

## TABLE OF CONTENTS

<b>Calendar for the 2003 M+C Renewal Process</b>	<b>ii</b>
<b>Calendar for the 2003 M+C Non-Renewal Process</b>	<b>iv</b>
<b>Calendar for the 2003 Cost Plans Non-Renewal Process</b>	<b>v</b>
<b>Part I. Statutory and Regulatory Information for Renewing M+C Contractors</b>	<b>1</b>
Reduced Part B Premium as a Medicare+Choice Benefit	1
Quality Assurance Program Focus on Racial and Ethnic Minorities	3
Section 617 “Employer” Group Waivers	3
Actuarial Review of Adjusted Community Rate Proposals	6
Election Period Changes for 2003	6
<b>Part II. Administrative Changes and Updates</b>	<b>7</b>
Instructions for Risk Adjustment Implementation	7
Medicare + Choice Contract	19
M+C Monitoring	19
Section 1876 Monitoring	19
Enhanced Payments for Congestive Heart Failure (CHF)	19
Standardized Appeal Notices	19
Coordination of Appeal Processes	20
Effectuation Requirements for Voluntary Disenrollments and Non-renewals	20
Health Insurance Portability and Accountability Act	21
Financial Information	21
<b>Part III. Renewal Process for 2003</b>	<b>22</b>
<b><i>Section 1. M+C Plan Renewals</i></b>	<b>22</b>
M+C Plan Renewal Guidelines	22
New M+C Plan Types	24
Partial County Requests	24
<b><i>Section 2. Guidance for ACR/PBP Submissions</i></b>	<b>24</b>
Clinical Trials	24
Cost Sharing Guidance	25
ACR Worksheet Changes	27
Instructions for Submitting Employer Group Health Plans	27
Health Plan Management System	29
Changes in the Plan Benefit Package and Summary of Benefits	30
<b><i>Section 3. Marketing</i></b>	<b>32</b>
Marketing Issues	32
Medicare Health Plan Compare Data	38
<b>Part IV. Non-Renewal Process for 2003</b>	<b>39</b>
<b>Part V. List of contacts</b>	<b>43</b>
<b>Attachments</b>	<b>45</b>

## CALENDAR FOR 2003 M+C RENEWAL PROCESS

<u>2002</u>	
<b>May 1</b>	<ul style="list-style-type: none"> <li>• CMS notifies M+COs of intent to renew contracts by this date.</li> <li>• CY 2003 Adjusted Community Rate Proposal (ACRP) Seminar.</li> </ul>
<b>May 6</b>	<ul style="list-style-type: none"> <li>• CY 2003 ACR, Plan Benefit Package (PBP), ACR/PBP Pre-Upload Validation (APV) tool, and technical instructions become available for download from the Health Plan Management System (HPMS)</li> </ul>
<b>June 3</b>	<ul style="list-style-type: none"> <li>• Partial county requests due</li> <li>• CMS begins accepting CY 2003 ACRPs via HPMS</li> </ul>
<b>July 1</b>	<ul style="list-style-type: none"> <li>• Final day for M+COs to submit CY 2003 ACRPs via HPMS.</li> <li>• Deadline for M+COs with employer-only plans to renew their CY2003 ACRPs via HPMS.</li> <li>• M+COs may submit CY 2003 summary of benefits (SB) and annual notice of change (ANOC) materials to CMS regional offices. (This date is based on the ACRP submission date – if the M+CO submits its final ACRP earlier, it may submit the CY 2003 marketing materials earlier to correspond with its ACRP submission date).</li> <li>• Section 1876 Cost-based contractors may voluntarily submit a PBP so information on benefits is included in <i>Medicare &amp; You</i> and Medicare Health Plan Compare (i.e. Medicare Compare).</li> </ul>
<b>July 10</b>	<ul style="list-style-type: none"> <li>• Final date for M+COs to submit <u>CY 2002</u> marketing materials for CMS's review and approval.</li> </ul>
<b>July 16-18</b>	<ul style="list-style-type: none"> <li>• M+COs preview the <i>Medicare &amp; You</i> CY 2003 items prior to CMS publication.</li> </ul>
<b>July 18</b>	<ul style="list-style-type: none"> <li>• M+COs should submit CY 2003 summary of benefits (SB) and annual notice of change (ANOC) materials to CMS regional offices to allow sufficient time for CMS's review and approval before the September 16 publication of "Medicare Health Plan Compare."</li> </ul>
<b>August 27-29</b>	<ul style="list-style-type: none"> <li>• M+COs preview plan data in "Medicare Health Plan Compare" and "Medicare Personal Plan Finder" prior to Internet release</li> </ul>
<b>August 31</b>	<ul style="list-style-type: none"> <li>• M+COs are required to include information in CY 2002 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2003.</li> </ul>
<b>September 1-October 1</b>	<ul style="list-style-type: none"> <li>• CMS mails <i>Medicare &amp; You</i> for CY 2003, which will contain health plan benefit and cost information.</li> </ul>
<b>September 3</b>	<ul style="list-style-type: none"> <li>• Tentative date for CMS's approval of all CY 2003 renewal ACRPs.</li> <li>• M+COs may begin marketing CY2003 benefits to Medicare beneficiaries through public media. (This date is based on the date CMS notifies organizations of ACRP approvals. However, if the organization's ACR has not been approved, a disclaimer "pending Federal approval" must be used on all <u>approved</u> marketing materials.</li> </ul>

	<ul style="list-style-type: none"> <li>• Latest date for M+COs to send ANOC and SB to CMS regional offices in order to ensure review, approval, and receipt by members before October 15 deadline. <u>Note:</u> 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 is October 4.</li> </ul>
<b>September 16</b>	<ul style="list-style-type: none"> <li>• CMS publishes plan data in “Medicare Health Plan Compare” and “Medicare Personal Plan Finder” on the Internet.</li> </ul>
<b>September 23</b>	<ul style="list-style-type: none"> <li>• To ensure that beneficiaries are notified by 10/2/2002, M+COs should send passive election letters by this date.</li> </ul>
<b>September 27</b>	<ul style="list-style-type: none"> <li>• Tentative date the Model 2003 EOC will be made available to all plans.</li> </ul>
<b>October 14</b>	<ul style="list-style-type: none"> <li>• Final date for marketing <u>CY 2002</u> plans (i.e., benefit packages) to Medicare beneficiaries through public media. <u>Note:</u> If the M+CO began marketing the CY 2003 benefit packages any time between September 1 and October 14 (but no earlier than September 1), it must cease marketing CY 2002 plans on the date it begins marketing the CY 2003 benefit packages.</li> </ul>
<b>October 15</b>	<ul style="list-style-type: none"> <li>• For M+COs: CY 2003 ANOC letters (with SBs) due to beneficiaries. M+COs must mail ANOC letters before this date to ensure receipt by enrollees by October 15. <i>Note: All marketing presentations and mailings to beneficiaries who inquire about CY 2003 enrollment must include a CY 2003 summary of benefits.</i></li> <li>• MCOs that will not implement HIPAA Transactions and Code sets by October 16, 2002, must submit a HIPAA Compliance Extension form.</li> </ul>
<b>October 16</b>	<ul style="list-style-type: none"> <li>• MCOs not requesting an extension for HIPAA compliance must implement standards for HIPAA transactions and code sets.</li> </ul>

<b><u>2003</u></b>	
<b>January 1</b>	<ul style="list-style-type: none"> <li>• Effective date for CY 2003 plan benefits.</li> </ul>
<b>March 1</b>	<ul style="list-style-type: none"> <li>• Expected deadline for distributing 2003 EOCs to plan members</li> </ul>
<b>April 14</b>	<ul style="list-style-type: none"> <li>• MCOs must implement HIPAA Privacy standards.</li> </ul>
<b>October 16</b>	<ul style="list-style-type: none"> <li>• MCOs that requested an extension for HIPAA compliance must implement standards for HIPAA Transactions and Code sets.</li> </ul>

## CALENDAR FOR THE 2003 M+C NON-RENEWAL PROCESS

<b>2002</b>	
<b>May 10</b>	<ul style="list-style-type: none"> <li>• CMS final non-renewal instructions and beneficiary plan withdrawal Qs &amp; As are posted on the CMS websites.</li> </ul>
<b>July 1</b>	<ul style="list-style-type: none"> <li>• Deadline for M+COs to submit a non-renewal or service area reduction notice to CMS.</li> </ul>
<b>July 8</b>	<ul style="list-style-type: none"> <li>• CMS issues an acknowledgement letter to all M+COs that are non-renewing or reducing their service area.</li> <li>• Press Release: Statement from CMS Administrator ( Tentative)</li> </ul>
<b>July 15</b>	<ul style="list-style-type: none"> <li>• Optional: M+COs that are non-renewing or reducing their service area sends Interim Letter to beneficiaries.</li> <li>• Fact sheet: “Protecting Beneficiaries when Medicare + Choice Plans withdraw” will be posted on CMS’ official website.</li> </ul>
<b>July 30</b>	<ul style="list-style-type: none"> <li>• CMS will release aggregate detailed information on non-renewals (i.e., ESRD beneficiaries, listing of abandoned counties, comparisons from year to year).</li> </ul>
<b>August 1</b>	<ul style="list-style-type: none"> <li>• The model final beneficiary notification, the state specific final beneficiary notification, and a model public notice are posted on CMS website, and sent to M+COs that are non-renewing or reducing their service area.</li> </ul>
<b>September 12</b>	<ul style="list-style-type: none"> <li>• CMS approves the final beneficiary letter. CMS will release SEP letters to remaining M+COs.</li> </ul>
<b>September 13</b>	<ul style="list-style-type: none"> <li>• M+COs can begin mailing final beneficiary letters. Final beneficiary letters must be personalized and dated 10/2/02, and be in the beneficiaries hands by 10/02/02.</li> </ul>
<b>October 2</b>	<ul style="list-style-type: none"> <li>• M+COs must publish a CMS approved notice in one or more newspapers of general circulation in each community or county in your contract area.</li> </ul>
<b>November 18</b>	<ul style="list-style-type: none"> <li>• CMS issues “close out” information/instructions to M+COs that are non-renewing or reducing their service area</li> </ul>

**CALENDAR FOR THE 2003 COST PLAN NON-RENEWAL PROCESS**

<b><u>2002</u></b>	
<b><u>August 1</u></b>	<ul style="list-style-type: none"> <li>• CMS Cost Plan non-renewal instructions are posted on the CMS websites.</li> </ul>
<b>October 2</b>	<ul style="list-style-type: none"> <li>• Deadline for Cost Plans to submit a non-renewal or service area reduction notice to CMS.</li> </ul>
<b>October 9</b>	<ul style="list-style-type: none"> <li>• CMS issues an acknowledgement letter to all Cost Plans that are non-renewing or reducing their service area.</li> <li>• The model final beneficiary notification, the state specific final beneficiary notification, and a model public notice are posted on CMS website, and sent to Cost Plans that are non-renewing or reducing their service area.</li> </ul>
<b>October 14</b>	<ul style="list-style-type: none"> <li>• CMS approves Cost Plans final beneficiary letter, and public notice.</li> </ul>
<b>October 23</b>	<ul style="list-style-type: none"> <li>• Cost Plans can begin mailing final beneficiary letters. Final beneficiary letters must be personalized and dated 11/2/02, and be in the beneficiaries hands by 11/02/02.</li> </ul>
<b>December 2</b>	<ul style="list-style-type: none"> <li>• Cost Plans must publish a CMS approved notice in one or more newspapers of general circulation in each community or county in your contract area.</li> </ul>

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

### **Benefits Improvement and Protections Act, Section 606: Reduced Part B Premium as an M+C Plan benefit**

#### ***The Law***

Section 606 of the Benefits Improvement and Protections Act of 2000 (BIPA) permits Medicare+Choice Organizations (M+COs) to offer enrollees reductions in their Part B premium as an "additional benefit" of joining the M+C plan. The "additional benefit" may be offered as part of the CY 2003 benefits.

#### ***Background***

Beneficiaries must pay the Federal Government a premium to receive Medicare Supplementary Medical Insurance (SMI) coverage, referred to as Medicare Part B. There are approximately 37 million Medicare beneficiaries who participate in the Medicare Part B program.

Approximately 86.5% of the Medicare beneficiaries pay their own Medicare Part B Premium, most by having a deduction made from their Social Security check or other retirement benefits. (A few receive a bill from Medicare and "write a check" to Medicare to pay their Medicare Part B premium).

The remaining 13.5% of the Medicare beneficiaries do not pay their own Medicare Part B premium. A third party, such as an employer or the State Medicaid program, pays it for them. The payer of the Medicare Part B Premium receives the benefit of any reduction in the Medicare Part B premium offered as a benefit in an M+C plan.

#### ***An Indirect Benefit***

Most benefits offered by an M+CO are provided directly to the beneficiary by the M+CO, such as additional health care services not offered by Medicare, or a reduction in the M+C premium, or cost-sharing that the beneficiary pays. This benefit option provided for under section 606, however, is "indirect" because the M+CO does not provide a benefit directly to the beneficiary. The M+CO will not change any direct benefits offered in the plan benefit package.

#### ***How It Works***

The M+CO agrees to accept a reduced capitation amount from Medicare for all the beneficiaries in a specific Plan Benefit Package. The amount that the capitation can be reduced may be up to, but not exceed 125% of the standard Medicare Part B Premium Amount. (Since the Medicare Part B Premium Amount for 2003 is \$56.90, the maximum amount that an M+CO can reduce the capitation amount per beneficiary in 2003 is \$71.13). The Medicare beneficiary's Medicare Part B Premium is then reduced by 80% of the amount the capitation payment to the M+CO is reduced, up to the Standard Part B Premium Amount. See table below.

