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

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
11	130		
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		150.1	
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NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2003
IMPLEMENTATION DATE: January 1, 2003

Red italicized font identifies new material.

Section 130, Certification of Data That Determine Payment Requirements, amends the payment certification language found in several places throughout the section and reads, "based on best knowledge, information and belief" by adding new qualifying language that reads, "as of the date specified on the attestation form." Also revises certification language found throughout the section by changing the word "certify" to "attest." Adds new language at the end of the section clarifying that the attestation requirement is applicable to all Medicare+Choice (M+C) contractors, including those that are nonrenewing or terminating their contracts with CMS.

Section 150, Section 617 "Employer" Group Waivers, adds a new section describing the authority given to CMS under the 2000 BIPA to waive or modify requirements that hinder the design of, the offering of, or the enrollment in M+C plans offered to employer groups and labor organizations (unions).

Section 150.1, Waiver Categories Approved, describes the categories of §617 employer group waivers under the authority granted in BIPA.

Section 150.1.1, Actuarial Swapping of Benefits Not Covered by Original Medicare, this section describes the waiver requirements for swapping different types of benefits (not covered by Medicare) of equal actuarial value between individual market M+C plans and employer or union plans.

Section 150.1.2, Actuarial Equivalence, this section describes the waiver requirements for Actuarial Equivalence. This waiver applies to both Medicare and non-Medicare covered benefits in cases where the M+CO is modifying the cost-sharing, benefit level and/or premium levels in an employer or union plan from the levels offered to the individual market.

Section 150.1.3, Employer/Labor-Only Plans, describes the requirements for M+CO employer/union plans offered exclusively to Medicare beneficiaries who are members of an employer group or union and the process for informing CMS of submission of ACRPs for employer/labor-only plans.

Section 150.1.4, Part B-Only Plans, states that M+COs may develop plans for Part B-only Medicare beneficiaries who are members of employer or union groups and refers to Chapter 7 for ACRP specific considerations for this type of plan.

Section 150.1.5, Other 617 Employer/Labor Groups, clarifies that no waivers are required for experience-rating of employer groups.

Section 150.2 - Instructions for Additional Employer/Union Group Waiver Requests, provides instructions and describes the requirements for submitting additional types of employer/labor group waiver requests.

Section 150.3 - Service Areas, describes service areas requirements for employer/labor-only plans.

Section 150.4 - General Considerations, describes general considerations involving employer/labor-only plans, with particular emphasis placed on discussing marketing material issues.

Appendix A - Certification of Risk Adjustment Data Information Relating to CMS Payment to a Medicare+Choice Organization, provides a model certification of risk adjustment data information relating to CMS payment to an M+CO.

130 - Certification of Data That Determine Payment Requirements – (Rev. 14, 09-27-02)

As a condition for receiving a M+C related monthly payment from CMS, the M+CO agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that *attests to (based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify.

The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to the fact* that each enrollee for whom the organization is requesting payment is validly enrolled in an M+C plan offered by the organization, and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief *as of the date specified on the attestation form)* is accurate, complete, and truthful.

The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to (based on best knowledge, information and belief, as of the date specified on the attestation form)* that the encounter data it submits are accurate, complete, and truthful. If such encounter data are generated by a related entity, contractor, or subcontractor of an M+CO, such entity, contractor, or subcontractor must similarly *attest to* (based on best knowledge, information, and belief, *as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data.

The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to (based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information in its ACR submission is accurate, complete, and truthful and fully conforms to the ACRP requirements.

This attestation requirement is applicable to all M+C contractors, including those that are nonrenewing or terminating their contracts.

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150 - Section 617 "Employer" Group Waivers – (Rev. 14, 09-27-02)

Section 617 of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provides authority for CMS to waive or modify requirements that hinder the design of, the offering of, or the enrollment in M+C plans offered to employer groups and labor organizations (unions). M+COs can now offer customized health care plans to Medicare-eligible members of employer groups and unions. The CMS will make capitated payments to M+COs to cover the costs of Medicare-eligible enrollees. The final benefit package of such a plan is developed through private negotiation between the M+CO and an employer or union. All such plans that M+COs negotiate with employers and unions must cover at least all Medicare Part A and Part B benefits. M+COs should not submit ACR information pricing

benefits privately negotiated with employers/unions that are not part of an M+C plan, or that are not part of a 617-plan designed specifically for employer groups or labor unions. (See §150.1.3.)

150.1 - Waiver Categories Approved (Rev. 14, 09-27-02)

The CMS has currently approved four categories of employer group waivers under the authority granted in BIPA. Two of the categories, "actuarial swapping" and "actuarial equivalence," enhance flexibility of build-ons to M+C plans designed for the individual market where the build-ons are part of an enhanced package intended for only members of an employer or union group. Another category of waiver allows an M+CO to design a plan (i.e., an employer-only or union-only plan) that cannot be offered to individuals and that has been designed to meet the specific needs of employers and unions. The fourth category relates to Medicare enrollees who belong to employer or union groups and who have only Medicare Part B coverage.

