# CMS Manual System

## Pub. 100-16 Medicare Managed Care

**Department of Health & Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

**Transmittal: 36** **Date: October 31, 2003**


**I. SUMMARY OF CHANGES:**

**Table of Contents -** Line item added for: (1) Section title changed for section 10.6; (2) New sections 50.7, 90.1, 90.2, 90.3; and (3) Section 120.2 previously omitted from Table of Contents in error.

**Throughout - Sections 10.4, 10.7, 20.2, 50.4, 60.1, 60.2, 80.1, 110.2, 110.5** - "Cost-sharing" is spelled without the hyphen beginning with this section and throughout.

**Section 10.3 - Types of Benefits -** New unnumbered subsections, "General Guidelines for Benefits" and "Complementary Benefits" are added.

**Section 10.4 - Availability and Structure of Plans -** The third through fifth bullet items regarding availability and structure of plans are added.

**Section 10.6 - Annual Caps on Additional and Supplemental Benefits -** Section title is changed from "Multiple Plans in One Service Area," and an example regarding prescription benefits due for a member who has left and re-enrolls is added to the section.

**Section 10.7 - CMS Review and Approval of M+C Benefits**

Introductory paragraphs of the section - A third bullet is added regarding prohibitions to be observed by M+C organizations when designing benefit plans.

Subsection "No Exclusions Related to Medicare Benefits That Are Not Present in Original Medicare Program" is moved to a later subsection, "Waiting Periods and Exclusions That Are Not Present in Original Medicare Program."

Subsection "Inpatient Hospital Rehabilitation Services" - The sentence regarding billing of an inpatient stay by an enrollee whose enrollment begins or ends on the day of an inpatient stay is deleted.

Subsections "Prescription Drug Discount Programs" and "Midyear Drug Benefit Changes" are added.

Subsection "Mid-Year Benefit Enhancements (MYBE)" - Text is added regarding adding enhancements to a plan. A reference to a list of drugs excluded from coverage is provided.

**Section 50.7 - The Visitor / Travel Program -** New section is added regarding offering extended visitor or traveler programs to members outside of the service area for up to 12 months.

**Section 70.2 - Requirements, Rights, and Beneficiary Protection -** Paragraphs are added regarding the service area that can be offered for employer group health plans by an M+C organization and the election of an M+C plan by beneficiaries with only Part B coverage.

**Section 90.1 - Definitions -** In the new section, definitions are presented regarding the National Coverage Determinations and legislative changes in benefits.

**Section 90.2 - General Rules -** A new section is added describing general rule of Medicare coverage

**Section 90.3 - Sources for Obtaining Information -** A new section is added regarding sources of information on coverage.

**Section 110.5 - Other Information That Is Disclosable -** A miscellaneous word change is made in third bullet, "Rights"; fourth bullet, "Medigap and Medicare Select"; and fifth bullet (second "sub-bullet"), "Premiums."

**Section 130.2 - Emergency and Urgently Needed Services** - Corrected name of chapter 13 in the cross reference from "Appeals" to "Medicare+Choice Beneficiary Grievances, Organization Determinations, and Appeals."

**NEW/REVISED MATERIAL - EFFECTIVE DATE: October 31, 2003**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.***

**II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)**

**(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | Chapter 4 / Table of Contents |
| R | Chapter 4 / 10.3 / Types of Benefits |
| R | Chapter 4 / 10.4 / Availability and Structure of Plans |
| R | Chapter 4 / 10.6 / Annual Caps on Additional and Supplemental Benefits |
| R | Chapter 4 / 10.7 / CMS Review and Approval of M+C Benefits |
| R | Chapter 4 / 20.2 / Additional Benefits |
| R | Chapter 4 / 50.4 / Enrollee Information and Disclosure |
| N | Chapter 4 / 50.7 / The Visitor / Travel Program |

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | Chapter 4 / 60.1 / Definitions |
| R | Chapter 4 / 60.2 / Factors That Influence Service Area Approvals |
| R | Chapter 4 / 70.2 / Requirements, Rights, and Beneficiary Protection |
| R | Chapter 4 / 80.1 / Basic Rule |
| N | Chapter 4 / 90.1 / Definitions |
| N | Chapter 4 / 90.2 / General Rules - |
| N | Chapter 4 / 90.3 / Sources for Obtaining Information |
| R | Chapter 4 / 110.2 / Disclosure Requirements at Enrollment (and Annually Thereafter) |
| R | Chapter 4 / 110.5 / Other Information That Is Disclosable |
| R | Chapter 4 /120.2/Access and Availability Rules for Coordinated Care Plans |
| R | Chapter 4 / 130.2 / Emergency and Urgently Needed Services |
| | |

**III. ATTACHMENTS:**

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|---|---|
| | **Business Requirements** |
| **X** | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Special Notification** |

