Medicare Managed Care Manual
Chapter 17 - Subchapter F
Benefits and Beneficiary Protections

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(Rev. 77, 10-28-05)

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10 - General Requirements

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

These guidelines reflect CMS's current interpretation of the provisions of the Cost Statute and Regulations (Chapter 42 of the Code of Federal Regulations, Parts 417) pertaining to benefits and beneficiary protections. These guidelines were developed after careful evaluation by CMS of current technology, coverage rules, and industry practices with respect to plan design, in light of recent changes to the Cost program enacted in the Medicare Modernization Act. The guidance set forth in this document may be subject to change as technology and industry practices in plan design and administration continue to evolve, and as CMS gains more experience administering the Cost program and its new health plan options.

(42 CFR 417.440) This §10, presents details and requirements related to the provision of benefits that are general in nature and not specific to any particular service. The following section, §20, presents details and requirements related to the provision of specific services.

10.1 - Medicare Covered Services

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(From §4.10.9 of the Medicare Managed Care Manual, Pub. 100-16) *Medicare cost plans*, (that is, HMOs or CMPs) must generally provide coverage of, by furnishing, arranging for, or making payment for, all *medically necessary and appropriate* services, *including supplies and DME*, that are covered by Part A and Part B of original Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if the enrollee is entitled only to benefits under Part B) that are **available** to beneficiaries residing in the plan's **geographic area.**

The services are considered **available** if either the sources of services are located in the *Medicare cost plan's* approved geographic area or it is common practice to refer patients to sources outside that geographic area (42 CFR 417.414(b)(2)).

(42 CFR 417.401) The term **geographic area** refers to the area found by CMS to be the area within which the *Medicare cost plan* furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Administration of the Medicare program is governed by *title XVIII* of the Social Security Act (the Act). Under the Medicare program, the scope of benefits available to eligible beneficiaries is prescribed by law and divided into several main parts. Part A is the hospital insurance program and Part B is the voluntary supplementary medical insurance program.

The scope of the benefits under Part A and Part B is defined in the Act. The scopes of Part A and Part B are discussed in *§1812* and *§1832* of the Act respectively, while *§1861* of the Act lays out the definition of medical and other health services. Each Medicare cost plan must offer at least all Part A benefits (other than hospice care) and all Part B benefits (or all Part B benefits to those entitled to only Part B) to all individuals residing in the area served by the plan in all benefit packages in its authorized geographic area. Some benefit categories are defined more broadly than others. Specific health care services must fit into one of these benefit categories, and not be otherwise excluded for coverage under the Medicare program.

The Act does not contain a comprehensive list of specific items or services eligible for Medicare coverage. Rather, it lists categories of items and services, and vests in the Secretary the authority to make determinations about which specific items and services within these categories can be covered under the Medicare program. That is, the Act allows Medicare to cover medical devices, surgical procedures and diagnostic services, but generally does not identify specific covered or excluded items or services. Further guidance is presented in the Code of Federal Regulations and CMS interpretations. Medicare payment is contingent upon a determination that:

- A service meets a benefit category;

- Is not specifically excluded from coverage; and

- The item or service is "reasonable and necessary."

Section *1862(a)(1)(A)* of the Act states that, subject to certain limited exceptions, no payment may be made for any expenses incurred for items or services that are not "reasonable and necessary" for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member. These authorities are exercised to make coverage determinations regarding whether a specific item or service meets one of the broadly defined benefit categories and can be covered under the Medicare program. National coverage decisions are published on the National Coverage Web site - for further information please see *§80* of this subchapter.

In the absence of a specific National Coverage Decision, coverage decisions are made at the discretion of local contractors. A Medicare cost plan is required to follow any local medical review policies (LMRP) issued by the fiscal intermediaries and carriers in its geographic area.

10.2 - Emergent and Urgent Care

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.401) Each Medicare enrollee is entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the *Medicare cost plan* if those services are:

- Emergency services or urgently needed services as defined below. The *Medicare cost plan* must pay for emergent and urgently needed services even from providers and suppliers outside the *Medicare cost plan* and even in the absence of the *Medicare cost plan*'s prior approval (42 CFR 417.414(c)); or

- Services denied by the Medicare cost plan and found upon appeal to be services the enrollee was entitled to have furnished by the *Medicare cost plan*.

Emergency Services means covered inpatient or outpatient services that are furnished by an appropriate source other than the *Medicare cost pla*n that:

- Are needed immediately because of an injury or sudden illness; or

- Are such that the time required to reach the *Medicare cost plan*'s providers or suppliers (or alternatives authorized by the *Medicare cost plan*) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as *(a)* transfer of the enrollee to the *Medicare cost plan*'s source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would

be unreasonable, given the distance and the nature of the ***medical*** condition; and *(b)* such services must be, or appear to be, needed immediately.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. For example, if the attending physician orders diagnostic pulmonary angiography as part of the evaluation for a member who is treated in an emergency room for chest pain, then a retrospective review, cannot decide that the angiography was unnecessary and refuse coverage.

The Medicare cost plan is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, the Medicare cost plan is not responsible for any costs, such as a biopsy, associated with treatment of skin lesions performed by the attending physician who is treating a fracture.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the Medicare cost plan.

