Guidance for Medicare Advantage Medical Savings Account (MSA) Plans

Legal Entity Requirements

Q: Must the entity offering the MSA plan be a risk-bearing entity?

A: Yes. Sec. 1855 says an MA organization must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage.

Part D Coverage

Q: Can an MSA member purchase a PDP independently, since MSA plans are not allowed to offer Part D prescription drug coverage?

A: Yes. This is the member's only option for obtaining Part D coverage.

Plan Design

Q: Can MSA plans be regional plans?

A: No. MSA plans are MA local plans. Per Sec. 1851(a)(2)(A), regional plans are coordinated care plans. MSA plans are not coordinated care plans, and thus cannot be regional plans.

Q: Can MSA plans offer partial county service area?

A: Partial county requests would only be approved in rare situations, i.e., the MAO is only licensed in part of the county. The primary reason CMS approves partial county service areas for MA coordinated care plans is the unavailability of contracted providers in certain counties due to natural barriers like mountains or rivers. It is unlikely that circumstances warranting a partial county service area would be present for an MA MSA plan.

Benefit Design

Q: Do the Medicare benefit limitations apply to the MSA program, or is the plan responsible for paying unlimited after the deductible is met? Example: Can the plan apply the benefit periods for SNF care or the 190 lifetime max on inpatient mental health benefits?

A: Yes. Medicare coverage limits apply, unless an optional supplemental benefit provides for additional coverage.

MSA Deductible Amount

Q: What is the deductible amount? Will plans always pay 100% of original Medicare-covered services after the deductible is met? Can a plan be designated that pays 80%?

A: The law defines the formula for determining the maximum Medicare MSA plan deductible for coverage of original Medicare benefits (except hospice services). For 2006 it is $8,850. The maximum deductible amount for 2007 will be announced in the Annual Rate Announcement the first week of April, 2006. Note that the MSA plan could offer optional supplemental benefits with premiums, deductibles and other cost sharing.

Per 42 C.F.R. §422.103(c), after the deductible is met, the plan must pay, at a minimum, the lesser of two amounts: (1) 100 percent of the expenses for the service; or (2) 100 percent of the amounts that would have been paid for the service under original Medicare, including the amounts that would be paid by the enrollee as deductibles and coinsurance.

The Medicare statute does not have a maximum out of pocket amount, because once an enrollee's countable expenses equal the plan deductible, the plan pays 100 percent of expenses for Medicare covered benefits, including the amount of cost sharing that would be paid if the enrollee were in original Fee-for-Service (FFS) Medicare. The MA organization cannot design an MSA plan that reduces its liability under §422.103(c) to anything less than 100 percent of the lesser of the two amounts specified.

The enrollee may still have to pay permitted "balance billing" after the deductible is met. (For example, non-participating physicians are permitted to balance bill up to the limiting charge -- 115% of the non-par fee schedule.) If the enrollee purchased any optional supplemental benefits under the plan, any responsibility for premiums and cost sharing would continue after the plan deductible for Part A/B benefits has been met.

MSA Plan Payment Prior to Deductible Being Met

Q: Are there any exceptions where a Medicare MSA plan would pay prior to the deductible being met? Can a plan do it as a design feature (for example, accident coverage)?

A: The MSA plan could offer an optional supplemental benefit, for a premium, for coverage of benefits that are not Part A or Part B benefits. Under 42 C.F.R. § 422.104(a), an optional supplemental benefit plan may not cover expenses that count toward the deductible. However, policies listed in 42 C.F.R. § 422.104(b) are not considered as covering the deductible for purposes of this rule. These policies include those providing for coverage for accidents, disability, dental care, vision care, or long-term care.

Q: Will CMS allow MSAs to pay more than the Medicare allowable fee-schedule amount to a non-contracting providers after the deductible is reached? How are non contracting providers reimbursed?

A: Sections 1852(k) and 1866(a)(1)(O), which are implemented in regulation at §422.214 as "Special rules for services furnished by noncontract providers," require that a non-contracting provider must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare. So, from an MSA plan member who has not yet met the deductible, a non-contracting provider must accept as payment in full the amount that would be received if the beneficiary were not in an MA plan (that is, the amount of combined reimbursement from fee-for-service Medicare and FFS beneficiary cost sharing). This applies to non-contracting providers both before and after the deductible is met. As noted above, the MAO could provide for a higher amount by contract, in which case sections 1852(k) and 1866(a)(1)(O) would not apply.

