Medicare Managed Care Manual
Chapter 1 - General Provisions

Table of Contents
(Rev. 81, 04-25-07)

---

10 - Introduction
(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

The Balanced Budget Act of 1997 (BBA) established a new Part C of the Medicare program, known as the Medicare+Choice (M+C) beginning in January 1999. M+C plans typically provided health care coverage that exceeded the coverage of original fee-for-service Medicare at a lower cost to Medicare beneficiaries. The primary goal of the M+C program was to provide Medicare beneficiaries with a wider range of health plan choices through which to obtain their Medicare benefits. To encourage greater participation by health plans, the BBA also changed the payment methodology to Medicare health plans including large payment increases in rural areas. As part of the M+C program, the BBA authorized CMS to contract with public or private organizations offering a variety of health plan options for beneficiaries, including both traditional managed care plans (such as those offered by HMOs that had been offered 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, as follows:

- M+C 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).

- M+C MSA plans (combinations of a high deductible M+C health insurance plan and a contribution to an M+C Medical Savings Account);
- M+C Private Fee-for-Service (PFFS) plans; and
- M+C Religious Fraternal Benefit (RFB) plans.

The M+C program in Part C of Medicare was replaced by the Medicare Advantage (MA) Program pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), enacted on December 8, 2003. Title II of the MMA made important changes to the M+C program by replacing it with a new Medicare Advantage (MA) program under Part C of Medicare. The MA program retains many provisions in the M+C program while updating and improving choice of plans for beneficiaries and restructuring how plans are paid. In addition, in conjunction with the new drug benefit provided by Title I of the MMA, changes made in the MMA to the MA program included improvements to the benefit structure which now allows (and in some cases requires) most MA plans to offer Part D prescription drug coverage.

Under the MMA, beneficiaries will have additional choices of plan options -- regional PPO plans and "specialized MA plans for special needs individuals" (Special Needs Plans or SNPs). The SNPs may limit their enrollment to special needs beneficiaries or they may serve a disproportionate percentage of special needs beneficiaries, thus ensuring that the health care needs of these special populations are met as effectively as possible. The benefit of establishing PPO regions nationally was to create market areas that cover the entire U.S., and to provide to as many beneficiaries as possible access to modern, integrated health benefits. The PPOs are a popular health plan option in the under 65 market, because they offer the advantage of cost savings from care coordination combined with the ability to see any provider. Prior to passage of the MMA, each Medicare plan selected the area (on a county by county basis) in which it offered services to Medicare beneficiaries. Most Medicare managed care plans were offered only in urban areas.

The new plan payment system incorporates principles of competition by moving from an administered pricing system to a bidding methodology beginning in 2006. Beginning in 2006, payments for local and regional MA plans will be based on competitive bids rather than administered pricing. The MA organizations will submit an annual aggregate bid amount for each MA plan. An aggregate plan bid is based upon the MA organization's determination of expected costs in the plan's service area for the national average beneficiary for providing non-drug benefits (that is, original Medicare (Part A and Part B)

benefits), Part D basic prescription drugs, and supplemental benefits if any (including reductions in cost sharing). We will negotiate bid amounts with plans in a manner similar to negotiations conducted by the Office of Personnel Management (OPM) with Federal Employee Health Benefit plans (FEHB). We will work with plans to ensure benefit packages meet the needs of our population and that information is made available to beneficiaries so that they can make decisions about which plans best meet their needs.

Our payment to an MA organization for an MA plan's coverage of original Medicare benefits depends on the relationship of the plan's basic A/B bid to the plan benchmark. For a plan with a basic A/B bid below its benchmark, we will pay the MA organization the basic A/B bid amount, adjusted by the individual enrollee's risk factor, plus the rebate amount. (The rebate is 75 percent of the difference between the plan bid and benchmark, and is used to provide mandatory supplemental benefits or reductions in Part B or Part D premiums. The government retains the other 25 percent.) For a plan with a bid equal to or above its benchmark, we will pay the MA organization the plan benchmark, adjusted by the individual enrollee's risk factor. In addition, we would pay the bid amount, if any, for Part D basic coverage.

With these new and improved choices, Medicare beneficiaries will have the opportunity to obtain improved benefits, improved services, and reduced costs. However, beneficiaries will still be able to retain their original Medicare coverage, enhanced by the new Part D drug benefit. All beneficiaries have the opportunity to switch among plans, or to, or from original Medicare during the annual election period (or ”open season”) in November and December.

