DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

DATE: April 14, 2015

TO: All Medicare Advantage Organizations and 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2016 Medicare Advantage Bid Review and Operations Guidance

This memorandum provides the following information for Medicare Advantage Organizations (MAOs), and, where specified, Section 1876 Cost Plans, as they prepare contract year (CY) 2016 bids for CMS review: information about several specific changes to the Plan Benefit Package (PBP) software for CY 2016; clarification of existing benefit policies; and detailed operational guidance to support plans' in their bid development. Guidance related to Medicare Medicaid Plans (MMPs) can be found on the Medicare-Medicaid Coordination Office (MMCO) webpage http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html.

Guidance in this memorandum references the April 6, 2015 CY 2016 Final Call Letter (specifically Section II, Part C), and the PBP bid submission module in the Health Plan Management System (HPMS). Therefore, we recommend MAOs and other Medicare health plans review these resources as well as this memorandum when developing their bids for CY 2016.

Bid Review

MAOs need to consider the CY 2016 Final Call Letter, this HPMS memo, and Chapter 4 of the Medicare Managed Care Manual (MMCM) for the necessary guidance on service category cost sharing standards, which bid review criteria apply to specific plan types, and the maximum out-of-pocket (MOOP) cost thresholds for CY 2016.

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans	Described in Call Letter or this HPMS Memo
Meaningful Difference	Yes	No	No	No	Call Letter
Total Beneficiary Cost	Yes	No	No	No	Both
Maximum Out-of – Pocket (MOOP) Limits	Yes	Yes	No	Yes	Both
PMPM Actuarial Equivalent Cost Sharing	Yes	Yes	No	Yes	Call Letter
Service Category Cost Sharing	Yes	Yes	Yes[1]	Yes	Call Letter
Optional Supplemental Benefit Value	Yes	Yes	No	No	Call Letter

[1] MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 CFR §§417.454(e) and 422.100(j)).

CMS has made changes to the service category cost sharing amounts, the PMPM Actuarial Equivalence factors, and the Total Beneficiary Cost (TBC) evaluation for CY 2016 and has provided these changes in the Final Call Letter and/or the applicable section below. Consistent with past years, MAOs must also address requirements implemented under the Affordable Care Act, such as the medical loss ratio and the health insurance providers' fee, and are expected to do so independently of our requirements for benefits or bid review. Therefore, we are not making specific adjustments or allowances for these changes in our benefits review requirements.

Meaningful Difference (Duplicative Plan Offerings)

Pursuant to §422.254(a)(4), MAOs offering more than one plan in a given service area must guarantee the plans are substantially different so that beneficiaries can easily identify the differences between those plans in order to determine which plan provides the highest value at the lowest cost to address their needs. For CY 2016, CMS will use plan-specific per member per month (PMPM) out-of-pocket cost (OOPC) estimates to identify meaningful differences in beneficiary costs among the same plan types. Detailed information related to this requirement can be found in the CY 2016 Final Call Letter.

Total Beneficiary Cost (TBC)

As stated in the CY 2016 Final Call Letter, CMS will exercise its authority under section 1854(a)(5)(C)(ii) of the Act to deny MAO bids if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next through the use of the TBC standard. A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By limiting excessive increases in the TBC from one year to the next, CMS is able to

confirm enrollees who continue enrollment in the same plan are not exposed to significant cost increases. As in past years, CMS will evaluate TBC for non-employer plans (excluding D-SNPs).

In mid-April, as in past years, CMS will provide plan-specific CY 2015 TBC values and the following adjustments that are incorporated in the TBC calculation to account for changes from one year to the next:

- Technical Adjustments: (1) annual changes in OOPC model software and (2) maximum Part B premium buy-down amount change in the bid pricing tool (no change for CY 2016).
- Payment Adjustments: (1) county benchmark, (2) coding intensity, and (3) quality bonus payment and/or rebate percentages.

CMS will maintain the TBC change threshold at $32.00 PMPM for CY 2016. A plan experiencing a net increase in adjustments must have an effective TBC change amount below the $32.00 PMPM requirement to avoid denial of the bid under section 1854(a)(5)(C)(ii). Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $32.00 PMPM requirement.

We have modified the TBC evaluation to support plans that improve quality compensation and experience large payment adjustments, along with holding plans accountable for lower quality. For CY 2016, the TBC change evaluation will be treated differently for the following specific situations:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $32.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., -1 times the TBC change limit of $32 PMPM) plus applicable technical adjustments.
- Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount less than -$32.00 PMPM will have a TBC change threshold of $64.00 PMPM (i.e., 2 times TBC change limit of $32.00 PMPM) plus applicable technical adjustments. That is, plans would not be allowed to make changes that result in greater than $64.00 worth of decreased benefits or increased premiums.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than -$32.00 PMPM will have a TBC change threshold of $64.00 PMPM (i.e., 2 times TBC change limit of $32.00) plus applicable technical adjustments.

Plans not accounted for in the three specific situations above will be evaluated at the $32 PMPM limit, similar to last year. We remind MAOs that the Office of the Actuary extends flexibility on margin requirements so MAOs can meet the TBC standard.

