



CENTER FOR DRUG AND HEALTH PLAN CHOICE

MEMORANDUM

DATE: April 16, 2010

TO: All Medicare Advantage Organizations, 1876 Cost Plans, and Demonstrations

FROM: Danielle R. Moon, J.D., M.P.A.
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RE: Benefits Policy and Operations Guidance Regarding Bid Submissions; Duplicative and Low Enrollment Plans; Cost Sharing Standards; General Benefits Policy Issues; and Plan Benefits Package (PBP) Reminders for Contract Year (CY) 2011

This memorandum addresses important issues to prepare Medicare Advantage Organizations (MAO), 1876 Cost Plans, and Demonstration plans for bid and benefit submission for CY 2011. All guidance contained in this document applies to MAOs and MA demonstrations, while items included under the sections titled, “Preventive Services,” “Other Benefit Policy Issues” and “PBP Instructions” also apply to 1876 cost plans.

The guidance in this memorandum advances CMS’ goals of establishing a more transparent and predictable process so that beneficiaries can select a plan that best meets their health care needs, while also being protected from high or unexpected cost sharing that could discourage enrollment by certain beneficiaries. In this guidance, CMS exercises its authority under our April 15, 2010 final regulation (75 FR 19678-19826) to establish maximum out-of-pocket (MOOP) limits and maximum cost sharing amounts for specific services, and provides guidance on a number of revisions to the Medicare Parts C and D program requirements set forth in these final regulations, and in the Patient Protection and Affordable Care Act of 2010 (PPACA) enacted on March 23, 2010.

In addition, this memorandum sets forth the process and instructions for MAOs to use to evaluate their bids prior to submission in order to ensure that their plan offerings in the same area are meaningfully different from one another and have sufficient enrollment. We also provide new guidance related to tiered cost sharing for medical benefits and the

limited instances where such tiering may be offered. Finally, the guidance includes clarifications of our benefits and cost-sharing policy and instructions for proper CY 2011 Plan Benefits Package (PBP) preparation.

This guidance also references our recently updated Chapter 4 of the Medicare Managed Care Manual (Benefits and Beneficiary Protections). Therefore, we recommend that MAOs and other Medicare health plans review Chapter 4 while designing their plans for CY 2011. Chapter 4 clarifies current Part C benefits policy and incorporates new policy topics in order to address many of the problematic issues that arose in prior bid seasons. Examples include: clarification of items and services that can be classified as supplemental benefits; multi-year benefits allowances; over-the-counter (OTC) drugs and Part B drugs covered by Medicare; meal and nutrition benefits; and Original Medicare cost sharing/caps. The link to Chapter 4 is:

<http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf>

Finally we note that there are several references throughout this document to our CY 2011 renewal/non-renewal guidance. That guidance document was released on April 16, 2010 as an HPMS memorandum.

I. Duplicative Plans and Plans With Low Enrollment

The large number of MA plan options that have been offered in many areas has made it difficult and confusing for beneficiaries to distinguish between these plans, and to choose the best option to meet their needs. MAOs should not submit CY 2011 bids for plans that have insufficient enrollment and/or are not meaningfully different from their other plan offerings in the area. CMS discussed this issue in our CY 2010 Call Letter, worked with MAOs to improve beneficiary choice prior to CY 2010 bid submissions, and addressed this in our April 15, 2010 final rule.

In 42 CFR § 422.254(a)(5) and 422.256(b)(4)(i), we specified that CMS would review bids to ensure that an MAO's plans in a given service area are meaningfully different from one another in terms of key benefits or plan characteristics such as cost sharing, benefits offered, or plan type. We also specified that, with some exceptions, we would use our authority under section 1857(c)(2)(B) of the Act and codified in 42 CFR §422.506(b)(1)(iv), to non-renew plans that do not have sufficient enrollment after a specified length of time. Also in the final rule, we stated that we would provide further guidance on each of these issues. CMS will address low enrollment and duplicative plans for CY 2011 with two separate processes, as described below.

The following guidance applies to non-employer MA plans, including Medicare Medical Savings Accounts (MSAs) and Special Needs Plans (SNPs). Note: We reserve the right to review employer plans for low enrollment and/or meaningful difference in future years.

A. Plans With Low Enrollment

In the next couple of weeks, CMS will send each MAO a list of low enrollment plans that have been in existence for three or more years but, as of April 2010, have fewer than 500 enrollees for non-SNP plans and 100 enrollees for SNP plans. The lists will not include low enrollment plans that CMS determines are located in service areas that do not have a sufficient number of competing options of the same plan type.

For each identified plan, MAOs must provide justification for low enrollment under the standards in the final rule or confirm through return email that the plan will be eliminated or consolidated with another of the organization's plans for CY 2011. If CMS does not find that there is a unique or compelling reason for maintaining a plan with low enrollment, CMS will non-renew the plan. Instructions for how to submit business cases, the timeframe for submissions, and what information is required in those submissions will be included with the list of low enrollment plans sent to the MAO.

