DATE: April 17, 2013

TO: All Medicare Advantage Organizations and 1876 Cost Plans

FROM: Danielle Moon, J.D., M.P.A., Director

SUBJECT: Contract Year 2014 Medicare Advantage Bid Review and Operations Guidance

This memorandum provides the following information for Medicare Advantage Organizations (MAOs), and, where specified, 1876 Cost Plans, as they prepare contract year (CY) 2014 bids for CMS review: information about several specific changes to regulation and the Plan Benefit Package (PBP) software for CY 2014; clarification of existing supplemental benefit policies; and detailed operational guidance to support plans’ bid development. Guidance related to Medicare Medicaid Plans (MMPs) can be found on the Medicare-Medicaid Coordination Office (MMCO) webpage http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html.

Please note that this guidance references the April 1, 2013 CY 2014 Final Call Letter (specifically Section II, Part C), and the PBP bid submission module in the Health Plan Management System (HPMS). Chapter 4 of the Medicare Managed Care Manual (MMCM) will be updated to reflect the changes to benefit policy made in the final Call Letter. Therefore, we recommend that MAOs and other Medicare health plans review these resources as well as this memorandum when developing their bids for CY 2014.

Bid Review

Organizations need to consider the CY 2014 Final Call Letter as well as this HPMS memo and Chapter 4 for the necessary guidance on service category cost sharing standards, which bid review criteria apply to specific plan types, and maximum out-of-pocket (MOOP) cost thresholds for CY 2014.
Plan Types and Applicable Bid Review Criteria

<table>
<thead>
<tr>
<th>Bid Review Criteria</th>
<th>Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)</th>
<th>Applies to Non-Employer Dual Eligible SNPs</th>
<th>Applies to 1876 Cost Plans</th>
<th>Applies to Employer Plans</th>
<th>Described in Call Letter or this HPMS Memo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Difference</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Both</td>
</tr>
<tr>
<td>Total Beneficiary Cost</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Both</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (MOOP) Limits</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Both</td>
</tr>
<tr>
<td>PMPM Actuarial Equivalent Cost Sharing</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Call Letter</td>
</tr>
<tr>
<td>Service Category Cost Sharing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes¹</td>
<td>Yes</td>
<td>Call Letter</td>
</tr>
<tr>
<td>Optional Supplemental Benefit Value</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Both</td>
</tr>
</tbody>
</table>

¹ Section 3202 of the ACA established that MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 CFR §§417.454(e) and 422.100(j)).

**Meaningful Difference (Duplicative Plan Offerings)**

MAOs offering more than one plan in a given service area must ensure that beneficiaries can easily identify the differences between plans of the same type to determine which plan provides the highest value at the lowest cost to address their needs. For CY 2014, CMS will use plan-specific per member per month (PMPM) out-of-pocket cost (OOPC) estimates to identify meaningful differences among the same plan types.

OOPC estimates are based on a nationally representative cohort of more than 10,000 Medicare beneficiaries represented in the 2008 and 2009 Medicare Current Beneficiary Survey data and are used to provide estimated plan cost information to beneficiaries on Medicare Plan Finder. Estimated out-of-pocket costs for each plan benefit package are calculated on the basis of utilization patterns for the MCBS cohort. The calculation includes Parts A, B, and D services and certain mandatory supplemental benefits, but not optional supplemental benefits. The plan’s current enrollment and risk scores will not affect the OOPC calculation. The CY 2014 OOPC model incorporates updated PBP and formulary data, as well as more precise brand and generic drug cost sharing estimates for gap coverage, which utilize Food and Drug Administration data. All documentation and instructions associated with running the OOPC model are posted on the CMS website at:

[http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html)

CMS will evaluate meaningful differences among CY 2014 non-employer and non-cost contractor plans offered by the same MAO, in the same county, as follows:

1. The MAO’s non-SNP plan offerings will be separated into five plan types on a county basis: (1) HMO; (2) HMO POS; (3) Local PPO; (4) Regional PPO; and (5) PFFS.
2. SNP plan offerings will be separated into groups representing the specific target populations served by the SNP. Chronic Care SNPs will be separated by the chronic disease served and Institutional SNPs will be separated into the following three categories: Institutional (Facility); Institutional Equivalent (Living in the Community); and a combination of Institutional (Facility) and Institutional Equivalent (Living in the Community). D-SNPs are excluded from the meaningful difference evaluation.