Q: Are there any exceptions where a Medicare MSA would pay providers prior to the enrollee's meeting the annual deductible? Can we do this as a design feature, for example, accident coverage?

A: In general, the MSA plan package may not provide supplemental benefits that cover expenses that count toward the plan deductible. However, §422.104(b) provides that certain types of insurance policies are not considered as designed to cover the deductible.

In addition, the MSA plan could offer an optional supplemental benefit, for a premium, for coverage of benefits that are not Medicare-covered benefits. The enrollee may use the benefit before the deductible for Medicare-covered benefits is met, so the MA organization would be making payments to providers for these non-Medicare covered benefits, subject to plan requirements for cost-sharing on the optional supplemental benefit.

Post-Deductible Cost-Sharing

Q: Could there be cost-sharing after the deductible is met?

A: Only for optional supplemental benefits and for any permitted balance billing charges not covered by the plan.

Maximum Out-of-Pocket Limit

Q: Is there a maximum out-of-pocket limit in addition to the maximum deductible, or are these the same?

A: For Medicare Advantage MSA plans, there is a maximum deductible set in law at Sec.

1859(b)(3)(B), implemented at §422.103(d). There is no separate out-of-pocket limit for Medicare-covered expenses because, once an enrollee's countable expenses equal the plan deductible, the plan pays 100 percent of expenses for original Medicare benefits, including the amount of cost sharing that would be paid if the enrollee were in FFS Medicare.

The enrollee may still have to pay permitted balance billing after the deductible is met. (For example, non-participating physicians are permitted to balance bill up to the limiting charge – 115% of the non-par fee schedule.)

An optional supplemental benefit providing coverage for non-Medicare covered benefits could be structured with a limit on out-of-pocket costs for those non-Medicare covered benefits.

Access and Coverage Standards

Q: Are there access standards for MA MSA plans?

A: MSAs do not have to demonstrate heath care access since members are able to access any Medicare certified provider.

Q: Do MSAs have to follow the local coverage policy of a local carrier for areas out of the plan's service area.

A: Yes. Similar to all other MA plans.

Q: Do MSA plans have all the same obligations as an FI in regard to claim edits and payments?
What about appeals and other administrative processes?

A: Subpart M of Part 422 of the 42 CFR (and related CMS guidance) provides information on the appeals process MA organizations must follow for all MA plan enrollees. The rules on coverage of services can be found in 42 CFR 422.101. Generally, an MSA organization for all MA plan enrollees must provide coverage consistent with Medicare statute, regulation, original Medicare manuals and instructions – unless they are superseded by regulations. Additionally, MA organizations must also abide by original Medicare local coverage policy.

Q: If an MAO experiences access issues, is it at risk for payments beyond Medicare for those enrollees' care?

A: Sections 1866(a)(1)(O) and 1852(k) of the Act protect both MA organizations and MA enrollees from changes over the Medicare rates, with the exception of permitted balance

billing.

Q: Can an MSA plan deny coverage because a member goes to an area to get a service that is covered in that area but not covered in the plan's service area?

A: No. However, an MSA plan can request a uniform local medical review for its service area under 42 CFR 422.101(b).

Value Added Items and Services

Q: Can MAOs include value-added programs such as health and wellness, etc., to Medicare MSA HDHPs? Would these be priced as administrative costs or would these be examples of services for supplemental premiums?

A: Guidance on VAIS (value-added items and services) for MA plans also would apply to MSA plans.

Q: Can an MAO choose at the benefit level to make some benefits richer (e.g., waive the 3-day prior hospital stay before SNF coverage begins)?

A: Waiver of the requirement for a 3-day hospital stay is permitted, under 42 CFR 422.101(c), at an MAO's option. If an MAO exercises this option, the SNF services are covered as a Part A benefit. MAOs could also provide additional benefits (other than coverage of services subject to the deductible as noted above) only as optional supplemental benefits. MSA plans may not include mandatory supplemental benefits.