As stated in our final rule, CMS recognizes there may be reasonable factors, such as specific populations served and geographic location, which lead to a plan's low enrollment. SNPs, for example, may legitimately have low enrollments because of their focus on a subset of enrollees with certain medical conditions. We will consider all such information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. MAOs are to follow the CY 2011 renewal/nonrenewal guidance to determine whether a low enrollment plan may be consolidated with another plan(s).

B. Duplicative Plan Offerings

MAOs offering more than one plan in a given service area should ensure that beneficiaries can easily identify the differences between the plans and determine which plan provides the highest value at the lowest cost based on their needs. For CY 2011, CMS will use plan-specific out-of-pocket cost (OOPC) estimates to identify meaningful differences among similar plan types. OOPC estimates are based on a nationally representative cohort of more than 13,000 Medicare beneficiaries represented in the 2004 and 2005 Medicare Current Beneficiary Survey data and are used to provide estimated plan cost information to beneficiaries on Medicare Options Compare. Estimated out-of-pocket costs for each plan benefit package are calculated on the basis of utilization patterns for that cohort. The calculation includes Parts A, B, and D services and mandatory supplemental benefits, but not optional supplemental benefits. For purposes of evaluating meaningful differences among MA plans, CMS will exclude premiums from the OOPC calculation. Current enrollment and risk scores will not affect the OOPC calculation. A summary of the OOPC estimates is available at:

<http://www.medicare.gov/MPPF/Include/DataSection/OOPC/OOPCCalculations.asp?language=English>.

In the next few weeks, CMS will provide MAOs with CY 2010 OOPC estimates for each of their current plans so that organizations can use the information in developing CY

2011 plan bids. CMS will evaluate meaningful differences among plans offered in the same county by a parent organization as follows:

1. Non-SNP plan offerings will be separated into five plan-type groups on a county basis: (1) HMO (2) HMOPOS; (3) Local PPO; (4) Regional PPO; and (5) PFFS. SNP plans will be separated into groups representing the various allowed SNP plan types.
2. Plans within each plan-type group will be further divided into MA-Only and MA-PD sub-groups for evaluation. That is, the presence or absence of a Part D benefit is considered a meaningful difference.
3. The combined Part C and Part D (if applicable) OOPC estimate will be calculated for each plan within the plan-type groups and sorted from high to low. There must be a total OOPC difference of at least **\$20.00** per member per month between each plan to be considered meaningfully different.

(Note: Employer plans are not included in this evaluation for CY 2011.)

CMS expects MAOs to submit CY 2011 plan bids that meet the meaningful difference requirements but will not prescribe how the MAOs should redesign benefits packages to achieve the differences. Plan bids that do not meet these requirements will not be approved by CMS. MAOs are to follow CY 2011 renewal/non-renewal guidance to determine if their plans may be consolidated with other plans.

II. CY 2011 Cost Sharing Standards

A. Maximum Out-of-Pocket (MOOP) Limits

CMS strives to ensure that MAOs develop more transparent plan benefit designs so that beneficiaries are better able to predict their out-of-pocket costs but are also protected from excessively high or unexpected cost sharing. To that end, CMS has encouraged MA plans to incorporate into their benefit designs a voluntary maximum out-of-pocket (MOOP) limit on enrollee spending that includes costs for all Parts A and B services.

In our April 15, 2010 final rule, we established a new mandatory MOOP requirement for local MA plans effective CY 2011. As provided at 42 CFR 422.100(f)(4), all local MA plans (employer and non-employer), including HMOs, HMOPOS, local PPO (LPPO) plans and PFFS plans must establish an annual MOOP limit on total enrollee cost sharing liability for Parts A and B services, the dollar amount of which will be set annually by CMS. D-SNPs are required to establish annual MOOP limits because an enrollee's eligibility for Medicaid may change during the year, leaving the enrollee liable for cost sharing and because the State Medicaid program would not be expected to pay more than the MOOP amount when it is responsible for the enrollee's cost sharing.

In addition, as provided at 42 CFR 422.100(f)(5), effective for CY 2011, LPPO plans are required to have a "catastrophic" limit inclusive of both in- and out-of-network cost sharing for all Parts A and B services, the dollar amount of which also will be set annually by CMS. All cost sharing (i.e., deductibles, coinsurance, and copayments) for Parts A and B services must be included in plans' MOOPs.

