

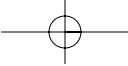
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Part 5

SPECIAL MARKET SEGMENTS

*"We're One
But we're not the same."*

—Bono [1991]



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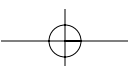


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HEALTH PLANS AND MEDICARE

Carlos J. Zarabozo and Sidney J. Lindenberg

Study Objectives

- Understand recent changes in the Medicare Modernization Act affecting Medicare managed care contracting and the significance of those changes.
- Understand the different types of Medicare D and Medicare Advantage programs.
- Understand what kinds of organizations can have Medicare Advantage contracts.
- Understand what the ongoing contract requirements are for organizations that have entered into contracts.
- Understand the factors the government uses in determining payments to Medicare Advantage organizations.
- Understand the rights and responsibilities of Medicare enrollees of health plans.
- Understand some of the issues related to how an organization administers a Medicare contract.

Discussion Topics

1. Discuss state licensure requirements that an organization must comply with to become a Medicare Advantage plan, any exceptions to the state licensure requirement, and any cases in which special consideration is given to particular types of entities.
2. Discuss the different types of Medicare Advantage plans, the key differences between them, and why such differences exist.
3. Discuss the impact of the new Medicare D drug benefit and how that benefit affects the market.

4. Discuss the kinds of consumer rights and protections available to enrollees, or prospective enrollees, of Medicare Advantage plans.
5. Discuss how the new reimbursement methodology for payments to Medicare Advantage plans will be applied. How does this differ from prior methodologies?

INTRODUCTION

On the morning of November 22, 2003, the House of Representatives passed a historic bill reforming the Medicare system. This event was historic in many ways. The hour of the morning happened to be 6:00 am or so, with passage of the bill coming after the voting on the floor was left open for a historic record of nearly 3 hours. Also historic was the content of the legislation that the House passed, which the Senate eventually passed and the president signed. The *Medicare Prescription Drug Improvement and Modernization Act of 2003* was heralded as the most significant reform of Medicare in the history of the program because it added drug coverage as a Medicare benefit, nearly 40 years after the beginning of Medicare. Although the headlines of the day were about the drug benefit, the bill that came to be known as the *Medicare Modernization Act* (MMA) also significantly changed the Medicare provisions dealing with private health plans. This chapter provides a summary of Medicare contracting provisions for managed care plans, and other types of plans, as modified by the MMA.

The chapter discusses Medicare private plan contracting from a primarily “operational” viewpoint. After the introductory sections, the sections of the chapter are ordered in a way that roughly matches the decision process of a person or organization deciding whether to enter into a Medicare contract. The chapter explains what kind of organization may enter into a risk contract, how the contractor is paid and what limits there are on the sources and uses of revenue under the contract, what the contractor is required to do, how marketing and information dissemination occurs, how enrollment occurs, and what rights beneficiaries and providers have.

BACKGROUND

With regard to the traditional Medicare program of Part A (hospital) and Part B (medical) benefits (as distinguished from the new drug benefit, Part D, that is described in the next section), one objective of the MMA was to extend the reach of private health plans in Medicare.* This was not a new goal for Congress, which had already tried a number of mechanisms to have health plans made available to more Medicare beneficiaries, and particularly to address the lack of such plans in rural areas, where nearly a quarter of Medicare’s 42 million beneficiaries reside. For example, the Balanced Budget Act of 1997 (BBA) introduced a payment “floor” for rural areas, which in some counties doubled the payment rates for Medicare plans operating in those counties. Although the payment floor did not bring more coordinated care plans such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to rural areas, the provision did lead to the proliferation of a particular type of plan newly authorized in the BBA, “private fee-for-service” (PFFS) plans (described later in this chapter).

Under the MMA, what had been the Medicare+Choice program became the Medicare Advantage (MA) program. To summarize briefly and succinctly what the MMA did with respect to health plans: it provided more money for health plans in a variety of ways. In addition, the MMA introduced a new approach to plan contracting through the

*In the case of the drug benefit, it is administered separately from the traditional Medicare program, and the benefit is available only through private plans, including through Medicare Advantage plans.

regional plan option. The Centers for Medicare and Medicaid Services (CMS), part of the federal Department of Health and Human Services (DHHS), has divided the United States into 26 regions. A regional plan agrees to offer PPO coverage throughout one or more of these regions. In addition to requiring that regional plans be set up as preferred provider organizations offered in every county of a region, payment rules and certain contracting provisions are different for regional plans.

In 2006, 36 states had a regional plan available. Although it was intended that regional plans would be the key to extending access to private plans throughout the country, 88% of Medicare beneficiaries have access to regional plans. This compares to the 80% of beneficiaries who have access to a “local” (nonregional) HMO or PPO (a historic—to use the word *historic* one last time—high in Medicare, exceeding the previous high of 74% in 1998), and the 99% of enrollees who have access to either a local coordinated care plan (HMO or PPO) or a PFFS plan (all of which are defined as local plans even though they may cover an entire region).¹ Thus, the MMA has been successful—one might say wildly successful—in extending the availability of private plans in Medicare.

The MMA created a second type of new MA plan—the Special Needs Plan (SNP). This type of plan may exclusively enroll, or enroll a disproportionate percentage of, special needs Medicare beneficiaries. Individuals with special needs include beneficiaries entitled to both Medicare and Medicaid (“dual eligibles” or “duals”), institutionalized beneficiaries, and individuals with severe or disabling chronic conditions.

THE MEDICARE PART D DRUG BENEFIT IN MEDICARE ADVANTAGE

All Medicare Advantage organizations other than PFFS plans and medical savings account (MSA) plans (both PFFS and MSA plans are described later in this chapter) are required to offer a plan with Medicare Part D drug coverage throughout their service area.

Organizations are free to offer plans that do not include drug coverage for beneficiaries electing to decline drug coverage. PFFS plans can include Part D drug coverage, but MSA plans are not permitted to include Part D coverage as part of the plan.

Overall Design and Financing of the Drug Benefit Program

As noted at the beginning of this chapter, 40 years after its inception, the Medicare program added drug coverage as a voluntary benefit to be administered, it was hoped (and the hope came to fruition), by private entities. The private entities are the “stand-alone” prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans.* The benefit is primarily paid for by Federal subsidies, with a portion paid by beneficiaries in the form of premiums and cost sharing, and a portion financed by plans that are partly at risk for the provision of the benefit. Access standards apply to ensure that beneficiaries have convenient access to pharmacies.

A major feature of the benefit is that the drug benefit for dual-eligible (Medicare/Medicaid) beneficiaries (also described later in this chapter) that was previously a Medicaid benefit became a federal benefit, with the states reimbursing the federal government for the cost of the benefit through a mechanism referred to as the “clawback.” Some drugs not covered under Part D continue to be provided through state programs. The migration to Part D of this population meant that there was a segment of the population that would be automatically enrolled in the otherwise voluntary Part D program. As explained later, this sometimes resulted in the assignment of this population into particular plans (or their being covered through MA

*Residents of long-term care (LTC) facilities obtain drug benefits from the pharmacy selected by the facility. There is a special enrollment period for people who enter, reside in, or leave an LTC facility.

if they were MA enrollees at the time of conversion from the state program to Part D).

Another feature of the program is that, in the interest of maintaining drug coverage for Medicare-eligible retirees through employers and unions—a major source of drug coverage for Medicare beneficiaries before the MMA—employers and unions could elect to continue to provide drug coverage, and they would receive a federal subsidy offsetting a portion of the cost.

There are four sources of federal payment to Part D plans for the benefit: (1) the direct subsidy (*ie*, the subsidization of beneficiary premiums) for all beneficiaries; (2) the low-income subsidy for Medicare/Medicaid dual-eligible beneficiaries and other low-income beneficiaries who apply for assistance under Part D rules (subsidizing premiums and cost sharing, fully or partly); (3) the reinsurance subsidy, whereby Medicare is responsible for the majority of costs at the catastrophic level of coverage; and (4) risk corridor payments, whereby risk is shared with plans around target amounts.

The Benefit Design

The statute specifies the Medicare drug benefit design, but variations in the design are permitted if they are actuarially equivalent to the basic benefit (as specified in law and regulations) or if there is an enhancement of the benefit (for which beneficiaries will pay an additional premium). The benefit is subsidized for all Medicare beneficiaries (as is Medicare Part B coverage), and low-income beneficiaries can receive additional subsidies for premiums and cost sharing.

The benefit is voluntary for beneficiaries, but delayed enrollment in Part D subjects a beneficiary to a premium penalty that the person pays throughout the entire coverage period after late enrollment. A penalty does not apply, however, if the person is not enrolling in Part D because he or she has “creditable coverage,” which is drug coverage from another source that is as good as or better

than Part D coverage. Many retirees have such coverage through their former employer and can retain the coverage. If the person loses the coverage—the employer discontinues the coverage—the individual is given the opportunity to enroll in Part D without a premium penalty.

The basic Part D benefit structure (referred to as the “defined standard” benefit) is somewhat complicated and is characterized by a “donut hole,” or coverage gap, during which an enrollee who has no low-income subsidy is responsible for 100% of the cost of drugs (albeit at the discounted rate that his or her plan offers). Figure 26-1 is the graphic display that CMS uses to illustrate the defined standard drug benefit (as of 2006).

In the standard benefit for 2006, there was a \$250 deductible, after which a beneficiary paid co-insurance of 25% until reaching \$2,250 (the “initial coverage limit”) in total drug expenditures (including the deductible). On reaching that point—the donut hole—the beneficiary pays 100% of the cost of drugs, as noted, until total expenditures reach \$5,100 (representing \$3,600 in true out-of-pocket costs for the beneficiary). At that point, catastrophic coverage begins. Under the standard benefit in 2006, catastrophic coverage had the beneficiary paying a 5% co-insurance (unless the person is a low-income beneficiary entitled to a subsidy that would pick up the co-insurance). The dollar amounts of the deductible, initial coverage limits, and catastrophic threshold will change from year to year; this explanation and Figure 26-1 use the 2006 dollar amounts.

Plans have the option of offering a benefit package that is different from the basic benefit. In place of the defined standard benefit, a plan may offer “actuarially equivalent standard coverage,” whereby the cost sharing is actuarially equivalent to the 25% level after the initial coverage limit and the 5% level after the catastrophic limit. For example, plans can use this approach to use copayments in lieu of cost sharing or to eliminate cost sharing for generic drugs. The other type of op-

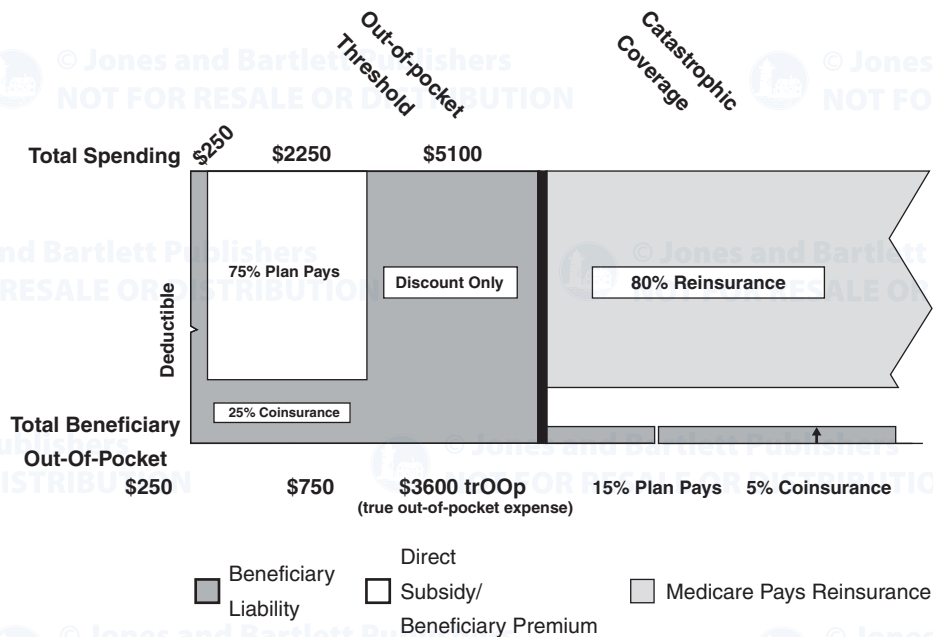


Figure 26-1 Standard Part D Benefit of 2006

Source: CMS.

tion that a plan can offer is an enhanced benefit that, for example, can fill in the deductible and/or the donut hole, but beneficiaries would pay the cost of such coverage through a plan premium, though an MA plan can also use rebate dollars (described later in this chapter) to buy down the Part D premium for any of the Part D options.

