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Department of Health &
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SUBJECT: Chapter 1, “General Provisions”

I. SUMMARY OF CHANGES: The revisions to Chapter 1 reflect guidance provided to Medicare Advantage (MA) organizations since the last update to Chapter 1 in June 2007, changes made based on public comments, and clarifications of existing policies, including:

- Adding language to reflect provisions included in the Medicare Improvements for Patients and Providers Act and the Affordable Care Act;
- Updating definitions of terms applicable to the MA program;
- Clarifying policies related to specific plan types; and
- Removing language on cost-sharing in enrollment-related costs from section 40 of the previous version of Chapter 1. These costs are described in 42 CFR 422.6, and plans are notified of the actual costs each year via separate guidance. This guidance will be included in a forthcoming revision of Chapter 8 of the Medicare Managed Care Manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 7, 2011
IMPLEMENTATION January 7, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Red italicized text identifies new material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|--------------|--|
| R | 1/Table of Contents |
| R | 1/10/Introduction |
| R | 1/20/Definitions |
| R | 1/30.1/General Rule |
| R | 1/30.2/Types of Coordinated Care Plans (CCPs) |
| R | 1/30.2.1/General Rule |
| R | 1/30.2.2/Health Maintenance Organizations (HMOs) |
| R | 1/30.2.3/Preferred Provider Organizations (PPOs) |
| R | 1/30.2.4/Special Needs Plans (SNPs) |
| R | 1/30.2.5/Senior Housing Facility Plans |

| | |
|---|---|
| N | 1/30.2.6/Other Types of MA Plans |
| R | 1/30.3/Medical Savings Account (MSA) Plans |
| R | 1/30.4/Private Fee-for-Service (PFFS) Plans |
| R | 1/30.5/Religious Fraternal Benefit (RFB) Plans |
| R | 1/30.6/Part B-only Plans |
| R | 1/30.7/Multiple Plans |
| R | 1/40/Section 1876 Cost Plans |
| N | 1/50/MA Requirement for Plans to Offer a Qualified Drug Plan Coverage |

III. FUNDING: No additional funding is currently provided by CMS; contractor activities are to be carried out within their own FY 2010 and/or future operating budgets determined by the organizations.

IV. ATTACHMENTS:

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|----------|--|
| | Business Requirements |
| X | Manual Instruction |
| | Confidential Requirements |
| | One-Time Notification |
| | One-Time Notification -Confidential |
| | Recurring Update Notification |

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual

Chapter 1 - General Provisions

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10 - Introduction

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

The Balanced Budget Act of 1997 (BBA) established a new Part C of the Medicare program, known *then* as the Medicare+Choice (M+C), *effective* January 1999. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations *to* offer a variety of health plan options for beneficiaries, including both traditional managed care plans (such as those offered by HMOs under §1876 of the Social Security Act) and new options that were not previously authorized. Four types of M+C plans were authorized under the new Part C of Medicare:

- *Coordinated* care plans, including:
 - Health *Maintenance Organizations (HMOs)* (with or without Point-of-Service options (POS));
 - Provider Sponsored Organizations (PSOs); and
 - Preferred Provider Organizations (PPOs).
- *Medicare* Medical Savings Account (*MSA*) *plans*;
- Private Fee-for-Service (PFFS) plans; and

- Religious Fraternal Benefit (RFB) plans.

The M+C program in Part C of Medicare was *renamed* the Medicare Advantage (MA) Program pursuant to *Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), which was enacted on December 8, 2003. The MMA updated and improved the choice of plans for beneficiaries under Part C, and changed the way benefits are established and payments are made. Under the MMA, beneficiaries may choose from additional plan options, including regional PPO (RPPO) plans and special needs plans (SNPs). Title I of the MMA further established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most MA plans to offer prescription drug coverage. More information about Part D requirements can be found in the Medicare Prescription Drug Benefit Manual at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage*

On July 15, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110-275) was enacted, revising and amending statutory provisions governing the MA and Part D programs. Among these were provisions that established new rules for PFFS plans, SNPs, and section 1876 cost plans.

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010, as passed by the Senate on December 24, 2009, and the House on March 21, 2010. The Health Care and Education Reconciliation Act (Pub. L. 111-152), which was enacted on March 30, 2010, modified a number of Medicare provisions in Pub. L. 111-148 and added several new provisions. The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152) are collectively referred to as the Affordable Care Act. The Affordable Care Act includes significant reforms to both the private health insurance industry and the Medicare and Medicaid programs. Provisions in the Affordable Care Act concerning the Part C and Part D programs largely focus on beneficiary protections, MA payments, and simplification of MA and Part D program processes.

