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MEMORANDUM

DATE: May 10, 2010

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

FROM: Danielle R. Moon, J.D., M.P.A.
Director
Medicare Drug & Health Plan Contract Administration Group

RE: Supplemental 2011 Benefits Policy and Operations Guidance on Application of the Mandatory Maximum Out-of-Pocket for Dual Eligible SNPs, and Cost Sharing for Preventive Services

This memorandum provides additional and clarifying information for Medicare Advantage Organizations, 1876 Cost Plans, and Demonstrations related to application of the mandatory Out of Pocket Maximum (MOOP) for dual-eligible Special Needs Plans (D-SNPs) and preventive services cost sharing to supplement the guidance provided in the April 16, 2010 memorandum entitled "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." As described below under item 2, we are strongly encouraging all MA and cost plans to furnish all Medicare covered preventative services at zero cost sharing starting in contract year 2011.

1. Application of the Mandatory Maximum Out-Of-Pocket Limit for Dual Eligible (DE) Beneficiaries Enrolled in MA Plans

In our Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs final rule (75 FR 19709), published April 15, 2010, we discuss the basis for requiring that MA plans establish an annual maximum out-of-pocket (MOOP) amount for enrollees. The specific basis for the establishment of a mandatory MOOP for all local MA plans, including special needs plans (SNPs), is to ensure that Medicare beneficiaries with significant health care needs are not discouraged from enrolling in MA plans. Accordingly, to protect beneficiaries from high out-of-pocket expenditures, local MA plans must establish a MOOP limit for their 2011 benefit package and then track its enrollees' out-of-pocket expenditures against that MOOP limit during the contract year.

We are clarifying, however, that for purposes of tracking out-of-pocket spending relative to its MOOP limit, a plan must count only the actual out-of-pocket expenditures for which each enrollee is responsible. Thus, for any DE enrollee, MA plans must count toward the MOOP limit only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost-sharing and not the cost sharing amounts for services the plan has established in its plan benefit package. Effectively, this means that for those DE enrollees who are not responsible for paying the Medicare Parts A and B cost sharing, the MOOP limit will rarely be reached. However, plans must still track out-of-pocket spending for these enrollees.

2. Preventive Services

Section 4103 of Patient Protection and Affordable Care Act of 2010 (PPACA) creates a new Medicare covered benefit effective for CY 2011, the Personalized Prevention Plan Services or “annual wellness visits.” As a new Medicare benefit, all Medicare Advantage plans are required to cover this new Medicare-covered benefit effective January 1, 2011. Information about the benefit will be made available later this year on the CMS web site at: www.cms.gov/. We also direct plans to the full text of the PPACA which may be found at:

<http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf>

In addition, Plans should refer to the official Medicare publication, “Your Medicare Benefits,” for information about what services are included in the listed benefits and how often the services may be provided. The publication may be accessed at:

<http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>

Attachment 1 provides information specific to completion of the Medicare-covered preventive services in the Plan Benefits Package.

ATTACHMENT 1: Technical Guidance Related to Completion of the Plan Benefit Package (PBP) for Medicare-Covered Preventive Benefits

MA plans that choose to charge zero cost sharing for Medicare-covered preventive services as encouraged by CMS, should not charge copayments or coinsurance for physician office visits when the only service(s) provided is a Medicare-covered preventive service(s). We realize that there may be circumstances in which an enrollee’s office visit to receive a preventive service may become a visit in which other, non-preventive services also are furnished. In such cases, the plan’s office visit cost sharing standards would apply.

As shown in the table below, for CY 2011, the new PPS benefit cost sharing must be entered in the same line as that for “Welcome to Medicare” IPPE. A revised Summary of Benefits (SB) sentence will generate for plans that reflects both the IPPE and the PPS Medicare benefits. The revised SB will read, “\$X copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.” The Original Medicare sentence will be revised to read, “When you get Medicare Part B, you have the option to select an initial preventive physical exam or personalized prevention plan services (Annual Wellness Exam) in the first 12 months of your coverage and to an annual wellness visit every 12 months thereafter. There is no copayment/coinsurance or deductible for these preventive services.”

The HIV screening cost sharing must be entered in PBP Section B-14A, with the Medicare-covered smoking cessation benefit. The SB sentence that generates for the Medicare-covered smoking cessation benefit will be revised to capture the addition of the HIV screening benefit.

Plans will be prompted in HPMS to attest that they are providing all Medicare-covered preventive services in-network at zero cost sharing. Failure to attest to zero cost sharing for all Medicare-covered preventive services in-network will result in the plan being presented on the SB and Medicare Options Compare as being a plan that does not cover all Medicare-covered preventive services in-network with zero cost sharing.

Reporting Preventive Services in the PBP for CY 2011

Preventive service	PBP Line & Service Category
Abdominal Aortic Aneurysm screening*	B-8a Diagnostic Procedures, Tests, and Lab Services
Bone mass measurement	B-14g Bone Mass Measure
Cardiovascular screening	B-8a Diagnostic Procedures, Tests, and Lab Services
Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)	B-14d Pap Smears & Pelvic Exam Screenings
Colorectal cancer screening	B-14f Colorectal Screening
Diabetes screening	B-14i Diabetes Monitoring
Diabetes Self-Management Training	B-14i Diabetes Monitoring
EKG Screening*	B-8a Diagnostic Procedures, Tests, and Lab Services

Flu Shots	B-14b Immunizations
Glaucoma Tests	B-17a Eye Exams
Hepatitis B	B-14b Immunizations
HIV screening	B-14a Health Education/Wellness
Breast Cancer Screening (Mammograms)	B-14h Mammography Screening
Medical Nutrition Therapy Services	B-14j Nutritional Training
Personalized Prevention Plan Services	B-14c (Routine) Physical Exams
Pneumococcal Shot	B-14b Immunizations
Prostate Cancer Screening	B-14e Prostate Cancer Screening
Smoking Cessation (counseling to stop smoking)	B-14a Health Education/Wellness
Welcome to Medicare Physical Exam (initial preventive physical exam)	B-14c (Routine) Physical Exams

*Service is only covered as a preventive service when referral is made as a result of the one-time “Welcome to Medicare” physical exam.