3. Plans within each plan type will be divided into MA-only and MA-PD sub-groups for evaluation. That is, the presence or absence of a Part D benefit is considered a meaningful difference.

4. The combined Part C and Part D OOPC PMPM estimate will be calculated for each plan. There must be a difference of at least $20.00 PMPM between the combined OOPC for each plan offered by the same MAO in the same county to be considered meaningfully different for 2014. Plan premium is not included in the meaningful difference evaluation.

Please note that using different providers or serving different populations are not considered meaningfully different characteristics between two plans of the same type.

CMS expects MAOs to submit CY 2014 plan bids that meet the meaningful difference requirements, but will not prescribe how the MAOs should redesign benefit packages to achieve the differences. Furthermore, CMS may choose not to allow MAOs to revise their bid submissions if a plan’s initial bid does not comply with meaningful difference requirements because MAOs have access to the necessary tools to calculate OOPC estimates for each plan prior to bid submission. CMS will not approve plan bids that do not meet these requirements. MAOs must follow the CY 2014 renewal/non-renewal guidance in the final Call Letter to determine whether and how their plans may be consolidated with other plans.

Note: CMS will utilize the CY 2014 bid season to obtain data from plans offering a POS benefit to establish a POS requirement for next year to be considered meaningfully different.

**Total Beneficiary Cost (TBC)**

CMS will again exercise its authority under section 1854(a)(5)(C)(ii) of the Affordable Care Act to deny MA organization bids, on a case-by-case basis, if it determines that the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next through the use of the TBC requirement. For CY 2014, the TBC requirement is no greater than $34.00 PMPM. A plan’s TBC is the sum of plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost-sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By limiting excessive increases in the TBC from one year to the next, CMS is able to ensure that beneficiaries who continue enrollment in the same plan are not exposed to significant cost increases. Note: To the extent that CMS increases the amount of the maximum Part B premium buy-down in the Bid Pricing Tool (BPT), we will provide a Part B premium adjustment.
for the difference between the maximum Part B premium buy-down for CY 2013 ($99.90) and the new amount ($104.90) for CY 2014.

For CY 2014, CMS is evaluating TBC for non-employer plans (excluding D-SNPs) and will calculate and provide factors for each plan that adjust for payment rate, quality bonus changes, coding intensity and other technical changes in the PBP software. Thus, plans experiencing a net increase in rebates resulting from changes to benchmarks/star ratings/coding intensity will have an effective TBC change amount below the $34.00 PMPM requirement. Conversely, plans experiencing a net decrease in rebates resulting from changes to benchmarks/star ratings/coding intensity will have an effective TBC change amount above the $34.00 PMPM requirement.

Based on this analysis, CMS will not deny a bid solely on the grounds that TBC has increased by too much from CY 2013 to CY 2014 if the increase is equal to or less than the plan-specific TBC amount. CMS reserves the right to further examine and request additional changes to a plan bid even if a plan’s TBC is within the required amount, if we find it is in the best interest of the MA program. We believe this approach not only protects beneficiaries from significant increases in cost sharing or decreases in benefits, but also ensures beneficiaries have access to viable and sustainable MA plan offerings. Otherwise, these plans will be treated as any other plan for the purpose of enforcing the TBC requirement.

The following describes how the TBC evaluation will be conducted for plans that consolidate or segment from one year to the next:

- **Consolidating Multiple Plans into One Plan:** The enrollment-weighted average of the CY 2013 plans will be compared to the CY 2014 plan.
- **Segmenting an Existing Plan:** Each CY 2014 segmented plan will be compared independently to the CY 2013 non-segmented plan.
- **Consolidating Previously Segmented Plans:** The enrollment-weighted average of the existing CY 2013 segmented plans will be compared to the non-segmented CY 2014 plan.

