

Medicare Advantage Benefits Policy and Implementation for Contract Year 2011

Objectives

- Provide an overview of and discuss the policy bases for new policies and procedures concerning:
 - Ensuring meaningful differences between plans offered by the same MAO in the same service area
 - Non-renewal of low enrollment plans

Reviewing MA Bids for Meaningful Differences: New Regulatory Provisions

42 CFR sections 422.254 (bid submissions) and 422.256 (bid review)

- Affect MAOs
- Apply to an organization's plan offerings in a service area
- Require that an organization's offerings of a particular plan type differ by premium, benefits, or cost-sharing structure
- Require a two-year transition period in cases of mergers/acquisitions/innovations

Reviewing MA Bids for Meaningful Differences: Policy Basis

Policy Goals:

- Ensure that an organization offering plans in the same service area provides significantly different choices to beneficiaries in terms of costs, benefits, or access to care
- Reduce beneficiary confusion about plan costs and benefits

Statutory Basis:

- Section 1857(e)(1) of the Social Security Act

New Statutory Authority:

- Section 3209 of PPACA

Reviewing MA Bids for Meaningful Differences: Guidance

- CMS-4085-F (75 FR 19736-19740)
- Annual guidance reflecting thresholds and criteria for the upcoming contract year:
 - For CY 2011, April 2010 benefits policy and operational guidance memo
 - For CY 2012 and beyond, Call Letter or other similar guidance vehicle

Non-Renewal of MA Plans Based on Low-Enrollment: New Regulatory Provisions

42 CFR sections 422.406(b)(1)(iv)

- Affect all MAOs
- Thresholds may vary annually
- Don't apply to new plans
- Other exceptions possible under certain circumstances, including—
 - Geographical location
 - Beneficiary population served by the plan

Non-Renewal of MA Plans Based on Low Enrollment: Policy Basis

Program Goals:


- Streamline and simplify the plan selection process for beneficiaries
- Ensure that plans are viable for the long term

Statutory Basis:

- Section 1857(c)(2)(B) of the Social Security Act

Non-Renewal of MA Plans Based on Low Enrollment: Guidance

- CMS-4085-F (75 FR 19740-19741)
- Annual guidance reflecting thresholds and criteria for the upcoming contract year:
 - For CY 2011, April 2010 benefits policy and operational guidance memo
 - For CY 2012 and beyond, Call Letter or other similar guidance vehicle



MEDICARE ADVANTAGE PLAN BENEFIT REVIEWS & RELATED ISSUES CONTRACT YEAR 2011

Objectives

Provide an overview of new MA benefits policies:

- Limits on Parts A and B services cost-sharing
 - Maximum out-of-pocket (MOOP) cost limit
 - Thresholds on Parts A & B cost-sharing
- The visitor/traveler benefit
- Prohibition on prior notification option
- CY 2011 plan renewal/non-renewal options

Maximum Out-of-Pocket (MOOP) Limit

Policy Goals:

- To ensure that enrollees with higher than average health care needs are not discouraged from enrolling in MA plan

Statutory Basis:

- Sections 1852(b)(1)(A), 1856(b)(1) and 1857(e)(1) of the SSA

MOOP Limits for CY 2011

42 CFR Section 422.100(f)(4)

- CMS will annually establish a MOOP limit on Parts A & B cost-sharing
- MOOP limit information will be made available annually through the Call Letter or similar vehicle
- The MOOP limit includes all Part A & B benefits but not premium or supplemental benefits
- The MOOP limit is applicable to HMOs, LPPOs, and PFFS plans
- In addition to the mandatory MOOP, plans may establish a lower, voluntary MOOP

MOOP Limits and PPO Plans

42 CFR Section 422.100(f)(5)

- In addition to the MOOP for in-network cost-sharing, LPPOs will be subject to a catastrophic cap for in-network and out-of-network cost-sharing
- The amount of the catastrophic cap will be established annually by CMS and communicated through the Call Letter or similar vehicle
- RPPO plans not subject to the MOOP or catastrophic caps established by CMS but are encouraged to establish benefits consistent with our limits

Cost Sharing Thresholds for Parts A & B Services

Policy Goals:

- To ensure that enrollees with higher than average health care costs are not discouraged from enrolling in an MA plan

Statutory Basis:

- Section 1852(b)(1) of the Social Security Act
- Section 3202 of the PPACA

Cost Sharing Thresholds for Parts A & B Services

- Section 3202 of the PPACA specifies cost sharing limits for certain services:
 - Chemotherapy
 - Dialysis
 - Skilled nursing care
- Section 3202 also provides the Secretary with authority to set limits for other Parts A & B services that require a high level of predictability and transparency

Parts A&B Cost-Sharing Threshold Bands

CMS will annually establish cost sharing thresholds tied to the mandatory and voluntary MOOP amounts

- Local MA plans adopting the mandatory MOOP amount will have tighter limits on Parts A&B cost sharing than plans adopting the voluntary MOOP (or a lower) amount
- RPPOs that exceed the CMS-established voluntary and mandatory MOOP amounts will receive greater scrutiny of their Parts A & B cost sharing amounts

Visitor/Traveler Benefit

Policy Goals:

- To ensure that enrollees who are out of an MA plan's service area for extended periods (more than six months) receive the plan benefit package

Statutory Basis:

- Section 1851(b) of the Social Security Act

Visitor/Traveler Benefit

42 CFR section 422.74(d)(4)(iii)

In return for retaining enrollees for months 7 to 12 after being out of the service area:

- The V/T benefit must cover the entire plan benefit package, including all Parts A & B services and supplemental benefits, at in-network cost sharing in selected areas where it will be offered
- Plans must offer the V/T benefit to all plan enrollees in the selected areas where it will be offered
- Plans must offer the V/T benefit only within the U.S. and its territories

Prohibition on Prior Notification

Policy Goals:

- To prevent beneficiary confusion and enhance cost-sharing transparency regarding plan rules

42 CFR sections 422.2, 422.4, and 422.105

- Affect local and regional PPOs, PFFS and MSA plans
- Prohibit prior notification as a condition for lowered cost sharing
- Prohibit PPOs from offering a “POS like” benefit

CY 2011 Plan Renewal/Non-Renewal Guidance

- Guiding principle is fostering beneficiary choice to the greatest extent possible and the protection of previous beneficiary choices
- All possible renewal/non-renewal scenarios are outlined in the guidance
- Any exceptions to the HPMS Plan Crosswalk specified in the guidance must be requested and approved by CMS

CY 2011 Plan Renewal/Non-Renewal Guidance

Highlights of plan renewal/non-renewal guidance:

- Renewal Plan with a Service Area Reduction – beneficiaries in reduced service area must be disenrolled to Original Medicare
- Non-Network and Partial Network PFFS plans – beneficiaries may be transitioned to partial or full network PFFS plans
- Renewing SNP with Ineligible or “Disproportionate Share” Members – beneficiaries not meeting special needs criteria must be disenrolled to Original Medicare by 12/31/10

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- Cost-sharing
- Renewal/non-renewal options
- Prior notification
- Visitor travel

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- Meaningful differences
- Non-renewal of low enrollment plans