CMS recognizes that a number of organizations (covering roughly one-third of all MA enrollees) do not have a MOOP, and will need to adjust their benefit designs and premiums to reflect this new limit. On the other hand, nearly 40 percent of MA plans (covering about one-third of all MA enrollees) do have voluntary, qualified MOOPs (\$3,400 for all Parts A and B services in CY 2010) and we do not want to eliminate incentives for organizations to maintain or establish this lower threshold. Therefore, for CY 2011, CMS will implement both a mandatory MOOP amount in accordance with the requirements at 42 CFR 422.100(f)(4) and continue to allow MAOs the option of adopting a lower, voluntary MOOP limit. MAOs that adopt the lower voluntary MOOP will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP.

We will assess the effects of our voluntary and mandatory MOOP amounts from year to year (including determining whether a voluntary MOOP is still needed), and will make upward or downward adjustments to ensure we continue to strike the right balance between affording beneficiaries protection from high out-of-pocket costs and maintaining MA plan viability in the marketplace.

Since implementation of the Medicare Modernization Act of 2003, RPPOs have been required to establish a MOOP for in-network cost sharing and a catastrophic limit inclusive of both in- and out-of-network cost sharing for Parts A and B services; however, those amounts are at the discretion of MAOs offering RPPO plans. For CY 2011, RPPOs will continue to be permitted to establish their own in-network MOOP and catastrophic limits, but we encourage them to adopt either the mandatory or voluntary MOOPs established in this memorandum. To the extent an RPPO sets its MOOP and catastrophic limits above the mandatory amounts set by CMS for other plan types, it may be subject to additional CMS review of its proposed Parts A and B services cost sharing amounts.

The chart below provides the CY 2011 mandatory MOOP amount that MA plans may not exceed, and the voluntary MOOP amount that would result in less scrutiny of individual service category cost sharing, if met.

CY 2011 Voluntary and Mandatory MOOP Amounts By Plan Type

Plan Type	Voluntary	Mandatory
HMO	\$3,400	\$6,700
HMO POS	\$3,400	\$6,700
Local PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
Regional PPO	\$3,400 In-network and \$5,100 Catastrophic*	Plan determined In-network and Catastrophic*

PFFS (full network)	\$3,400 In- and out-of network	\$6,700 In- and out-of network
PFFS (partial network)	\$3,400 In- and out-of network	\$6,700 In- and out-of network
PFFS (non-network)	\$3,400	\$6,700

*Catastrophic MOOP is inclusive of in- and out-of-network Parts A and B services.

The MA MOOP amounts are based on a beneficiary-level distribution of Parts A and B cost sharing for individuals enrolled in Original Medicare. The mandatory MOOP amount represents the 95th percentile of projected beneficiary spending in CY 2011. Stated differently, 5 percent of Original Medicare beneficiaries are expected to incur \$6,700 or more in Parts A and B deductibles and coinsurance in CY 2011. The CY 2011 voluntary MOOP amount of \$3,400 remains at the CY 2010 level. This level was established for CY 2010 because, consistent with established methodology, it represented the 85th percentile of projected Original Medicare out-of-pocket costs. For CY 2011, we determined that it is preferable to maintain the MOOP at this level, which is slightly above the 85th percentile, but expect to establish the voluntary MOOP in future years at the 85th percentile.

We determined the catastrophic MOOP amounts for LPPOs and RPPOs by multiplying the respective MOOP amounts by 1.5 for the relevant year. Thus, the voluntary catastrophic MOOP amount for LPPOs in CY 2011 is calculated as \$3,400 x 1.5 = \$5,100. Similarly, the mandatory catastrophic MOOP amount for LPPOs in CY 2011 is calculated as \$6,700 x 1.5 = \$10,000 (with rounding).

Due to the timing of our April 15, 2010 final rule, CMS cannot update the CY 2011 Plan Benefit Package (PBP) software to incorporate the terms used in the MOOP policy described above. Instead, “Maximum Enrollee Out-of-Pocket Costs” will be considered synonymous with “Maximum Out-of-Pocket” and “Catastrophic” will be considered synonymous with “Combined” in the CY 2011 PBP. The following chart identifies where MOOP amounts should be placed in the PBP for CY 2011 for Parts A and B services.

CY 2011 PBP Options for MOOP Amounts By Plan Type

Plan Type	PBP Option(s) for MOOP Amounts	Other Instructions/Comments
HMO	In-network	“In-network” is only option available in the PBP
HMO with Optional Supplemental POS	In-network	“In-network” is only option available in the PBP
HMO with Mandatory Supplemental POS	In-network	Select “No” for both “Combined” and “Out-of-Network” in the PBP

Local PPO	In-network and Combined	Select "No" for "Out-of-Network" in the PBP
Regional PPO	In-network and Combined	Select "No" for "Out-of-Network" in the PBP
PFFS (full network)	Combined	Select "No" for both "In-Network" and "Out-of-Network" in the PBP
PFFS (partial network)	Combined	Select "No" for both "In-Network" and "Out-of-Network" in the PBP
PFFS (non-network)	General	"General" is the only option available in the PBP

B. Discriminatory Cost Sharing Assessments

For CY 2011, CMS has established three benefit discrimination assessments for non-employer MA plans:

1. Per Member Per Month (PMPM) Actuarial Equivalent (AE) Cost Sharing Maximums;
2. Service Category Cost Sharing Standards; and
3. Discriminatory Pattern Analysis.

