2, Section 40.4.2).

The HMO and PPO model EOCs will be available by August 5. Use of the model language is not mandatory; however, it will facilitate the review of the marketing materials.

Please refer to the "Calendar for 2006 MA and Medicare Cost Plan Renewal Process" for the time frames for sending EOCs into the Regional Offices for review. The time frames were established to ensure that organizations submit EOCs in time to have them reviewed, approved, printed, and mailed to members by the February 1, 2006 deadline.

Medicare Personal Plan Finder Data

Starting October 13, the CY 2006 health plan data will appear on the "Medicare Personal Plan Finder" in the standardized summary of benefits format. In addition, "Medicare Personal Plan Finder" will continue to include charts displaying several HEDIS and CAHPS measures, as well as disenrollment reasons data. However, for this year only, out-of-pocket costs will not be available.

This year, Cost plans will be able to enter the number of physicians in their network into HPMS, which will then be displayed on the Medicare Personal Plan Finder.

Plans can preview their data in HPMS from September 16-19. If there are any issues with the data, plans can notify CMS at compchart@cms.hhs.gov.

Medicare & You 2006

The *Medicare & You* 2006 handbook will contain health plan benefit and Medicare prescription drug plan comparison information. This information may be similar to the health plan information provided in the *Medicare & You* 2005 handbook released last Fall. One CAHPS measure will be included in *Medicare & You* 2006.

Special Requirements for Medicare Cost Plans

Cost plans are required to offer a basic A/B or B-only benefit package – 1876(c)(2)(A)(ii)(I). Therefore, cost plans that will offer Part D must make basic Part D coverage available in such a basic A/B benefit package, before they sell the members any additional optional supplemental benefits. We will check for this on HPMS. Also, cost plans that offer Part D must submit PBP through HPMS.

Part IV. MA Plans Non-Renewal Process for 2005

Section 1. Notices and Letters

Interim Notification Letter - For MA Organizations giving official notification prior to June 6, 2005.

CMS may require an MA organization to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. MA organizations that use the 2005 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these MA organizations must inform their RO of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

MA organizations that revise the CMS Model Interim Notification Letter must submit their letter to their RO for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than October 2, 2005. CMS strongly encourages MA organizations to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated October 2, 2005 to assure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that MA organizations must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states are California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. Should there be changes to this list of states with additional protections, CMS will inform all non-renewing MA organizations prior to the time they develop their final notification letter.

MA organizations may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Finally, in accordance with 42 CFR 422.506(a)(2)(ii), CMS will provide each non-renewing MEDICARE ADVANTAGE ORGANIZATION with a list of those Medicare health plans (MA and Medicare Cost Plans), if any, that will be available to affected beneficiaries as alternative choices in 2006. Medicare Advantage Organizations must include this list of "remaining health plans" in final notification letters, including those health plans that have CMS-approved capacity limits. The letter must call special attention to the fact that Medicare Cost Plans may have a different open enrollment cycle from MA organizations. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas, of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

Regional Office Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS Regional Offices (ROs) prior to release. MA Organizations may submit draft copies of their final notification letters to CMS ROs as early as August 1, but no later than September 9, 2005. Since the final notification letter is reviewed as part of a separate and unique process, it is not subject to the 10-day rule for marketing material review, but the RO will give priority review to the submitted final notification letter. CMS strongly suggests that MA organizations use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. All RO reviews of final notification letters based on the model will be completed before September 16, 2005. CMS encourages MA Organizations to consider this review period when making plans to meet the October 2, 2005 deadline for delivery of these final notification letters to beneficiaries.

Medigap Information

Non-renewing MA organizations must inform all affected Medicare beneficiaries, including the disabled and individuals with End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Full information on this topic is provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter with appropriate language. If used, this model language will assure accurate communication of these technical provisions.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing MA organization in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. MA organizations must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2005 effective date. Beneficiaries may be required to

submit this written documentation to a Medigap issuer as proof of their right to purchase certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp.

