

Medicare Advantage Benefits Policy and Implementation for Contract Year 2011

Objectives

- Convey current scope, important bid dates and where to get additional information for CY 2011
- Summarize benefit design and cost-sharing guidance
- Discuss benefit changes and clarifications for problematic topics in previous years
- Emphasize importance of quality bid submissions and provide information on plan corrections

Overview of Non-Employer MA Plans

CY 2010 Plan Offerings:

- 2,844 non-employer MA plans
- HMOs represent 62% of MA plans
- PFFS plans have decreased from 740 plans in CY 2009 to 435 plans in CY 2010
- Average of 38 MA plans offered to beneficiaries in each county
- More than 98% of beneficiaries have at least 10 MA plan options

Plan Benefit Packages: Important Dates

April 9	PBP & BPT software available in HPMS
May 14	HPMS available to accept bids
June 7	Bid Submission Deadline (11:59 p.m. PDT)
Aug/Sep	Attestations/Contracts
October 1	Deadline for plan correction requests; marketing begins

Tools for Getting Started

Use available tools prior to developing and submitting your PBP(s):

- Patient Protection and Affordable Care Act (PPACA)
- Final Regulation CMS-4085-F (April 15, 2010)
- HPMS Memo regarding benefits policy and operational guidance
- CMS guidance documents, including Managed Care Manual -- Chapter 4 (Benefits and Beneficiary Protections)
- Participate in User Group Calls
- Go to <https://MABenefitsMailbox.lmi.org> to submit benefit policy and PBP questions before June 7th deadline

CY 2011 MA Benefit Goals

- Review MA bids to ensure cost sharing amounts and benefit designs do not discriminate against or steer beneficiaries on the basis of health status --- Section 1852 (b)(1) of the SSA and 42 CFR §422.100
- Implement new regulation's mandatory MOOP requirement
- Encourage plans to use a lower, voluntary MOOP by providing flexibility in cost sharing standards
- Align cost sharing standards with PPACA provisions that require Medicare FFS coverage levels or better for certain services

MA Regulation Changes for CY 2011

- All local MA plans (employer and non-employer) – including HMOs, HMOs with POS, local PPO plans, and PFFS plans will be required to establish a mandatory MOOP for A/B services
- Lower, voluntary MOOP amount allows flexibility in individual service category cost sharing to provide beneficiaries with greater protection than mandatory MOOP

MA Regulation Changes for CY 2011 (Con' t)

- Local PPO plans will be required to have a catastrophic limit inclusive of both in- and out-of-network cost sharing for A/B services
- HMO Point of Service (POS) plans do not have a catastrophic MOOP requirement since POS is a supplemental benefit
- All deductibles, coinsurance, and co-payments for A/B services are included in the MOOP calculation

CY 2011 Maximum Out-of-Pocket (MOOP) Amounts by Plan Type

Plan Type	Voluntary MOOP	Mandatory MOOP
HMO	\$3,400	\$6,700
HMO POS	\$3,400	\$6,700
Local PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
Regional PPO	\$3,400 In-network and \$5,100 Catastrophic*	Plan determined for In-network and Catastrophic*
PFFS (full network)	\$3,400 In- and out-of-network	\$6,700 In- and out-of-network
PFFS (partial network)	\$3,400 In- and out-of-network	\$6,700 In- and out-of-network
PFFS (non-network)	\$3,400 In- and out-of-network	\$6,700 In- and out-of-network

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

Entering Maximum Out-of-Pocket (MOOP) Amounts into the PBP

Plan Type	PBP Option(s) for MOOP Amounts	Other Instructions/Comments
HMO	In-network	“In-network” is only option available in the PBP
HMO with Optional Supp. POS	In-network	“In-network” is only option available in the PBP
HMO with Mandatory Supp. POS	In-network	Select “No” for both “Combined” and “Out-of-Network” in the PBP
Local PPO	In-network and Combined	Select “No” for “Out-of-Network” in the PBP
Regional PPO	In-network and Combined	Select “No” for “Out-of-Network” in the PBP
PFFS (full network)	Combined	Select “No” for both “In-Network” and “Out-of-Network” in the PBP
PFFS (partial network)	Combined	Select “No” for both “In-Network” and “Out-of-Network” in the PBP
PFFS (non-network)	General	“General” is the only option available in the PBP

CY 2011 MA Cost Sharing Review Approach

- Communicate cost sharing standards through HPMS Memorandum prior to bid submission:
 - Actuarial equivalence standards
 - Service category standards -- greater flexibility for plans adopting the lower, voluntary MOOP
- Following bid submission, CMS will ensure bids conform with cost sharing standards and are not discriminatory

PPACA Requirements are Reflected in CY 2011 Cost Sharing Standards

Services with cost sharing no greater than 100% of FFS:

- Renal dialysis
- Part B chemotherapy drugs and administration services
- Skilled Nursing Facility (SNF)
 - Overall cost sharing less than or actuarially equivalent to FFS
 - Some cost sharing permitted for the first 20 days
 - Per-day cost sharing must not exceed CMS standard for the first 20 days or FFS amount for duration of SNF benefit

CY 2011 MA Actuarial Equivalence Test

- All MA plans must not exceed cost sharing in Medicare FFS at the plan level (i.e., all service categories combined)
- For CY 2011, plan cost sharing for the following specific service categories must not exceed Medicare FFS from an actuarial equivalence perspective:
 - Inpatient
 - Skilled Nursing Facility (SNF)
 - Home Health
 - Durable Medical Equipment (DME)
 - Part B Drugs

CY 2011 MA Service Category Cost Sharing Standards (1 of 2)