The PMPM actuarial equivalent cost sharing maximums and service category cost sharing standards described below are provided in advance of the bid submission deadline with the expectation that all CY 2011 plan bids will conform to these standards when submitted on or before June 7, 2010. CMS will perform a discriminatory pattern analysis following bid submission to identify and correct discriminatory benefit design elements not anticipated by the standards.

Also note that benefit design and cost sharing amounts approved for CY 2010 will not be automatically acceptable for CY 2011 because a separate and distinct review is conducted each contract year.

C. Per Member Per Month (PMPM) Actuarial Equivalent (AE) Cost Sharing Maximums

The actuarially estimated total MA cost sharing for Parts A and B services must not exceed cost sharing for those services in Original Medicare. As in CY 2010, CMS also will apply this requirement separately to the following service categories for CY 2011: Inpatient Facility; Skilled Nursing Facility (SNF); Home Health Services; Durable Medical Equipment (DME); and Part B drugs.

Whether in the aggregate, or on a service-specific basis, excess cost sharing is identified by comparing two values found in Worksheet 4 of the Bid Pricing Tool (BPT). Specifically, a plan's PMPM cost sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) is compared to Original Medicare actuarially equivalent cost sharing (BPT Worksheet 4, Section IIA, column n). For inpatient facility and SNF services, the AE Original Medicare cost sharing values, unlike plan cost sharing values,

do not include Part B cost sharing; therefore, an adjustment factor is applied to these AE Original Medicare values to incorporate Part B cost sharing and to make the comparison valid. Also, since Original Medicare has no cost sharing for home health services, a different approach is used: here the comparison amount is set equal to 15 percent (column #4) of the allowed amount for home health.

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

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

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

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

D. Service Category Cost Sharing Standards

In our April 15, 2010 final rule, we established a new requirement at 42 CFR 422.100(f)(6) that MA plan cost sharing for Parts A and B services specified by CMS not exceed levels annually determined by CMS to be discriminatory. In addition, section 3202 (“Benefit Protection and Simplification”) of the PPACA specifies that, unless a specified exception applies, the cost sharing charged by MA plans for chemotherapy administration services, renal dialysis services, and skilled nursing care may not exceed the cost sharing for those services under Parts A and B. In establishing service category cost sharing thresholds for other services, we will be cognizant of the need to strike a

balance between affording beneficiaries with reasonable protection from high out-of-pocket expenses and our desire that the MA program remain viable for beneficiaries. We will adjust the limits annually, including the specific Parts A and B services subject to the limit, as necessary based on previous years' experience and other factors as needed to ensure that this balance is maintained. For purposes of setting cost sharing thresholds for Parts A and B services, CMS will review the prior year's bid data, as well as actuarial equivalency relative to Original Medicare, in order to identify cost sharing outliers.

Similar to last year, CMS is focusing these standards on those Parts A and B services that are more likely to have a discriminatory impact on sicker beneficiaries. The standards are based on a combination of patient utilization scenarios and Original Medicare. The rationales selected for utilization scenarios reflect length of stays or the number of visits generated by average to sicker patients. Some service categories have multiple utilization scenarios in an effort to ensure that plans will consistently distribute cost sharing amounts in a manner that does not discriminate. Standards that are based on Original Medicare may be met using coinsurance or actuarially equivalent copayments.

As discussed in the MOOP section of this memorandum, for CY 2011, in addition to establishing a mandatory MOOP limit, we are continuing our current policy of offering MA plans the option of adopting a lower voluntary MOOP with greater flexibility in Parts A and B cost sharing than is available for plans that adopt the higher mandatory MOOP. Since RPPOs may determine their own MOOP amounts for CY 2011, RPPOs not adopting the voluntary MOOP will be reviewed on the basis of the mandatory MOOP standards. To the extent an RPPO sets its MOOP and catastrophic limits above the mandatory amounts set by CMS for local PPOs, it may be subject to additional CMS review of its proposed cost sharing amounts.

The chart below summarizes the standards and cost sharing amounts by MOOP type (e.g., mandatory or voluntary) for local MA plans. CY 2011 plan bids must reflect enrollee cost sharing that is not greater than the amounts described below. For LPPOs and RPPOs, these standards will be applied to in-network services. All standards assume that the enrollee will experience the full amount of applicable deductibles, copayments, and/or coinsurance for the service received.