Urgently Needed Services means covered services that are needed by an enrollee who is temporarily absent from the *Medicare cost plan*'s geographic area and that:

- Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and
- Cannot be delayed until the enrollee returns to the *Medicare cost plan*'s geographic area.

The Medicare cost plan need not pay for post-stabilization services offered outside of its network or not approved by the *Medicare cost plan* if:

- These services are not emergency;
- These services are not urgently needed; and
- These services are not offered by the *Medicare cost plan* as a basic or optional supplemental benefit.

However, medically necessary follow-up care to emergency and urgent care is covered, if the care cannot be delayed without adverse medical effects.

Routine out-of-area renal dialysis is covered only under original Medicare.

10.3 - Optional Supplemental Benefits

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

In addition to offering a basic benefit package (that is, Medicare-covered benefits), each *Medicare cost plan* may offer (for election by the enrollee and without regard to health status) optional supplemental services or benefits - that is, services or benefits that are in addition to those included in the basic benefits. All optional supplemental benefits must

be offered for a period of at least 30 consecutive days to both new plan enrollees and to all current enrollees of a plan at least once a year.

Although a Medicare cost plan may limit the availability of optional supplemental benefits to current enrollees as described above, enrollees may voluntarily drop or discontinue optional supplemental benefits any time during the contract year upon proper advance notice to the *Medicare cost plan*.

The *Medicare cost plan* may not set health status standards for those enrollees whom it will accept for these optional supplemental services.

States may mandate that non-Medicare benefits be offered to *Medicare cost plan* enrollees as optional supplemental benefits.

10.4 - Prescription Drug Coverage

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(70 FR 4243, Jan 28, 2005) A Medicare cost plan offering a cost plan may, but is not required to, offer prescription drug coverage. There are three methods of offering prescription drug coverage in a cost plan:

1) No Offering of a Part D Plan

The Medicare cost plan may elect not to offer qualified Part D coverage. In such a case the Medicare cost plan may offer non-qualified prescription drug coverage as an optional supplemental benefit. This non-qualified prescription drug coverage may be, but is not required to be, ***creditable,*** *as defined in 42 CFR 423.56. Enrollees of a cost plan not offering qualified Part D coverage may elect to concurrently enroll in a Prescription Drug Plan (PDP).*

2) Offering of Basic, Part D Coverage

An organization may elect to offer a Medicare cost plan that provides basic part D coverage. If the organization so elects, then this Part D coverage must be offered as an optional supplemental benefit; that is, an enrollee has the option, but not the obligation, to purchase Part D coverage under the plan. All enrollees who purchase the Part D coverage offered by the Medicare cost plan must receive coverage of Part A and Part B, [or Part B only (for beneficiaries who are not entitled to Part A)] benefits under that cost plan. If the enrollee elects not to elect the Part D coverage offered by the Medicare cost plan, then such an enrollee may concurrently enroll in a Prescription Drug Plan (PDP). A Medicare cost plan offering qualified Part D coverage, may not offer non-qualified prescription drug coverage. (See 42 CFR 423.104(f)(4).)

3) Offering of Both Basic and Enhanced Alternative Part D Coverage

The Medicare cost plan may elect to offer both basic and enhanced alternative Part D coverage as optional supplemental benefits. An enrollee may then elect to either: (a) Purchase the basic Part D coverage; (b) Purchase the enhanced alternative Part D coverage; or (c) To purchase neither. If the enrollee elects not to elect part D coverage through the cost plan, the enrollee retains his/her right to concurrently enroll in another Prescription Drug Plan (PDP). A Medicare cost plan offering qualified Part D coverage, may not offer non-qualified prescription drug coverage. (See 42 CFR 423.104(f)(4).)

If a Medicare cost plan offers qualified Part D coverage then the funding for the Part D coverage is separate from the CMS funding for Part A and/or B coverage (42 CFR 417.534(c)). Consequently, a Medicare cost plan may not apply reductions or non-collection of deductibles and coinsurance for Part A and/or B services to subsidize Part D coverage.

See §60 of this chapter for information on benefits in a Medicare cost employer group health plan.

10.5 - Waiting Periods and Exclusions Not Present In Original Medicare

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §20.6 of the Medicare Managed Care Manual) All beneficiaries must be provided all medically necessary benefits covered in the plan in which they enroll (including supplemental benefits) at the time of their initial enrollment. Waiting periods or exclusions from coverage, due to pre-existing conditions, are not permitted. However, a *Medicare cost plan* can deny coverage of Medicare-covered services when the services do not meet the standard of being medically necessary and appropriate. In addition, a *Medicare cost plan* may impose limitations or exclusions on Medicare-covered benefits to the extent that such limitations or exclusions are present in the original Medicare statute or regulations.

10.6 - Services, Supplies and DME

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Each Medicare enrollee is entitled to receive:

- Health care services;
- Supplies, and
- DME;

either:

- Directly from; or

- Through arrangements made by the Medicare cost plan.

10.7 - Cost-Sharing and Deductibles

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.452(a)(3)) The sum of the amounts the Medicare cost plan charges its Medicare enrollees for Medicare deductibles and coinsurance may not exceed, on the average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in the Medicare cost plan.