No additional request or notice is required for those waivers that are already published (below). In addition, waiver requests that have already been submitted to CMS but not yet approved should not be resubmitted, unless requested.

150.1.1 - Actuarial Swapping of Benefits not Covered by Original Medicare – (Rev. 14, 09-27-02)

Medicare+Choice Organizations (M+COs) may swap different types of benefits (not covered under original Medicare) of equal actuarial value between an M+C plan offered to the individual market and an employer or union plan. The swaps may be used if an employer or union prefers a different benefit package for its employees/members than the M+CO offers to the individual market. Examples of actuarial swapping include:

1. *An employer may prefer a vision benefit as opposed to the dental benefit the M+CO offers to the individual market. M+CO designs a vision benefit for the employer that has equal actuarial value to dental benefit and swaps them in the plan it offers to the employer.*

2. *A union may prefer a dental and a vision benefit as opposed to the prescription drug benefit the M+CO offers to the individual market. M+CO designs a combined dental and vision benefit that has equal actuarial value to the prescription drug benefit and swaps them in the plan it offers to the union.*

Absent an approved waiver, swapping benefits would violate the uniformity of benefits rule in the M+C statute.

M+COs do not need to obtain specific advance approval from CMS for each employer/union group to which the swap will be offered in order to take advantage of the increased flexibility available in actuarial swapping. Rather, when an M+CO submits ACRPs for the M+C plans it intends to offer to individuals, the M+CO must inform CMS at that time of its intention to make actuarial swaps. In its ACR cover letter to CMS, the organization must identify both the benefits that might be swapped during negotiations with employers and unions and the M+C plan

covering those benefits. After CMS gives the M+CO its general approval for the possible swaps, the organization can make specific swaps in negotiations with employers or unions in the context of CMS's general approval and without obtaining further specific approval from CMS for them.

150.1.2 - Actuarial Equivalence – (Rev. 14, 09-27-02)

When negotiating with employers or unions, M+COs can raise cost sharing (coinsurance, copayments and/or deductibles) for specific plan benefits by providing a higher benefit level and/or a modified premium compared to what is offered to the individual market. Generally, waivers approved in this category have been related to prescription drug benefits. For example:

1. *An M+CO might offer a plan to individuals with a $500 per year drug benefit with a $5 copayment per prescription unit. M+CO might want to offer employers and unions an M+C plan that includes an unlimited prescription drug benefit with a $10 copayment per prescription unit, or the same $500 drug benefit with a $10 copayment and a reduced premium.*

2. *An M+CO might offer a plan to individuals with a $10 copayment for all physician office visits (primary care and specialist). M+CO might want to offer employers and unions an M+C plan that includes a $5 copayment for primary care physician visits and a $20 copayment for specialist physician visits.*

An M+CO may take advantage of this flexibility by informing CMS of its intentions when it submits its ACRPs for M+C plans it intends to offer to the individual market. In its ACR cover letter to CMS, the M+CO must identify the following:

- *The cost-sharing amounts it intends to increase or decrease and the M+C plan containing the cost sharing;*
- *Any modification to the premium it will charge; and*
- *Any change in the benefit related to the changed cost sharing or modified premium.*

The CMS will allow this category of waiver to M+COs that need it for purposes of a contract with an employer group or union. Unlike actuarial swapping, this waiver can apply to both Medicare-covered benefits and non-Medicare-covered benefits. An M+CO is permitted to modify the cost-sharing, benefit level and/or premium in a plan offered only to employers or unions from the levels of cost-sharing, benefits and premiums offered to the individual market as long as the minimum required Medicare coverage levels are met and as long as the modification does not have the affect of denying or discouraging access to covered medically-necessary health care items and services.

150.1.3 - Employer/Labor-Only Plans - (Rev. 14, 09-27-02)

M+COs can develop employer/union-only plans offered exclusively to Medicare beneficiaries who are members of an employer group or union. This type of plan allows the M+CO to develop benefit packages customized for specific employers or unions. However, the employer/union plans would not need to be marketed or made available to individual Medicare beneficiaries in

the market. Additionally, such customized plans would not appear on Medicare Compare. Employer/union-only plans are subject to monitoring by CMS to ensure compliance with other regulatory requirements, such as appeal and grievance mechanisms.

An M+CO may take advantage of this flexibility by informing CMS of its intentions when it submits its ACRPs for M+C plans it intends to offer to the individual market. M+CO would simply submit an additional ACRP for each employer/labor-only plan it intends to renew for the coming year.

Unlike ACRPs for M+C plans that will be offered to the individual market and renewal ACRPs for employer/labor-only plans which must be submitted by statutorily required due dates (on or before: September 9, 2002; September 8, 2003; September 13, 2004: July 1 of each other year), ACRPs for new employer/labor-only plans can be submitted on a flow basis and need only be submitted 30 days prior to the period for which the plan(s) will be offered to employers and unions.

150.1.4 - Part B-Only Plans - (Rev. 14, 09-27-02)

Certain federal, state and local employees do not have Part A Medicare coverage. M+COs can develop plans for Part B-only Medicare beneficiaries who are members of employer or union groups. See Chapter 7 (Worksheet C1 instructions) of the ACR Instructions for specific considerations related to this type of plan.