In designing a drug benefit, PDPs and MA-PDs may have a formulary, but CMS ensures that there is adequate coverage within classes of drugs and that the formularies used by plans do not discourage enrollment among certain groups of people.* CMS approves formularies in advance of the bidding process for plans to complete their bids. There is also an exception process for bene-

*Formulary review requirements are posted on the CMS Web site at http://www.cms.hhs.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp#TopOfPage. This Web address is current at the time of publication, but may be subject to change.

ficiaries to obtain drugs not on a plan's formulary or to obtain the drugs at a lower cost-sharing level.

Payment and Bidding for Part D

Figure 26-1 also illustrates the points at which the government subsidizes the costs, or shares in the cost of the coverage, for all beneficiaries. The government shares risk with health plans for the provision of the Part D benefit after beneficiaries reach the catastrophic level of coverage. (As of 2006, there is also a demonstration project in which plans accept capitation payments in lieu of the reinsurance subsidy.)

The Part D bid of an MA organization is separate from the bid for Medicare A/B benefits, though as noted, A/B rebate dollars can be used to reduce the Part D premium of an MA-PD plan. The bidding process for Medicare A/B benefits by MA plans, including the issue of rebates, is described later in this chapter.

The Part D bid is based on the standard benefit (even for a plan offering an enhanced benefit). The standard benefit excludes beneficiary cost sharing, reinsurance, and low-income cost-sharing subsidies. For a plan offering an enhanced benefit, to arrive at a standard benefit bid the cost associated with induced utilization because of lowered cost sharing must be excluded. This exclusion from the bid is in addition to excluding the cost to the plan of drugs that are not covered in the standard benefit—such as when the enhancement of the plan consists of doing away with the deductible—and excluding as a cost the filling in of cost sharing that would otherwise be the enrollee's responsibility in a standard benefit. The bids are based on the plan's projected enrollment, adjusted by the expected risk factors of the population, to arrive at a standardized bid. CMS has developed risk factors for Part D separate from those for the MA A/B bidding and payment process.

The Part D bids of MA-PD plans and those of standalone PDPs are aggregated and weighted by enrollment in the prior year to arrive at a "national average monthly bid amount."^{*} This bid amount is used to determine the basic beneficiary premium, taking into account the government's direct subsidy of the Part D benefit. The basic beneficiary premium is 25.5% of the national average bid amount (*ie*, about three-fourths of the premium is subsidized), less projected reinsurance payments the government will make.

The premium at the individual plan level for a PDP or an MA-PD is the basic beneficiary premium, adjusted by the difference between (1) the national average bid amount across all plans and (2) the plan's standardized bid (standardized to a person with average risk, or a risk score of 1.0). That is, there are higher premiums for plans bidding over the national average monthly bid, which the

beneficiary would pay. MA-PD plans may lower the premium (including to zero), using rebate dollars from the Medicare A/B bid, as previously mentioned. As noted earlier, a beneficiary may also be required to pay an additional premium penalty if he or she delayed enrollment in Part D, unless the delay was caused by the loss of creditable coverage benefits from another source.

Once an individual reaches the out-of-pocket threshold (the catastrophic limit—\$3,600 in true out-of-pocket [trOOP] in 2006), Medicare will reimburse 80% of allowable individual costs under the reinsurance provisions of the law.^{*} Organizations are permitted to obtain commercial reinsurance for the risk they assume in covering Part D drugs. Plans will receive interim payments for reinsurance, based on their bids, and there is a reconciliation performed after the end of the year.

Risk Corridor Payments and Targets

The government's risk sharing with plans occurs in corridors surrounding a target amount. The target amount is computed as the total direct government subsidy, plus beneficiary premiums, less administrative costs. The administrative costs are based on the percentage administration included in the plan bid. Risk corridor payment adjustments are made on allowed amounts actually incurred by the plan above or below the target amount.

Risk corridor payment adjustments are based on allowed amounts actually incurred by the plan above or below the target. The

^{*}There are certain rules about what can or cannot be counted as a beneficiary "true" out-of-pocket (OOP) cost. For example, most third-party payments cannot count as a beneficiary out-of-pocket expense. An important point is that a beneficiary's out-of-pocket expenses for drugs that are not on his or her plan's formulary do not count toward true out-of-pocket costs in determining whether the beneficiary has reached the out-of-pocket limit.

^{*}Not included are the bids of MA private fee-for-service plans or special needs plans, or the bids of cost-reimbursed plans.

adjusted allowable risk corridor costs are composed of (1) the covered Part D drug costs as determined by claims—ingredient cost, dispensing fee, and any sales tax—less (2) cost sharing, low-income subsidy payments, the drug costs and cost sharing of enhanced benefits, the induced utilization of an enhanced benefit, and any rebate dollars applicable to Part D drugs.

For 2006 and 2007, it is anticipated that plans would be at full risk for adjusted allowable risk corridor costs within 2.5% above or below the target. Plans with adjusted allowable costs above the “first threshold” limit of 102.5% of the target, up to the “second threshold” limit of 105% of the target, would be at risk for 25% of those costs. Above 105% of the target, plans would be at risk for 20% of the costs. If plans have savings in relation to the target, they are shared with the government, with plans retaining 25% of the savings and the remainder going to the government.

From 2008 to 2011, the level of risk assumed by plans increases. Plans are at full risk for allowable costs that are 5% above or below the target. Plans would have 50% risk between the first (105% of the target) and second (110% of the target) threshold levels. After the 110% level, plans would be at risk for 20% of the costs. For allowable costs below the target, plans would retain 50% of the savings between 95% and 90% of the target, and 20% of the savings below 90% of the target.

After 2011, the threshold amounts would be determined in such a way as to produce incentives for market entry. However, the first threshold risk percentage has to be 5% or more, and the second threshold percentage has to be 10% or more of the target amount.

Low-Income Subsidy Provisions

Low-income individuals are given financial assistance for their cost sharing and premiums for the Part D benefit. For those with the highest level of subsidy, the full-benefit dual eligibles with Medicaid coverage whose incomes are at or below 100% of the federal

poverty level, their only cost-sharing obligation is a nominal copayment (\$1 for a generic drug or preferred multiple source, and \$3 for any other drug) until the catastrophic limit is reached (the equivalent of \$3,600 in out-of-pocket expenses, if the individual had not had a low-income subsidy). For full-benefit duals with income above 100% but below 135% of the federal poverty level who meet an assets test, there is also only nominal cost sharing (\$2/\$5). For beneficiaries with income below 150% of the federal poverty level and limited resources who apply for assistance, there is premium assistance based on a sliding scale and partial assistance with cost sharing. CMS notifies the plan of a member’s eligibility for low-income subsidization.

For a full-benefit dual to have his or her entire Part D premium subsidized, the person must be enrolled in a plan with a premium at or below a certain level in a given region. That is, not all plans would be available to low-income individuals with the premium fully subsidized. The premium subsidy amount for a PDP region is the greater of (1) the low-income benchmark premium (essentially the enrollment-weighted average of all PDP premiums for basic drug coverage [the standard benefit] and the MA-PD drug premiums) or (2) the lowest monthly premium for a plan that offers basic prescription drug coverage. A person may enroll in a higher-cost plan by paying the difference between the computed premium subsidy amount and the actual premium.

BASIC REQUIREMENTS FOR ANY ORGANIZATION TO BE ELIGIBLE FOR A MEDICARE RISK CONTRACT

State Licensure

The most basic requirement for an organization to obtain a Medicare contract is that the organization must be licensed by the appropriate state regulatory authority as a risk-bearing entity under a scope of licensure that permits the organization to assume risk for

the comprehensive set of benefits that compose Medicare Parts A and B (as well as Part D). For all organizations, CMS requires that the state provide a certification that the nature of the licensure or authority to offer risk products is, in the opinion of the state, consistent with the requirements for assumption of risk as an MA organization.

Under CMS's regulatory interpretation of the statute, an entity need not be formally licensed by the state regulatory body overseeing HMOs and health insurers, as long as that regulatory body finds the legal status and financial status of the organization to be sufficient to manage the risk entailed by a Medicare risk contract. For example, an organization operating in a state as a "state-defined" Medicaid HMO that was not licensed by the insurance department (as the state regulatory body licensing HMOs in the particular state), but that was instead authorized to operate as a Medicaid plan by the state health department, could have an MA contract as long as the insurance department consented—agreeing, for example, that the state health department's standards for Medicaid contracts were sufficient for the purposes of MA contracting.

For regional plans (regional PPOs) only, the state licensure requirement can be temporarily waived if an organization is licensed in at least one of the states of the CMS-designated region and the organization has applied for licensure in the other state(s) in the region. State licensure requirements and regulatory oversight are discussed further in Chapter 33.

Minimum Enrollment

An organization seeking a Medicare Advantage contract must meet a minimum enrollment requirement of 5,000 "individuals . . . who are receiving health benefits through the organization," or 1,500 such individuals if the organization primarily serves rural areas. However, the requirement may be waived during the first three Medicare contract years.

TYPES OF MEDICARE PLANS

As noted earlier, the MMA introduced the regional plan concept, setting up an important distinction between regional plans (all of which are PPOs serving an entire region) and all other plans—referred to as "local" plans. Even though a local PPO may cover every county in one of the 26 MA regions, such a local plan is not considered a regional plan unless it chooses that designation and adheres to the rules that apply to regional plans.

The Medicare law also makes a distinction between coordinated care plans and other plans. Coordinated care plans include HMOs, PPOs (both regional and local), provider-sponsored organizations that operate like HMOs, and HMOs with point-of-service products. Other types of MA plans include PFFS plans and Medicare medical savings account (MSA) plans. One basis of the difference between the two broad categories is that coordinated care plans can require enrollees to use a network of providers for coverage of Medicare services. Other than in an emergency, a coordinated care plan has no obligation to cover the cost of care if a nonnetwork provider is used, even if the care would have been covered in fee-for-service Medicare. Private fee-for-service plans and MSA plans are not network plans in the sense of being able to limit coverage to a network. Enrollees of such plans have the right to expect the plan to cover the cost of care at any provider willing to accept the individual as a patient, consistent with the rules of the plan regarding coverage (*eg*, an MSA plan has no coverage before a deductible is met).

There are other differences between the two major categories—coordinated care plans and others—in terms of the statutory provisions that apply. With respect to bidding, while coordinated care plans are subject to a review of actuarial soundness and acceptability of the bids, and there can be negotiation over the bid, the bids of MSA plans and private fee-for-service plans are not subject to that level of review or negotiation.

Another difference between the two major categories is that MSA plans and private fee-for-service plans are not subject to the quality improvement requirements applied to coordinated care plans.

On the assumption that most readers are familiar with the HMO model and HMOs with point-of-service products,* this section describes the features of each of the other types of MA contracting organizations recognized under Medicare law.

Plan versus Organization

Because of certain statutory provisions, CMS makes a distinction between an organization holding an MA contract and the “plans” that organization offers. One organization may offer multiple plans in a given service area or multiple areas (including noncontiguous areas), as long as each plan meets applicable MA standards. The plans may differ slightly (*eg*, point-of-service benefits are or are not included) or they may be significantly different: the same organization offers a PFFS plan and a traditional HMO option. As will be discussed, each plan must have a uniform premium and benefit offering available to all residents of the service area of the plan (except that—to further confuse matters—there can also be “segments” of plans with different premiums). Where one organization has multiple plans, CMS will treat plans as severable if, for example, the need arises to impose a corrective action on a given plan or if a termination or nonrenewal of a particular plan of the organization is deemed appropriate. With regard to the bidding process that is explained later, there is a separate bid required for each plan.

Preferred Provider Organizations and Regional Plans

The Medicare law defines a preferred provider organization, but the definition is provided

*See Chapter 2 for descriptions of these types of models.

only in connection with quality improvement requirements that may or may not apply to the plan. According to the law, a PPO is a “plan that . . . has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; . . . provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and . . . is offered by an organization that is not licensed or organized under state law as a health maintenance organization.” Except perhaps for the very last provision, the definition seems to be consistent with most people’s opinion of what a PPO is. The definition is placed in the statutory section dealing with the reporting of quality indicators and states that local PPOs will provide data for contracted providers only (and that regional PPOs will have their own rules on quality reporting, established by CMS, but which would not exceed the requirements imposed on local PPOs).