(The maximum capitation reduction amount for 2003 is \$71.13, and 80% of \$71.13 is the Standard Medicare Part B premium amount of \$56.90)

<b>Per beneficiary reduction in CMS's capitation payment to the M+CO</b>	<b>Medicare Part B Premium Reduction (80% of Capitation Reduction)</b>	<b>Increase in Annuity as a result of this "indirect benefit"*</b>
\$71.13	\$56.90	\$56.90
\$60.00	\$48.00	\$48.00
\$55.00	\$44.00	\$44.00
\$50.00	\$40.00	\$40.00
\$25.00	\$20.00	\$20.00

\*As a result of rounding by the specific agencies that issue the annuity payments, i.e., Social Security Administration, Railroad Retirement Board, or the Office Personnel Management, the exact amount may differ by a minimal amount.

### ***Considerations***

An M+CO may not reduce the capitation payment to an amount that will result in a Medicare Part B Premium reduction greater than the Standard Medicare Part B Premium amount. When combined with other "additional benefits", as defined in ACR instructions, the total "additional benefits" cannot exceed the adjusted excess as submitted on the ACR. This benefit must be offered to all beneficiaries who are enrolled in a specific plan benefit package. (An M+CO may choose to offer more than one Plan Benefit Package). No beneficiary will receive a reduction that exceeds the amount that they pay for the Medicare Part B Premium. (Approximately 0.34% of Medicare beneficiary's pay less than the Standard Part B Premium.) If a beneficiary's Medicare Part B Premium is less than the amount of the Part B premium reduction, and reducing the premium by the full amount offered by the M+CO would result in a "negative number," the beneficiary's premium would be reduced to \$0.

There will be no "rebates". (The M+CO capitation rate will still be reduced by the same amount for every beneficiary in that Plan Benefit Package, even if some beneficiaries have a Medicare Part B Premium that is less than the amount of the reduction offered by that M+CO).

### ***Implementation***

CMS has made an effort to minimize special requirements for M+COs who choose to offer this benefit, by requesting no special submissions and integrating this benefit into the normal M+CO approval processes. Attachment 1 is a list of Questions and Answers to assist M+COs with this provision.

CMS will provide training for M+CO staff regarding beneficiary education, language that can be used in Marketing Materials, and will work with the Social Security Administration, Railroad Retirement Board, and Office of Personnel Management on the language that is used in the monthly benefit letter they send to annuitants. Attachment 2 is draft model language for marketing materials.

CMS and SSA computer systems are exchanging information to implement this benefit. These systems have cut-offs for processing the different payments they make on their own timeline. This, along with the allowable enrollment effective dates, may mean beneficiaries who enroll in January 2003 may not see their initial Medicare Part B Premium Reduction until March 2003.

The Social Security rounding rules may result in the amount of the reduction not being exactly 80% of the capitation reduction.

***Why would an M+CO offer this benefit?***

This benefit may make the Plan Benefit Package more attractive to Medicare beneficiaries who have the option of joining an M+C plan through their employer. In some instances an M+CO is required to offer the same benefits to Medicare and Non-Medicare Beneficiaries under the employer requirements. Because there is adjusted excess available as submitted in the ACR, the Plan can use this towards the indirect benefit that will affect only Medicare beneficiaries.

**Quality Assurance Program focus on Racial and Ethnic Minorities**

Section 616 of BIPA requires CMS to submit biennial Reports to Congress regarding how M+C quality assurance programs focus on racial and ethnic minorities. CMS will submit the first report to Congress in December 2002, and will include information voluntarily provided to CMS by M+COs as well as other data sources. As the next Report to Congress is not due until December 2004, CMS does not plan to collect national information for that Report in 2003; it is CMS's intention to collect it early in 2004.

**Section 617 “Employer” Group Waivers**

Section 617 of BIPA provided authority for the Secretary to waive or modify requirements that hinder the design of, the offering of, or the enrollment in M+C plans offered to employers and unions. See Chapter 14, “Waivers to Facilitate M+CO Contracts with Employer or Union M+C Groups” of CMS document “Instructions for Completing the Adjusted Community Rate Pricing Form for Contract Year 2003” for specific instructions on how to submit an ACR filing related to employer/labor organization-only plans. This document is on the Internet at:  
<http://www.hcfa.gov/medicare/acr2003instr.pdf>

***Waiver Categories Approved***

CMS has currently approved four categories of employer group waivers. No additional request or notice is required for those waivers that are already published. In addition, waiver requests that were submitted in 2002 should not be resubmitted, unless requested.

- A. *Actuarial Swapping of Benefits not Covered by Original Medicare:* M+COs may swap different types of benefits (not covered under original Medicare) of equal actuarial value between an M+C plan offered to the individual market and an employer or union plan. The swaps may be used if an employer or union prefers a different benefit package for its employees/members than the M+CO offers to the individual market. For example, an employer may prefer a vision benefit as opposed to the dental benefit the M+CO offers to the individual market.
- B. *Actuarial Equivalence:* When negotiating with employers or unions, M+COs can raise cost sharing (coinsurance, copayments and/or deductibles) for specific plan benefits by providing a higher benefit level and/or a modified premium compared to what is offered to the individual market. Generally, waivers approved in this category have been related to prescription drug benefits. For example, an M+CO might offer a plan with \$500 per year

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

- C. *Employer-Only Plans*: M+COs can develop employer/union-only plans as the basis for developing packages 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. However, the employer/union plan would not need to be marketed or made available to individual Medicare beneficiaries in the market. Additionally, such customized plans would not appear on Medicare Compare.
- D. *Part B-Only Plans*: Certain federal, state and local employees do not have Part A Medicare coverage. M+COs can develop plans for Part B-only Medicare beneficiaries who are members of employer or union groups. See Chapter 7, “Worksheet C1 – Part B-Only Maximum Charge for Part A Benefits,” for specific considerations related to this type of plan. On the Internet, see [http://www.hcfa.gov/pubforms/86\\_mmc/mc86c07.htm](http://www.hcfa.gov/pubforms/86_mmc/mc86c07.htm).

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

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

### ***Service Areas***

Service areas of employer-only plans need not be restricted or linked to the service areas identified by the M+CO for the M+C plans it offers to individuals. Therefore, the service area of the employer-only plan may be larger or smaller than the service areas of the organization's M+C plans offered to individuals. If the service area is larger than the currently approved service area under the M+C contract, CMS is not requiring either a new plan application or a service area expansion. However, the M+CO is responsible for ensuring that plan benefits are available and accessible to Medicare enrollees with reasonable promptness and in a manner that ensures continuity of care in the provision of benefits. Organizations may accomplish this by either furnishing benefits directly, arranging for them, and/or by paying non-contracted providers for plan benefits. Generally, an M+CO satisfies the requirement for payment to a non-contracted provider when it pays the amount (including cost-sharing) that the provider would have received, had the service been provided to a fee-for-service Medicare beneficiary. An M+CO must have a State license to offer health benefits and it must offer an M+C plan under that license. The M+CO must offer at least one M+C plan to individuals somewhere in the State in which an employer/union-only plan is offered.

### ***General Considerations***

M+COs are not subject to the requirements in 42 CFR 422.80(a) related to pre-review and approval by CMS of marketing materials created specifically for M+C employer/union group

plans. M+COs are required to send informational copies of employer/union group-specific marketing materials to its Regional Office within 14 days of their release/use.

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

***Instructions for Additional Employer/Union Group Waiver Requests***

The waiver request must include the name of the M+CO and fully address the following:

- contract numbers affected by the waiver request (or indication that the request applies to all M+C plans nationwide under the M+CO)
- provisions of existing requirements to be waived/modified
- executive summary of the recommended process/modification and rationale
- detailed description of the waiver request including flow charts, details of processes, etc., if applicable
- the problems(s) with the current requirements that are hindering the design or offering of, or enrollment in M+C plans
- how the waiver will remedy the problem(s)
- expected improvements and outcomes for beneficiaries
- how the M+C program, the employer, and/or M+CO will benefit
- required systems modifications, if applicable
- desired/recommended implementation date
- other details specific to the particular waiver that would assist CMS in the approval of the request
- a general estimate of the burden and/or administrative costs that will be reduced by granting such waiver
- contact person, phone and fax numbers and email address

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

Timing of our approval of waiver requests will depend on the number and complexity of waiver proposals received.

We will act on all section 617 employer group waiver requests on an ongoing basis. As we have done for the waivers already approved, CMS will announce the availability of new waiver types to all M+COs.

If you need additional information please send your inquiry [eghpwaivers@cms.hhs.gov](mailto:eghpwaivers@cms.hhs.gov), or you may contact Tom Hutchinson at 410-786-8953.

### **Actuarial Review of Adjusted Community Rate Proposals**

Section 622 of BIPA 2000 requires the Chief Actuary of CMS to determine the appropriateness of the actuarial rates, amounts, and assumptions used by M+COs during the preparation of ACR proposals. The effective date for the implementation of Section 622 is May 1, 2001 and applies to any ACR submitted on or after the date.

CMS actuaries are planning to fulfill the statutory obligation in several ways. First, CMS will utilize statistical methods to identify plans with submitted values that appear to be inconsistent with other ACR submissions. CMS will then perform a more thorough review of the materials supporting the calculations for such “outlier” plans. Examples of items that may be reviewed are trends in benefit costs from the base period to the contract period, and the ratio of inpatient expenditures to total direct medical costs for Medicare-covered services. Additionally, CMS expects to perform on-site actuarial reviews to be conducted as part of the audit process.

Finally, CMS is asking M+COs to submit an actuarial certification for each ACR proposal, to be signed by the M+CO’s actuary, or its consulting actuary, attesting to the appropriateness of the actuarial methods and assumptions underlying the ACR submission. While the following language is recommended, comparable language would similarly signify to CMS that the actuarial assumptions in question have been prepared following Actuarial Standards of Practice.

*I certify, that to the best of my knowledge and judgment, the data, actuarial assumptions, and actuarial methods underlying this Adjusted Community Rate Proposal conform to the appropriate Actuarial Standards of Practice, as promulgated by the Actuarial Standards Board, and that the results reasonably reflect the statutory purpose for which the estimates are prepared. Furthermore, I believe that the benefits provided by this plan are reasonable in relation to the total of the Medicare capitation payments and enrollee premiums.*

A signed statement should be labeled “Attachment 2” and included with the ACR documentation immediately behind the Initial Rate documentation.

### **Election Period Changes for 2003**

As of January 1, 2003, beneficiaries may make plan elections (including electing other plans offered by an M+CO or the Original Medicare Plan) at the following times: upon becoming newly eligible/entitled for Medicare Parts A and B, during the Annual Election Period (AEP) in November, and once during the Open Enrollment Period (OEP). The OEP extends from January through the end of March. With a few exceptions, Medicare beneficiaries cannot enroll in or disenroll from an M+C plan - or return to the original Medicare Plan - at any other time of the year.

For additional information regarding election periods, including Special Election Periods and other exceptions, see Section 30 in Chapter 2 of the Medicare Managed Care Manual:

[http://www.CMS.gov/pubforms/86\\_mmc/mc86c02.htm](http://www.CMS.gov/pubforms/86_mmc/mc86c02.htm)

Additional information can also be found at the election period changes (lock-in) webpage:

<http://www.CMS.gov/medicare/lockin.htm>

## **PART II. ADMINISTRATIVE CHANGES AND UPDATES**

### **Instructions for Risk Adjustment Implementation**

#### ***Background***

The Balanced Budget Act of 1997 gave the Secretary of Health and Human Services the authority to collect inpatient hospital data for discharges on or after July 1, 1997. CMS implemented the Principal Inpatient - Diagnostic Cost Group (PIP-DCG) risk adjustment method based on the principal inpatient hospital discharge diagnosis. The encounter data collection was expanded in 2000-2001 to include physician and hospital outpatient data. In May 2001, the Secretary announced a suspension of the requirements for filing physician and hospital outpatient encounter data collection pending a review of the administrative burden that was associated with that effort. As a direct result of that review, including consultation with M+C organizations, these instructions implement a streamlined process for M+C organizations to collect and submit data for risk adjustment, balancing burden reduction with improved payment accuracy.

#### ***Effective Dates***

These instructions are effective for all risk adjustment data submitted for dates of service on or after July 1, 2002. Data from that date forward must be submitted for relevant diagnoses noted during hospital inpatient stays and hospital outpatient and physician visits. M+C organizations may begin submitting data on October 1, 2002 and must meet their first quarterly submission requirement by December 31, 2002. In addition, these instructions provide the guidelines for submitting 2003 reconciliation data for the PIP-DCG model after October 1, 2002.

#### ***Reporting***

The requirements as described herein shall apply to all M+C organizations, the Program of All-Inclusive Care for the Elderly (PACE) and all active capitated demonstrations except United Mine Workers Association (UMWA) and the Department of Defense (DoD) Tricare. Additional data requirements may be required for demonstrations at the time of their renewal, typically under the “Special Terms and Conditions” section of their waiver.

#### ***Provider Type Definitions***

The following sections define the provider types from which M+C organizations may submit diagnoses. Any diagnoses received from the provider types as defined may be submitted. For information on the minimum requirements for diagnosis submission, see the data submission instructions below. The provider types and their respective codes are hospital inpatient, which is further subdivided into principal hospital inpatient (01) and other hospital inpatient (02); hospital outpatient (10); and physician (20).