Public Notice of Non-Renewal

Non-renewing MA organizations must publish a public notice of non-renewal at least 90 days prior to the end of the contract year (i.e., October 2, 2005) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. MA organizations that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these MA Organizations must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

MA organizations that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages MA organizations to consider this review period when making plans to meet the October 2, 2005 deadline for release of these public notices.

Section 2. Enrollment

Mandatory Enrollments: Initial Coverage Election Period (ICEP) and Special Election Period

Non-renewing MA organizations **must** continue to accept enrollments from individuals during their ICEP and SEPs until November 30, 2005. MA organizations should address specific questions about enrollment closures to their RO Plan Managers.

Marketing/Enrollment Materials

Once the MA organization notifies CMS if its non-renewal decision, all marketing and enrollment materials to individuals in their ICEP or SEP must announce the MA Organization's decision to non-renew. The following is an example of the model language an MA organization may use in marketing and enrollment materials for individuals during an ICEP or SEP:

> "<Insert plan name> will [(not be renewing its Medicare Advantage contract) or (will not be serving the following counties: <insert county names>)] effective January 1, 2006. You may choose to enroll in our plan, but your coverage will automatically end on December 31, 2005, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another MA plan effective January 1, 2006, you will be changed to Original Medicare on that date. You will receive additional information about your rights and options for 2005 in a Final Notification Letter on October 2, 2005, or thereafter if your enrollment is after this date."

NOTE: A statement announcing the MA Organization's decision to non-renew must be included on all pre-enrollment and advertising-related materials. Sales representatives must use this language in all presentations about the plan. If the MA organization chooses to use the model addendum above,

and simply to affix this to materials that have been approved by CMS, the material does not require CMS review or approval. However, if the MA organization modifies the addendum or marketing material in any way, the material (including the addendum) must be reviewed and approved by CMS prior to dissemination.

Since MA organizations are required to accept ICEP and SEP enrollments through November 30, there may be a few cases where individuals are enrolled after an MA organization's final notification letters are mailed. In these cases, the MA organization must provide a final notification letter dated October 2, 2005 to each affected beneficiary, along with the confirmation of enrollment letter. These final notification letters must also include the individual beneficiary's name and address.

Section 3. Systems Issues

Non-Renewed Contracts

Non-renewing MA organizations should **not** submit disenrollments for any members who will remain in their organization through December 31, 2005. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the MA organizations has submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan are placed in Original Medicare in a timely manner.

Non-renewing MA organizations should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the MA organizations receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2005), Medicare Advantage organizations must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December 31, 2005). Therefore, it is important that non-renewing MA organizations submit any final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

MA organizations will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

Service Area Reductions

MA organizations with service area reductions for 2006 must disenroll all members who reside in the non-renewed area or county**.** MA organizations must submit disenrollment records for all affected members no later than the cut-off date (12/13/2005) in December, the last operating month of their current contracts.

CMS will provide MA organizations with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third week of December 2005, and verify the disenrollments for all submitted members. MA organizations will also receive a separate communication with specific systems instructions from CMS.

MA organizations with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

Health Plan Management System (HPMS) Issues

Non-renewing MA organizations **must not assign** a Plan Benefit Package (PBP) in HPMS to any county that is included in the request for a service area reduction.

MA organizations that intend to non-renew a county for individuals, but to continue the county for employer group health plan members, must notify CMS of their intention in writing by May 2, 2005, in order for the HPMS system to accommodate the request. This notice should be sent to Gloria Parker at gparker@cms.hhs.gov.

Section 4. Other Information

Partial County Service Area Reduction Requests

Service Area Reduction
The current county integrity policy affords CMS significant discretion to approve exceptions to the principle of county integrity. The general exceptions to the county integrity policy and documentation requirements can be found under section 60.3 in chapter 4 of the Medicare Managed Care Manual.

MA organizations must submit partial county requests to CMS for review and approval. CMS reviews each request on a case-by-case basis. In keeping with the current MA regulatory requirements, CMS will perform analysis of demographic information to ensure nondiscriminatory impact on excluded parts of a county or counties and excluded populations.