150.1.5 - Other 617 Employer/Labor Groups Waivers - (Rev. 14, 09-27-02)

We received waiver requests to allow M+COs to experience-rate employer groups. However, we believe that a waiver is not required in this instance since M+COs already have the flexibility to negotiate separate group rates with employers.

150.2 - Instructions for Additional Employer/Union Group Waiver Requests - (Rev. 14, 09-27-02)

The CMS will review additional types of employer/labor group waiver requests on a flow basis. An M+CO may request a new type of waiver at any time. Such a waiver request must include the name of the M+CO and fully address the following issues:

- *Contract numbers affected by the waiver request (or an indication that the request applies to all M+C plans nationwide under the parent organization);*
- *Provisions of existing requirements to be waived/modified;*
- *Executive summary of the recommended process/modification and rationale;*
- *Detailed description of the waiver request including flow charts, details of processes, etc. - where applicable;*

- *The problems(s) with the current requirements that are hindering the design or offering of, or enrollment in M+C plans to employer groups or labor organizations (unions);*

- *How the waiver will remedy the problem(s);*

- *Expected improvements and outcomes for beneficiaries ;*

- *How the M+C program, the employer/union, and/or M+CO will benefit;*

- *Required CMS systems modifications - where applicable;*

- *Desired/recommended implementation date;*

- *Other details specific to the particular waiver that would assist CMS in the evaluation/approval of the request;*

- *A general estimate of the burden and/or administrative costs that will be reduced by granting such waiver;*

- *Contact person, phone and fax numbers and email address*

M+COs should submit waiver proposals electronically to eghpwaivers@cms.hhs.gov. We prefer that proposals are in the form of a Word document attachment to an e-mail, however, this is not mandatory. CMS may need to contact the M+CO for additional information and to discuss issues unique to the request.

We will act on all §617 employer/labor group waiver requests on an ongoing basis. Timing of our approval of waiver requests will depend on the number and complexity of waiver proposals received. As we have done for the waivers already approved, CMS will announce the availability of new waiver types to all M+COs through various means, including updates in this Manual.

Employer/union-only plans are still subject to monitoring by CMS to ensure compliance with other regulatory requirements, for example, M+C appeal and grievance requirements.

150.3 - Service Areas - (Rev. 14, 09-27-02)

Service areas of employer/labor-only plans need not be restricted or linked to the service areas identified by the M+CO for the M+C plans it offers to individuals. Therefore, the service area of the employer/labor-only plan may be larger or smaller than the service areas of the organization's M+C plans offered to individuals. If the service area is larger than the currently approved service area under the M+C contract, CMS is not requiring either a new plan application or a service area expansion. However, the M+CO is responsible for ensuring that plan benefits are available and accessible to Medicare enrollees with reasonable promptness and in a manner that ensures continuity of care in the provision of benefits. Organizations may

accomplish this by either furnishing benefits directly, arranging for them, and/or by paying non-contracted providers for plan benefits. Generally, an M+CO satisfies the requirement for payment to a non-contracted provider when it pays the amount (including cost-sharing) that the provider would have received, had the service been provided to a fee-for-service Medicare beneficiary. An M+CO must have a State license to offer health benefits and it must offer an M+C plan under that license. M+CO must offer at least one M+C plan to individuals somewhere in the same State in which an employer/union-only plan is offered.

150.4 - General Considerations - (Rev. 14, 09-27-02)

M+COs are not subject to the requirements in 42 CFR 422.80(a) related to pre-review and approval by CMS of marketing materials created specifically for M+C employer/union-only plans. An M+CO is required, however, to send informational copies of employer/union group-specific marketing materials to its regional office within 14 days of their release/use.

M+COs are responsible for the accuracy of the employer/union-only group marketing materials, including making any corrections to those materials where necessary. The CMS has not granted waiver requests to forego the provision of specific information to enrollees, as required by 42 CFR §422.111. This information is critical for members to completely understand the benefits in a plan, rules for obtaining covered services, and the rights they have as members of the plan.

APPENDIX A

CERTIFICATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE+CHOICE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare and Medicaid Services (CMS) formerly the Health Care Financing Administration (HCFA) and (INSERT NAME OF M+CO), hereafter referred to as the M+CO, governing the operation of the following Medicare +Choice plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the M+CO hereby requests payment under the contract, and in doing so, makes the following certification concerning CMS payments to the M+CO. The M+CO acknowledges that the information described below directly affects the calculation of CMS payments to the M+CO or additional benefit obligations of the M+CO and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The M+CO has reported to CMS for the period of (INDICATE DATES) all required risk adjustment data available to the M+CO with respect to the above-stated M+C plans. Based on best knowledge, information, and belief, "as of the date indicated below," all information submitted to CMS in this report is accurate, complete, and truthful.

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(INDICATE TITLE [CEO, CFO, or delegate])
on behalf of
(INDICATE M+CO)

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DATE