CY 2011 Cost Sharing Requirements

	Voluntary MOOP (\$3,400)	Mandatory MOOP (\$6,700)
Service Category	Cost Sharing Limits	Cost Sharing Limits
Inpatient - 60 days	N/A	\$3,935
Inpatient - 10 days	\$2,231	\$1,785
Inpatient - 6 days	\$2,016	\$1,613
Mental Health Inpatient - 60 days	\$2,471	\$1,977
Mental Health Inpatient - 15 days	\$2,156	\$1,796
Skilled Nursing Facility – First 20 Days ¹	\$100/day	\$50/day

Skilled Nursing Facility – Days 21 through 100 ¹	No greater than Original Medicare	No greater than Original Medicare
Home Health – 37 visits	\$1,110	0
Physician Mental Health	\$40 or coinsurance no greater than Original Medicare	\$40 or coinsurance no greater than Original Medicare
Renal Dialysis -156 visits	No greater than Original Medicare	No greater than Original Medicare
Part B Drugs-Chemotherapy ²	No greater than Original Medicare	No greater than Original Medicare
Part B Drugs-Radiation	No greater than Original Medicare	No greater than Original Medicare
Part B Drugs-Other	No greater than Original Medicare	No greater than Original Medicare
DME-Equipment ³	N/A	No greater than Original Medicare
DME-Prosthetics ³	N/A	No greater than Original Medicare
DME-Medical Supplies ³	N/A	No greater than Original Medicare
DME-Diabetes Monitoring Supplies ³	N/A	No greater than Original Medicare

1. MA plans may have cost sharing for the first 20 days of a SNF stay, consistent with cost sharing guidance, but per-day and overall cost sharing for subsequent SNF days must not exceed Original Medicare cost sharing levels.
2. Part B drugs-chemotherapy includes administration services. Chemotherapy drugs and administration services in an inpatient setting are covered under the MA plan’s inpatient benefit coverage.
3. DME cost sharing varies by service or supply.

E. Discriminatory Pattern Analysis

Following CY 2011 plan bid submissions, CMS will ensure that MA plans conform to the actuarial equivalence and service category standards described above. In addition, CMS will analyze bids to ensure that discriminatory benefit designs are identified and corrected. This could include bids that meet standards but have cost sharing amounts that are distributed in a manner that may discriminate against sicker, higher-cost patients. This analysis may also evaluate the impact of benefit design on patient health status and/or certain disease states. CMS will contact plans to discuss and correct any issues that are identified as a result these analyses.

III. Preventive Services

As mandated by the PPACA, effective CY 2011, there will be zero cost sharing under Original Medicare for all Medicare-covered preventive services recommended with a grade of “A” or “B” by the U.S. Preventive Services Task Force. Currently, most MA plans provide zero cost sharing for all or most of the Medicare-covered preventive services.

We expect that, like Original Medicare, all Medicare health plans also will provide Medicare-covered preventive services without cost sharing charges. As evidenced by the many plans that currently provide preventive services without cost sharing charges, prevention services have been important components of coordinated care for many years. CMS will emphasize the importance of beneficiary access to preventive services in CY 2011 by highlighting preventive services in Medicare Options Compare (MOC), as well as the ANOC and EOC, and will clearly identify plans that do provide all preventive services with zero cost sharing and plans that do not. We intend to issue rulemaking to establish zero cost sharing for the services for all Medicare health plan enrollees beginning in CY 2012, and to integrate measurement of the benefits into our performance ratings.

We are strongly encouraging all Medicare health plans to charge zero cost sharing for the following benefits effective CY 2011:

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Screenings
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colon Cancer Screening (Colorectal)
- Diabetes Screenings
- Diabetes Self-Management Training
- EKG Screening
- Flu Shots
- Glaucoma Tests
- HIV Screening
- Hepatitis B Shots
- Breast Cancer Screening (Mammograms)
- Medical Nutrition Therapy Services
- Pneumococcal Shot
- Prostate Cancer Screenings
- Smoking Cessation (counseling to stop smoking)
- Welcome to Medicare Physical Exam (one-time physical exam)

IV. Other Benefit Policy Issues

A. Plan Corrections for 2011

CMS expects that requests for plan corrections for CY 2011 will be minimal. As required by 42 CFR 422.254, submission of the final actuarial certification and the bid attestation serve as documentation that the final bid submission has been verified and is complete and accurate at the time of submission. A request for a plan correction indicates the presence of inaccuracies and/or the incompleteness of a bid and calls into question an organization's ability to submit correct bids and the validity of the final actuarial certification and bid attestation. Please be advised that an organization requesting a plan correction will receive a corrective action warning letter. An organization that received a warning letter for CY 2010 may receive a corrective action plan (CAP) if it requests a plan correction for CY 2011.