One of the distinctions between regional plans (all of which, again, are PPOs) and local PPOs is that the law specifies that regional plans that wish to impose a deductible must have a single deductible for Part A and Part B services (unlike fee-for-service Medicare). The single deductible may be different for in-network and nonnetwork services, and it may be waived for preventive services or other services. The regional plan is required to have a catastrophic limit on out-of-pocket expenditures for in-network items and services that are Medicare-covered benefits, and a limit for total Medicare-covered expenditures. Although regional PPOs are required to have a network of providers, the access standard can be met by paying for nonnetwork services at Medicare fee-for-service rates. There is also a provision whereby the Medicare program will make payments to an “essential provider,” defined as a hospital that is necessary to include in the network but which, after a good faith effort on the part of the plan, does not agree to a contract with

payment at Medicare rates. For such cases, Congress has authorized funding of \$25 billion to provide additional Medicare payments to an “essential” hospital to have services provided to regional MA plan enrollees.

Private Fee-for-Service Plans

An organization may choose to enter into a contract with CMS to offer a private insurance plan that reimburses providers on a fee-for-service basis and does not limit enrollees to the use of network providers: an MA PFFS plan. As an enrollee of an MA PFFS plan, a Medicare beneficiary may use any Medicare-participating provider who agrees to provide services to the beneficiary, and the organization sponsoring the PFFS plan (*eg*, a private insurer) will make payment for covered services in a manner similar to a traditional indemnity plan operating in the private marketplace. A PFFS plan may not pay its providers on other than a fee-for-service basis, and it may not place providers at financial risk for the utilization of services.

The PFFS plan may have a network of providers who agree to the terms of the plan, but the law also provides for “deemed” participating providers. A provider is deemed to be a participating provider if he or she (or the entity) is aware of the beneficiary’s enrollment in the PFFS plan and the provider is aware of, or has been given a reasonable opportunity to be made aware of, the terms and conditions of payment under the plan “in a manner reasonably designed to effect informed agreement” to participate, as stated in the regulations. A noncontracting provider may receive, in total payments (from the PFFS plan and from enrollee cost sharing), only an amount equal to what would have been paid in total under original Medicare. Contracting and deemed providers may also receive additional payments from the enrollee (“balance billing”) up to 15% of the PFFS plan payment amount. The PFFS organization is charged with ensuring that providers adhere to the limits on permissible

balance billed amounts; failure to monitor adherence to the requirement can result in CMS’s decision not to renew the organization’s contract. Enrollees may incur additional liability if the PFFS retrospectively denies coverage (as not Medicare-covered or for non-Medicare-covered benefits not covered under the plan).

As noted in the Conference Report accompanying the BBA of 1997, which introduced PFFS plans, the PFFS option is the first Medicare option that had the structure of a defined contribution. That is, the government contribution toward the cost of the option is limited to the MA payment amount, but there are no limits on what the organization may charge as a member premium for the benefit package. This is now the case for all plans under the MMA, as explained in the section on bidding.

Medical Savings Account Plans

The MA MSA option is a medical savings account combined with a high-deductible plan that is responsible for paying 100% of the cost of covered care after a deductible is met. A portion of the capitation that would otherwise be paid to the MA organization is deposited in an account that the beneficiary can use, on a tax-preferred basis, to finance the cost of medical care, including medical care that is not covered by Medicare. The Medicare payment to the enrollee’s account is made at the beginning of the year for use during the year or in subsequent years (*ie*, unused funds roll over). The Medicare contribution may also be used to finance the cost of items or services that the Internal Revenue Service does not define as qualified medical expenses, and in such a case the withdrawal from the account would be taxable. After an enrollee meets the deductible of the high-deductible plan, the MA MSA plan covers 100% of the cost of Medicare-covered services (up to Medicare payment limits). There is no member premium for an MA MSA plan (unless the plan’s equivalent of a bid exceeds

the benchmark, in which case there is no enrollee deposit possible), and only Medicare services may be included in the plan, though additional benefits can be offered through an optional supplemental package.

The rationale for MSA plans, similar to the rationale discussed in Chapters 1, 2, and 20 regarding consumer-directed health plans (CDHPs), is that they eliminate “first dollar” coverage by a third party and thereby make individuals more prudent purchasers of health care. That is, until the deductible is met, a Medicare beneficiary uses his or her own money—including any money available from the MSA account—to pay for the cost of care. The actual expenses a person must incur out-of-pocket will vary with his or her health care needs, by the size of the deductible (no minimum has been established, but the maximum is \$9,500 per year in 2007), and by the level of contribution available from Medicare. In some cases, it may take several years to accumulate a Medicare contribution equal to the deductible.

On choosing this option, a Medicare beneficiary must remain enrolled in the MA MSA plan for at least 1 year (or until the next MA annual coordinated election period if coverage began during a person’s initial period of Medicare eligibility during the calendar year). Certain beneficiaries are not eligible to enroll in the MSA option: those on Medicaid and individuals obtaining health care coverage through certain federal programs such as the Federal Employees Health Benefits Program. A person must also reside in the United States at least half the year to be eligible to enroll.

In July 2006, CMS announced the availability of an MSA demonstration project whereby the benefit package would be changed to more closely resemble Health Savings Accounts (HSAs—a type of CDHP introduced by the MMA for the non-Medicare market). In the demonstration, there is a specified minimum deductible (\$2,000 in 2007) and a maximum deductible (\$9,500, as under the statute for nondemonstration plans), and a plan can provide coverage for preventive ser-

vices prior to a person’s meeting the deductible (as in the case of an HSA). The demonstration also permits plans to impose cost sharing between the deductible and the out-of-pocket limit, and to use differential cost sharing depending on whether the enrollee uses contracted or noncontracted providers. Under the demonstration, the MSA plan can include only service areas comprising an entire state, whereas nondemonstration MSAs can choose in which counties to operate without covering an entire state.

Service Areas and Special Rules for Employer Group Plans

In the early history of the Medicare HMO program, an organization’s Medicare service area was required to match its commercial service area, although one would be hard put to find specific statutory language expressing such a requirement. It was assumed that an organization would merely add a Medicare line of business to its products, with much of the remaining structure untouched (service area, provider network, and so forth).

Over time, CMS changed its policy and permitted organizations to operate in a smaller area for Medicare, as long as “county integrity” was maintained. That is, an organization could choose which counties within its authorized service area it wanted to include in the Medicare contract, but a geographical unit smaller than a county could not be designated as the Medicare service area for a given county unless the organization served only that portion of the county in its other lines of business. CMS approved Medicare service area designations requested by applicants on the basis of network adequacy (the ability to provide the full range of services under the contract in the service area), using standards to prevent discrimination or other “gaming” through service area configurations. This is essentially the current policy. However, there is a requirement that a plan’s premium and benefits be uniform throughout the service area (or in each “segment” of the plan’s service area), which often

dictates how an organization wishes to designate the service areas of its plans.

With regard to employer group offerings (discussed later), a health plan may elect to serve a particular county or set of counties only for employer group accounts. That is, although there is an open enrollment requirement for MA plans, a health plan can limit enrollment in a county to only those Medicare beneficiaries enrolling in a plan sponsored by an employer or union for its Medicare retirees.

Other Special Rules for Employer Group Retirees

Although CMS has historically offered health plans wide latitude in their arrangements with employers and unions that offer Medicare coverage to their retirees, the MMA went further by including a very broad waiver provision that encourages the offering of employer- or union-sponsored plans, including the option of having employers or unions directly contract with CMS as Medicare Advantage plans (as opposed to the indirect method of having the employer or union offer benefits through a licensed HMO or other type of health plan operating in the marketplace). To facilitate retiree coverage, among the kinds of waivers CMS has allowed recently are waivers allowing plans to enroll beneficiaries from outside the plan's service area, waivers pertaining to the publication of evidences of coverage and marketing material, and a waiver allowing plans to use Employee Retirement Income Security Act (ERISA) appeals provisions rather than Medicare appeals provisions.²

PAYMENT

Payment to plans is based on payment rates established by law and a comparison of these payment rates to plan bids under what is referred to as a competitive bidding system. In many respects the bidding system is similar to the earlier system of plans filing adjusted

community rate proposals to determine premiums and benefit packages.

Local MA Plans

The Bid

The bid of a local MA plan for coverage of Medicare A and B services is compared to a benchmark to determine whether there is a premium for Medicare-covered services and to determine the level of savings a plan projects if the plan believes that it can provide the Medicare package for less than the benchmark. For a plan operating in a single county, the benchmark is the county MA payment rate that is published in advance of the calendar year.

To explain the bidding process using the simplest of examples—a one-county plan—the plan would submit a bid for Medicare A and B services for its expected enrollment. That is, the plan would predict the demographic and health status makeup of its expected enrollment using the demographic and health status adjustment factors that form the basis of Medicare payments at the level of the individual enrollee. If, for example, the benchmark in a given county is \$1,000, and a plan is bidding at the benchmark, but the plan expects a relatively sicker enrollment averaging 1.1 times sicker (*ie*, 10% sicker) than the average, the average payment will be \$1,100 across the expected membership. If the plan is bidding at the benchmark, it means that the plan projects that its revenue needs would average \$1,100 per person to provide the Medicare A and B benefit. If the same plan expected a healthier set of enrollees—at 0.8 the average health status (*ie*, 20% less sick)—the benchmark would average \$800 (*ie*, the expected actual payments from Medicare), and, all other things being equal, the plan revenue requirements for the A and B benefits would be \$800.

For a plan that is bidding above the benchmark, enrollees will have to pay a premium for the Medicare A and B benefit package. This

A/B premium is determined based on a bid-to-benchmark comparison for a beneficiary of average health status (a 1.0 beneficiary)—that is, the bid and benchmark are standardized to determine the member premium for A and B benefits. In the case of a county in which the benchmark is \$1,000, where a plan expects an enrollment with exactly average health status (1.0), and the plan bids \$1,100 for covering the A/B benefits, Medicare beneficiaries will have to pay \$100 for A/B coverage in that plan.

To continue the example, assume instead that the plan had bid \$1,210 (1.1 times \$1,100) because it was expecting enrollees to be 1.1 times sicker than average. Enrollees of the 1.1 plan would still pay \$100 for A/B benefits through the plan because the bid and benchmark comparison is done on a normalized basis (1.0 risk status) for determining the A/B premium. In such a case, what is referred to as the government premium adjustment would result in a payment from CMS for a “1.1 person” of the plan bid (\$1,210) less the premium revenue from the enrollee (\$100), or \$1,110. The \$1,110 payment is \$10 more than the benchmark payment for a 1.1 person ($\$1,000 \times 1.1 = \$1,100$). In the case of a plan expecting an enrollment that on average has a 0.8 health status (healthier than average), the beneficiary premium would still be computed on a standardized basis—that is, for a 1.0 person. If this plan’s bid for the expected enrollment was \$880 (which normalizes to \$1,100 for a “1.0 person”), the CMS payment for a “0.8 person” would be \$780, in recognition of the \$100 revenue received from the member. In this case, the plan receives from CMS \$20 less than what the benchmark payment would have been for a “0.8 person” (\$800).

The preceding example of the government premium adjustment illustrates how each plan is made whole for its revenue needs through a combination of member premiums and payments for Medicare. The basic approach of the MMA is to pay plans their bids. Beneficiaries

are expected to choose among plans based on quality and price. For plans bidding over the benchmark, the government premium adjustment serves to put all plans on an equal footing with regard to price in that both plans in these examples operate at an equal level of efficiency (or inefficiency) in their ability to provide the Medicare A and B benefits. The revenue needs for providing the benefit exceed the benchmark, but the difference in revenue needs between one plan and the other, for their expected enrollment (\$1,210 versus \$880), is based solely on the risk status of the expected membership, not on the greater efficiency of one plan versus the other.

This example also illustrates a difference between the MMA provisions and pre-MMA law for risk contractors (under Medicare+Choice). The ability to charge a premium for Medicare A and B services because a plan’s revenue needs were greater than the Medicare payment in a given county did not exist prior to the MMA, except in the case of private fee-for-service plans. Previously, a plan had to live with the Medicare payment as the maximum revenue for the provision of A and B services, plus revenue representing Medicare’s cost sharing, which was also limited to the equivalent of what the beneficiary obligation would have been in fee-for-service Medicare.