10.8 - Cap On Beneficiary Monetary Responsibility

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §10.4 of the Medicare Managed Care Manual): A Medicare cost plan enrollee should never pay more than the plan required cost sharing – coinsurance, deductibles and copays. This cap on beneficiary liability holds even:

- *If a provider or delegated provider declares insolvency resulting in a plan loss;*
- *If a non-contracted provider which provided services to the enrollee, for emergent or urgent care is entitled to balanced billing; and*
- *This cap on beneficiary liability prohibits a plan from requiring a beneficiary to first pay a contracted provider, except for copayments, and then receive reimbursement from the Medicare cost organization.*

10.9 - Electronic Deduction of Premium

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

- *A Medicare cost plan offering a Part D benefit must offer the option to enrollees of having their Part D premiums deducted electronically from their Social Security payment;*
- *The cost plan or CMP may also offer the option of electronically paying for premiums from sources other than their Social Security Payment, but may not charge or discount for this option.*
- *The cost plan or CMP is not required to offer enrollees the option of electronic payment of non-Part D premiums.*

10.10 - Services without Authorization

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

If a Cost plan enrollee receives services:

- *Under the direction or authorization of a plan physician;*
- *Correctly identifies himself or herself as a member of that plan to the contracted provider before receiving the items or services; and*
- *(The enrollee) has not been informed that he or she is liable for the costs of such services,*

then the plan must cover such services. This means that the plan does not have the right, after a service is received, to retroactively overturn a plan physician's decision that an item or service is medically reasonable and necessary. For example, a plan cannot retroactively deny a contracted physician's referral of a member for specialty care even when there are plan preauthorization requirements. In such a case the plan cannot penalize the member if a contracting provider fails to follow plan preauthorization rules.

An enrollee is considered informed that he or she is liable for the costs of a service if:

- *The enrollee should be expected to know the service is not covered by Medicare or under the plan, e.g., acupuncture; or*
- *The contracting provider explicitly advises the enrollee prior to the service or referral that the service is not or will not be covered.*

Although a plan may require the Medicare enrollee to receive prior authorization from a primary care physician or a gatekeeper before specialty care is received, if a plan physician provides or directs a beneficiary to receive a covered Medicare service without following the plan's internal procedures, then the plan must pay for the service. A beneficiary who has already received a service may not be penalized if the authorizing physician's referral was improper or the specialist delivered the service without the necessary authorization.

The enrollee should never pay more than the plan required cost sharing - coinsurance, deductibles and copays.

10.11 - Provider Enrollee Relationships

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The CMS encourages a personal relationship between providers and enrollees. As such, providers are frequently called upon to give advice and referrals. It is of the utmost importance that a provider who refers a patient to a provider of a non-covered service

ensures that the enrollee is aware of his or her obligation to pay for such non-covered services.

10.12 - Non-Contracting Physician Assistant

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

A service provided to a cost plan or CMP enrollee who properly requested this service from a contracted physician who employs a non-contracted physician assistant is classified as a plan provided service. Therefore the physician assistant cannot look to the member for direct reimbursement. The cost-plan member must be held-harmless from incurring costs that exceed the copay that is otherwise applicable to the service in question.

10.13 - Part B Services from a Non Plan Provider

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

When a Medicare Cost Plan is legally obligated to cover services provided by a non-plan provider, who provided plan-covered part B services to one of its enrollees, then the cost plan must indemnify the member from incurring liability greater than the cost sharing due under the plan. In such a case, the deductibles and co-insurance normally due under original Medicare must be reduced by the plan on behalf of the enrollee to the cost sharing amounts that otherwise apply in the Medicare Cost Plan for such services.

20 - Requirements of Specific Benefits

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

20.1 - General Guidelines for Benefits

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

All benefits that are part of the Medicare Cost Plan must satisfy the following guidelines:

- *All benefits must be directly health-related, that is, health care services or items whose primary purpose is to prevent or cure, actual or imminent, illness or injury for which the MA plan incurs a cost that is not solely administrative;*
- *All benefits must be offered uniformly to all enrollees;*
- *All benefits must be explicitly mentioned in the appropriate marketing vehicles*.

20.2 - Chiropractic Services

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Section 1861(r) of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation. (As a standard Medicare Part B benefit, manual manipulation of the spine to correct a subluxation must be made available to enrollees of cost plans.) The statute specifically references manual manipulation of the spine to correct a subluxation as a physician service. Thus, Medicare cost plan organizations offering cost plans must use physicians, which include chiropractors, to perform this service. They may not use non-physician physical therapists for manual manipulation of the spine to correct a subluxation. Medicare cost plans may continue to use physical therapists to treat enrollees for conditions not requiring physician services as defined in §1861 (r) of the Social Security Act.

20.3 - Drugs That Are Covered Under Original Medicare

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §20.9 of the Medicare Managed Care Manual) For this *subsection*, the term "drug" means "drug or biological." *As indicated in §10.1, a Medicare cost plan must provide its enrollees with coverage of all drugs covered under original Medicare Part B. Part B Medicare covers drugs in a limited number of cases including the following:*

- Drugs that the Medicare cost plan enrollee takes while using durable medical equipment (such as nebulizers) that were authorized by the enrollee's Medicare cost plan;
- Clotting factors if the enrollee is diagnosed with specific blood-clotting disorders;
- Immunosuppressive drugs, if the enrollee had an organ transplant that was covered by Medicare;
- Injectable osteoporosis drugs, if the enrollee has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug;
- Antigens;
- Certain oral anti-cancer drugs and anti-nausea drugs; and
- Erythropoietin by injection if the member has end-stage renal disease and needs this drug to treat anemia.