# Medicare Managed Care Manual

## Chapter 4 -Benefits and Beneficiary Protections

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**(Last Updated - Rev. 36, 10-31-03)**

Table of Contents


1 - Introduction

10 - General Requirements

- 10.1 - Basic Rule
- 10.2 - Services of Noncontracting Providers and Suppliers
- 10.3 - Types of Benefits
- 10.4 - Availability and Structure of Plans
- 10.5 - Terms of M+C Plans
- *10.6 - Annual Caps on Additional and Supplemental Benefits*
- 10.7 - CMS Review and Approval of M+C Benefits
- 10.8 - Requirements Relating to Medicare Conditions of Participation
- 10.9 - Provider Networks

20 - Requirements Relating to Benefits

- 20.1 - Basic Benefits
- 20.2 - Additional Benefits
- 20.3 - Supplemental Benefits - Mandatory Supplemental and Optional Supplemental
- 20.4 - Basic Versus Supplemental Benefits

30 - Medicare Covered Benefits

40 - M+C Medical Savings Account Plan Benefits

- 40.1 - General Rule
- 40.2 - Countable expenses
- 40.3 - Services After the Deductible
- 40.4 - Balance Billing
- 40.5 - The Annual Deductible
- 40.6 - Special Rules on Supplemental Benefits for M+C Medical Savings Account Plans

50 - Point of Service Option
- 50.1 - General Rule
- 50.2 - Accessing Plan Contracting Providers
- 50.3 - Financial Cap
- 50.4 - Enrollee Information and Disclosure
- 50.5 - Prompt Payment
- 50.6 - POS-Related Data
- *50.7 - The Visitor/Travel Program*

60 - Service Area
- 60.1 - Definitions
- 60.2 - Factors That Influence Service Area Approvals
- 60.3 - The "County Integrity Rule"

70 - Coordination of Benefits With Employer Group Health Plans and Medicaid
- 70.1 - General Rule
- 70.2 - Requirements, Rights, and Beneficiary Protection

80 - Medicare Secondary Payer (MSP) Procedures
- 80.1 - Basic Rule
- 80.2 - Responsibilities of the M+C Organization
- 80.3 - Medicare Benefits Secondary to Group Health Plans and Large Group Health Plans
- 80.4 - Collecting From Other Entities
- 80.5 - Collecting From Other Insurers or the Enrollee
- 80.6 - Collecting From GHPs and LGHPs
- 80.7 - MSP Rules and State Laws

90 - National Coverage Determinations and Legislative Changes In Benefits
- *90.1 - Definitions*
- *90.2 - General Rules*
- *90.3 - Sources for Obtaining Information*

100 - Discrimination Against Beneficiaries Prohibited
- 100.1 - General Prohibition
- 100.2 - Additional Requirements
- 100.3 - An M+C Organization's Responsibility

110 - Disclosure Requirements

110.1 - Introduction

110.2 - Disclosure Requirements at Enrollment (and Annually Thereafter)

110.3 - Disclosure Upon Request

110.4 - Information Pertaining to an M+C Organization Changing Their Rules or Provider Network

110.5 - Other Information That Is Disclosable

120 - Access to (and Availability of) Services

120.1 - Introduction

120.2 - Access and Availability Rules for Coordinated Care Plans

120.3 - Rules for All M+C Organizations to Ensure Continuity of Care

130 - Ambulance, Emergency and Urgently Needed, and Post-Stabilization Care Services

130.1 - Ambulance

130.2 - Emergency and Urgently Needed Services

130.3 - Post-Stabilization Care Services

140 - Confidentiality and Accuracy of Enrollee Records

140.1 - General Rule

150 - Private Fee-For-Service Plans

160 - Information on Advance Directives

160.1 - Definition

160.2 - Basic Rule

160.3 - State Law Primary

160.4 - Content of Enrollee Information and Other M+C Obligations

160.5 - Incapacitated Enrollees

160.6 - Community Education Requirements

160.7 - M+C Organization Rights

160.8 - Appeal and Anti-Discrimination Rights

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## 10.3 - Types of Benefits

*(Rev. 10-31-03)*

An M+C plan includes, at a minimum, basic benefits and may also include mandatory supplemental benefits and optional supplemental benefits.

- **Basic benefits** are all Medicare-covered services, except hospice services, and additional benefits, as defined below and meeting the requirements specified in 42 CFR 422.312.

- **Additional benefits** are part of the package of basic benefits for which beneficiaries are not charged a premium, beyond any premium the M+C organization is permitted to charge for original Medicare benefits. The costs of additional benefits are funded by the difference between an organization's "adjusted community rate" (ACR) for the original Medicare benefit package and the amount of the M+C payment made to the organization by CMS, plus any approved enrollee cost sharing. A more detailed discussion on "additional benefits" is found in Chapter 8 of this manual, "Premiums and Cost Sharing."