#	Service Category	Voluntary MOOP	Mandatory MOOP
1	IP Acute-60 days	N/A	\$3,935
2	IP Acute-10 days	\$2,231	\$1,785
3	IP Acute-6 days	\$2,016	\$1,613
4	IP Psych-60 days	\$2,471	\$1,977
5	IP Psych-15 days	\$2,156	\$1,796
6	SNF-First 20 Days	\$100/day	\$50/day
7	SNF days - 21 through 100	No greater than FFS	No greater than FFS
8	Home Hlth-37 visits	\$1,110	\$0

CY 2011 MA Service Category Cost Sharing Standards (2 of 2)

#	Service Category	Voluntary MOOP	Mandatory MOOP
9	Physician Mental Health Visit	100% FFS / \$40	100% FFS / \$40
10	Renal Dialysis (156 visits)	100% FFS	100% FFS
11	Part B Drugs-Chemotherapy (including administration services)	100% FFS	100% FFS
12	Part B Drugs-Radiation	100% FFS	100% FFS
13	Part B Drugs-Other	100% FFS	100% FFS
14	DME-Equipment	N/A	100% FFS
15	DME-Prosthetics	N/A	100% FFS
16	DME-Medical Supplies	N/A	100% FFS
17	DME-Diabetes Monitoring Supplies	N/A	100% FFS

Preventive Services

- As mandated by the PPACA for 2011, there will be zero cost sharing under Original Medicare for all Medicare-covered preventive services recommended with a grade of “A” or “B” by the U.S. Preventive Services Task Force
- For CY 2011, CMS is strongly encouraging all Medicare health plans to charge zero cost sharing for preventive services listed in the HPMS Benefits Memo

Preventive Services

- Preventive services will be highlighted in the MOC, ANOC and EOC to identify plans that provide all preventive services with zero cost sharing and those plans that don't
- CMS intends to issue rulemaking to establish zero cost sharing for these services for all Medicare health plan enrollees beginning in CY 2012 and to integrate measurement of the benefits into our performance ratings

Improving Choice for Beneficiaries

CMS Will Improve Choice for CY 2011 by:

- Contacting MAOs in the near future to eliminate low enrollment plans prior to bid submission
- Communicating detailed guidance so that MAOs can submit meaningfully different plan bids
- Allowing MAOs to consolidate or eliminate CY 2011 plans in accordance with renewal/non-renewal guidance from CMS

CY 2011 Low Enrollment Plan Approach

- For CY 2011, focus will be on plans operating for at least three years (e.g., plans operating in '08, '09, and '10)
- CMS will contact parent organizations in the near future to potentially eliminate plans
 - Non-SNPs with fewer than 500 enrollees
 - SNPs with fewer than 100 enrollees
- MAOs should agree to eliminate plan(s) or submit a business case to CMS for an exception in limited situations (e.g., SNP, MA only)
- Instructions will be provided in CMS communication

CY 2011 Meaningful Difference Approach (1 of 2)

- For CY 2011, CMS will:
 - Evaluate all plan bids for meaningful difference at the county level using out-of-pocket cost (OOPC) data
 - Provide parent organizations with their OOPC data for each CY 2010 plan prior to bid submission to use in developing CY 2011 bids
 - Reserve the right to evaluate submitted bids on criteria other than OOPC data to ensure meaningful difference
- Non-SNPs are meaningfully different based on:
 - Presence of Part D benefit (i.e., MA-Only or MA-PD)
 - Plan Type (i.e., HMO, Local PPO, Regional PPO, and PFFS)

CY 2011 Meaningful Difference Approach (2 of 2)

- SNPs are meaningfully different based on:
 - Plan Type
 - Unique Populations Served
 - Dual Eligible (e.g., full dual)
 - Institutional (e.g., community based)
 - Chronic Care (e.g., CHF)
- For CY 2011, the acceptable difference between plan values will be \$20 per member per month, based on out-of-pocket cost (OOPC) data for both Part C and Part D benefits combined
 - For purposes of evaluating meaningful differences among MA plans cost sharing, CMS will exclude premiums from the OOPC calculation

Quality Bid Submissions

- Extremely important that PBP submission is accurate and complete for bid review and marketing materials
 - Compare PBP to BPT
 - Review notes
 - Generate a Summary of Benefits to ensure marketing materials will be correct
- Actuarial certification
- Communicate and coordinate within your organization

Plan Correction Requests

- All plan correction requests due no later than October 1, 2010 -- No exceptions to this deadline
- Request for plan correction indicates inaccuracies and/or incompleteness of bid and MAO's inability to submit a correct bid with valid information
- In general, CMS will issue warning letters to MAOs requesting plan corrections for 2011
- An organization that received a warning letter for CY 2010 may receive a corrective action plan (CAP) if it requests a plan correction for CY 2011

Summary

- Deadline for bid submissions is June 7 -- No late submissions will be accepted
- Submit complete and accurate bids before the deadline
- If you experience difficulty uploading your bid, contact HPMS at 1-800-220-2028 or hpms@cms.hhs.gov before the deadline
- Go to <https://MABenefitsMailbox.lmi.org> to submit benefit policy or PBP questions before June 7th deadline_

Bid Team Contacts

Name	Phone	Email	Responsibility
Dale Summers	410-786-5135	Dale.Summers2@cms.hhs.gov	Region VI
Dana Burley	410-786-4547	Dana.Burley@cms.hhs.gov	Regions IX, X
Yasmin Galvez	410-786-0434	Yasmin.Galvez@cms.hhs.gov	Region II
Geralyn Glenn	410-786-0973	Geralyn.Glenn@cms.hhs.gov	Regions I, III, V
Venita Scott	410-786-3139	Venita.Scott@cms.hhs.gov	Regions IV, VII, VIII
TBA	TBA	TBA	Region IV