The plan-specific data that CMS will post on HPMS in mid-April is shown in the following table. Note: Item I is determined based on the current star ratings. Should there be any changes due to the appeals process, plan sponsors will be notified of their corresponding revised TBC adjustment factors.
Plan-Specific TBC Calculation

<table>
<thead>
<tr>
<th>Steps</th>
<th>Item</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2013 TBC</td>
<td>A</td>
<td>OOPC value</td>
<td>Each of these plan-specific values will be provided by CMS through an HPMS posting</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Premium (net of rebates)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Total TBC</td>
<td></td>
</tr>
</tbody>
</table>

| CY 2014 TBC            | D         | OOPC value            | Calculated using OOPC Model Tools                                           |
|                        | E         | Premium (net of rebates) | Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14               |
|                        | F         | Total TBC             | Calculation: D plus E                                                      |

| Apply TBC Adjustments  | G         | Unadjusted TBC change | Calculation: F minus C                                                   |
|                        | H         | Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2013 ($99.90) and the new amount for CY 2014 ($104.90) | Value is $5.00 for all plans                                               |

| I                       | Impact of benchmark/bonus payment/ coding intensity change | Plan-specific value will be provided by CMS through an HPMS posting |
| J                       | Impact of changes in OOPC Model between CY 2013 and CY 2014 | Plan-specific value will be provided by CMS through an HPMS posting |

| K                       | Adjusted TBC change | Calculation: G – H + I – J |

| Evaluation              | L         | Apply CMS requirements | Plan is likely to be accepted, if K is ≤ $34.00 PMPM                       |

As described in the exhibit above, CMS will provide, through HPMS, CY 2014 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of Part B premium (full premium or partial as a result of a Part B premium buy-down). Based on the CMS release of SAS software files in early April, MAOs will be able to calculate their plan-specific CY 2014 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2014 (Item E). Premium (net of rebates) can be found in the Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14.

The *Unadjusted TBC Change* between CY 2013 and CY 2014 (Item G) is the difference between CY 2013 Total TBC (Item C) and CY 2014 Total TBC (Item F), i.e., \( G = F - C \). The *Adjusted TBC Change amount* (Item K) reflects the Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2013 ($99.90) and the new amount for CY 2014 (Item H), Impact of Benchmark/Bonus Payment/ Coding Intensity Changes (Item I), as well as the Impact of Changes in the OOPC Model between CY 2013 and CY 2014 (Item J). It should be noted, however, that these elements impact TBC in different directions, i.e., \( K = G - H + I - J \).
The Adjusted TBC Change amount (Item K) will be compared to the $34.00 PMPM TBC change amount threshold. Those plan bids with Adjusted TBC Change amounts higher than the $34.00 PMPM threshold will be further scrutinized and may be denied. Plan bids with Adjusted TBC Change amounts that are equal to or less than the $34.00 PMPM threshold are likely to be accepted. However, as stated above, CMS reserves the right to further examine and request additional changes to a plan bid, even if the Adjusted TBC change (Item K) is within the threshold, if we find it is in the best interest of the MA program.

Illustrative Calculation for Item I: Impact of Benchmark/Bonus Payment/Coding Intensity Change Adjustment Factor

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table demonstrates how the payment adjustment is calculated. The Payment Adjustment is the 2014 Rebate minus the 2013 Rebate. The 2013 Bid and Benchmark are taken from the 2013 BPT. For purposes of this calculation the CY 2013 bid amount is assumed to grow by the same MA growth percentage as used in the CY 2014 ratebook development. The 2014 Benchmark is the weighted average of county-specific payment rates using the 2014 ratebook and projected enrollment from the 2013 BPT. The change in MA coding intensity is taken into consideration in calculating the 2014 Benchmark. The Rebate percentage (Rebate %) depends on the plan’s Quality Bonus Payment (QBP) rating for the year. The Rebate is calculated as the Benchmark minus the Bid (if the Bid is less than the Benchmark this difference is multiplied by the Rebate %). The Plan 001 example shows the calculation for a plan where the bid is greater than the benchmark. The Plan 002 example shows the calculation for a plan where the bid is less than the benchmark.

<table>
<thead>
<tr>
<th>Bid ID</th>
<th>2013 Values</th>
<th>2014 Values</th>
<th>Payment Adj.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bid Amt.</td>
<td>Benchmark</td>
<td>Rebate</td>
</tr>
<tr>
<td>Plan 001</td>
<td>$1,000</td>
<td>$950</td>
<td>58.3%</td>
</tr>
<tr>
<td>Plan 002</td>
<td>$1,000</td>
<td>$1,050</td>
<td>58.3%</td>
</tr>
</tbody>
</table>

We encourage organizations to participate in User Group Calls conducted by the Office of the Actuary in April and May that will provide them with the opportunity to obtain responses to their technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