#### ***Hospital Inpatient Data***

Inpatient hospital data should be differentiated based on whether it is received from within or outside of the M+C organization’s provider network. Because the Code of Federal Regulations (CFR) requires that all M+C organization network hospitals have a Medicare provider agreement (see 42CFR422.204(a)3(i)), by extension, a network provider should have a Medicare provider billing number for a hospital inpatient facility. If a facility does not have a hospital inpatient Medicare provider number, the M+C organization shall not submit diagnoses from that facility as

hospital inpatient data. Table 1, at the end of these instructions, gives the list of valid provider number ranges for hospital inpatient facilities. Please note that it is not necessary for M+C organizations to receive the Medicare provider number from the hospital on incoming transactions, i.e., the M+C organization may utilize its own provider identifications system. Regardless of how M+C organizations identify their facilities, M+C organizations must be able to distinguish diagnoses submitted by facilities that qualify as Medicare hospital inpatient facilities from diagnoses submitted by non-qualifying facilities.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital inpatient facility. If the provider is a Medicare-certified hospital inpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare certified but is a Department of Veterans Affairs (VA) or DoD facility, the M+C organization must verify that it is a legitimate inpatient facility by contacting the Customer Service and Support Center (CSSC) prior to submitting data from that facility. If the hospital is not Medicare certified or VA/DoD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital inpatient facility prior to submitting any diagnoses from that facility.

To aid in determining whether or not a provider is a Medicare-certified hospital inpatient facility, the M+C organization may refer to the Medicare provider number. The Medicare provider number has a two-digit state code followed by four digits that identify the type of provider and the specific provider number. Table 1 outlines the number ranges for all facility types that CMS considers to be Medicare hospital inpatient facilities. The XX in the first two positions of every number represents the state code. If the facility's Medicare provider number is unknown, the M+C organization may verify the provider number with the facility's billing department.

Some hospitals also operate Skilled Nursing Facilities (SNFs) as separate components within the hospital or have components with "swing beds" that can be used for either hospital inpatient or SNF stays. M+C organizations shall not submit any diagnoses for stays in the SNF component of a hospital or from swing bed stays when the swing beds were utilized as SNF beds. Stays in both of these circumstances qualify as SNF stays and do not qualify as hospital inpatient stays. If the Medicare provider number is on the incoming transaction from the facility, the M+C organization may distinguish the SNF or SNF swing-bed stays by the presence of a U, W, Y or Z in the third position of the Medicare provider number (e.g., 11U001).

### ***Principal Hospital Inpatient and Other Hospital Inpatient Diagnoses***

M+C organizations must differentiate between the principal hospital inpatient diagnosis and all other hospital inpatient diagnoses when coding the provider type on the new risk adjustment transaction. According to the *Official ICD-9 CM Guidelines for Coding and Reporting*, the principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". The principal diagnosis as reported by the hospital shall be coded as Provider Type 01, Principal Hospital Inpatient. CMS strongly recommends that M+C organizations continue to collect electronic encounter data or claims from hospital inpatient stays to ensure the proper identification of the principal diagnosis.

The remaining diagnoses from a hospital inpatient stay shall be coded as Provider Type 02, Other Hospital Inpatient. The guidance for coding other conditions appears in *Official ICD-9 CM Guidelines for Coding and Reporting*, as well as in the section of these instructions titled *Coexisting Conditions*.

### ***Outpatient Hospital Data***

Hospital outpatient data includes any diagnoses from a hospital outpatient department, excluding diagnoses that are derived only from claims or encounters for laboratory services, ambulance, or durable medical equipment, prosthetics, orthotics, and supplies. Hospital outpatient departments include all provider types listed on Table 2 at the end of these instructions. Along with the provider types in the table, Table 2 also lists the valid Medicare provider number ranges for those provider types. The XX in the first two positions of every range represents the state code component of the Medicare provider number.

Because Medicare has multiple number ranges for many provider types, and continuous number ranges feature multiple provider types, a simplified list with the continuous valid Medicare provider number ranges for hospital outpatient facilities is provided in Table 3. CMS has included Federally Qualified Health Centers, Community Mental Health Centers, and Rural Health clinics in the list of outpatient facilities to ensure M+C organizations are allowed to submit complete physician data. These three facility types utilize a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

M+C organizations should determine which providers qualify as hospital outpatient facilities in a similar manner as they determine which providers qualify as hospital inpatient facilities. As with hospital inpatient data, diagnoses collected from network providers are differentiated from diagnoses collected from non-network providers. Because all M+C organization network hospitals must have a provider agreement, all network hospital outpatient facilities must have a Medicare provider number within the range of valid hospital outpatient provider numbers (see Table 3 below). If a facility does not have a hospital outpatient Medicare provider number, the M+C organization shall not submit diagnoses from that facility as hospital outpatient data. It is not necessary that M+C organizations receive the Medicare provider number on incoming risk adjustment transactions, even if the transactions are electronic encounters or claims. However, M+C organizations must be able to distinguish diagnoses submitted by providers that qualify as hospital outpatient facilities from diagnoses submitted by non-qualifying providers.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital outpatient facility. If the provider is a Medicare-certified hospital outpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare certified but is a VA or DoD facility, the M+C organization must verify that it is a legitimate outpatient facility by contacting the CSSC prior to submitting data from that facility. If the hospital is not Medicare certified or VA/DoD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital outpatient facility prior to submitting any diagnoses from that facility.

As with hospital inpatient facilities, if the facility's Medicare provider number is unknown, the M+C organization may verify the provider number by contacting facility's billing department.

### ***Physician Data***

For purposes of risk adjustment data, physicians are defined by the specialty list in Table 4. This list includes certain non-physician practitioners, who for purposes of risk adjustment data will be covered under the broad definition of physicians. This list also includes multi-specialty groups and clinics. This inclusion is solely intended to allow M+C organizations to submit data based on claims received from groups and clinics that bill M+C organizations on behalf of individual practitioners covered on the specialty list.

Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as defined above) for medical services. Pathology and radiology services represent the only allowable exceptions to the face-to-face visit requirement, since pathologists do not routinely see patients and radiologists are not required to see patients to perform their services. Medicare fee-for-service coverage and payment rules do not apply to risk adjustment data; therefore, M+C organizations may submit diagnoses noted by a physician even when the services rendered on the visit are not Medicare-covered services. The diagnoses should be coded in accordance with the diagnosis coding guidelines in these instructions.

### ***Data Collection***

M+C organizations have several options for collecting data to support the risk adjustment submission. When M+C organizations collect data from providers, they may choose to utilize: 1) the standard claim or encounter formats, 2) a superbill, or 3) the minimum data set, i.e., the format used to report risk adjustment data to CMS.

Standard claim and encounter formats currently include the UB-92, the National Standard Format (NSF), and ANSI X12 837. All M+C organizations that collect electronic fee-for-service claim or no-pay encounters from their provider networks shall utilize the data from these transactions to prepare their risk adjustment data submissions. M+C organizations with capitated or mixed networks may also choose to use an electronic claim or encounter format to collect risk adjustment data from their capitated providers.

When Health Insurance Portability and Accountability Act (HIPAA) transaction standards become mandatory, all electronic claims or encounters sent from providers (physicians and hospitals) to health plans (M+C organizations) will constitute HIPAA-covered transactions. Any M+C organization that utilizes an electronic claim or encounter format for their risk adjustment data collection will need to convert to ANSI X12 837 version 40.10 when HIPAA standards become mandatory.

M+C organizations may elect to utilize a superbill or the minimum data set (HIC, diagnosis, "from date," "through date," and provider type) to collect risk adjustment data. Use of a superbill or the minimum data set to collect diagnoses does not violate HIPAA transaction standards, since neither of these data collection methods constitutes a covered transaction, i.e., these transactions are not claims or encounters. However, any M+C organization that utilizes an electronic claim or encounter to collect diagnoses from their providers shall submit the diagnoses

collected on those claims and encounters. M+C organizations shall not utilize a superbill or the minimum risk adjustment data set to obtain diagnoses from providers who submit electronic claims or encounters, except when correcting erroneous diagnoses or supplementing incomplete diagnoses.

Regardless of the method(s) that the M+C organization utilizes to collect data from providers, any M+C organization may utilize any submission method accepted by CMS (UB-92, NSF, ANSI, risk adjustment data format, or direct data entry).

### ***Diagnostic Coding***

Medicare utilizes ICD-9-CM as the official diagnosis code set for all lines of business. In accordance with this policy, CMS will utilize ICD-9 diagnosis codes in the determination of risk adjustment factors. M+C organizations must submit for each beneficiary all relevant ICD-9 codes that are utilized in the risk adjustment model. M+C organizations must submit each relevant diagnosis at least once during a risk adjustment data reporting period, with the first period being July 1, 2002 – June 30, 2003. Future risk adjustment data reporting periods will be announced January 15, 2003.

At a minimum, the submitted ICD-9 codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. CMS has provided a list of the minimal ICD-9 codes required to group diagnoses for risk adjustment. In all cases, coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model. For the complete list of diagnoses used in the risk adjustment model, as well as the list of diagnoses with the minimum specificity required to group for the model, see web links at the end of these instructions.

M+C organizations must apply the following guidelines when collecting data from their provider networks. If the M+C organization utilizes an abbreviated method of collecting diagnoses, such as a superbill, the diagnoses may be coded to the highest level of specificity or to the level of specificity necessary to group the diagnosis appropriately for risk adjusted payments. If the M+C organization collects data using an encounter or claim format, the codes should already be at the highest level of specificity. CMS encourages M+C organizations to utilize the full level of specificity in submitting risk adjustment data. Regardless of the level of specificity of submitted diagnoses, a medical record must substantiate all diagnostic information provided to CMS.

The *Official ICD-9 CM Guidelines for Coding and Reporting* (see web links at end of instructions) provides guidance on diagnosis coding. This document provides guidelines for hospital inpatient, hospital outpatient and physician services.

ICD-9-CM codes are updated on an annual basis. Physicians and providers must begin using the ICD-9-CM codes as updated in October 2001 for risk adjustment data submitted on or after July 1, 2002. It is very important that physicians and providers use the most recent version of the ICD-9-CM coding book. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Information regarding ICD-9-CM codes is available on the Internet at [www.hcfa.gov](http://www.hcfa.gov).

### ***Coexisting Conditions***

Physicians and providers should use the *Official ICD –9-CM Guidelines for Coding and Reporting* and Medicare fee-for-service rules when submitting risk adjustment data to M+C organizations. The official guidelines that govern those coexisting conditions that may be coded and reported by hospital inpatient, hospital outpatient and physician providers are summarized below. The guidelines for inpatient hospital stays are as follows:

“...all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

The guidelines for coexisting conditions that should be coded for hospital outpatient and physician services are as follows:

“Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.”

Physicians and hospital outpatient departments shall not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, or “working” diagnosis. Rather, physicians and hospital outpatient departments shall code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

### ***Alternative Data Sources (ADS)***

Alternative data sources include diagnostic data from sources other than inpatient hospital, outpatient hospital, and physician services. M+C organizations may use ADS as a check to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes. Two examples of ADS include pharmacy records and information provided to national or state cancer registries.

Note that M+C organizations may not utilize ADS as an alternative to diagnoses from a provider. If M+C organizations elect to utilize one or more ADS, they must ensure that the diagnosis reported to CMS is recorded in the beneficiary’s medical record for the data collection period or that the medical record documents the clinical evidence of that specific diagnosis for the data collection period.

For example, prescription of an ACE inhibitor, alone, would not be considered as sufficient the sole data source of "clinical evidence" of CHF; instead the medical record would need to document an appropriate clinician's diagnosis of congestive heart failure during the data collection period (eg., where an "appropriate clinician" is a physician/nurse practitioner/physician assistant). A laboratory test showing one reading of high blood sugar

would also not be considered to be sufficient "clinical evidence" of diabetes--the medical record would need to document a clinician's diagnosis of diabetes during the data collection period.

### ***Diagnosis Submission***

For each enrolled beneficiary, M+C organizations shall submit each relevant diagnosis at least once during a data collection period. A relevant diagnosis is one that meets three criteria:

- 1) the diagnosis is utilized in the model;
- 2) the diagnosis was received from one of the three provider types covered by the risk adjustment requirements; and
- 3) the diagnosis was collected according to the risk adjustment data collection instructions.

M+C organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that diagnosis was recorded based on a visit to one of the three provider types covered by the risk adjustment data collection requirements. The first data collection period will cover all diagnoses submitted for dates of service from July 1, 2002 through June 30, 2003.

CMS will utilize the “through date” of a particular diagnosis when determining the “date of service” for purposes of risk adjustment; i.e., all diagnoses that have a “through date” that falls within the data collection year will be utilized in the risk adjustment model. For hospital inpatient diagnoses, the “through date” should be the date of discharge. All hospital inpatient diagnoses shall have a “through date”. For physician and hospital outpatient diagnoses, the “through date” should represent either the exact date of a patient visit or the last visit date for a series of services. For outpatient and physician diagnoses that correspond to a single date of service, M+C organizations have the option of submitting only the “from date”, leaving the “through date” blank. When a M+C organization submits a “from date” and no “through date”, the Risk Adjustment Processing System (RAPS) will automatically copy the “from date” into the “through date” field. The returned file, provided to the M+C organization, will contain both a “from date” and “through date” for every diagnosis.

### ***Date Span***

Date span is the number of days between the “from date” and “through date” on a diagnosis. For inpatient diagnoses, the “from date” and “through date” should always represent the admission and discharge dates respectively. Therefore, the date span should never be greater than the length of the inpatient stay. For physician and hospital outpatient data, the date span shall not exceed 30 days.

### ***Submission Frequency***

M+C organizations shall submit at least once per calendar quarter. Each quarter’s submission should represent approximately one quarter of the data that the M+C organization will submit over the course of the year. The amount of records and diagnoses to which this corresponds depends upon the type of submission a M+C organization selects. If a M+C organization elects to use a claim or encounter submission, the ratio of records and diagnoses to enrollees will be much higher than if a M+C organization elects to use a quarterly summary transaction.