Preventive Benefits

Q: Can an MA MSA plan offer first-dollar coverage for preventive services? If there cannot be first-dollar coverage for Medicare-covered preventive services, can the MA organization offer an optional supplemental benefit offering first-dollar coverage for non-Medicare covered preventive services?

A: The MSA plan cannot offer first-dollar coverage for any Medicare-covered benefit. The plan may offer an optional supplemental benefit with first-dollar coverage for preventive benefits not covered by Medicare.

Provider Issues

Q: Can a provider decide whether or not to treat an MSA plan member?

A: Yes, with the exception of rules regarding emergency rooms, and any contractual obligation that may be in place under a contract with the MAO.

Q: If a plan chose not to contract with a provider, how will the plan know if they are participating with Medicare or not? What are the claim payment obligations if the provider is not a Medicare participating provider? What if they don't accept assignment?

A: The CMS/OIG Sanction/Reinstatement list identifies providers that are not eligible to participate in Medicare. An MAO is not required to pay for services furnished by such providers. We note that a physician who has not signed a participation agreement is not required to accept Medicare assignment. If they do not, then they are permitted to balance bill up to 115% of the physician fee schedule amount. See §1848(g) of the Act.

Q: What happens if the provider is willing to see the plan's members but their wait time to get an appointment is 1-2 months? Are there CMS standards that the plan will be held to?

A: CMS has not mandated wait times when members must be seen. However, CMS expects members to be able to access emergency services in a timely manner. Members have a choice of receiving care at any Medicare provider willing to serve the beneficiary. Therefore, accessibility and availability times are not evaluated by CMS. The MAO is free to contract with preferred providers who meet the plans internal access standards.

Q: What is the frequency of provider status updates (quarterly, annually)? "CMS did state that they may allow us the same latitude they provided the PFFS organizations this year, which was to handle all providers as Medicare Participating." How will the MAO know the status of a provider? What database will the MAO be using?

A: MAOs offering MSA Plans are not required to update or report information to CMS on provider eligibility. MAOs offering MSA Plans should, however, ensure that any preferred providers under contract have not opted out of Medicare and are not on the OIG sanction list.

Preferred Providers

Q: Is there any difference in the requirements for network and non-network MSAs?

A: The statute no longer provides for MSA plans to limit enrollees to a network of providers. However, an MSA may still have a network of contracted providers. As noted above, access requirements do not apply. However, MSAs are responsible for explaining to the member any difference in costs between a contractor provider and non- contractor providers.

Q: Can an MA MSA plan offer a network of preferred providers with whom it has negotiated lower total payment amounts for MSA plan enrollees?

A: Yes, the MSA plan can offer enrollees access to preferred providers who have contracted to offer services to MSA plan enrollees at total prices that are lower than what the providers would charge under fee-for-service Medicare. However, MSA enrollees may not be restricted to those providers. By including MSA plans under 1852(k)(1) of the Act, Congress made it clear that MSA enrollees are subject only to permitted "balance billing" in the same way that all other Medicare beneficiaries are. The inducement for an MSA plan enrollee to use network providers prior to meeting the annual deductible would be solely to obtain covered health care at a "discounted" rate. After the deductible is met, the inducement would be either to avoid permitted "balance billing" or to maintain a trusted provider relationship – in other words, continuity of care considerations. Note that the MAO sponsoring the MSA plan would be responsible for "full" reimbursement (see 42 CFR 422.103(c)) to all providers (including non-network providers) after the deductible is met.

Q: Could a network MSA "force" members to use only contracted providers once their deductible is met?

A: No. MSA plan enrollees can choose what providers they see, regardless of whether they have met the plan deductible or not.

Use of Medicare-Certified Providers

Q: In the Health Services Delivery section of the application, there is the following question: "Describe how the organization will assure that services will be provided through institutions, entities and persons who have qualified under the appropriate requirements of Title 18?". What type of response is CMS looking for to this question? Does the MAO offering an MSA Plan have an obligation to educate members about only seeing providers who are eligible for Medicare payment? Does it have an obligation to confirm this eligibility? Would an applicant provide CMS with information sufficient to answer the question if it indicated that it will pay all providers the amount they would have received under original Medicare FFS?