A component of expenditures for Medicare A/B services that has to come from individual Medicare beneficiaries (or is paid through supplemental coverage) is Medicare’s cost sharing, such as the inpatient hospital (Part A) and Part B deductibles, and the 20% coinsurance for physician and supplier services. These expenditures are not the responsibility of the Medicare program, and therefore would not be included in determining Medicare program expenditures. For Medicare Advantage plans this means, for example, that only the Medicare program’s expenditures, and not those of beneficiaries for A/B cost sharing, are included in the benchmark of a county where the benchmark was set at 100% of projected fee-for-service costs.

In implementing the Medicare Advantage program, the MMA changed the approach to computing the value of Medicare cost sharing associated with the A/B benefit package, and the law also changed provisions regarding the amount that could be collected as Medicare cost sharing. Previously, the cost sharing limit, and the assumed revenue from cost sharing a plan would have to collect from members, was—for all plans—equal to the national average actuarial value of A/B cost sharing in fee-for-service Medicare. The MMA takes a different approach. The A/B cost sharing that can be collected from enrollees is computed using a proportional method, varying by geographic area, based on categories of service and the level of cost sharing for such services in fee-for-service Medicare. For example, for skilled nursing facility care, cost sharing in a particular area represents 18.7% of Medicare's skilled nursing expenditures. This percentage is applied to a plan's bid for providing Medicare-covered skilled nursing care for purposes of determining a level of cost sharing that would be actuarially equivalent to that of Medicare (resulting in a computed level of cost sharing that might be less than Medicare fee-for-service if, for example, a plan has the same rate of utilization of skilled nursing care but the services are obtained at a discount off of Medicare rates). The sum of the actuarially equivalent level of cost sharing for each category of service, based on a plan's bid, represents the portion of plan revenue that is expected to be derived from cost sharing for Medicare-covered services.

As noted earlier, another departure from the past is that the proportional factors used to determine cost sharing and the upper limit of cost sharing—which was previously a national figure—are now determined for the specific geographic area(s) in which a plan operates, generally at the level of the Metropolitan Statistical Area (or for all nonmetropolitan areas in a given state). Note that for a regional plan, in determining whether the actuarial limit of cost sharing is exceeded, CMS

considers only the catastrophic limit on out-of-pocket expenses for in-network benefits (not out-of-network benefits).

With respect to the upper limit of cost sharing for Medicare A and B benefits, the MMA changed the earlier approach in another way. Under pre-MMA rules, the total of the actuarial value of cost sharing at the point of service, plus any portion of the plan premium charged in lieu of Medicare cost sharing at the point of service, could not exceed the national actuarial value of Medicare's cost sharing (except in the case of PFFS plans). Under the MMA, cost sharing that is charged in the form of a premium rather than beneficiary out-of-pocket cost sharing at the point of service is not included when evaluating whether a plan's cost sharing for Medicare-covered services exceeds the actuarial value for the geographic area in fee-for-service Medicare.

This approach reflects the grand scheme of things in which all plans are paid their bid, and the total revenue a plan needs to provide the A and B services will be received in the form of government payments, member premiums, and cost sharing. Under pre-MMA law, only PFFS plans could charge a premium that would allow them to exceed the then-equivalent of a county benchmark plus allowable cost sharing.

Bids Below the Benchmark and the "Rebate"

The far more common case among MA plans would be a plan bidding below the benchmark because plans bidding above the benchmark may not be particularly attractive to beneficiaries. A plan bidding below the benchmark generates savings, 75% of which are given over to beneficiaries in the form of extra benefits such as cost sharing reductions in A/B, a reduced Part B or Part D (drug) premium, or added benefits not covered by Medicare (such as vision or dental care). The 75% of savings is referred to as the rebate. The 25% retention of savings by the government is a new feature under the MMA.

The amount of savings a plan generates is computed based on its expected enrollment. That is, the bid to benchmark comparison is not on a standardized basis (1.0), but rather it is based on actual expected expenditures compared to actual projected payments from Medicare. As was previously true, such savings have to be returned to beneficiaries in the form of extra benefits, as just noted, though with the advent of the Part D drug benefit, rebate dollars can be used to reduce, fully or partly, any Part D premium. Plans can “mix and match” the benefits they choose to fund with rebate dollars.

The rebate dollars are a fixed revenue stream. That is to say, once the rebate amount has been determined based on the expected enrollment in advance of the contract year, the per capita dollar amount CMS pays for funding rebates remains unchanged. If for example, a plan computed that it could provide a rebate valued at \$44 a month (*eg*, it chooses to reduce each enrollee’s part B premium by \$44), the plan receives \$44 per enrollee per month to finance rebates, regardless of the actual risk and demographic status of its enrollees. However, the bid that generated the \$44 in savings, which is the basis of CMS’s payment to the plan, is subject to risk adjustment (and geographic adjustment, as explained later) at the level of the individual enrollee.

Geographic Adjustment and the Bid

More common than a single-county bid is a bid that covers more than one county. In such a case, the bid takes into account the county of residence of the expected enrollees, and the benchmark is a weighted average of the benchmarks across the counties, based on the expected enrollment from each county (and the demographic and other risk characteristics of the expected enrollment). This is illustrated in Table 26-1, which shows both the effect on the bid of different benchmarks in each county as well as the expected average health status (shown as risk) of the enrollees coming from each county. Note that

the risk-adjusted bid and the risk-adjusted benchmark, as explained earlier, are used to determine the amount of the rebate.

In the example of Table 26-1, because the risk-adjusted bid is below the risk-adjusted benchmark, there is no basic premium for Medicare A and B services. If, for example, the plan described in Table 26-1 had bid \$700.50 for the expected population, there would be a premium charged for Medicare services, computed on the basis of a 1.0 benchmark (\$792) and a standardized (1.0) bid (equal to \$809, rounded). The member basic premium for Parts A and B services would be \$17 per month—which is greater than the risk-adjusted bid-to-benchmark difference would be for this over-the-benchmark plan (\$700.50 less \$690.50, or \$10). As explained earlier, the \$10 difference is smaller than the \$17 premium because the plan is expecting a healthier than average population.

Other Components of the Bid; Use of Rebate Dollars

Also part of the bidding process is the presentation of a bid for non-Medicare-covered services, which can be either mandatory or optional. Optional benefits are financed entirely by member premiums and can be declined by an enrollee. Mandatory benefits cannot be declined. However, non-Medicare benefits can be financed by rebate dollars. In the example of Table 26-1, the \$60 rebate can be used to finance the inclusion of \$60 worth of non-Medicare benefits for each enrollee.

As noted earlier, the rebate may also be used to reduce Medicare cost sharing, the value of which is determined through the bidding process. In the example of Table 26-1, the plan may have computed Medicare cost sharing as averaging \$90 per month. The plan may use its rebate dollars to buy down \$60 of cost sharing and charge beneficiaries a premium of \$30 per month to finance the Medicare cost-sharing obligation (in which case there could be no cost sharing for Medicare benefits at the point of service; alternatively there could be no

Table 26-1 Example of Local Medicare Advantage Plan Bidding, Below the Benchmark, Multiple Counties

	Local Monthly MA Payment (= Benchmark of One-County Plan)	Expected Number of Enrollees	Computation of Weighted-Average Benchmark If All 1.0 Risk (Each County's Portion of Total Benchmark)	Expected Risk Score of Enrollees in Each County	Revised Weighted Average Benchmark Based on Expected Risk	Projected Plan Revenue on Expected Risk and County of Origin of Enrollees = BID
Big County	\$1,000	100	\$455	0.9	\$409.50	
Medium County	\$700	70	\$223	0.8	\$178.40	
Small County	\$500	50	\$114	0.9	\$102.60	
Total or Average		220	\$792		\$690.50	\$610.50
					Savings (risk-adjusted benchmark less bid)	\$80.00
					Rebate (75% of savings)	\$60.00

premium, and the plan can have cost sharing charges at the point of service, the actuarial value of which averages \$30 per month).

Geographic Adjustment at the Time of Payment

When it comes time to pay plans that have submitted multicounty bids, the payment is the standardized bid (or the standardized benchmark—for plans at or above the benchmark), adjusted for geography and the risk status of individual enrollees. The way in which the geographic adjustment is made is via what is called the intra-service area rate (ISAR) adjustment. This serves to “correct” erroneous projections regarding the county of origin by adjusting the bid based on the relationship among the local MA payment rates of the individual counties that are included in the bid. For example, if a plan was expecting an equal enrollment distribution from two counties, one of which had a benchmark of \$1,000 and the other a benchmark of \$500, and the plan bid equals the benchmark, the bid and benchmark would equal \$750 for the plan for each enrollee. If the enrollee was coming from the \$1,000 county, the plan-level benchmark of \$750 would have an ISAR adjustment ($1 \frac{1}{3}$) to arrive at a payment of \$1,000. If all enrollees came from the \$1,000 county, each enrollee (with a 1.0 risk status) would have a payment of \$1,000. (The ISAR adjustment does not apply to the MA MSA plans, and the adjustment can be done differently for regional plans, as explained later.)

As noted earlier, the rebate dollars remain fixed and are not subject to adjustment for geography or for risk status of the actual enrollment.

Regional Plan Benchmarks and Bids

The principle of bidding is the same for regional plans as for local plans, except that there is a different method for determining regional benchmarks, and there is an alternative approach to ISAR adjustment that plans may choose. The plan-level benchmark for

regional plans (all of which are of necessity composed of multiple counties) is determined not on the basis of the expected enrollment across counties, but rather through a formula made of two components. One component includes plan bids (the competitive component), and the other component is the statutory component that sets a portion of the benchmark for a region based on the Medicare population distribution in the region. The MMA specified which percentage of the regional benchmark would be composed of each of these two components. The statutory component of the benchmark is the Medicare population-weighted average of all local MA payments in the region, times the percentage of Medicare beneficiaries throughout the nation who are *not* enrolled in MA (*ie*, are in fee-for-service Medicare). The plan bid component is the enrollment-weighted average of all regional plan bids, based on the plans’ expected enrollment, times the percentage of Medicare beneficiaries in the nation enrolled in MA plans.

As noted earlier, the introduction of regional plans was intended to extend the availability of private plans and to make coordinated care plans available in rural areas. The MMA provided a number of advantages to regional plans. Through 2007, regional plans share risk with the government, and through 2007 regional plans, which are structured as PPOs, do not face any competition from new local Medicare Advantage PPOs.

Beginning in 2012 and thereafter, regional plans have access to a stabilization fund of \$3.5 billion, plus half of the government share of savings from regional plan bids (the 25 percent of savings that is the government share of savings in the bid-to-benchmark comparison to determine rebate amounts). The stabilization fund is used to subsidize an organization operating as a national plan covering all 26 regions of the nation as a regional MA plan, entitling such an organization to a 3% increase in the benchmark for 1 year. The fund is also used to encourage new entry of regional organizations into regions

where no regional plans are available, by increasing the benchmark, and to encourage the retention of a regional MA organization in a particular region if an organization is contemplating exiting the program and fewer than two MA regional plans would be available and the enrollment in regional MA plans in that region is below the national average.

A payment option available to regional plans only is the use of a plan-specified ISAR adjustment. CMS allows regional plans to specify the relative cost (revenue needs) by county for purposes of making the geographic adjustment that applies at the point of payment. That is, when the county-level payment is determined based on the residence of the individual beneficiary, whereas a local plan's bid is adjusted by the relationship between the county's MA payment rate and the rate for other counties in the service area of the plan, the regional plan can specify what the relationship is among county rates.

To repeat the example from the local plan ISAR explanation earlier in this section, if a plan was expecting an equal enrollment distribution from two counties, one of which had a benchmark (*ie*, local MA county payment rate) of \$1,000 and the other a benchmark of \$500, and the plan bid equals the benchmark, the bid and benchmark would equal \$750 for the plan for each enrollee. If the enrollee was coming from the \$1,000 county, the plan-level benchmark of \$750 would have an ISAR adjustment ($1\frac{1}{3}$) to arrive at a payment of \$1,000. A regional plan could state that the relationship in revenue needs between the two counties was something other than the $1\frac{1}{3}$ applicable to local plans that is based on the county MA payment rates.