CMS will monitor submissions to ensure that all M+C organizations meet the quarterly submission requirements. For M+C organizations that do not receive a regular submission of superbills, claims, or encounter data from their providers, CMS strongly recommends that these organizations request new diagnoses from all network providers on a quarterly basis at a minimum to ensure accurate, complete and timely data submission.

### ***Submission Methods***

Data submission to CMS may be accomplished through any of the following methods:

- 1) full or abbreviated UB-92 Version 6.0;
- 2) full or abbreviated National Standard Format (NSF) Version 3.1;
- 3) ANSI X12 837 Version 30.51 (only for those submitters currently utilizing this version);
- 4) ANSI X12 837 Version 40.10;
- 5) the new RAPS format; and
- 6) on-line direct data entry (DDE) available through Palmetto Government Benefits Administrators.

Regardless of the method of submission that a M+C organization selects, all transactions will be subject to the same edits. The Front-End Risk Adjustment System (FERAS) will automatically format all DDE transactions in the RAPS format. Transactions that are submitted in claim or encounter formats will be converted to the RAPS format prior to going through any editing. The mapping from each claim or encounter transaction to the RAPS format is on the CSSC web site at [www.mcoservice.com](http://www.mcoservice.com).

Each M+C organization should select the most efficient method for data submission, taking into account the unique nature of its data systems. M+C organizations may elect to utilize more than one submission method. All transactions will be submitted using the same network connectivity that M+C organizations currently utilize for encounter data submission. For assistance in utilizing any of the submission methods, please contact the Customer Service and Support Center (CSSC) at 1-877-534-2772.

### ***Deleting Diagnoses***

The RAPS will not perform adjustment processing. In place of the current adjustment process, there will be a diagnosis delete function available that will serve the same purpose. Each diagnosis cluster (diagnosis code, from and “through date”s, and provider type) will be stored separately as a unique cluster associated with a person’s HIC number. If a diagnosis was submitted in error and needs to be corrected, the original diagnosis cluster must be resubmitted with a delete indicator in the appropriate field. The correct diagnosis may be sent as a normal transaction. Delete transactions may only be submitted using the RAPS format or the DDE function. When a delete record is received, CMS will maintain the original diagnosis cluster on file and add to it a delete indicator and the date of the deletion.

### ***2003 Hospital Inpatient Data***

M+C organizations should submit as much 2003 data as possible through the existing encounter data processing system. 2003 data is defined as hospital inpatient data for dates of discharge from July 1, 2001 through June 30, 2002. Any data submitted on or before September 27, 2002

will be processed through the existing systems and will be reported back to the M+C organizations in the existing report formats. This includes all data that is submitted in September 2002 and finalized in October 2002. Please note that the deadline for submitting data for 2003 risk adjustment is September 6, 2002, and the 2002 reconciliation data submission deadline will be September 27, 2002.

M+C organizations may submit reconciliation data for 2003 after the October 1, 2002 implementation of RAPS. Reconciliation data will be run through the PIP-DCG model. All reconciliation data must be submitted utilizing a full UB-92, the encounter version of the UB-92, or the ANSI X12 837 to ensure the accuracy of the PIP-DCG model. M+C organizations should submit only the 111 or 11Z bill types. The data will be converted at the FERAS into the RAPS format and sent through the normal RAPS processing. The returned report will be in the RAPS format, rather than the encounter data report formats. The transaction will be stored as one set of diagnosis clusters to maintain the integrity of the original transaction.

M+C organizations shall not submit adjustment transactions for 2003 reconciliation data after October 1, 2002. Any data submitted after that date should be submitted as a 111 or 11Z bill type. When M+C organizations need to correct a previously submitted transaction, M+C organizations shall send a new 111 or 11Z with the corrected information. In the same manner as CMS handled the original abbreviated hospital inpatient encounter data, CMS will check the from and “through date”s to identify duplicate inpatient transactions, determine which of the duplicate transactions was submitted most recently, and utilize the most recent transaction for calculating the risk adjustment factor.

#### ***Electronic Data Interchange (EDI) Agreements***

All M+C organizations should have EDI agreements on file at Palmetto GBA, the front-end recipient of all encounter data. The language in encounter data EDI agreements has been updated to reflect the change from encounter data submission to risk adjustment data submission. All M+C organizations must complete a new EDI agreement prior to submitting to the new system. This change does not in any way change the network connectivity M+C organizations currently utilize, but merely aligns the language in the agreement with the new data rules.

#### ***Use of Third Party Submitters***

M+C organizations may continue to utilize third-party vendors to submit risk adjustment data. Regardless who submits the data, CMS holds the M+C organization accountable for the content of the submission.

#### ***Data Validation***

A sample of risk adjustment data used for making payments may be validated against hospital inpatient, hospital outpatient, and physician medical records to ensure the accuracy of medical information. Risk adjustment data will be validated to the extent that the diagnostic information justifies appropriate payment under the risk adjustment model. M+C organizations will be provided with additional information as the process for these reviews is developed.

M+C organizations must submit risk adjustment data that are substantiated by the physician or provider’s full medical record. M+C organizations must maintain sufficient information to trace

the submitted diagnosis back to the hospital or physician that originally reported the diagnosis. Since M+C organizations may submit summary level transactions without a link to a specific encounter or claim, establishing an appropriate audit trail to the original source of the data requires diligent information management on the part of the M+C organization.

***Web Links***

The following web links contain information cited within these instructions.

RAPS format, mapping, and edits	<a href="http://www.mcoservice.com">www.mcoservice.com</a>
ICD-9-CM Public Use Files	<a href="http://www.hcfa.gov/stats/pufiles.htm">http://www.hcfa.gov/stats/pufiles.htm</a>
ICD-9-CM Coding Guidelines	<a href="http://www.cdc.gov/nchs/datawh/ftpserv/ftp9/ftp9.htm">http://www.cdc.gov/nchs/datawh/ftpserv/ftp9/ftp9.htm</a>
Diagnosis Codes for Risk Adjustment	<a href="http://www.hcfa.gov/MEDICARE/rskadjdata.htm">http://www.hcfa.gov/MEDICARE/rskadjdata.htm</a>

**Table 1: Hospital Inpatient Facility Types Acceptable for Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges**

<b>Type of Inpatient Hospital Facility</b>	<b>Number Range</b>
Short-term (General and Specialty) Hospitals	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399
Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1990-XX1999
Long-term Hospitals	XX2000-XX2299
Rehabilitation Hospitals	XX3025-XX3099
Children's Hospitals	XX3300-XX3399
Psychiatric Hospitals	XX4000-XX4499

**Table 2: Facility Types Acceptable for Hospital Outpatient Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges**

<b>Type of Outpatient Hospital Facility</b>	<b>Number Range</b>
Short-term (General and Specialty) Hospitals	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399
Community Mental Health Centers	XX1400-XX1499 XX4600-XX4799 XX4900-XX4999
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	XX1800-XX1999
Long-term Hospitals/	XX2000-XX2299
Rehabilitation Hospitals	XX3025-XX3099
Children's Hospitals	XX3300-XX3399
Rural Health Clinic, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999
Psychiatric Hospitals	XX4000-XX4499

**Table 3: Continuous Valid Medicare Provider Number Ranges For Hospital Outpatient Facilities**

XX0001-XX0899 (also includes XXS001-XXS899 and XXT001-XXT899)
XX1225-XX1499
XX1800-XX2299
XX3025-XX3099
XX3300-XX3499
XX3800-XX3999
XX4000-XX4499
XX4600-XX4799
XX4900-XX4999

**Table 4: Specialties Acceptable for Physician Risk Adjustment Data Submission and Associated Medicare Specialty Numbers**

01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal medicine
12	Osteopathic manipulative therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/gynecology
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic surgery
22	Pathology
24	Plastic and reconstructive surgery
25	Physical medicine and rehabilitation
26	Psychiatry
28	Colorectal surgery
29	Pulmonary disease
30	Diagnostic radiology
33	Thoracic surgery
34	Urology
35	Chiropractic
36	Nuclear medicine
37	Pediatric medicine
38	Geriatric medicine
39	Nephrology
40	Hand surgery
41	Optometry (specifically means optometrist)
42	Certified Nurse Midwife

43	Certified Registered Nurse Anesthetist
44	Infectious disease
46	Endocrinology
48	Podiatry
50	Nurse practitioner
62	Psychologist
64	Audiologist
65	Physical therapist
66	Rheumatology
67	Occupational therapist
68	Clinical psychologist
70	Multispecialty clinic or group practice
76	Peripheral vascular disease
77	Vascular surgery
78	Cardiac surgery
79	Addiction medicine
80	Licensed clinical social worker
81	Critical care (intensivists)
82	Hematology
83	Hematology/oncology
84	Preventative medicine
85	Maxillofacial surgery
86	Neuropsychiatry
89	Certified clinical nurse specialist
90	Medical oncology
91	Surgical oncology
92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
97	Physician assistant
98	Gynecologist/oncologist
99	Unknown physician specialty

### **Medicare + Choice Contract**

CMS issued a renewable contract in 2002. There will be no major modifications to the contract, however, there will be a slight change to Attachment B of the contract, Certification Of Encounter Data Information Relating To CMS Payment To A Medicare + Choice Organization. This modification reflects the change from encounter data to risk adjustment data certification. See Attachment 3 for a redlined version displaying the changes from the 2002 certification. This updated certification form will be placed in the July update of the M+C Manual. Submission requirements for the Attachment B of the M+C contract have not changed. The 2002 version of Attachment B is due on December 31<sup>st</sup>.

### **M+C Monitoring**

While the current practice of biennial monitoring visits will continue in contract year 2003 the Agency will begin to transition to a performance assessment program based in part on the use of Medicare managed care performance metrics. These performance metrics are currently under development. They will include outcomes-oriented data such as HEDIS, CAHPS/Disenrollment, HOS, disenrollment rates, and financial data. Additional data, such as, appeals from the reconsideration contractor, may also be included. During the summer of 2002 CMS will conduct listening sessions with M+COs regarding the performance assessment program. M+COs will receive notice of these sessions through the Regional Offices.

The revision of the M+C monitoring guide will be available during the summer of 2002. Regional Offices will begin implementing its use over the second half of the year. Regional Offices will provide M+COs with 60 to 90 days of advance notice prior to using the new M+C monitoring guide for an onsite review. Dates of information sessions to orient M+COs to the new guide will be distributed at the time of its release.

### **Section 1876 Monitoring**

The Section 1876 monitoring guide will be updated during contract year 2003. Section 1876 contractors will receive notice of the timeline for the release of the new guide and any changes in ongoing oversight in early 2003.

### **Enhanced Payments for Congestive Heart Failure (CHF)**

Beginning January 1, 2003, M+C organizations that meet certain quality thresholds will be eligible to receive extra payments for their members that had a primary diagnosis of CHF if they chose to participate in the activity beginning in 2002. OPL 2000.129 describes the requirements and the associated payment methodology. Basically, the population will include those with inpatient discharge diagnoses of CHF between July 1, 1999 through June 30, 2002. Depending on when the discharge occurred in relation to the payment year, M+C organizations would receive extra payment based on a minimum of one-third of the PIP-DCG 16 amount, subject to the risk adjustment transition blend of 10%.

### **Standardized Appeal Notices**

As of January 2002, M+C organizations have been required to use standardized notices to inform enrollees of denials of medical services or payment and associated appeal rights.

The notices include the Notice of Denial of Medical Coverage (NDMC) and the Notice of Denial of Payment (NDP).

CMS notified the public in the June 28, 2000 M+C Final Rule that other appeal-related notices would be standardized as well. CMS intends to focus test and publish in the Federal Register four other notices that will complete the appeals standardization process in 2003. The first of the four notices meets the requirements of the Grijalva v. Shalala agreement. The remaining three notices fulfill regulatory requirements that are not related to the Grijalva settlement agreement.

Consistent with Grijalva, M+C organizations would be required to give enrollees notice prior to the termination of provider services. This notice will provide notification of an impending discharge that will allow the enrollee to challenge the M+C organization's discharge decision through an independent review process.

The second notice would fulfill § 422.568(c), which requires practitioners to provide general notices to enrollees about their right to obtain a detailed notice from their M+C organization if the enrollee believes that the practitioner has denied coverage. The third notice pertains to an M+C organization's obligation under § 422.584(d)(2)(ii)–(iv) to provide notices to enrollees of their right to file grievances when their requests for expedited reviews have been denied. Finally, § 422.590(e) requires M+C organizations to notify enrollees when M+C organizations forward case files to the independent review entity (IRE), i.e., the Center for Health Dispute Resolution, for reconsideration.

#### **Coordination of Appeal Processes**

We intend to provide guidance on how M+C organizations should process appeals for enrollees that are entitled to benefits under both an M+C plan as well as an employer group health plan. We cannot clarify that the M+C appeals process will apply to an entire benefit package until CMS is able to work through these issues with other federal agencies such as the Office of Personnel Management and the Department of Labor.

#### **Effectuation Requirements for Voluntary Disenrollments and Non-Renewals**

We will issue guidance on how M+C organizations should effectuate appeals in the following situations: (1) when enrollees voluntarily disenroll from their health plans and (2) for post M+C contract non-renewals or service area reductions. We have formed a crosscutting work-group to identify the issues and problems associated with effectuation of claims and pre-service appeals.

For voluntary disenrollments that involve claim-related appeals, we intend to require the M+C organization to effectuate the appeal in accordance with the IRE's decision letter. For voluntary disenrollments that involve pre-service appeals, we will consider recommendations to allow the former M+C organization to offer to furnish the service within its network. If the enrollee agrees, the M+C organization would be obligated to furnish the service. The enrollee's cost sharing obligations would be limited to those applicable at the time that the enrollee made the initial request for service. If the enrollee elects not to have the services furnished through the M+C organization's network, the new plan – whether Original Medicare or another Medicare managed care plan – may be responsible for providing the service.

