Last Updated: April 2020

Frequently Asked Questions
Medicare Advantage Benefits Mailbox

SUBJECTS: Plan Benefit Package, Supplemental Benefits, and Plan-Specific Requirements.

Plan Benefit Package (PBP)

All PBP Categories

1. **Q. Should Medicare Advantage (MA) plans enter data for minimum/maximum cost sharing fields that define tiered cost sharing for medical benefits, along with an appropriate note describing tiers for the service category?**
   A. 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 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.

2. **Q. What would be an acceptable note for PBP categories that require prior authorization (PA) after a certain number of visits?**
   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."

3. **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 organization 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 the Part B premium or plan-specific premium.

Section 1a-b: Inpatient Hospital

4. **Q. Can a plan place a limit on the Inpatient Substance Abuse benefit in an Inpatient Psychiatric Hospital?**
   A. No, a plan cannot limit access to a Medicare Part A benefit. Please review the Medicare Managed Care Manual (MMCM), 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.

5. **Q. How should inpatient mental health benefits be addressed 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.

Section 8: Outpatient Diagnostic Procedures, Tests, Labs, and Radiology

6. **Q. Please 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.

Section 13: Acupuncture

7. **Q. Now that Medicare covers Acupuncture for chronic low back pain, how can a plan still offer acupuncture as a supplemental benefit?**
   A. Medicare covers acupuncture for chronic low back pain for a specified number of visits when reasonable and necessary for treatment of chronic low back pain. Medicare Advantage plans must provide the Medicare-covered acupuncture benefit specified in National Coverage Determination (NCD) 30.3.3,1 beginning Jan 29, 2020 (the date of the NCD decision memo) as a basic benefit (i.e., non-supplemental benefit). MA organizations must comply with NCDs in furnishing and covering basic benefits under § 422.101. The Medicare-covered benefit requires that providers meet the educational requirements specified in the NCD. Cost sharing for Medicare-covered acupuncture should be included in the appropriate service category within B7 Healthcare Professional Services, under whichever sub-category the provider meets the educational requirements that is offering the service (i.e., 7g if offered by Other Healthcare Professional). If the MA plan currently offers acupuncture as a supplemental benefit (in PBP B-13a) for CY 2020, the supplemental portion of the benefit would only include services not specified in the NCD. This means that if the MA plan permits acupuncture for conditions other than lower back pain or permits enrollees to go to an acupuncture practitioner with fewer restrictions than specified in the NCD, the plan would continue

[1] The manual is expected to be updated in the near future to address the NCD.

to treat those services (that would not be covered by Medicare) as a supplemental benefit.

Section 14: Preventive and Other Defined Services

8. 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:

B-14a Medicare-covered Zero Dollar Preventive Services: 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 sharing in accordance with Original Medicare. Organizations 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. Organizations are responsible for staying up-to-date on other Medicare-covered preventive services for which cost sharing may apply.

9. Q. How can organizations manage the frequency of preventive services for enrollees that change plans and the new organization 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 organization must use available resources to determine what services the enrollee is eligible to receive. CMS expects organizations 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 organization verify the enrollee's eligibility in order to provide the services to him/her.

Section 16: Dental

10. Q. 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 must enter the cost sharing for Medicare-covered comprehensive dental in PBP Section B-16b 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.

Supplemental Benefits

General Guidance

1. **Q. Are all MA plan types (e.g., MA-only, MA-PD, I-SNP, D-SNP, and C-SNP) permitted to offer special supplemental benefits to chronically ill enrollees, known as SSBCI?**
   A. All MA plan types except MSAs are able to offer SSBCI, as long as the enrollees meet the criteria according to Section 1852(a)(3)(D)(ii). See CY 2020 Final Call Letter, issued April 1, 2019, pages 188-191 and HPMS Memo titled: "Implementing Supplemental Benefits for Chronically Ill Enrollees," issued April 24, 2019. Section 1876 cost plans are not permitted to offer these services.

2. **Q. Can MA plans define supplemental benefit limits for greater than one year (e.g., eye glasses or hearing aids)?**
   A. CMS encourages MA organizations to design benefit packages for one contract year to minimize potential beneficiary confusion. However, plans may offer multi-year supplemental benefits in accordance with the MMCM, Chapter 4, Section 30.1. For example, it is permissible for an MA plan to cover one new pair of eyeglasses every two years.

3. **Q. Can MA 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.

Maximum Plan Benefit Coverage Amount

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. If a CY 2021 MA plan wants to offer the same maximum plan benefit coverage amount for multiple supplemental benefits, how would it be entered in the Plan Benefit Package?**
   A. Plans have the flexibility to establish a maximum plan benefit coverage amount for each supplemental benefit or a combined amount that includes multiple supplemental benefits. Plans will enter these combined benefits in Section D. The screens will allow the plan to offer groups of supplemental benefits together with a single maximum plan benefit amount. Plans may also indicate if the enrollee must pick one or more benefits from a list of supplemental benefits by responding to the following question: "Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?" If the plan offers combined benefits in these screens, the plan must first offer them in Section B. Each benefit may only be offered in one combined supplemental benefit package. Due to this capability, plans will use the plan maximum in section D for the combined benefit and should not enter the plan maximum in each applicable PBP service category in section B. Plans offering packages of combined supplemental benefits should not duplicate the data entry from the Combined Benefits screens to the Max Plan Benefit Coverage screens in section D.

Optional Supplemental Benefits

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. Enrollees who choose an optional supplemental benefit (e.g., dental and hearing aids) 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. MA organizations 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 uniformly to all enrollees; however, the organization can establish limits to the supplemental package.

Plan-Specific Requirements

MA-Only

1. **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.

2. **Q. Can an organization offer a MA-only plan without also offering an MA-PD plan in the service area?**
   A. Pursuant to § 422.4(c), an MA organization cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MA organization in that same service area includes qualified Part D prescription drug coverage meeting the requirements of § 423.104. That is, each MA organization (defined as the legal entity that signs the MA contract for the CMS evaluation) must ensure that if it is offering a MA-only coordinated care plan (i.e., no Part D coverage), it also offers at least one MA-PD plan in each county covered by the MA organization's service area(s). Additional information is also provided in Chapter 4, section 10.15 of the MMCM. A SNP or EGWP plan offered by the same organization in the same service area does not satisfy this requirement for non-SNPs. The legal entity must complete the attestation for all MA-only plans.

Preferred Provider Organizations (PPO)

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.

4. **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.

5. **Q. Can PPO plans have an exceptions process for their benefits by using prior authorization?**
   A. As indicated in the MMCM, 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.