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CALENDAR FOR 2004 M+C AND MEDICARE COST PLAN RENEWAL PROCESS

2003	
June 6	• CY 2004 ACR, Plan Benefit Package (PBP), and technical instructions become available for download from the Health Plan Management System (HPMS).
June 17-18	• CY 2004 Adjusted Community Rate Proposal (ACRP) Seminar.
June 30	• CMS distributes CY 2004 Summary of Benefits instructions to the industry.
July 1	• ACR/PBP Pre-Upload Validation (APV) tool available through HPMS
July 25	• Final date for M+COs and Medicare cost plans to submit **CY 2003** marketing materials for CMS's review and approval.
August 1	• CMS begins accepting CY 2004 ACRPs via HPMS and CY 2004 marketing material. (M+COs using Option #2 of the streamlined marketing review process may submit marketing materials earlier.) • Earliest date M+COs and Medicare cost plans may begin marketing CY2004 benefit packages. Prior to marketing CY2004 benefit packages, M+COs must submit ACRPs to CMS. M+COs and Medicare cost plans must cease marketing CY 2003 benefit packages on the date they begin marketing CY 2004 benefit packages. • Due date to submit Provider Specific Plans and Renewal Plan Splits as outlined in Part III, Section 1 of these renewal instructions.
August 5	• The 2004 Model EOCs will be available to all plans – M+C and Cost.
August 22	• M+COs and Medicare cost plans should have submitted CY 2004 summary of benefits (SB) and annual notice of change (ANOC) materials to CMS regional offices so that these materials can be reviewed and approved prior to the October 21st publication of "Medicare Personal Plan Finder".
September 8	• Final day for M+COs to submit CY 2004 ACRPs via HPMS. • Deadline for M+COs with employer-only plans to renew their CY2004 ACRPs via HPMS. • Final date for M+COs to send Modified Annual Notice of Change letter, which includes information on member's passive election, to their regional office for review and approval in order to meet M+C plan termination and service area reduction notification requirements and ensure that beneficiaries are notified by the October 2nd deadline. • Medicare Cost Plans are encouraged to submit a PBP by this date so information on benefits is included in *Medicare &You* and Medicare Personal Plan Finder. • M+COs and Medicare cost plans may begin marketing CY2004

	benefits to Medicare beneficiaries through public media once the marketing materials receive approval from CMS. If the M+C organization's ACR has not been approved, a disclaimer "pending Federal approval" must be used on all approved marketing materials. • M+COs and Medicare cost plans are required to include information in CY 2003 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2004.
September 17	• Final date for M+COs to send CY2004 non-model ANOCs to CMS regional offices. M+COs are encouraged to submit all ANOCs to CMS in advance of these dates to ensure the review, approval, printing and receipt by members before the October 31 deadline. Note: If the M+CO follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB to the Regional Office is October 21.
September 17-18	• M+COs and Medicare cost plans preview the 2004 *Medicare & You* Handbook data in HPMS prior to CMS publication.
September 17-19	• M+COs and if applicable, Medicare cost plans, preview the 2004 "Medicare Personal Plan Finder" plan data in HPMS prior to Internet release.
October 1-30	• Medicare cost plans (HMO/CMP) budget forecast are due no later than 90 days prior to the beginning of the contract period. This date is October 2 for calendar-year Cost Plans renewing on January 1. • CMS mails *Medicare & You* for CY 2004, which will contain health plan benefit and cost information.
October 6	• Final date to review and approve the CY2004 ACRPs submitted by M+COs offering one or more plans with a benefit reducing the Part B premium.
October 14	• Final date for marketing CY 2003 M+CO and Medicare cost plans (i.e., benefit packages) to Medicare beneficiaries through public media. Note: If the organization- began marketing the CY 2004 benefit packages any time between August 1st and October 14th (but no earlier than August 1st), it must cease marketing CY 2003 plans through public media on the date it begins marketing the CY 2004 benefit packages (M+COs and Medicare cost plans may continue to market the 2003 plans to employer group members aging into Medicare and to individuals inquiring about the 2003 plan).
October 15	• Final date for Medicare cost plans to send CY2004 non-model ANOCs and SBs to CMS regional offices in order to ensure review, approval, and receipt by members before December 1 deadline. Note: If the Medicare cost plan follows the ANOC and SB models without modification, the final date to send the ANOC and SB is November 20.
October 16	• All M+COs and Medicare cost plans must be HIPAA compliant

	with the implementation standards for HIPAA transactions and code sets.
October 21	• CMS publishes plan data in "Medicare Personal Plan Finder" on the Internet.
October 31	• For M+COs: CY 2004 ANOC letters (with SBs) due to beneficiaries. M+COs must mail ANOC letters before this date to ensure receipt by enrollees by October 31st. • *Note: All marketing presentations and mailings to beneficiaries who inquire about CY 2004 enrollment must include a CY 2004 summary of benefits.*
November 1	• Tentative date for CMS's approval of all CY 2004 renewal ACRPs. • M+COs may begin submitting Mid-Year Benefit Enhancements and proposals for new mid-year plans. • Health Care Prepayment Plans (HCPPs) budget forecast are due no later than 60 days prior to the beginning of the contract period. For calendar year HCPPs this date is November 1.
December 2	• For Medicare cost plans: CY 2004 ANOC letters (with SBs) due to beneficiaries. Medicare cost plans must mail ANOC letters before this date to ensure receipt by enrollees by December 2. *Note: All marketing presentations and mailings to beneficiaries who inquire about CY 2004 enrollment must include a CY 2004 summary of benefits.*
December 19	• Final date for M+COs and Medicare cost plans to send CY2004 non-model EOCs to CMS regional offices. Organizations are encouraged to submit EOCs to CMS in advance of these dates to ensure the review, approval, printing and receipt by members before the February 2, 2004 deadline. Note: If the organization follows the EOC model without modification, the final date to send the EOC to the Regional Office is January 23, 2004. *Note: These dates are contingent upon CMS' release date of the 2004 Model EOCs*

2004	
January 1	• Effective date for CY 2004 plan benefits.
February 1	• First effective Date for Mid-Year Benefit Enhancements and new mid-year plans.
February 2	• Deadline for distributing 2004 EOCs to plan members. *Note: This date is contingent upon CMS' release date of the 2004 Model EOCs.*

CALENDAR FOR THE 2004 M+C NON-RENEWAL PROCESS

2003	
June 1	• CMS posts final non-renewal instructions and beneficiary plan withdrawal Qs & As on the CMS websites.
August 1	• Deadline for M+COs to notify CMS of an intention to non-renew a county for individuals, but continue the county for employer group health plan members. • CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS websites, and sends copies of the letters to M+COs that are non-renewing or reducing their service area. • Deadline for M+COs to submit partial county service area reduction requests.
September 8	• Deadline for M+COs to submit a non-renewal or service area reduction notice to CMS.
September 10	• CMS issues an acknowledgement letter to all M+COs that are non-renewing or reducing their service area.
September 12	• CMS approves M+COs' final notification letter. • CMS will release a Special Election Period (SEP) letter to M +COs remaining in the non-renewed service areas. • M+COs can begin mailing the final notification letter. The final notification letter must be personalized and dated 10/2/03. The letter must be in the beneficiaries' hand by 10/02/03.
September 16	• CMS will release detailed information on the 2004 non-renewals. • Press Release: Statement from CMS Administrator (Tentative)
October 2	• M+COs must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.
November 18	• CMS issues " close out" information/instructions to M+COs that are non-renewing or reducing their service area.

- Early Notification: If M+COs notify the public of a nonrenewal before September 8, then it must send a CMS-approved interim notification letter to beneficiaries.

CALENDAR FOR THE 2004 MEDICARE COST PLAN NON-RENEWAL PROCESS

2003	
August 1	• CMS posts the 2004 Medicare Cost Plan non-renewal instructions on the CMS website. • CMS posts the model final notification letter, the state-specific final notification letter, and a model public notice on the CMS websites and sends copies of the letters to Medicare Cost Plans that are non-renewing or reducing their service area.
October 2	• Deadline for Medicare Cost Plans to submit a non-renewal or service area reduction notice to CMS.
October 9	• CMS issues an acknowledgement letter to all Medicare Cost Plans that are non-renewing or reducing their service area.
October 14	• CMS approves Medicare Cost Plans' final beneficiary letter and public notice.
October 23	• Medicare Cost Plans can begin mailing the final notification letter. The final notification letter must be personalized and dated 11/3/03, and be in the beneficiaries' hands by 11/03/03.
December 2	• Medicare Cost Plans must publish a CMS approved public notice in one or more newspapers of general circulation in each community or county in their contract areas.

PART I. STATUTORY AND REGULATORY INFORMATION FOR RENEWING M+C CONTRACTORS

New Federal Regulations Impacting Medicare+Choice Organizations

On October 25, 2002 CMS issued a proposed rule 4041-P for implementing BIPA provisions and correcting regulatory text that was operationally problematic. In July 2003, CMS anticipates publishing Final Rule 4041-F. Many of the statutory provisions of the BIPA legislation intended to reduce administrative burden or increase flexibility for managed care plans have already been implemented. For example, allowing M+COs to offer customized health care plans to Medicare-eligible members of employer groups and unions, and allowing M+COs to use premium reductions as an additional benefit for M+C enrollees. By in large, final rule 4041-F contains clarifying changes to the regulatory text that was presented in proposed rule 4041-P.

Financial Limitation on Incurred Expenses for Rehabilitation Services

Section 4541 of BBA 1997 established a financial limitation on FFS incurred expenses for all outpatient physical, occupational and speech (PT/OT/SP) therapy services other than those provided in a hospital outpatient setting. BBRA 1999 and BIPA 2000 imposed a temporary moratorium on these caps that has now expired. The caps will be effective July 1, 2003 under FFS due to implementation issues and will be calculated on services delivered on or after July 1, 2003. The caps were originally established at a calendar year per beneficiary limit of $1500 for PT and SP combined, and another $1500 for OT. The BBA required that the caps be updated annually based on the Medical Economic Index (MEI). In 2003 the updated limits are $1590. For 2004, the projected MEI is 2.0% and the estimated caps are $1622.

These therapy caps stipulate FFS payment limits, not benefit coverage limits—since PT, SP and OT benefits remain unlimited in the hospital outpatient setting. Consequently, these caps do not restrict M+C benefits. M+COs may continue to provide such services in settings other than in hospital outpatient departments even after the FFS payment limit has been reached. This means plans are free to continue to provide medically necessary therapy in the most appropriate setting as determined by clinical considerations. When they do so, such services are considered an additional benefit to be stated in the PBP. In other words, if the plan does not implement the financial limitations, the cost amount up to the financial cap is reported as Medicare-covered benefits, and any cost amount beyond the cap is reported as an additional benefit on the ACR. Incidentally, this FFS payment limit on non-hospital-based therapies had no effect on M+C payment rates for 2003 or 2004, since the dollar amounts involved are far too small to have affected the statutory formulas for calculating the county rates.

For any M+C plan choosing to implement these payment limits for non-hospital outpatient department services, member notification related to limits on payment for services would need to occur in pre-enrollment marketing materials, as well as at the time a particular payment limit is reached. Such notification would need to include a statement that services continue to be available through hospital outpatient departments. Comparable FFS rules including examples of suggested timing and forms of notification can be found in Program Memorandum AB-02-057 available on our website at: http://www.cms.hhs.gov/manuals/pm_trans/AB03057.pdf. When Medicare cost plans have non-institutional providers of PT/OT/SP services bill carriers directly

for these services, the tracking and notification responsibilities discussed above do not apply to cost plans.

Updating the M+C contract

Because of regulatory and other program changes that have occurred since CMS produced the 2002 Medicare+Choice (M+C) coordinated care plan contract, CMS must modify the M+C coordinated care plan contract for 2004. CMS released a draft of the modified M+C contract to industry for comment in May 2003. For now, we are aware of the following program changes that require a modification of the M+C coordinated care plan contract:

- Change in the ACRP filing date deadline and notice of contract non-renewal date--from July 1 to the second Monday in September
- Changes in data that determine payment—from submission of physician and hospital outpatient encounter data to submission of risk-adjustment data
- Changes to data certification attachments (pursuant to changes in submission of data to determine payment—from encounter data to risk-adjustment data)
- Change to CMS contract termination provisions to capture regulatory change that allows for contract termination pursuant to marketing violations
- Incorporating HIPAA provisions pursuant to requirements of other laws and regulations.

PART II. ADMINISTRATIVE CHANGES AND UPDATES

Changes in Risk Adjustment Implementation

Instructions for risk adjustment included in the 2003 instructions remain applicable for 2004. Specific changes in implementation that differ include updated risk adjustment data collection and submission dates:

CY	Data Collection Start Date	Dates of Service	Initial Submission Deadline	Reconciliation Data Submission Deadline
2003	Jul 1, 2001	Jul 1, 2001– Jun 30, 2002	Sep 6, 2002	Sep 26, 2003
2004	Jul 1, 2002	Jul 1, 2002– Jun 30, 2003	Sep 5, 2003	Sep 24, 2004
2004*	Jan 1, 2003	Jan 1, 2003- Dec 31, 2003	Mar 5, 2004	Mar 4, 2005
2005	Jul 1, 2003	Jul 1, 2003- Jun 30, 2004	Sep 3, 2004	Sep 30, 2005
2005*	Jan 1, 2004	Jan 1, 2004- Dec 31, 2004	Mar 4, 2005	Mar 3, 2006

*Denotes non-lagged schedule.