We also intend to supplement prior instructions on how a non-renewing M+C organization must effectuate appeal decisions handed down subsequent to the termination of their contracts. Although CMS continues to maintain that M+C organizations must effectuate decisions for claim-related appeals, we have not determined how the M+C organization should handle pre-service appeals. We believe that positions on effectuation requirements for disenrollments (as outlined above) may be useful in formulating procedures for non-renewing M+C organizations. However, we have not constructed an appropriate policy for instances where an enrollee already has received the service in question under a new M+C organization or Original Medicare. We intend to continue to work through these issues and provide guidance in 2003.

### **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.

M+COs are designated as health plans and must have the capability to exchange these transactions electronically. CMS will provide specific instructions for transactions and code sets, privacy, and security in separate letters. Any changes to requirements for enrollment will be addressed in enrollment instructions outlined in Chapter 2 of the Managed Care Manual.

### **Financial Information**

CMS has developed a revised format for M+CO use when submitting banking information. This information is housed in the PICS system. It includes the current banking information, as well as the information necessary to accurately complete the transfer of information to the Internal Revenue Service.

*The EIN name reflected on this form, must exactly match the name registered with IRS for that EIN.*

If your MCO's name and address as reflected on your contract with CMS differs from the name that is registered with the EIN/TIN you have supplied, please provide CMS with an update of this information in Attachment 4 to your CMS technical support person. Should any of your banking information change at any time, please be sure to provide the new information in the attached format. Even if the difference is minor (abbreviation rather than spelled out name), you must submit the revised form.

## **PART III. RENEWAL PROCESS FOR 2003**

### **Section 1. M+C Plan Renewals**

#### **M+C Plan Renewal Guidelines**

##### ***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+COs can offer multiple M+C Plans in the same or different service areas. Each M+C plan consists of basic benefits (Medicare covered benefits (Part 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+CO.

In general, CMS has determined that an M+C Plan that has a Plan Identification number in contract year (CY) 2002 is a renewal M+C Plan in CY2003 if all or part of the M+C Plan's current service area remains in CY2003. M+COs may change the benefits of a renewal M+C Plan from year to year. M+COs 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 (CY2002 Plan ID number).

**M+C Plan Renewal:** An existing CY 2002 M+C Plan that will continue to operate (in CY 2003) in all or part of the M+C Plan's service area.

**M+C Plan Termination:** An existing M+C Plan offered in CY2002 in which Medicare beneficiaries are currently enrolled, but will not remain enrolled in that M+C plan in CY2003; unless covered under the M+C Plan Renewal Guidelines.

**M+C Plan Service Area Expansion:** The addition of a county or part of a county to an existing M+C Plan during the ACR Renewal Process.

**M+C Plan Service Area Reduction:** The removal of a county or part of a county from an existing M+C Plan during the ACR Renewal Process.

##### ***Guidelines***

1. If an M+CO **renews** an M+C plan in CY2003, all beneficiaries currently enrolled in that M+C Plan must remain enrolled in the same M+C Plan in CY2003, unless the M+C Plan reduces its service area (See #4 below). This situation would not constitute an M+C Plan termination (with Medigap rights) for those enrollees that live in the remaining M+C Plan service area. These enrollees would remain enrolled in the renewal M+C Plan, unless they disenroll from the M+C plan or enroll in a different M+C plan. Since this is a renewal plan, the plan ID would be the same in CY 2003 as in CY 2002.

2. If an M+CO ***combines*** two or more M+C Plans offered in CY2002 into a single plan, by offering the same benefits under all renewal M+C Plans in CY2003, the M+CO must designate which of the two M+C Plans will be the "consolidated renewal" M+C Plan in CY2003. CMS will "administratively consolidate" the applicable M+C Plans into the designated "consolidated renewal" M+C Plan in CY2003. This situation would also not constitute an M+C Plan termination. All current enrollees would remain enrolled in the renewal M+C Plan, unless they disenroll from the M+C plan or enroll in a different M+C plan. There would be no Medigap rights.
3. If an M+CO wants to ***split*** a CY 2002 M+C Plan service area in CY2003, it must determine which part of the service area will be designated as the renewal M+C Plan service area and which part of the service area will constitute the M+C Plan's service area reduction. The renewal M+C Plan must retain the same Plan ID number it had in CY2002. This situation would not constitute an M+C Plan termination for the remaining service area of the renewal M+C Plan. All current enrollees that live in the remaining service area of the renewal M+C Plan would remain enrolled in the renewal M+C Plan, unless they disenroll from the M+C Plan or enroll in a different M+C plan. There would be no Medigap rights. (See below for special ANOC Notice considerations.) Notification of enrollees that live in the reduced area of the M+C plan would be subject to #4 below.

**Exception:** If the M+CO splits an existing CY2002 M+C Plan service area in CY 2003 (as described above) and the only difference between the M+C Plans is premium charge, then this situation would not constitute an M+C Plan termination for current enrollees. Current enrollees will remain enrollees of the M+C Plans according to county designations determined by the M+CO, unless they disenroll from the M+C plan or enroll in a different M+C plan. There would be no Medigap rights.

4. If an M+CO ***reduces the service area*** of a CY2002 M+C Plan and makes the reduced area part of a new or renewal M+C Plan's service area in CY2003, the M+CO must offer "passive" elections (see below) in CY2003 to all of the current enrollees who reside in the reduced service area, unless the exception above applies.
5. Under limited circumstances, CMS may permit an M+CO to split a single CY2002 M+C Plan into more than one M+C Plan in CY2003 based on provider groups. CMS may permit M+COs to administratively enroll current plan members into particular M+C Plans in CY2003, which contain the member's current provider group. The new M+C Plan(s) must be offered in the current CY2002 service area. This option requires special permission from CMS, and is being undertaken based on information provided by the Secretary's Regulatory Reform Committee. If M+COs are considering this option, contact Marty Abeln at 410-786-1032.

M+COs must provide CMS with a description of M+C Plan changes that are noted in the above guidelines that require (1) CY2003 M+C Plan designations, (2) M+C Plan consolidations, (3) M+C Plan service area reductions, with or without "automatic"

elections (4) M+C Plan terminations and (5) CMS special permission. This information should be provided in the Plan Crosswalk in HPMS.

***Beneficiary M+C Termination/Area Reduction Rights***

Regulations require that when an M+CO terminates an M+C Plan or discontinues offering the plan in any portion of the area where the plan had previously been available, the M+CO must give each affected M+C plan enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the M+C Program including Medigap rights, 90 days before the termination date. In addition, under ordinary rules, enrollees would be required to elect to enroll in a new M+C Plan being offered in their area.

***Passive Elections***

CMS is exercising its discretion to specify what constitutes an M+C Plan termination or service area reduction using the above guidelines and definitions. This is to ensure that Medicare beneficiaries' rights are protected. CMS is also exercising its discretion to specify the manner in which elections are made by permitting some enrollees to be informed that they may make a "passive" election of a new M+C Plan by taking no action. "Passive" elections must be made available if the M+CO reduces its service area as described in #4 above. This process requires the following disclosure to plan members. The M+CO must send a modified ANOC to the enrollee setting forth the available options. Although the ANOC information ordinarily would not be due until a later date, the M+CO must provide the ANOC information for the new M+C Plan by October 2, 2002. 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.

**New M+C Plan Types**

M+COs that want to offer a new M+C plan type, e.g. Private Fee For Service or PPO plan, must submit a written request to CMS. CMS will review the request and determine if additional information is needed and in what format the information should be submitted; e.g. new application, new contract. The effective date of the new plan type will be determined based on the type of request.

**Partial County Requests**

The county integrity policy affords broad discretion to approve partial county service area requests. These requests may be submitted as part of an initial application, a service area expansion, or a contract non-renewal/service area reduction. Such requests will be reviewed on a case-by-case basis. The general exceptions to the county integrity policy are described on pages 2 and 3 of OPL99.090 on the CMS.gov/medicare/opl090.htm web site. Partial county requests related to a contract renewal/service area reduction must be submitted to CMS no later than June 3, 2002.

**Section 2. Guidance for ACR/PBP Submissions**

**Clinical Trials**

Clinical trial services covered by the September 19, 2000 National Coverage Determination (NCD) are considered part of the M+C plan. However, for CY2003 CMS is continuing to pay for clinical trial services covered by the NCD on a fee-for-service

basis. Therefore, M+COs have three options for determining cost-sharing for coverage of qualifying clinical trials in plan benefit packages for CY 2003.

1. Retain a cost-sharing structure for these services that reflects Original Medicare rules, whereby M+C enrollees are liable for coinsurance amounts applicable to services paid under Medicare fee for service rules.
2. Add a specific clinical trials benefit and cost-sharing structure to the plan's ACRP (even though CMS's payment will be based on the original Medicare rules), and make the necessary adjustments to the plan's cost-sharing structures across all other benefit categories in order not to exceed the limit on beneficiary liability for CY 2003.
3. Instead of adding a specific clinical trials benefit, treat each covered clinical trial service as falling within the benefit category appropriate for that service. Plans can apply the cost-sharing structure for each benefit category to any clinical trial service that falls within that category, e.g., inpatient hospitalization cost-sharing applies to inpatient hospitalizations for clinical trial services.

In addition, M+C organizations should not confuse clinical trial coverage under the NCD (see OPL 2001.135) with Medicare's policy on IDE (Investigational Device Exemption) coverage. Category B IDE trials are not a deemed category of trials under the NCD. Category B IDE trials have been covered, at contractor discretion, since November 1, 1995, under 42 CFR 405.201 to 405.215. Since Category B IDE services have been covered since 1995, the costs for these services are included in the M+C rates. Therefore, these claims are not paid on a fee-for-service basis by fiscal intermediaries and carriers.

When making its coverage determination, the M+C organization must comply with any written local medical review policies with jurisdiction for claims in the geographic area in which services are covered under the M+C plan, under 42 C.F.R. 422.101(b)(3). However, since these services are not covered by the clinical trials NCD, M+C organizations can apply plan rules, including prior authorization rules, when determining whether to cover an enrollee's participation in a Category B IDE trial.

There has been no change in regulation on the treatment of Category B IDE trials, and providers should continue sending these claims to M+C organizations.

### **Cost sharing Guidance**

In the fall of 2001, CMS identified a number of M+COs that submitted adjusted community rate proposals (ACRPs) for plans with benefit designs containing substantial cost sharing increases from previous years. These increases were especially notable for dialysis services and chemotherapy drugs. While CMS worked cooperatively with these organizations to address the agency's concerns in advance of decisions whether to accept or reject the ACR, the display of these cost-sharing trends based on the proposed benefit designs on Medicare Compare shifted the issue into the public realm. Therefore, we are providing this general guidance to assist M+COs in preparing ACRPs that will not create these concerns with the public.

CMS will focus on high cost sharing for Medicare-covered benefits, including those mentioned above, in reviewing ACRPs. We will not approve any ACRP that we find would have the effect of discriminating based on health status. **Thus, benefit designs that were approved this past year (CY 2002) will not necessarily be approved this coming year (CY 2003).**

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 permits coordinated care plans to allocate premiums and cost sharing, as long as those allocations do not exceed an annually published national actuarial per member per month limit - \$101.61 for CY 2003.
- 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).

Prior to the era of constrained payment, the vast majority of health plans were not put in a position where the above two principles would ever collide. Although CMS raised this cost sharing issue in the 2002 ACR instructions as a matter of potential concern, there was no impetus at that time for CMS to develop more specific criteria to help plans balance these two interests. As a result of last year's experience, we now believe it important to provide additional guidance. CMS will use the following factors in reviewing proposed 2003 M+C plan cost sharing amounts.

1. Plans that set a total annual copay 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 \$2,500 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 caps above \$2,500 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 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.

**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.

### **ACR Worksheet Changes**

The ACR Worksheets have incurred minor changes for contract year 2003. The most prominent changes are described below.

New information can be found on Worksheet A. Worksheet A (Cover Sheet), Part IA now has a new line (line 11) to display the amount an M+CO has asked CMS to withhold from their monthly payment to fund a reduction in enrollees' out-of-pocket costs of the part B monthly premium. Worksheet E displays the same value. The worksheet also has a new Part IV that will allow you to update, as necessary, the standard Medicare Part B premium that CMS estimates will apply to traditional Medicare enrollees in 2003. The data in Part IV triggers internal checks on your entry on line 11.

If an error message is shown on Worksheet E, it will also appear on Worksheet A. This will ensure that all three persons signing the ACR will know of an error before signing the certification statement on the cover sheet.

All of the material displaying costs, cost sharing, and premiums for Optional Supplemental Benefits in 2003 has been combined in the new Worksheet F (Adjusted Community Rate for Optional Supplemental Benefits). Last year these materials were entered separately in three different worksheets (worksheets C, D, and E).

Please see pages 10 and 11 of the Instructions for Completing the ACR for further detail as to what is new for contract year 2003 ACR. The ACR instructions are located at [www.hcfa.gov/medicare/acr2003instr.pdf](http://www.hcfa.gov/medicare/acr2003instr.pdf). Please also review these instructions for further guidance on submittal requirements and required documentation.

### **Instructions for Submitting Employer Group Health Plans**

Beginning with CY 2003, M+COs will be required to electronically submit their renewal employer group health plans (EGHPs) via HPMS. These M+COs will be required to submit both an ACR and a PBP for each employer/union-only plan. 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 CY2003 will see pre-populated information in HPMS based on CY2002 data.

Initial employer-only ACRPs may be submitted at any time during the calendar year. However, all submissions received for CY 2003 will only be effective through December 31, 2003. CMS is requiring these employer-only plans to submit their renewal materials for CY 2004 during the annual renewal season.