Although CMS expects that the original PBP submitted by an MAO or other Medicare health plan is a true representation of the benefits package it intends to offer, the plan corrections module will be available in HPMS for CY 2011 for a limited period, beginning in mid- September through October 1, 2010. Consistent with marketing and open enrollment coordination, MAOs will not be able to request plan corrections for CY 2011 benefits packages after the October 1, 2010 deadline. This will ensure that correct bid information will be available for review on Medicare Options Compare in time for the annual enrollment start date. Only changes to the PBP that are supported by the BPT are allowed during the plan correction period.

B. Chiropractic Copayment Limit

Manual manipulation of the spine that is medically reasonable and necessary to correct a subluxation is an Original Medicare Part B benefit that must be made available to MA enrollees. MA enrollee cost sharing for chiropractic services (reported by CPT codes 98940, 98941 and 98942) cannot exceed 50 percent of the actuarial equivalent value of the costs of the services, and the cost sharing structure cannot discriminate against beneficiaries who are most likely to need those services. For additional cost sharing information, MA plans may refer to Chapter 4 of the Medicare Managed Care Manual, section 10.20 (Chiropractic Services).

C. PPO Supplemental Benefits/Caps

PPO plans wishing to cap the dollar value of supplemental benefits must use the same cap for both in-network and out-of-network benefits. PPO plans offering an optional supplemental benefit must offer the same benefit in-network and out-of-network. Cost sharing for out-of-network services may be higher than for in-network services and those amounts must be clearly identified in the PBP.

D. Visitor/Traveler (V/T) Benefits

Under plan enrollment rules, MA plans must disenroll enrollees who are continuously absent from the plan's service area for six months or more. However, our regulations at 42 CFR 422.74(d)(iii) allow MA plans to retain enrollees out of their service area for up to twelve months if they offer a V/T benefit. Over the past several years, we have noted confusion by MA plans regarding the requirements for offering a V/T benefit. In our April 15, 2010 final rule, we clarified the requirements for a V/T benefit if an MA plan wants to offer its members the opportunity to remain enrolled in their plan when they are absent from the plan's service area from six to twelve months in areas designated by the MA plan.

As provided in 42 CFR 422.74(d)(iii), MA plans may offer a V/T benefit only within the United States or its territories. The specific requirements for the V/T benefit are as follows:

- It must be available to all plan enrollees who are temporarily in the designated geographic areas where the V/T benefit is offered.

- Enrollees who are temporarily in a plan designated V/T area may remain enrolled in the MA plan from 6 to 12 months.
- The plan furnishes all plan covered services in its designated V/T area(s), including all Medicare Parts A and B services and all mandatory and optional supplemental benefits at in-network cost sharing levels, consistent with Medicare access and availability requirements at 42 CFR 422.112.
- An MAO that is not able to form a network of direct contracted providers to furnish supplemental benefits in an area in which it offers a V/T benefit may, with CMS approval, allow its enrollees to obtain plan covered services from non-contracted providers as long as the plan can ensure that its members have access to providers willing to furnish services in that area.

E. Foreign Travel Benefit

MA plans can offer limited coverage for emergency, or urgently needed, health care services for its members who temporarily travel outside the United States. If the MA plan offers foreign travel coverage as a mandatory supplemental benefit, the cost of the benefit should be nominal or CMS may determine that the benefit discriminates based on health status. For CY 2011, a foreign travel benefit can be entered as an optional or mandatory supplemental benefit at Section 4a “Emergency Care” for worldwide coverage in the PBP.

MA plans must disenroll beneficiaries who are absent from the plan service area for six months or more of the applicable contract year. The foreign travel benefit is separate from the visitor/traveler benefit, described above, which allows plans to retain enrollees who are outside of the plan service area for up to a year but who must be in the United States and its territories during an extended absence from the plan service area.

F. Copayment and Coinsurance Transparency

As mentioned elsewhere in this memo, CMS wants to ensure that beneficiaries can estimate their out-of-pocket costs and can select a plan that best meets their individual health care needs. Co-payments cannot exceed coinsurance standards on an actuarially equivalent basis.

Stratified copayments based on the cumulative number of visits (e.g., cost sharing of \$5 for visits 1 through 5 and \$10 for visits 6 and greater) are not permitted because they violate uniform cost sharing rules at 42 CFR 100(d)(2). However, plans may use a stratified copayment arrangement for DME and/or Part B drugs. For each strata, the copayment amount must not be greater than the CMS coinsurance requirement for the lower limit of the strata. To avoid complexity, the number of copayment strata must not exceed four. The co-payment structure must also be explained in the PBP notes field.

The example below illustrates an acceptable stratified copayment approach to a service category with a wide range of costs and a 20% coinsurance standard.