A: See 42 CFR 422.204(b)(3). An MSA plan can only count toward the deductible or provide reimbursement to Medicare *certified* providers of services (see §1861(u)). (There are exceptions for emergency services.) All other providers that are reimbursed for Medicare-covered "basic benefits" must be Medicare *certifiable*. The response in the application should be to the issue of how the MSA will determine if a provider of services is Medicare certified, and how it will determine that other providers are qualified (*certifiable*) to provide Medicare services – in other words, that they have not "opted-out" of Medicare or that they have not been excluded (by the OIG) from the Medicare program. It is not a question about access. Basically an MSA plan will need to inform enrolled members of their responsibility

to ensure that they use only providers that are eligible to provide Medicare-covered services and for which coverage is provided under the MSA plan.

Non-Participating Physicians/Providers

Q: After the MA MSA deductible is met, if the member obtains services from a non-Medicare participating physician, is the plan responsible for paying the amount the physician is allowed to balance bill (i.e., the additional 15%)?

A: If the MSA plan package includes coverage for the permitted balance billing amount before and/or after the deductible is met, then the plan is responsible for paying these amounts. The enrollee is responsible for paying permitted balance billing in situations where the plan does not offer such coverage.

Q: Will CMS allow an MAO to pay more than the Medicare allowable fee-schedule to a non-contracting provider? Note: the member will also be paying that same higher fee schedule when they are in their deductible period. Could an MAO reimburse a non-contracting provider at the Medicare fee schedule when it is the member's responsibility (within the deductible), and pay more than the Medicare fee-schedule when the deductible is met. Can an MAO pick and choose to pay some non-contracting providers more than the Medicare fee schedule and others at the fee schedule without contracting with them? Does the answer differ if we took a State-by-State approach?

A: No. Section 1852(k), which is implemented in regulation at §422.214 as Special rules for services furnished by non-contract providers, was amended by the 2003 MMA to include MSA plans. The rule is that non-contracting providers must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare. So, from an MSA plan member who has not yet met the deductible, a non-contracting provider must accept as payment in full the amount that that would be received in if the beneficiary were not in an MA plan - that is, the amount of combined reimbursement from fee-for-service Medicare and FFS beneficiary cost sharing.

An MA organization could define specific payment arrangement with specific providers through contractual arrangements, including paying more than original Medicare.

If an MSA plan does have contracted providers, the MSA plan member would have the option of using those providers or non-contracting providers.

Optional Supplemental Benefits

Q: Can preventive services be paid under an MSA Plan without regard to deductible?

A: Yes, if the services are not otherwise covered by Medicare. Medicare-covered preventive

services subject to the deductible may not be covered under an optional supplemental benefit plan.

Q: What about preventive benefits that would normally be covered under Medicare, e.g., mammograms?

A: For Medicare-covered preventive services the statute and regulation say that 100% is to be paid by the MSA plan member **before** the MSA deductible is met, and 100% is to be paid by the MA organization sponsoring the MSA plan **after** the deductible is met.

Q: The statute and regulations at 42 C.F.R. § 422.104(a) say that optional supplemental benefits cannot buy down the plan deductible for original Medicare benefits. Section 422.104(b), however, provides that certain types of coverage are not considered to be buying down the deductible for purposes of this provision. These include policies covering accidents, disability, dental care, vision care, or long-term care. Can the MSA plan sell these policies as optional supplemental benefits in the MSA plan?

A: Yes. However, to the extent these policies cover services that would otherwise be covered by Medicare, payments do not count toward the deductible.

Q: Does the beneficiary have the option of withholding optional supplemental plan premiums via his/her Social Security check?

A: Yes. Per §422.262(f), enrollees MA plans, including Medicare MSA plans, have the option of paying premiums through withholding from their Social Security benefit.

Enrollment & Disenrollment

Q: What happens to dollars in a Medicare Advantage (MA) Medical Savings Account (MSA) if a member disenrolls and moves to a MA plan? Would the member have to return to the MA MSA plan to have access to those dollars? In the meantime, what would happen to the dollars not being used?