- **Mandatory supplemental benefits** are M+C plan benefits not otherwise covered under original Medicare to which anyone who enrolls in an M+C plan, offering such benefits, is entitled. Thus, additional benefits (included in the basic benefit package) and mandatory supplemental benefits are similar in that they are not covered by original Medicare, and all M+C enrollees must receive them as part of their M+C plan. See Chapter 8 of this manual, "Premiums and Cost Sharing," for additional discussion.

- **Optional supplemental benefits** are similar to additional and mandatory supplemental benefits in that they are benefits that are not covered by original Medicare. However, plan enrollees may choose whether to elect and pay for optional supplemental benefits. The M+C organizations may offer M+C plans that offer individual items or groups of items and services as optional supplemental benefits.

***General Guidelines for Benefits***

*M+C Plans have a great deal of flexibility in the benefits they may offer. However all benefits that are part of the M+C plan must satisfy the following guidelines:*

- *All benefits must be health-related;*

- *All benefits must be offered uniformly to all enrollees;*

- *All benefits must be priced in the ACR; and*

- *All benefits must be explicitly mentioned in the various marketing vehicles such as the Summary of Benefits (SOB), etc.*

***Complementary Benefits***

- *Plans may offer to their enrollees, either through associations or through employers, the right to purchase complimentary benefits – that is, benefits that are in addition to the benefits that are part of the M+C plan. These complimentary benefits are not within CMS jurisdiction. We note that the normal Federal Preemption authority provided under the M+C program does not apply to complimentary benefits. Therefore, the M+C plan must comply with all state regulations governing such benefits.*

## 10.4 - Availability and Structure of Plans

***(Rev. 10-31-03)***

An M+C organization offering an M+C plan must offer it:

- To all Medicare beneficiaries with Parts A and B of Medicare residing in the service area of the M+C plan;

- At a uniform premium, with uniform benefits and *cost sharing* throughout the plan's service area, or segment of service area when such segments have been approved. (Individuals with ESRD are generally excluded from enrollment. See 42 CFR 422.50(a)(2).);

- *Although an M+C Organization plan may "tier" its cost sharing to beneficiaries for the same service based on provider, (with the exception of post-stabilization services for which the copayment must be the same or lower for non-plan providers as for plan providers), nevertheless, all beneficiaries must be charged the same amount for the same service with the same provider. All beneficiaries must have access to all providers in the network;*

- *The uniform premium requirement prohibits plans from offering nominal discounts to those enrollees electing to pay premiums electronically. A plan may offer the option of electronically paying for premiums, but may not charge or discount for this option; and*

- *An M+C 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, ambulance, urgent care or dialysis, is entitled to balanced billing; and*

- *If the plan designates the enrollee as an intermediary of payment. (For example, it is prohibited for a plan to pay an enrollee who has been balanced billed by a non-contracted provider).*

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## *10.6 - Annual Caps on Additional and Supplemental Benefits*

***(Rev. 10-31-03)***

An M+C organization may offer more than one M+C plan in the same service area. However, each plan and its benefit package, is subject to the conditions and limitations that are established for the M+C program. Financial caps for a benefit can only be imposed at the M+C plan level.

For example, if an M+C organization offers two plans in the same service area, then an enrollee, who has exhausted the Rx benefit of one plan, is entitled to the drug benefit of the other plan, should the enrollee join it.

*However, a member who uses, for example, 75 percent of his or her plan's Rx benefit (offered as either an additional or supplemental benefit) and leaves the plan – to either Fee-For-Service or another M+C plan; if this member re-enrolls in that plan during the same contract year, then the plan is only obligated to provide the remaining 25 percent of the annual Rx benefit.*

## 10.7 - CMS Review and Approval of M+C Benefits

***(Rev. 10-31-03)***

The CMS reviews and approves M+C benefits using written policy guidelines and requirements in this manual, managed care manual updates, and other CMS instructions to ensure that:

- Medicare-covered services meet CMS guidelines under original fee-for-service Medicare;
- M+C organizations are not designing benefits to discriminate against beneficiaries with higher health care costs; and
- *In no case can an M+C organization design a cost sharing structure for plans that:*
  - *Promotes discrimination;*
  - *Discourages enrollment;*
  - *Steers specific subsets of Medicare beneficiaries to particular M+C plans;*

- *Inhibits access to services (see 42 CFR 422.100(g) and 422.752(a)(4)); and*

- *Designs cost sharing differentials in such a way as to preclude choice by the beneficiary. (For example, an M+C organization cannot charge higher copays for all providers in the western portion of the county while charging lower copayments for providers in the eastern portion of the county).*

- Benefit design meets other M+C program requirements.