The plan-specific data elements that CMS will post on HPMS in mid/late April are shown in the following table. This table and calculation accounts for changes in quality bonus payment and/or rebate percentage or star rating (as described above) so that all plans are evaluated against a $32 PMPM TBC change threshold. Should there be any changes due to the appeals process, plan sponsors will be notified of their corresponding revised TBC adjustment factors.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2015 TBC	A	OOPC value	Each of these plan-specific values will be provided by CMS through an HPMS posting
	B	Premium (net of rebates)	
	C	Total TBC	
CY 2016 TBC	D	OOPC value	Plan calculates using OOPC Model Tools
	E	Premium (net of rebates)	Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14
	F	Total TBC	Calculation: D plus E
Apply TBC Adjustments	G	Unadjusted TBC change	Calculation: F minus C
	Payment adjustments (including county benchmark, coding intensity, quality bonus payment and/or rebate percentages)		
	H	Gross Payment Adjustment	Plan-specific value will be provided by CMS through an HPMS posting
	I	Plan Situation	CMS defines whether the TBC calculation will be modified for each plan to account for changes in quality bonus payment and/or rebate percentage or star rating through an HPMS posting
	J	Payment Adjustment Based on Plan Situation	Plan-specific value will be provided by CMS through an HPMS posting
	Technical Adjustments		
	K	Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2015 ($104.90) and the amount for CY 2016 ($104.90)	Value is $0.00 for all plans
	L	Impact of changes in OOPC Model between CY 2015 and CY 2016	Plan-specific value will be provided by CMS through an HPMS posting
Evaluation	M	Adjusted TBC change	Calculation: G + J - K - L Plan is likely to pass the TBC evaluation if M is less than or equal to $32 PMPM

IMPORTANT NOTE: The order of several items in the above table has been changed from previous years to align with the CY 2016 calculation.

As described in the exhibit above, CMS will provide, through the HPMS posting, CY 2016 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of Part B premium (full premium or partial as a result of a Part B premium buy-down). Based on the CMS release of SAS software files in early April, MAOs will be able to calculate their plan-specific CY 2016 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2016 (Item E). Premium (net of rebates) can be found in the Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 – Cell L14.

The *Unadjusted* TBC Change between CY 2015 and CY 2016 (Item G) is the difference between CY 2016 Total TBC (Item F) and CY 2015 Total TBC (Item C) , i.e., G = F – C. The *Adjusted* TBC Change amount (Item M) reflects the impact of the payment adjustment and technical adjustments. CMS will provide payment adjustment information through the HPMS posting. The Gross Payment Adjustment (Item H) accounts for changes in county benchmark, coding intensity, quality bonus payment and/or rebate percentages. The Plan Situation (Item I) defines whether the TBC calculation will be modified with an alternative Payment Adjustment Based on the Plan Situation (Item J) to account for changes in the quality bonus payment and/or rebate percentage or star rating as indicated in the following table.

Plan Situation	Payment Adjustment Based on the Plan Situation
Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $32.00 PMPM	Maximized at $32
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount less than -$32.00 PMPM	Minimized at -$32
Plans with a star rating below 3.0 and an overall payment adjustment amount less than -$32.00	Minimized at -$32
Plans that are not accounted for in the three categories above	Same as Gross Payment Adjustment

The HPMS posting will also provide Technical Adjustments, including Part B premium adjustment (Item K) and the Impact of Changes in the OOPC model between CY 2015 and CY 2016 (Item L). It should be noted, however, these elements impact TBC in different directions, i.e., M = G + J - K – L.

Plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $32 PMPM are likely to be accepted, since the calculation accounts for changes in quality bonus payment and/or rebate percentage or star rating. As stated above, CMS reserves the right to further examine and

request additional changes to a plan bid, even if the Adjusted TBC change is within the threshold.

Illustrative Calculation for Payment Adjustments

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table shows examples of how the payment adjustment is calculated. The Payment Adjustment is the CY 2016 Rebate minus the 2015 Rebate. The CY 2015 Bid Amount and Benchmark are taken from the CY 2015 BPT. For purposes of this calculation the CY 2015 Bid Amount is assumed to grow by the same MA growth percentage as used in the CY 2016 ratebook development. The CY 2016 Benchmark is the weighted average of county-specific payment rates using the CY 2016 ratebook and projected enrollment from the CY 2015 BPT. The change in MA coding intensity is taken into consideration in calculating the CY 2016 Benchmark. The Rebate percentage (Rebate %) depends on the plan's Quality Bonus Payment (QBP) rating for the year. The Rebate is calculated as the Benchmark minus the Bid Amount (if the Bid Amount is less than the Benchmark the difference is multiplied by the Rebate %).

Bid ID	2015 Values					2016 Values					Rebate Difference (Gross Payment Adj.)	Payment Adj. Based on Plan Situation
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate		
Plan 001	3	$1,000	$950	50%	($50.00)	3	1,050.40	$998	50%	($52.52)	($2.52)	($2.52)
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,050.40	$1,103	50%	$26.26	$1.26	$1.26
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,050.40	$1,366	65%	$204.83	$54.83	$32.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,050.40	$1,366	50%	$157.56	($37.44)	($32.00)
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,050.40	$1,431	65%	$247.08	$52.08	$32.00
Plan 006	4	$1,000	$1,365	65%	$237.25	3.5	1,050.40	$1,366	65%	$204.84	($32.41)	($32.00)
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,050.40	$1,261	50%	$105.30	($44.70)	($32.00)

Notes:

a. Plans 001 through 004 have benchmark growth of 5.04%.
b. Plan 001 bid amount is greater than the rebate in both years; therefore the difference is not multiplied by the rebate percentage.
c. Plan 002 (and plans 003-007) bid amount is less than the benchmark in both years; therefore the difference is multiplied by the rebate percentage.
d. Plan 003 has an increase in rebate percentage; therefore the payment adjustment is maximized at $32.
e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -$32.
f. Plan 005 has benchmark growth of 5.04% plus 5.0% to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $32.
g. Plan 006 has benchmark growth of 5.04% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$32.

h. Plan 007 has a 2016 star rating below 3.0; therefore the payment adjustment is minimized at -$32.