A: The account is the property of the member, subject to CMS' rules for disenrollment or death during a contract year. Therefore, any funds in the account from prior contract years remain the property of the member. However, under 42 C.F.R. § 422.314(c)(3), if the beneficiary's coverage ends during the year, CMS is to recover the amount of the payment that corresponds to the remaining months of that year.

Q: What will happen to a beneficiary who receives all their money in January and disenrolls in

March? How will CMS recover the funds?

A: The law requires that the government's contribution to the account occur in an annual lump sum deposit made during the first month the beneficiary's enrollment in the MSA plan is effective (if the beneficiary has opened the account in a timely manner). As noted in our prior response, amounts associated with months after a beneficiary disenrollment are to be recovered by CMS. Under the questioner's example, amounts associated with the months of March through December would be recovered by CMS.

Q: Would dual-eligibles be able to enroll in an MA MSA plan?

A: No. Individuals eligible for Medicare cost-sharing under Medicaid State plans are not eligible to elect an MA MSA plan.

Q: Will applicants be able to enroll through Medicare's website as they do with other MA plans?

A: Medicare MSA plan elections must be made via a signed enrollment form. No other enrollment mechanisms are available for MA MSA plan enrollments.

Q: Do MA enrollment periods and limitations apply to MSA plans?

A: There are special rules for MA MSA plans, described in summary below:

Individuals may enroll in MSA plans only during the initial coverage election period (ICEP) or annual election period (AEP). They may disenroll only during the AEP or if a special election period (SEP) applies.

In addition to existing MA eligibility requirements, an individual is not eligible to elect an MA MSA if:

- s/he is eligible for or covered under other health benefits programs, including Federal Employee Health Benefits, Department of Veteran Affairs or Department of Defense;
- s/he is eligible for Medicare cost-sharing under Medicaid State plans; and/or
- s/he receives health benefits that cover all or part of the annual deductible under the MA MSA plan (i.e. Medicare supplemental policy).

An individual who elects an MA MSA plan during an annual election period and has never before elected an MA MSA plan may revoke (i.e. "cancel") that election, but must do so by December 15 of the year in which s/he elected the Medicare MSA plan.

Q: Can MSA plans enroll an individual who has coverage primary to Medicare?

A: No - refer to previous question.

Q: If an MA MSA plan found out through the working aged survey that a member had primary insurance could/should they disenroll the member?

A: Organizations planning to offer MSA plans are reminded of the importance of the requirement to verify critical eligibility information such as this as a part of the enrollment process in order to avoid such scenarios. However, if it is later determined that an individual was not eligible for the MSA plan at the time s/he enrolled, the enrollment is invalid and must be cancelled back to the original effective date.

Q: Can the MSA plan disenroll a member for non-payment of provider claims before the deductible is met?

A: Generally, no; however, the non-payment of provider claims could potentially meet the criteria for involuntary disenrollment for disruptive behavior. See Section 50.3.2 of Chapter 2 of the Medicare Managed Care Manual for additional information.

Q: Does a beneficiary enrolling mid-year via an initial coverage election period (aging-in mid-year) have to pay the entire annual deductible? Or is the deductible pro-rated, as CMS does with the deposit?

A: CMS will allow insurers to decide how to deal with a partial-year enrollee, e.g. an insurer could include a "carry-over" rule where bills incurred during a specified period could be carried over to the following year and applied to next year's deductible.

Q: Do enrollment capacity waivers apply to MSA plans?

A: Yes, see 1854(a)(1)(A)(iii).

Approved Banks, Custodian Rules

Q: How does CMS view the use of electronic card transactions (i.e., debit cards) for accessing Medicare MSA funds?

A: Yes, electronic card transactions are permissible.

Q: Can MAOs set up trustee accounts with incentives to make it more likely those beneficiaries

in employer MA MSA plan would use these trustee accounts for the Medicare MSA funds?

A: The firm can tell the public what the advantages are of selecting their MSA plan, including any benefits associated with signing up with the account sponsored by the MSA Plan sponsor, (e.g., a debit card for an account with no fees, or a credit card with special benefits.)

Q: In the MARx manual Chapter E, exhibit E-13 notes file layouts for banking information (trustee routing number, bank account number, bank account type) Is this a requirement or optional data field?

A: These are required fields for MSAs.

Balance Billing

Q: How does balance billing work under MSAs?