MA organizations should send requests to the appropriate Regional Office Plan Manager with a copy to Sid Lindenberg in CMS' Central Office. The request must be received at CMS no later than May 2005.

"Close-Out" Information

In the fall of 2005, CMS will send a "close-out" letter to non-renewing MA organizations with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to assure that affected beneficiaries experience a smooth transition from membership in the non-renewing MA organizations to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the MA organizations after the last day of its contract.

Non-renewing MA organizations may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract. For example, if an affected Medicare member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing MA organization may be responsible for all Part A inpatient hospital services until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B. If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing MA organization will pay the covered charges through the last day of the contract; Original Medicare or the next

Medicare health plan elected by the beneficiary will pay from the next day forward through the Medicare intermediary.

After the end of the contract period (i.e., December 31, 2005), MA organizations remaining obligations to CMS include:

(1) Submission of risk adjustment data to CMS. This data will be used to calculate risk-adjusted payments to Medicare Advantage organizations. Therefore, CMS must have all the required historical data for each beneficiary who has been enrolled in a Medicare health plan in order for this data to be accurate. Non-renewing contractors must continue to submit the required hospital inpatient, hospital outpatient and physician risk adjustment for services provided to all its Medicare beneficiaries enrolled during calendar year 2005.

(2) Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the MA contract for the ten year period following non-renewal.

(3) Update of plan contact information in HPMS. This will allow CMS to continue to contact appropriate persons in non-renewing Medicare Advantage Organizations until all activity is complete.

(4) Participation in the CMS process to complete final reconciliation of CMS accounts with the Medicare Advantage organizations, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

(5) Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its MA contract was extant.

MA organizations with further questions related to their Medicare contract non-renewals should contact their RO Plan Managers.

Part V. Medicare Cost Plan Non-Renewal Process for 2005

Section 1. Notices and Letters

Interim Notification Letter - For Medicare Cost Plans giving official notification prior to October 2, 2005.

CMS will strongly encourage a Medicare cost plan to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. Medicare cost plans that use the 2005 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these Medicare cost plans must inform their RO of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

Medicare cost plans that revise the CMS Model Interim Notification Letter must submit their letter to their CMS RO for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than November 2, 2005. CMS strongly encourages Medicare cost plans to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated November 2, 2005 to ensure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that Medicare cost plans must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states include California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. **If there are changes to this list of states with additional protections, CMS will inform all non-renewing Medicare cost plans prior to the time they develop their final notification letter.**

Medicare cost plans may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Medicare cost plans must include a list of remaining Medicare health plans in the final notification letters that will be available to affected beneficiaries as alternative choices in 2006. The list should include those Medicare health plans that have CMS-approved capacity limits. The final notification letter must call special attention to the fact that some Medicare health plans may have a different open enrollment cycle from Medicare cost plans. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

Regional Office Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS ROs prior to release. Medicare cost plans may submit draft copies of their final notification letters to CMS ROs starting September 1, 2005 but no later than October 2, 2005. CMS RO will give priority review to the submitted final notification letter. CMS strongly suggests that Medicare cost plans use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. CMS encourages Medicare cost plans to consider this review period when making plans to meet the November 2, 2005 deadline for delivery of these final notification letters to beneficiaries.

Medigap Information

Non-renewing Medicare cost plans must inform all affected Medicare beneficiaries, including individuals who are eligible for Medicare due to a disability or End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Details on this topic are provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter. If used, this model language will ensure accurate communication of these technical provisions.

Medicare cost plans are required to provide or arrange for supplemental coverage of benefits related to a pre-existing condition with respect to any exclusion period for all Medicare beneficiaries age 65 or older. For beneficiaries under age 65 who are entitled to Medicare due to a disability or End Stage Renal Disease (ESRD), the cost plan must arrange for supplemental coverage if it is available in the marketplace. Please see §1876(c)(3)(F) and under CMS (HCFA) Medicare Cost Plan contract provision, Article IV, General Conditions, item R.

