Frequently Asked Questions

NOTE: The questions in this document cover the following subjects: General Topics, Supplemental Benefits, Plan Benefit Package (PBP) Data Entry/Cost Sharing and Preferred Provider Organizations.

General Topics

1. **Q. How are plans to manage the frequency of preventive services for enrollees that change plans and the new plan has no knowledge of when the enrollee received preventive services previously?**

   A. In order to furnish services to new plan enrollees on a schedule that is consistent with the Original Medicare requirements, the plan must use available resources to determine what services the enrollee is eligible to receive. CMS expects plans to make reasonable efforts to obtain information about a plan enrollee's eligibility for Medicare-covered preventive screening services. The enrollee's previous providers may be able to provide some information. However, we understand obtaining that information may not always be possible and therefore, do not require that the plan verify the enrollee's eligibility in order to provide the services to him/her.

2. **Q. Is the plan-specific premium or Part B premium included in the Maximum Out-of-Pocket (MOOP) calculation?**

   A. No. All MA plans must establish limits on enrollee out-of-pocket spending that do not exceed the annual maximum out-of-pocket limits established by CMS. Although the MOOP requirement is for Parts A and B services, an MAO can include supplemental benefits as services subject to the MOOP. The MOOP calculation includes enrollee cost sharing (e.g., copayments, coinsurance and deductibles), but does not include either the Part B premium or plan-specific premium.

3. **Q. Can a MAO offer a MA-only plan without also offering an MA-PD plan in the service area?**

   A. If a MA legal entity is offering a MA-only (i.e., no Part D coverage) coordinated care plan, it must offer at least one MA-PD plan in each county for the legal entity's service area. As stated in Chapter 4, §10.15 of the Medicare Managed Care Manual and as provided at 42 C.F.R. §422.4(c), an MAO cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MAO in that same service area includes qualified Part D prescription drug coverage meeting the

requirements of §423.104. A Special Needs Plan (SNP) or Employer Group Waiver Plan (EGWP) offered by the same legal entity in the same service area does not satisfy this requirement for non-SNPs.

Supplemental Benefits

1. **Q. Can MA plans define supplemental benefit limits for greater than one year (e.g., eye glasses or hearing aids)?**

   A. CMS encourages plans to design benefit packages based on one contract year to minimize potential beneficiary confusion. However, plans may offer multi-year supplemental benefits in accordance with the Medicare Managed Care Manual, Chapter 4, Section 30.1. For example, it is permissible for an MA plan to cover one new pair of eyeglasses every two years.

2. **Q. Can MA-only plans (i.e., no Part D coverage) cover home infusion drugs under the Part B benefit with a coinsurance?**

   A. No, only MA-PD plans may offer a bundled home infusion mandatory supplemental drug benefit.

3. **Q. In which service category of the PBP should "Telehealth services" be entered?**

   A. Telehealth is a Medicare-covered Part B service and is not listed separately in the Plan Benefit Package (PBP). Plans providing a supplemental benefit that includes services and/or geographic areas not covered by the Original Medicare Telehealth benefit, should enter this benefit in 14c as a remote access technology and specify limitations in the notes field (e.g., benefit expands the services and/or geographic areas covered by Original Medicare Telehealth benefit). Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline) is a supplemental benefit that can be entered in 14c of the PBP and is described in the Medicare Managed Care Manual, Chapter 4, Section 30.3, Examples of Eligible Supplemental Benefits.

4. **Q. What does the term "Maximum plan benefit coverage amount" mean and how is it applied?**

   A. Maximum plan benefit coverage amount is the maximum dollar limit per period that a plan will cover towards a supplemental benefit service(s). Stated differently, the maximum plan benefit coverage amount is the plan contribution; it does not include any enrollee cost sharing. A maximum plan benefit coverage limit is not applicable for Medicare Parts A and B services.

5. **Q. My question relates to Dental Office Visits (16a/16b). PBP service category 16a includes dental office visits for cleanings, x-rays, fluoride treatments and oral exams.**

How should the PBP reflect other services provided during an office visit (e.g., space maintainers, mouth guards). Where are Medicare-covered dental services captured in the PBP?

A. Organizations should enter the cost sharing for Medicare-covered comprehensive dental in service category 16b and nowhere else in the PBP to avoid duplication of entries. If there is a range of cost sharing for non-Medicare-covered dental office visits(16a), please provide the minimum/maximum cost sharing and briefly describe covered services and related cost sharing (i.e., dental codes should not be included in the notes field). Additional information can be provided in the ANOC/EOC.

6. **Q. How should optional supplemental benefits for dental be entered into the PBP?**

   A. PBP Section B-16 must be completed and data entry fields allow the plan to offer the benefits as either mandatory or optional supplemental. PBP Section D also includes a screen that must be completed for optional supplemental benefits.

7. **Q. We would like to offer an optional supplemental package which includes preventive dental, eyeglasses, hearing aids and/or fitness benefits. We know that enrollees who choose an optional supplemental benefit are not obligated to keep this benefit for the entire benefit year and can request disenrollment from that benefit with a 30 day notice. Can a plan prorate benefit coverage based on the number of months that the enrollee pays a premium? For example, an annual eyeglass benefit has a maximum of $240 or $20 per month for enrollees in the optional supplemental benefit package. Based on this approach, the enrollee would receive benefit coverage for $120 if s/he paid six months of premium.**

   A. MAOs that intend to offer optional supplemental benefits during open enrollment must offer the benefits for the first 30 days. The plan may then choose to offer the optional supplemental benefits for the rest of the year or not. The plan must establish its policy based on when the enrollee can purchase the optional supplemental benefits. CMS does not allow, in the example provided, the proration of benefit coverage. The benefits must be offered and available; however, the MAO can establish limits to the supplemental package.