Over time, participating plans will be 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 the original Parts A and B of Medicare, the new Part D drug benefit, and that apply these innovative techniques, will pass on savings that may result from these care coordination techniques to the enrollee through reduced premiums or additional benefits.

On January 28, 2005, CMS published the MA regulation that implements provisions of the Social Security Act that establishes and regulates the MA Program, enacted in Title II of the MMA. In addition, in early 2005, CMS published annual notices, such as the Advance Notice of Methodological Changes, the Final Rate Announcement and Call Letter. This manual sets forth in one place the operational guidance on the current program regulations for MA organizations.

20 - Definitions

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

In the MA regulation, published on January 28, 2005, we removed several definitions from the regulations including “ACR,” “Additional Benefits,” “Adjusted Community

Rate," and "M+C," as these terms became obsolete with the establishment of the Medicare Advantage program in the MMA. We also revised the definitions of "Basic Benefits," "Benefits," "Mandatory Supplemental Benefits," and "Service Area," to be consistent with the MMA. In addition, we added new definitions of "institutionalized," "MA," "MA-Prescription Drug Plan," MA Regional Plan," "Prescription Drug Plan (PDP)," "Prescription Drug Plan (PDP) sponsor," "Special Needs Individual," and Specialized MA plans for special needs individuals." Finally, in definitions that previously contained "M+C," we have replaced them with "MA," and changed "Religious and Fraternal" to "Religious Fraternal." We are adding to this chapter the definition of "segment." Definitions specific to certain chapters will be found in those chapters. Otherwise, the definitions below reflect definitions found in Subpart A of the MA regulation and/or specific manuals as appropriate. In addition, throughout the manual, we have made nomenclature changes as follows: changed "Medicare+Choice" to "Medicare Advantage," and "M+C" to "MA."

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 - An amount billed by a provider that represents the difference between the amount the provider can legally charge an individual for a service and the amount the individual's health insurer pays for the service (including plan cost-sharing paid by the individual).

Basic benefits - All Medicare-covered benefits (except hospice services).

Benefits - Health care services that are intended to maintain or improve the health status of enrollees, 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.

Coinsurance - A fixed percentage of the total amount paid for a health care service that can be charged to an MA enrollee on a per-service basis.

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.

Employer Group Health Plan (EGHP) – *An employment based 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 an employment based 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 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 (these plans are 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 themselves become a PDP or Medicare Advantage plan for their members. See Chapter 9 of this manual for more information on EGWPs.*

Institutionalized - For the purpose of defining a special needs individual, 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. *The definition of an institutionalized individual, for the purpose of determining who is eligible to enroll in an institutional Special Needs Plan (SNP), may include those living in the community, but requiring an institutional level of care based on an assessment tool that is consistent with State requirements.*

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 - stands for Medicare Advantage.

MA Eligible Individual - See Chapter 2, §20.

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 set 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 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 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 whether the benefits are provided within the network of providers. 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. (See Chapter *4*.)

Mandatory Supplemental Benefits - Health care services 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.

MSA - stands for medical savings account.
MSA Trustee – See §422.262(b) of the MA regulation for requirements.

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

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

Prescription Drug Plan (PDP) - A PDP has the definition set forth at §423.4 of the Prescription Drug Benefit Regulation.

Prescription drug plan (PDP) sponsor - A prescription drug plan sponsor has the definition set forth in §423.4 of the Prescription Drug Benefit Regulation.

Point of Service (POS) - A benefit option that an MA coordinated care plan can offer to its Medicare enrollees as an additional, mandatory supplemental, or optional supplemental benefit. Under the POS benefit option, the MA plan allows members the option of receiving specified services outside of the MA plan'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.

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 §422.114(c).

RFB Plan - An MA plan that is offered by an RFB society.

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 – As described in Chapter *4* of this manual and at §422.262(c)(2) of the MA regulation, 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 §422.254 is separately submitted to CMS.