- *Not Usually Self-Administered (NUSA) Drugs. If a drug is defined as: (a) not usually self-administered (NUSA) by the carrier in the area covered by the Medicare cost plan, and (b) the drug is delivered incident to a physician service, then it is classified as a Medicare-covered drug under Part B. Some Medicare cost plans contract with specialty pharmacies to supply NUSA drugs to their providers, instead of having the provider purchase and bill the plan. If the drugs are furnished incident to a physician's service and they are covered in that setting by the carrier whose coverage decisions are followed by the Medicare cost plan, they are still classified as Part B drugs -- regardless of the payment arrangements.*

  A Medicare cost plan cannot make their own determinations of what is a Medicare-covered Part B drug; rather carriers make these determinations.

  A NUSA drug obtained by an enrollee at a pharmacy is not covered under Part B.

20.4 - Drug Benefit Caps

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §20.8 of the Medicare Managed Care Manual)

As outlined above in §10.4, under certain circumstances, a Medicare cost plan may offer coverage for outpatient prescription drugs that would not normally be covered under the original Medicare program. The CMS has approved non-Medicare prescription drug benefits that provide for annual, quarterly and monthly caps on the dollar amount of benefits available to enrolled members. A Medicare cost plan may also pro-rate an annual drug benefit that has an annual cap. Pro-rating of the annual cap is permitted according to the member's enrollment date, since this would be similar to, but more generous than, a quarterly or monthly cap. (42 CFR 417.104(a)(4)(ii)) The tracking of out of pocket maximums is the responsibility of the enrollee, not the plan. As indicated in §100 of this subchapter, the Medicare cost plan must clearly notify the beneficiary of this limitation.

20.5 - Prescription Drug Card

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Although transitional assistance funds may remain available in 2006, enrollment in the Drug Card program ends on December 31, 2005.

20.6 - Authorization and Cost-Sharing

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Medicare cost plans:

- Must permit in-network direct access to influenza vaccines;
- May not impose cost sharing for influenza vaccines; and
- Must permit in-network direct access to screening mammographies.
- Non-emergent non-urgent-care services that *Medicare cost plan* enrollees obtain from non-network providers, when not referred, are covered under original Medicare and subject to Medicare Fee-for-Service coinsurance and deductible requirements.

30 - Hospice

(Rev. 61, 09-03-04)

A Medicare cost plan is not reimbursed through the §1876 cost Program for the provision of Hospice care. Medicare-covered Hospice care may only be furnished by a Medicare Certified Hospice. An enrollee may elect hospice care if they are entitled to Part A Medicare benefits and if a physician certifies the enrollee as terminally ill.

(42 CFR 417.423(2)(b)) Individuals who have already made a hospice election may not enroll in a *Medicare cost plan*. However an individual who makes a hospice election while enrolled in a *Medicare cost plan* may remain with the *Medicare cost plan* during the hospice election.

(42 CFR 417.414(b)(3)) Each *Medicare cost plan* must inform their Medicare enrollees about the availability of hospice care if:

- A hospice participating in Medicare is located within the Medicare cost plan's geographic area; or
- It is common practice to refer patients to hospices outside the geographic area.

(42 CFR 417.440(c)) An individual enrolled in a *Medicare cost plan* who elects to receive hospice care waives the right to receive from the *Medicare cost plan* any Medicare services that:

- Are equivalent to hospice care; or
- Are related to the terminal condition for which the enrollee elected hospice care or to a related condition.

However, since the *Medicare cost plan* continues to receive interim payments during the period of hospice election, they must also continue to provide and pay for all non-hospice related care that the Medicare member seeks from the *Medicare cost plan* provided that:

- His or her attending physician is an employee or contractor of the *Medicare cost plan*;
- His or her attending physician is not an employee of the Hospice; and
- His or her attending physician does not receive compensation from the hospice for these activities.

In the event an enrollee elects hospice care the relevant start and termination dates of coverage are discussed in the subpart of this cost chapter dealing with enrollment.

40 - Financial Responsibility

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

40.1 - Financial Responsibility - General

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.414(c)) The *Medicare cost plan* assumes financial responsibility to provide reasonable reimbursement to its enrollees for:

- Emergency services; and
- Urgently needed services (as defined above);

even:

- From providers and suppliers outside the *Medicare cost plan*;

and even:

- In the absence of the *Medicare cost plan*'s prior approval.

The *Medicare cost plan* also assumes financial responsibility for:

- Services that were initially denied, but later granted, due to an appeal by the enrollee.

(42 CFR 417.452) A *Medicare cost* plan may impose:

- Deductibles;
- Coinsurance; or
- Copays;

for any of the services which it provides except for influenza vaccines for which no copays may be charged.

The *Medicare cost plan* may impose annual, semi-annual, quarterly, monthly or any other periodic limits on the Optional Supplemental Benefits it offers its enrollees provided these limits are not prohibited by State law.