CMS strives to ensure that MAOs develop more transparent plan benefit designs so that beneficiaries are better able to predict their out-of-pocket costs and are protected from excessively high or unexpected cost sharing. As codified at 42 CFR §422.100(f)(4) and (5), all local MA plans, (employer and non-employer), including HMOs, HMOPOS, Local PPO (LPPO) plans, Regional PPO (RPPO) plans, SNPs (including D-SNPs), and PFFS plans must establish an annual MOOP limit on total enrollee cost sharing liability for Parts A and B services, the dollar amount of which will be set annually by CMS. In addition, LPPO and RPPO (as codified at 42 CFR §422.101(d)(3)) plans, are required to have a combined limit inclusive of both in- and out-of-network cost sharing for all Parts A and B services, the dollar amount of which also will be set annually by CMS.
For CY 2014, we continue to encourage organizations to establish lower voluntary MOOP thresholds. Therefore, MAOs that adopt voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits.

Plans are responsible for tracking enrolled beneficiaries’ out-of-pocket spending and to alert them and plan providers when the spending limit is reached. D-SNPs also must track enrollee cost sharing but should include only those amounts the enrollee is responsible for paying net of any State responsibility or exemption from cost sharing.

The following chart identifies where MOOP amounts should be placed in the PBP for CY 2014 for all Parts A and B services.

**CY 2014 PBP Options for MOOP Amount by Plan Type**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Required MOOP Amounts</th>
<th>Plan also may choose to enter in the PBP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>In-network</td>
<td>“In-network” is only option available in the PBP</td>
</tr>
<tr>
<td>HMO with Optional Supp. POS</td>
<td>In-network</td>
<td>“In-network” is only option available in the PBP</td>
</tr>
<tr>
<td>HMO with Mandatory Supp. POS</td>
<td>In-network</td>
<td>“No” or enter amounts for “Combined” and/or “Out-of-Network” as applicable</td>
</tr>
<tr>
<td>Local PPO</td>
<td>In-network and Combined</td>
<td>“No” or enter an amount for “Out-of-Network” as applicable</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>In-network and Combined</td>
<td>“No” or enter an amount for “Out-of-Network” as applicable</td>
</tr>
<tr>
<td>PFFS (full network)</td>
<td>Combined</td>
<td>“No” or enter amounts for “In-Network” and/or “Out-of-Network” as applicable</td>
</tr>
<tr>
<td>PFFS (partial network)</td>
<td>Combined</td>
<td>“No” or enter amounts for “In-Network” and/or “Out-of-Network” as applicable</td>
</tr>
<tr>
<td>PFFS (non-network)</td>
<td>General</td>
<td>“General” is the only option available in the PBP</td>
</tr>
</tbody>
</table>

**Optional Supplemental Cost Sharing**

CMS will review non-employer bid submissions to ensure that beneficiaries electing optional supplemental benefits are receiving reasonable value. MAOs must ensure that the total value of all optional supplemental benefits offered in non-employer plans under each contract comply with the following requirements: (a) margin is no greater than 15% and (b) retention, defined as margin plus administrative expenses, is no greater than 30%.
Discriminatory Pattern Analysis

During review of CY 2014 plan bid submissions, CMS will ensure that MA plans conform to the cost sharing requirements. In addition, CMS will analyze bids to ensure that discriminatory benefit designs are identified and corrected. This could include bids that meet standards but have cost sharing amounts that are distributed in a manner that may discriminate against sicker, higher-cost patients. This analysis may also evaluate the impact of benefit design on patient health status and/or certain disease states. CMS will contact plans to discuss and correct any issues that are identified as a result of these analyses.

CY 2014 Plan Benefit Package (PBP) Changes

CMS has revised PBP sections in an effort to simplify data entry, address areas that caused confusion in the past, and better reflect MA plans’ and 1876 cost contractors’ offerings.

Updated Service Category Descriptions

We have updated the Medicare benefit and service category descriptions within the PBP software. CMS strongly encourages MAOs to review these descriptions as they complete their bids in order to ensure their understanding of the specific benefits they propose to offer to beneficiaries is consistent with CMS definitions and guidance. Please note that if the descriptor completely describes the benefit, there is no need to enter anything in the notes field.