When submitting initial or renewal employer-only ACRPs, M+COs are required to provide a cover letter detailing the following information. (These requirements are generally the same as outlined in the Supplemental ACR Instructions dated August 15, 2001.):

- CMS will allow M+COs the flexibility to swap benefits (not covered under original Medicare) of equal value when an employer prefers a different benefit package than what the M+CO offers to the individual market without specific approval from CMS. In the cover letter, the organization must identify which benefits and the M+C plan covering those benefits that may be swapped during negotiations with employers and/or unions. Do not include any computations in your cover letter. Do not include any of these computations in the back-up materials you are submitting to CMS. Do retain documentation in your files on the ACR value of each benefit swapped and the computations that underlie the ACR values of benefits being swapped. Calculate the ACR values for the benefits that the employer or union has chosen to be swapped consistent with the CMS instructions for ACR calculations. Retain these documents so they can be reviewed during the audit process of the affected ACR.
- CMS will allow M+COs the flexibility to raise cost sharing (coinsurance, copayments, and deductibles) for certain benefits by providing a higher benefit level and/or a modified premium. In the cover letter, the organization must identify which cost sharing amounts of which M+C plans it intends to increase and the modification to the premium it will charge for that benefit. Do not include any computations in your cover letter. Do not include any of these computations in the back-up materials you are submitting to CMS. Do retain documentation in your files on the ACR value of each actuarially equivalent benefit and the computations that underlie the ACR values of these actuarially equivalent benefits. Calculate the ACR values for the actuarially equivalent benefits that the employer or union has chosen consistent with the CMS instructions for ACR calculations. Retain these documents so they can be reviewed during the audit process of the affected ACR.
- The worksheet B - Base Period Costs should reflect only employer and/or union group members' costs for Medicare covered and additional benefits. CMS recommends that additional benefits be kept to a minimum to increase flexibility. All supplemental benefits should be negotiated with the specific employer or union group as part of private negotiations (see section 42CFR422.106). The remaining worksheets should be completed as instructed in the ACR instructions. An exception to the requirement to use

only employer and/or union group members' costs will be granted upon notification in the cover letter.

If no cover letter is provided with an employer-only ACRP submission, or the cover letter is silent with respect to the disclosures noted above, CMS would assume the M+CO is not requesting a waiver.

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.

HPMS will automatically give EGHPs a plan ID in the 800 series to each initial or renewal employer-only M+C plan at the time the ACRP for the plan is submitted.

CMS will not include Employer-only plans in Medicare Compare or the Handbook.

### **Health Plan Management System**

#### ***HPMS Access***

Medicare managed care organizations (MCO) must use the Health Plan Management System (HPMS) to electronically submit their ACRs and PBPs for Contract Year (CY) 2003. The HPMS Extranet requires that MCOs establish connectivity to the Medicare Data Communications Network (MDCN), a secure network maintained for CMS by AT&T Global Services (AGS). After establishing connectivity to the MDCN, MCOs will access the HPMS at <http://32.82.208.82/> using the Microsoft Internet Explorer browser version 5.0 or higher.

MCOs should refer to OPL #101, "Migration of Medicare Managed Care Organizations to the Medicare Data Communications Network (MDCN) for Health Plan Management System (HPMS) Access," for technical direction on accessing HPMS via the MDCN.

CMS also requires that all users obtain a CMS Identification Tracking System (HITS) user ID to access HPMS. CMS will use the HITS user ID to authenticate user access rights and apply the appropriate security levels. Please contact Don Freeburger (410-786-4586 or [DFreeburger@cms.hhs.gov](mailto:DFreeburger@cms.hhs.gov)) or Neetu Balani (410-786-2548 or [NBalani@cms.hhs.gov](mailto:NBalani@cms.hhs.gov)) to obtain a HITS user ID.

#### ***HPMS Updates***

CMS has implemented the following HPMS updates for the CY 2003 ACRP renewal process:

- **Employer-Only Plans.** Beginning in CY 2003, Medicare MCOs must electronically submit their ACRs and PBPs for employer-only plans using HPMS. HPMS will assign an employer-only flag to these plans so that they can be easily identified among the other plan benefit packages offered by an

MCO. HPMS will also include the CY 2002 employer-only plans submitted to CMS on diskette in the MCO's starting plan base for CY 2003.

- New MCO Contacts. Medicare MCOs will be required to enter organization (H number) level contact information for the following new areas: Appeals/Grievances, Quality, and general Medicare information. CMS will provide detailed definitions for each of these contacts. We have also made modifications to the collection of customer service contact information in order to alleviate the confusion experienced during CY 2002. Specifically, we have created one organization level contact for CMS inquiries regarding customer service operations, and one plan level contact for beneficiary inquiries regarding prospective membership (i.e., for use by Medicare Health Plan Compare, the Summary of Benefits, and the *Medicare & You* handbook).
- Pre-Population of MCO Contacts. In order to reduce data entry burden, HPMS is pre-populating the CY 2003 MCO contact information module with each MCO's current set of organization and plan level contacts for CY 2002. This pre-population will ease the amount of new data entry so that MCOs can focus on correcting and adjusting their current contact information to reflect changes for CY 2003.

#### ***Updating MCO Contact Information in HPMS***

As in previous contract years, CMS relies heavily on the contact information provided by Medicare MCOs in the General MCO Information module within HPMS. CMS uses this information to correspond with MCOs on many aspects of Medicare business, from the mailing of ACRP approval letters, ACR audit information, and M+C contracts to the distribution of e-mails on risk adjustment materials and important letters on policy changes. In the event that the contact information in HPMS is incorrect, these types of communications could be delayed, fail to provide an MCO with critical information, or reduce the amount of time an MCO has to respond to CMS. As a result, it is strongly encouraged that all MCO contact information be updated regularly in HPMS in order to ensure improved communication between CMS and MCOs.

#### ***Cost Report Filing in HPMS***

CMS is now developing an HPMS module to support the electronic filing of cost reports. This new module will enable both 1876 and 1833 Cost contractors to download the budget forecast, interim report, and final cost report spreadsheets, upload the completed spreadsheets, and view reports of their submitted cost report data. CMS recently conducted a pilot project with a group of 1876 and 1833 plan representatives to test the download, upload, and reporting functions. The results of the pilot are now being evaluated and modifications are being made to the functionality, where necessary.

#### **Changes in the Plan Benefit Package and Summary of Benefits**

For CY2003 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:

***Part B Premium Reduction***

As of January 1, 2003, M+COs are permitted to offer a reduction to the Medicare Standard Part B Premium as an additional benefit. CMS has added questions to the PBP 2003 to enable plans to describe the new Part B premium reduction. In addition, the SB 2003 will generate corresponding sentences describing the Part B premium reduction. When offering this reduction, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium. As with the ACR, the PBP 2003 will include a validation edit to ensure that the payment reduction amount meets this criteria. For further details, see Section I. Statutory and Regulatory changes.

***Skilled Nursing Facility***

For CY 2003 M+COs will have two choices for reporting the 3-day inpatient hospital waiver for skilled nursing facility (SNF) stays. This policy is the same that was applied for CY2002.

For pricing of the ACR, one choice allows an M+CO to cost out SNF stays that occur after the 3-day hospital stay as a Medicare Covered Benefit, and any SNF days not following a 3-day hospital stay as an Additional or Mandatory Supplemental benefit. If the M+CO chooses to cost out SNF stays in this manner, the PBP should be coded to reflect a waiver of the 3-day hospital stay. A note in the PBP text should be added indicating that the plan may elect to waive 3-day hospital stay based on its own criteria, and the SNF stay will be applied against the Medicare Covered Benefit of 100 SNF days.

The second choice for pricing of the ACR, allows the M+CO to cost out the SNF stays as a Medicare Covered Benefit regardless of whether the SNF stay occurs after a 3-day hospital stay. This is the same manner in which the M+CO cost out the benefit in previous years. If this choice is selected, the M+CO should make a note of the method of cost allocation in the documentation of the ACR. For coding the PBP, the same process as described above should be followed. However, the APV tool based on a discrepancy between the ACR and PBP will generate an error. Therefore, in addition, there should be a brief statement in the text section of the SNF category of the PBP to the effect of, “cost allocation different between ACR and PBP based on Q&A released on September 7, 2001”. The error generated by the APV tool based on this “discrepancy” will not affect the upload of the ACRP.

***Optional Supplemental Benefits***

CMS has made certain changes to the Plan Benefit Package to display more information concerning Optional Supplemental benefits on the Summary of Benefits for the following service categories: Chiropractic, Podiatrist, Transportation, Outpatient Drugs, Dental-Preventative, Dental-Comprehensive, Vision-Eye Exams, Vision-Eye Wear, Hearing-Hearing Exams, Hearing-Hearing Aids, and Point-of-Service. The Summary of Benefits report will display the premium and relevant sentences for these service categories if they are offered as Optional Supplemental Benefits.

In order to provide the information accurately in the PBP, the M+CO should enter Optional Supplemental benefits either in Section B or in Section D of the PBP. For example;

- If a plan only offers Outpatient Prescription Drugs as an Optional Supplemental benefit (no Additional or Mandatory Supplemental benefit) then the plan should provide this information in Section B of the PBP.
- If a plan offers both an Additional or Mandatory Supplemental Outpatient Prescription Drug benefit plus an Optional Supplemental Outpatient Prescription Drug benefit (step-up), then the plan should enter the Additional or Mandatory Supplemental benefit in Section B of the PBP and the Optional Supplemental benefit in Section D of the PBP.
- If a plan offers more than one Optional Supplemental benefit then the plan should enter the data for one benefit in Section B of the PBP and the other in Section D of the PBP. Section D allows for detailed data entry of Optional Supplemental Benefits for the service categories listed above. For further details see the “PBP 2003 Data Entry Instructions.”

NOTE: The M+CO should **not** describe or enter step-up benefits in PBP Service Categories B-13c, B-13d, or B-13e.

*Note: For the optional supplemental benefit packages, sentences will not be generated for the cost-sharing for Medicare-covered benefits.*

### ***Nutrition Therapy***

Nutrition therapy for Medicare beneficiaries with diabetes is now a Medicare covered benefit. Information pertaining to nutrition therapy should be entered in the PBP under section 14I, Diabetes Monitoring.

## **Section 3. Marketing**

### **Marketing Issues**

#### ***“Streamlined” Marketing Review Process***

Last year, when the ACRP submission date was moved to September 17, 2002, CMS instituted a temporary “streamlined” marketing review process for 2002 Fall campaign marketing materials. Upon reviewing the outcome of that process, CMS has decided to implement improvements to marketing review that will take effect for review of 2003 Fall campaign marketing materials.

With the exception of #3 below, the following process only applies to M+COs and only applies to 2003 marketing materials for the 2003 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).

The marketing review process involves:

1. Allowing M+COs to obtain approval of their plan marketing materials based on submitted ACRPs.

In particular:

- Organizations are encouraged to begin submitting the 2003 marketing materials by July 1 (i.e., the date that it has submitted the ACRP to CMS).
  - The CMS Regional Office will review the materials and provide approvals based on the submitted ACRP information.
  - If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved or under review, the organization must also resubmit the marketing materials (or change pages) to the region for a new approval.
  - Once CMS formally approves the ACRP (by September 3), the organization may begin using the materials.
  - All M+COs may market 2003 benefits starting September 3. However, if an M+CO's ACR has not been approved, disclaimer language "pending Federal approval" must be used on all approved marketing materials. Organizations can continue to use the disclaimer on EGHP materials.
  - 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, 2003.
2. Allowing an M+CO to request the “old” marketing review process.

The process outlined in #1 above is not required. Any organization that would prefer to have its marketing materials reviewed (and approved) after it has received approval for its ACRP may request such a review. However, the organization should be aware that if it chooses this option, its marketing materials will not be ready for use until after September 1 (i.e., the date when most organizations that use the process outlined in #1 above will be ready to market their 2003 products).

**CMS Regional Offices will assume an organization is using the process outlined in #1 above unless otherwise requested by the organization.**

3. Discontinuation of the “final verification” process. This applies to all 2003 marketing materials (i.e., not only the 2003 fall campaign materials) and to all Medicare managed care organizations (not just M+COs).

The organization will not be required to send the Regional Office a “camera ready copy” of the marketing material before it can make the materials available to the public. Instead, the organization must send a copy of what is used to the Regional Office for its files at the same time it is made available to the public.

***Additional Instructions for Marketing CY 2002 Benefits***

**CY 2002 Marketing Deadlines.** M+COs should cease using public media to market CY 2002 plans effective October 14, 2002. If the M+CO begins marketing the CY 2003 plan between September 1 and October 14, it should cease using public media to market CY 2002 plans the day before it begins marketing the CY 2003 plans. "Public media" includes billboards, radio, TV, and print advertisements, and direct mail. "Medicare Compare" information for CY 2002, however, will continue to be accessible on the Internet until mid-December 2002.

M+COs are required to submit all remaining CY 2002 marketing materials to CMS by no later than July 10. This deadline will allow CMS to begin focusing resources on the review of marketing materials for CY 2003.

Effective August 31, 2002, all M+COs must include appropriate disclaimers in CY 2002 marketing materials as necessary. Disclaimers are required whenever an organization advertises a CY 2002 benefit, premium, or co-payment that will change effective January 1, 2003 (or whenever an organization accepts an election form for an effective date in 2003 after September 1). 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 1.

CMS has provided the following model disclaimer to be used by organizations with benefit changes in 2003. If an organization knows its benefits are not changing for 2003, 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 following is to be used in marketing and enrollment of all CY 2002 plans beginning September 1, 2002, when changes will occur effective January 1, 2003:

*"Benefits, premiums and copayments will change on January 1, 2003. Please contact [insert plan name] for details."*

***CY 2003 Summary of Benefits and Annual Notice of Change***

All M+COs, Section 1876 cost contractors, and certain managed-care demonstration projects must use the standardized Summary of Benefits (SB) as part of the Annual Notice of Change (ANOC).