Per CMS regulations, no special provisions need to be made to provide a "Guaranteed Issue" (i.e., no medical screening, or coverage of pre-existing conditions) Medigap policy, if such a policy is not available in the marketplace. If Medigap issuers in a **particular state do not sell Medigap policies to beneficiaries who are eligible for Medicare due to a disability, the Medicare Cost Plan will still need to provide supplemental coverage for pre-existing conditions.**

Under HMO/CMP Manual Section 3004.5(A)(2), Provide Services Directly, it states, "You may directly provide or arrange for the provision of services related to pre-existing conditions with no charge to the beneficiary."

Under the "Medicare cost contract" the Medicare cost plans sign at the inception of their contract, Article IV, General Conditions, (R) it again refers to providing for benefits of pre-existing conditions for " the lesser of six months or the duration of such period."

Per NAIC and HIPAA, the definition of what constitutes a "pre-existing condition" is as follows, "Pre-existing conditions should be limited to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy."

CMS's interpretation is that coverage for pre-existing conditions for the disabled is a requirement whether a disabled beneficiary: 1) applies for and obtains a Medigap policy with a pre-existing

condition exclusion; or 2) applies for and is denied coverage under a Medigap policy. Individuals who are eligible for Medicare due to age have similar protections. The beneficiary will still need to be provided coverage for pre-existing conditions, even if the cost plan has to provide such coverage directly. CMS believes that an individual who is eligible for Medicare due to a disability must make an attempt to obtain a Medigap policy before the cost plan can be required to provide coverage directly. The Medicare cost plan will not be required to provide coverage for pre-existing conditions for those members (aged and disabled) who do not seek a Medigap policy.

The coverage of pre-existing conditions is limited to those costs **related to the pre-existing condition** that result in Medicare cost-sharing amounts, such as Part A and B deductibles and coinsurance and excess part B charges, up to the limiting charge.

CMS will allow the Medicare cost plan to require that all disabled members go to the Medicare cost plans' physicians for treatment, during the time the Medicare Cost Plan is providing coverage for the pre-existing condition. The Medicare cost plan must coordinate and track these beneficiaries during the enrollment period and during the time they are receiving services. CMS must be able to track compliance.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing Medicare cost plans in order to choose from broader range of Medigap policies available on a guaranteed issue basis. Medicare cost plans must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2005 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to buy certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at
http://www.cms.hhs.gov/manuals/116_mmc/mc86c02.pdf

Public Notice of Non-Renewal

Non-renewing Medicare cost plans must publish a public notice of non-renewal at least 30 days prior to the end of the contract year (i.e., December 2, 2005) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. Medicare cost plans that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these Medicare Cost Plans must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

Medicare cost plans that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages Medicare cost plans to consider this review period when making plans to meet the November 2, 2005 deadline for release of these public notices.

Section 2. Systems Issues

Non-renewed Contracts

Non-renewing Medicare cost plans should **not** submit disenrollments for any members who will remain in their organization through December 31, 2005. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the Medicare cost plan submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan or Medicare cost plan are placed in Original Medicare in a timely manner.

Non-renewing Medicare cost plans should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the Medicare cost plans receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2005), Medicare cost plans must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December 31, 2005). Therefore, it is important that non-renewing Medicare cost plans submit any final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

Medicare cost plans will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

Service Area Reductions

Medicare cost plans with service area reductions for 2006 must disenroll all members who reside in the non-renewed area or county**.** Medicare cost plans must submit disenrollment records for all affected members no later than their appropriate cut-off date (12/13/2005) in December, the last operating month of their current contracts.

CMS will provide Medicare cost plans with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third week of December 2005, and verify the disenrollments for all submitted members. Medicare cost plans will also receive a separate communication with specific systems instructions from CMS.

Medicare cost plans with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

Section 3. Other Information

"Close-Out" Information

In the Fall of 2005, CMS will send a "close-out" letter to non-renewing Medicare cost plans with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to ensure that affected beneficiaries experience a smooth transition from membership in the non-renewing Medicare cost plan to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the Medicare cost plan after the last day of its contract.

Non-renewing Medicare cost plans may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract.