Emergency Care/Worldwide Coverage (B4c)

The supplemental benefit, Worldwide Coverage, has been moved from B4a: Emergency Care, into the new section B4c: Worldwide Coverage. MAOs should ensure that all screens within Emergency Care are completed correctly due to this change in the PBP software.

Outpatient Diagnostic Procedures and Tests and Lab Services (B8a), Outpatient Diagnostic and Therapeutic Radiological Services (B8b), and Outpatient Hospital Services (B9a) Cost Sharing Overlap

There are many services an enrollee may receive in the outpatient department of a hospital, and CMS understands there may be some cost sharing overlap between service categories B8a/b and B9a. The cost sharing amounts entered in B8a/b must fall within the cost share maximum entered at B9a.

Ambulance/Transportation Services (B10a)

B10a: Ambulance Services only applies to a one-way trip, which has been clarified within the PBP service category description.

The supplemental benefit “Medical Transport” has been added to B10b: Transportation Services. MAOs are allowed to offer medically necessary transportation as a supplemental benefit. A plan may provide transportation to locations where its enrollees can access their health benefits. The
plan must arrange transportation exclusively to these places. Transportation should not consist of items or services that can be used for other non-medical transportation (such as a free train or bus pass).

**Acupuncture and Other Alternative Therapies (B13a)**

The name of B13a: Acupuncture has been changed to B13a: Acupuncture and Other Alternative Therapies. See Chapter 4 of the Medicare Managed Care Manual (MMCM) for further details.

**OTC Items and Services (B13b)**

The name of B13b: OTC has been changed to B13b: OTC Items and Services. This section should include drugs and other items as described in Chapter 4.

**Dual Eligible SNPs with Highly Integrated Services (B13g)**

The name of B13g: Highly Integrated D-SNP has been changed to B13g: Dual SNPs with Highly Integrated Services. As defined in the Final Call Letter for CY 2014, certain SNPs can qualify for benefit flexibility.

**Preventive and Other Defined Supplemental Services (B14)**

The name of B-14: Preventive Services has been changed to B-14: Preventive and Other Defined Supplemental Services.

The name of B14c: Supplemental Education/Wellness Programs has been changed to B14c: Supplemental Education/Health Management Programs. The supplemental benefit “Nutrition Education” has been renamed “Nutritional Benefit” in B14c.

The following supplemental benefit options have been added to B14c: Supplemental Education/Health Management Programs:

- Enhanced Disease Management,
- Telemonitoring, and
- Web/Telephone-Based Technology.

MAOs must be sure that these benefits are entered at B14c if offered for CY 2014 rather than in the “other” section of the PBP as was required last year.

**RPPO and LPPO**

**Deductibles**

CMS would like to take this opportunity to clarify the RPPO and LPPO deductible guidance. MAOs have the following two options related to a plan deductible for their RPPO and LPPO plans:

1. Charge no deductible for their plan; OR
2. Charge a single plan deductible. If a plan deductible is to be charged, the plan has the following options related to application of the deductible. The deductible:
   a. **Must** include all out-of-network A&B services;
      i. Exception: May exclude the $0 cost share preventive services from the deductible for out-of-network services;
   b. **Must** exclude $0 cost share preventive services from the deductible for in-network;
      i. Exception: May include any other in-network A&B services and mandatory supplemental benefits;
   c. May limit the enrollee’s financial exposure to the single deductible within selected in-network service categories.

If the plan varies the deductible charges by service category, the amount of the differential deductibles at each of the given service categories may not be greater than the plan level deductible, but the sum of the differential amounts may be greater than the plan level deductible.

In the PBP; Section C, RPPOs and LPPOs must follow the deductible rules below:
- If an RPPO or LPPO plan chooses Medicare-defined cost sharing for 1a: Inpatient Hospital – Acute or 1b: Inpatient Psychiatric, then it cannot choose Part B Deductible within Section D.
- If an OON group includes any A&B services, that OON group may not have a separate OON deductible.

**Maximum Plan Benefit Coverage**

Additionally, an edit rule has been added to the PBP for RPPO and LPPO plans that requires that, if a maximum plan benefit coverage amount is entered in an in-Network service category, the same Out-of-Network maximum plan benefit coverage amount must also be entered for that specific service category.