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. In deciding whether to approve an MA plan's proposed service area, CMS considers the following criteria:

- For local MA plans:
    - Whether the area meets the “county integrity rule” that a service area generally consists of a full county or counties;

- However, CMS may approve a service area that includes only a portion of a county if it determines that the "partial county" area is necessary, nondiscriminatory, and in the best interests of the beneficiaries (see Chapter 4, §60.3 for information on partial counties). CMS may also consider the extent to which the proposed service area mirrors service areas of existing commercial health care plans or MA plans offered by the organization.

- For all MA coordinated care plans, whether the contracting provider network meets the access and availability standards set forth in §422.112 of the regulation. Although not all contracting providers must be located within the plan's service area, CMS must determine that all services covered under the plan are accessible from the service area.

- For MA regional plans, whether the service area consists of the entire region.

Special Needs Individual - An MA eligible individual who is institutionalized, as defined above, is entitled to medical assistance under a State plan under title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

Specialized MA Plans for Special Needs Individuals (special needs plans or SNPs) - An MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth at §422.4(a)(1)(iv) of the MA regulation and that, beginning January 1, 2006, provides Part D benefits under 42 CFR Part 423. A SNP is also an MA plan that has been designated by CMS as meeting the MA SNP requirements, as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

30 - Types of MA Plans

30.1 - General Rule

(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

There are three basic types of MA plans open to all MA-eligible Medicare beneficiaries if offered in the service area in which they reside: coordinated care plans (CCPs), private fee-for-service (PFFS) plans and Medical Savings Account (MSA) plans. CCPs include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), and Preferred Provider organizations (PPOs). In addition, members of a religious fraternal benefit society may enroll in a religious fraternal benefit (RFB) plan. An RFB plan may be any type of MA plan. The MMA created two new types of CCPs: regional PPO plans and specialized MA plans for exclusive or disproportionate enrollment of special needs individuals. A regional PPO plan is a health plan that operates as a PPO but that also serves an entire CMS-designated MA region. Local PPO plans are not

required to serve an entire MA region and do not have to meet other MA regional plan requirements. Special needs plans may be any type of MA coordinated care plan, including either a local or regional PPO plan. These new plans and other types of MA plans are described in more detail below.

30.2 - Types of Coordinated Care Plans

30.2.1 - General Rule

(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

A coordinated care plan (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. Coordinated care plans may include 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. Coordinated care plans include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs) and religious fraternal benefits plans (RFBs), and other network plans. We provide more detail below on HMOs, PSOs, local and regional PPOs and special needs plans (SNPs) to distinguish how they differ from one another as CCPs.

30.2.2 - Health Maintenance Organization (HMO)

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

An HMO is a CCP as described above and is generally the most restrictive of the CCP models in controlling utilization (e.g., requiring referrals from a gatekeeper/PCP) and restricting 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 also offer a point of service (POS) benefit option. A point of service (POS) benefit is an HMO's agreement to provide enrollees with additional choices in obtaining specified health care services without complying with the plan's normal referral or prior authorization rules, but generally also requires that enrollees incur higher financial liability (cost sharing) for such POS services. Unlike an MA PPO, an MA organization offering an HMOPOS 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. A local MA HMO plan may not implement a POS benefit until it has been approved by CMS. The POS benefit option is further described in Chapter 4.

Cost Plans - Cost plan means 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. Medicare enrollees are not restricted to the HMO or CMP for receipt of covered Medicare services, i.e., 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. Beginning in 2006, Cost Plans will be permitted to offer Part D of Medicare but only as an optional supplemental benefit. In other words, a cost plan that elects to offer qualified prescription drug coverage may offer alternative coverage as an optional supplemental benefit only if the cost plan also offers basic prescription drug coverage. Thus, an enrollee in the cost plan may, at the individual's option, elect whether to receive qualified prescription drug coverage under the cost plan. If so, the enrollee has the option to elect whether to receive basic prescription drug coverage or if offered by the cost plan, enhanced alternative coverage.

There can be no new cost plans. Cost plans are permitted to expand service areas, as long as requests for such expansions are submitted on or before September 1, 2006, and all other requirements are met. Beginning in 2008, cost plans located in areas where there are two or more MA CCPs meeting minimum enrollment requirements will not *be* renewed by CMS. *This means affected cost plans would first receive non-renewal notices in 2008 and would not be able to offer the plan in 2009. We will use data from 2007 to determine whether a cost plan may be offered in 2009.* (See Chapters 3 and 4 respectively for topic-related discussions regarding cost plans.)