If an affected Medicare cost plan member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing Medicare cost plan is responsible for all appropriate costs and/or cost-sharing associated with Part A inpatient hospital services, until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B.

If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing Medicare cost plans will pay appropriate costs and/or cost-sharing associated with the covered charges through the last day of the contract; Original Medicare or the next Medicare health plan elected by the beneficiary will assume responsibility from the next day forward.

After the end of the contract period (i.e., December 31, 2005), Medicare Cost Plans' remaining obligations to CMS include:

1. Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the Medicare cost plan contract for the six year period following non-renewal or 3 years following the issuance of the Notice of Program Reimbursement (NPR), whichever is later.

2. Update of plan contact information in HPMS, should the Medicare cost plan access HPMS. Should the Medicare Cost Plan not access HPMS, they will be required to keep the appropriate RO informed of contact information. This will allow CMS to continue to contact appropriate persons in non-renewing Medicare cost plans until all activity is complete.

3. Participation in the CMS process to complete final reconciliation of CMS accounts with the Medicare cost plans, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

4. Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its Medicare cost plan contract was extant.

5. Submission of risk adjustment data to CMS. This data will be used to calculate risk-adjusted payments to Medicare Advantage organizations. Therefore, CMS must have all the required

historical data for each beneficiary who has been enrolled in a Medicare health plan in order for this data to be accurate. Non-renewing contractors must continue to submit the required hospital inpatient, hospital outpatient and physician risk adjustment for services provided to all its Medicare beneficiaries enrolled during calendar year 2005.

Medicare cost plans with further questions related to their Medicare cost contract non-renewals should contact their RO Plan Managers.

Part VI. List of Contacts

Part C Contacts

Benefits: Frank Szeflinski, 303-844-7119, Russell Hendel, 410-786-0329

Bid worksheet changes: Rich Coyle, 410-786-6393; Nancy Kitchen, 410-786-7637

Calendar/Non-renewal processes: Lettica Ramsey, 410-786-5262

Calendar/Renewal Process: Daniella Stanley, 410-786-3723

Cost Plan Appeals and Grievance Issues: Tim Roe, 410-786-2006

Cost Plan Issues: Frank Szeflinski, 303-844-7119; Nancy Kitchen, 410-786-7637

Cost-Sharing Guidance: Marty Abeln, 410-786-1032

General HPMS Information: Tim Hoogerwerf, 410-786-9962; Kristin Finch 410-786-2873

HIPAA: Yolanda Robinson, 410-786-7627

HPMS Help Desk: 1-800-220-2028 or hpms@nerdvana.fu.com

HPMS Connectivity: Don Freeburger, 410-786-4586

HPMS User IDs and Passwords: Neetu Jhagwani, 410-786-2548

Marketing Issues: David Lewis, 410-786-6645

Medicare Personal Plan Finder Data: Michael McCann, 410-786-2539

Medicare & You 2006: Amy Miner, 410-786-5242

MA Contract: Helaine Fingold, 410-786-5014

MA Plan Renewal Guidelines, General: Gloria Parker**,** 410-786-9281

Mid-Year Benefit Enhancements: Yasmin Galvez 410-786-0434; Frank Szeflinski, 303-844-7119

Non-Renewal Process for 2005: Lettica Ramsey, 410-786-5262

Operational Instructions for Completing the Plan Crosswalk: Kim Miegel (enrollment system), 410-786-3311; Randy Brauer 410-786-1618 (enrollment issues); Lori Robinson (HPMS plan crosswalk), 410-786-1826

MA Enrollment: Danielle Moon, 410-786-5724

PBP Changes: Pam Nicholson, 410-786-0263

Part C Appeals and Grievance Issues: Chris Gayhead, 410-786-6429

Part D Contacts

Lynn Orlosky (410) 786-9064 or **Randy Brauer** (410)786-1618 (for issues related to eligibility, elections, enrollment, including auto-enrollment of dual eligible beneficiaries)

Catherine Windfield-Jones 410-786-6674 (creditable coverage).

Mel Sanders (410) 786-8355 (for issues related to marketing and user fees).