A: "Balance billing" is the permitted "balance billing" that non-Medicare participating physicians may charge original Medicare enrollees under the "limiting charge" rule – see §1848(g) of the Act. MSAs may not provide supplemental benefits that cover expenses that count toward the MSA deductible (see 42 CFR 422.104(a)). MSAs also may not cover items and services covered under Medicare Parts A/B as optional supplemental benefits, because such benefits are "basic" benefits – see 42 CFR 422.100(c)(1). On the other hand, permitted "balance billing" amounts, to the extent they are not counted toward the MSA deductible, and to the extent they are not Medicare covered, may be covered as optional supplemental benefits in an MSA plan. Also note that non-participating DME suppliers are not bound by balance billing limits.

Q: Can the plan have different rules about who pays permitted balance billing before and after the deductible is met?

A: The MA organization must establish clear rules on who is responsible for payment of permitted balance billing. The MSA plan rules could require that the enrollee is always responsible for any balance billing – before or after the deductible is met (per Sec. 1859(b)(3)(A)(ii) and Sec. 1852(a)(2)(A)). On the other hand, the plan could recognize balance billing amounts paid by the enrollee as being a "countable expense" toward meeting the deductible and/or as reimbursable by the plan after the deductible is met.

Finally, if the plan offers a panel of preferred providers who charge either less or more than what the enrollee would owe a non-contracting provider (and non-contracting providers must accept as payment in full the amount they would receive under original Medicare, per Sec. 1852(k)), the plan must clarify whether the enrollee would owe balance billing amounts to these providers.

MSA Account and TROOP

Q: Does CMS anticipate any scenario in which the MSA and the High Deductible Health Plan (HDHP) components could be administered by different MA organizations?

A: The beneficiary is allowed to establish the medical savings account with any qualified Trustee under IRS rules. CMS will only be contracting with one entity with regards to the high-deductible MSA plan i.e., the MAO enrolling the beneficiary. The scenario where a single beneficiary's MSA high-deductible health plan and Medical Savings Account are sponsored by different MA organizations would only happen if one of the MA organizations is also a qualified Trustee under IRS rules, and sold the medical savings account to the beneficiary.

Q: Please confirm that there are no issues with an individual enrolling with a Medicare MSA and a PDP with the same carrier as long as the plans are not combined to form an MSA-PD.

A: An MSA plan enrollee can also join a PDP with the same carrier as long as the Part C and Part D coverage are not marketed as one benefit or plan, i.e. as an MSA-PD. They must be separate plans. Also note that an MSA enrollee must be free to enroll in any available PDP.

Payment Issues

Q: What is CMS' payment to an MA organization for an MSA plan enrollee?

A: CMS pays an MA organization a prospective monthly amount for each Medicare MSA plan enrollee, based on the following formula:

Standardized A/B benchmark * enrollee's risk factor minus 1/12th of the annual lump sum deposit

The Intra-Service Area Rates (ISAR) adjustment does not apply to MSA plans (per Sec. 1853(a)(1)(B)(iii)), as it does to coordinated care and private-fee-for-service plans. Thus, the bid is not converted to plan-specific county payment rates.

Q: Are MSA plan payments risk adjusted?

A: Section 1853(a)(1)(B)(iii) defines CMS payments to MAOs offering MSA plans, including the requirement to adjust payments for the health status of members. As required under 1853(a)(1)(B)(iii) and 422.304(c)(2), CMS' payments to MAOs for their MSA plan enrollees must be subject to risk adjustment, as described at 422.308(c).

Q: How would an MAO offering an MSA plan implement risk adjustment, in particular collect diagnosis codes?

A: It is the responsibility of the MAO offering the MSA plan to establish processes for capturing and submitting to CMS data used for purposes of risk adjustment, as required at 42 CFR 422.310. An MAO might choose, for example, to capture diagnoses by adjudicating claims from providers. The plan could require a member to make sure to submit proper forms from providers they see in order to have their expenditure recorded as a "countable expense" against the deductible. The plan could offer a panel of preferred providers for discounted rates, which the member could choose (or not) to use, and these providers would already be wired to send diagnostic data to the plan on patients.