The *Medicare cost plan* may not impose caps on any Medicare covered benefit unless original Medicare also imposes a cap (for example, the 100-day limit on SNF benefits).

The deductibles and coinsurances may be paid by or on behalf of the enrollee in the form of a:

- Premium;
- Membership fee;
- Charge per unit; or
- Other similar charge.

(42 CFR 417.454) The *Medicare cost plan* must agree to charge its Medicare enrollees only for the:

- Deductible and coinsurance amounts applicable to furnished Medicare covered services;
- Premium and cost-sharing charges for services offered as supplemental benefits provided that the sum of the amounts the *Medicare cost plan* charges its Medicare enrollees for these services does not exceed the actuarial value for those services (42 CFR 417.452(d)(3));
- Charges for services not covered under the plan; and
- Services for which Medicare is not the primary payer if payment for the services has been made to the enrollee (42 CFR 417.528(b)(2)).

40.2 - Refunds and Recoupment

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.456(b)) A *Medicare cost plan must* agree to refund all amounts **incorrectly collected** from its Medicare enrollees, or from others on behalf of the enrollees, and any **other amounts due** the enrollees or others on their behalf.

(42 CFR 417.456(a)) **Amounts incorrectly collected** means amounts collected that are in excess of those due to:

- Deductibles;
- Coinsurances;
- Non-covered Medicare services (which are not supplemental benefits);
- Services for which Medicare is not the primary payer; or
- Supplemental benefit premiums and copays**.**

Amounts incorrectly collected include amounts collected when the enrollee was believed not entitled to Medicare benefits, *and the services were furnished while the person was enrolled in the cost plan,* if the enrollee is later determined, upon appeal, to have been entitled to Medicare benefits and CMS is liable for these payments.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the Medicare cost plan if they were:

- Emergency services;
- Urgently needed services for which the *Medicare cost plan* has assumed financial responsibility; or
- On appeal, found to be services the enrollee was entitled to have furnished by the *Medicare cost plan*.

In general a *Medicare cost plan* may make payments to enrollees either in the form of lump sum payments, premium adjustment, or both.

40.3 - Refunds by Lump Sum Payments

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.456(c)) A *Medicare cost plan* must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

- Incorrectly collected amounts that were not collected as premiums;
- Other amounts due; and
- All amounts due, if the *Medicare cost plan* is going out of business.

40.4 - Refund by Premium Adjustment or Lump Sum Payment or Both

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

A Medicare cost plan may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for:

- Amounts that were incorrectly collected in the form of premiums; or
- For amounts that were incorrectly collected through a combination of premium payments and other charges.

If an enrollee has died or cannot be located after reasonable effort by the *Medicare cost plan, the Medicare cost plan* must make the refund in accordance with State law.

If the *Medicare cost plan* does not make refunds in accordance with the above payment methods by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, CMS reduces its payment to the *Medicare cost plan* by the amounts incorrectly collected or otherwise due, and arranges for those amounts to be paid to the Medicare enrollee.

40.5 - Recoupment

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.458) A *Medicare cost plan* agrees not to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period except in the following circumstances:

- The *Medicare cost plan* failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of:

- Underestimation of the actuarial value of the deductible and coinsurance amounts; or

- A billing error;

- The *Medicare cost plan* has identified the amounts and obtained advance CMS approval of the recoupment and the method and timing of recoupment;

- The *Medicare cost plan* collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

50 - Out-of-Area, Out-of-Network and Extended Absence

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Services obtained from non-network providers (when not referred) are covered under the Fee-For-Service program (and thus subject to Medicare Fee-For-Service coinsurance and deductible requirements), unless they are emergency or urgently needed services. For emergency or urgently needed services the *Medicare cost plan* is liable for reimbursement and the contracted member cost sharing applies. Emergency and urgently needed services are defined in §10.2 of this subpart.

As discussed in further detail in the enrollment section of this chapter *Medicare cost plans* must disenroll an individual if that individual has **permanently moved** from the *Medicare cost plan*'s geographic area. An uninterrupted absence of 90 days is deemed to be a **permanent move** and the individual must be disenrolled unless the *Medicare cost plan* offers an **extended absence option** (42 CFR 417.460).

A *Medicare cost plan* that chooses to offer an **extended absence option** may retain members who temporarily (more than 90 days but less than one year) leave the geographic area but remain in the United States either:

- By paying for all covered services for such members based on mutually agreeable restrictions; or

- By providing services through an affiliated organization (42 CFR 417.460(f)(2)).

(42 CFR 417.460(f)(2)(ii)-(iii)) A *Medicare cost plan* that chooses to exercise this exception must make the option available to all Medicare enrollees who are absent for an extended period from their geographic areas. However, a *Medicare cost plan* may limit this option to enrollees who go to a geographic area served by an affiliated Medicare cost plan.