**CY 2014 Supplemental Benefits**

CMS’ interests are in ensuring all beneficiaries receive high quality, effective health care services, and we would like to take this opportunity to reiterate those goals and encourage plans to offer supplemental benefits to enrollees that are of value and based on sound medical practice. CMS is clarifying its existing guidance regarding certain supplemental benefits that have generated questions in the past.

**Counseling Services (B13d, e, f)**

Medicare Part B covers individual and group therapy services to diagnose and treat a mental illness. The Part B coverage usually requires a physician referral for mental health care and is based on a mental health diagnosis.

Counseling services not covered by Original Medicare may be eligible as a supplemental benefit offered to all beneficiaries. The services must be provided by practitioners who are state-
licensed or state-certified to furnish the services, are practicing in the state in which they are licensed or certified, and are furnishing services within the scope of practice defined by their licensing or certifying state. These services are not intended to diagnose and treat a mental illness. These supplemental benefits may address general topics, such as: coping with life changes; conflict resolution; or grief counseling and be offered as individual or group sessions for enrolled beneficiaries.

MA plans offering counseling services as a supplemental benefit may have family members present during the counseling session, however, they may not participate in the session as beneficiaries of the counseling.

**In-Home Safety Assessments (B13d, e, f)**

In CY 2013, there was some confusion as to whether bathroom safety devices as part of the In-Home Safety Assessment described in the MMCM, Chapter 4 should be entered in PBP-B13b (OTC) or PBP 13d,e,f (Other). For CY 2014, CMS would like to clarify that, if a plan chooses to offer the In-Home Safety Assessment, then the benefit should be designated in the PBP-B13d, e, or f (Other) service category. Bathroom safety devices should be placed in the PBP-B13b (OTC) service category when bathroom safety devices are offered as its own supplemental benefit and not part of the In-Home Safety Assessment benefit.

**Medical Nutrition Therapy (MNT) (B13d, e, f)**

Medicare covers MNT for specific stages of kidney disease and diabetes. However, any MNT services offered by the plan that are in addition to those covered by Original Medicare would be considered supplemental. MNT offered as a supplemental benefit should be entered in PBP-B13d, e, or f (Other) and not confused with the nutritional benefit in PBP-B14c.

**Annual Physical Exam (B14b)**

CMS revised section B14b of the PBP by renaming the section “Annual Physical Exam.” This field is to be used by plans that choose to offer as a supplemental benefit, an exam that complements and in no way duplicates activities or services that are already covered by the plan as required Part A and B services, such as the Annual Wellness Visit or the “Welcome to Medicare” exam. Plans must enter any cost sharing and a full description of the proposed physical exam supplemental benefit in the notes field for this PBP item for CMS to review. Plans should note that they may not offer more than one annual exam.

**Nutritional Benefit Limits (B14c)**

If plans impose visit or time limits on a supplemental nutritional benefit, the plan must specify such a limit in PBP-B14c notes. If the notes do not specify a limit, the benefit is assumed to be unlimited.

**Examples of Ineligible Supplemental Benefits**

We are clarifying that the following services may not be offered as supplemental benefits:
• **Loaner DME items when the beneficiary’s rented or owned DME is being repaired**: Plans may not offer as a supplemental benefit loaner DME. Loaner DME is a required Medicare Part B service. MAOs are required to “provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Medicare Part A and B” (see 422.101(a)). Therefore, if a beneficiary’s Medicare-covered DME item needs to be repaired or replaced, the MAO is responsible for maintaining continuity of care for its enrolled beneficiary by ensuring uninterrupted access to the medically necessary covered DME item. The MAO must purchase or rent a replacement item for the beneficiary to use.

• **Electronic medical records and electronic data storage devices**: Plans may not offer electronic health records, electronic data storage devices, or practice management systems (e.g., appointment making, prescription refills) as supplemental benefits, because these activities are not “health benefits.”

• **Pap Smear/Pelvic Exam**: Plans will be required to adhere to the Medicare Part B benefits schedule, and will not be allowed to offer the $0 cost sharing preventive services, screening Pap smears and screening pelvic exams annually as supplemental benefits. Our interests are in ensuring that beneficiaries receive high quality, effective health care services from their MA plans, and we are concerned that not adhering to the schedule for screening services adopted by original Medicare is inconsistent with that goal. That schedule calls for covered $0 cost sharing screening Pap smears and screening pelvic exams once every 24 months for women not at high risk for developing cervical or vaginal cancer. For beneficiaries who are at high risk of developing cervical or vaginal cancer or are of childbearing age with an abnormal Pap smear within the previous 3 years, the screenings are covered annually. As for all Medicare Part B benefits, plans must cover all medically necessary pap smears and pelvic exams.