<u>Cost Range for Service</u>	<u>Copayment Amount</u>
\$0 - \$199	\$0
\$200 - \$499	\$40
\$500 - \$999	\$100
\$1,000 and above	\$200

Although CMS believes that out-of-pocket cost estimation is easier for beneficiaries when the MA plan presents those costs in terms of copayments rather than as coinsurance amounts, CMS will not consider the imposition of coinsurance as discriminatory as long as the specific cost sharing amount is in compliance with CMS' standards.

G. Tiered Cost Sharing for Medical Benefits

For CY 2011, MAOs should limit plan cost sharing tiers for medical benefits in a manner that is consistent with the conditions of transparency and uniform cost sharing (see Chapter 4 section 10.10). We specifically note that cost sharing tiers for medical benefits may not be based on the provider group an enrollee selects within the MA plan. For example, if an MA plan's provider network is made up of two or more physician groups, an MA plan may not require different cost sharing based on the physician group the member selects upon enrollment. Basing a plan's cost sharing on the physician group a member selects creates multiple MA plans, and conflicts with uniformity requirements, because members are substantially locking themselves into different cost sharing structures depending on which physician group is selected. Any CY 2011 cost sharing tiers in a plan's medical benefit design should be clearly reflected in the plan's marketing material and PBP. We will review any cost sharing tiers for medical benefits submitted for CY 2011 and determine if further action limiting cost sharing tiers is required through future rule making.

H. Prohibition on Prior Notification Rules by PPO, PFFS and MSA Plans

CMS has determined that the complexity of cost sharing designs that include prior notification rules makes it more difficult for both enrollees and providers to understand the enrollee's cost sharing obligation in advance of receiving services. In order to reduce the complexity of MA plans' cost sharing designs and improve transparency for enrollees and providers, we codified our policy in our April 15, 2010 final rule, to prohibit PFFS plans, PPO plans (for out-of-network services) and MSA plans from establishing prior notification rules if the plan provides lower cost sharing when prior notification rules have been satisfied. Specifically, in that final rule, we revised 42 CFR §§422.4(a)(1)(v), (a)(2), and (a)(3) to prohibit PPO, PFFS, and MSA plans, respectively, from establishing prior notification rules under which an enrollee is charged lower cost sharing when either the enrollee or the provider notifies the plan before a service is furnished. This policy is effective for CY 2011.

In order to operationalize these provisions, we removed the cost share reduction questions from the CY 2011 PBP software for LPPOs and RPPOs (for out-of-network services) and PFFS plans. In addition, PPO, PFFS, and MSA plans may not use the PBP notes fields to describe or establish prior notification rules.

We encourage MA plans to take an active role in educating enrollees and providers about their rights in accordance with 42 CFR 422.566 to request a written advance coverage determination from the plan prior to the enrollee receiving the service in order to confirm that the service is medically necessary and will be covered by the plan. MA plans should provide clear explanations of the process for requesting a written advance coverage determination in member materials and respond to requests from enrollees and providers on a timely basis. Plans may encourage enrollees and providers to request written advance coverage determinations prior to receiving/providing costly services. MA plans may use requests for written advance coverage determinations as a tool to identify enrollees who may qualify for disease management and case management programs or who require further care coordination.

I. Prohibition on Offering of POS-Like Benefits by PPO Plans

We determined that our current policy allowing PPOs to offer a POS-like benefit with different levels of beneficiary cost sharing for services depending on whether the enrollee followed preauthorization, pre-certification, or pre-notification rules before receiving out-of-network services is confusing and vulnerable to abuse by plans that use the policy as a prior authorization mechanism for non-network services. Therefore, in our April 15, 2010 final rule, we prohibit PPO plans from offering POS-like benefits, effective CY 2011. Specifically, we revised the definition of POS in 42 CFR §422.2 and §422.105(b), (c), and (f) to reflect our policy that only HMOs may offer a POS benefit. This change is consistent with section 1851(a)(2)(A)(i) of the Act, which states that an HMO may include a POS option. PPO plans may not use the notes fields in the PBP software to describe or establish POS-like benefits.

J. Limits on Optional Supplemental Benefits

Consistent with 42 CFR 422.102, neither cost share buy-down of Original Medicare benefits nor State Medicaid wraparound benefits may be offered as optional supplemental benefits.

K. Medicare-Covered Eyeglass Frames

As in Original Medicare, MA plans must cover standard eyeglass frames or contact lenses following cataract surgery with lens replacement. MA plans may establish a cap on standard eye frames offered by the MA plan. Any MA plan providing a cap must be able to demonstrate that the cap amount does cover standard eye frames in the geographic service area serviced by the plan.

L. Skilled Nursing Facility (SNF) Coverage

In accordance with 42 CFR 422.624(b), prior to termination of SNF services the provider must deliver valid written notice to the enrollee of the MAO's decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission to the provider. The MAO is financially liable for continued services until two days after the enrollee receives valid notice.