When a *Medicare cost plan* offers an extended absence option it must provide all Part A and Part B services; however, *non-Part D supplemental benefits may be discontinued on leaving the geographic area as long as the member is not required to continue paying the premium or portion of a premium that corresponds to these services.*

60 - Cost Employer Group Health Plans (EGHP)

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR.440(b)) In general, since enrollment in a *Medicare cost plan* is at the organizational (not the plan) level, therefore, all enrollees of *Medicare cost plan* must receive the same basic package for the same cost-sharing or copayment amounts. However, employer groups can negotiate privately an EGHP on behalf of employer group members. An EGHP:

- May elect only some, but not all of the optional supplemental benefits offered by Medicare cost plan for its members;
- May "buy-down" premium and cost-sharing for its members; and
- May negotiate for benefits not covered by Medicare. Such privately negotiated non-Medicare benefits (with their associated premiums and copays) are deemed "outside" the CMS Medicare contract.

70 - Medicare Secondary Payer

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

70.1 - The Basic Rule

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The rules for Medicare Secondary payer are covered with computational detail in Chapter 17B of the Medicare Managed Care Manual. The following also apply to Medicare cost plans:

70.2 - Collection From GHPs and LGHPs

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

When a *Medicare Cost Plan* is the secondary payer to an employer group health plan, the coordination of benefits occurs in the aggregate through the cost report process. This process results in a copayment as part of the *Medicare cost plan* benefit package for which every enrollee is liable. Therefore, there is no coordination of benefits on a

beneficiary-specific basis that would relieve an enrollee with employer group health plan coverage of his or her cost sharing obligation under the *Medicare cost plan*. As a result, the enrollee remains liable for payment of the *Medicare cost plan*'s cost sharing regardless of whether Medicare is primary or secondary. However, under 42 CFR 417.454, which addresses beneficiary financial protection contained in the contract between the Medicare cost plan and CMS, the *Medicare cost plan* is responsible for relieving the beneficiary of responsibility for payment of health care costs other than cost sharing, and therefore, the *Medicare cost plan must* relieve the enrollee of his or her liability under the terms of the employer group health plan.

For example, if the employer group health plan (the primary payer) has a copayment of $20 and the *Medicare cost plan* has a copayment of $10 for the service the beneficiary received, the beneficiary cannot be liable to pay more than the plan copayment of $10. The *Medicare cost plan* must absolve the beneficiary of the liability for any amount in excess of the plan copayment of $10.

70.3 - MSP Rules and State Laws

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The following guidelines govern the imposition of taxes on payments related to Cost plans.

Payments by CMS, for the reasonable costs of cost plans, for covered Medicare Part A and B services, under an §1876 cost contract, do not technically represent a premium, but rather a reimbursement, under the Medicare program, for benefits to which Medicare enrollees are entitled. Therefore States cannot impose a premium tax on these payments.

Non-Part D Premiums charged to cost plan members for the actuarial value of fee-for-service deductibles and coinsurance are properly construed as premiums and would be correctly subject to State taxes.

For premiums related to the Part D offering of a cost plan, there is specific preemption and waiver of State taxes. See Chapter 17b of the Medicare Managed Care Manual, §410 - Taxes Assessed Against the Medicare cost plan. Also see the preamble to Subpart J, 70 FR January 28, 2005.

(70 FR 4666, Jan 28. 2005) Other than the specific preemption authority related to the Part D benefits offered by a cost plan, there is no specific preemption authority provided to cost plans. Therefore, to the extent State law does not invalidate or conflict with Federal law and regulation related to cost plans, States have the authority to require compliance with applicable State authority.

80 - National Coverage Determinations and Legislative Changes in Benefits

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

80.1 - Definitions

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §90 of the Medicare Managed Care Manual) A National Coverage determination (NCD) is a determination by CMS about whether or not a particular item or service is covered nationally under Medicare. A *Medicare cost plan* must comply with all NCDs.

A legislative change in benefits refers to new Medicare coverage of an item or service mandated by the Congress.

80.2 - General Rules

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Medicare coverage policies specify which benefits are provided under the Medicare program and under what circumstances (including the clinical criteria under which the item or service must be provided). Medicare coverage policies have several sources:

1. National coverage determinations made by CMS;

2. Other coverage guidelines and instructions issued by CMS (e.g., Program Memoranda and Program Transmittals);

3. Legislative changes in benefits; and

4. Local medical review policies established by Medicare contractors for local areas.

As indicated in §10.1 of this subpart *Medicare cost plans* must provide all Medicare-covered benefits. Consequently, *Medicare cost plans*, must furnish, arrange, or pay for all new NCDs and legislative changes as soon as they take effect. This is true independent of whether the NCD or legislative change meets a criterion for **significant cost**. A determination of **significant cost** has no relevance to the *Medicare cost plan* program. For these services or benefits, the Medicare enrollee will be responsible for *Medicare cost plan* cost sharing as approved by CMS. The costs incurred by the *Medicare cost plan* for furnishing of these benefits may be included on their annual cost report.

80.3 - Sources for Obtaining Information

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

In an effort to make the coverage process more open, understandable, and predictable, CMS has redesigned its Medicare coverage process. Part of the redesign includes using the Internet to inform interested parties about how national coverage determinations are made and the progress of each issue under coverage review.

- *The **Medicare Coverage Homepage***

  The Medicare Coverage Homepage, located at http://cms.hhs.gov/coverage/ has links that:

  - *Provide a listing of all **National Coverage Determinations; and***
  - *Enable you to **Search the Database.***

  Both pending and closed coverage determinations are listed. For each coverage topic CMS provides a staff name and e-mail link so interested parties can use the Internet to send questions and to provide feedback.