The new risk adjustment model and implementation approaches are described in the March 28, 2003, 45 Day *Notice for 2004 M+C Rates* (http://cms.hhs.gov/healthplans/rates). Final implementation and approval are in the May 12, 2003 *Announcement of Calendar Year 2004 Medicare+Choice Payment Rates*. Complete instructions for risk adjustment implementation will be published in chapter 7 of the Medicare Managed Care Manual (http://cms.hhs.gov/manuals/116_mmc/mc86toc.asp). This information is cross-referenced on: http://cms.hhs.gov/riskadj.

Clarification of Monthly Certification of Enrollment Changes

The Monthly Certification of Enrollment Changes (also known as the Monthly Attestations) are now to be sent to IntegriGuard. The Certification must be sent within 45 days after the availability of the GROUCH reports being validated. Dates have been incorporated into the GHP Monthly Schedule for 2003 and 2004. A revised model letter is available if needed.

Drug Formulary Policy

CMS is providing M+C organizations and Medicare cost plans the opportunity to change their drug formulary during the contract year. Plans are allowed to add or remove drugs from their formulary and move drugs to different tier levels. Plans that wish to remove a drug from their formulary during the contract year are required to establish an exceptions process. The exceptions process will provide physicians a mechanism to continue prescribing drugs that are determined to be medically necessary and that were on the formulary when the Medicare beneficiary enrolled. Organizations that change their forumulary must provide a description in their Evidence of Coverage and 2004 Annual Notice of Change stating that they might remove a drug from the formulary or move a drug to a different tier during the contract year. In addition, enrollment materials and the EOC must provide information on the availability of the exception

process. The M+CO or Cost HMO/CMP will determine how the exceptions process will work and can include reviewers who determine whether or not the request for an exception is medically appropriate and/or whether or not an exception will be granted.

Not usually self-administered drugs administered incident to physician services

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

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

CMS will be providing a list of drugs that are not covered under separate cover.

This requirement does not apply to, or affect, Medicare cost plans and their cost reports.

Implementation of Final Rule Resulting from Grijalva v. Shalala

Consistent with our April 4, 2003 final rule, M+C enrollees who are receiving covered services from SNFs, HHAs, or CORFs will have an opportunity to request an expedited, independent review if they are dissatisfied with an M+CO's decision to terminate these services. Under the final rule, providers are responsible for delivering a short notice that services will end no later than two days before termination. In cases where enrollees express dissatisfaction with this decision, M+C organizations will need to prepare a more detailed notice of the reason for the termination, and provide the notice to both the enrollee and the independent review entity (IRE). The IRE will make its decision within 72 hours of the enrollee's request for a review. We intend to issue further guidance on the details of how this process will work later this summer. We anticipate that M+COs will have an opportunity to comment on this guidance before it is finalized. In addition, the termination notices associated with the process will be published in the Federal Register for public comment. See following section for more information regarding notices.

Appeal Notices

In 2004, we intend to develop a model notice to enrollees about the right to file grievances when M+C organizations deny requests for expedited organization determinations or reconsiderations. Also, we will develop a model notice for M+C organizations to inform enrollees when M+C organizations forward case files to the independent review entity, i.e., the Center for Health Dispute Resolution, for reconsideration. We will work with the M+C organizations to develop this notice.

Consistent with the final rule to implement the Grijalva v. Shalala settlement agreement, providers will be responsible for delivering a short notice to enrollees no later than two days before termination of services in SNFs, HHAs and CORFs. This notice will alert the enrollee to the impending service termination and provide information on appeal rights. In those rare situations where enrollees object to the service termination, M+C organizations will be required to provide detailed notices explaining the specific reasons for the termination decision. Both notices will be published in the Federal Register for public comment later this summer. M+C organizations and providers must implement the new notice requirements in January 2004. Cost HMO/CMPs should reference the May 20, 2003 communication from Robert Donnelly, Director, Health Plan Policy Group, entitled "Issuance of Noncoverage Notices by Cost Plans for Inpatient Hospital Discharges."

Health Insurance Portability and Accountability Act

The Administrative Simplification provisions of HIPAA require that the Secretary of the Health and Human Services adopt a set of national electronic data interchange (EDI) standards for the health care industry. The Department was to adopt standards for: (1) transactions and code sets, (2) identifiers for health plans, providers, employers, and individuals for use in the transactions, (3) security of health information, and (4) privacy of health information.
MCOs , Medicare cost plans, and HCPPs are designated as health plans and must comply with the HIPAA requirements. All health plans must have the capability to exchange covered transactions electronically and meet the other HIPAA requirements as a covered entity. CMS will continue to provide specific instructions for transactions and code sets, privacy, and security in separate letters.

Redesigned Managed Care System Cutover

The redesigned Medicare managed care system (MMCS) is scheduled for implementation mid-year 2004.

A parallel testing process between the legacy Group Health Plan (GHP) system and the MMCS will begin at the end of 2003 and extend into 2004. If the testing is successful, CMS will start processing enrollment information through the MMCS by the summer of 2004.

Overall, the impacts will be minimal; the formats of the enrollment, disenrollment and correction transactions will not change. All of the current report layouts will remain the same. The GROUCH system will be replaced by a new user interface, but the download process will remain as it is today. About 6 – 10 new transaction reply codes will be added to enhance the information CMS provides related to maintenance updates for your members. The online access to McCoy will convert to a web-based application; but the functionality and the data provided will be the same. M+COs, Medicare Cost Plans and HCPPs will now be able to input enrollments and disenrollments online. Training and User Guides will be provided at a later date.

A major change will occur in the timeliness of the availability of the membership information. "Final" monthly processing will still occur; but as plans submit transactions during the month, transaction reply listings and membership reports containing data processed to date will be available. In addition, plans will be able to correct submitted transactions online based on errors

that they see on their exception reports. As membership processing will be occurring real-time throughout the month, the time necessary for the final payment run is expected to be much shorter. The downtime for the online access each month is expected to be minimal.

As MMCS implementation draws nearer, more information will be distributed to all Medicare managed care contractors.

Payment for Working Aged M+CO Members Using an Annual Contract-Level Factor

In our ongoing effort to reduce administrative burden, beginning in January 2004 payment for working aged M+C members will be based on a contract level factor. The number of working aged used in the calculation will be obtained by way of an annual survey. The survey will be conducted by the M+CO to determine which members are actually working aged. CMS will not rely on the current Medicare Secondary Payor data residing in the Common Working File after December 2003. M+COs will be asked to survey their membership every March and report the total working aged members from that list to CMS in September of each year. In order to implement this payment change for January, M+COs will be allowed to use surveys they have already collected between August 2002 and during contract year 2003, and report their working aged to CMS by December 15, 2003. Detailed reporting instructions will be released in a separate systems letter later this month. Please see methodology and examples below.

An MCO will identify from surveys which of its enrollees are in Working Aged status on the March 2003 MMR. A contract-level factor will then be determined, comparing payments for all (except Hospice, ESRD and Disabled) enrollees of the contract, computed with Working Aged rates in effect, to a second time computed without. The contract-level factor, once determined, will be frozen for the year.

Subsequent disenrollments/enrollments of beneficiaries identified by survey as Working Aged, will have no bearing on the calculation of a monthly contract-level Working Aged adjustment. Only the amount of the overall payment will affect the size of the monthly adjustment.

Beneficiaries identified by any MCO as Working Aged will be flagged[1] on 2004 Monthly Membership Reports, even though payments to these beneficiaries will reflect non-Working Aged rates on the MMR itself. The number of flagged beneficiaries will not correlate with the monthly contract-level Working Aged adjustment amount.

$$\text{Contract-level WA Factor} = \frac{Z_2 - Z_1}{Z_2}$$

WHERE:

Z_1 = sum of blended payment dollars for all enrollees (except Hospice, ESRD and Disabled), calculating payment for WA beneficiaries at **WA rates.**

[1] A beneficiary will only be flagged as Working Aged if identified as such by an MCO survey, or in the event of non-response, based upon CMS systems data.

Z_2 = sum of blended payment dollars for all enrollees (except Hospice, ESRD and Disabled), calculating payment for WA beneficiaries at "**non-WA" rates**[2].

AND:

- Beneficiary pool from March 2003 MMR. Those identified by MCO survey as Working Aged status on this report will determine WA beneficiaries for the purpose of determining the contract-level factor.
- 2004 payment factors/rates/transition blend percentage will be used to compute the dollars above.
- Hospice, ESRD and disabled beneficiaries are excluded from calculation.

Application:

A monthly contract-level Working Aged adjustment would be calculated by multiplying the net monthly payment (after excluding the payments for ESRD, hospice and disabled members) by the MCO-level working aged factor. The resulting amount will be deducted from the monthly payment to the M+CO. The reduction will appear on the Plan Payment Report.

[2] "Non-WA rates" means whatever rates would prevail by ignoring the Working Aged status. In any event, non-WA rates exclude Hospice, ESRD and Disabled rates.

PART III. RENEWAL PROCESS FOR 2004

Section 1. M+C Plan Renewals

Background

An M+C Plan is the health benefits and pricing package that an M+CO offers to beneficiaries who reside in the plan's approved service area. M+C organization can offer multiple M+C Plans in the same or different service areas. Each M+C plan consists of basic benefits (Medicare covered benefits (Parts A and B) plus additional benefits) and any mandatory and/or optional supplemental benefits. As described in the M+C regulations at 42 CFR 422.66, a beneficiary enrolls in a specific M+C Plan offered by an M+C organization.

In general, CMS has determined that an M+C Plan that has a Plan Identification Number in contract year (CY) 2003 is a renewal M+C Plan in CY2004 if all or part of the M+C Plan's current service area remains in CY2004. M+C organizations may change the benefits of a renewal M+C Plan from year to year. M+C organizations may also add new M+C Plans, reduce the service area of a renewal M+C Plan, expand the service area of a renewal M+C Plan or terminate an M+C Plan. Within the established definitions and guidelines discussed below, CMS will determine how beneficiary rights will be ensured and how beneficiary elections will be made.

Definitions

Existing M+C Plan: An approved M+C Plan in which the service area is fixed for the term of the contract (CY2003 Plan ID Number).

Contract Service Area: The service area approved for an M+C organization by CMS, within which an M+C eligible individual or employer-group member may enroll in a particular M+C plan(s).

Plan Service Area: The defined service area, within which an M+C plan must be available to all M+C eligible individuals or employer-group members who reside in the area.

M+C Plan Renewal: An existing CY 2003 M+C Plan that will continue to operate (in CY2004) in all or part of the M+C Plan's service area.

M+C Plan Termination: An existing M+C Plan offered in CY2003 in which Medicare beneficiaries are currently enrolled, but the M+C Plan will not be offered in CY2004.

M+C Plan Service Area Expansion (SAE): The addition of an approved full county or an approved partial county to an existing M+C Plan during the ACR Renewal Process.

M+C Plan Service Area Reduction (SAR): The removal of an approved full county or an approved partial county from an existing M+C Plan during the ACR Renewal Process.

Passive Elections

Under Medicare laws and regulations, Medicare beneficiaries must make an election to enroll in an M+C plan and CMS specifies the form and manner in which such elections are made. CMS has determined that it is legally permissible to provide for enrollment in an M+C plan under a passive election process in specific, limited circumstances as shown in the chart that follows. A passive election is defined as a process by which a beneficiary is informed that he or she may make an election of a new M+C plan by taking no action.

When a passive election is used in connection with a SAR or plan termination, the M+CO must send a modified ANOC to the enrollees setting forth the available options, including Medigap rights. Although the ANOC information ordinarily may not be due until a later date, the M+CO must provide the ANOC information for the new M+C Plan by October 2, 2003. This will satisfy the M+C Plan termination notification requirements and give the enrollees time to decide whether to "elect" the new plan by taking no action.

When a passive election is used in an M+C plan renewal that ***does not*** include a termination or SAR, there are no Medigap rights. The M+C organization should use the regular ANOC and include passive enrollment language to inform enrollees about their respective plans and other choices for CY2004.

M+C Plan Renewal Guidelines and Operational Instructions for M+C Organizations

The following chart outlines the M+C plan renewal guidelines and describes the relationships that can be established between CY 2003 and 2004 plans and how each one relates to the HPMS plan crosswalk, the enrollment system actions to be performed by either the M+C organization or CMS, whether and which type of enrollment application is required, and the requirements for beneficiary notifications. **It is extremely important that M+C organizations review this chart for guidance when determining their plan structures for CY 2004**. Technical instructions for completing the HPMS plan crosswalk for each type of relationship will be provided to M+C organizations separately.