M. CY 2011 Occupational Therapy and Physical Therapy/Speech Language Pathology Caps

The CY 2011 caps on therapy payments under Original Medicare are \$1,860 per year per beneficiary for occupational therapy (OT) services and \$1,860 for physical therapy (PT) and speech language pathology (SLP) services per year per beneficiary.

N. Copayment Rates for Medicare Outpatient Psychiatric Services

Section 102 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1833(c) of the Act to phase out the discriminatory higher Part B cost sharing for outpatient psychiatric services beginning in CY 2010. Prior to CY 2010, under the Original Medicare program, the beneficiary coinsurance for outpatient psychiatric services was effectively 50 percent because only 62.5 percent of such expenses were considered to be Medicare "incurred expenses" when determining the copayment and deductible amounts (42 CFR 410.155).

As required in section 1833(c) of the Act, beginning CY 2010 and ending with CY 2014, Medicare "incurred expenses" for outpatient psychiatric services will be transitioned from 62.5 percent to 100 percent, which will effectively reduce the beneficiary copayment amounts to 20 percent, consistent with the coinsurance for almost all other Part B services.

For CY 2011, the Medicare "incurred expenses" will be 68.5 percent and the beneficiary coinsurance amount will be equivalent to 45 percent for outpatient psychiatric services.

O. Regional Preferred Provider Organizations (RPPOs) May Not Have Part B-Only Enrollees

An RPPO plan must cover enrollees eligible for both Part A and Part B of Medicare. Medicare beneficiaries with Medicare coverage only under Part B have not been allowed to elect an MA plan since December 31, 1998 unless they were members of employer or union groups. Employer/union groups may offer local MA plans to Part B only employer union members (Chapter 9, section 20.1.4 of the manual on Employer/Union Sponsored Group Health Plans.) However, we note that RPPOs may not be offered to Part B only employer/union members or individuals.

P. Application of MOOP and Cost Sharing Limits to Employer Plans

We also note that as MA plans, employer plans are subject to the cost sharing and MOOP limits that will apply to all MA plans in CY 2011. However, employer plans can request that CMS approve a waiver under its authority at section 1857(i) of the Social Security Act.

V. PBP Instructions

A. Office Visit Charges

In CY 2010 CMS instructed plans to enter the office visit cost share range for all providers in the PBP primary care physician (PCP) field. For CY 2011, only the PCP cost sharing must be entered in the PCP cost sharing data field. In addition, where applicable, CMS has created office visit minimum and maximum cost sharing data entry fields that plans should use to enter the office visit cost sharing amounts. The data captured in these fields will be reflected in the Summary of Benefits.

If a plan has an office visit charge for a service category that does not have a standard office visit data entry field, the plan must describe the visit and the charges in a PBP notes field.

B. Supplemental Benefits for Cost Plans

CMS regulations do not give Section 1876 cost plans the authority to offer mandatory supplemental benefits. However, cost plans have the option to enter their optional supplemental benefits as mandatory supplemental benefits in the PBP so that their Summary of Benefits information will be comparable to other MA plan types.

C. Zero-Cost Out-of-Network Benefits

MA PPO plans offering out-of-network benefits that require no cost sharing should continue the practice of entering “0” in the appropriate service category standard data fields.

D. Cardiovascular Screening

In the past, some plans have offered cardiovascular screening services more frequently than Original Medicare allows. Because the PBP software has no standard data fields dedicated to this type of supplemental benefit, the plan must describe offerings of any additional cardiovascular screenings in the PBP notes for subcategory 8a (Outpatient Clinical/Diagnostic/Therapeutic Services).

E. Unreserved PBP Service Categories

The CY 2011 PBP has two “other” categories (B-13e and B-13f) that may be used to define an acceptable supplemental benefit for which the PBP software lacks a reserved subcategory.

F. Cost Sharing for SNPs Serving Dual-Eligibles

PBPs for plans serving dual-eligible enrollees must show the plans' actual out-of-pocket charges (if any) for covered services even though generally Medicaid will pay for them.

G. In- and Out-of-Network Wellness Benefits

If a PBP subcategory B-14a (Education and Wellness Programs) standard supplemental benefit is offered through a telephone hot line, and is accessible to all plan enrollees in all geographic locations, then the PPO has fulfilled its obligation of providing benefits in and out of network.

H. Flu/Pneumonia Shots

PPO and HMOPOS plan types with PBP category B-14b (Immunizations) out-of-network/POS cost sharing should include a PBP note indicating that such charges do not apply to flu and pneumonia immunizations when they are the only services received during a provider visit.

We appreciate your cooperation on these important matters. Please direct any questions about topics addressed in this memo to CMS at <https://mabenefitsmailbox.lmi.org/>.