30.2.3 - Provider Sponsored Organization (PSO)

(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

A PSO is a public or private entity that is established or organized, and operated by a provider or group of affiliated providers. A PSO provides a substantial proportion (as defined in §422.352 of the MA regulation) of the health care services under the MA contract directly through the provider or affiliated group of providers. When the PSO is a group, it is composed of affiliated providers who share, directly or indirectly, substantial financial risk, as determined under §422.356 of the MA regulation, for the provision of services that are the obligation of the PSO under the MA contract; and have at least a majority financial interest in the PSO.

30.2.4 - Preferred Provider Organization (PPO)

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

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; and only for purposes of quality improvement requirements in §422.152(e) of the MA regulation is offered by an organization that is not licensed or organized under State law as an HMO.

Local PPOs - A local PPO is a PPO that is not a regional PPO. It is a PPO with a service area that is less than a region that may consist of a county, partial county, or multiple county service areas.

Regional PPOs (RPPOs) - The MMA introduced the Regional PPO option in an effort to expand the reach of Medicare managed care to Medicare beneficiaries, including those in rural areas. The RPPOs can only be offered in an MA Region which is defined as an area within the 50 States and the District of Columbia. Congress did not include Puerto Rico or the other U.S. territories in the areas in which organizations could offer Regional PPOs. CMS established 26 regions for MA PPOs (refer to *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/MAPDRegions.pdf* for information on regions).

The MMA states that RPPO plan service areas cannot be segmented and the benefit package must be uniform across the Region, as described in Chapter 4. An MA organization may offer an RPPO in multiple MA regions.

Although MA regional plans will have many similarities with local MA plans, the Congress provided for a number of unique financial incentives as well as licensing and access flexibilities designed to encourage and support the introduction of these types of plans. These incentives/flexibilities will assist plans as they enter this new line of business and learn the market dynamics of serving beneficiaries across larger geographic areas. Regional MA organizations that want to take advantage of these financial incentives will need to cover an entire MA region – which may include rural areas or areas that have not been served by Medicare managed care plans in the past.

In order to encourage the development of RPPOs, the MMA established a 2-year moratorium on the entry of local PPO plans into new service areas. The moratorium prevents the offering of any local PPO plan in a service area unless the MA organization was offering a local PPO plan in that service area as of December 31, 2005. An MA organization that has offered a local PPO plan in a given service area prior to 2006 can continue to do so and can also add other PPO plan options in that service area with CMS approval. The service area where local PPO plans are offered cannot be expanded in 2006 and 2007.

Regional MA 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 MA regional plans 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.

30.2.5 - Special Needs Plans (SNPs)

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

A*ny* type of coordinated care plan that meets CMS' requirements*, offers Part D, and receives approval as a special needs plan may offer a SNP. A SNP may* exclusively

enroll *a targeted population of* special needs individuals as defined above or *offer a SNP that* enrolls a *disproportionate percentage* of special needs individuals. *A* "disproportionate percentage" SNP *is one* that enrolls a greater proportion of the target group (dually eligible, institutionalized, or those with a specified chronic illness or disability) of special needs individuals than occur nationally in the Medicare population based on data acceptable to CMS. Further information on eligibility, enrollment and marketing of SNPs may be found in Chapters 2 and 3 of the 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) - "dual eligibles;" and other high-risk groups of chronically ill or disabled individuals who would benefit from enrollment in this type of plan. *An "*Institutionalized*" Individual is defined in the regulation 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, *i*ntermediate *c*are *f*acility for the *m*entally *r*etarded (ICF/MR) or inpatient psychiatric facility. 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.*

The CMS expanded the definition of institutionalized individuals to include those living in the community, but requiring an institutional level of care based on a state approved assessment tool.

The CMS did not set forth in regulation a detailed definition of severe and disabling chronic condition to allow plan flexibility in serving special needs populations with certain diagnoses or conditions. CMS will review and evaluate on a case-by-case basis proposals for specialized MA plans that serve severe or disabling chronic disease categories. Among the criteria considered will be the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against "sicker" members of the target population.

Please refer to the SNP portion of the Coordinated Care Plan application for instructions on how to request a SNP.