**Benefits Affecting Screening Mammography, Influenza Vaccine, and Pneumococcal Vaccine**

Enrollees of an M+C organization may directly access (through self-referral) screening mammography and influenza vaccine. The organization may not impose *cost sharing* for influenza vaccine and pneumococcal vaccine on their M+C plan enrollees.

**Inpatient Hospital Rehabilitation Services**

Medically necessary inpatient hospital rehabilitation services cannot be limited to a greater extent than they are under the original Medicare program - 60 days, plus 30 coinsurance days, plus remaining lifetime reserve days per Medicare benefit period

**Value-Added Items and Services**

Value added items and services (VAIS) may not be part of an M+C plan's benefit package as either a basic or supplemental benefit. Value-added items and services are discussed more fully in Chapter 3 of this manual, "Marketing."

***Prescription Drug Discount Programs***

*Although M+C organizations are now allowed to list their Pharmacy discount programs in the Plan Benefit Package (PBP) (see Chapter 3 of this manual, "Marketing," for further details), nevertheless, these discount programs are not considered "benefits" within the definition stated in current regulations.*

**Waiting Periods *and Exclusions That Are Not Present in Original Medicare***

All beneficiaries must be provided all medically necessary benefits covered in the plan in which they enroll (including optional supplemental benefits) at the time of their initial enrollment. Waiting periods or exclusions from coverage, due to pre-existing conditions, are not permitted. *However, an M+C organization can deny coverage of Medicare-covered services when the services do not meet the standard of being medically necessary and appropriate. In addition, an M+C organization 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.*

**Annual Beneficiary Out-of-Pocket Cap**

Each year CMS will announce a total annual beneficiary copay cap on member liability associated with Medicare-covered benefits. If an M+C plan does not propose a limit on beneficiary liability at or below the published cap, CMS will conduct an intensified review of the benefit package in the submitted ACR to ensure that the proposed *cost sharing* structure does not discriminate against "sicker" beneficiaries, inappropriately encourage disenrollment or discourage enrollment. With acceptable justification, CMS provides latitude to those plans with member out-of-pocket caps above the published limit as long as the *cost sharing* is spread across widely used health care services. The CMS will not approve higher caps that concentrate *cost sharing* on specific services, such as dialysis or chemotherapy drugs. Generally, CMS considers monthly premiums and broad-based deductibles as more equitable and potentially less discriminatory than copayments and coinsurance related to infrequently used services.

**Drug Benefits**

M+C organizations frequently design M+C plans in which a beneficiary receives coverage for outpatient prescription drugs that would not normally be covered under the 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. An M+C organization 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. However, marketing materials, both pre-and post-enrollment (Summary of Benefits, EOC) must clearly and accurately describe this limitation.

**Drugs That Are Covered Under Original Medicare**

For this subsection, the term "drug" means "drug or biological."

- Injectable drugs that have been determined by Medicare carriers (and in some cases Fiscal Intermediaries) to be "usually not self-administered" and that are administered incident to physician services. For further information, see PM AB-02-072 (May 15, 2002) and PM AB-02-139 (October 11, 2002), found at CMS 2002 Program Memos;

- Drugs that the M+C enrollee takes while using durable medical equipment (such as nebulizers) that were authorized by the enrollee's M+C plan;

- Clotting factors if the enrollee is diagnosed with specific clotting disorders;

- Immunosuppressive drugs, if the enrollee had an organ transplant that was covered by Medicare;

- Injectable osteoporosis drugs, if the enrollee is homebound, 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.

Effective August 1, 2002, if an M+C enrollee wishes to receive a "not usually self-administered" drug in a physician's office, *then* the M+C organization must cover the drug and the service of administering the drug. That is, M+C organizations may not make a determination of whether it was reasonable and necessary for the patient to choose to have his or her drug administered incident to physician services. (M+C organizations can continue to make determinations concerning the appropriateness of a drug to treat a patient's condition, and the appropriateness of the intravenous or injection form as opposed to the oral form of the drug.)

The M+C organizations can choose to cover, as an additional benefit, injectable drugs that the local carrier has determined are not usually self-administered, but that members purchase at a pharmacy and administer at home. However, M+C enrollees always have the option of receiving the Medicare-covered benefit, i.e., administration of the covered drug in a physician's office.