• **Rewards and Incentives**: Rewards and incentives are not eligible supplemental benefits and CMS does not expect to see rewards or incentives in CY 2014 PBPs. Rewards and incentives are marketing tools and information related to how they may be offered is provided in the CMS Marketing Guidelines (Chapter 3 of the MMCM).

**Other Benefit Policy Issues**

**Medicare-Covered Zero Cost Sharing Preventive Services ($0 CSPS)**

In addition to a number of preventive services for which cost sharing may be charged, there are many preventive services that must be offered, without charge, to all Medicare beneficiaries. Examples of preventive services that are covered by Medicare but for which the beneficiary may be charged cost sharing, are annual glaucoma screening tests for beneficiaries who are at high risk of developing glaucoma and digital rectal exams to screen for prostate cancer.

The list of $0 CSPS may change periodically. Beginning last year (CY 2013), CMS revised the related attestation statement in the PBP and no longer lists $0 CSPS. The attestation statement does not refer to a discrete list of services in the PBP, but rather to all preventive services that
must be covered by all MAOs and 1876 cost contractors without cost sharing. The attestation states: “I attest that there is no coinsurance, copayment, or deductible for all preventive services that are offered at zero dollar cost sharing under Original Medicare.”

Although we do not here offer a comprehensive list of preventive services that will have to be provided without cost sharing for CY 2014, below is the most current listing of those services.

- Abdominal Aortic Aneurysm Screening;
- Annual Wellness Visit, Including Personalized Prevention Plan Services;
- Bone Mass Measurements;
- Cardiovascular Screening;
- Colorectal Rectal Cancer Screenings;
- Diabetes Screening;
- Hepatitis B Vaccine and Administration;
- HIV Screening;
- Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam);
- Intensive Behavioral Therapy for Cardiovascular Disease;
- Intensive Behavioral Therapy for Obesity;
- Mammography Screening;
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease);
- Pap Smear/Pelvic Exam Screening;
- Pneumococcal Vaccine and Administration;
- Prostate Cancer Screening (PSA);
- Seasonal Influenza Virus Vaccine and Administration;
- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse;
- Screening for Depression in Adults;
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs; and
- Smoking and Tobacco-Use Cessation Counseling Services.

**Important Note:** MAOs can refer to the link below for the most updated list of the Medicare-covered preventive services:


**Reading/Interpreting Test Results**

The reading and interpretation of test results is considered to be one service; therefore there should be one cost share amount. CMS will not allow plans to unbundle the reading or interpretation of test results from the total cost of the service.

**Observation Costs**

A plan may not charge a separate cost share for observation services. Observation services are among the many services that a patient may receive in the outpatient department of a hospital.
and as such, the cost sharing for observation services is included in the cost sharing for hospital outpatient services entered at 9a.

**Part B Premium Buy-down**

Under the Medicare regulations and statute, MAOs that have rebate dollars available may allocate those dollars to the provision of supplemental benefits, prescription drug coverage payment or payment toward the Part B premium (see 42 CFR §422.266(b) and 1854(a)(1)(B) of the Act). We encourage MAOs with rebate dollars to prioritize elimination or reduction of the plan premium. We believe this use of rebate dollars facilitates transparency for beneficiaries in choosing MA plans.

**Cost Sharing for MA Plans Serving Dual – Eligibles (D-SNPs)**

CMS expects MA organizations to communicate Medicare Advantage and State Medicaid benefits to Dual Eligible SNP beneficiaries in a comprehensive and transparent manner. For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. Specifically, a D-SNP may not include any Medicaid benefits in the PBP. For example, if a plan contains a preventive dental benefit for which it receives revenue from the State Medicaid agency to provide, that benefit must not be included in the PBP.

MA organizations are required to attest in the PBP that the additional supplemental benefit(s) that the SNP describes do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, and, if appropriate, Part D Medicare services through the local jurisdiction in which they reside. This segregation of Medicare only benefits in the PBP is necessary so that CMS can appropriately account for the Medicare benefit package and costs to the Medicare program. Please note: D-SNPs must furnish their enrollees with a description of the Medicaid benefits and cost sharing that are available to them in marketing materials (see 42 CFR §422.111(b)(2)(iii)).