Contract Year 2004 Guidance for Medicare+Choice Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
1	New Plan Added		A new 2004 plan with no link to a 2003 plan.	The M+CO must submit election transactions.	Beneficiaries are required to complete an enrollment form. Beneficiaries who are already enrolled in another plan in the same organization can complete the short enrollment form.	Beneficiaries are sent a regular ANOC.
2	Renewal Plan	If an M+CO continues to offer a CY2003 M+C plan in CY2004 and retains all of the same service area, **it must retain the same Plan ID number** in order for all currently enrolled beneficiaries to remain in the same M+C Plan in CY2004.	A 2004 plan that links to a 2003 plan and retains all of its plan service area from 2003.	**The renewal plan ID must remain the same** so that beneficiaries will remain in the same plan ID. The M+CO **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
3	Consolidated Renewal Plan	If an M+CO ***combines*** two or more M+C Plans offered in CY2003 into a single renewal plan so that all beneficiaries in the combined plans are offered the same benefits in CY2004, the M+CO must designate which of the renewal Plan IDs will be retained in CY2004 after consolidation. **Note:** If an M+CO reduces a county while performing this activity, the M+CO must follow the Renewal Plan with SAR rules for handling beneficiaries in the reduced county.	Two or more 2003 plans that consolidate into one 2004 plan.	**The M+COs designated renewal plan ID must remain the same** so that CMS can consolidate the beneficiary's election by moving them in the designated renewal plan ID. The M+CO **does not** submit any transactions.	No enrollment application is required.	Beneficiaries are sent a regular ANOC.
4	Renewal Plan with an SAE		A 2004 plan that links to a 2003 plan and retains all of its plan service area from 2003, but also adds one or more new counties.	**The renewal plan ID must remain the same** so that beneficiaries in the current service area will remain in the same plan ID. The M+CO **does not** submit any transactions for these members. However, the M+CO must submit election transactions for the beneficiaries involved in the service area expansion.	Beneficiaries who wish to enroll for the new county are required to complete an enrollment form. An exception is that only the short enrollment form needs to be completed if the beneficiary is currently enrolled in another M+C plan offered by the same M+C organization.	Beneficiaries are sent a regular ANOC.

Contract Year 2004 Guidance for Medicare+Choice Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
5	Renewal Plan with a SAR.	If an M+CO ***reduces the service area*** of a CY2003 M+C Plan and makes the reduced area part of a new or renewal M+C Plan service area in CY2004, the M+CO must offer passive elections in CY2004 to all of the current enrollees who reside in the reduced service area. ***Note:** When the SAR county(ies) is not contained in another M+C plan (contract SAR), the M+CO must submit transactions to disenroll the beneficiaries from the plan. Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights. To enroll in a different M+C plan, these beneficiaries must complete an enrollment form. The model modified ANOC will be available on the CMS website at: http://www.cms.hhs.gov/healthplans/ no later than May 12, 2003.	A 2004 plan that links to a 2003 plan and retains only a portion of its plan service area.	**The renewal plan ID must remain the same** so that beneficiaries in the renewal portion of the service area will remain in the same plan ID. The M+CO **does not** submit any transactions for these members. When the SAR county(ies) is contained in another plan, the M+CO **must submit transactions** to passively enroll the beneficiaries into another plan.	Beneficiaries in the renewal portion need do nothing. Beneficiaries impacted by the plan SAR **must be offered passive elections into another plan offered by the organization.**	Beneficiaries continuing in the same plan that were not impacted by the SAR are sent a regular ANOC. Beneficiaries impacted by the plan SAR (passively enrolled) are sent a modified ANOC and receive guaranteed issue Medigap rights.
6	Renewal Plan Split Based on Provider Groups	If one CY2003 M+C Plan splits into two or more CY2004 M+C Plans in order to reflect the beneficiary's provider group choice, both CY2004 M+C Plans must have the same service area. The CY2003 M+C plan ID must be designated as the renewal plan in CY2004. **Provider-Specific Plan Splits require prior approval from CMS.** M+COs wishing to offer provider-specific plans effective January 1, 2004 must submit their formal requests to their CMS Regional Office Plan Managers with a cc to their CO Plan Manager no later than August 1, 2003. CMS will review such requests on a case-by-case basis and make its determination based upon information that the M+CO submits as part of its proposal. For further information and format requirements, refer to the CMS website at: http://www.cms.hhs.gov/healthplans/.	Two or more 2004 plans that are created from one 2003 plan with membership determined by provider choice.	If the beneficiary's appropriate plan based on provider group choice is the renewal plan ID, beneficiaries remain in the same plan ID. The M+CO **does not** submit any transactions for these members. Otherwise, the M+CO **must submit transactions** to passively enroll beneficiaries into the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.

Contract Year 2004 Guidance for Medicare+Choice Plan Renewals						
	Activity	Guidelines	HPMS Plan Crosswalk	System Enrollment Activities Submitted to CMS	Enrollment Procedures	Beneficiary Notification
7	Renewal Plan Split by Optional Supplemental Benefit Choice	If one CY2003 M+C Plan splits into two or more CY2004 M+C Plans because one or more M+C Plans has a mandatory benefit based on last year's optional supplemental benefit, and therefore a different monthly premium, the CY2004 M+C Plans must have the same service area and basic benefit cost-sharing amounts. The CY2003 M+C plan ID must be designated as the renewal plan in CY2004. **Requires prior approval from CMS.** M+COs wishing to offer the Renewal Plan Split by Optional Supplemental Benefit Choice effective January 1, 2004 must submit their written requests to Randy Brauer with a cc to their CMS Central Office and Regional Office Plan Managers no later than August 1, 2003.	A CY2003 plan that has an optional supplemental benefit(s) is split into 2 or more plans; 1 with only basic benefits and 1 (or more) with the same basic benefits and the former optional supplemental(s) as a mandatory benefit(s).	If the beneficiary's appropriate plan based on benefit choice is the renewal plan ID, beneficiaries will remain in the same plan ID. The M+CO **does not** submit any transactions for these members. Otherwise, the M+CO **must submit transactions** to passively enroll beneficiaries to the new plan ID.	Beneficiaries in the renewal plan need do nothing. Beneficiaries not in the renewal plan must be offered passive elections into the new plan offered by the organization. Beneficiaries who wish to decline the passive election offer must complete the short election form.	Beneficiaries continuing in the renewal plan receive the regular ANOC. Beneficiaries offered passive elections into the new plan are sent the regular ANOC with passive enrollment language.
8	Renewal Plan Split by Premium and/or Cost-sharing based on segmented service area	The M+CO splits an existing CY2003 M+C Plan service area in CY2004 and the only difference between the M+C Plans is premium charge and/or cost-sharing. A segment cannot be smaller than a payment area (e.g. county). The M+CO must submit a separate ACRP for each segment. The CY2003 M+C plan ID must be designated as the renewal plan in CY2004.	A 2003 plan that is segmented into two or more 2004 Plan IDs that share identical benefit packages with the exception of premium and/or cost-sharing.	If the beneficiary's appropriate plan based on service area is the renewal plan ID, beneficiaries will remain enrolled in the same plan ID. The M+CO **does not** submit any transactions for these members. Otherwise, the M+CO **must submit transactions** to reflect the beneficiary's election based on service area.	Nothing is required	Beneficiaries are sent a regular ANOC.
9	Terminated Plan		A 2003 plan that is no longer offered in 2004.	If the beneficiary elects to enroll in another plan with the same organization, the M+CO **must submit transactions** to enroll the beneficiary in another plan with the organization; CMS disenrolls beneficiaries to FFS who do not elect another plan with the same M+CO or a different M+CO.	Beneficiaries are required to complete an enrollment election if they choose to enroll in another plan. Beneficiaries who elect to enroll in another plan with the same organization can complete the short enrollment form.	Beneficiaries are sent a termination notice and receive guaranteed issue Medigap rights.

* Note: See the non-renewal instructions for a contract non-renewal or service area reduction.

Section 2. Guidance for ACR/PBP submissions

ACR Worksheet Changes

The method M+COs will use to calculate ACRs for 2004 generally will be the same as for 2003. However, ACR forms for 2004 will have some changes. For example:

- Worksheets A, B, and D will have additional lines to display separately relevant reinsurance premiums and reinsurance recoveries;
- Worksheet A1 will allow for the statutory change in the phase-in of risk adjustment of payment rates for 2004 to 70 percent demographic factors and 30 percent risk adjustment. Worksheet A1 also will allow for the effects on payment rates of implementing a new comprehensive risk adjustment method (the CMS Hierarchical Condition Category model);
- The requirement for the Vice President of Marketing to sign the certification on Worksheet A has been eliminated; only the CEO and CFO are required to sign.

The items listed above are not an all-inclusive list. The ACR instructions for 2004 will summarize all of the changes to ACR forms and instructions.

Modifications to the ACR Instructions

Base-Period Service Area. The 2003 ACR instructions stated that the base-period data on Worksheet B would be affected if the service area changed between the base period and the contract period. Furthermore, the ACR instructions for 2004 will say that Worksheet B will reflect the base-period costs for the plan's entire base period service area, not the service area for the contract period.

For example, suppose a plan offered in CY2002 served counties X, Y, and Z. The same plan will be offered in CY2004, but will only serve counties X and Y. Worksheet B should include cost data for all the base-year counties – counties X, Y, and Z. In other words, do **not** exclude the cost for county Z even though it will no longer be included in the plan's service area for the contract year.

This approach alleviates the requirement to make any adjustments to base-period data on Worksheet B. As a result, the base-period data will be more easily tracked to the financial statements. All adjustments, including any adjustments for changes in the service area, should be made on Worksheet D as an expected variation.

Base-Period Data. In general, M+COs should include both the costs of individual plan members and employer group members on the ACR of the individual plan. Employer group members of an employer-only plan that existed in the base period are not to be included on Worksheet B in ACRs for M+C plans offered to individuals, but rather on Worksheet B of the employer-only plan.

The base-period data entered on Worksheet B should vary depending on the nature of the transition of a plan between the base period and the contract period; however, the base-period data for an M+C plan should not be duplicated on 2 or more CY2004 ACRs if

multiple plans are offered in CY 2004. The chart below provides more detail on the different possible transitions and which base-period data should be included on Worksheet B.

In the event that a CY2002 plan has been terminated and will not be offered in CY2004 (**and** was not consolidated with another plan for CY2004), the base-period data for the terminated plan should be included in the substantiation that accompanies the hard copy of one of the ACRs for other plans under the same H-number. Be sure this material clearly shows the ID of the terminated plan. (For the definition of a terminated plan, see Section 1 of Part III, "M+C Plan Renewal Guidelines.") The base-period data for terminated plans is necessary so that CMS will have complete base-period data for the ACR(s) submitted for CY 2002.

Base Period (2002)	Contract Period (2004)	Worksheet B Cost
Plan A	Renewing Plan A	Plan A costs
Plan A and Plan B	Plan A and B consolidated into Plan A	Plan A costs and Plan B costs consolidated
Plan A	Plan A split into 2 plans or 2 segments - Plan B and Plan C	Split Plan A costs between Plan B and Plan C
Plan A	Plan A terminated. Not consolidated with other plan. Not offered in CY 2004	No ACR needed for terminated plan. Submit hard-copy base-period data with supporting documentation for any other plan under the same H-number.
Plan B not offered	Plan B offered	New plan – Worksheet B should be blank

Grouping of Health Care Components. As in prior years, M+COs will be permitted to group data in the health care components (lines 1-19) on Worksheet B of the ACR. However, grouping methods used in prior years will not necessarily be acceptable in 2004, especially methods that group all cost data on one line. CMS is requiring M+COs to use as many health care components as possible. Payments made on a capitation basis should be allocated to the appropriate health care component. Reasonable allocation methods, including using claims data as a basis for the allocation, is acceptable. CMS realizes that these allocations are estimates.

At a minimum, CMS would like to see data allocated to the following lines (if applicable):

Line 1 –Inpatient Hospital Services
Line 2 – Skilled Nursing Services
Line 4 – ER/Post Stab./Urgent Care
Line 6 – Home Health
Line 7 – Health Care Professionals

Line 8 – Clin./Diag./Therap.Rad. Lab
Line 9 – Outpatient Hospital Services
Line 10 – Ambulance/Transportation
Line 11 – DME
Line 12 – Renal Dialysis
Line 15 – Outpatient Drugs/Prescription Drug
Line 19 – POS
Line 20 – COB

Prior approval of the grouping methodology is not required. However, M+COs must include a detailed description of the grouping method in the substantiation submitted with the hard copy of the ACR. See the "Transmittal Instructions" for more information.

Beginning in 2004, M+COs will be permitted to group data in the health care components on Worksheet D using the same grouping methodology that is used on Worksheet B. As with Worksheet B, M+COs must include a detailed description of the grouping method in the substantiation submitted with the hard copy of the ACR.

Amounts Collected. The line titled "Total Revenue" (line 29 of Worksheet B of the 2004 ACR) is to include cost-sharing and premiums collected from members in the base period. The 2003 ACR instructions said to exclude any amounts collected from CMS; however, beginning in 2004, M+COs are to include any M+C revenue (or M+C capitation) amounts received from CMS as well as the cost-sharing and premiums collected from members.