Special needs plans will have to prepare and submit a bid like other MA plans. In addition, SNPs will be paid the same as other MA plans, based on the plan's enrollment. There are no special payment features specific to special needs plans. However, a risk adjustment payment methodology is being phased in for all MA plans. Under risk adjustment, payments are more accurate because they reflect the health status of an organization's enrollees. Therefore, to the extent that a SNP enrolls less healthy beneficiaries, they will receive higher payments to account for higher risk health status. (For more information on MA payment, go to Chapter *7*.)

There are two other types of MA plans besides CCPs that are open to general Medicare enrollment. They are the MSA plans and the Private Fee-for-Service plans described below. We also provide information on religious fraternal benefit (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 a MSA or PFFS.

30.3 - Medical Savings Account (MSA) Plans

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

An MSA plan is combined with a contribution into the enrollee's MA MSA. The Balanced Budget Act of 1997 (BBA) authorized a demonstration project for Medical Savings Account (MSA) plans when it created the M+C program. The MMA made MSAs a permanent type of Medicare plan option and lifted several restrictions that had been in effect during the MSA demonstration: Elimination of the time limit on enrollment and the limit on the number of beneficiaries who could enroll; and extension of 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 now 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 fee-for-service Medicare had the individual not been enrolled in the MSA plan. Finally, MSA plans are exempt from certain quality improvement requirements.

An MA MSA plan is a plan that pays at least for the services described in §422.101 of the MA regulation, after the enrollee has incurred countable expenses (as specified in the plan) equal in amount to the annual deductible specified in §422.103(d); and meets all other applicable requirements. An MA MSA 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. (See Chapter *7* for more information on MSA payment.)

A Medicare Advantage MSA plan will combine a high-deductible insurance policy and a savings account for health care expenses. CMS will pay premiums for the insurance policies and make a contribution to beneficiaries' MSAs. CMS payment for an MSA plan enrollee, which is the sum of the plan premium (bid) and the deposit to the enrollee's MSA, will be similar to payments made for other types of MA plans that have bids equal to the benchmark. The only beneficiary premium will be a premium for supplemental benefits, if any, offered by the plan. Beneficiaries will use the money in their MSAs to pay for their health care before the high deductible is reached. Once the deductible is met, the MA organization offering the MSA plan will be responsible for payment of 100 percent of the expenses related to covered services. The maximum annual MSA deductible is set by law. For 2005, an MSA plan's deductible may not exceed $8,450.

30.4 - Private Fee-for-Service (PFFS) Plans
(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

An MA private fee-for-service plan is 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. A PFFS plan 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.

Enrollees in a PFFS plan are not limited to a provider network. Members of a PFFS plan can go to any doctor or hospital in the U.S. that is eligible to be paid by Medicare and is willing to accept the plan's terms of payment. However, if the PFFS has a network of providers, the enrollee's cost-sharing may be higher if s/he seeks care from non-network providers.

A PFFS is subject to all MA requirements, with certain exceptions, such as beneficiary protections and quality assurance, discussed in Chapters 4 and 5 respectively. In addition, in §30.7 below, a PFFS may choose to offer Part D prescription drugs or not.

30.5 - Religious Fraternal Benefit (RFB) Plans
(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

As defined above in §20 of this Chapter, RFBs are MA plans that are offered by an RFB society and may limit enrollment exclusively to members of a related religious fraternal benefit society. An RFB society also defined in §20 above of this Chapter, 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 or MSA or CCP.

30.6 - Multiple Plans
(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

Finally, under its contract, an MA organization may offer multiple plans as approved by CMS, regardless of type, provided that the MA organization is licensed or approved under State law to provide those types of plans, subject to the PPO moratorium discussed above.

30.7 - MA Requirement for Plans to Offer a Qualified Drug Plan Coverage
(Rev. 68, Issued: 09-02-05, Effective Date: 09-02-05)

Under §422.4 of the MA regulation, we included a rule for MA Plans' Part D coverage. Most MA plans are required to offer at least one plan with Part D coverage as follows:

Section 423.104(f)(3) of the Prescription Drug Regulation (FR 70 4194) prohibits an MA organization from offering an MA coordinated care plan in an area unless that plan or another plan offered by the MA organization in that same area includes required prescription drug coverage. This rule applies only to coordinated care plans.