Regulations governing the MA program are found at 42 CFR Part 422 and Part 423. These regulations have been amended to reflect changes made to the MA program by the MMA and the MIPPA. We will be implementing the Part C and Part D provisions specified in the Affordable Care Act through regulations in the spring of 2011.

The MA plan payment system incorporates principles of competition by *using* a bidding methodology. *Payments* for local and regional MA plans *are based in part on a bid submitted by the MA organization offering the plan.* MA organizations submit an annual aggregate bid amount for each MA plan. A plan bid is based upon *an* MA organization's *estimate* of expected costs *for providing enrollee health care benefits in a plan's service area. The total bid amount submitted reflects the organization's estimate of its revenue needed to provide* non-drug benefits (that is, *Original Medicare (Part A and Part B)*

benefits); Part D basic prescription *drug coverage (as defined in 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual), if included in the plan; and any* supplemental benefits (including reductions in cost sharing *to enrollees*). We negotiate bid amounts with *MA organizations* in a manner similar to negotiations conducted by the Office of Personnel Management (OPM) with *organizations offering* Federal Employee Health Benefit (*FEHB*) plans. We work with *MA organizations* to ensure benefit packages meet the needs of *beneficiaries* and that information is made available so that *beneficiaries* can make *informed* decisions about *the* plans *that* best meet their needs.

Our payment to an MA organization for an MA plan's coverage of *Original* Medicare benefits depends on the relationship *between* the plan's basic A/B bid *and a “benchmark” amount established for that county as required by statute*. For a plan with a basic A/B bid below its benchmark, we pay the MA organization the basic A/B bid amount, adjusted by the individual enrollee's risk factor, plus *a* rebate amount *determined by law*. The rebate is used to provide mandatory supplemental benefits *and/or* reductions in Part B or Part D premiums. For a plan with a bid equal to or above its benchmark, we pay the MA organization the benchmark, adjusted by the individual enrollee's risk factor. In addition, *we pay a direct subsidy for the Part D basic prescription drug coverage. The direct subsidy is determined by the risk adjusted standardized bid net of beneficiary premiums.*

CMS encourages MA organizations to design packages that provide a variety of high quality benefits at a reduced cost to Medicare beneficiaries. Under an MA plan, at minimum, beneficiaries receive the same benefits that are covered under Original Medicare, and in most cases, also receive Part D prescription drug benefits through the plan. Effective in 2011 for contract year 2012, all beneficiaries have the opportunity to change MA plans or to return to Original Medicare during the annual election period (fall open season) from October 15 through December 7.

Participating organizations are under continued competitive pressure to improve their benefits, reduce their premiums and cost sharing, and improve their networks and services, in order to gain or retain market share. In addition, we expect plans to use integrated health plan approaches such as disease prevention, disease management, and other care coordination techniques. In doing so, integrated plans that combine Parts A and B *benefits and* Part D *prescription drug benefits*, and that apply these innovative techniques, *can* pass on savings that may result from these care coordination techniques to the enrollee through reduced premiums or *supplemental* benefits.

Note: Even though section 1876 cost plans are not MA plans, we discuss them as appropriate, in this chapter because they follow many of the same rules and guidance as MA plans. See Chapters 3, 5, 12, 13, and 17 of this manual for additional information on cost plans.

20 - Definitions

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Arrangement - A written agreement between an MA organization and a provider or provider network under which the provider agrees to furnish specified services to the organization's enrollees while the MA organization retains responsibility for the services, and Medicare payment to the organization discharges the enrollee's obligation to pay for the services, other than plan cost-sharing.

Balance Billing – *The rules governing balance billing for HMOs, PPOs, and RPOs are discussed in section 10.22 of Chapter 4 of this manual. The rules for PFFS plans will be discussed in the new Chapter 16a of this manual.*

Basic benefits - All Medicare benefits *covered under Part A and Part B* (except hospice services).

Benefits - *An item or service that is directly health related; that is, a service or item whose primary purpose is to prevent, cure, or diminish an illness or injury that is actually present or expected to occur in the future, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process. For a complete discussion, see Chapter 4, section 30.1 of this manual.*

Coinsurance – *A portion of medical expenses for a service, usually a fixed percentage that the MA enrollee must pay out of pocket. Generally, an MA plan would not have a coinsurance and copayment for the same service.*

Coordinated Care Plan (CCP) - *A plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements. CCPs may use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include HMOs, PSOs, local and regional PPOs, and senior housing facility plans. SNPs can be offered under any type of a CCP that meets CMS' requirements.*

Copayment - A fixed amount that can be charged to an MA plan enrollee on a per-service basis.