Actuarial Standards of Practice. CMS requests, but does not require, that M+COs prepare the projection and claim reserve facets of the ACR in accordance with the appropriate Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. The ASOPs are available on the American Academy of Actuaries' web site at, www.actuary.org. Particular emphasis should be placed on the following standards: (i) ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*, (ii) ASOP No. 23, *Data Quality*, and (iii) ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*. CMS realizes that many M+COs use actuaries to prepare their ACRs. This is evidenced by the fact that over 47 percent of the 2003 ACRs were accompanied by a voluntary actuarial certification. Therefore, we feel that it is appropriate to notify actuaries of the specific professional standards that are to be used in the preparation of an ACR.

Changes to the Plan Benefit Package (PBP) and Summary of Benefits (SB)

For CY2004 the Plan Benefit Package (PBP) and Summary of Benefits (SB) have had substantial improvements. CMS has worked with industry representatives, including M+COs over the past year to improve both the PBP and the SB.

Some of the improvements that have been initiated and implemented during the past year are as follows:

Section B - Inpatient Psychiatric
For the CY 2004 PBP software, Medicare Covered Inpatient Psychiatric has been coded to provide cost-sharing up to 90 days, even though Medicare covers 190 lifetime days in a Psychiatric Hospital. The PBP has been coded in this manner based on the Fee-for-Service payment structure. It is important to note that Medicare has not changed its coverage of the Inpatient Psychiatric benefit. In order to generate the appropriate sentences in the Summary of Benefits and on Medicare Personal Plan Finder for days beyond 90, the M+CO or Cost HMO/CMP should describe these days as additional days under additional or mandatory benefits in the PBP data entry screens. CMS will continue to investigate methods for improving this category in the PBP software.

Section B - Prescription Drugs
CMS has changed the Prescription Drugs section to allow M+C organizations (M+COs), Medicare cost plans and HCPPs to structure their drug benefits as tiers. Plans may utilize up to five tiers as group labels to assist with more accurately describing plan benefits. These organizations will also be able to explain which drugs are included in the respective tiers (i.e. Generic and/or Brand).

New Section C for Preferred Provider Organization (PPO) plans
Section C will no longer capture information for exclusions and restrictions of plan coverage. Instead, Section C will be designed exclusively for M+C or demonstration PPO plans to describe their out-of-network benefits. In addition, a Summary of Benefits (SB) crosswalk for Section C was developed to generate the appropriate SB sentences.

Section D – Cost-sharing
This section has been changed to allow more specific benefit coverage details for plan deductibles and plan level Maximum Enrollee Out-of-Pocket Costs. Plans will be able to select individual service categories from a pick list and apply the appropriate deductibles and Maximum Enrollee Out-of-Pocket costs accordingly. Also, M+COs and Cost HMOs/CMPs will be able to enter cost-sharing information across all benefits or Medicare Covered only benefits.

CMS will continue to monitor high cost-sharing for Medicare-covered benefits. Therefore, CMS has added a new question to the PBP in section D that captures the plan's Medicare Covered Services cap amount. This question will be used as part of the 2004 cost-sharing review.

Section 3 of the Summary of Benefits
In the past, Section 3 of the SB has been limited to 4 pages in length. Now, Section 3 may be up to 6 pages in length. Section 40.5.1 of Chapter 3 of the Medicare Managed Care Manual will be modified to reflect this change. This expansion of the SB is to allow health plans greater flexibility in the description of plan benefits. In addition, the expansion will allow health plans to meet CMS' beneficiary disclosure requirements in areas such as new cost-sharing structures.

Notes - Prescription Drug Discount Programs
Beginning in contract year 2004 organizations will be permitted to display in the PBP note section information about any discount prescription drug program, such as a drug card. This is in addition to changes allowed last year when organizations were allowed to reference their pharmacy discount programs in section 3 of their Summary of benefits. As required in Chapter 3, the following disclaimers must still be referenced in the SB:

(1) This program is not offered under our contract with Medicare, but is available to all enrollees who are members of [Name of M+CO);
(2) This program is not subject to the Medicare appeals process. Any disputes regarding this program may be subject to the [Name of M+CO] grievance process; and
(3) Should a problem arise with this program, please call [Name of M+CO] for assistance at [M+CO customer service number]. Our customer service hours are [Enter hours].

In addition, the SB must clearly state (in the location that the program is described) that the program will be available for the entire contract year.

This change in the PBP is not intended to reclassify pharmacy discount programs as "benefits" within the definition stated in current regulations. Rather, the change is to acknowledge the need to permit organizations the opportunity to advertise and market any and all pharmacy programs.

Instructions for Submitting Employer Group Health Plans
M+COs are permitted to develop M+C plans offered exclusively to Medicare beneficiaries who are members of an employer or union group. This type of plan allows the M+CO to develop a minimal base package that can be customized for specific employers or unions. In developing an employer-only plan, CMS encourages M+COs to create a benefit package with as few mandatory supplemental benefits as possible. This gives M+COs greater flexibility in negotiating with employers and/or unions. The portion of the final benefit package that results from negotiations with employers and/or unions are not required to be submitted to CMS.

M+COs that wish to renew employer-only plans offered in contract year 2003, are required to electronically submit both an ACR and PBP for the renewal employer group health plans (EGHPs) via HPMS. The renewal employer/union-only plans must be submitted by September 8, 2003 for a January 1, 2004 effective date. The same versions of the ACR and PBP software will be used for these plans as for other M+C plans. M+COs renewing employer-only plans for CY2004 will see pre-populated information in HPMS based on CY2003 data.

New employer-only ACRPs may be submitted at any time during the calendar year. CMS recommends submitting new employer-only plans 3-4 weeks prior to the requested effective date. However, all submissions received for CY 2004 will only be effective through December 31, 2004. (CMS is requiring these employer-only plans to submit their renewal materials for CY 2005 during the annual renewal season in 2005.)

Both new and renewal EGHPs submitted by the September 8, 2003 deadline will automatically be given a January 1, 2004 effective date. New EGHPs created and submitted after the September 8, 2003 deadline, but no later than December 1, 2003 for a January 1, 2004 effective date must enter January **2**, 2004 as the proposed effective date in HPMS. Upon approval of the ACRP, CMS will change the effective date to January 1, 2004.

A Medicare beneficiary with Medicare coverage only under Part B cannot elect an M+C plan after December 31, 1998, unless they are members of employer or union groups. If M+COs plan on enrolling Medicare beneficiaries with Part B-only coverage in an employer-only plan, these organizations must prepare a Part-B only ACRP. Failure to create a separate B-only plan will result in the rejection of any enrollments submitted on behalf of individuals without Part A by the CMS managed care payment system. Further guidance on developing B-only plans is provided in the "Instructions for Completing the ACRP Form for Contract Year 2004".

M+COs can offer a service area to their employer group health plans that is larger than is offered to their M+C plans for Medicare individuals. **M+COs that intend to offer a larger service area must notify their CMS CO plan manager no later than 30 days in advance of uploading their employer group health plan ACRP to HPMS.** CMS must have advance notification to ensure that the new employer group health plan counties will be included in HPMS for the plan creation process. In addition, submit documentation of state licensure in the extended counties to your CMS CO plan manager.

CMS will continue to exclude Employer-only plans from the Medicare Personal Plan Finder and the Handbook.

EGHP Enrollment Reporting by M+COs

Beginning in 2004, CMS will begin to track the enrollment of EGHP members. Currently, not all EGHP members are enrolled in EGHP-only plans so not all EGHP members are known. This information is important to CMS during renewal time. The method of submittal and the data required will be developed in a way to minimize burden on the MCOs.

Further information regarding this activity will be contained in the Systems letter that you will receive in June 2003.

Rules Governing the Offering of Optional Supplemental Benefits

All enrollees in an M+C plan must be given the opportunity to select any optional supplemental benefits offered by their M+C plan (see 42 CFR section 422.102(b)).

Optional supplemental benefits must be offered, at the time of initial enrollment, to all Medicare beneficiaries electing enrollment in the M+C plan. The M+C organization may either:

(1) continuously offer each optional supplemental benefit uniformly to all enrollees for the entire contract year, or

(2) choose to place a time limit, of not less than 30 consecutive days, during which a new enrollee can select any particular optional supplemental benefit offered by the M+C plan. An M+C Plan must similarly offer, each year, to its continuing enrollees, the right to purchase optional supplemental benefits during the AEP and during the first 30 days of January.

After the enrollees' 30-day selection period ends the optional benefits may be closed to that enrollee for the rest of that contract year.

> Example: Typically, individuals will elect a plan in November during the AEP, with enrollment effective January 1st. The individual can simultaneously have optional supplemental benefit coverage begin January 1st. If the individual does not select the optional supplemental benefit the M+C plan is still obligated to offer the enrollee the right to purchase the optional supplemental benefit during the first 30 days of enrollment.

Enrollees may voluntarily drop or discontinue optional supplemental benefits any time during the contract year upon proper advance notice to the M+C organization.

Mid-Year Benefit Enhancements (MYBE)

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

- Adding new benefits at no additional cost to the plan enrollee;
- Reducing premiums;
- Reducing cost-sharing (i.e., copayments, coinsurance, and deductibles); or
- Adding new benefits with some premium and/or cost-sharing. This type of MYBE may be offered as follows:
  - Adding new mandatory supplemental benefits with cost-sharing;
  - Adding new optional supplemental benefits with premium and/or cost-sharing;

A mandatory supplemental benefit may be added to a M+C plan for $0 premium. All beneficiary costs for new mandatory supplemental benefits must be in the form of cost-sharing. In this way the beneficiary retains the right to either access the new benefit (with financial liability for the additional cost-sharing) or not. Furthermore, a M+CO is permitted to offer optional supplemental benefits with an additional monthly premium (with or without additional cost-sharing), but only with explicit CMS approval. Again, the beneficiary retains the right to either access the new benefit (with financial liability for the additional premium and/or cost-sharing) or not. (See the section on optional supplemental benefits for more information.)

A revised ACR & PBP submitted through HPMS is required. In addition, a hardcopy of the ACR, including new signatures, and any supporting documentation related to the enhancement must be mailed to the following address:

LMI
Attn: ACRP
2000 Corporate Ridge
McLean, VA 22102-7805

CMS will begin accepting proposals to enhance M+C plans beginning November 1, 2003 and continuing through August 1, 2004. Proposed enhancements to M+C plans will be effective no earlier than February 1, 2004 and must obtain prior approval from CMS. Organizations may request that an enhancement be effective at some later date, however, all effective dates must occur on the first of the month.

Organizations are required to notify plan members of benefit enhancements at least 30 days prior to the effective date. All member notifications and other revised marketing materials must be submitted to the CMS regional office for approval. The streamlined marketing process will continue to apply to benefit enhancements (see Marketing section). Therefore, approved marketing materials that include the disclaimer, "pending federal approval", may be sent to plan members prior to the approval of the ACRP. However, the ACRP must be successfully submitted electronically through HPMS before any marketing materials related to the enhancement may be sent. It is recommended that organizations submit proposals for benefit enhancements at least 45 days prior to the requested effective date to meet the 30-day notification requirement.

New Mid-Year Plans

M+COs may submit an application to create new M+C plans during the contract year. The new M+C plan must be introduced in an approved service area, meet network adequacy requirements, and have reasonable benefits and cost-sharing. New plans must be approved by CMS and may not be marketed prior to CMS approval of the plan. The new plan cannot replace any existing plans where the ACR has been approved. The M+CO must maintain an adequate provider network to ensure access and availability of all medical services for existing plans and the new mid-year plan. The approved renewal plans must continue to be marketed to members throughout the contract year even if a new plan is offered in the same service area during the contract year. The application for a new plan must be submitted to the M+CO's regional office (RO) plan manager with a cc: to the central office (CO) plan manager. The application will be placed on the CMS website shortly.

An ACR & PBP submitted through HPMS is required. In addition, a hardcopy of the ACR, including signatures, and all supporting documentation for the new plan must be mailed to the following address:

LMI

Attn: ACRP
2000 Corporate Ridge
McLean, VA 22102-7805

CMS will begin accepting ACRPs to add a new M+C plan in 2004 beginning November 2003 and continuing through July 2004. Upon upload of the ACRP for the new plan in HPMS, the M+CO will be asked to select a proposed effective date. New plans will be effective no earlier than February 1 and no later than September 1 during the contract year. Please note that all effective dates must occur on the first of the month. The approved effective date may differ from the proposed effective date depending on the review and approval process of the application.

Cost-sharing Guidance

In May of 2002, CMS included cost-sharing guidance in the annual call letter to assist M+COs in the preparation of the 2003 adjusted community rate proposals (ACRPs). This guidance had been developed in response to the high cost-sharing features of many ACRPs that had been submitted in previous years. Of particular concern prior to 2003 were the substantial increases in beneficiary cost-sharing that were experienced for dialysis and chemotherapy drugs. These services are still of particular concern. In addition, for the 2003 benefit year CMS noted further substantial cost-sharing increases in other medical categories such as inpatient stays; outpatient facilities; and ambulatory surgical centers. For the 2004 benefit year CMS will continue to focus on high cost-sharing for Medicare-covered benefits in reviewing ACRPs. We will not approve any ACRP that we find would have the effect of discriminating based on health status. We plan to pay greater attention to plans that have high co-insurance percentages in addition to those with high copayments. We will apply similar scrutiny to cost-based plans and in reviewing any Part B premium reduction plans (BIPA 606). CMS will not approve any BIPA 606 plan whose cost-sharing appears to substantially negate the Part B premium refund.

