# Operational Policy Letter #56

## Department of Health and Human Services

## Health Care Financing Administration

## Center for Health Plans and Providers

## Medicare Managed Care

**October 2, 1997**

---

**ADMINISTRATION OF FLU VACCINES**

**Background:**

On May 1,1993 flu shots became a covered benefit for Medicare beneficiaries. This coverage requirement applied also to services provided to Medicare beneficiaries who are members of Medicare-contracting HMOs and CMPs (managed care plans).

Congress attached such importance to the universal accessibility of this benefit that it exempted it from any beneficiary deductible or coinsurance liability. See Section 1833(a)(1)(B) of the Social Security Act. In addition, this benefit was made available as a freestanding benefit that could be accessed without the involvement of a physician.

**Discussion:**

We have compiled information that, in spite of our past requests to Medicare-contracting managed care plans to stop imposing co-payments on Medicare enrollees for in-network flu shots, there are still a significant number of plans who are charging co-payments for this service. We believe this is inconsistent with Congress' intent that no out-of-pocket liability be associated with obtaining these shots. Also, we have been informed that at least in part as a result of the imposition of co-payments by plans, an increasing number of Medicare managed care enrollees are receiving flu shots from facilities not affiliated with the plan in which they are enrolled.

HCFA has continued to pay managed care plans the actuarial value of 95 percent of the fee-for-service cost of providing these shots on the assumption that the shots would be furnished to members within the managed care plan's network and would be paid for by the managed care plan. Yet, we have become aware that a substantial number of managed care enrollees are obtaining flu shots out of network and that the HMO or CMP in which they are enrolled accordingly is incurring no cost. In addition, the non-network providers of these shots have been experiencing large dollar losses as a result of going

uncompensated for this service. These losses are threatening the continuing accessibility of these shots.

When such large numbers of Medicare-contracting managed care members receive inoculations at out-of-network locations, it is clear that Medicare-contracting managed care plans are not providing sufficient accessibility to these shots within their networks. Medicare law requires that Medicare contracting managed care plans make those Medicare covered services "available and accessible" that are "available to individuals residing in the geographic area." See Section 1876(c)(2)(A) and (4)(A) of the Social Security Act, and 42CFR417.416(e).

When managed care plans charge co-payments for services for which Congress expressly precluded the normal cost-sharing for non-enrolled beneficiaries, we believe the plans are not providing the required accessibility to this service for their members. In addition, when there is evidence that the Medicare contracting managed care plan is not arranging to provide (and pay) for this service, this is further evidence that reasonable in-plan accessibility to this service is not being provided.

**Conclusion:**

In light of the above determinations, we are requiring that the following steps be taken by plans before the next contract year:

a. Eliminate any co-payment on flu shots given after January 1, 1998.
b. Attach to the hard copies of the beneficiary information form for the year 1998 the list of providers of these shots with whom the plan has made arrangements for the administration of this vaccine to the members of the plan for the year 1998.
c. Allow Medicare members of contracting managed care plans to self-refer for flu shots to any provider on the list of contracting providers

We will review the list of flu shot providers submitted under these steps to determine whether a plan has provided sufficient access to beneficiaries. If we determine that sufficient in-network access is not being provided, we will presume that the plan is relying upon non-network providers to fulfill its obligation to provide flu shots to its enrollees, and that the plan accordingly is responsible for paying such non-network providers for these shots.

We are developing the capacity to accumulate information regarding which Medicare members of our contracting managed care plans receive flu shots in most out-of-network locations from the Medicare fee-for-service roster billing system. If we see that a substantial percentage of a given managed care plan's enrollees are receiving flu shots out of network, we again will presume that the plan is relying upon non-network providers to fulfill its obligation to its enrollees, and that the plan is responsible for paying the non-network providers serving its enrollees.

In either of the above two cases in which we determine that a managed care plan is responsible for payment for out-of-network flu shots, we will forward this information to the record keeping component of these out-of-network providers so that they can bill the managed care plan involved for the costs of providing these shots.

**Contact:**

HCFA Regional Office Managed Care Staff