*A list of drugs excluded from coverage, by carrier, is available on the HPMS Web site.*

**Mid-Year Benefit Enhancements (MYBE)**

The CMS will continue to permit M+C organizations to enhance their benefit plans during a contract year. Pursuant to 42 CFR 422.300(b)(1), enhancements may include one or a combination of the following elements:

- Adding new benefits at no additional cost to the plan enrollee;
- Reducing premiums;
- Reducing cost sharing (i.e., copayments, coinsurance, and deductibles);
- *Reducing premiums: The M+C organization may also reduce or eliminate standard Part B premiums. The reduction must be applied uniformly to all similarly situated enrollees of the M+C plan. Further quantitative details on the allowed percentage of reduction may be found in Chapter 7 of this manual, "Payments";*
- *Adding new mandatory supplemental benefits with cost sharing; and*
- *Adding new optional supplemental benefits with premium and/or cost sharing.*

*A mandatory supplemental benefit may be added to a M+C plan for $0 premium. All beneficiary costs for new mandatory supplemental benefits must be in the form of cost*

*sharing. In this way the beneficiary retains the right to either access the new benefit (with financial liability for the additional cost sharing) or not. Furthermore, a M+C organization is permitted to offer optional supplemental benefits with an additional monthly premium (with or without additional cost sharing), but only with explicit CMS approval. Again, the beneficiary retains the right to either access the new benefit (with financial liability for the additional premium and/or cost sharing) or not. (See the section on optional supplemental benefits for more information.)*

***Midyear Drug Benefit Changes***

*The CMS is providing M+C organizations the opportunity to change their drug formulary during the contract year. Plans may:*

- *Add drugs to their formulary;*
- *Remove drugs from their formulary; or*
- *Move drugs to different tier levels.*

*Plans that wish to remove a drug from their formulary during the contract year are required to establish an exceptions process. This exceptions process will provide physicians a mechanism to continue prescribing drugs that are determined to be medically necessary and that were on the formulary when the Medicare beneficiary enrolled. The M+C organization will determine how the exceptions process will work, and can include reviewers who determine whether or not the request for an exception is medically appropriate, and/or whether or not an exception will be granted.*

*M+C organizations that change their formulary must notify beneficiaries thru appropriate vehicles as detailed in Chapter 3 of this manual, "Marketing."*

**Multi-Year Benefits**

These are services that are provided to a plan's Medicare enrollees over a period exceeding one year. For example, a plan may include coverage of one new pair of eyeglasses every 2 years. Details on marketing criteria for multi-year benefits are provided in the Must Use/Can't Use/Can Use chart located in Chapter 3 of this manual, Marketing."

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## 20.2 - Additional Benefits

***(Rev. 10-31-03)***

This section provides a brief discussion on payment for additional benefits. A more detailed discussion on additional benefits requirements can be found in Chapter 8 of this manual, "Premiums and Cost Sharing."

Additional Benefits are:

- Healthcare services not covered by Medicare;
- Reductions in premium or *cost sharing* for Medicare covered services; and/or
- Reductions in the Medicare Beneficiaries standard Part B premium.

Additional benefits are funded by the "adjusted excess" as defined in the ACR.

Chapter 8 of this manual, "Premiums and Cost Sharing," presents detailed definitions of "adjusted excess" and related terms.

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## 50.4 - Enrollee Information and Disclosure

***(Rev. 10-31-03)***

Organizations offering a POS benefit must be able to provide enrollees with timely information on the POS financial limits, coverage rules, and enrollee *cost sharing* for a given service, including the capacity to provide enrollees with advance coverage information over the phone. For example, enrollees should be able to phone the organization offering the POS benefit, and be informed how close they are to reaching the financial cap on the benefit. In addition, the plan should be able to advise an enrollee whether a particular service will be paid for under a POS benefit, how much the member will pay out-of-pocket, and how much the plan will contribute under the POS benefit.

Furthermore, M+C organizations must maintain written rules on how to obtain health benefits through the POS benefit. The M+C organization must provide to beneficiaries enrolling in a plan with a POS benefit an "evidence of coverage" document, or otherwise provide written documentation that specifies all costs and possible financial risks to the enrollee including:

- Any premiums and *cost sharing* for which the enrollee is responsible;
- Annual limits on benefits and out-of-pocket expenditures;
- Potential financial responsibility for services for which the plan denies payment because they were not covered under the POS benefit, or exceeded the dollar limit for the benefit; and
- The annual maximum out-of-pocket expense an enrollee could incur.

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## *50.7 - The Visitor/Travel Program*

***(Rev. 10-31-03)***

*An M+C organization can offer extended "visitor" or "traveler" programs to members who have been out of the service area for up to 12 months, provided that the plan includes the full range of services available to other members. The M+C organizations offering these programs may limit their availability to certain areas and may impose restrictions on obtaining benefits, except for urgent, emergent, post-stabilization care, and renal dialysis. These organizations do not have to disenroll members in these extended programs who remain out of the service area for up to 12 months. However, those M+C organizations without this program must continue to disenroll members once they have been out of the service area for more than 6 months.*

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## 60.1 - Definitions

***(Rev. 10-31-03)***

A service area is a geographical area approved by CMS within which an M+C eligible individual may enroll in a particular M+C plan offered by an M+C organization. An M+C plan's service area does not need to be contiguous.