Risk Adjustment

An important change in payment policy addresses the issue of selection bias among Medicare risk plans. Previously, the payment adjustment factors were limited to demographic factors such as age and sex. Beginning in the year 2000, on a phased-in basis, CMS payments to health plans are adjusted

at the individual level by demographic factors and health status factors of a plan's individual enrollees, based on diagnostic information submitted by Medicare Advantage plans. The factors are available at the CMS Web site. As of 2004, the demographic factors include age/sex, Medicaid, and previous entitlement to Medicare as a disabled person. There is a separate set of factors for the institutionalized, and there are adjustments made for the "working aged" (beneficiaries who have employment-based health care coverage that is primary in relation to Medicare coverage).

The health status risk adjustment system is known as the CMS-Hierarchical Condition Categories (CMS-HCC) system, which is based on diagnoses made in inpatient and outpatient settings as well as physician settings of care. Beneficiaries are classified by disease group, including a no-disease group. There are different factors within each disease group, and beneficiaries are placed in the most severe category within a specific disease group. The payment adjustment factors become additive when a person is included in more than one disease group.

The diagnostic information for the CMS-HCC adjustments is based on a minimum data set submitted by health plans at least once per quarter. The risk adjustment system is based on the factors as they apply to the entire Medicare population, and therefore Medicare fee-for-service beneficiaries are included when the factors are determined and updated. Payments to health plans are affected by a lag in updating of the factors. At the beginning of the year, payments are based on factors computed for a 12-month period that began 18 months prior to January. In the middle of the year, CMS updates the payment factors and makes retroactive adjustments to payments for the first half of the year. After the end of the contract year, there is a calculation of final reconciliation factors based on diagnostic data for the payment year in question. The final reconciliation occurs in the fall of the following year, and MA plans are allowed one year to correct initial diagnostic data for an individual. A

health plan's data submissions are subject to validation and monitoring to ensure the integrity of the risk adjustment system.

There continues to be a phase-in of risk-adjusted payments in that, while (as of 2006) health plans continue to enroll healthier-than-average beneficiaries, Medicare does not fully reduce plan payments to the level that would occur if the system were fully phased in. Instead, MA plans receive a portion of the difference in payment between the fully risk-adjusted level and the level of payment based on an exclusively demographic adjustment system without health status factors. In 2007, health plans received 60% of this difference; in 2008, plans will receive 45% of the difference; in 2009, 30%; and in 2010, the last phase-in year, 15%. The difference is redistributed among health plans based on the relative health status of each plan's enrollees.

User Fees

One more factor affects payments, which is a reduction in payments on the basis of a pro rata user fee collected from all MA organizations for the cost of MA information activities described later in this chapter and for counseling and assistance programs.

Announcement of Rates; Computation of Rates

The announcement of rates for each calendar year occurs early in the year to allow time for development of the informational material necessary for the coordinated open enrollment period. At least 45 days before the announcement of rates, CMS is required to provide advance notice of proposed changes to be made in the methodology and invite comment on those changes and on the actuarial assumptions that form the basis of the following year's payment rates. By the first Monday of April, the rates for the subsequent year are published. This rate book lists, for all U.S. counties, Medicare Part A and Part B base rates for the aged and the disabled (beneficiaries younger than 65 years entitled to Med-

icare because of their disability), together with the demographic and health status adjustment factors that are to be used to adjust the base rates. State-level rates are given for individuals with end-stage renal disease, for whom payment is made on the basis of a separate risk adjustment system. Also announced in the spring are the statutory components of the benchmarks for regional plans.

The Tyranny of the Calendar

The Medicare Advantage program forces organizations to do advance planning revolving around the various deadlines that are imposed. Table 26-2, lifted wholesale from the CMS Web site, shows all the dates of relevance to an MA plan for the 2007 contract year; although specific dates will change each year, Table 26-2 illustrates the relative points in time for specific activities. By March, a newly contracting organization needs to know what its intentions are for the following year, and if the organization is unable to submit a bid by June, it will be another year and a half before the organization will be able to enroll its first Medicare members. Table 26-2 also provides a quick summary of the major steps that a plan has to take in operating a Medicare contract.

Premium Tax Prohibition and Other Preemption of State Laws

The MMA continues the federal law that prohibits states from imposing premium taxes on CMS payments to MA organizations, and the MMA broadened the federal preemption of state law provisions so that all state laws are preempted with respect to Medicare Advantage plans and their Medicare operations, except for state laws governing health plan licensure and solvency standards.

WHAT THE CONTRACT REQUIRES

All MA organizations sign a standard contract; there is no negotiation over the terms of the contract. The contractor must comply with the terms of the contract, federal regula-

Table 26–2 Key Projected Dates in the 2007 Application/Renewal Process for Medicare Health Plan Organizations and Prescription Drug Plans

This calendar outlines key dates in the 2007 individual and employer group market Medicare Advantage (MA), Medicare Advantage-Prescription Drug (MA-PD), Prescription Drug Plan (PDP) application and renewal processes, as well as in the 1833 and 1876 cost plan renewal processes. This calendar is posted on the CMS Web site at www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CY2007timeline.pdf. This calendar will be updated and expanded periodically. We encourage you to check the Web site and calendar regularly for changes and to take note of the timelines and deadlines for participating in these programs.

2006

March	<p>March 20—Deadline for submission of ALL 2007 initial Applications MA, MA-PD (including SNPs and Demonstrations), PDP, Direct Contract Employer/Union-Only Group Waiver Plans (EGWPs), and MA Organization, PDP, or Cost Based Plan Sponsor offering EGWPs, and ALL 2007 SAE applications</p> <p>March 22—Issuance of final formulary guidance</p> <p>March 27—Release of Health Plan Management System (HPMS) formulary submissions module</p> <p>March 30—Posting of the final call letters</p> <p>March 31—Transition Guidance Release target date</p>
April	<p>April 3—Issuance of Calendar Year (CY) 2007 Medicare Advantage Payment Rates</p> <p>April 3—2007 Reporting Requirements Comment period ends</p> <p>April 5, 6, 11—Bidders Conference (April 5 MA-PD Sessions, April 6 Actuaries Sessions, April 11 Actuaries Repeat Sessions)</p> <p>April 7—Plan Creation module, Plan Benefit Package, and Bid Pricing Tool available on HPMS</p> <p>April 17—Formulary Submissions Due from all MA-PDs and PDPs (including Direct Contract EGWPs and MA Organizations, PDPs and Cost-PD [for Part D] Sponsors offering EGWPs)</p>
May	<p>May 1—Deadline for CMS to inform currently contracted organizations that CMS has authorized renewal of their contract</p> <p>May 1—Transition Policy Submission target date</p> <p>May 1—Deadline for notifying CMS of organization's intent to stop offering RPPO's in an MA region</p> <p>May 15—End of IEP for Part D and AEP for MA</p> <p>May 19—PBP/BPT upload module available on HPMS</p>
June	<p>June 5—Deadline for submission of bids for all MA, MA-PD, Cost PD and PDP applicants and renewing organizations (including direct contract EGWPs and MA organizations, PDPs and cost based plan sponsors offering EGWPs)</p> <p>June 6—Submission of CY 2007 marketing materials scheduled to begin</p> <p>June 30—End of the MA Open Enrollment Period</p>
July	<p>July 15—Last date by which applicant must receive a determination (as a result of either CMS' initial application review or a favorable redetermination) that it is qualified to enter into a Part D contract for program year 2007</p>
August	<p>August 5—Deadline for cost plans not offering Part D to submit A/B benefit information in order to appear in Medicare Compare and Medicare and You Handbook</p>
September	<p>Early September—CMS signs contract with successful Part C & Part D applicants</p> <p>September 14–15—Plans preview data for the <i>Medicare and You 2007</i> handbook (date tentative)</p>

continues

Table 26–2 Key Projected Dates in the 2007 Application/Renewal Process for Medicare Health Plan Organizations and Prescription Drug Plans—continued

October	October 2—Deadline for cost plan information of intent to non-renew for 2007 October 12 (tentatively scheduled)—Medicare Personal Plan Finder and Medicare Personal Drug Plan Finder data goes up on the Web October 30— <i>Medicare and You 2007</i> handbooks in mail to beneficiaries
November	November 15—2007 Annual Coordinated Election Period begins
December	December 31—2007 Annual Coordinated Election Period ends

Source: CMS.

tions and statutes governing the contract, and certain other federal laws, as outlined in the standard contract (*eg*, the Civil Rights Act of 1964, the Americans with Disabilities Act, Health Insurance Portability and Accountability Act [HIPAA], among others). However, federal acquisition regulations do not apply to MA contracts.

In contrast to prior regulations, the MA regulations are much more explicit in listing the contracting requirements that an MA organization must comply with and their responsibilities with respect to subcontractors. The standard for administrative and management capability is carried over from prior regulations but now includes a compliance plan to ensure that the MA organization has dedicated and accountable resources to ensure compliance with MA contract requirements.

CMS has also exercised regulatory discretion in certain areas, for example, in departing from the practice of making renewals of contracts automatic in the absence of notice by either party of an intent not to renew. Instead, CMS will make a determination each year as to whether a contract should be renewed. CMS may choose not to renew a contract if the organization has failed to implement quality improvement, has an insufficient level of enrollment, or has committed an action that would subject the organization to a civil money penalty under MA rules.

Due process provisions for contract nonrenewals and terminations are clarified in the regulations. There is also a provision allowing CMS to terminate a contract immediately be-

fore the outcome of any appeal of the decision if a situation arises in which the health of enrollees is put at risk because services are not made available.

Some Basic Requirements

An organization must have sufficient administrative ability to carry out the terms of a Medicare contract. Organizations are also required to be able to provide at least the Medicare benefit package to their Medicare enrollees, following Medicare coverage rules.

A contractor must make available all the Medicare services available in fee-for-service Medicare to beneficiaries residing in the service area and must use Medicare-certified providers—hospitals, skilled nursing facilities, and home health agencies. The plan's physicians and suppliers must not be barred from participation in either Medicare or Medicaid because of program abuse or fraud.

For network plans, services must be available through staff providers or providers that are under contract with the organization (with an exception for regional plans, as discussed earlier). Although all plans must follow Medicare coverage guidelines applicable in the geographic area in terms of what services are considered to be “reasonable and necessary” and therefore covered by Medicare, because Medicare's fee-for-service coverage varies by area (*ie*, there are local coverage determinations), a regional MA plan may elect to have any local coverage determination that applies in any part of an MA region

apply to all parts of that same MA region. An example of some of these access requirements as they apply to network physicians is provided in Chapter 5.

Organizations are required to provide the benefits in a manner that ensures quality, availability, and accessibility of services. However, some of the requirements vary between network plans (HMOs, PPOs) and non-network plans (PFFS plans and MSA plans).

Under a network plan, an organization must be able to provide 24-hour emergency services and must have provisions for the payment of claims for emergency services within the service area and for out-of-area emergent or urgently needed services. All services that an organization is required to render (including any non-Medicare services in the benefit packages) must be accessible with reasonable promptness, and there must be a record keeping system that ensures continuity of care. The organization is required to maintain the confidentiality of the medical and nonmedical records of its Medicare members.

Quality Standards

Each MA plan (other than PFFS and MSA plans) must have an ongoing quality improvement program through which the organization conducts quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction. The organization must also encourage its providers to participate in CMS and DHHS quality improvement initiatives.

In addition, each plan must have a chronic care improvement program (CCIP). The CCIP identifies enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program, and the program must have a mechanism for monitoring enrollees' participation. MA organizations are required to submit annual reports on their CCIP program to CMS.

Other quality requirements include the need to follow written policies and procedures that

reflect current standards of medical practice when processing requests for initial or continued authorization of services (see Chapter 9). The plan must have in effect mechanisms to detect both underutilization and overutilization of services. A plan must be able to measure its performance, using the measurement tools required by CMS. Plans will report information on quality and outcomes measures to CMS so that CMS can provide this information to Medicare beneficiaries.

MA plans are responsible for selecting and initiating quality improvement projects on topics relevant to their population, as discussed in more detail in Chapter 15. The quality improvement projects that an organization undertakes are to focus on specified clinical and nonclinical areas and would involve performance measurement, system interventions, performance improvement, and systematic and periodic follow-up on the effect of the interventions. Quality improvement project reports will be submitted as part of a health plan's CMS monitoring visit (occurring every 3 years). Project reports will be collected as part of presite visit preparation and will be sent to a review entity. Results of the project evaluation will be incorporated into the monitoring report, and any corrective action plan requirements will also be fulfilled under ongoing monitoring oversight.