The following two regulatory citations provide general guidance to M+C plans on benefit design and cost-sharing limits.

- 42 CFR 422.308 establishes a global actuarial equivalency standard for basic benefits which permit coordinated care plans to allocate premiums and cost-sharing, as long as those allocations do not exceed, in the aggregate, an annually published national actuarial per member per month limit. In contract year 2004 this amount will be $113.34.
- Medicare+Choice regulatory requirements specify that organizations may not design benefit packages that discriminate, discourage enrollment or hasten disenrollment of severely ill or chronically ill beneficiaries - 42 CFR 422.100(g) and 42 CFR 422.752(a)(4).

CMS will use the following factors in reviewing proposed 2004 M+COs cost-sharing amounts.

1. Plans that set a total annual cost-sharing cap on member liability at an appropriate level will have great latitude in establishing cost-sharing amounts for individual services. CMS will review caps to verify that they are within actuarial standards. Working with the

CMS Office of Actuary, we have determined that a total annual cap of $2,560 for out-of-pocket expenses for Medicare-covered services, excluding monthly basic premium, would be an appropriate level for this purpose. We reached this conclusion by considering the method of setting out of pocket caps in the Federally-qualified HMO program, enrollee costs under Medigap, and continuance tables of out-of-pocket costs for Medicare services.

With acceptable justification, we will also give some latitude to those plans with out-of-pocket (OOP) caps above $2,560 that impose higher copay amounts as long as the cost sharing is spread across widely used health care services. We will not approve plans with higher caps that concentrate cost-sharing on specific services, such as dialysis and chemotherapy drugs.

2. CMS will carefully examine plans that do not have an annual cap on member liability that meets the level identified above. This is to ensure that the proposed cost-sharing structure does not discriminate against "sicker" beneficiaries, or that the proposed cost-sharing structure does not inappropriately encourage disenrollment or discourage enrollment. We are particularly concerned with the cost-sharing levels for dialysis and chemotherapy drugs.

3. CMS will use fee-for-service (FFS) cost-sharing for a given service as a reference point when evaluating proposed M+C cost-sharing amounts for a specific service. We recognize that some FFS services have no cost-sharing, such as home health, and will accept reasonable cost-sharing levels for these services. However, to ensure against discriminatory practices, CMS will review all cost-sharing to ensure that out-of-pocket costs on specific items and services, e.g. Medicare covered drugs, are not significantly higher than cost-sharing imposed on services in general.

4.We also will pay attention to high cost-sharing levels that are charged for each admission to an inpatient setting or skilled nursing facility. We encourage MCOs to consider cost-sharing levels to be based on benefit periods as administered under Original Medicare. In Original Medicare, a benefit period begins the day a Medicare beneficiary enters the hospital, or skilled nursing facility, and ends when the member has received no additional hospital or SNF services for a period of 60 days in a row. A Medicare beneficiary is charged the hospital or SNF deductible only once during this benefit period regardless of the number of admissions. CMS will allow some latitude for organizations that incorporate benefit periods into their benefit designs.

5. No dollar limits can be placed on the provision of Medicare-covered drugs. CMS does, however, encourage health plans to include the cost of these drugs in any cap that limits beneficiary out-of-pocket costs.

In reviewing ACRPs, CMS will consider that premiums and broad-based deductibles are more equitable ways to spread costs than copays and coinsurance, since these premiums and deductibles spread costs more broadly among enrollees. We plan to provide feedback to plans as soon as possible after the ACRPs are

submitted on any concerns with regard to their proposed cost-sharing amounts. This is estimated to begin about September 15th.

Other Cost-sharing Issues

Facility Fees and Other Indirect Cost-sharing Amounts

It has recently come to our attention that some M+COs are charging facility fees that were neither included in the ACR nor adequately explained in their marketing materials. To ensure that CMS has reviewed and approved facility fees and other indirect cost-sharing amounts, and that Medicare beneficiaries are fully and clearly informed of these amounts in the marketing materials, the following rules will apply to any cost-sharing amounts charged to the member:

For all health care items or services, any cost-sharing amounts charged to members in conjunction with receiving the service must be entered in the PBP cost-sharing fields. This applies whether the cost-sharing is in the form of copayments, coinsurance, and/or deductibles. If the amounts vary within a range, the range should be specified in the PBP cost-sharing fields. The "Notes" section for that particular benefit category should contain a full and clear description of how the cost-sharing amounts will be applied.

If the cost-sharing amounts are approved in the PBP, then all marketing materials that refer to that benefit and indicate what the member's cost-sharing is must fully and accurately describe all costs charged to the member. For example, an M+CO may choose not to charge a copay or other cost-sharing amount for the actual service (e.g., mammograms), but instead charge a facility fee for mammograms received at a freestanding radiological facility. In this case, marketing materials cannot indicate "You pay nothing" or "no copay" or other similar language. Instead, the marketing material should say "No copay for mammograms, but a facility fee of $X will apply if you receive this service at a freestanding radiological facility."

Administrative Fees

It has also come to our attention that some M+COs and Medicare cost plans may be charging "administrative fees" to Medicare members for things such as missed appointments or for not paying a copay at the time of service. Under the M+C program such charges are only allowable if the charge is priced in the ACR and documentation is submitted that clearly shows these charges are priced in the ACR. Further, these additional charges must be clearly outlined in the note section of the PBP and be included in the Evidence of Coverage.

In regard to Medicare cost plans, 42 CFR 417.454, "Charges to Medicare Enrollees," states that Medicare cost plans may only charge Medicare enrollees for: 1) deductible and coinsurance amounts applicable to furnished services, 2) charges for non-covered services, and 3) services for which Medicare is not the primary payer. Since CMS already reimburses Medicare Cost Plans for administrative costs, such additional costs cannot be "passed on" to individual Medicare enrollees for missing an appointment or for not paying a copay at the time of service. Unlike M+COs, Cost HMOs/CMPs have the right to disenroll members for non-payment of copays. As long as a Medicare cost plans

informs members that they can be disenrolled for non-payment of copays, then that remedy is available.

Different provider cost-sharing within an M+C Plan

A M+CO plan may charge different cost-sharing to beneficiaries for the same service based on provider, with the exception of post-stabilization services for which the copayment must be the same or lower for non-plan providers as for plan providers However, all beneficiaries must be charged the same amount for the same service with the same provider. All beneficiaries must have access to all providers in the network.

In no case, can an M+CO design a cost-sharing structure for plans that promotes discrimination, discourages enrollment, steers specific subsets of Medicare beneficiaries to particular M+C plans or inhibits access to services (see 42 CFR section 422.100(g) & 422.752(a)(4)). Cost-sharing differentials cannot be designed in such a way as to preclude choice by the beneficiary. For example, an M+CO cannot charge higher copays for all providers in the western portion of the county while charging lower copays for providers in the eastern portion of the county.

Required SB and PBP Disclosure of Plan Cost-sharing

M+COs must provide information concerning the different cost-sharing structures in Section 3 of the Summary of Benefits. It is the responsibility of the M+CO to adequately explain the charge structure to beneficiaries.

For example, to ensure that CMS has sufficient information to assess the structure of hospital benefits, M+COs will be required to detail the structure of any variable cost-sharing for inpatient hospital services completely in the "Notes" section of the PBP. The detail provided should address the cost-sharing for each hospital as well as any additional restrictions that may apply to this benefit. CMS will use this section of the PBP along with the other documentation to be submitted to the regional office at the time of ACR submission as it determines the approval status of the ACR. More specific guidance for tiered hospital benefits is outlined below.

In addition, if different cost-sharing structures exist for any inpatient facility, a statement explaining to beneficiaries that they need to check with their physician to find out what inpatient facilities the physician has admitting privileges needs to be provided in Section 3 of the SB. In PBP categories that provide for a minimum/maximum cost-sharing structure in the data driven format, M+COs must provide the lowest and the highest cost-sharing amounts that would be applicable for each particular benefit. In categories where minimum/maximum data entry does not exist, M+COs must provide the cost-sharing amounts in the notes section of the appropriate category. M+COs must adequately price the varying cost-sharing amounts on Worksheet C of the ACR and must fully document the differences in the cost-sharing in the substantiation of Worksheet C.

Tiered Hospital Benefits

As discussed above a M+C plan can establish different cost-sharing based on its contracting providers that can also include the hospitals in its network. In the past year

there has been some confusion regarding the conditions under which a hospital can be considered a "network provider". For a hospital to be classified as a "network provider" the M+CO offering the plan must be able to establish that it meets the following criteria:

1. Disclosure – The M+C plan must disclose to its enrollees the hospitals available within its provider network.
2. Contract – There must be a contract in place that meets CMS requirements.
3. Access – The hospital must be accessible to the membership in the plan. Documentation of such access can include, but is not limited to, a demonstrable referral pattern to the facility or for newly contracted hospitals evidence that providers have admitting privileges at the facility.

To ensure that CMS has sufficient information to assess the structure of tiered hospital benefits offered by M+C plans, M+COs, will be required to submit the following to the regional office for its plans that have tiered hospital benefits.

1. Current Provider Directory reflecting network hospitals
2. A list of network hospitals for each tier
3. Proposed EOC and SB language describing the tiered benefit.
4. Maps reflecting locations of all hospitals.
5. For hospitals new to the network a copy of the first and last page of the contract with the MCO.

Additionally, M+COs must ensure that enrollees in the M+C plans it offers have continued access to the full range of cost-sharing (available in their plan) throughout the contract year. In the event that a M+C plan is no longer able to provide the range of cost-sharing as indicated in the PBP, the M+CO must notify CMS of such changes. If for example, there are no longer in-network facilities for a given tier this must be disclosed to enrollees in the plan and the cost-sharing for inpatient hospital care may need to be revised. Changes of this nature may impact on the applicability of the impacted tiers.

Health Plan Management System (HPMS)

Important Notice about HPMS Access Change

In an effort to simplify and streamline HPMS access, CMS will be migrating HPMS from its current home in the Medicare Data Communications Network (MDCN) within the AT&T Global Network back to an Internet environment. Once this migration is complete, Medicare managed care organizations (M+COs, Medicare Cost Plans and HCPPs) will be able to access HPMS by using their corporate Internet Service Provider (ISP) accounts. As a result, users will not need an AT&T account for HPMS access. CMS is working toward implementing this access change as early as the first quarter of 2004.

Users will be required to use a Microsoft Internet Explorer browser version 5.0 or higher with 128-bit encryption in order to access HPMS. CMS plans to provide all users with an opportunity to pilot test their new connectivity to HPMS prior to its official

implementation. Further details about the migration initiative and pilot test will be provided to users as soon as they become available.

It is extremely important to remember that this change would **only** affect access to HPMS. An AT&T account may still be required for access to other CMS systems, like the Group Health Plan (GHP) system or the Medicare Beneficiary Database (MBD). Users should refrain from modifying existing contractual arrangements with AT&T until receiving official notice from CMS regarding the definitive migration timeframe.

If you have questions about the migration and its impact on your organization, please contact Don Freeburger (410-786-4586 or DFreeburger@cms.hhs.gov) or Lori Robinson (410-786-1826 or LRobinson1@cms.hhs.gov).

HPMS User IDs and Passwords

Medicare M+COs and Cost HMOs/CMPs must use HPMS to electronically submit their ACRs and PBPs for Contract Year (CY) 2004. CMS requires that all users obtain a CMS Identification Tracking System (HITS) user ID to access the system. CMS uses the HITS user ID to authenticate user access rights and apply the appropriate security levels. Please contact Neetu Jhagwani (410-786-2548 or Njhagwani@cms.hhs.gov) or Don Freeburger (410-786-4586 or DFreeburger@cms.hhs.gov) to obtain a HITS user ID.

HPMS System Updates

CMS has implemented the following HPMS changes for the CY 2004 ACRP renewal process:

- Customer Service Contact Information – In response to several plan requests, HPMS will enable Medicare M+COs and Cost HMOs/CMPs to differentiate between the customer service contact information for current versus prospective members. Specifically, CMS split the existing plan-level customer service contact in HPMS into two separate contacts: one for current members and one for prospective members. Medicare Personal Plan Finder, the Summary of Benefits, and the *Medicare & You* handbook will use this customer service contact information.

- Physician Network Data – HPMS will ask Medicare M+COs and Cost HMOs/CMPs to provide some limited information regarding their physician networks. These questions include whether the plan provides a website that lists the physicians who are part of their network, whether this website identifies the physicians who are currently accepting new patients, the website URL, and how many physicians are part of the network (i.e., in a pre-defined range format). CMS will use these data to display information on Medicare Personal Plan Finder.