The basic requirement of service area is that each M+C plan offered by an M+C organization must be offered to all beneficiaries in an M+C plan's service area with a uniform benefit package and uniform *cost sharing* arrangements.

The designation of an M+C plan's service area affects the following five items:

- **Payment Rate:** The service area designation determines CMS' payment rate to the M+C organization based on the counties included in the service area;
- **Required Benefits:** The designation affects which benefits will be provided under the M+C plan, because benefits and premiums must be uniform for all Medicare beneficiaries residing in the plan's service area;
- **Eligibility:** The designation determines which Medicare beneficiaries are able to elect the plan. The M+C organizations are obligated to enroll any M+C eligible resident in the service area who elects the plan during "open" enrollment periods (provided an approved capacity limit has not yet been reached (see Chapter 2 of this manual, "Enrollment and Disenrollment"));
- **Access Requirements:** For coordinated care plans, the designation identifies the geographical area within which the plan's covered services must be "available and accessible;" and

- **Urgent Care Requirement:** For coordination care plans, the designation defines the boundaries beyond which the organization must always assume financial liability for urgently needed care.

## 60.2 - Factors That Influence Service Area Approvals

***(Rev. 10-31-03)***

In deciding whether to approve an M+C plan's service area, CMS considers the following:

- Whether each M+C plan (except for Employer Only plans - see Chapter 8 of this manual, "Premiums and Cost Sharing") will be made available to all M+C eligible individuals within the plan's service area;

- Whether the plan will offer a uniform premium, benefit package and *cost sharing* arrangement to all beneficiaries in the service area, or segment of a service area;

- Whether the service area meets the "county integrity rule" described below;

- Whether, for coordinated care plans and network MSA plans, the contracting provider network meets the CMS access and availability standards for the service area, as explained in §120 of this chapter, even if some of the contracting providers are physically located outside of the service area; and

- Whether there is any evidence that the service area is being manipulated to avoid areas with "sicker" people or that it would be discriminatory in some other way. In this regard, CMS also considers the extent to which the proposed service area mirrors service areas of existing commercial or M+C plans offered by the M+C organization. However, CMS may approve single county non-network M+C MSA plans even if the M+C organization's commercial plans have multiple county service areas.

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## 70.2 - Requirements, Rights, and Beneficiary Protection

***(Rev. 10-31-03)***

All requirements, rights, and protections that apply to the M+C program also apply to all M+C plan benefits - the basic, mandatory and optional supplemental benefits discussed in this chapter. By contrast, the employer (or State Medicaid) benefits that **complement** the M+C plan benefits are not considered M+C benefits and are therefore beyond the scope of M+C regulations. Marketing materials associated with the complement benefits are also not subject to CMS approval. (See Chapter 8 of this manual, "Premiums and Cost Sharing," for further discussion.)

*The M+C plans can offer a service area to their employee group health plan that is larger than is offered to their M+C plans for Medicare individuals.*

*A Medicare beneficiary with only Part B coverage can only elect an M+C plan if they are members of an employer or union group.*

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## 80.1 - Basic Rule

***(Rev. 10-31-03)***

The CMS does not pay for services to the extent that there is a third party that is required to be the primary payer. The principles on *cost sharing* that are discussed below may not apply in circumstances where CMS has granted an employer group waiver. (See Chapter 8 of this manual, "Premiums and Cost Sharing," for further discussion.)

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## *90.1 - Definitions*

***(Rev. 10-31-03)***

*A **national coverage determination (NCD)** is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. An NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.*

*A **legislative change in benefits** is a coverage requirement adopted by the Congress and mandated by statute.*

*The term **significant cost**, as it relates to a particular NCD or legislative change in benefits, means either of the following:*

A. *The average cost of furnishing a single service exceeds a cost threshold that:*

   - *For calendar years 1998 and 1999, is $100,000; and*
   - *For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described at 42 CFR 422.254(b).*

B. *The estimated cost of all Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national standardized annual capitation rate, as described at 42 CFR 422.254(f), multiplied by the total number of Medicare beneficiaries for the applicable calendar year.*

*For purposes of computing the minimum percentage increase rate only (defined at 42 CFR 422.256), the above test is applied to all NCDs or legislative changes in benefits,*

*in the aggregate, for a given year. If the sum of the average cost of each NCD or legislative change in benefits exceeds the amount in (A) above or the aggregate costs of all NCDs and legislative changes for a year exceeds the percentage in (B) above, the costs are considered* ***significant.***

## *90.2 - General Rules*

***(Rev. 36, 10-31-03)***

*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.*

*The M+C organizations must provide all Medicare-covered benefits (see §20.1.).*

- *When the significant –cost criterion is met:*

    - *Prior to the adjustment of the annual M+C capitation rate:*

      *If CMS determines and announces that an individual NCD service or legislative change in benefits* ***does*** *meet a criterion for significant cost described in §90.1 above, then the M+C organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. Although the service or benefit may not be included in the services M+C organizations must cover under their contract in exchange for monthly capitation payment, the M+C organization must still provide coverage of the NCD service or legislative change in benefits by furnishing or arranging for the service.*