The following describes how the TBC evaluation will be conducted for organizations that consolidate or segment plans from one year to the next:

- Consolidating Multiple Non-segmented Plans into One Plan: The enrollment-weighted average of the CY 2015 plans will be compared to the CY 2016 plan.
- Segmenting an Existing Plan: The TBC for each CY 2016 segmented plan will be compared independently to the CY 2015 non-segmented plan.
- Consolidating Previously Segmented Plans: The enrollment-weighted average TBCs of the existing CY 2015 segmented plans will be compared to the non-segmented CY 2016 plan.

We encourage organizations to participate in User Group Calls conducted by the Office of the Actuary in April and May, providing organizations with the opportunity to obtain responses to their technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

As codified at 42 CFR §422.100(f)(4) and (5), and §422.101(d)(2) and (3), all MA plans, including employer group plans and SNPs, must establish limits on enrollee out-of-pocket spending that do not exceed the annual maximum amounts set by CMS. Although the MOOP requirement is for Parts A and B services, an MAO can include supplemental benefits as services subject to the MOOP.

For CY 2016, we continue to encourage organizations to establish the lower, voluntary MOOP thresholds. MAOs adopting voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits. Plans are responsible for tracking enrolled beneficiaries' out-of-pocket spending and to alert beneficiaries and plan providers when the spending limit is reached. D-SNPs also must track enrollee cost sharing but should include only those amounts the enrollee is responsible for paying net of any State responsibility or exemption from cost sharing.

The CY 2016 Final Call Letter defines MOOP requirements by plan type. The following chart identifies the required MOOP amounts by plan type that are to be reflected in the PBP for CY 2016 for all Parts A and B services.

CY 2016 PBP Options for Entering MOOP Amounts by Plan Type

Plan Type	Required MOOP Amounts	Plan also may choose to enter in the PBP:
HMO	In-network	"In-network" is only option available in the PBP
HMO with Optional Supp. Point of Service (POS)	In-network	"In-network" is only option available in the PBP
HMO with Mandatory Supp. POS	In-network	"No" or enter amounts for "Combined" and/or "Out-of-Network" as applicable
Local Preferred Provider Organization (LPPO)	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
Regional Preferred Provider Organization (RPPO)	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
PFFS (full network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (partial network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (non-network)	General	"General" is the only option available in the PBP

Service Category Cost Sharing Supporting Documentation in the Bid Pricing Tool (BPT)

Service category cost sharing requirements can be found in the CY 2016 Final Call Letter dated April 6, 2015. Please note plans with benefit designs using a coinsurance or copayment amount for which there is not an established limit (e.g., coinsurance for inpatient or copayment for durable medical equipment) must submit a document that clearly demonstrates how the coinsurance or copayment amount satisfies CMS service category requirements with their initial bid. This document must be submitted as part of supporting documentation for the BPT as described in the 'Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2016, Appendix B-Supporting Documentation.'

Discriminatory Pattern Analysis

CMS will confirm that plans satisfy cost sharing requirements and will analyze bids to identify other services that may not adhere to cost sharing guidance. *See* Medicare Managed Care Manual, Chapter 4, § 50. For example, cardiac and pulmonary rehabilitation services are not included in service category cost sharing standards, but plans are expected to make sure their cost sharing aligns with Chapter 4 guidance. CMS will evaluate and analyze both whether cost-sharing levels satisfy Medicare Advantage requirements or are defined or administered in a manner that may discriminate against sicker or higher-cost patients. This analysis may also evaluate the impact of benefit design on patient health status and/or certain disease states. CMS

will contact plans to discuss and correct any issues that are identified as a result of these analyses.

CY 2016 Part C Benefit Policy Updates

CMS strives to make sure all enrollees receive high quality, effective health care services, and we therefore encourage plans to offer benefits to enrollees that are of value and based on sound medical practice. Below, we clarify our guidance regarding certain benefits that has generated questions in the past.

PBP Notes

When offering benefits in accordance with Chapter 4 guidance, no note is necessary; however, when a note is required, the following should be considered. A satisfactory note in the PBP contains only information applicable to the service category in which the note section is located and provides clear, relevant information reviewers need for bid evaluation. Furthermore, a satisfactory note:

- Is consistent with the data entry in the corresponding section of the PBP.
- As appropriate, provides a brief description of the different cost sharing levels included in ranges in the data field. For example, cost sharing amounts that fall in between the minimum and maximum for some highly utilized services (if applicable).
- Is consistent with guidance in Chapter 4 of the Medicare Managed Care Manual:
    - If PBP notes are required based on Chapter 4 guidance (e.g., Nutritional/Dietary Benefit, and Fitness Benefit), the note must provide the required description.
    - If a plan is offering more extensive services for a particular supplemental benefit, the note will describe only those services over and above what is described in Chapter 4.
    - If there is no description in Chapter 4 for a supplemental benefit being offered, the benefit is to be entered in the Other (13d, 13e and 13f) category of the PBP and the note must describe the benefit.