Actuarial Review of Adjusted Community Rate Proposals

As you may be aware, CMS' Office of the Actuary (OACT) participated, for the first time, in the up-front review of the 2003 ACRs. OACT's involvement with the review was precipitated by BIPA 2000, Section 622, (§1854(a)(5)), which states that CMS'

Chief Actuary will review the appropriateness of the actuarial assumptions and data used to develop the ACRs, basic and supplemental premiums, and other submitted values. OACT's efforts were integrated into the desk review performed by CMS' Centers for Beneficiary Choices/Division of Finance and Benefits and supporting contractors. The process and standards to be applied by OACT in their review of the 2004 ACRs will be similar to that of 2003.

Actuarial certification

Many of the assumptions and analyses used in the development of an ACR require generally accepted actuarial methodologies and techniques. However, CMS does not require a detailed demonstration of the data sources and methods used to project the revenue and cost components of the ACR. Having an actuarial certification accompany the ACR filing provides CMS with the confidence that the revenue and cost projections are developed in an appropriate, professional manner. However, given that there are often several acceptable projection techniques, and a range of reasonable assumptions, CMS may still ask for clarification from an M+CO that has provided an actuarial certification.

Section 3. Marketing

Marketing Issues

"Streamlined" Marketing Review Process

For the past two years CMS established a "temporary" streamlined marketing review process for certain marketing materials. Beginning with the 2004 Fall campaign, this process will be permanent. The following outlines the process (with some slight changes from last year's process), which will be incorporated into Chapter 3 of the Medicare Managed Care Manual.

The streamlined marketing review process only applies to M+COs and the SHMO, Evercare and PPO demonstrations (it does not apply to Medicare cost plans). It only applies to marketing materials developed for the Fall campaign (i.e., the ANOC, the SB, and materials necessary to develop an annual enrollment period marketing package in the Fall to encourage members to join the plan) and marketing materials developed to notify members of any mid-year benefit enhancements. It does not apply to the Evidence of Coverage.

All organizations may begin using the CMS-approved marketing materials to market CY 2004 benefits starting September 8th. An organization may choose one of two ways to have materials reviewed and approved.

Option 1: M+COs can obtain approval of their plan marketing materials based on *submitted* ACRPs.

- The CMS Regional Office will review the materials based on the submitted (i.e., not yet approved) ACRP information.

- Organizations are encouraged to begin submitting the 2004 marketing materials for review at the same time they submit their ACRP to CMS.

- The organization must use the "pending Federal approval" disclaimer on the materials until the ACRP is approved by CMS. Once the ACRP is approved, the M+CO must remove the disclaimer.

- If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved or under review, the organization is responsible for correcting all marketing materials to reflect these ACRP changes. The material does not need another approval by CMS.

- As with last year, any organization that uses marketing materials containing errors (e.g., the benefit or cost-sharing information differs from that in the approved ACRP) will be required to correct those materials for prospective members and send errata sheets/addenda to current members before January 1, 2004. CMS will conduct a retrospective review of a sample of M+C plan materials and will notify the M+CO if corrections are necessary. The M+CO will be expected to conduct a self-review of all other marketing materials for plans not included in the sample and to issue CMS-approved correction notices as necessary.

Option 2: An M+CO can submit materials without cost-sharing/benefit information contained in the "template" material

- The RO will review the template and the M+CO will be responsible for inserting the accurate cost-sharing/benefit information after approval is received.

- Material Submission Dates: Organizations can submit these 2004 marketing materials for review before August 1st, since these materials would not contain the ACRP information.

- The M+CO must use the "pending Federal approval" disclaimer on the materials until the ACR is approved by CMS. Once the ACR is approved, the M+CO must remove the disclaimer.

- If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved or under review, the organization is responsible for correcting all marketing materials to reflect these ACRP changes. The material does not need another approval by CMS.

- As with last year, any organization that uses marketing materials containing errors (e.g., the benefit or cost-sharing information differs from that in the approved ACRP) will be required to correct those materials for prospective members and send errata sheets/addenda to current members before January 1, 2004. CMS will conduct a retrospective review of a sample of M+C plan materials and will notify the M+CO if corrections are necessary. The M+CO will be expected to conduct a

self-review of all other marketing materials for plans not included in the sample and to issue CMS-approved correction notices as necessary.

Additional Instructions for Marketing CY 2003 Benefits

CY 2003 Marketing Deadlines. M+COs and Medicare cost plans must cease using public media to market CY 2003 plans effective October 14, 2003. If the M+CO/Medicare cost plan begins marketing the CY 2004 plan between September 8th and October 14th, it must cease using public media to market CY 2003 plans the day before it begins marketing the CY 2004 plans. (M+COs and Medicare cost plans may continue to market the 2003 plans to employer group members aging into Medicare and to individuals inquiring about the 2003 plan). "Public media" includes billboards, radio, TV, and print advertisements, and direct mail.

M+COs and Medicare cost plans are required to submit all remaining CY 2003 marketing materials to CMS by no later than July 25th. This deadline will allow CMS to begin focusing resources on the review of marketing materials for CY 2004.

Effective August 30, 2003, all M+COs and Medicare cost plans must include appropriate disclaimers in CY 2003 marketing materials as necessary. Disclaimers are required whenever an organization advertises a CY 2003 benefit, premium, or copayment that will change effective January 1, 2004 (or whenever an organization accepts an election form for an effective date in 2004 after September 1st). The disclaimer must be in the form of an attachment or an addendum to all marketing materials, including advertisements and enrollment election forms, that alerts potential members that changes will occur on January 1st.

CMS has provided the following model disclaimer to be used by organizations with benefit changes in 2004. If an organization knows its benefits are not changing for 2004, the disclaimer is not required. Additional regional office review and approval is not required if this disclaimer is used verbatim. CMS review and approval is required if the language is modified. The disclaimer must be used on all marketing for enrollment beginning September 8:

> *"Benefits, premiums and/or copayments may change on January 1, 2004. Please contact [insert plan name] for details."*

CY 2004 Summary of Benefits and Annual Notice of Change

M+COs, Medicare cost plans, and certain demonstration projects must use a Summary of Benefits (SB) to describe specific offerings of the January 2004 benefit and premium plans. A cover letter (ANOC) that highlights the specific changes in benefits, premiums and plan rules effective on January 1, 2004 must accompany the SB. A model letter is contained in Section 40.1.3 of Chapter 3 of the Medicare Managed Care Manual.

All M+COs, and certain managed-care demonstration projects must use the standardized SB as part of the Annual Notice of Change (ANOC).

Medicare cost plans are not required to use the standardized SB, however they are required to provide members with an SB along with the ANOC. If a Medicare cost plan intends to have the plan appear in Medicare Personal Plan Finder, it will need to complete the Plan Benefit Package (PBP) to create a standardized SB.

General instructions for the SB have been included in Section 40.5 of Chapter 3 of the Medicare Managed Care Manual. The instructions apply to M+COs and Demonstration Projects who are required to utilize the SB. Chapter 3, Section 40.5.2, provides SB instructions specific to Medicare cost plans. Given that these instructions are now contained in Chapter 3, the annual SB instructions will not be sent out to all organizations. However, M+C organizations will receive information regarding the 2004 SB changes by June 30.

All members of M+COs must receive the ANOC and SB no later than October 31. If the M+CO follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB to the Regional Office for approval is October 21. If the organization uses a non-model ANOC, it should submit the ANOC to the Regional Office for approval by September 17 to allow time for review, approval, printing and mailing.

All members of Medicare cost plans must receive the ANOC and SB no later than December 1st. Therefore, Medicare cost plans should submit the ANOC and SB for review to the Regional Office for approval before October 15th (or before November 20th if the M+CO has followed the ANOC and SB models without modification) to allow time for review, approval, printing and mailing.

Instructions for Marketing CY 2004 Benefits

Beginning September 8th, all M+COs and Medicare cost plans that actively market M+C plans may begin using approved CY 2004 benefit package marketing materials. All M+COs must begin using approved CY 2004 benefit package marketing materials no later than October 15th. All marketing presentations and all mailings to Medicare beneficiaries concerning CY 2004 enrollment (annual election period) must include an SB describing CY 2004 benefit package information. Renewing plans may continue to send and orally present CY 2003 plan information to individuals who specifically ask for it and may continue to enroll individuals for effective dates before January 2004, based on an individual's election period and on other requirements of the law, regulations, and previously issued guidance.

CY 2004 Evidence of Coverage (EOC)

The deadline for distributing CY 2004 EOCs to all plan members (M+CO, PPO and Medicare Cost) is no later than February 2, 2004. All M+COs and Medicare cost plans must also send an EOC to all new members no later than two weeks after the member's effective date of coverage.

This year, CMS will provide CY2004 Model EOCs for HMOs, PPOs and Medicare Cost Plans. (Medicare cost plans will not use the model EOC addendum provided by CMS

last year and instead will receive a complete model specific to Medicare cost plans). These three models will be made available by August. Use of this model language is not mandatory; however, it will facilitate the review of the marketing materials. All other Medicare managed care organizations and demonstrations that are required to send an EOC to their members may base as much of the language of their EOC on this model as they can, since it is considered by CMS to be acceptable language. Of course, these entities must modify any language in their respective EOCs to conform to the statutory and regulatory requirements under which they operate. CMS plans to provide a 2005 model EOC for Private fee-for-service plans in 2004.

Guidance for VAIS language

The Value Added Items and Services (VAIS) are partly defined by what they are not - they are not benefits under the M+C program. The M+C regulations at §42 CFR 422.2 define benefits using a three-prong test; 1). Health care items or services that are intended to maintain or improve the health status of enrollees, 2). The M+C organization must incur a cost or liability related to the item or service (not just an administrative cost), 3). The item or service is submitted and approved through the Adjusted Community Rate (ACR) process. All three parts of the definition must be met for an item or service to be considered a benefit under M+C. Also, a discount is a reduction in price of an item or service where the savings is passed on to the beneficiary. Words such as rebate, allowance, and discount are <u>not</u> permitted in the PBP since they're describing a VAIS. Value-added items and services may also be offered by Medicare Cost Plans. Howerver, VAIS are non-covered services for which Cost Plans are not reimbursed. An exception to this rule is allowed when describing prescription drug discount programs. See Section 2, "Changes to the PBP and SB" for additional information.

Requests to Change Hard Copy Summary of Benefits

CMS may allow, on a very limited basis, changes to hard copy Summary of Benefits. Any approved changes will NOT result in changes in Medicare Personal Plan Finder, nor will result in changes to the Plan Benefit Package. However, requests may be considered for future changes to the Plan Benefit Package

<u>What types of Changes will be Permitted?</u>

The only changes that will be permitted are those that would correct inaccurate or misleading information presented to beneficiaries in the hard copy Summary of Benefits. For example, if a plan does not have a network, a change <u>may</u> be permitted to remove a sentence referring to the requirement that members see doctors within the plan's network.

<u>What types of Changes will NOT be Permitted?</u>

Requests for changes in which the existing sentences are accurate will not be permitted. M+COs and Cost HMOs/CMPs will NOT be permitted to add additional sentences in Section 2 of the Summary of Benefits in order to further explain their benefits. CMS will not allow changes in wording, based on individual preferences.

<u>How to request a change</u>

To request a change to the hard copy Summary of Benefits, e-mail your request to sb2004@cms.hhs.gov. The subject line in the request must read: "Hard Copy SB Change Request." In the request, provide:

1. The H number and Plan ID—each H number and Plan ID should be in a separate e-mail.
2. The Regional Office and Contact who review the M+CO or Cost Plan marketing material.
3. The existing standardized Summary of Benefits language.
4. An explanation of why the existing standardized language is inaccurate.
5. A modified sentence.

How will CMS review the requests?

A cross-functional workgroup will review each request. The workgroup will determine if the current standardized wording is inaccurate or misleading. If the workgroup denies the request, CMS will notify the plan and the plan must adhere to the standardized language. If the workgroup permits a change, CMS will notify the plan with the approved language. Note that the approved language will be decided by CMS and will be considered "standardized." CMS will also notify the Regional Office of the approved language. If the request is based on a preferred wording, the request will not be approved.

"Medicare Personal Plan Finder" Data

Starting Tuesday, October 21, the CY 2004 health plan data will appear on the "Medicare Personal Plan Finder" in the standardized summary of benefits format. In addition, "Medicare Personal Plan Finder" will continue to include graphs displaying several HEDIS and CAHPS measures, as well as disenrollment reasons data.

Special Note about Removing "Medicare Health Plan Compare"

In October 2001, CMS launched the Medicare Personal Plan Finder comprehensive tool to serve as a new resource of health plan information on Medicare.gov. CMS has fully integrated all of the M+C Summary of Benefit information included in Medicare Health Plan Compare, as well as Medicare supplemental insurance information included in Medigap Compare in the new tool. Now that the new tool is fully operational and being widely used by our target audiences, we will be removing the Medicare Health Plan Compare and the Medigap Compare tools from the Medicare.gov website in August of 2003.