      *Chapter 7, "Payment to M+C Organizations," contains the detailed rules on payment for NCD services or legislative changes in benefits that meet the significant cost threshold. Included is a* ***description of services*** *for which M+C organizations are responsible to pay for in the contract year prior to the adjustment of the annual M+C capitation to account for the significant cost NCD service or legislative change in benefits. During this period, M+C enrollees are responsible for any applicable coinsurance amounts under original Medicare.*

- *After adjustment of the annual M+C capitation rate is made:*

  *For the contract year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect, the service or benefit is included in the M+C organization's contract with CMS and is a covered benefit under the contract. Subject to all applicable rules under the M+C program, the M+C organization must furnish, arrange, or pay for the NCD service or legislative change in benefits. The M+C organizations may establish separate plan rules for these services and benefits, subject to CMS review and approval. The CMS may, at its discretion, issue overriding instructions limiting or revising the M+C plan rules, depending on the specific NCD or legislative change in benefits.*

  *For these services or benefits, the Medicare enrollee is responsible for any M+C plan cost sharing, as approved by CMS or unless otherwise instructed by CMS.*

- *When the significant-cost criterion is not met:*

  *If CMS determines that an NCD or legislative change in benefits **does not** meet a criterion for significant cost described in §90.1 above, the M+C organization is required to provide coverage for the NCD or legislative change in benefits, and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.*

## *90.3 - Sources for Obtaining Information*

***(Rev. 10-31-03)***

*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 NCDs are made and the progress of each coverage issue under review.*

*The Web page on NCDs, found at http://www.cms.hhs.gov/ncdr/ncdr_index.asp, lists both pending and closed coverage determinations. For each coverage topic on the NCD web page, CMS provides a staff name and e-mail link so interested parties can use the Internet to send questions and to provide feedback. To search for other information supporting the national coverage determination process, visit http://www.cms.hhs.gov/ncdr/.*

*The Coverage Issues Manual is the primary record of Medicare national coverage policies, and includes a discussion of the circumstances under which items and services are covered. Newly contracted M+C organizations are put on the distribution list to receive the Coverage Issuances Manual, CMS Publication 6. This distribution list includes regular updates. Alternatively, one may sign up to subscribe to the Coverage*

*List by visiting the "Medicare Coverage Policy - Home Page," which may be found at http://www.cms.hhs.gov/coverage. Additional information on new coverage can be found at http://www.cms.hhs.gov/manuals.*

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## 110.2 - Disclosure Requirements at Enrollment (and Annually Thereafter)

***(Rev. 10-31-03)***

At the time of enrollment (and at least annually thereafter) an M+C organization must provide each enrollee electing an M+C plan it offers, the information listed below. The description must be presented in a clear, accurate, and standardized manner.

**Service area -** The M+C plan's service area and any enrollment continuation area.

**Benefits -** The benefits offered under the plan, including applicable conditions and limitations, premiums and *cost sharing* (such as copayment, deductibles, and co-insurance), and any other conditions associated with receipt or use of benefits; and for purposes of comparison:

- The benefits offered under original Medicare, including covered services, beneficiary *cost sharing*, and any beneficiary liability for balance billing; and

- The availability of the Medicare hospice option and any approved hospices in the service area, including those that the M+C organization owns, controls, or has financial interest in.

**Access -** The number, mix, and addresses of providers from whom enrollees may obtain services; any out-of network coverage; any POS option, including the supplemental premium for that option; and how the M+C organization meets the access to service requirements for access to services offered under the plan, which are discussed below in §120.

**Out-of-area coverage -** provided under the plan, including coverage provided to individuals eligible to enroll in the plan who may reside outside the service area of the M+C plan as provided under a provision set forth at 42 CFR 422.50(a)(3)(ii).

**Emergency coverage -** Coverage of emergency services, including:

- An explanation of what constitutes an emergency (M+C organizations must use the definitions of emergency services and emergency medical condition that are presented below in §130);

- The appropriate use of emergency services. The M+C organization must clearly state that prior authorization cannot be required for emergency services;

- The process and procedures for obtaining emergency services, including the use of the 911 telephone system or its local equivalent; and

- The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the M+C plan.

**Supplemental benefits -** Any mandatory or optional supplemental benefits and the premiums for those benefits.

**Prior authorization and review rules -** Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The M+C organization must instruct enrollees that, in cases where non contracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit a bill directly to the M+C organization for processing and determination of enrollee liability, if any.