M+COs, cost contractors, and certain demonstration projects must use the SB and describe specific offerings of the January 2003 benefit and premium plans. A cover letter or ANOC letter that highlights the specific changes in benefits, premiums, and plan rules effective on January 1, 2003 must accompany the SB. A model ANOC letter is contained in Attachment 5.

M+COs should submit the ANOC and SB to the regional office before August 31 (or before October 4 if the M+CO has followed the ANOC model without modification) to allow for review, approval, printing, and mailing before October 15 (the date all members

must have received the ANOC and SB for 2003 benefits). Section 1876 Cost contractors should submit the ANOC and SB before October 16 to allow for review, approval and printing before November 30.

An organization is permitted to use a lower grade paper for the SB that they will use as part of the annual notification than the high-gloss paper they might ordinarily use when distributing the SB as a marketing piece.

If the M+CO lists only one plan in the SB, the ANOC must notify beneficiaries that additional plans are available, including specific information on how beneficiaries can obtain more details. If the M+CO lists more than one plan offering on the SB enclosed with the ANOC, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB, and to note in the ANOC that other plans are available in the service area and that these plans are listed on the enclosed SB.

#### ***Instructions for Marketing CY 2003 Benefits***

Beginning September 1, all M+COs that actively market M+C plans may begin using approved CY 2003 benefit package marketing materials. All M+COs must begin using approved CY 2003 benefit package marketing materials no later than October 15. All marketing presentations and all mailings to Medicare beneficiaries concerning CY 2003 enrollment (annual election period) must include a standardized SB describing CY 2003 benefit package information. Renewing plans may continue to send and orally present CY 2002 plan information to individuals who specifically ask for it and may continue to enroll individuals for effective dates before January 2003, based on an individual's election period and on other requirements of the law, regulations, and previously issued guidance.

#### ***CY 2003 Evidence of Coverage (EOC)***

The expected deadline for distributing CY 2003 EOCs to all plan members is no later than March 1, 2003. All health plans must also send an EOC to all new members no later than two weeks after the member's effective date of coverage.

CMS will provide all M+COs with the CY2003 EOC model language by September. Use of this model language is not mandatory; however, it will facilitate the review of the marketing materials. In addition, any M+CO that follows the EOC model without modification is given a 10-day marketing review period. 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 with the statutory and regulatory requirements under which they operate.

This year we made changes in several sections of the EOC, including Prescription Drugs, and Rights and Responsibilities. Once again, there will be a number of opportunities this year to provide input on the model EOC for CY 2003. Model sections will periodically be posted on the CMS web site in the Medicare managed care marketing section. Any

comments on or questions about the project should be sent to [EOC2003@cms.hhs.gov](mailto:EOC2003@cms.hhs.gov) by May 30th.

### ***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 Health Plan Compare, 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

#### What types of Changes will be Permitted?

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 may be permitted to remove a sentence referring to the requirement that members see doctors within the plan's network.

#### What types of Changes will NOT be Permitted?

Requests for changes in which the existing sentences are accurate will not be permitted. MCOs 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.

#### How to request a change?

To request a change to the hard copy Summary of Benefits, e-mail your request to [sb2003@cms.hhs.gov](mailto:sb2003@cms.hhs.gov). The subject line in the request must read: "Hard Copy SB Change Request" In the request, you should 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 MCO 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 MCO and the MCO must adhere to the standardized language. If the workgroup permits a change, CMS will notify the MCO 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. Requests for these types of changes should be made during the annual requirements request (scheduled for the fall of 2002).

### ***Marketing of Value Added Items and Services (VAIS)***

VAIS are items and services offered to M+C plan members and prospective members. Section 422.2 defines benefits using a three-prong test: (1) healthcare items or services that are intended to maintain or improve the health status of enrollees; (2) the M+C organizations must incur a cost or liability directly related to the item or service and not just an administrative cost; (3) the item or service is submitted and approved through the Adjusted Community Rate benefit process. CMS permits M+COs to market VAIS; although VAIS does not meet the definition of benefits, therefore may not appear in the ACR or PBP.

Organizations can include a page on the VAIS along with the ANOC and SB in one bound brochure. The value added services must be clearly distinct from the ANOC and SB (such as a different color piece of paper) and the information on value added items and services must include all disclaimers required in the marketing chapter of the Medicare Managed Care Manual. Organizations may also mention VAIS in their newsletters.

#### *For Pharmacy Discounts:*

As of CY 2002, when applicable, organizations will be permitted to reference their pharmacy discount program (a VAIS) in section 3 (plan specific section) of their 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].

The SB must clearly state (in the location that the pharmacy discount program is described) that the program will be available for the entire contract year.

**NOTE: The proposed changes to the privacy rule may impact the marketing of VAIS. If the proposed changes become effective (mid-year 2003), M+COs may have to request a member's authorization, in writing, prior to marketing any VAIS. If a member does not authorize receipt of such marketing, M+COs would have to honor the member's request and not send any VAIS communications without an authorization. M+COs should monitor the privacy rule requirements and consider them before making any marketing material printing decisions.**

### ***Marketing of Multiple Lines of Business***

M+COs may market multiple lines of business in accordance with the following:

- Advertisement of multiple lines of business in direct mail marketing materials with the same document as the one that is advertising the M+C product, is permissible as long as the non M+C lines of business are clearly and understandably distinct from the M+C product.

- M+COs that advertise non-M+C products with an M+C product must pro-rate any costs so that costs of marketing non-M+C products are not included as plan related costs on Adjusted Community Rate proposal submissions
- Direct mail M+C marketing materials sent to current members describing other lines of business should include instructions describing how individuals may opt out of receiving future marketing communications

**Exception:** M+COs that disclose non-M+C lines of business at the time they send a plan nonrenewal notice may only do so using separate enclosures in the same envelope. M+COs may not include non-M+C lines of business within the actual nonrenewal notice.

### **Medicare Health Plan Compare Data**

#### ***Medicare Compare and Medicare Personal Plan Finder Data***

Starting Monday, September 16, the CY 2003 health plan data will appear on “Medicare Health Plan Compare” and “Medicare Personal Plan Finder” in the standardized summary of benefits format. In addition, “Medicare Health Plan Compare” and “Medicare Personal Plan Finder” will continue to include graphs displaying several HEDIS and CAHPS measures, as well as disenrollment reasons data.

#### ***Medicare & You 2003***

It is expected that the health plan benefit and cost comparison information in *Medicare & You 2003* will be similar to the 2002 health plan information provided in the supplemental mailing that was released in the Fall of 2001. The HEDIS, CAHPS and disenrollment reasons data will not be included in *Medicare & You 2003*.

#### ***Special Requirements for Section 1876 Cost contractors***

CMS will again display comparative information about Section 1876 Medicare cost contractors for CY 2003. To be included in CMS' information, cost contractors must submit a PBP by July 1, 2002 for each benefit package they will offer in CY 2003. Benefit information about cost contractors who do not submit a PBP will not be included in *Medicare & You*, “Medicare Health Plan Compare” or in “Medicare Personal Plan Finder.”

Cost contractors who cannot submit a 2003 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](mailto:compchart@cms.hhs.gov). In this circumstance, cost contractors should enter their CY 2002 premium amount in the PBP. Furthermore, *Medicare & You* will indicate "Not available" in the premium field and information in "Medicare Health Plan Compare" and “Medicare Personal Plan Finder” will remain blank.

## **Part IV. Non-Renewal Process for 2003**

### **Final Beneficiary Letter**

Beneficiaries must receive the final beneficiary letter by October 2, 2002. The letter must be dated October 2, 2002 to ensure consistency in applying the guaranteed issue window of Medigap rights for beneficiaries. M+COs must ensure that beneficiaries receive the final beneficiary letter no later than October 2, 2002; therefore, CMS strongly encourages MCOs to use first class postage. A model final beneficiary letter will be provided.

We will prepare state specific language for 21 states that have special Medigap protections beyond Federal law requirements. You should use the appropriate state specific language in your Final Beneficiary Letter. The states are: California, Connecticut, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Texas, Washington, and Wisconsin.

The final beneficiary letter must be reviewed and approved by your CMS Regional Office prior to its release. Beginning 1, 2002, M+COs can submit a draft copy of their final beneficiary letter to the appropriate CMS Regional Office, but no later than September 5, 2002. The CMS Regional Office will give priority review to the draft final beneficiary letter. We expect to complete the review and approval process of the draft final beneficiary notice in no more than 5 business days, and no later than September 12, 2002. Since the final beneficiary notice is reviewed as part of a separate and unique process, the final beneficiary notice is not subject to the 10-day review process for marketing material review. We encourage M+COs to use the model letter provided with as few changes as possible.

In accordance with 42 CFR 422.506(a)(2)(ii), CMS will send a list of the remaining M+C plans and cost plans to be included in the final beneficiary letter on or before September 5, 2002. M+COs that are in areas with remaining M+C plans will be required to include the list of remaining M+C plans in the letter. (M+COs should remember that beneficiary effective dates are different for Cost Plans. CMS will include language in the model final beneficiary letter directing the affected members to contact the cost plans for information on enrollment time lines).

Although other remaining M+C plans may have approved capacity limits, these plans should be listed in the final beneficiary letter. CMS will include language in the model beneficiary letter instructing beneficiaries to contact the M+CO to find out if it is accepting new members.

The M+CO may not include information about its Medicare supplemental coverage product in the body of the final beneficiary letter. However, the Medicare supplemental coverage product information can be mailed in the same envelope as the final beneficiary letter.

Individual beneficiary names and addresses must be inserted on the final beneficiary letter because some beneficiaries may need the letter to show proof of their special rights

to Medigap insurers and other M+C plans. The M+CO should prepare appropriately for their mailing (e.g. proper size 8" x 11" envelopes).

The model final beneficiary letter can be up to 15 pages long.

CMS will inform remaining M+COs in areas of nonrenewing plans of their responsibility regarding non-renewal activity in the area and the SEP. These M+COs will be listed in the nonrenewal letter.

### **Public Notification**

A nonrenewal public notice must be published at least 90 days prior to the end of the contract year (Oct 2, 2002) in one or more newspapers of general circulation in each community or county in your contract area. A model nonrenewal public notice will be provided.

M+COs that use the CMS Model Nonrenewal Public Notice without any revisions do not need to submit the notice to the CMS Regional Office for review and approval prior to its release. However, the M+CO must advise the Regional Office of the date the notice will be released and within 5 days **after publication, submit a photocopy or clipping of the notice containing the name of the newspaper and publication date.**

M+COs that revise the Model Nonrenewal Public Notice must submit the notice to their CMS Regional Office for an expedited review and approval prior to its release. We expect the review and approval process of the notice to be no more than 5 business days.

### **Important Medigap Information for Medicare Beneficiaries**

M+COs must notify all Medicare beneficiaries, including the disabled and ESRD beneficiaries of the obligations of issuers of Medicare supplemental policies. The required language for doing this is included in the model beneficiary letters (attached).

### **Initial Coverage Election Period (ICEP) and Special Election Period (SEP)**

M+COs **must continue** to accept enrollments from individuals in their ICEP and SEPs until November 30, 2002. Please contact your Regional Office Plan Manager should you have specific questions about enrollment closures.

Beginning July 1, 2002, marketing and enrollment materials to individuals in their ICEP or SEP must announce the M+COs decision to non-renew. The following is an example of the language an M+CO may use in marketing and enrollment materials for individuals in their 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, 2003. You may choose to enroll in our plan, but your coverage will automatically end on December 31, 2002, (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 1,2003, you will be returned to Original Medicare on that

date. You will receive additional information about your rights and options for 2003.”

**NOTE: This statement 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 affix this to materials that have been approved by CMS, then the material does not require CMS review or approval. However, if the M+CO modifies the addendum or marketing material in any way, then 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 the final beneficiary letters are mailed. In these cases, the final beneficiary letter dated October 2 must be provided with the confirmation of enrollment letter, and must include the individual beneficiary name and address on the letters.

### **Systems Issues**

#### ***Non-renewed Contracts***

Do **not** submit disenrollments for any members who will remain in your organization through December 31, 2002. During the last month of your contract, CMS will conduct a mass disenrollment for all of your remaining plan members after all other normal transactions for all Medicare managed care organizations have been processed. This will allow enrollment into other Medicare managed care organizations and will not interfere with any final month disenrollments you have submitted. This is the best method to ensure that all members who do not enroll in another M+C plan are placed in Original Medicare in a timely manner.

Do 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 you receive the request. Should some members request disenrollment effective the first day of the last month of your contract (i.e., 12/01/02), you are required to submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that you do so, because during the mass disenrollment to be 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 (12/31/02). Therefore, please submit any final month deletions in accordance with the scheduled cut-off date for the final month of your contract.

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

#### ***Service Area Reductions***

M+COs must disenroll all members who reside in the terminated area or county. **It will be necessary for the M+CO to submit disenrollment records for all affected**

**members** no later than the cut-off date (12/10/2002) of the last operating month of the current contract.

The M+CO will receive a reply listing of all submitted transactions. You must review this report as soon as it is received, approximately the third week of December 2002, and verify the disenrollments for all submitted members. The M+CO will receive a separate communication with specific systems instructions from CMS.

### ***Medigap Issues***

An individual in a managed care trial period must actively and voluntarily disenroll from managed care in order to choose from a broader range of Medigap policies available for guarantee issue to beneficiaries in a trial period. For these beneficiaries, the M+CO must provide the beneficiary with written documentation of the voluntary disenrollment, even if the voluntary request is made for a December 31st effective date. A beneficiary may need to submit this written documentation to a Medigap insurer as proof of the right to purchase certain Medigap policies on a guaranteed issue basis. **Refer to Exhibits 11 and 12 of OPL 99.100 for model beneficiary letters confirming voluntary disenrollments.**

If you have any questions about the enrollment/disenrollment/systems issues, please contact Jacqueline Buise at (410) 786-7607.