PBP Data Entry/Cost Sharing

1. **Q. How should we address inpatient mental health benefits in the PBP? The benefit descriptions for PBP Section B service category 1a includes coverage for mental health care and B-1b describes both psychiatric care received in a psychiatric unit of a general acute hospital, as well as acute care received in a free standing psychiatric hospital.**

   A. Cost sharing for acute mental health services delivered on a psychiatric unit of a general inpatient acute hospital should be reflected in 1a, as the benefit description for

inpatient acute services received in a general hospital also includes mental health care. Acute mental health services delivered in a free-standing Medicare certified psychiatric facility should be reflected in 1b.

2. **Q. Can a plan limit the Inpatient Substance Abuse benefit to an Inpatient Psychiatric Hospital?**

   A. No, an MA plan cannot limit access to a Medicare Part A benefit. Please review the Medicare Managed Care Manual, Chapter 4 Section 10.5 Federal Requirements Related to Uniform Benefits and Non-Discrimination, 10.5.2 Anti-Discrimination and 10.5.3 Review for Discrimination and Steering, which states that a plan cannot inhibit access to services.

3. **Q. We have some PBP categories that require prior authorization (PA) after reaching a certain number of visits. What would an acceptable note be in this situation?**

   A. For plans requiring a prior authorization after a certain number of visits for some categories, the following would satisfy our requirements: "PA required after a certain number of visits for selected services. Enrollees will be instructed to contact Plan for details in marketing materials."

4. **Q. Please verify that the minimum/maximum fields are to be used to show tiered cost sharing for medical benefits, along with an appropriate note describing tiers for the service category.**

   A. That is correct. Plans tiering medical benefits complete PBP Section A-6 and specific screens for tiering inpatient and skilled nursing facility services in the PBP. For other services, the minimum/maximum fields in the PBP are to be used to show tiered cost sharing of medical benefits, along with an appropriate note describing the tiers for the service category. All plans (not just plans tiering medical benefits) can use minimum/maximum fields to indicate a range of cost sharing within a service category along with appropriate note descriptions.

5. **Q. What is the difference between the preventive services reference in 14a compared to 14e?**

   *A. Preventive services are entered in **two** service categories of the PBP:*

   <u>B-14a Medicare-covered Zero Dollar Preventive Services</u>: Preventive services in this service category are subject to §422.100(k), which requires MA plans to provide coverage of certain preventive services in-network at zero cost share in accordance with Original Medicare. MAOs are responsible for staying up-to-date on which Medicare-covered zero dollar preventive services must be offered.

B-14e Other Medicare-covered Preventive Services: Preventive services for which Original Medicare charges cost sharing are to be placed in this service category even if the plan chooses not to apply cost sharing. For example, "prostate cancer screening - digital rectal exam" should be included in this service category. MAOs are responsible for staying up-to-date on other Medicare-covered preventive services for which cost sharing may apply.

6. **Q. Can CMS clarify the question in 8b: "If a member receives multiple services at the same location on the same day, does only the maximum copay apply?" For example, does this refer to multiple services of the same type (such as a CT of head and chest) or services that fall into each category (such as CT and PET)?**

   A. This refers to the services that fall into each category, not multiple services of the same type.

Preferred Provider Organizations (PPO)

1. **Q. Can PPO plans have an exceptions process for their benefits by using prior authorization?**

   A. As indicated in the Medicare Managed Care Manual, Chapter 4, Section 110.4, PPO plans must provide reimbursement for all plan-covered medically necessary services received from non-contracted providers without prior authorization requirements. However, both enrollees and providers can request a prior written advance determination of coverage from the plan prior to receiving/providing services.

2. **Q. Does a PPO satisfy the requirement to provide a supplemental benefit both in-network and out-of-network when the service is nationally available to their enrollees?**

   A. A service that is nationally available to all enrollees does satisfy the PPO requirement of offering the supplemental benefit in-network and out-of-network.

3. **Q. What supplemental benefits do not require an out-of-network benefit for PPOs? For example, some supplemental benefits such as remote access technologies, telemonitoring services, safety devices such as shower safety bars, and health education would not be possible to operationally administer on an out-of-network basis.**

   A. As codified at 42 CFR §422.4(a)(1)(v)(B), PPOs are required to provide reimbursement for all covered services both in-network and out-of-network. An enrollee

may receive out-of-network services either because s/he chooses to receive them from an out-of-network provider or because s/he is traveling outside of the service area and has either the need or desire for a covered service. Although the plan may charge different cost sharing for services received out-of-network, all appropriate services must be available to the plan's enrollees. The plan must make reasonable accommodations for enrollees to obtain such services.

Given the flexibility afforded to MA organizations in defining supplemental benefits, it is difficult to definitively state exceptions and/or accommodations for each type of benefit or service. As a result, we are willing to respond to specific plan questions or proposals. In general, a remote access technology, nursing hotline or telemonitoring services could be made available through use of a toll-free number or reimbursement could be provided for use of an out of-network fitness facility if the enrollee has an in-network fitness facility membership benefit. There is no expectation; however, that shower safety bars that a plan may offer for the enrollee's home would also be available as an out-of-network benefit.

CY 2019 Implementation Questions (October 2018)

1. **Q. For CY 2019, can plans provide tablets as part of the in-home equipment and telecommunication technology to monitor enrollees with specific health conditions (e.g., hypertension or heart failure)?**

   A. *Yes. Plans may provide tablets as part of the telemonitoring services supplemental benefit as long as the benefit is offered in accordance with Chapter 4 of the MMCM and is configured with only primarily health related applications.*