Cost Plan - A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost reimbursement contract under §1876(h) of the Act.

Cost-sharing - Costs incurred by the enrollee that may include deductibles, coinsurance, and copayments.

Dual-eligible – An MA eligible individual who is also entitled to Medical Assistance under a State Plan under Title XIX (Medicaid). A chart describing the various categories of individuals who are collectively known as dual-eligibles can be found at <https://www.cms.gov/MedicareEnRpts/Downloads/Buy-InDefinitions.pdf>.

Employer Group Health Plan (EGHP) – A group plan sponsored by an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations to furnish benefits to the entity’s employees, former employees, or members or former members of the labor organization. Employers and unions may sponsor a group plan by enrolling their members in one of the following kinds of Employer Group Health Plans (EGHPs) – a Medicare plan that is open to general enrollment (i.e., individual beneficiaries) or an employer/union-only group waiver plan (EGWP) where enrollment is restricted solely to individuals who are beneficiaries or participants in the employer or union sponsored group plan. See Chapter 9 of this manual *and Chapter 12 of the Medicare Prescription Drug Benefit Manual* for more information on EGHPs.

Employer/Union-Only Group Waiver Plan (EGWP) – A type of employer group plan where membership is restricted solely to employer or union sponsored group plan members. There are two basic categories of EGWPs: (1) “800 series” EGWPs - plans offered by PDPs, MA Organizations, or Part D Cost Plan Sponsors to employer and union group sponsors (known as “800 series” plans because of the way they are enumerated in CMS systems); and (2) Direct Contract EGWPs - employers or unions that directly contract with CMS to become a PDP or MA plan for their members. See Chapter 9 of this manual *and Chapter 12 of the Medicare Prescription Drug Benefit Manual* for more information on EGWPs.

Institutionalized - An MA eligible individual who continuously resides, or who is expected to continuously reside, for 90 days or longer in a long-term care facility which is a skilled nursing facility (SNF) nursing facility (NF); SNF/NF; an intermediate care facility for the mentally retarded (ICF/MR); or an inpatient psychiatric facility (*42 CFR 422.2*). *For purposes of SNPs, CMS may also consider as institutionalized those individuals living in the community, but requiring an institutional level of care based on a State-approved assessment.*

Licensed by the State as a risk-bearing entity - The entity is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage, such that the entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an MA contract.

MA Eligible Individual – *An individual eligible to elect an MA plan who meets the requirements specified in Chapter 2, section 20 of this manual.*

MA Local Plan - An MA plan that is not an MA regional plan.

MA Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

MA Plan - Health benefits coverage offered under a policy or contract by an MA organization that includes a specific *package* of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area (or segment of the service area) of the MA plan.

MA Plan Enrollee - An MA eligible individual who has elected an MA plan offered by an MA organization.

MA-Prescription Drug Plan (MA-PD Plan) - An MA plan that provides qualified prescription drug coverage, *as defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual*, under Part D of the Social Security Act.

MA Regional Plan - A coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire *CMS-designated MA* regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services when the benefits are provided within the network of providers. *As discussed in Chapter 4, section 110.1 of this manual, an MA regional plan, upon CMS preapproval, can also use methods other than written agreements with providers to establish that access requirements are met.*

The MA regional plan may be *a* joint enterprise where each health plan in the joint enterprise holds a State license in the State in which it does business and meets all applicable Medicare requirements.

Mandatory Supplemental Benefits - *Non-drug* health care services *or items* not covered by Medicare that an MA enrollee must accept or purchase as part of an MA plan. The benefits may include reductions in cost sharing for benefits under the *Original* Medicare fee-for-service program and are paid for in the form of premiums and cost sharing, or by an application of the beneficiary rebate rule in §1854(b)(1)(C)(ii)(I) of the Act, or both. *See Chapter 4, section 10.3 of this manual for further details on mandatory supplemental benefits.*

MSA Plan - *Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established in conjunction with an MSA plan for the purpose of paying the qualified medical expenses of the account holder). See 42 CFR 422.4.*

MSA Trustee – *An MSA Trustee may be a bank, an insurance company, or any other entity that is approved by the Internal Revenue Service to be a trustee or custodian of an individual retirement account (IRA) and that meets requirements of 42 CFR 422.314(b).*

National Coverage Determination (NCD) - A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular *item or* service under Medicare. An NCD does not include a determination of what code, if any, is assigned to *an item or* service or a determination about the payment amount for the *item or* service. Refer to Chapter 4, *section 80 of this manual* for more information on NCDs.