We also require that all Special Needs Plans, which are a type of MA coordinated care plan, 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 Parts A and B of Title XVIII of the Social Security Act. The MA organizations offering private fee-for-service plans can choose to offer qualified Part D coverage meeting the requirements in §423.104 in that plan. (See Chapters 17 and 18 for rules related to cost plans offering Part D (§423.104(f)(4) and §417.440(b)(2)).

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.

“Required” prescription drug coverage means coverage of Part D drugs under an MA-PD plan that consists of either: (1) Basic prescription drug coverage; or (2) Enhanced alternative coverage, provided there is no MA monthly supplemental beneficiary premium due to the application of a credit against the premium of a rebate. The exception to 423.104(f)(3) is that SNPs must offer Part D, regardless of whether the SNP sponsor offers another coordinated care MA-PD plan in the same service area as the SNP.

40 - Cost-Sharing in Enrollment-Related Costs

(Rev. 81, Issued: 04-25-07, Effective: 04-25-07, Implementation: 04-25-07)

This section of Chapter 1 describes the procedures that CMS follows to determine the aggregate annual cost sharing in enrollment-related costs, also known as ``user fees'' to be contributed by MA organizations and PDP sponsors under Medicare Part D and to assess the required user fees for each MA plan offered by MA organizations and PDP sponsors. The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under §1851 of the Social Security Act.

The purpose of the user fee assessment is to charge and collect from each MA plan offered by an MA organization its pro rata share of fees for dissemination of enrollment information, for health insurance counseling and assistance programs, and to charge and collect from each PDP sponsor its pro rata share of fees for dissemination of enrollment information for the prescription drug benefit. *The MA plans and PDP sponsors are required to make these payments to CMS under 42 CFR 422.6 and 42 CFR 423.6, respectively.*

The CMS collects the fees over 9 consecutive months beginning with January of each fiscal year. The aggregate amount of fees for a fiscal year is the lesser of:

- The estimated costs to be incurred by CMS in that fiscal year to carry out the activities described in paragraph (b) of this section; or

- For fiscal year 2006 and each succeeding year, $200 million, the applicable portion (as defined below) of $200 million.

The applicable portion for an MA plan is, for a fiscal year, CMS's estimate of Medicare Part C and D expenditures for those MA organizations as a percentage of all expenditures under title XVIII and for PDP sponsors. The applicable portion is CMS's estimate of Medicare Part D prescription drug expenditures for PDP sponsors as a percentage of all expenditures under title XVIII.

The amount of the applicable portion of the user fee that each MA organization and PDP sponsor must pay is assessed as a percentage of the total Medicare payments to each organization. CMS determines the annual assessment percentage rate separately for MA organizations and for PDPs using the following formula:

- The assessment formula for MA organizations (including MA-PD plans) is C divided by A times B where:

    - A is the total estimated January payments to all MA organizations subject to the assessment;

    - B is the 9-month (January through September) assessment period; and

    - C is the total fiscal year MA organization user fee assessment amount determined by taking the lesser of the estimated costs to be incurred by CMS in that fiscal year to carry out the activities described above; or for fiscal year 2006 and each succeeding year, the applicable portion (as defined below) of $200 million.

- The assessment formula for PDPs is C divided by A times B where:

    - A is the total estimated January payments to all PDP sponsors subject to the assessment;

- B is the 9-month (January through September) assessment period; and

- C is the total fiscal year MA organization user fee assessment amount determined by taking the lesser of the estimated costs to be incurred by CMS in that fiscal year to carry out the activities described above; or for fiscal year 2006 and each succeeding year, the applicable portion (as defined below) of $200 million.

The CMS determines each MA organization's and PDP sponsor's pro rata share of the annual fee on the basis of the organization's calculated monthly payment amount during the 9 consecutive months beginning with January. CMS calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in CMS' payment system on the first day of the month.

The CMS deducts the organization's fee from the amount of Federal funds otherwise payable to the MA organization or PDP sponsor for that month. If assessments reach the amount authorized for the year before the end of September, CMS discontinues the assessment. If there are delays in determining the amount of the annual aggregate fees specified at §422.6 (d)(2) of the MA regulation, or the fee percentage rate specified in §422.6 (f)(2) of the MA regulation, CMS may adjust the assessment time period and the fee percentage amount.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R81MCM	04/25/2007	Updates to Chapter 1, “General Provisions”	04/25/2007	N/A