**Grievance and appeals procedures -** All grievance and appeal rights and procedures.

**Quality Assurance program -** A description of the quality assurance program that is required for all M+C organizations.

**Disenrollment rights and responsibilities**

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## 110.5 - Other Information That Is Disclosable

***(Rev. 10-31-03)***

This section contains a list of other disclosable information that must be disclosed upon request. Information for many (but not all) of the topics are found in the Evidence of Coverage (EOC). The EOC is annually published on the CMS Web site at http://www.cms.hhs.gov/. Information for other topic areas, such as comparative information, can be found in the "Medicare & You Handbook" that is published every year, as well as on the CMS Web site at http://www.medicare.gov/, under Medicare Personal Plan Finder. The M+C organizations are obligated to assist M+C plan enrollees in obtaining the information provided by CMS.

- **Benefits under original Medicare -** Including covered services, beneficiary *cost sharing* (such as copayments and coinsurance), and any beneficiary liability for balance billing.

- **Enrollment procedure** - Information and instructions on how to exercise election options provided by the organization.

- **Rights -** *A* general description of procedural rights (including grievance and appeal procedures) under original Medicare and the M+C program, and the right

to be protected against discrimination based on the factors that are addressed in §100 of this chapter.

- **Medigap and Medicare Select -** *A* general description of the benefits, enrollment rights, and requirements applicable to Medicare supplemental policies under §1882 of the Act, and provisions relating to Medicare select policies under §1882(t) of the Act.

- **Potential for contract termination -** The fact that an M+C organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that organization's M+C plan.

- **Comparative information -** A list of M+C plans that are (or will be) available to residents in the service area in the following calendar year, and, for each available plan, information on the aspects described below, in a manner that facilitates comparison among plans:

    - **Benefits**:

        - Covered services that are beyond those provided under original Medicare;

        - Any beneficiary *cost sharing*;

        - Any maximum limitation on out-of-pocket expenses that may apply;

        - In the case of an M+C private fee-for-service plan, differences in cost sharing, enrollee premiums, and balance billing, as compared to M+C plans;

        - The extent to which an enrollee may obtain benefits through out-of-network health care providers;

        - The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers; and

        - The coverage of emergency and urgently needed services.

    - **Premiums -** The M+C monthly basic beneficiary premiums, the M+C monthly supplemental beneficiary premium*, and any reduction in Part B premiums;*

    - **The plan's service area;**

- **Quality and performance indicators** for benefits under a plan to the extent they are available, (and how they compare with indicators under original Medicare), as follows:
    - Disenrollment rates for Medicare enrollees for the two previous years, excluding disenrollment due to death or moving outside the plan's service area calculated according to CMS guidelines;
    - Medicare enrollee satisfaction;
    - Health outcomes;
    - Plan-level appeal data;
    - The recent record of plan compliance with M+C requirements; and
    - Other performance indicators.
- **Supplemental benefits -** Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and premiums and other terms and conditions for those benefits.

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## 130.2 - Emergency and Urgently Needed Services

***(Rev. 10-31-03)***

**Definitions**

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency services** are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

**Urgently needed services** are covered services that are not emergency services as defined in this section, provided when an enrollee is temporarily absent from the M+C

plan's service (or, if applicable, continuation) area when the services are medically necessary and immediately required:

- As a result of an unforeseen illness, injury, or condition; and
- It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

Note that under unusual and extraordinary circumstances, services may be considered urgently needed services when the enrollee is in the service or continuation area, but the organization's provider network is temporarily unavailable or inaccessible.

**M+C organization responsibility.** The M+C organization is financially responsible for emergency services and urgently needed services:

- Regardless of whether services are obtained within or outside the M+C organization;
- Regardless of whether there is prior authorization for the services. In addition:
    - No materials furnished to enrollees (including wallet card instructions) may contain instructions to seek prior authorization for emergency or urgently needed services, and enrollees must be informed of their right to call 911;
    - No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the enrollee has been stabilized.
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis; and
- Whenever a plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan.

**Stabilization of an Emergency Medical Condition**

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

Chapter 13 of this manual, "*Medicare+Choice Beneficiary Grievances, Organization Determinations, and* Appeals," addresses the enrollee's right to request a Quality Improvement Organization review for hospital discharges to a lower level of care. For transfers from one inpatient setting to another inpatient setting, an enrollee (or person authorized to act on his or her behalf) who disagrees with the decision and believes the enrollee cannot safely be transferred, can request that the organization pay for continued out-of-network services. If the M+C organization declines to pay for the services, appeal rights are available to the enrollee.

**Limit on Charges for Emergency Services**

Enrollees' charges for emergency services, i.e., outpatient and inpatient services until stabilized (as defined above), cannot exceed the lesser of :

- $50; or
- What the enrollee would be charged if he or she obtained the services through the M+C organization.

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