- ***The NCD Manual:***

  The **Medicare National Coverage Determinations Manual**, Pub. 100-3, is the primary record of Medicare national coverage policies, and includes a discussion of the circumstances under which items and services are covered. This manual may be accessed at http://cms.hhs.gov/manuals/103_cov_determ.

- ***Program Transmittals***

  Additional information on new coverage can be found in the **Program Transmittals** that transmit CMS' new policies and procedures. Links to the **Program Transmittals** may be found at http://cms.hhs.gov/manuals/transmittals.

90 - Discrimination Against Beneficiaries Prohibited

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

90.1 - General Prohibition

(Chapter 4, §100 of the Medicare Managed Care Manual) Except for not enrolling most individuals who have been medically determined to have end-stage renal disease, and except for not enrolling enrollees who have already elected hospice, a *Medicare cost plan* may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in Medicare cost plan on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental, as well as physical illness;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of domestic violence; and
- Disability.

An individual who develops end-stage renal disease while enrolled in a health plan offered by the Medicare cost plan organization, is eligible to elect a cost plan. For additional guidance on eligibility and enrollment see Chapter 17d of this manual, "Medicare Cost Plan Enrollment and Disenrollment Instructions."

90.2 - Additional Requirements

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

A *Medicare cost plan* is also required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act.

90.3 - A Medicare Cost Plan's Responsibility

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

A *Medicare cost plan* must ensure that they have procedures in place to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

100 - Disclosure Requirements

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.436) A *Medicare cost plan* must offer its plan to Medicare beneficiaries and provide to those interested in enrolling, adequate written descriptions of the Medicare cost plan's rules, procedures, benefits, fees and other charges, services, and other information necessary for beneficiaries to make an informed decision about enrollment. The *Medicare cost plan* must furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter. If a *Medicare cost plan* changes its rules, it must submit the changes to CMS in accordance with proper procedure and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

A *Medicare cost plan* must maintain written rules that deal with, but need not be limited to the following:

- All benefits provided under the contract;
- *To the extent the plan offers Part D as an MA-PD plan, the information at 42 CFR 423.128;*
- How and where to obtain services from or through the *Medicare cost plan*;
- The restrictions on coverage for services furnished from sources outside the *Medicare cost plan*, other than emergency services and urgently needed services;
- The obligation of the *Medicare cost plan* to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services;
- Any services other than the emergency or urgently needed services that the *Medicare cost plan* chooses to provide from sources outside the *Medicare cost plan*;
- The fact that the enrollee may receive services through any Medicare provider and supplier at Medicare cost-sharing levels;
- Premium information, including the amount (or if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable;
- Grievance and appeal procedures;
- Disenrollment rights;

- The obligation of an enrollee who is leaving the *Medicare cost plan*'s geographic area for more than 90 days to notify the *Medicare cost plan* of the move or extended absence and the *Medicare cost plan*'s policies concerning retention of enrollees who leave the geographic area for more than 90 days;

- The expiration date of the Medicare contract with CMS and notice that both CMS and the *Medicare cost plan* are authorized by law to terminate or refuse to renew the contract, and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in the *Medicare cost plan*;

- Advance directives (see §130 below); and

- Any other matters that CMS may prescribe.

For further information on disclosure see the subpart of this chapter that deals with Marketing materials.

110 - Confidentiality and Records

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

General Rule

For any medical records or other health and enrollment information it maintains with respect to enrollees, a *Medicare cost plan* must establish procedures to do the following:

- Abide by all Federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The *Medicare cost plan* must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify:

    - For what purposes the information will be used within the organization and

    - To whom and for what purposes it will disclose the information outside the organization;

- Ensure that medical information is released only in accordance with applicable Federal or state law, or pursuant to court orders or subpoenas;

- Maintain the records and information in an accurate and timely manner; and

- Ensure timely access by enrollees to the records and information that pertains to them.

120 - Availability, Accessibility, and Continuity

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

120.1 - The Basic Rule

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(42 CFR 417.416 supplemented with material from the Medicare Managed Care Manual)

The *Medicare cost plan* must ensure that the:

- Basic required services; and
- Any other optional supplemental services;

for which the Medicare enrollee has contracted are:

- Available;
- Accessible; and
- Furnished in a manner that ensures continuity.

120.2 - Certification

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations.

- Hospitals, SNFs, HHAs, CORFs, and providers of outpatient physical therapy or speech-language pathology services must meet the applicable conditions of participation in Medicare;
- Suppliers must meet the conditions for coverage or conditions for certification of their services;
- If more than one type of practitioner is qualified to furnish a particular service, the *Medicare cost plan* may select the type of practitioner to be used.

120.3 - Provider Adequacy

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The provider networks for Medicare enrollees must be sufficient to deliver both:

- Inpatient; and
- Outpatient services;

for both:

- Primary; and
- Specialty services;

to both:

- Current; and
- Expected Medicare members.

The obligation on the *Medicare cost plan* to provide services remains even if there is a loss of providers in a portion of the geographic area. *Medicare cost plans* must inform members, in writing, 30 days before a physician or supplier terminates affiliation.