### **HPMS Issues**

**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 nonrenew a county for individuals, but continue the county for employer group health plan members must notify CMS in writing by June 3 in order for the HPMS system to accommodate this request. This notice should be sent to Rosanna Johnson (rjohnson3@cms.hhs.gov.)

### **Other Information**

Your organization may be responsible for costs incurred for Medicare beneficiaries hospitalized beyond the last day of the contract. If your Medicare beneficiary is hospitalized in a prospective payment system (PPS) hospital, your organization is responsible for all Part A inpatient hospital services until the beneficiary is discharged. For any other services, original Medicare or the next Medicare managed care organization that the beneficiary enrolls with 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. Your organization will pay the covered charges through the last day of the contract; original Medicare or the next Medicare managed care organization will pay from the next day forward through the Medicare intermediary.

Your organization's remaining obligations to CMS require among other things:

- (1) M+COs to submit encounter 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 managed care plan for this data to be accurate. Terminating contractors must continue to

submit the required inpatient encounter data for services provided to all the organization's Medicare beneficiaries enrolled during calendar year 2002, and

- (2) M+COs to maintain and provide CMS access to books, records, and other documents related to the operation of a M+C contract. M+COs are to maintain these records and allow CMS access to them for 6 years. CMS will send a "close-out" letter with complete details regarding ongoing obligations in the fall of 2002.
- (3) You must update your contact information in CMS's systems. This will allow CMS to contact the appropriate person in your organization.

By following these instructions, your Medicare members will be provided a smooth transition from your organization to another option of health coverage.

If you have other questions related to the non-renewal of your Medicare contract, please call your Regional Office plan manager.

#### **PART V: LIST OF CONTACTS**

**ACR Audit information:** Kristin Finch, 410-786-2873 or [Kfinch@cms.hhs.gov](mailto:Kfinch@cms.hhs.gov)

**ACR/PBP:** For assistance in completing the CY 2003 ACR and PBP, please direct questions to [ACR2003@cms.hhs.gov](mailto:ACR2003@cms.hhs.gov) and [PBP2003@cms.hhs.gov](mailto:PBP2003@cms.hhs.gov), respectively. CMS will post and continually update a series of questions and answers about the ACRP process on [www.CMS.gov/medicare/acrp.htm](http://www.CMS.gov/medicare/acrp.htm)

**Appeals:** Chris Gayhead, 410-786-6429

**Banking information:** Dawn Arnold, 410-786-6337

**BIPA 606:** Carol Nicholson, 410-786-9289

**Consolidation of ACR Cost Data:** Please send all notices and questions regarding requests to consolidate ACR cost data to [ACRCostCombine@cms.hhs.gov](mailto:ACRCostCombine@cms.hhs.gov)

**Election Periods for 2003:** Randy Brauer (410) 786-1618

**EOC:** Questions or comments about the CY 2003 model EOC should be sent to [EOC2003@cms.hhs.gov](mailto:EOC2003@cms.hhs.gov).

**General HPMS Information:** For general questions on HPMS, please contact Lori Robinson at either 410-786-1826 or [LRobinson1@cms.hhs.gov](mailto:LRobinson1@cms.hhs.gov)

**HIPAA:** Yolanda Robinson, 410-786-7627; Donna Dalfonzo-Wiggs, 410-786-9289

**HPMS Help Desk:** For technical assistance on the HPMS and its technical processes, including the download and upload of ACRP submissions, please contact the HPMS Help Desk at either 1-800-220-2028 or [hpms@nerdvana.fu.com](mailto:hpms@nerdvana.fu.com)

**HPMS-HITS User IDs and Passwords:** HPMS access requires a HITS user ID and password. Please contact Don Freeburger (410-786-4586 or [DFreeburger@cms.hhs.gov](mailto:DFreeburger@cms.hhs.gov)) or Neetu Balani (410-786-2548 or [NBalani@cms.hhs.gov](mailto:NBalani@cms.hhs.gov)) to obtain a HITS user ID and password.

**Marketing Review:** Please contact your Regional Office marketing contact with questions about the review of marketing materials. If necessary, your PCT representative will forward the questions to CMS central office staff for resolution.

**M+C Plan Renewal Guidelines:** Marty Abeln, 410-786-1032 (Policy); Rosanna Johnson, 410-786-1148 (Operations)

**M+C Contract and Attestations:** Melissa Fannin, 410-786-0609

**M+C Non-renewals:** Leticia Ramsey, 410-786-5262

**“Medicare & You,” “Medicare Health Plan Compare”, and “Medicare Personal Plan Finder”:** Valerie Hartz, 410-786-6013 or [compchart@cms.hhs.gov](mailto:compchart@cms.hhs.gov).

**New M+C Plan Types:** Sid Lindenberg, 410-786-1157

**Partial County Requests:** Sid Lindenberg, 410-786-1157 (Operations); Marty Abeln, 410-786-1032 (Policy)

**Performance Assessment:** Chris Eisenberg, 410-786-5509

**Risk adjustment:** Jeff Grant, 410-786-7160

**Summary of Benefits:** [SB2003@cms.hhs.gov](mailto:SB2003@cms.hhs.gov).

## ATTACHMENT 1

### **Benefits Improvement and Protection Act of 2000** **Section 606—Medicare Part B Premium Reduction** **Frequently Asked Questions**

1. **Q:** What is the Medicare Part B premium?  
**A:** Your Medicare Part B Premium is the monthly amount you pay for your Medicare Part B benefits. For some, a third party, such as an employer or a State Medicaid program, pays the Medicare Part B premium.
2. **Q:** What is the Plan premium?  
**A:** Your Plan premium is the amount you or your employer pays for your [Health Plan Name] benefits.
3. **Q:** How will I see the reduction?  
**A:** The reduction will appear as an increase in your Social Security or OPM Annuity check (or a lower bill from Medicare if you pay directly).
4. **Q:** How much will my new Part B premium be?  
**A:** All beneficiaries who are enrolled in [Health Plan Name] will receive the same reduction, however, the new amount that you will pay for your Part B premium will depend upon the amount that you currently pay.
5. **Q:** When will I see the reduction?  
**A:** *(if not a member as of January 1, 2003)*  
You will notice the increase in your Social Security or OPM Annuity check within two months of joining [Health Plan Name].  
**A:** *(if an existing member as of January 1, 2003)*  
You will notice the increase in your Social Security or OPM Annuity check within two months of January 1, 2003.
6. **Q:** Will I have to do anything to receive my reduced Medicare Part B premium?  
**A:** No, as long as you are a member of [Health Plan Name], we will work directly with Medicare to reduce your Medicare Part B premium.
7. **Q:** Can the reduction be greater than my existing Medicare Part B premium?  
**A:** No. The reduction will never be greater than your Medicare Part B premium.
8. **Q:** Will I receive any money from Medicare or [Health Plan Name]?  
**A:** No. Since the reduced amount will never be more than your existing Medicare Part B premium, you will not receive any money.
9. **Q:** How long will the reduction last?  
**A:** Your Medicare Part B premium will remain at the reduced rate for the entire calendar year (2003), if you remain a member of [Health Plan Name].

## ATTACHMENT 2

### **Benefits Improvement and Protection Act of 2000** **Section 606—Medicare Part B Premium Reduction**

#### **Model Language for M+C Marketing Materials**

*[Health Plan Name and Logo]*

*Attention Current and Prospective [Health Plan Name] Members:*

Due to a new law passed by congress, [Health Plan Name] can now offer you a reduction in the amount that you pay for your monthly Medicare Part B premium. The amount that you will continue to pay for your Part B premium after this reduction will depend upon the total amount that you owe the Medicare program for your Part B benefits. This reduction will be effective for all Medicare beneficiaries who are members of [Health Plan Name]. The reduced monthly Medicare Part B premium will continue at least through December 31, of this year. Keep in mind that the Medicare Part B premium must be paid each month for you to keep getting Medicare Part B covered services. [Health Plan Name] may give you extra benefits, and you may have to pay a monthly premium to [Health Plan Name] in addition to the monthly Medicare Part B premium.

**ATTACHMENT 3**

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

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

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

\_\_\_\_\_  
(INDICATE TITLE [CEO, CFO, or delegate])  
on behalf of

(INDICATE M+C ORGANIZATION)

**ATTACHMENT 4**

**PAYMENT INFORMATION FORM**

As Government vendors, organizations with Medicare contracts are paid by the Department of Treasury through an Electronic Funds Transfer (EFT) program. Government vendor payments are directly deposited into corporate accounts at financial institutions on the expected payment date. Additionally, CMS must have the EIN/TIN and associated name as filed with the IRS.

Please provide the following information to assist the Centers for Medicare and Medicaid Services in establishing payment arrangements for your organization, should it be awarded a Medicare + Choice contract.

**ORGANIZATION INFORMATION**

NAME OF ORGANIZATION: \_\_\_\_\_  
DBA, if any: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP CODE: \_\_\_\_\_

CONTACT PERSON NAME: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_

CONTRACT NO's.: H \_\_\_\_\_; H \_\_\_\_\_; H \_\_\_\_\_; H \_\_\_\_\_  
*(If known)*

EMPLOYER/TAX IDENTIFICATION NUMBER (EIN or TIN): \_\_\_\_\_

A FORM 1099.MISC WILL BE MAILED TO YOU AT THIS ADDRESS:

TIN/EIN NAME: \_\_\_\_\_  
STR1: \_\_\_\_\_  
STR2: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ - \_\_\_\_\_

**FINANCIAL INSTITUTION**

NAME OF BANK: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP CODE: \_\_\_\_\_ - \_\_\_\_\_

ACH/EFT COORDINATOR NAME: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_

NINE DIGIT ROUTING TRANSIT (ABA) NUMBER: \_\_\_\_\_

DEPOSITOR ACCOUNT TITLE: \_\_\_\_\_

DEPOSITOR ACCOUNT NUMBER: \_\_\_\_\_

TYPE OF ACCOUNT (CHECKING OR SAVINGS): \_\_\_\_\_

To verify account data, please attach a copy of a voided check.

**SIGNATURE & TITLE OF ORGANIZATION'S AUTHORIZED REPRESENTATIVE :**

\_\_\_\_\_  
DATE: \_\_\_\_\_

**ATTACHMENT 5**

***MODEL ANNUAL NOTICE OF CHANGE (ANOC) - January 1, 2003***

**Date: [No later than] October 15, 2002**

**Name Medicare Number**

**Address Member Number**

**Health Plan Name\***

Dear (member name or "Member"):

Starting January 1, 2003, the premium that you pay to {Health Plan Name} will (increase/decrease) from \$\_\_\_\_\_ to \$\_\_\_\_\_ **OR** (stay the same at \$\_\_\_\_\_ ) per month.

*[M+COs that wish to provide for enrollees of a terminated M+C plan to "elect" a different M+C plan by taking no action (see section III.) must insert the following information: The notice must inform enrollees that if they wish to enroll in the M+C plan in question, they need take no action, and they will be enrolled in that plan effective January 1. The notice must also provide instructions on how these enrollees can choose not to elect the other M+C plan (i.e., by indicating that they do not wish to make this election, which would return them to Original Medicare, or by electing a different plan), and must provide information on the enrollee's Medigap rights, which apply if they do not elect the other M+C plan offered by the M+CO.]*

*[\*If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member is currently enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information. If the MCO lists more than one plan offering on the SB enclosed with the ANOC, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB, and to note in the ANOC that other plans are available in the service area and that these plans are listed on the enclosed SB.]*

Medicare has reviewed and approved the changes to the benefits, premiums, copayments and plan rules in this letter and on the enclosed Summary of Benefits. All changes begin January 1, 2003, and will be in effect through December 31, 2003.

*[Clearly describe all plan benefit changes, including changes in copayments, annual drug cap, drug coverage [formulary/generic], and any new benefits that will be offered by the plan in 2003 or that will be covered by Original Medicare. Also describe any benefits offered in 2002 that will no longer be offered by the plan in 2003. Organizations that do not include an SB, which describes all plans, offered by the organization must include a statement that additional plans are available with information for the beneficiary on how to get further details].*

*[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]*

*[All M+COs include the following paragraph.]* Now is a good time to review your coverage with {M+C Name}. Between January and the end of March 2003, you can only leave or join a plan once, including leaving a plan to be in Original Medicare. After that, you must stay with your plan for the rest of the year. In certain cases, like if you move, you may be able to choose another plan.

A new Evidence of Coverage (is enclosed) **OR** (will be sent to you by March) **OR** (will be sent to you next year). A Summary of Benefits is also enclosed. We are required to use the Summary of Benefits for both current members, like you, as well as for people who are thinking about enrolling in {Health Plan Name}. This means that some of the language at the beginning of the document may make it seem like you are not already a member of {Health Plan Name}. Rest assured that you are a member of {Health Plan Name} and will be one for the coming year if you do nothing to change your Medicare coverage.

The following information is available upon request:

- Additional information from CMS by calling 1-800 MEDICARE.
- Additional information from {Health Plan Name} on the procedures we use to control utilization of services and expenditures.
- Additional information on the number and disposition in aggregate of grievances and appeals filed by members of {Health Plan Name}.
- A summary description of the method of compensation for physicians used by {Health Plan Name}.
- A description of our financial condition, including a summary of our most recently audited statement.

If you have any questions about these changes or if you would like additional information, please call our Member Services Department, Monday through Friday, (hours of operation) on (health plan phone number). [Include a TTY phone number "for the hearing impaired."]  
We look forward to serving you now and in the future.

Sincerely,

Plan Representative

ENCLOSURE - 1/2003 Summary of Benefits