Year-to-Year Comparisons on the Website

In response to a recent Congressional request, CMS will be reporting differences in costs and benefits offered by health plans from 2003 and 2004 on its consumer website, www.medicare.gov. The information will initially be reported as a pilot in both California and Florida in October 2003, at which time the 2004 health plan data will be released. The pilot will be evaluated shortly after the October release and we anticipate releasing this new functionality nationally at a later date.

While CMS currently keeps past year's data (for the first two months after the new year's data is reported on the website), we realize that this detailed format can be somewhat cumbersome for users to identify what costs and benefits have changed from year to year.

As a result, CMS will provide a new side-by-side comparison chart that summarizes the changes for key service categories so that users can quickly see information that may help them in making their health care decisions.

Medicare & You 2004

It is expected that the health plan benefit and cost comparison information in *Medicare & You* 2004 will be similar to the health plan information provided in the Medicare & You 2003 booklet released last Fall. One CAHPS measure will be included in *Medicare & You* 2004.

Special Requirements for Medicare Cost Plans

CMS will again display comparative information about Medicare Cost Plans for CY 2004. To be included in CMS' information, Medicare Cost Plan contractors must submit a PBP by September 8, 2003 for each benefit package they will offer in CY 2004. Benefit information about Medicare Cost Plan contractors who do not submit a PBP will not be included in *Medicare & You,* or in the "Medicare Personal Plan Finder."

Medicare Cost Plan contractors who cannot submit a 2004 premium amount for their benefit packages in their PBP should send an email to Valerie Hartz of the Center for Beneficiary Choices at compchart@cms.hhs.gov. In this circumstance, Medicare Cost Plan contractors should enter their CY 2003 premium amount in the PBP. Furthermore, *Medicare & You* wi11 indicate "Not available" in the premium field and information in "Medicare Personal Plan Finder" will remain blank.

PART IV. M+CO NON-RENEWAL PROCESS FOR 2004

Section 1 –Notices and Letters

A. Interim Notification Letter - For M+COs giving official notification prior to September 8, 2003.

CMS may require an M+CO to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. M+COs that use the 2003 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these M+COs must inform their Regional Office of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

M+COs that revise the CMS Model Interim Notification Letter must submit their letter to their CMS Regional Office for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

B. Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than October 2, 2003. CMS strongly encourages M+COs to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated October 2, 2003 to assure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that M+COs must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states are California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. Should there be changes to this list of states with additional protections, CMS will inform all non-renewing M+COs prior to the time they develop their final notification letter.

M+COs may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Finally, in accordance with 42 CFR 422.506(a)(2)(ii), CMS will provide each non-renewing M+CO with a list of those Medicare health plans (M+C and Medicare Cost Plans), if any, that will be available to affected beneficiaries as alternative choices in 2004. M+COs must include this list of "remaining health plans" in final notification letters, including those health plans that have CMS-approved capacity limits. The letter must call special attention to the fact that Medicare Cost Plans may have a different open

enrollment cycle from M+C organizations. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas, of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

RO Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS Regional Offices (ROs) prior to release. M+COs may submit draft copies of their final notification letters to CMS ROs as early as August 1, but no later than September 8, 2003. Since the final notification letter is reviewed as part of a separate and unique process, it is not subject to the 10-day rule for marketing material review, but the CMS Regional Office will give priority review to the submitted final notification letter. CMS strongly suggests that M+COs use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. All RO reviews of final notification letters based on the model will be completed before September 13, 2003. CMS encourages M+COs to consider this review period when making plans to meet the October 2, 2003 deadline for delivery of these final notification letters to beneficiaries.

C. Medigap Information

Non-renewing M+COs must inform all affected Medicare beneficiaries, including the disabled and individuals with End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Full information on this topic is provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter with appropriate language. If used, this model language will assure accurate communication of these technical provisions.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing M+CO in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. M+COs must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2003 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to purchase certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp

D. Public Notice of Non-Renewal

Non-renewing M+COs must publish a public notice of non-renewal at least 90 days prior to the end of the contract year (i.e., October 2, 2003) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. M+COs that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these M+COs must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

M+COs that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages M+COs to consider this review period when making plans to meet the October 2, 2003 deadline for release of these public notices.

Section 2 –Enrollment

A. Mandatory Enrollments: Initial Coverage Election Period (ICEP) and Special Election Period (SEP)

Non-renewing M+COs **must** continue to accept enrollments from individuals during their ICEP and SEPs until November 30, 2003. M+COs should address specific questions about enrollment closures to their Regional Office Plan Managers.

B. Marketing/Enrollment Materials

Once the M+CO notifies CMS if its non-renewal decision, all marketing and enrollment materials to individuals in their ICEP or SEP must announce the M+CO's decision to non-renew. The following is an example of the model language an M+CO may use in marketing and enrollment materials for individuals during an ICEP or SEP:

> ", <Insert plan name> will [(not be renewing its Medicare+Choice contract) or (will not be serving the following counties: <insert county names>)] effective January 1, 2004. You may choose to enroll in our plan, but your coverage will automatically end on December 31, 2003, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another M+C plan effective January 1, 2004, you will be changed to Original Medicare on that date. You will receive additional information about your rights and options for 2004 in a Final Notification Letter on October 2, 2003, or thereafter if your enrollment is after this date."

***NOTE*: A statement announcing the M+CO's decision to non-renew must be included on all pre-enrollment and advertising-related materials. Sales representatives must use this language in all presentations about the plan. If the M+CO chooses to use the model addendum above, and simply to affix this to**

materials that have been approved by CMS, the material does not require CMS review or approval. However, if the M+CO modifies the addendum or marketing material in any way, the material (including the addendum) must be reviewed and approved by CMS prior to dissemination.

Since M+COs are required to accept ICEP and SEP enrollments through November 30, there may be a few cases where individuals are enrolled after an M+CO's final notification letters are mailed. In these cases, the M+CO must provide a final notification letter dated October 2, 2003 to each affected beneficiary, along with the confirmation of enrollment letter. These final notification letters must also include the individual beneficiary's name and address.

Section 3 - Systems Issues

A. Non-renewed Contracts

Non-renewing M+COs should **not** submit disenrollments for any members who will remain in their organization through December 31, 2003. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the M+CO has submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan are placed in Original Medicare in a timely manner.

Non-renewing M+COs should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the M+COs receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2003), M+COs must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December 31,2003). Therefore, it is important that non-renewing M+COs submit any final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

M+COs will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

B. Service Area Reductions

M+COs with service area reductions for 2004 must disenroll all members who reside in the non-renewed area or county**.** M+COs must submit disenrollment records for all affected members no later than the cut-off date (12/10/2003) in December, the last operating month of their current contracts.

CMS will provide M+COs with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third

week of December 2003, and verify the disenrollments for all submitted members. M+COs will also receive a separate communication with specific systems instructions from CMS.

M+COs with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

C. Health Plan Management System (HPMS) Issues

Non-renewing M+COs **must not assign** a Plan Benefit Package (PBP) in HPMS to any county that is included in the request for a service area reduction.

M+COs that intend to non-renew a county for individuals, but to continue the county for employer group health plan members, must notify CMS of their intention in writing by August 1, 2003, in order for the HPMS system to accommodate the request. This notice should be sent to Rosanna Johnson at rjohnson3@cms.hhs.gov

Section 4 - Other Information

A. Partial County Service Area Reduction Requests

- ***Service Area Reduction***

The current county integrity policy affords CMS significant discretion to approve exceptions to the principle of county integrity. The general exceptions to the county integrity policy and documentation requirements can be found on pages 2 and 3 of OPL99.090 on CMS' website at http://www.cms.hhs.gov/healthplans/opl/opl090.pdf.

M+COs must submit partial county requests to CMS for review and approval. CMS reviews each request on a case-by-case basis. In keeping with the current M+C regulatory requirements, CMS will perform analysis of demographic information to ensure nondiscriminatory impact on excluded parts of a county or counties and excluded populations.

M+COs should send requests to the appropriate Regional Office Plan Manager with a copy to Sid Lindenberg in CMS' Central Office. The request must be received at CMS no later than August 1, 2003.

- ***Reconciliation of ZIP Codes***

M+COs and Medicare cost plans that have an approved service area with partial counties will need to regularly reconcile the zip codes within the approved partial counties. The post office is continually adding new zip codes, and reassigning or splitting others. CMS regularly updates zip codes in its database for full counties, but maintenance of partial counties is done manually by CO Plan Managers.

Although it has always been an expectation that M+COs and Medicare Cost Plans would review their service areas, many have not done so. The need for this reconciliation has become increasingly important within the last few years, as CMS has moved to data driven decisions and systems. The accuracy of information in the Medicare Personal Plan

Finder about M+C plan(s) and Medicare Cost Plans is only as good as the data about their partial counties in CMS' system. Additionally, a number of M+COs in recent years have requested reduction of partial county service areas during the non-renewal season. In this case, CMS needs accurate zip code information about the current partial counties in order to analyze the demographic impact of proposed reductions, which is part of the decision making process.

M+COs and Medicare Cost Plans should contact their Central Office Plan Manager for instructions about the specific information they must submit to document the need for service area zip code revisions. (Please note that this revision process may not be used to add new areas to a current service area.) When submitting revisions to the appropriate CO Plan Manager, M+COs and Medicare Cost Plans should also send an informational copy to their RO Plan Manager.

B. "Close-Out" Information

In the fall of 2003, CMS will send a "close-out" letter to non-renewing M+COs with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to assure that affected beneficiaries experience a smooth transition from membership in the non-renewing M+CO to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the M+CO after the last day of its contract.

Non-renewing M+COs may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract. If an affected Medicare member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing M+CO is responsible for all Part A inpatient hospital services until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B. If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing M+CO will pay the covered charges through the last day of the contract; Original Medicare or the next Medicare health plan elected by the beneficiary will pay from the next day forward through the Medicare intermediary.

After the end of the contract period (i.e., December 31, 2003), M+COs' remaining obligations to CMS include:

(1) Submission of risk adjustment data to CMS. This data will be used to calculate risk-adjusted payments to M+COs. Therefore, CMS must have all the required historical data for each beneficiary who has been enrolled in a Medicare health plan in order for this data to be accurate. Non-renewing contractors must continue to submit the required inpatient risk adjustment for services provided to all its Medicare beneficiaries enrolled during calendar year 2003.

(2) Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the M+C contract for the six year period following non-renewal.

(3) Update of plan contact information in HPMS. This will allow CMS to continue to contact appropriate persons in non-renewing M+COs until all activity is complete.

(4) Participation in the CMS process to complete final reconciliation of CMS accounts with the M+CO's, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

(5) Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its M+C contract was extant.

M+COs with further questions related to their Medicare contract non-renewals should contact their Regional Office Plan Managers.

PART V. MEDICARE COST PLAN NON-RENEWAL PROCESS FOR 2004

Section 1 –Notices and Letters

A. Interim Notification Letter - For Medicare Cost Plans giving official notification prior to October 2, 2003.

CMS will strongly encourage a Medicare Cost Plan to send a CMS-approved interim notification letter to affected beneficiaries if it finds that it is in the best interest of the program. Medicare Cost Plans that use the 2003 CMS Model Interim Notification Letter without any revisions do not need to submit their letter to their CMS Regional Offices (ROs) for review and approval prior to release. However, these Medicare Cost Plans must inform their Regional Office of the dates the letter was mailed. They must simultaneously send the RO a dated copy of the letter.

Medicare Cost Plans that revise the CMS Model Interim Notification Letter must submit their letter to their CMS Regional Office for review and approval prior to release. Revised letters must not exceed two pages in length. It is anticipated that the RO review and approval process for interim notification letters will be expedited and take no more than 5 business days.

B. Final Notification Letter to Beneficiaries

Delivery Deadline

All affected beneficiaries must receive their final notification letter no later than November 3, 2003. CMS strongly encourages Medicare Cost Plans to use first class postage to assure their meeting this delivery deadline. Regardless of when they are mailed, all letters must be dated November 3, 2003 to ensure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries.

Content and Format

As in years past, CMS will provide a Model Final Notification Letter. CMS will also prepare a CMS "State-Specific" Model Final Notification Letter that Medicare Cost Plans must use if they serve beneficiaries in 23 states that have special Medigap protections beyond Federal law requirements. These states include California, Colorado, Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. **If there are changes to this list of states with additional protections, CMS will inform all non-renewing Medicare Cost Plans prior to the time they develop their final notification letter.**

Medicare Cost Plans may **not** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

Medicare Cost Plans must include a list of remaining Medicare health plans in the final notification letters that will be available to affected beneficiaries as alternative choices in

2004. The list should include those Medicare health plans that have CMS-approved capacity limits. The final notification letter must call special attention to the fact that some Medicare Health Plans may have a different open enrollment cycle from Medicare Cost Plans. The final notification letter should suggest that beneficiaries contact these remaining Medicare health plans to see whether these plans are accepting new members and to learn their open enrollment dates. Under separate cover, CMS will inform Medicare health plans that remain in non-renewing plans' service areas of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

The final notification letter may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. Individual beneficiary names and addresses must be inserted in the letter to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health plans.