120.4 - Availability

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Generally, a *Medicare cost plan* is obligated to provide all Medicare covered services, even if Medicare certified facilities are not available in the geographic area. For example, if Fee-For-Service beneficiaries commonly seek services in another town outside the geographic area then the *Medicare cost plan* must provide these services to its enrollees in a similar manner.

120.5 - Accessibility

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* must ensure that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollees with respect to:

- Geographic location;
- Hours of operation;

- Provision of after hours service; and
- Medically necessary emergency services must be available twenty-four hours a day, seven days a week.

A general rule of thumb is the 30-30 rule that asserts that services must be available either within 30 miles of an enrollee's residence or within 30 minutes travel time. Exceptions however may be made if usual travel patterns for Fee-For-Service beneficiaries in parts of the geographic area exceed these amounts (as happens for example, in rural areas).

The *Medicare cost plan* must have systems in place to collect data and evaluate the availability and accessibility of services provided or arranged for by the *Medicare cost plan*. Some typical factors that are evaluated are:

- Waiting times;
- Member complaints;
- Emergency and urgent care;
- Requests for changes of primary care physicians;
- Physician requests to close their practice to new patients;
- Referrals; and
- Back-up arrangements.

120.6 - Continuity of Care

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes:

- Linkages between primary and specialty care;
- Coordination among specialists;
- Appropriate combinations of prescribed medications;
- Coordinated use of ancillary services;
- Appropriate discharge planning; and

- Timely placement at different levels of care including hospital, skilled nursing and home health care.

(42 CFR 417.407(f), 42 CFR 417.122(b)) In the case of insolvency the HMO must continue to provide benefits to all enrollees for the duration of the contract period for which payment was made.

120.7 - Recordkeeping

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* must maintain a health (including medical) recordkeeping system through which pertinent information relating to the health care of its Medicare enrollees is accumulated and is readily available to appropriate professionals.

130 - Information on Advance Directives

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

(Chapter 4, §160 of the Medicare Managed Care Manual)

130.1 - Definition

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

130.2 - The Basic Rule

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The Medicare cost plan must:

- Maintain written policies and procedures that meet the requirements for advance directives that are set forth in this section; and

- Provide to its adult enrollees, at the time of initial enrollment, written information on their rights under the law of the state in which the *Medicare cost plan* furnishes services to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.

The *Medicare cost plan* is permitted to contract with other entities to furnish information concerning advance directive requirements. However, the organization remains legally responsible for ensuring that the requirements of this section are met. The details of what written information must be given to the enrollee as well as other obligations of the *Medicare cost plan* are outlined below.

130.3 - State Law Primary

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* program's advance directive requirements, which Fee-For-Service providers have been following for some years, are guidelines, which refer to state law, whether statutory or recognized by the courts of the State. Therefore, *Medicare cost plans* must comply with the advance directive requirements of the states in which they provide services. The CMS cannot give detailed guidelines as to what constitutes best efforts in each state. Medicare regulations give *Medicare cost plans* and states a great deal of flexibility, and CMS is prepared to work with the HMO and CMP (and the state, if needed) to ensure that advance directive requirements conform to Federal law.

Changes in State law must be reflected in the information HMOs and CMPs provide their enrollees as soon as possible, but no later than 90 days after the effective date of the state law or the date of the court order.

130.4 - Content of Enrollee Information and Other Medicare cost plan Obligations

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The written information provided to enrollees must, at a minimum, include a description of the *Medicare cost plan*'s written policies on advance directives including an explanation of the following:

- That the organization cannot refuse care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

- The right to file a complaint about an organization's noncompliance with advance directive requirements, and where to file the complaint;

- That the plan must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

- That the *Medicare cost plan* is required to comply with State law;

- That the *Medicare cost plan* must educate its staff about its policies and procedures for advance directives; and

- That the *Medicare cost plan* must provide for community education regarding advance directives.

If the *Medicare cost plan* cannot implement an advance directive as a matter of conscience, it must issue a clear and precise written statement of this limitation. The statement must include information that:

- Explains the differences between institution-wide objections based on conscience and those that may be raised by individual physicians;

- Identifies the state legal authority permitting such objection; and

- Describes the range of medical conditions or procedures affected by the conscience objection.

130.5 - Incapacitated Enrollees

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information due to an incapacitating condition, the *Medicare cost plan* may give advance directive information to the enrollee's family or surrogate.

The *Medicare cost plan* is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

130.6 - Community Education Requirements

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* must provide for community education regarding advance directives either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the *Medicare cost plan*, for separate parts of the community. Although the same written materials are not required for all settings, the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives. A *Medicare cost plan* must be able to document its community education efforts.

130.7 - Medicare Cost Organization Rights

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

The *Medicare cost plan* is not required to provide care that conflicts with an advance directive. The *Medicare cost plan* is not required to implement an advance directive if, as a matter of conscience, the *Medicare cost plan* cannot implement an advance directive and state law allows any health care provider or any agent of the provider to conscientiously object.

130.8 - Appeal and Anti-Discrimination Rights

(Rev. 77, Issued: 10-28-05, Effective Date: 10-28-05)

A *Medicare cost plan* may not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Furthermore, the *Medicare cost plan* must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Agency.