A satisfactory note does <u>not</u> contain the following:

- Detailed CPT codes or exhaustive lists of every procedure covered by the benefit.
- Bid Pricing Tool explanations.
- Terms such as "etc., or misc." in the notes field.
- Restatement of the PBP questions.
- The term "pre-certification." Plans should use appropriate terminology such as "authorization" or "referral" as defined in the current Chapter 4 section 110.1.
- Reference to Medicaid benefits.
- Linking of Supplemental Benefits to Model of Care (MOC) Requirements.

Medicare-Covered Preventive Services

The Medicare-Covered Zero Cost Sharing Preventive Services ($0 CSPS) may change periodically; plans are responsible for monitoring changes and must offer all services identified as a Medicare-Covered $0 CSPS throughout the year. Plans are encouraged to refer to the link below for a complete list of Medicare-Covered Preventive Services.

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

Not all preventive services are required to be covered at $0 cost sharing by Medicare (e.g., annual glaucoma screening tests for beneficiaries who are at high risk of developing glaucoma and digital rectal exams to screen for prostate cancer).

In summary, the following is how preventive services should be entered in the PBP:

- Medicare-covered $0 CSPS preventive services will remain in section 14a of the PBP (no change from previous years).
- Medicare-covered preventive services with cost sharing but the plan is offering the benefit at zero dollars, must list these benefits in the 14a notes field, except for glaucoma which will remain in 17a and diabetes self-management training which will remain in 14e. Plans will be able to use the free form text field in the Summary of Benefits to explain which services they are offering at zero dollars.
- Medicare-covered preventive services with cost sharing will continue to be placed in the service categories where the benefit can be received.

Observation Costs

A plan may not charge separate cost sharing for observation services. Observation services are among the many services a patient may receive in the outpatient department of a hospital and as such, the cost sharing for observation services needs to be included in the cost sharing for hospital outpatient services entered at 9a.

Rewards & Incentives

Rewards and incentives are not considered plan benefits or eligible supplemental benefits and CMS does not expect to see rewards or incentives in CY 2016 PBPs. Rewards and incentives are programs plans may offer consistent with regulations at 42 CFR 422.134 and guidance issued in the December 4, 2014 HPMS memo titled, "Rewards and Incentives Program Guidance."

Premium Buy-down

In accordance with section 1854(a)(1)(B) of the Social Security Act and regulations at 42 CFR §422.266(b), MAOs with rebate dollars available may allocate those dollars to the provision of supplemental benefits, prescription drug coverage premium or payment toward the Part B premium. We encourage MAOs with rebate dollars to prioritize elimination or reduction of the

MA and Part D premiums prior to reducing the Part B premium, as this facilitates transparency for beneficiaries in choosing MA plans.

Cost Sharing for Special Needs Plans Serving Dual – Eligible Enrollees (D-SNPs)

CMS expects MA organizations to communicate MA and State Medicaid benefits to Dual Eligible SNP beneficiaries in a comprehensive and transparent manner. For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. For example, if a plan contains a preventive dental benefit for which it receives payment from the State Medicaid agency to provide, that benefit must not be included in the PBP.

Plans are required to attest in the PBP that any supplemental benefit(s) the SNP proposes to offer do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, and, if appropriate, Part D Medicare services, through the local jurisdiction in which they reside. This segregation of Medicare-only benefits in the PBP is necessary so CMS can appropriately account for the Medicare benefit package and costs to the Medicare program. Please note: D-SNPs must furnish their enrollees with a description of both the Medicare and Medicaid benefits and cost sharing that are available to them in marketing materials (see 42 CFR §422.111(b)(2)(iii)).

In addition, benefits separately purchased by an employer or union that wrap around the Medicare benefit package may not be included in the PBP.

Maximum Out-of-Pocket Costs (MOOP) for Dual Eligible Special Needs Plans (D-SNPs)

Although it may be rare that a dual-eligible enrollee would be responsible for paying any cost sharing (because the State Medicaid program is making those payments on his/her behalf), all MA plans must track enrollees' actual out-of-pocket spending, if any, for covered services to be able to certify an enrollee does not spend more than the MOOP amount limit established by the plan. A dual-eligible enrollee may incur responsibility for the costs of care if the plan charges cost sharing for covered services and the enrollee loses his or her Medicaid eligibility.

Currently, SNPs have the flexibility to establish $0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees. Otherwise, if the SNP does charge cost sharing for covered services, it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

Benefits Flexibility for Certain Dual Eligible Special Needs Plans

As explained in the Medicare Managed Care Manual (Chapter 16b, Section 40.4.4), we allow certain D-SNPs that meet qualifying criteria to offer specific supplemental benefits beyond those currently permitted for MA plans. Qualifying D-SNPs wishing to offer any of the approved additional supplemental benefit categories described in the Medicare Managed Care Manual are to enter the proposed benefit(s) in section B13g of the PBP. CMS will review all submitted bids

and will determine whether the additional supplemental benefits entered are consistent with CMS guidance. Of D-SNPs that express an interest in benefit flexibility, CMS notifies those plans that do not qualify to participate in the supplemental benefits flexibility initiative and therefore, will not be able to enter the additional supplemental benefits in the PBP.

