CMS Manual System

Pub. 100-16 Medicare Managed Care

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

Transmittal 39 **Date: November 14, 2003**

I. SUMMARY OF CHANGES:

Chapter 5 - Quality Assessment

Exhibit II - Submitting Patient-Level Data - Three bullets - ("Claims Timeliness," "Call Answer Timeliness," and "Call Abandonment") are deleted under subsection 2, "Access/Availability of Care."

Chapter 8 - Premiums and Cost-Sharing

Section 55.1 – General Rule - Inserted a cross reference referring reader to Chapter 4, §10.3, for discussion on mandatory supplemental as well as optional supplemental benefits.

NEW\REVISED – EFFECTIVE: November 14, 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 5 / Exhibit II / Submitting Patient-Level Data
R	Chapter 8 / Section 55.1 / General Rule

III. ATTACHMENTS:

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

Exhibit II - Submitting Patient-Level Data

(Rev. 39, 11-14-03)

Required Measures

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by reporting unit. The HIC number is assigned by CMS to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

NOTE: Section 1876 cost contracts (whether or not they convert to become an M+C MCO in the reporting year) should only report patient-level data for the summary measures that are listed in Attachment I.A for the following three domains.

1 - Effectiveness of Care

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women Who Had a Fracture

Beta Blocker Treatment After A Heart Attack

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication Management

Cholesterol Management After Acute Cardiovascular Events

Controlling High Blood Pressure

2 - Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

3 - Use of Services

Frequency of Selected Procedures

Inpatient Utilization - General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization - Nonacute Care

Mental Health Utilization- Inpatient Discharges and Average Length of Stay

Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay

Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Identification of Alcohol and Other Drug Services

To be useful, patient-level data must match the summary data for the measures discussed here, i.e., the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO should make a copy, or "freeze" its database when the summary measures are calculated. If the measure was calculated using the hybrid methodology, the patient-level data should be reported on the minimum required sample size (411) or the total denominator population if less than 411. National Committee for Quality Assurance (NCQA) will provide MCOs with exact file specifications and explicit instructions by the spring of the reporting year, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement. These instructions and file specifications will be posted on NCQA's Web site at http://www.ncqa.org. MCOs are advised to frequently review the NCQA Web site for updates on the data submission process.

55.1 - General Rule

(Rev. 39, 11-14-03)

The M+C organizations can enhance M+C plans during a calendar year if CMS approves the changes, known as mid-year benefit enhancements (MYBEs).

The M+C organizations proposing enhancements must submit the same material to CMS as described under §40. Generally, CMS will accept proposals to enhance M+C plans beginning November 1 (for MYBEs applying to the following calendar year) and continuing through August 1 (for MYBEs applying to the current calendar year). The CMS will approve changes in M+C plans as quickly as possible so beneficiary notification can occur in a timely manner. Proposed enhancements to M+C plans can be effective no earlier than February 1. The CMS will determine the effective date of any approved benefit enhancement when it approves the proposed enhancement.

Proposed MYBEs may include one or a combination of the following elements:

- Adding a new benefit (or benefits) at no additional cost to a plan enrollee. A new "no cost" benefit can be added as an additional benefit or a mandatory supplemental benefit;
- Adding a new benefit (or benefits) with a premium, cost-sharing, or both. An M+C organization can offer a MYBE in this way as either a mandatory supplemental benefit or an optional supplemental benefit:
    - If a MYBE is offered as a mandatory supplemental benefit, it must be offered for $0 [additional] monthly premium. In other words, any beneficiary costs for mandatory supplemental benefits offered mid-year must all be in the form of cost sharing. In this way, enrollees retain the right either to use the new benefit (and become liable for the additional cost-sharing) or not to use the benefit.
    - An M+C organization also is permitted to offer certain MYBEs as optional supplemental benefits with an additional monthly premium (with or without additional cost sharing).
- Reducing premiums; and
- Reducing other cost-sharing amounts (that is, copayments, coinsurance, or deductibles).

An M+C organization cannot replace a coinsurance amount (i.e., cost sharing that is defined as a percentage of benefit cost) with a copayment amount (i.e., cost sharing that is defined as a fixed cost per service) during a calendar year because, in an individual case, this could increase a beneficiary's cost. However, an M+C organization can add additional cost-sharing options during a calendar year. For example, a plan could allow beneficiaries to pay the lesser of its coinsurance amount or copayment amount for a particular plan benefit. M+C organizations must offer all CMS-approved enhancements of an M+C plan to existing enrollees (and to new enrollees when an M+C plan is otherwise open to new enrollment) throughout the M+C plan's service area. The CMS

will not approve proposed changes to M+C plan benefits or cost sharing that do not meet the above requirements.

In addition, see Chapter 4 of this manual, §10.3, for discussion on mandatory supplemental as well as optional supplemental benefits

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