Optional Supplemental Benefits - Health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually. *See Chapter 4, section 10.3 of this manual for further details on optional supplemental benefits.*

Original Medicare - Health insurance *that is* available under Medicare Part A and Part B through the traditional fee-for-service payment system.

Part B-only Plan - *An MA plan (except a regional PPO plan) that covers the Medicare benefits that are covered under Part B and supplemental benefits. Only those Medicare beneficiaries who are entitled to benefits under Medicare Part B and who do not have Part A coverage may enroll in a Part B-only plan. See section 30.6 for further details on Part B-only plans.*

Prescription Drug Plan (PDP) - A PDP has the definition set forth at *42 CFR 423.4*.

Prescription Drug Plan (PDP) Sponsor - A prescription drug plan sponsor has the definition set forth in *42 CFR 423.4*.

Point of Service (POS) - A benefit option that an MA *HMO* plan can offer to its Medicare enrollees as a mandatory supplemental or optional supplemental benefit. Under the POS benefit option, the *HMO* allows members the option of receiving specified services outside of the *HMO's* provider network. In return for this flexibility, members typically have higher cost-sharing requirements for services received, and where offered as a mandatory or optional supplemental benefit, may also be charged a premium for the POS benefit option. *See Chapter 4, section 100 of this manual for further details on POS options.*

Private Fee-for-Service (PFFS) Plan – *A PFFS plan is defined as an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. MIPPA added that although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, MIPPA also allows PFFS plans to increase payment rates to a provider*

based on increased utilization of specified preventive or screening services. See section 30.4 for further details on PFFS plans.

Provider - Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.

Provider Network - The providers with which an MA organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an MA coordinated care or PFFS plan that has a contracted network under *42 CFR* 422.114(c).

Religious Fraternal Benefit (RFB) Plan - An MA plan that is offered by an RFB society *under which enrollment is limited to that RFB society's members.*

Religious Fraternal Benefit (RFB) Society - An organization that is described in §501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under §501(a) of that Act; and is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches.

Segment –A segment is a distinct portion of the service area of an MA local plan consisting of at least a full county in which benefits, premiums, and cost sharing are uniformly offered to all eligible Medicare beneficiaries residing in that distinct portion, and for which the information specified in *42 CFR* 422.254 is separately submitted to CMS.

Senior Housing Facility Plan - *An MA coordinated care plan established by the Affordable Care Act that limits enrollment to residents of continuing care retirement communities (an arrangement under which housing and health-related services are provided or arranged through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period); provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate; and provides transportation services for beneficiaries to specialty providers outside of the facility.*

Service Area - A geographic area that for local MA plans is a county or multiple counties, and for MA regional plans is a region approved by CMS within which an MA-eligible individual may enroll in a particular MA plan offered by an MA organization. Each MA plan must be available to all MA-eligible individuals within the plan's service area. Counties do not need to be contiguous, and under limited circumstances, CMS may approve the inclusion of “partial” counties in a service area. *The rules for establishing partial counties are discussed in Chapter 4, section 160 of this manual.*

Severe or disabling chronic condition - *Defined as “one or more co-morbid and medically complex conditions that are substantially disabling or life-threatening, high*

risk of hospitalization or other adverse outcomes, and needing specialized delivery systems across domains of care.”

CMS in collaboration with industry and medical experts approved the following 15 SNP-specific conditions for 2010: (1) autoimmune disorders; (2) cancer; (3) cardiovascular disorders; (4) chronic alcohol and other drug dependence; (5) chronic and disabling mental health conditions; (6) chronic heart failure; (7) chronic lung disorders; (8) dementia; (9) diabetes mellitus; (10) end-stage renal disease; (11) end-stage renal disease requiring dialysis (any mode of dialysis); (12) HIV/AIDS; (13) neurological disorders; (14) severe hematologic disorders; and (15) stroke.

For more information on the 15 chronic condition expert panel, the 2008 Special Needs Plan Chronic Condition Panel Final Report is available at http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/SNP_CC_Panel_Final_Report.zip.