Tiered Cost Sharing for Medical Benefits

MAOs may choose to tier the cost sharing for contracted providers as an incentive to encourage enrollees to seek care from providers the plan identifies based on efficiency and quality data. In addition to other standards for this plan design that are described in the Medicare Managed Care Manual, Chapter 4, the tiered cost sharing must be applied so that all plan enrollees are charged the same cost sharing amount for any specific provider and all providers are available and accessible to all enrollees in the plan in order to ensure benefit and cost-sharing uniformity under 42 CFR 422.100(d).

Consistent with past years, CMS expects MAOs to submit a proposal summarizing their intent to tier medical benefits prior to bid submission. For CY 2016, MAOs must submit a tiering request document directly to CMS through an electronic mailbox and will no longer need to contact the Regional Office Account Manager. MAOs may submit their tiering requests to the following mailbox through April 29, 2015: https://mabenefitsmailbox.lmi.org/MedicalTiering.aspx.

The tiered medical benefit design must satisfy the following standards:

- The plan fully discloses tiered cost-sharing amounts and requirements to enrollees and plan providers;
- The services at each tier of cost-sharing are available to all enrollees;
- Enrollees may not be limited to obtaining services from providers/suppliers assigned to a particular tier;
- All enrollees are charged the same amount for the same service provided by the same provider; and
- Deductibles, MOOP, and Out of Network (OON) benefits cannot be tiered.

The following examples of 'differential cost-sharing' are allowable, and not considered to be tiering of medical benefits:

- Facility settings for furnishing some services, such as diagnostic imaging services; and
- In-network versus out-of-network services.

Plans are expected to confirm they are tiering medical benefits and the applicable service categories in Section A of the PBP. This is a new PBP change further described below. Plans must use minimum/maximum data entry and notes fields to describe tiering in each applicable section of the PBP.

CY 2016 Plan Benefit Package (PBP) Changes

CMS has revised PBP sections in an effort to simplify data entry, address areas causing confusion in the past, and better reflect MAOs' and Section 1876 cost contractors' offerings.

Identifying Tiered Cost Sharing for Medical Benefits in the PBP

CMS has made several updates to the PBP in an effort to review and track plans offering tiered cost sharing for Medicare and/or supplemental benefits. Please see policy changes related to tiering of medical benefits in the section above. The PBP changes are as follows:

- A question has been added to Section A: "Do any of your outpatient services have tiered cost sharing? Please note: Inpatient Hospital Services that have tiered cost sharing are entered in Section B of the PBP." Plans will be asked to identify the service categories with tiered cost sharing from a pick list.
- Minimum/maximum fields have been added for all service categories except for B-4a: Emergency Care, B-4c: Worldwide Emergency/ Urgent Coverage, B-10a: Ambulance Services, B-15: Medicare Part B Rx Drugs, B-20: Prescription Drugs OR any MMP specific categories. No new ranges have been added for B-16: Dental.
- B-1a: Inpatient Hospital-Acute and B-1b: Inpatient Hospital Psychiatric –A second tiering question has been added to address tiering the "additional days" supplemental benefit. The maximum number of Additional Days covered must be the same for all tiers, however the intervals to get to that maximum number of days, as well as the cost sharing amounts, can vary by tier.
- B-2: SNF –The tiered cost sharing structure that is currently in place for B-1a: Inpatient Hospital-Acute and B-1b: Inpatient Hospital Psychiatric has been added to B-2: SNF.
- Each service category that has tiered cost sharing will require a note explaining the levels of tiering as they relate to the minimum/maximum cost sharing.

Cost Sharing Ranges

CMS has added cost sharing ranges (i.e., minimum/maximum) to the following categories in the PBP to accommodate multiple cost sharing amounts for different settings:

B-4c: Worldwide Emergency/ Urgent Coverage
B-5: Partial Hospitalization
B-9d: Outpatient Blood Services
B-10b: Transportation Services
B-13a: Acupuncture
B-13b: Over-the-Counter (OTC) Items and Services
B-13c: Meal Benefit
B-13d: Other 1
B-13e: Other 2
B-13f: Other 3
B-13g: Dual Eligible SNP with Highly Integrated Services
B-14b: Annual Physical Exam

B-14c: Eligible Supplemental Benefits as Defined in Chapter 4
B-17b: Eyewear
B-18b: Hearing Aids

Plans are required to include a note if a cost sharing range is entered (either minimum/maximum or copay and coinsurance).

Benefit Period in B-1a: Inpatient Hospital-Acute, B-1b: Inpatient Hospital Psychiatric and B-2 Skilled Nursing Facility (SNF)

The following question has been added to the CY2016 PBP in B-1a: Inpatient Hospital-Acute, B-1b: Inpatient Hospital Psychiatric and B-2: SNF:

"What is your inpatient hospital benefit period?" (Select one)
-Original Medicare
-Annual
-Other, describe

This new question indicates that MAOs have the ability to choose the type of benefit period for the service categories stated above. The MAO can follow Original Medicare's benefit period, offer an annual benefit period (one annual inpatient deductible) or create its own benefit period. If the MAO chooses "other," they must describe their benefit period in the notes section. It is up to the MAO to decide which benefit period they will provide for their plan.