The plan must perform a formal evaluation at least annually of the impact and effectiveness of its program, and all problems that are revealed through internal surveillance, complaints, or other mechanisms must be corrected.

Quality Reports and Surveys

In addition to the reporting and auditing of Health Plan Employer Data Information Set (HEDIS)* data, which is the responsibility of MA organizations, Medicare enrollees

*See Chapter 23 for detailed descriptions of HEDIS and CAHPS.

of health plans participate in satisfaction surveys—the annual Consumer Assessment of Health Plans Survey (CAHPS) for enrollees and disenrollees, the quarterly CAHPS Disenrollment Reasons Survey, and the Health Outcomes Survey (HOS). CMS arranges for and pays for administration of the CAHPS survey, whereas MA organizations are responsible for administering the HOS survey. PPOs report on a subset of HEDIS data.

CMS uses the reported data to provide information to Medicare beneficiaries and others. The HEDIS, CAHPS, and Disenrollment summary data are part of the Medicare Personal Plan Finder, the online tool at Medicare.gov that beneficiaries can use to select Medicare health plans. CMS also expects plans to use the data, including HOS data, for internal quality improvement. The data should help plans identify some of the areas where their quality improvement efforts need to be targeted and may be used as the baseline data for quality improvement projects. Additionally, all four data sets may be used for research purposes by public or private entities.

CMS may target areas that warrant further review based on the data. For example, CMS has developed a Performance Assessment System that will array information from the HEDIS, HOS, CAHPS, and Disenrollment data sets in a manner that will permit performance evaluation by CMS. Plans can also view their own information online via secured access to the CMS's Health Plan Management System.

External Review

Coordinated care plans are subject to external review of the quality of care they render. The Quality Improvement Organizations (QIOs, formerly peer review organizations) that are under contract to CMS to review the quality of care of hospitals in fee-for-service Medicare also review the quality of care among MA enrollees. The current approach

to the role of the QIOs moves away from review of individual cases and toward a collaborative approach focusing on patterns of care. QIOs are also authorized to provide technical assistance to plans when they design their quality improvement projects and to evaluate the results of these projects. QIOs also review complaints by MA enrollees about the quality of care in an MA plan. As in fee-for-service Medicare, QIOs process beneficiary requests for review of hospital discharge decisions.

Deemed Compliance with Quality Requirements

MA organizations may meet certain quality standards through accreditation by a private accrediting body (such as the National Committee for Quality Assurance; see Chapter 23). The only requirements that may be deemed as met are quality assessment and performance improvement requirements and confidentiality and accuracy of enrollee records requirements. The accrediting organization must be approved by CMS, with approval subject to notice and comment in the *Federal Register*. Approval of the accrediting body may be withdrawn under certain conditions.

LIMITATIONS ON PHYSICIAN INCENTIVE PLANS

A plan that has a physician incentive plan that places physicians at substantial financial risk, as defined in Medicare regulations, for the care of Medicare or Medicaid enrollees, must provide for continuous monitoring of the potential effects of the incentive plan on access or quality of care. This monitoring should include assessment of the results of surveys of enrollees and former enrollees, and the plan should review utilization data to identify patterns of possible underutilization of services that may be related to the incentive plan. Concerns identified as a result of this monitoring should be considered in development of the organization's focus areas

for quality improvement projects. More detail on these limitations is provided in Chapter 5.

CONSUMER PROTECTIONS

MA plans are subject to certain requirements relating to access to services for beneficiaries, information to be provided to enrollees, and appeal rights that must be provided to Medicare members.

Access Standards

With regard to access to care standards, the regulations have a number of requirements, including the following:

- Requiring unrestricted communication between patients and health care professionals through the prohibition of “gag” clauses
- Using the “prudent lay person” definition of what constitutes an emergency, the liability of the MA organization for the cost of such care, and a requirement to cover appropriate maintenance and poststabilization care after an emergency
- Covering out-of-area dialysis during an enrollee’s temporary absence from the service area
- Limiting copayments for emergency services to no more than \$50
- Specifying that the decision of the examining physician treating the individual enrollee prevails regarding when the enrollee may be considered stabilized for discharge or transfer (codification of existing policy)
- Requiring plans to permit women enrollees to choose direct access to a women’s health specialist within the network for women’s routine and preventive health
- Requiring that services be provided in a “culturally competent” manner (*ie*, with sensitivity toward cultural, ethnic, and language differences)

Information on Advance Directives

MA organizations must meet the same requirements applicable to hospitals under Medicare with regard to maintaining written policies and procedures for advance directives.

Member Appeals and Grievances

MA enrollees have the right to an administrative and judicial appeals process for claims and payment issues, and the right to a plan grievance process for other issues. The rules for Medicare appeals (referred to in regulations as organization determinations) pertain to decisions regarding coverage or cost of an item or service included in the Medicare contract (Medicare-covered items and services and additional and supplemental benefits), including payment for out-of-network services received in an emergency.

Appeals

The steps of the appeals process include the following:

- The determination by the organization (or a subcontracted entity)
- Reconsideration by the organization, or, if the organization proposes a reconsideration decision adverse to the beneficiary, review of that decision by an external review entity under contract to CMS
- Review by an administrative law judge (for claims valued at \$110 at the time of publication [an indexed amount subject to change each year]) of the external review entity’s decision if adverse to the beneficiary (but the MA organization is not entitled to appeal a decision by the external review entity when the decision is in favor of the beneficiary)
- Review of the administrative law judge decision by the Departmental Appeals Board of the US Department of Health and Human Services (a right available to members and to the MA organization)

- Judicial review in federal court for claims valued at \$1,090 or more (as of the time of publication—this amount is also indexed)

The first-level determination is to be made by the MA organization within 14 days (or “as expeditiously as the enrollee’s health condition requires” but no later than 14 days), and a reconsideration decision (by the organization or the review entity) is to be made within 30 days (with the same requirement for expeditious processing). For expedited appeals, the standard is that a decision must be rendered within 72 hours.

QIOs also review beneficiary complaints, including beneficiary appeals about the appropriateness of a hospital discharge. Expedited time frames similar to those of fee-for-service Medicare apply in such a case.

Grievances

Grievances against a plan, as opposed to Medicare appeals, are subject to different standards. Beneficiaries must currently be afforded a meaningful grievance right when the matter in dispute is an issue other than coverage or cost of an item or service the MA organization is obligated to provide. The statute requires organizations to provide data on the number of grievances and their disposition in the aggregate on an enrollee’s request.

PROVIDER PROTECTIONS AND RIGHTS

Medicare contracting health plans are required to afford certain rights to contracting providers, and plans are required to make timely payment on claims from noncontracting providers.

Basic Provider Rights

The MA statute contains provider protections, including the following:

- A provision prohibiting discrimination against particular providers, in selection

of providers or payment or indemnification provisions, solely on the basis of the provider’s licensure status

- Appeal rights afforded to providers in the event of exclusion from a network
- A requirement that MA organizations consult with plan physicians regarding medical policy, quality, and medical management procedures

The MA statute also permits a health care professional to refuse to provide advice, counseling, or referral for a service that the provider objects to on moral and religious grounds, as long as the MA organization provides notification to enrollees of the applicability of this provision.

Prompt Payment to Noncontracted Providers

MA plans are required to meet the same prompt payment standards that apply to Medicare carriers and intermediaries in fee-for-service Medicare with respect to the timeliness of payments made to noncontracted physicians and other providers. The standards apply to clean claims; that is, claims having no “defect or impropriety” as the law says and not lacking “substantiating documentation” or “requiring special treatment.” The standard is that 95% of clean claims must be paid within 30 days.

ENROLLMENT OF MEDICARE BENEFICIARIES INTO MA PLANS

There are specific rules that MA plans must follow with respect to enrollment and disenrollment of Medicare beneficiaries.

Information Dissemination

Until the BBA, marketing and information dissemination regarding private health plan options were primarily functions undertaken by the contracting organizations themselves.

The BBA sought to increase CMS's role in the dissemination of information and also took a number of steps to facilitate MA enrollment in certain cases, such as when a person first becomes eligible for Medicare. Beginning with an information campaign in 1998 and a coordinated open enrollment in 1999, the BBA directed CMS to provide comparative information containing comprehensive, detailed information about health plan choices. As noted, this activity is funded by user fees imposed on participating MA plans. CMS is also required to maintain a toll-free number accessible to beneficiaries residing in areas with MA plans.

The national Medicare education program includes a Medicare handbook with prominent mention of private health plan options and the Internet site at <http://www.medicare.gov>, which provides comparative information on all plan choices. The outreach and education program also includes a toll-free number (1-800-Medicare or 1-800-633-4227), local health fairs before the annual election period, and other outreach efforts with various partners.

Enrollment and Election Periods

A previous version of this chapter published many years ago began, "TGIF—The Government Is Frightening, unless you know your acronyms." Acronyms continue to abound at CMS, particularly on the subject of enrollment, with the Annual (A), Initial (I), Open (O), and Special (S) Enrollment Periods (EPs). The AEP is what is commonly referred to as an open enrollment period, during which time any eligible Medicare beneficiary may enroll in an MA plan. IEPs and SEPs apply to particular circumstances, with IEPs applicable to individuals newly becoming eligible for Medicare and SEPs applicable to special circumstances.

Who May Enroll

Except in the case of a plan that is not open for enrollment because it has a capacity

waiver, or a plan for which enrollment is limited to special needs individuals or employer group members only, during an election period, any Medicare beneficiary residing in the service area of an MA plan is entitled to enroll in the plan, as long as the person has both Part A (hospital insurance) and Part B (supplementary medical insurance) of Medicare. Medicare beneficiaries who are Medicaid recipients may also enroll.

The only Medicare beneficiaries not entitled to enroll (and to whom a plan must refuse enrollment under the law) are beneficiaries who have end-stage renal disease (ESRD), whether aged, disabled, or entitled to Medicare solely because of their disease. However, enrollees who acquire ESRD after enrollment in the plan may not be disenrolled because they have ESRD, and individuals who were enrolled as non-Medicare members of a plan who have ESRD may be retained as Medicare enrollees on becoming eligible for Medicare. The one exception to the rule is that there can be special needs plans offered to individuals with ESRD, who would not otherwise be entitled to enroll in an MA plan.

The annual election period (AEP) runs from November 15 through December 31, for enrollments effective the following calendar year. This is an election period in the sense that what occurs is an election between traditional fee-for-service Medicare and enrollment in an MA plan, along with the election of drug coverage under traditional Medicare or through MA. After what is referred to as the open enrollment period (OEP), January 1 through March 31, a Medicare beneficiary is locked in to the election he or she has made for the remainder of the calendar year. During the January to March OEP, individuals may make one election in or out of Medicare Advantage, but there can be no change in the person's election of drug coverage. For example, a person who elected a Medicare Advantage plan with drug coverage (an MA-PD [prescription drug] plan) on December 25, 2006, may return to traditional fee-for-

service Medicare, but he or she must enroll in a stand-alone prescription drug plan (PDP) because of the election with respect to drug coverage made in the annual election period.

An individual who becomes MA eligible during the year may make one MA "OEP-NEW" election during the period that begins the month the individual is entitled to both Part A and Part B and ends the last day of the third month of entitlement, or on December 31, whichever occurs first. An OEP-NEW election is separate from an OEP election. OEP and OEP-NEW elections are effective on the first of the month following the month the election was made.

During this annual election period, beneficiaries receive comparative information on all of their health care options, including fee-for-service Medicare and its Medigap (supplemental coverage) options. They may elect new coverage and switch back and forth between MA and traditional fee-for-service Medicare, effective the following January. Newly eligible enrollees who do not choose an MA plan are deemed to have chosen the original Medicare fee-for-service option, except that "age-ins" enrolled in a contracting plan may be deemed to have elected the entity's MA plan.

MA plans are also required to be open during special election periods, for example plans must accept beneficiaries when they first become entitled to Medicare, and they must be open when another organization in the service area terminates a Medicare contract. Organizations that have MA contracts are required to offer the option of continued enrollment as Medicare members to current non-Medicare enrollees when they become eligible for Medicare and meet MA eligibility criteria (*eg*, having both Part A and Part B).