Vanessa Duran (214) 767-6435 (for issues related to benefits and beneficiary protections, including Part D benefit packages, Part D covered drugs, pharmacy network access standards, and plan information dissemination requirements).

Jean Stiller (410) 786-0708 (for issues related to Part B/Part D coverage interactions and coordination of benefits in claims processing including the tracking of true-out-of-pocket (TROOP) costs).

Craig Miner, RPH. (410) 786-1889 (for issues of pharmacy benefit cost and utilization management, formulary development, medication therapy management, and electronic prescribing).

Deborah Larwood (410) 786-9500 (for issues related to quality assurance, privacy of records, programs to combat fraud, waste and abuse, and program oversight).

Mark Newsom (410) 786-3198 (for issues of submission, review, negotiation, and approval of risk and limited risk bids for PDPs and MA-PD plans; the calculation of the national average bid amount; determination and collection of enrollee premiums; calculation and payment of direct and reinsurance subsidies and risk-sharing; and retroactive adjustments and reconciliations.)

Rebecca Paul (410) 786-0852 (for issues related to demonstrations).

Jim Slade (410) 786-1073 (for issues of licensing and waiver of licensure, the assumption of financial risk for unsubsidized coverage, solvency requirements for unlicensed sponsors or sponsors who are not licensed in all States in the region in which it wants to offer a PDP and for issues related to pre-emption of State law).

Christine Hinds (410) 786-4578 (for issues of coordination of Part D plans with providers of other prescription drug coverage including Medicare Advantage plans, state pharmaceutical assistance programs (SPAPs), Medicaid, and other retiree prescription drug plans; also for issues related to eligibility for and payment of subsidies for assistance with premium and cost-sharing amounts for Part D eligible individuals with lower income and resources; for rules for States on eligibility determinations for low-income subsidies and general State payment provisions including the phased-down State contribution to drug benefit costs assumed by Medicare).

Mark Smith (410) 786-8015 (for issues related to conditions necessary to contract with Medicare as a PDP sponsor, as well as contract requirements, intermediate sanctions, termination procedures and change of ownership requirements.)

Frank Szeflinski (303) 844-7119 (for issues related to cost-based HMOs and CMPS offering Part D coverage.)

John Scott (410) 786-3636 (for issues related to the procedures PDP sponsors must follow with regard to grievances, coverage determinations, and appeals.)

Mark Smith (410) 786-8015 (for plan contractual issues and issues related to solicitation, review and approval of fallback prescription drug plan proposals; fallback contract requirements; and enrollee premiums and plan payments specific to fallback plans.)

Jim Mayhew (410) 786-9244 (for issues related to the alternative retiree drug subsidy and other employer sponsor options.)

Marty Abeln (410) 786-1032 (for issues related to employer group waivers).

Joanne Sinsheimer (410) 786-4620 (for issues related to physician self-referral prohibitions.)

Brenda Hudson (410) 786-4085 (for issues related to PACE organizations offering Part D coverage.)

Julie Walton (410) 786-4622 (for issues related to provisions on Medicare supplemental (Medigap) policies.)

Tracey McCutcheon (410) 786-6715 (for other Part D assistance).

Jane McClard (**410) 786-4460** (for SNP Passive Enrollment)

Part VII. WEB Reference List

MMA PDP and MA program http://www.cms.hhs.gov/medicarereform/pdbma
Medicare Health Plans http://www.cms.hhs.gov/healthplans
2006 Medicare Advantage Payment Rates http://www.cms.hhs.gov/healthplans/rates
Demo Plan Guidance http://www.cms.hhs.gov/researchers/demos/
Drug Card Info http://www.cms.hhs.gov/medicarereform/drugcard/
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PACE	http://www.cms.hhs.gov/pace/default.asp
Part D	http://www.cms.hhs.gov/medicarereform/pdbma/
PDP	http://www.cms.hhs.gov/pdps
Qs & As	http://www.cms.hhs.gov/medicarereform/medicarereformfaqs.asp
MA Bid instructions	http://www.cms.hhs.gov/healthplans/madvantage/draftmabidinstructions.pdf