Special Needs Individual - *An MA eligible individual who is: (1) institutionalized in a SNF, NF, ICF/MR or psychiatric facility or is a person with similar needs living in the community; (2) dually eligible for Medicare and Medicaid; or (3) has a severe or disabling chronic condition as defined above.*

Special Needs Plan (SNP) - *An MA coordinated care plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more severe or disabling chronic conditions, as defined above and set forth at 42 CFR 422.4(a)(1)(iv) of the MA regulation, and provides Part D benefits under 42 CFR Part 423.*

As set forth in 42 CFR 422.4(a)(1)(iv), SNPs are MA coordinated care plans that provide alternatives to traditional Medicare programs for beneficiaries with complex medical conditions. SNPs are categorized into three groups depending on the beneficiary population they target. The categories are described in section 30.2.4 of this chapter.

30.1 - General Rule

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

There are three basic types of MA plans open to all MA-eligible Medicare beneficiaries *residing* in the *authorized* service area *of the plan*: (1) CCPs, (2) PFFS plans, and (3) MSA plans. CCPs include HMOs, PSOs, *local and regional PPOs, and senior housing facility plans. The authority to offer PSOs expired on November 1, 2002. SNPs can be offered under any type of a CCP that meets CMS' requirements. The statute permits members of a religious fraternal benefit society (RFB) to enroll in an RFB plan if one is offered by their RFB. An RFB plan may be any type of MA plan. These MA plan types are described in more detail below.*

30.2 - Types of Coordinated Care Plans (CCPs)

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

30.2.1 - General Rule

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

A CCP is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. The CCP network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality *requirements*. *CCPs use mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. CCPs include plans offered by HMOs, local or regional PPOs, PSOs, and senior housing facility plans. As noted above, the authority to offer PSOs expired on November 1, 2002. SNPs can be offered under any type of a CCP that meets CMS' requirements.* We provide more *details* below on *the differences between HMOs, local and regional PPOs, SNPs, and senior housing facility plans. See Chapter 4, section 110 of this manual for a more detailed discussion of network requirements for CCPs.*

30.2.2 - Health Maintenance Organizations (HMOs)

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

An HMO is a CCP as described *in section 30.2.1* and is generally the most restrictive of the CCP models *since it controls* utilization (e.g., requiring referrals from a gatekeeper/PCP) and *restricts* the network of providers from which a beneficiary can receive non-urgent/emergent covered services.

To ease restrictions on access to out-of-network providers, however, an HMO may offer a point of service (POS) benefit option. *Under the POS benefit option, an HMO allows members the option of receiving specified services outside of the plan's provider network. An HMOPOS benefit option provides enrollees with additional choices in obtaining specified health care services without complying with the plan's normal referral or prior authorization rules, but it generally also requires that enrollees incur higher financial liability (cost sharing) for such POS services. An HMO offering a POS benefit option can limit out-of-network coverage to a specific service or services, and can also limit the dollar amount of coverage that will be provided.*

The HMOPOS option may be offered as a mandatory supplemental benefit or as an optional supplemental benefit. The POS benefit option is further described in Chapter 4, *section 100 of this manual.*

30.2.3 - Preferred Provider Organizations (PPOs)

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

A PPO is a plan that:

- *Has* a network of providers that have 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;
- *Only* for purposes of quality improvement requirements in *42 CFR* 422.152(e), is offered by an organization that is not licensed or organized under State law as an HMO; *and*
- *Does not permit prior notification for out-of-network services—that is, a reduction in the plan's standard cost-sharing levels when the out-of-network provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee voluntarily notifies the PPO plan prior to receiving plan-covered services from an out-of-network provider.*

Local PPOs - A local PPO is a PPO that is not a regional PPO (*RPPO*). It is a PPO with a service area that is *specified by the organization offering the plan and approved by CMS*. It may consist of a county, partial county, or multiple county service areas. *Local PPO plans do not have to meet the regulatory requirements that are specific to regional PPOs.*

Regional PPOs (RPPOs) - The MMA introduced the *RPPO* option in an effort to expand the *access* of Medicare managed care to Medicare beneficiaries, including those in rural areas. RPPOs can only be offered in *one* of *26 MA regions* established by *CMS* (refer to <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/MAPDRegions.pdf> for *the location of MA* regions).

RPPO plan service areas cannot be segmented, and the benefit package must be uniform across the *region* as described in Chapter 4, *section 10.10 of this manual*. An MA organization may offer an RPPO in multiple MA regions.

RPPO plans offered by MA organizations must be licensed or otherwise authorized under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers one or more plans. However, MA organizations offering *RPPOs* in multi-State regions may obtain a temporary waiver of State licensure as long as they are licensed to bear risk in at least one State of the region and have filed an application in the other States within the region. The MA regional plans may be joint enterprises where each health plan in the joint enterprise holds a state license in the state in which it does business and meets all applicable Medicare requirements.