In addition, benefits separately purchased by an employer or union which wrap around the Medicare benefit package, also cannot be included in the PBP.

**Tiered Cost Sharing for Medical Benefits**

CMS is aware that some MA plans offer plan benefit structures that incorporate limited tiered cost sharing consistent with CMS guidance (e.g., Chapter 4 of the MMCM). Because CMS is committed both to protecting beneficiaries from discriminatory cost sharing and allowing MAOs to exercise maximum flexibility within the bounds of our beneficiary protections, for CY 2014, MAOs that choose to charge tiered cost sharing for medical benefits must notify their CMS account manager and submit a request document (provided through the CMS account manager) by April 26, 2013 of their intention to offer plans that include tiered cost sharing (e.g., for the inpatient hospital service category). MAOs will be required to provide a detailed description of proposed tiered cost sharing, including identification and descriptions of the hospitals in the plans’ networks and the tiered cost sharing to be charged for each entity. As part of the request
document, MAOs intending to tier a particular benefit within a plan must explicitly address the following in order for CMS to determine whether the proposed approach is acceptable:

- Demonstrate that enrollees will have equal access to all of the specified tiers for services offered by the MA plan and that the tiers are transparent to prospective and actively enrolled beneficiaries and plan providers. A basic principal of plan design is that prospective and current enrollees are able to anticipate what their costs will be in a given MA plan. The MAO offering a tiered MA plan must be able to describe its tiering structure in the bid so that a reasonable person can readily comprehend it.
- Explanation of how tiering the cost of benefits affects plan enrollees. For example, is the plan introducing tiers to encourage enrollees to seek care from providers with demonstrated quality advantages?

**PBP and the Model of Care (MOC)**

Please note that your PBP should be consistent with, and support your MOC. Any services referenced in the MOC must be reflected in the PBP for the plan. The PBP, not the MOC, is the tool to be utilized for providing information about plan benefits and services.

**Plan Corrections for CY 2014**

CMS expects that requests for MA, cost plan and PDP corrections for CY 2014 will be minimal. As required by 42 CFR §§422.254, 423.265(c)(3) and 423.505(k)(4), submission of the final actuarial certification and the bid attestation serves as documentation that the final bid submission has been verified and is complete and accurate at the time of submission. A request for a plan correction indicates the presence of inaccuracies and/or the incompleteness of a bid and calls into question an organization’s ability to submit correct bids and the validity of the final actuarial certification and bid attestation.

After bids are approved, CMS will not reopen the submission gates to correct errors identified by the plan until the plan correction window in September. The plan correction window will be open from mid-September to October 1, 2013. Only changes to the PBP that are supported by the BPT are allowed during the plan corrections period.

CMS has determined that, given the limited timeframe for review of the corrected PBP in relation to the initial posting of plan data in Medicare Plan Finder (MPF), the affected plans will be suppressed in MPF for the initial release until the bid is corrected and approved, and the MPF is updated for the second release in early November. Please be advised that an organization requesting a plan correction will receive a corrective action warning letter. An organization that received a warning letter for CY 2013 may receive a corrective action plan if it requests a plan correction for CY 2014.

**MA Benefit Mailbox**

The MA benefit mailbox includes links to a variety of reference materials, frequently asked questions (FAQs) and answers to questions submitted during CY 2014 bid preparation. CMS
strongly encourages MAOs to review the available resources before submitting a question to ensure we have not already provided information on a specific topic.

MAOs can submit questions regarding policy, cost sharing, and supplemental benefits to this mailbox. CMS will review benefit questions and will provide appropriate responses. We appreciate your cooperation with regard to these important issues.

Please direct MA benefit questions to CMS at: https://MABenefitsMailbox.lmi.org/.

Other questions may be directed to the appropriate mailbox identified below:

- Technical HPMS questions (e.g. PBP download, plan creation, bid, upload), please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov
- Technical questions about the Out-of-Pocket Cost (OOPC) model, please submit an email to OOPC@cms.hhs.gov
- Part D policy questions about meaningful difference, please submit an email to partDbenefits@cms.hhs.gov
- Bid Pricing tool (BPT) questions, please submit an email to actuarial-bids@cms.hhs.gov