Q: Will CMS use the HPMS system to notify MAOs offering MSA plans how to determine payments to non-contracting providers?

A: Information for MA plans on how to determine payments to non-contracted providers can be found on the CMS website at https://63.240.208.147/healthplans/rates/out-of-network/default.asp#_Toc77576976.

Q: Will CMS use the HPMS system to notify MAOs offering MSA plans of changes to Medicare payment methods, policies and required administrative rules? How will CMS involve carriers in significant anticipated changes in Medicare payment methods (e.g., an ICD-10 based Medicare DRG payment transition)? Will CMS-Medicare consult with MAOs on significant anticipated changes in Medicare payment methods and factor the time it will take for MAOs to implement these policies into Medicare's implementation schedule?

A: Current methods for training and updating carriers will be utilized.

Employer and Union Groups

Q: Can MAOs offer MSA plans to employer and union groups?

A: Yes. An MAO can offer MA MSA plans in the group market provided that it offers non-group local MA MSA coverage in the same state in which it offers the group coverage. A group MA MSA plan is generally subject to the same requirements as non-group plans although, under Sec. 1857(i) of the Social Security Act, CMS has the authority to waive or modify requirements that may hinder the design of, the offering of, or the enrollment in an employer or union-sponsored MA plan. Guidance papers outlining MA waivers granted for 2006 can be found at http://www.cms.hhs.gov/EmpGrpWaivers/. Some of the waivers include modification of the service area requirement as outlined above, waiver of the minimum enrollment requirement, and modification of the marketing and dissemination rules. Additional waivers can be requested and will be reviewed on a case by case basis.

An employer or union group MA MSA plan also will be subject to the same restrictions outlined in the Social Security Act and Internal Revenue Code as non-group MA MSA plans. For example, the funding for a beneficiary's MSA account can only come from CMS. See 42 CFR §422.314(c)(2) and Internal Revenue Code §138(b)(2). A beneficiary who has additional coverage that may cover all or part of the deductible of an MA MSA plan cannot enroll into a MA MSA plan. See 42 CFR §422.56(d). An MSA plan cannot provide Part D coverage although a beneficiary enrolled in an MA MSA plan can obtain Part D coverage through a separate stand-alone prescription drug plan (PDP). See §422.4(c)(2).

Every MAO that wishes to provide a group MA MSA plan in 2007 must submit a Medicare Advantage Initial Contract for MSA Plans application, along with a 2007 Application for MA Organizations to Offer New Employer/Union-Only group Waiver Plans (EGWPs), by the application deadline. The timeline for MA MSA group plans on application, formulary and bid submissions will be the same as for non-group MA MSA plans. Any questions on the group MA MSA application process can be submitted to the Employer Policy and Operations Group (EPOG) at CMS. The appropriate contact at EPOG for information and questions is Jim Mayhew, Director of the Policy Division, who can reached at james.mayhew@cms.hhs.gov.

Q: Can employers or individual account holders deposit money into an MA Medicare Savings Account (MSA)?

A: No, in accordance IRC §138(b)(2)(A), only CMS can deposit funds into an MA MSA.

Q: Can a retiree enroll in an MA MSA plan?

A: Yes, regular MA rules apply. Retirees can enroll into an MA MSA plan.

Q: Can the employer pay the optional supplemental premiums and/or premiums for any of the policies under §422.104(b)?

A: Yes, employers can pay the premiums of the supplemental plans permitted under §422.104(b).

Marketing Issues

Q: Will MAOs offering MSA plans complete the PBP?

A: Yes, MAOs offering MSA Plans will be able to access all Sections of the PBP and Notes. MSAs should complete Sections A, B, C-Foreign V/T (if applicable) and D of PBP.

Q: What information will be input on the PBP?

A: MSA will input all in-network, and if applicable "OON" benefit info. (This may only amount to recognizing a "discount" or reduced costs when seeing participating providers.) Balance billing and other pre/post deductible info can be included in Notes fields where appropriate.

Q: Were exclusive sentences on the Summary of Benefits developed for MSAs?

A: No, exclusive MSA sentences are not in the Summary of Benefits.

Q: Will MSA information be included in the Medicare Personal Plan Finder (MPPF)?