30.2.4 - *Special Needs Plans (SNPs)*

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

A SNP is an MA coordinated care plan (under either an HMO, PPO, or RPO plan type) that meets CMS' requirements, offers Part D, and has received approval as a special needs plan. A SNP exclusively enrolls a targeted population of special needs individuals as defined in Section 20. Further information on eligibility, enrollment, and marketing of SNPs will be provided in the new Chapter 16b of this manual.

The MMA designated three specific segments of the Medicare population as special needs individuals: *institutionalized individuals*; those entitled to Medical Assistance under a State Plan under Title XIX (Medicaid) (*i.e.*, dual eligibles); and other high-risk groups of *individuals with one or more severe or disabling chronic conditions specified by CMS* who would find enrollment in this type of plan *beneficial*.

The three SNP categories that correspond to the targeted populations are:

- 1. Chronic Condition SNPs (C-SNPs) - designed for beneficiaries with severe or disabling chronic conditions who would benefit from enrollment in a coordinated care plan;*
- 2. Dual-eligible SNPs (D-SNPs) - designed for beneficiaries entitled to medical assistance under both Medicare and a State's Medicaid program (Title XIX of the Act); and*
- 3. Institutionalized SNPs (I-SNPs) - serve beneficiaries who reside or are expecting to reside for 90 days or longer in a long term care facility. Beneficiaries living in the community but requiring a level of care equivalent to that of those individuals in long term care facilities are also eligible to enroll in an I-SNP.*

An “*institutionalized*” individual is defined at 42 CFR 422.2 as an individual residing or expected to reside for 90 days or longer in a skilled nursing facility (SNF), nursing facility (NF), SNF/NF, intermediate care facility for the mentally retarded (ICF/MR), or inpatient psychiatric facility. *CMS has expanded the definition of institutionalized individuals to include those living in the community, but requiring an institutional level of care consistent with State requirements.* Enrollment of a special needs individual on the basis of the potential for a 90-day stay must be based on a CMS-approved assessment. That assessment must be developed by the plan and submitted to CMS for approval as marketing material.

Please refer to the SNP portion of the MA application for instructions on how to *apply to offer* a SNP. *We will provide additional information on the SNP application and approval process in the new Chapter 16b of this manual, and at <http://www.cms.hhs.gov/SpecialNeedsPlans>.*

30.2.5– Senior Housing Facility Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Section 3208 of the Affordable Care Act established that senior housing facility plans participating as of December 31, 2009 in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year may continue participation as MA senior housing facility plans. MA senior housing facility plans must:

- *Limit enrollment to residents of continuing care retirement communities, that is, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period;*
- *Provide primary care services onsite and have a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate; and*
- *Provide transportation services for beneficiaries to specialty providers outside of the facility.*

30.2.6 - Other Types of MA Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Two other types of MA plans that are not CCPs are open to general Medicare enrollment. These are MSA and PFFS plans described in sections 30.3 and 30.4, respectively. Section 30.5 provides information on RFB plans, which may limit enrollment to members of religious fraternal benefit societies. An RFB plan may be a CCP or any other type of MA plan, such as an MSA or a PFFS plan. Section 30.6 provides information on Part B-only plans, which may be any type of MA plan (except a regional PPO plan) that covers the Medicare benefits that are covered under Part B and supplemental benefits.

30.3 - Medical Savings Account (MSA) Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Medicare Medical Savings Account (MSA) plans combine a high deductible MA plan and a medical savings account (which is an account established in conjunction with an MSA plan for the purpose of paying the qualified medical expenses of the account holder).

The Balanced Budget Act of 1997 (BBA) *authorized MSA plans on a demonstration basis* when it created the M+C program. The MMA of 2003 made *Medicare* MSAs a permanent type of Medicare plan option and lifted several restrictions that had been in effect during the MSA demonstration, *including elimination* of the time limit on enrollment *in an MSA* and *a* limit on the number of beneficiaries who could enroll. *The MMA extended* the protection from balance billing by non-contracting providers to include MSA enrollees (in addition to enrollees in coordinated care plans). A physician or other entity that does not have a contract with an MSA plan is required to accept as

payment in full, for covered services provided to an MSA plan enrollee, the amount the physician or other entity could have collected from *Original* Medicare had the individual not been enrolled in the MSA plan.