B-2: SNF Non-Medicare Covered Stay

The PBP will not allow non-MMP plans to select "Non-Medicare-covered stay" for the question "Select type of benefit for the Non-Medicare-covered stay."

An on screen note has been added to inform users that only MMPs will be allowed to select the "Non-Medicare-covered stay" option.

B-4b: Urgently Needed Services

The service category name of B-4b has been changed from "B-4b: Urgently Needed Care" to "B-4b: Urgently Needed Services".

B-4a: Emergency Care and B-4b: Urgently Needed Services

The following on screen notes have been added regarding Emergency Care and Urgently Needed Services cost sharing:

"Cost sharing cannot be greater than the amount established by CMS in the Final Call Letter for Medicare-covered Emergency Care."

"Cost sharing cannot be greater than the amount established by CMS in the Final Call Letter for Medicare-covered Urgently Needed Services."

B-4c: Worldwide Emergency/Urgent Coverage

The service category name of B-4c has changed from "Worldwide Emergency Coverage" to "Worldwide Emergency/Urgent Coverage."

B-7b: Chiropractic Services

The B-7b: Chiropractic Services supplemental benefit has been updated by adding "/Other" to the current enhanced benefit "Routine Care" so it will read "Routine Care/Other."

B-7b: Chiropractic Services and B-13a: Acupuncture Combination Benefit

Section B-7b: Chiropractic Services and Section B-13a: Acupuncture will be linked in the PBP for plans offering a combined chiropractic services and acupuncture benefit.

After entering the number of visits or the maximum benefit amount, a new question, "Do you offer a combined Acupuncture and Chiropractor Services benefit?" will be asked. A new validation confirms the two benefits have matching maximum plan benefit amounts, number of visits, cost sharing, and limits.

The benefits are also linked in the same way for OON/POS if indicated in Section B.

Separate Office Visit in B-8a: Outpatient Diagnostic Procedures/Tests/Lab Services, B-8b: Outpatient Diagnostic/Therapeutic Radiology Services, B-14e: Diabetes Self-Management Training, B-17a: Eye Exams, and Section C OON/POS

The "separate office visit may apply" question and the separate physician charge questions have been removed from the following service categories:

- B-8a: Outpatient Diagnostic Procedures/Tests/Lab Services
- B-8b: Outpatient Diagnostic/Therapeutic Radiology Services
- B-14e: Diabetes Self-Management Training
- B-17a: Eye Exams
- OON/POS-Groups in Section C.

The following questions have been deleted from the PBP:
1) "Indicate whether a separate physician/professional service cost share applies: (Sometimes, describe/No)"
2) "Is there an enrollee Coinsurance for a separate physician/professional service? (Yes/No)"
3) "Indicate Minimum/Maximum Coinsurance percentage for a separate physician/professional service: (minimum/maximum)"
4) "Is there an enrollee Copayment for a separate physician/professional service? (Yes/No)"

5) "Indicate Minimum/Maximum Copayment amount for a separate physician/professional service: (minimum/maximum)"

MAOs can still charge the separate office visit cost share, but it no longer needs to be defined in the PBP at the various service categories. Once the data is entered in the PCP and specialist service categories, there is no need for additional entry.

B-13c: Meal Benefit

The Meal Benefit duration data entry has been changed from weeks to days and a data entry field has been added for plans to identify the maximum number of meals an individual enrollee could receive during the year for this benefit.

Updated PBP language:
"How many days does your Meal Benefit last?"
"What is the maximum number of meals the benefit provides?"

Movement of "Alternative Therapies" from B-13a: Acupuncture to B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

"Other Alternative Therapies" has been deleted from B-13a and B-13a has been renamed "Acupuncture." "Alternative Therapies" has been moved to B-14c as a supplemental benefit. Plans are required to include a note in B-14c when offering Alternative Therapies.

"Weight Management" added to B-14c: Eligible Supplemental Benefits as defined in Chapter 4

"Weight Management" has been added as a supplemental benefit to B-14c: Eligible Supplemental Benefits as identified in Chapter 4. MAOs must describe their benefit in the notes section of the PBP and may not offer meals as part of those weight management programs.

B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

The following benefit titles in B-14c have been modified to match the guidance in Chapter 4:

CY 2015 PBP Benefit Title	**Updated CY 2016 PBP Benefit Title**
Nutritional Benefit	Nutritional/Dietary Benefit
Additional Smoking and Tobacco Use Cessation	Additional Sessions of Smoking and Tobacco Cessation Counseling
Membership in Health Club/Fitness Classes	Fitness Benefit
Nursing Hotline	Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)
Web/Phone-Based Technology	
Tele-monitoring	Telemonitoring Services
Additional sessions of Medical Nutrition Therapy (MNT)	Medical Nutrition Therapy

Maximum Plan Benefit Amounts in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

CMS has added a maximum plan benefit amount data entry field to every service category under B-14c: Eligible Supplemental Benefits as Defined in Chapter 4.