RO Review

Unlike the process for CMS review of interim notification letters, all final notification letters, including those based on the CMS Model Final Notification Letter, must be reviewed and approved by appropriate CMS Regional Offices (ROs) prior to release. Medicare Cost Plans may submit draft copies of their final notification letters to CMS ROs starting September 15, 2003 but no later than October 2, 2003. CMS Regional Office will give priority review to the submitted final notification letter. CMS strongly suggests that Medicare Cost Plans use the CMS Model Final Notification Letter with as few changes as possible to expedite the review process. If the model is used, CMS expects RO review and approval to take no more than 5 business days. CMS encourages Medicare Cost Plans to consider this review period when making plans to meet the November 3, 2003 deadline for delivery of these final notification letters to beneficiaries.

C. Medigap Information

Non-renewing Medicare Cost Plans must inform all affected Medicare beneficiaries, including individuals who are eligible for Medicare due to a disability or End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Details on this topic are provided in the CMS Model Final Notification Letter and the CMS "State Specific" Model Notification Letter. If used, this model language will ensure accurate communication of these technical provisions.

Medicare Cost Plans are required to provide or arrange for supplemental coverage of benefits related to a pre-existing condition with respect to any exclusion period for all Medicare beneficiaries age 65 or older. For beneficiaries under age 65 who are entitled to Medicare due to a disability or End Stage Renal Disease (ESRD), the cost plan must arrange for supplemental coverage if it is available in the marketplace. Please see §1876(c)(3)(F) and under CMS (HCFA) Medicare Cost Plan contract provision, Article IV, General Conditions, item R.

Per CMS regulations, no special provisions need to be made to provide a "Guaranteed Issue" (i.e., no medical screening, or coverage of pre-existing conditions) Medigap

policy, if such a policy is not available in the marketplace. If Medigap issuers in a **particular state do not sell Medigap policies to beneficiaries who are eligible for Medicare due to a disability, the Medicare Cost Plan will still need to provide supplemental coverage for pre-existing conditions.**

Under HMO/CMP Manual Section 3004.5(A)(2), Provide Services Directly, it states, "You may directly provide or arrange for the provision of services related to pre-existing conditions with no charge to the beneficiary."

Under the "Medicare cost contract" the Medicare Cost Plans sign at the inception of their contract, Article IV, General Conditions, (R) it again refers to providing for benefits of pre-existing conditions for " the lesser of six months or the duration of such period."

Per NAIC and HIPAA, the definition of what constitutes a "pre-existing condition" is as follows, "Pre-existing conditions should be limited to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy."

CMS's interpretation is that coverage for pre-existing conditions for the disabled is a requirement whether a disabled beneficiary: 1) applies for and obtains a Medigap policy with a pre-existing condition exclusion; or 2) applies for and is denied coverage under a Medigap policy. Individuals who are eligible for Medicare due to age have similar protections. The beneficiary will still need to be provided coverage for pre-existing conditions, even if the cost plan has to provide such coverage directly. CMS believes that an individual who is eligible for Medicare due to a disability must make an attempt to obtain a Medigap policy before the cost plan can be required to provide coverage directly. The Medicare Cost Plan will not be required to provide coverage for pre-existing conditions for those members (aged and disabled) who do not seek a Medigap policy.

The coverage of pre-existing conditions is limited to those costs **related to the pre-existing condition** that result in Medicare cost-sharing amounts, such as Part A and B deductibles and coinsurance and excess part B charges, up to the limiting charge.

CMS will allow the Medicare Cost Plan to require that all disabled members go to the Medicare Cost Plans' physicians for treatment, during the time the Medicare Cost Plan is providing coverage for the pre-existing condition. The Medicare Cost Plan must coordinate and track these beneficiaries during the enrollment period and during the time they are receiving services. CMS must be able to track compliance.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing Medicare Cost Plans in order to choose from broader range of Medigap policies available on a guaranteed issue basis. Medicare Cost Plans must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2003 effective date. Beneficiaries may be required to submit

this written documentation to a Medigap issuer as proof of their right to buy certain Medigap policies on a guaranteed issue basis. CMS Model Beneficiary Letters Confirming Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, Exhibits 11 and 12 on CMS' website at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp

D. Public Notice of Non-Renewal

Non-renewing Medicare Cost Plans must publish a public notice of non-renewal at least 30 days prior to the end of the contract year (i.e., December 2, 2003) in one or more newspapers of general circulation in each community or county in their contract areas. CMS will provide a Model Public Notice of Non-Renewal. Medicare Cost Plans that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these Medicare Cost Plans must inform their ROs of the date the notice will be released and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date.

Medicare Cost Plans that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to be expedited and to require no more than 5 business days. CMS encourages Medicare Cost Plans to consider this review period when making plans to meet the November 3, 2003 deadline for release of these public notices.

Section 2 - Systems Issues

A. Non-renewed Contracts

Non-renewing Medicare Cost Plans should **not** submit disenrollments for any members who will remain in their organization through December 31, 2003. During the last month of the contract, CMS will conduct a mass disenrollment of all remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment of affected members into other Medicare health plans and will not interfere with any final month disenrollments the Medicare Cost Plan submitted. This method will ensure that all affected members who do not enroll in another Medicare health plan or Medicare Cost Plan are placed in Original Medicare in a timely manner.

Non-renewing Medicare Cost Plans should submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled to be disenrolled effective the first day of the month after the month in which the Medicare Cost Plans receive the request. Should some members request disenrollment effective the first day of the last month of their contracts (i.e., December 1, 2003), Medicare Cost Plans must submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that they do so because, during the mass disenrollment conducted by CMS, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (i.e., December 31, 2003). Therefore, it is important that non-renewing Medicare Cost Plans submit any

final month deletions in accordance with the scheduled cut-off date for the final month of their contract.

Medicare Cost Plans will not receive a reply listing report for the members who are disenrolled through the CMS mass disenrollment.

B. Service Area Reductions

Medicare Cost Plans with service area reductions for 2004 must disenroll all members who reside in the non-renewed area or county**.** Medicare Cost Plans must submit disenrollment records for all affected members no later than their appropriate cut-off date (12/10/2003) in December, the last operating month of their current contracts.

CMS will provide Medicare Cost Plans with a reply listing of all submitted transactions. The organization must review this report as soon as it is received, approximately the third week of December 2003, and verify the disenrollments for all submitted members. Medicare Cost Plans will also receive a separate communication with specific systems instructions from CMS.

Medicare Cost Plans with any questions about the enrollment/disenrollment systems issues should contact Jacqueline Buise at jbuise@cms.hhs.gov or (410-786-7607).

C. Health Plan Management System (HPMS) Issues

Non-renewing Medicare Cost Plans **must not assign** a Plan Benefit Package (PBP) in HPMS to any county that is included in the request for a service area reduction.

Section 3 - Other Information

A. Reconciliation of ZIP Codes

Medicare Cost Plans that have an approved service area with partial counties will need to regularly reconcile the zip codes within the approved partial counties. The post office is continually adding new zip codes, and reassigning or splitting others. CMS regularly updates zip codes in its database for full counties, but maintenance of partial counties is done manually by CO Plan Managers. The need for this reconciliation has become increasingly important within the last few years, as CMS has moved to data driven decisions and systems.

Medicare Cost Plans should contact their Central Office Plan Manager for instructions about the specific information they must submit to document the need for service area zip code revisions. (Please note that this revision process may not be used to add new areas to a current service area.) When submitting revisions to the appropriate CO Plan Manager, Medicare Cost Plans should also send an informational copy to their RO Plan Manager.

B. "Close-Out" Information

In the fall of 2003, CMS will send a "close-out" letter to non-renewing Medicare Cost Plans with complete details regarding their ongoing obligations after non-renewal. These instructions are intended to ensure that affected beneficiaries experience a smooth

transition from membership in the non-renewing Medicare Cost Plan to another health coverage option. Additionally, the instructions provide an efficient and orderly method of defining those tasks that are the responsibility of the Medicare Cost Plan after the last day of its contract.

Non-renewing Medicare Cost Plans may be responsible for costs incurred for affected Medicare beneficiaries hospitalized beyond the last day of the contract.

If an affected Medicare Cost Plan member is hospitalized in a prospective payment system (PPS) hospital, the non-renewing Medicare Cost Plan is responsible for all appropriate costs and/or cost-sharing associated with Part A inpatient hospital services, until the beneficiary is discharged. For any other services, Original Medicare or the next Medicare health plan that the beneficiary elects will assume payment for Part B.

If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. The non-renewing Medicare Cost Plans will pay appropriate costs and/or cost-sharing associated with the covered charges through the last day of the contract; Original Medicare or the next Medicare health plan elected by the beneficiary will assume responsibility from the next day forward.

After the end of the contract period (i.e., December 31, 2003), Medicare Cost Plans' remaining obligations to CMS include:

1. Maintenance and provision to CMS of access to books, records, and other documents related to the operation of the Medicare Cost Plan contract for the six year period following non-renewal or 3 years following the issuance of the Notice of Program Reimbursement (NPR), whichever is later.

2. Update of plan contact information in HPMS, should the Medicare Cost Plan access HPMS. Should the Medicare Cost Plan not access HPMS, they will be required to keep the appropriate RO informed of contact information. This will allow CMS to continue to contact appropriate persons in non-renewing Medicare Cost Plans until all activity is complete.

3. Participation in the CMS process to complete final reconciliation of CMS accounts with the Medicare Cost Plans, including reimbursing CMS for any overpayments and seeking reimbursement from CMS for any previously identified underpayments.

4. Upholding its obligations under the Medicare appeals process to actions related to denials of services and payments made while its Medicare Cost Plan contract was extant.

Medicare Cost Plans with further questions related to their Medicare Cost contract non-renewals should contact their Regional Office Plan Managers.

PART VI. LIST OF CONTACTS

ACR worksheet changes: Tanette Downs, 410-786-7616; Sean Dalenberg, 410-786-0300; Frank Szeflinkski, 303-844-7119

Calendar/Non-renewal processes: Lettica Ramsey, 410-786-5262

Calendar/Renewal Process: Phil Doerr, 410-786-1059

Certification of enrollment changes: Carol Eaton, 410-786-6165

Cost Plan issues: Mark Alark, 410-786-7609

Cost-sharing guidance: Tony Hausner, 410-786-1093

Drug formulary policy: Tony Hausner, 410-786-1093

Drugs and incident-to physicians' services: Terese Klitenic, 410-786-5942

EGHP Enrollment Reporting by M+COs: Kim Miegel, 410-786-3311

Financial Limitation on Rehab Services: Tracey McCutcheon, 410-786-6715

General HPMS Information: Tim Hoogerwerf, 410-786-9962

HIPAA: Yolanda Robinson, 410-786-7627

HPMS Help Desk: The HPMS Help Desk,1-800-220-2028 or hpms@nerdvana.fu.com.

HPMS Internet Migration Initiative: Don Freeburger, 410-786-4586 or Lori Robinson, 410-786-1826

HPMS User IDs and Passwords: Neetu Jhagwani, 410-786-2548 or Don Freeburger, 410-786-4586

Implementation of Grijalva v. Shalala and Appeals Notices: Chris Gayhead, 410-786-6429

Instructions for Submitting Employer Group Health Plans: Tanette Downs, 410-786-7616; Sean Dalenberg, 410-786-0300; Frank Szeflinkski, 303-844-7119

Marketing issues: Mel Sanders, 410-786-8355

Medicare Personal Plan Finder Data and *Medicare & You* 2004: Valerie Hartz, 410-786-6013

M+C contract: Christine Perenich, 410-786-2987

M+C Plan Renewal Guidelines, General: Shellae Louden, 410-786-7632

Mid-Year Benefit Enhancements: Tanette Downs, 410-786-7616; Sean Dalenberg, 410-786-0300; Frank Szeflinkski, 303-844-7119

New Federal Regulations Impacting M+COs: Chris Eisenberg, 410-786-5509

Non-Renewal Process for 2004: Lettica Ramsey, 410-786-5262

Operational instructions for MCOs to Complete the Plan Crosswalk: Kim Miegel (systems), 410-786-3311; Randy Brauer (enrollment issues), Lori Robinson (HPMS plan crosswalk), 410-786-1826; Rosanna Johnson (other issues), 410-786-1148

Optional Supplemental Benefits: Marty Abeln, 410-786-1032

Office of the Actuary's Review of 2004 ACRs: Richard Coyle, 410-786-6393

Partial County Requests: Sid Lindenberg, 410-786-1157

Passive elections: Danielle Moon, 410-786-5724

PBP changes: Jermaine Staggers, 410-786-1958

Provider-Specific Plan Proposals: Rosanna Johnson, 410-786-1148

Redesigned Managed Care System Cutover: Kim Miegel, 410-786-3311

Renewal Plan Splits by Optional Supplemental Benefit Choice: Randy Brauer, 410-786-1618

Renewal Plan Splits by Provider Group: Mary McLean, 410-786-7815

Separate PBPs for EGHP B-only waiver members: Tanette Downs, 410-786-7616; Sean Dalenberg, 410-786-0300; Frank Szeflinkski, 303-844-7119

Tiered Hospital Benefits: Rosanna Johnson, 410-786-1148

Working Aged Process: Kim Miegel, 410-786-3311