An MSA plan is a plan that pays at least for the services described in *42 CFR* 422.101 of the MA *regulations*, after the enrollee has incurred countable expenses (as specified in the plan) equal in amount to the annual deductible specified in *42 CFR* 422.103(d); *does not permit prior notification—that is, a reduction in the plan's standard cost-sharing levels when the provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee voluntarily notifies the MSA plan prior to receiving plan-covered services from a provider*; and meets all other requirements *applicable to MA plans*. An MSA *account* means a trust or custodial account that is established in conjunction with an MSA plan for the purpose of paying the qualified expenses of the account holder; and into which no deposits are made other than contributions by CMS under the MA program, or a trustee-to-trustee transfer or rollover from another MA MSA of the same account holder, in accordance with the requirements of §§ 138 and 220 of the Internal Revenue Code. *An MSA trustee may be a bank, an insurance company, or any other entity that is approved by the Internal Revenue Service to be a trustee or custodian of an individual retirement account (IRA) and that meets the requirements of 42 CFR 422.314(b).*

CMS will pay premiums for the insurance policies and make a contribution to enrollee MSA accounts. Beneficiaries use the money in their *MSA account* 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 expenses related to covered services. The maximum annual MSA deductible is set by law *and is updated annually.*

30.4 - Private Fee-for-Service (PFFS) Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

A private fee-for-service (*PFFS*) plan is an MA plan that:

(1) Pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(2) Does not vary the rates for a provider based on the utilization of that provider's services (*subject to the exceptions described below*);

(3) Does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment; *and*

(4) *Does not permit prior notification—that is, a reduction in the plan's standard cost-sharing levels when the provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee*

voluntarily notifies the PFFS plan prior to receiving plan-covered services from a provider.

Exceptions for varying PFFS provider payment rates: Although payment rates cannot vary based solely on utilization of services by a provider, a PFFS plan is permitted to vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. Furthermore, PFFS plans may also increase payment rates to a provider based on increased utilization of specified preventive or screening services. See the definition of a PFFS plan in 42 CFR 422.4(a)(3).

Generally, a PFFS plan is subject to all MA requirements, including beneficiary protections. In addition, as indicated in section 50 below, a PFFS plan may choose whether to offer Part D prescription drug coverage. PFFS plans will be discussed in detail in the new Chapter 16a of this manual.

Members of a PFFS plan can go to any provider, such as a doctor or hospital, in the United States, if the provider agrees to accept the plan's terms of payment before providing services to the member and the provider is eligible to provide services under Original Medicare. However, providers can decide whether or not to accept the PFFS plan's term and conditions of payment each time they see a PFFS plan member.

Non-employer PFFS plans:

Beginning with plan year 2011, non-employer PFFS plans that are operating in a network area (as defined in section 1852(d)(5)(B) of the Act) must meet MA access requirements (as described in 1852(d)(4) of the Act) through signed contracts with providers to furnish all Medicare Part A and Part B services, and thereby operate as full network PFFS plans. PFFS plans located in network areas may no longer meet MA access requirements by establishing payment rates that are not less than the rates that apply under Original Medicare and having providers deemed to be contracted as described in 42 CFR 422.216(f).

Members of full network PFFS plans can also receive out-of-network services from non-contracting providers who do not have a signed contract with the plan, as long as the provider meets the deeming conditions described in 42 CFR 422.216(f). However, these plans may establish higher cost sharing requirements for members who obtain covered services from deemed providers instead of providers who have a signed contract with the plan.

The list of network areas for non-employer PFFS plans is available at <http://www.cms.gov/PrivateFeeforServicePlans/>.

Non-employer PFFS plans operating in areas that are not considered network areas can continue to operate as non-network plans, where the plans meet MA access requirements by establishing payment rates that are not less than the rates that apply under Original

Medicare and using deemed providers as described in 42 CFR 422.216(f). These plans may also operate as full network or partial network PFFS plans.

Employer PFFS plans:

Beginning with plan year 2011, all employer/union sponsored PFFS plans that have waivers under section 1857(i) of the Act must meet MA access requirements (as described in 1852(d)(4) of the Act) through signed contracts with providers to furnish all Medicare Part A and Part B services, and thereby operate as full network PFFS plans. These PFFS plans may no longer meet MA access requirements by establishing payment rates that are not less than the rates that apply under Original Medicare and having providers deemed to be contracted as described in 42 CFR 422.216(f).

The rules for full network non-employer PFFS plans described above also apply to full network employer PFFS plans.