Required Notes in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

Notes will now be required for the following benefits (when they are offered) under B-14c: Eligible Supplemental Benefits as Defined in Chapter 4:

- Nutritional/Dietary Benefit
- Fitness Benefit
- Telemonitoring Services
- Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)
- Bathroom Safety Devices
- Weight Management
- Alternative Therapies

Notes are optional for all other services under B-14c: Eligible Supplemental Benefits as Defined in Chapter 4.

Nutritional/Dietary Benefit and Additional sessions of Smoking and Tobacco Cessation Counseling in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

New data entry options have been added to the following benefits under B-14c: Eligible Supplemental Benefits as Defined in Chapter 4:

- Nutritional/Dietary Benefit: indicate number and duration of visits offered
- Additional Smoking and Tobacco Use Cessation Counseling: Indicate number of visits offered in addition to Medicare

A note is required for the Nutritional/Dietary benefit. The note must match the data entry and describe whether the benefit is for classes and/or individual counseling.

Medical Nutrition Therapy (MNT) in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

Two new subcategories have been added as part of the Medical Nutrition Therapy benefit in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4. If "Medical Nutrition Therapy" is selected as a benefit from the pick list then after a plan indicates whether it is a mandatory or optional benefit they will be required to provide information on these two new subcategories:

"Do you offer Additional Sessions for Medicare-covered diseases? Yes/No"

If "Yes," the plan will enter the number of visits or hours.

"Do you offer Coverage for non-Medicare covered diseases? Yes/No"
"Describe that coverage in the Notes field."

If "Yes," the plan will enter the number of visits or hours.

Re-admission Prevention in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

The Readmission Prevention benefit as defined in Chapter 4 includes meals and bathroom safety components that can also be considered separate and stand-alone benefits. We have added data entry fields in the PBP for meals and bathroom safety that apply to the Readmission Prevention benefit, but also preserved the stand-alone benefit fields.

The following questions have been added to the PBP to reflect this new benefit:

"Select type of benefit for Re-admission Prevention: (Mandatory/Optional)"

"The Re-admission Prevention benefit includes:
- Meals
- Medication Reconciliation
- In-Home Safety Assessment

Does your Re-admission Prevention benefit include any other services? If yes, please define the benefit below and describe the benefit in the notes field. (Yes/No)"

Additionally, data entry fields have been added where plans must describe the meal benefit included in the Re-admission Prevention Program, including the number of days the meal benefit lasts, and the maximum number of meals the benefit provides.

SNPs and Enhanced Disease Management in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4

A new edit rule has been added preventing SNPs from choosing Enhanced Disease Management in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 as a supplemental benefit.

LPPO/RPPO Edit Rules in B-16a: Preventive Dental, B-16b: Comprehensive Dental, B-17a: Eye Exams, B-17b: Eyewear, B-18a: Hearing Exams and B-18b: Hearing Aids

The following LPPO/RPPO edit rules have been added to the PBP, particularly as they apply to the following PBP Sections B-16a: Preventive Dental, B-16b: Comprehensive Dental, B-17a: Eye Exams, B-17b: Eyewear, B-18a: Hearing Exams and B-18b: Hearing Aids:

1) If a plan offers a Maximum Plan Benefit Coverage amount in one of the above service categories and applies it to both In-network and Out-of-network services, then the plan must

enter "No" to offering a Maximum Plan Benefit Out-of-network for that specific category.

2) If a plan offers a Maximum Plan Benefit Coverage amount in one of the above service categories and applies it to In-network services only, then the plan must offer the exact same cost sharing Out-of-network for that specific category.

3) If a plan offers a Maximum Plan Benefit Coverage amount in B-16a: Preventive Dental, and then offers a "Maximum Plan Benefit Coverage amount that is covered under the previous category" in B-16b: Comprehensive Dental, then the Out-of-network amounts must be exactly the same.

B-17a: Eye Exams

CMS has updated the B-17a: Eye Exams supplemental benefit by adding "/Other" to the current enhanced benefit "Routine Eye Exams" so it will now read "Routine Eye Exams/Other."

B-18b: Hearing Aids

A note has been added to B-18b: Hearing Aids, requesting that plans clarify that the hearing aid maximum plan benefit amount is either "per ear" or "for both ears combined" in the notes field.

LPPO and/or RPPO OON Coverage for Part A in Section C

A new edit rule has been added in Section C for LPPO and/or RPPO plans. The rule requires a minimum of 90 days be covered OON for Medicare Part A services, referring to B-1a: Inpatient Hospital-Acute and B-1b: Inpatient Hospital Psychiatric.

Section C POS MOOP and POS as a Mandatory Benefit

Section C POS MOOP questions have been disabled when a plan offers POS as a mandatory benefit. The MOOP questions for HMO plans that offer mandatory POS benefits must be entered in Section D of the PBP software.

Section C POS General

The following question has been changed on the POS - General - Base 6 screen:

From:

"Does this POS benefit include all practitioners who are state-licensed or state-certified to furnish the services? If no, please briefly describe provider limitations."

To:

"Does this POS benefit include all providers licensed and certified to furnish the services? If no, please briefly describe provider limitations."

OON/POS Validation

A validation has been added to the PBP when a benefit category is added to the OON/POS benefit; it must and can only be included in one group.

Visitor Travel (V/T)

The following question and on-screen note have been added to the V/T - General - US screen:

"Select geographic area:
-In the United States and its territories
-Other- please define in the marketing materials (MAO must define the geographic areas within the United States and its territories where the V/T benefit is available)."