A: Yes, MSA information will be included in the MPPF for the Medicare Advantage plans that offer MSAs.

Q: Will CMS be providing model language for the EOC and enrollment application?

A: CMS does not intend to develop a separate model EOC for MSAs. MSAs are local plans and are treated in the same manner as other MA plans. MAOs offering MSA's should use the model EOC document located on the CMS Healthplans Website, and modify it accordingly to reflect the way MSA benefits work.

Bidding

Q: Do MAOs submit bids for Medicare MSA plans?

A: Yes. An MAO will submit to CMS the first Monday of June a bid submission for offering a Medicare MSA plan.

Plan A/B bid. Like other local MA plans, the Medicare MSA plan A/B bid (called the "monthly MSA premium" in statute) represents the organization's monthly revenue requirements for coverage of original Medicare benefits in a service area, except that the MSA plan bid is for a high deductible plan. The MSA plan A/B bid reflects the expected risk profile of plan enrollees. Unlike the case of other local MA plans, a Medicare MSA plan bid is not subject to CMS review.

Benchmark. Per Sec. 1853(j), the local MA standardized A/B benchmark is based on capitation rates for a geographic area (county). The benchmark calculation for MSA plans is the same as for other local MA plans: the weighted average of county capitation rates in the plans' service area, weighted by plan projected enrollment per county.

The MA Organization will provide in the bid pricing tool the expected plan average risk score that informed determination of the allowed costs for the bid. The plan A/B benchmark is then calculated using the same formula as for other local MA Organizations: the plan-level projected risk score multiplied by the standardized A/B benchmark. The plan A/B benchmark is used in the Medicare MSA deposit calculation (see below). The benchmark constitutes the upper limit of the Medicare's monthly payment for an MA plan enrollee.

Deposit calculation. The 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 all MA plans under section 1853. The deposit into each Medicare MSA enrollee's account is calculated at the service area level, and it reflects the plan's projected plan average risk score:

Annual lump sum deposit = (plan A/B benchmark minus the plan A/B bid), annualized

An MSA plan cannot charge a basic beneficiary premium (see Section 1854(b)(1)(B of the Act)), and cannot offer a mandatory supplemental benefit (see Section 1852(a)(3)(A)). An MSA plan may not offer Part D coverage, although MSA plan enrollees may enroll in a PDP. Any non-Medicare-covered benefits must be offered as optional supplemental benefit(s). The MA Organization would submit a bid amount for these supplemental benefits as part of the June bid submission.

MSA Contracts

Q: If an MAO chooses to contract with providers for rates higher than Medicare rates, would it have to contract with a sufficient number of providers to meet access standards?

A: MSA plans are not subject to the access standards that apply to coordinated care plans. Members are free to receive services from any Medicare certified provider. We note that if a contract with a provider specifies a higher payment amount than the Medicare rate, the beneficiary presumably would have to pay that higher amount during the deductible period. The statute only requires, however, that the beneficiary be credited with "at least" the Medicare rate as counting toward the deductible. (After the deductible is met, the MAO must pay "at least" the lesser of the provider's charge or the Medicare rate. Presumably in the example posed in the question, the MAO would be paying a higher amount than this to contracting providers once the deductible is met.) We would encourage any MAO that contracts for a provider to receive amounts higher than the Medicare rate to fully credit such higher amount toward the deductible if enrollees are required to pay such amounts.

Q: Does the fact that an MAO has a contract with providers for commercial products interact at all with providers participating in their Medicare Advantage product?
A: No, the commercial product is not related to the MSA Medicare Product.

Q: What are the consequences to an MAO if they sign a contract to offer an MSA and then pull out of the contract at a later date? (For example, a plan may sign a contract to offer an MSA and then later in the year, the plan determines that offering an MSA would not be profitable and want out of their contract.)

A: Under 42 CFR 422.512(a), an MAO may only unilaterally terminate a contract with CMS if we were to fail substantially to carry out our obligations under the contract (e.g., to pay the MAO). If an MAO otherwise unilaterally terminates its contract, under 42 CFR 422.758 (b), CMS can impose a Civil Monetary Penalty of $250 per enrollee or $100,000, whichever is greater. In addition, CMS will not contract with that MAO for the following two years.