30.5 - Religious Fraternal Benefit (RFB) Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

As defined above in *section 20*, RFB *plans* are MA plans that are offered by an RFB society and may limit enrollment exclusively to members of *the RFB* society. An RFB society, also defined in *section 20*, is an organization that is described in §501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under §501(a) of that Act, and is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches. An RFB is an organization that may be any type of MA plan, including PFFS, MSA, or CCP.

30.6 – Part B-only Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Part B-only plans are MA plans (except regional PPO plans) that cover the Medicare benefits that are covered under Part B and supplemental benefits. Only those Medicare beneficiaries who are entitled to benefits under Medicare Part B and who do not have Part A coverage may enroll in a Part B-only plan.

MA organizations can develop local MA plans for Part B-only Medicare beneficiaries who are members of employer/union groups. In permitting such plans, CMS has waived the existing regulations that prohibit individuals only eligible for Part B from enrolling in MA plans. For a complete discussion of Part B-only plans offered by EGWPs, see Chapter 9, section 20.1.4 of this manual. Note that CMS has not approved an EGWP waiver that would permit the offering of Part B-only RPP0 plans.

For MA plans that are not EGWPs, there can be no new plans that enroll Part B-only beneficiaries. Existing plans with Part B-only beneficiaries may continue operating as

long as they have membership and their underlying organization renews them. However, they may not enroll new Part B-only members.

30.7 - Multiple Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Under its contract, an MA organization may offer multiple plans of the same plan type (e.g., HMO, PPO, MSA) as approved by CMS provided that the MA organization is licensed or approved under State law to provide those types of plans. MA organizations offering more than one plan in a given service area should ensure that meaningful differences between these plans are transparent, readily discernable to beneficiaries and designed to provide the highest value at the lowest cost. Examples of meaningful differences in plan benefit designs include plan type (e.g., HMO, HMOPOS, local PPO, regional PPO, PFFS, and SNP); whether Part D benefits are provided; and significant differences in the premiums or cost sharing charged for benefits, and what supplemental benefits are offered. A large number of duplicative plan options in a market area can make it difficult and confusing for beneficiaries to understand, evaluate, and choose the best option to meet their needs. To ensure that beneficiaries are able to make an informed choice among plans being offered, CMS works with MA organizations to minimize market confusion and to assure beneficiaries have meaningful choices through plan consolidation and/or elimination.

40 – Section 1876 Cost Plans

(Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

Section 1876 cost plans are not MA plans and are authorized under a different section of the Social Security Act than MA plans. However, because such plans are a health plan option for some Medicare beneficiaries and because the plans are sometimes confused with MA plans, we discuss them briefly in this chapter. We specify requirements and policies for cost plans in other chapters of the Managed Care Manual, including chapters 3, 5, 12, 13, and 17.

Section 1876 cost plans are plans operated by an HMO or Competitive Medical Plan (CMP) in accordance with a cost reimbursement contract under section 1876 of the Act and Title 42, Part 417 of the Code of Federal Regulations. Medicare cost plan enrollees are not restricted to the HMO or CMP network for receipt of covered Medicare services (i.e., Original Medicare services may be received through non-HMO/CMP sources and are reimbursed separately by Medicare intermediaries and carriers). Medicare payment to the HMO/CMP is based on the reasonable costs of providing services to the Medicare beneficiaries.

Since 2006, cost plans have been permitted to offer Part D coverage. For additional information, see Chapter 17f, section 10.4 of this manual.

There can be no new cost plans. Beginning in 2010, cost plans located in areas where there is adequate competition from other organization types, as defined in 42 CFR 417.402, will not be renewed by CMS. This means affected cost plans would receive non-renewal notices in 2012 and would not be able to offer the plan in 2013.

50 - MA Requirement for Plans to Offer a Qualified Drug Plan Coverage (Rev. 95, Issued: 01-07-11, Effective: 01-07-11, Implementation: 01-07-11)

As provided in 42 CFR 422.4(c), an MA organization cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MA organization in that same service area includes required prescription drug coverage. Required prescription drug coverage is defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual. This rule applies only to coordinated care plans. For more information about this rule, refer to section 10.5 of Chapter 4 of this manual and section 20.4.4 of Chapter 5 of the Prescription Drug Benefit Manual.

All SNPs, which are a type of MA coordinated care plan, must provide Part D prescription drug coverage. 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.

However, MA organizations offering MSA plans are not permitted to offer prescription drug coverage, other than that required under *Medicare* Parts A and B. MA organizations offering *PFFS* plans may choose to offer qualified Part D coverage (*as defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual*) under those plans.

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, (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.