Disenrollment and the Lock-In

As noted earlier, beneficiaries may only disenroll from an MA coordinated care plan and choose another plan, leave Medicare fee-for-service to enroll in an MA plan, or return to Medicare fee-for-service one time during the

first 3 months of the calendar year. Beneficiaries will be effectively locked in to their MA plan election for the remaining 9 months after this window.

Exceptions to the lock-in period are available for enrollees under the following circumstances: the MA plan contract is terminated, the beneficiary leaves the plan service area, the MA plan fails to provide covered benefits or is found to be improperly marketing the Medicare product, or under other conditions specified by CMS. In the years 2007 and 2008, there is another exception whereby beneficiaries in fee-for-service Medicare have a one-time opportunity to enroll in an MA-only (not MA-PD) plan outside of the open enrollment period. For example, a beneficiary could decide in July of 2007 to enroll in an MA-only plan after having elected fee-for-service Medicare coverage (and a stand-alone PDP plan) during the open enrollment period. The person's Part D election would be unaffected by the MA enrollment. In addition, the lock-in does not apply to institutionalized individuals or to beneficiaries entitled to both Medicare and Medicaid. These categories of individuals may elect fee-for-service Medicare coverage or choose another MA plan at any time during the year.

Involuntary Disenrollment

An MA organization may involuntarily disenroll a Medicare beneficiary if the person leaves the service area permanently (defined by regulations as an absence lasting more than 12 months); if the person has committed fraud in enrolling in a plan or permits others to use his or her enrollment card to obtain care, for failure to pay premiums in a timely manner (including optional supplemental premiums), or because of disruptive or abusive behavior, subject to CMS approval.

Capacity Limits

Although a plan is ordinarily required to be open for enrollment during the election and

enrollment periods described previously, a plan may limit or close its enrollment if it does not have the capacity to continue enrollment. In such a case, a plan may discontinue enrollment but may set aside a specified number of vacancies to enroll members who age-in from the plan's commercial product into its Medicare product. Capacity limits may be based on several different reasons and the limit may apply to specific plan benefit packages or counties in different configurations, for example, by plan or by county.

MARKETING RULES

MA provisions include requirements specifying the type of marketing plans are required or permitted to undertake, as well as specifying prohibited marketing activities.

Basic Requirement

The basic marketing requirement is that an organization must market its MA plan or plans throughout the entire service area in a nondiscriminatory manner. Prospective enrollees must be given descriptive material sufficient for them to make an informed choice. One of the required marketing documents is a standardized summary of benefits form that uses standard benefit definitions and a standardized format to allow beneficiaries to make "apples to apples" comparisons among MA offerings and between MA and fee-for-service.

Prohibited Marketing

Prohibited marketing activities include door-to-door solicitation, discriminatory marketing (avoiding low-income areas, for example), and misleading marketing or misrepresentation. These activities are subject to sanctions, including suspension of enrollment, suspension of payment for new enrollees, or civil monetary penalties. MA plans are prohibited from giving monetary incentives as an inducement to enroll and from completing any

portion of the enrollment application for a prospective enrollee.

Prior Approval

All marketing and enrollment material (including enrollment forms) an organization proposes to use must have CMS prior approval. CMS has 45 days to review marketing materials. If 45 days pass without CMS comments on the material, it is deemed approved. If an MA plan's marketing materials were approved for one service area, they will be deemed to be approved in all of the plan's service areas, except with regard to area-specific information.

For certain marketing and enrollment documents, CMS has developed model language. Use of the model language reduces the approval time period to 10 days. Under certain circumstances, CMS also allows a "file and use" approach for certain materials, whereby no prior approval is required.

Description of Plan (Evidence of Coverage)

The statute specifies the kind of information an MA member must receive on enrollment and annually thereafter. This includes information on benefits and exclusions; the number, mix, and distribution of plan providers; out-of-network and out-of-area coverage; emergency coverage—how it is defined and how to gain access to emergency care (including use of 911 services); prior authorization or other review requirements; grievances and appeals; and a description of the plan's quality assurance program. On request, the organization must provide information on utilization control practices, the number and disposition of appeals and grievances, and a summary description of physician compensation.

Notifications to Enrollees

Medicare enrollees must be notified at least 30 days in advance of changes in plan mem-

bership rules (which must be approved by CMS). However, for the change in benefits occurring from one year to the next, the notice must be sent by October 15 before the coordinated open enrollment period.

THE CONTRACTING PROCESS

The first step in the contracting process is to submit an application in the manner described in the following sections of this chapter. The following are some of the issues addressed in the application:

- Legal and financial structure of the organization
- Types, numbers, and location of providers the plan will use
- Listing of benefits
- Description of the Medicare marketing strategy
- Copies of marketing material to be used
- Evidence of coverage or subscriber agreement listing membership rules, enrollee rights, and plan benefits
- Quality assurance plan
- Enrollment and disenrollment procedures
- Grievance and Medicare appeals procedures

The application review is done jointly by CMS's central and regional offices and will involve a site visit.

CMS uses a highly automated process for plans to submit bid information and plan descriptions that form the basis of the Medicare "personal plan finder" at <http://www.medicare.gov>. One of the first actions that a new applicant must take is to gain access to this system, the Health Plan Management System (HPMS).

Health Plan Management System

The HPMS system serves many different and crucial functions in CMS for both contractors and the government. Since 2001, HPMS has supported various functions in support of

the communication between CMS and contracting organizations, as well as the monitoring of Medicare Advantage organizations. HPMS is also the means by which marketing material is submitted for review, and CMS uses the HPMS system to inform plans of new developments, training opportunities, deadlines, and so forth. Stand-alone prescription drug plans are also supported through HPMS.

At the end of March of each year, the HPMS formulary submission module for MA-PDs and PDPs is released. In early April, the MA plan creation module, the plan benefit package (PBP), and bid pricing tool (BPT) become available to organizations on HPMS. Formulary submissions are due in mid-April from all MA-PDs and PDPs, including direct contract employer group plans, Medicare Advantage organizations, PDPs, and cost-based plan sponsors offering Part D employer group plans.

In mid-May, the PBP/BPT upload module is available on HPMS. The first week of June is the deadline for submission of bids via HPMS for all MA, MA-PD, Cost PD, and PDP applications and renewing contracting organizations. A new MA or PDP applicant with no prior or current access to HPMS must complete and submit a signed hard copy of the form.*

The organization's initial request for CMS systems access should be for HPMS access alone and submitted with its application. MA and PDP applicants and contractors are required to access HPMS to execute a variety of Medicare functions, including the application process, formulary submission, bid submission, ongoing operations of the MA and Part D programs, reporting and oversight activities, and so forth. Failure to have access to HPMS will endanger the timely progress of

*This form can be found at <http://www.cms.hhs.gov/mdcn/access.pdf>. This Web address was current at the time of publication, but may be subject to change.

application review during the critical 8-week time frame. CMS provides MA and PDP applicant organizations with additional technical instructions on how to access HPMS, including the Web site address, once the request for a user ID has been processed.

A new MA or PDP applicant (same legal entity) organization that already has HPMS access for other functions, such as for another MA or PDP plan or product, need not request a new CMS user ID. Once the organization has received its new pending contract number, it can contact CMS and request that the new contract number be assigned to an existing HPMS user ID.

Currently contracting Medicare Advantage organizations complete the HPMS plan crosswalk when uploading their next year contract bids and to designate the relationship between plans they offer in the current year to plans being submitted for the following year. A Medicare Advantage organization is free to change benefits, premiums, and cost sharing under an MA plan or an MA-PD plan from year to year.

Part D sponsors provide notice to CMS of a decision to renew contracts for the following year by submitting a new set of bids in early June. They are required to submit one or more formularies through HPMS in April in accordance with the released Final Formulary Guidance.

The Call Letter and Key Projected Dates Calendar

In April of each year, CMS releases the call letter for the next contract year, which provides instructions and guidance for MA and MA-PD plans. A separate call letter is issued for stand-alone PDPs. The call letter includes both new and clarified policy statements as well as restatements of existing program requirements. It also provides instructions with regard to contract renewal and nonrenewal processes for the next year for currently contracting MA, MA-PD, and cost contract plans (which are described later in this section).

The calendar illustrated in Table 26-2 earlier in this chapter is posted on the CMS Web site early in the year and is updated and expanded periodically. It outlines key dates for application and renewal processes for individual and employer group market MAs, MA-PDPs, and PDPs, as well as cost-based plans.

In February, the draft call letter for the next year's contracts is posted on the Web for public comment, and CMS issues the Advance Notice of Methodological Changes for the next contract year's MA payment rates.

In March, PDP and MA-PD final formulary guidance is released as is the HPMS formulary submissions module (FSM) and the final call letters for MAs, MA-PDs, and PDPs. In April, CMS issues the next year's MA payment rates, holds a bidders' conference, and makes available on HPMS the plan creation module, the plan benefit package, and bid pricing tool.

Early May is the deadline for CMS to inform currently contracted organizations that renewal of their contracts has been authorized. The plan benefit package and bid pricing tool upload module becomes available on HPMS. In early June, all bid submissions are due as are all notifications from currently contracting organizations of their intent to not renew contracts for the following year.

In September, Medicare Advantage organizations can first preview their plan(s) data as they will appear in the *Medicare and You* handbook. In October, Medicare Personal Plan Finder and Medicare Personal Drug Plan Finder data are available on the Medicare Web site, and *Medicare and You* handbooks are mailed to Medicare beneficiaries.

Applying to CMS for a Medicare Advantage Contract

Current year applications for the following MA contract types are posted at <http://www.cms.hhs.gov/MedicareAdvantageApps/>*

*This Web address was current at the time of publication, but may be subject to change.

- Coordinated Care Plan (CCP)
- Regional Preferred Provider Organization (RPPO)
- Private-Fee-for-Service (PFFS)
- Medical Savings Account (MSA)
- Application for Service Area Expansion (SAE; described later)

Medicare Advantage organizations offering CCP or PFFS plans in the current year that want to expand the existing service areas in the following year use the Service Area Expansion Application (SAE). A date in mid-March is usually the deadline for submission.

There is not a separate application for a MA Special Needs Plan (SNP), which is a type of coordinated care plan.* Organizations that do not hold a current contract with CMS complete the full MA CCP application to apply to offer an SNP. Any contracting MA organization that wants to add an SNP in its contracted service area must complete the SNP section of the MA CCP application. Any contracting MA organization that wants to expand its service area and add an SNP in that expanded service area completes the MA SAE application, including the SNP section of the SAE application. All these applications require submission of a Part D (drug benefit) application as well.

Managed care organizations/sponsors interested in applying for a Medicare Advantage and/or MA-PD contract with CMS for the next contract year are required to submit applications to CMS in March. If an applicant currently has an MA contract, it is nevertheless required to complete a new application to offer one or more different plan types. A current contractor is generally permitted to submit an abbreviated application that focuses only on additional or different information requirements specific to the new plan type(s) that it wants to offer. Organizations

applying to become qualified to enter into an MA contract with CMS for the first time complete the entire application. A Medicare Advantage organization submissions matrix has been posted at the CMS Web site to assist applicants in submitting application-related documents and items.

Medicare Advantage CCPs must offer at least one MA plan that includes Part D prescription drug benefits in each of their service areas. All new or expanding CCP-offering organizations must submit an MA prescription drug plan sponsor application as a condition of approval of the CCP application. The Part D application is found at the CMS Web site. The MMA continues to prohibit new cost-based plans (under section 1876 of the Social Security Act) and precludes any organization from operating a cost-based plan in the same area in which it operates an MA plan; such plans are briefly described later in this section.

CMS also issues guidance and information through HPMS and conducts industry outreach through conference calls and other mechanisms. One or more conference calls are typically scheduled to discuss the MA/MA-PD call letter following its release.

Medicare Advantage organizations submit next contract year marketing materials such as the Summary of Benefits (SB) and Annual Notice of Change (ANOC—the advance notice of new contract year changes provided to current enrollees) after bid submission. All marketing materials are submitted via the HPMS marketing module. Regional office staff will review the materials and approve or disapprove them. After CMS approves the Medicare Advantage organization's bid, any necessary changes to conditionally approved or approved marketing materials must be re-submitted to CMS based on the approved bid. All Medicare Advantage organizations are required to place on all marketing materials the CMS contract number as part of their unique material identification number. Contract number and unique material identification numbers must be printed on the front page of the Summary of Benefits and Evi-

*SNP guidance is found at <http://www.cms.hhs.gov/SpecialNeedsPlan/>. This Web address was current at the time of publication, but may be subject to change.

dence of Coverage. The member identification card must include the contract number and Plan Benefit Package (PBP) number.