"The V/T benefit must furnish all plan-covered services in its designated V/T service area(s), including all Medicare Parts A and B services and all mandatory and optional supplemental benefits, at in-network cost-sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112"

Additionally, the "Notes (Optional)" field has been deleted.

OON Maximum Plan Benefit Rules for PFFS plans

The OON Maximum Plan Benefit rules for PFFS plans have been updated. If a network PFFS plan creates an OON group containing both Medicare-covered benefits and non-Medicare-covered benefits, then the field for the Maximum Plan Benefit will be disabled.

Section D Differential Deductible and Worldwide Emergency/Urgent Coverage

B-4c: Worldwide Emergency/Urgent Coverage has been added in the Section D Differential Deductible list for LPPO/RPPO plan types on the Plan Deductible LPPO/RPPO - Base 3 screen. A new field has been added on the following screen, "Indicate Differential Deductible Amount for Worldwide Emergency/Urgent Coverage:"

Section D MOOP

The Section D MOOP screens/rules have been modified to make data entry simpler. This includes the following changes:

- The order of the Section D Screens for Network plans has changed. The new order is: In-Network MOOP, Combined MOOP, Out-of-Network MOOP.
- The "Voluntary" and "Mandatory" question on the INN screen for Network PFFS plans has been disabled.
- The "Voluntary" and "Mandatory" question on the Combined screen for LPPO/RPPO plans has been disabled.

- On the Maximum Enrollee Cost Limit (Combined) – Base 1 screen, "(Network PFFS plans only)" has been added to the end of the Voluntary/Mandatory question so it reads: "Is your Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost at the Voluntary or Mandatory Level? (Network PFFS plans only)."
- The Deductible screens in Section D have been re-ordered to mirror the new MOOP screen order: In-Network Deductible, Combined Deductible, Out-of-Network Deductible.

Validation Changes/Rules:

- Cost Share validations in the Section B categories will be enforced against the In-Network MOOP selection for PPO, HMOPOS plans and combined selection for Network PFFS plans.
- The Combined MOOP must be no less than the In-network MOOP, and no greater than the allowable Combined (Voluntary or Mandatory) MOOP amounts.
- If In-network is Mandatory then the Mandatory cost share limits will be enforced in Section B.
- If In-network is Voluntary then the Voluntary cost share limits will be enforced in Section B.
- Combined MOOP value will be governed by In-network MOOP.
- HMOPOS plans can have an OON MOOP offered in Section C (only if they offer an optional POS benefit) and Section D (only if they offer a mandatory POS benefit).

$0 MOOP

The following validations are being implemented when a plan includes a $0 MOOP:

- Plans must select "No" to the following Standard Bid questions in Section A:
  - "Is your organization filing a standard bid for Section B of the PBP?"
  - "Is your organization filing a standard bid for Section C of the PBP?"
  - "Is your organization filing a standard bid for Section D of the PBP?"
- Plans must select "No" to all deductible questions for all Section B categories.
- Plans must select "No" to all deductible questions for all Section C categories (OON/POS).
- Plans must select "No" to the following deductible questions in Section D:
  - "Do you offer an Annual Deductible?" on the Plan Deductible Local PPO/Regional PPO - Base 1 screen.
  - "Is there a Combined (In-Network and Out-of-Network) Deductible amount?" on the Plan Deductible-(Combined) - Base 1 Screen.
  - "Is there an Out-of-Network (OON) Plan Deductible?" on the Plan Deductible-(Out-of-Network) Screen.
  - "Is there an In-Network Plan Deductible?" on the Plan Deductible- (In-Network) Screen.
  - "Is there a Plan Deductible?" on the Plan Deductible (Non-Network) Screen.

A pop up note has been added that tells the plan they must enter more than $0 for their MOOP or not enter a deductible when the user enters $0 MOOP.

Updated Service Category Descriptions

We have updated some of the Medicare benefit and service category descriptions within the PBP software. CMS strongly encourages MAOs to review the new PBP descriptions as they prepare their bids to ensure consistency of proposed benefits with the CMS definitions and guidance. These service category descriptions can be viewed within the PBP software, or can be viewed in HPMS under the "Service Category Report" found in the 2016 Bid Reports section of HPMS.

Reference Materials and Submission of Questions

The MA benefits mailbox at: https://MABenefitsMailbox.lmi.org/ includes links to a variety of reference materials, frequently asked questions (FAQs), and answers to questions submitted during CY 2016 bid preparation. CMS strongly encourages MAOs to review the available resources before submitting a question to confirm we have not already provided information on a specific topic.

MAOs can submit questions regarding policy, cost sharing, and supplemental benefits to this mailbox for CMS review and response. We appreciate your cooperation in this regard.

Other questions may be directed to the appropriate mailbox as specified below:

- Technical HPMS questions (e.g. PBP download, plan creation, bid, upload), please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov.
- Technical questions about the Out-of-Pocket Cost (OOPC) model, please submit an email to OOPC@cms.hhs.gov.
- Part D policy questions about meaningful difference, please submit an email to partDbenefits@cms.hhs.gov.
- Bid Pricing tool (BPT) questions, please submit an email toBidReviewC@cms.hhs.gov.