As noted previously, CMS regional and central office staff review MA applications. Regional PPO and MSA applications are handled directly by central office staff.

Regional Preferred Provider Organizations

If an applicant wanting to offer an RPPO plan currently has an MA contract with CMS, it is usually permitted to submit an abbreviated application that focuses on additional or differing requirements specific to the RPPO requirements. As previously noted, each RPPO applicant entity must demonstrate state licensure in at least one state in each region for which it is applying and attest that it will apply for or has already been granted licensure in the remaining states in each region prior to September of the year prior to the contract year. Licensure waiver issues with regard to Part D applications must be resolved as well.

Entities that wish to offer an RPPO in multiple regions or to offer multiple RPPO products in one region can submit a single application but must provide full and complete information about each product in each proposed region. As is the case with other MA application types, full documentation of arrangements for health services delivery in the region or regions should be made at the time of application submission.

Private Fee-for-Service Applications

The major difference in the application process for a PFFS plan is the issue of the validation of the claims system, given that PFFS plans are not coordinated care plans and pay noncontracted deemed providers at Medicare fee-for-service rates. An applicant to offer a PFFS plan can validate its claim system in the PFFS application process by one of the following methods:

- Use of a claims system previously tested by CMS (such as a third-party claims administrator previously validated by CMS)
- Use of a CMS-approved claims system for a PFFS plan
- Validation of the applicant's own claims system

In the case of a plan using its own claims system, the applicant must demonstrate that it operates a system that is duly tested and able to properly pay providers at rates that are not less than rates under traditional fee-for-service Medicare. In addition, the applicant must agree to sign an attestation form that it has instituted a reimbursement grid and tested its claims system; that it will submit provider dispute resolution policies and procedures to address written or verbal provider disputes/complaints, particularly with regard to reimbursement amounts. The plan must submit biweekly reports to CMS with regard to provider complaints, verbal and written, for 6 months following receipt of the first PFFS claim, along with data with regard to enrollee appeals/complaints related to claims for the same time period.

Special Needs Plans

As noted earlier, the MMA created a second type of new MA plan, the SNP, which can exclusively enroll or disproportionately enroll special needs Medicare beneficiaries. Those SNPs that elect to enroll a disproportionate percentage of a target population must maintain enrollment in the SNP for that target population as a percentage of total SNP enrollment greater than the proportion that occurs nationally in the Medicare beneficiary population. The three types of beneficiaries that SNPs might serve are as follows:

Special needs plans for dual eligibles. Dual eligibles are divided into different eligibility categories based on income relative to the federal poverty level and assets. Of 7 million dual eligibles as of 2006, about 6 million are full duals who

qualify to receive full Medicaid benefits. Beneficiaries with higher income and asset levels are eligible for more limited Medicaid coverage under the categories of the Medicare Savings Program (MSP).

SNPs for dual eligibles are the most common type of SNP plan, and these plans may either accept all dual eligibles or limit enrollment to full benefit duals. The same MA organization can elect to offer two dual-eligible SNPs in the same service area: one for full-benefit duals and another for all duals. However, SNPs cannot limit enrollment solely to the MSP duals. All SNPs apply the same premium and copayments to all members. States may pay Medicare's Part B premium for all dual eligibles and cost sharing for all duals and qualified Medicare beneficiaries (QMBs). States may also pay SNP premiums and/or copayments for certain members or contract with an SNP for some or all Medicaid services.

Special needs plans for institutionalized beneficiaries. Institutional SNPs serve beneficiaries who reside or are expected to reside for 90 days or more in a long-term care facility. They may also elect to enroll beneficiaries living in the community who require an equivalent level of care. CMS has permitted organizations offering these plans to limit enrollment to contracted long-term care facilities within a geographic service area. The SNP must identify in its application to CMS whether it will be facility-based and/or community-based. Community-based enrollees must meet the criteria of the state for nursing home certification (certifiable population).

Special needs plans for beneficiaries with severe or disabling chronic conditions. Chronic care SNPs are designed for beneficiaries with severe chronic diseases and/or conditions. CMS has to date evaluated these proposed SNP applications on a case-by-case basis. That evaluation considers the appropriateness of the tar-

get population, the clinical programs and expertise available, and how the SNP will cover the target population without discrimination against sicker enrollees.

The major characteristic that distinguishes SNPs from other MA plans is their ability to limit enrollment (a statutory provision that expires at the end of 2008, unless extended or made permanent by the Congress). SNPs are paid on the same basis as other MA plans.

SNP applicants must indicate whether they are exclusive to the target population or are disproportionate share plans. The SNP is then restricted to that option through the contract year. A SNP that selects disproportionate share status is required to market to all Medicare beneficiaries.

Dual-eligible and chronic condition SNPs are required to meet all MA requirements for collecting and reporting HEDIS, CAHPS, and HOS at present. Institutional SNPs are not required to report HEDIS measures. CMS will extract the Minimum Data Set (MDS) measures used for nursing homes.

Section 1876 Cost-Based Plans

No new cost-based plan applications under section 1876 are being accepted by CMS (as opposed to cost reimbursement arrangements under section 1833 for employer/union groups). Cost-based plans may continue contracting with CMS through contract year 2007. Cost-based plans have the option of providing Medicare Part D benefits beginning in contract year 2007.

After September 1, 2006, service area expansion applications received from cost-based plans will be accepted only if there are less than two MA plans of the same type meeting minimum enrollment requirements in the area in which the cost-based plan intends to expand. CMS provides cost-based plans with data on competing MA plans in the service areas in which they are offered. Where there is already an existing MA-PD plan or PDP plan in the area in which the

cost-based PD plan proposes to expand, no midyear service area expansion will be permitted into that area.

Cost-based plans must be open for enrollment for a period of a least 30 consecutive days. They may offer a Part D plan as an optional supplemental benefit. Enrollment in this optional supplemental benefit must take place during a Part D plan enrollment period. Individuals who disenroll from the cost-based plan are automatically disenrolled from the optional supplemental Part D plan and may enroll in another Part D plan only during established Part D enrollment periods.

Service Area Expansions and New Midyear Plans

An MA organization can apply to CMS to offer a new midyear MA plan or request an SAE of an existing MA plan only if that plan's bid is not included in a competitive benchmark calculation required by the MMA and only if there are no contracting competitors in the geographic area(s) the new plan would serve. The comparison to determine if midyear entry of a new plan or the service area expansion of an existing MA-PD plan will introduce unfair competition is whether there are other Part D competitors: MA-PD plans and stand-alone PDPs. The comparison to determine whether midyear entry or service area expansion of an MA-only plan will introduce unfair competition is whether or not there are other MA competitors: MA-only and MA-PDs.

In 2006, there was a national PDP plan, which meant that every county had at least one PDP. Consequently, no SNP plan was able to offer a new midyear plan or an SAE during 2006 because each SNP must offer Part D benefits (must be an MA-PD).

Web Sites and the Managed Care Manual

The CMS Web site at <http://www.cms.hhs.gov> contains an index page at www.cms.hhs.gov/home/medicare.asp that links the user to in-

formation on Medicare topics. Under Health Plans can be found links to topics such as the Benefit Pricing Tool, Bid Form, and Plan Benefit Package, Health Care Prepayment Plans (section 1833 cost-reimbursed contracts for employer-union groups covering only Part B services), Cost Plans, Private Fee-for-Service Plans, and Special Needs Plans. Under Medicare Advantage are MA applications and information on MA-PD contracting.

Also at this Web site is a link to Regulations and Guidance, which includes the manuals, including Chapters 1 to 15 and 17 to 20 of the Medicare *Managed Care Manual*, Publication 100-16, and a link to the Part C Marketing Guidelines for MA organizations.

Other Web sites relating to Medicare Advantage are the following:

- Employer/Union-Only Group Waiver Plans (EGWP) Guidance at <http://www.cms.hhs.gov/EmpGrpWaivers/>
- Prescription Drug Coverage General information at <http://www.cms.hhs.gov/PrescriptionDrugCovGenInfo/>
- Medicare Health Plans at <http://www.cms.hhs.gov/HelathPlanGenInfo/>
- 2006 Medicare Advantage Payment Rates at <http://www.cms.hhs.gov/MedicareAdvgtSpecRateStats/AD?list.asp#TopOfPage>
- MA Applications at <http://www.cms.hhs.gov/MedicareAdvantageApps/>

All Web site addresses are current at the time of publication, but may be subject to change.

CONTRACTOR MONITORING

Once an organization signs a Medicare contract, CMS maintains ongoing monitoring of the plan. The monitoring is accomplished through self-reporting of financial and other information by the organization on a quarterly basis. If certain criteria are met, the information may be reported on a yearly basis.

Specific to Medicare is a monitoring process that is performed by the CMS central office and, principally, by the 10 regional offices of the CMS. By the end of the first year of con-

tracting, each plan will have a monitoring visit, during which the reviewers will determine whether the health plan is complying with regulatory requirements in such areas as financial arrangements, legal and financial requirements for the entity as a whole, quality of care issues, marketing practices, enrollment/disenrollment, claims payment, and grievance and appeals procedures. The reviewers follow a specific written protocol in conducting the review. After such a monitoring visit, a report is prepared, and if necessary, the organization is required to submit a corrective action plan to correct any deficiencies. Close monitoring of the plan continues until CMS is satisfied that the problems have been resolved. If the initial review goes well, there may not necessarily be a review of the same plan for another 2 years.

CMS must conduct a financial audit of one-third of the plans each year. This means that CMS and its contractors will visit each plan every 3 years to review financial records, including documentation used to develop plan bids, establish administrative costs, and pay providers.

CONCLUSION

The *Federal Register* does not immediately spring to mind as a good source if one is searching for amusing anecdotes in the history of health care policy. However, in volume 69, number 148, of the *Federal Register* of Tuesday, August 3, 2004, page 46,921, there is a little dig at people who presume to make predictions of what the future will bring in health care. That particular *FR* publication—the proposed rules for implementation of the MA provisions of the MMA—noted that when the BBA of 1997 introduced the option of provider-sponsored health plans, it was predicted that provider-based plans would proliferate and take over the world of Medicare managed care. The *FR* of 2004 goes on to point out that the prediction was not even remotely accurate.

So what is one to make of the projections and predictions made in the same August 3,

2004, *FR* publication regarding the Medicare Advantage program—for example, predicting that MA PFFS plans would not be very competitive (page 46,931), or that in 2006 there would be 3 million enrollees of regional MA plans (page 46,928)? What about the fear, as the MMA was being crafted, that no private plans would want to assume even partial risk for providing a drug benefit to Medicare beneficiaries? Given that enrollment in MA private fee-for-service plans was about 750,000 in mid-2006 (compared to about 38,000 in August of 2004), and that regional plans had 83,000 enrollees in mid-2006, and given the number of PDPs and MA-PD plans in 2006, the lesson to be learned is perhaps that predictions are dangerous—something that was stated in the conclusion of the preceding version of this chapter of the *Handbook*, and which seems to hold true to this day. Furthermore, as any student of managed care trends knows, numbers cited today about managed care plans and benefit designs can change drastically in 5 years, up or down.

Instead of making predictions, this chapter concludes with a number of elliptical and possibly cryptic observations about Medicare in general and the MA program. The federal budget has a large deficit. As a federal entitlement program, Medicare contributes to that deficit. The number of Medicare beneficiaries is expected to increase exponentially in the very near future. As indicated by the first two words of its title, the Balanced Budget Act of 1997 sought to address a budget issue by reducing Medicare outlays. A federal budget that has a large deficit is not a balanced budget. Therefore, to conclude, it seems that something is probably going to happen in the future with regard to Medicare, including the outlays that Medicare makes in payments to providers and health plans and outlays that Medicare makes through the subsidization of beneficiary costs. Of course the prediction that something is going to happen could itself be wrong, in the same way that all those *Federal Register* predictions were wrong. We shall see.

References

1. Data are from Table 9-1 of the Medicare Payment Advisory Commission's "Report to the Congress: Increasing the Value of Medicare," June 2006, p. 206. The section of the report on Medicare Advantage is available at http://www.medpac.gov/publications/congressional_reports/Jun06_Ch09.pdf.
2. At the time of publication, information on waivers can be found at the CMS Web site, at <http://www.cms.hhs.gov/EmpGrpWaivers>.