NEVADA RURAL HOSPITAL PARTNERS
An alliance of rural hospitals

4600 Kietzke Lane
Suite I-209
Reno, Nevada 89502
(775) 827-4770
Fax (775) 827-0939
www.nrhp.org

Joan Hall
President

July 7, 2015

Nevada Division of Insurance
1818 East College Parkway
Carson City, NV 89706

Thank you once again for allowing NRHP to express rural hospital concerns over the draft proposed regulations LCB **File No. R049-14** on Adequacy of Network. As stated in previous testimony, the goal of NRHP is to ensure that there are insurance plans available for rural Nevadans that allow access to care in local communities. I do appreciate the inclusion of many of the issues previously expressed - the recognition of established patterns of care and telehealth.

However, in **Section 6(2)**, which I recognize as directly from the federal requirements, access to health care for citizens in rural Nevada will not be met. Included are two maps that demonstrate this for easier understanding. I will point out the following issues:

- In Nevada's geographic service area 4, which includes 10 of Nevada's 17 counties and has an expansive geographic area, there are seven rural hospitals listed on the federal ECP listing.

  Subsection (a) "at least 30% of ECP in each geographic service area" – would only mandate two hospitals be included in a network.

  Subsection (b) "at least one ECP from each category in the following list" – mandates only one of each provider type in this vast area and is also unacceptable to each of these communities.

- In Nevada's geographic service area 1, which includes Clark and Nye Counties, there are four rural Critical Access Hospitals all listed on the federal ECP listing – the 30% mandate of these ECPs would be only be one rural hospital – again, in the vast geographical area of Nye County alone, that is problematic. Who would be forced to go to Las Vegas – the citizens of Mesquite, Pahrump, or Tonopah?

- In Nevada's geographic service area 3, which includes Carson, Douglas, Lyon, and Storey counties, there are two Critical Access Hospitals listed as ECPs – which would be included in the network?

NRHP suggests that **Section 6 (2) (a) and (b)** be changed to read:

For the purposes of subsection 1, a network plan that includes:

(a) 100% of the rural hospitals listed as ECPs in each geographic service area covered by the network plan; and

(b) in each rural community, at least one essential community provider from each category in the following list: (1-5) shall be deemed sufficient.

I appreciate your consideration and look forward to continuing to work with the DOI and stakeholders on this very important topic.

Sincerely

Joan Hall
President

Nevada Rural Hospital Partners - 2015 Consortium Map

Pershing General Hospital
Acute Beds 13
LTC Beds 25
RHC 1
Miles to closest NV urban center 93

Humboldt General Hospital
Acute Beds 23
LTC Beds 30
RHC 1
Miles to closest NV urban center 167

Battle Mountain General Hospital
Acute Beds 7
LTC Beds 18
RHC 1
Miles to closest NV urban center 219

Banner Churchill Community Hospital
Acute Beds 40
Miles to closest NV urban center 63

Incline Village Community Hospital
Acute Beds 4
Miles to closest NV urban center 35

Carson Valley Medical Center
Acute Beds 23
RHC 2
Miles to closest NV urban center 22

South Lyon Medical Center
Acute Beds 14
LTC Beds 49
RHC 3
Miles to closest NV urban center 81

Mount Grant General Hospital
Acute Beds 11
LTC Beds 24
RHC 1
Miles to closest NV urban center 134

Desert View Hospital
Acute Beds 25
Miles to closest NV urban center 63

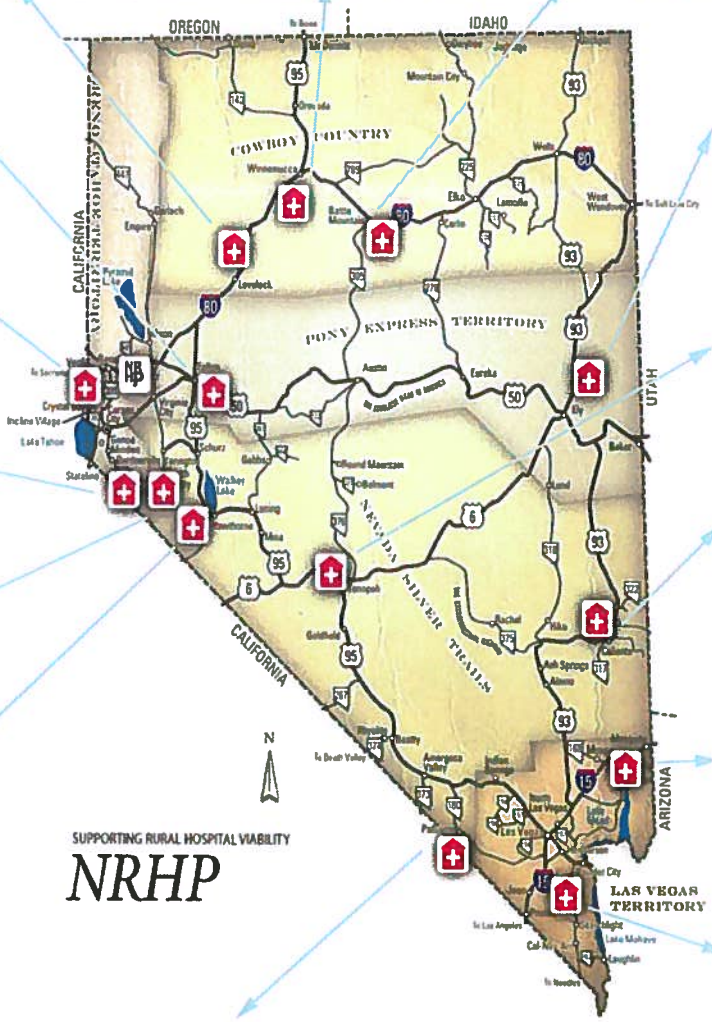
William Bee Ririe Hospital
Acute Beds 25
RHC 1
Miles to closest NV urban center 242

Nye Regional Medical Center
Acute Beds 12
Miles to closest NV urban center 210

Grover C Dils Medical Center
Acute Beds 4
LTC Beds 16
RHC 1
Miles to closest NV urban center 151

Mesa View Regional Hospital
Acute Beds 25
Miles to closest NV urban center 79

Boulder City Hospital
Acute Beds 24
LTC Beds 47
Miles to closest NV urban center 10

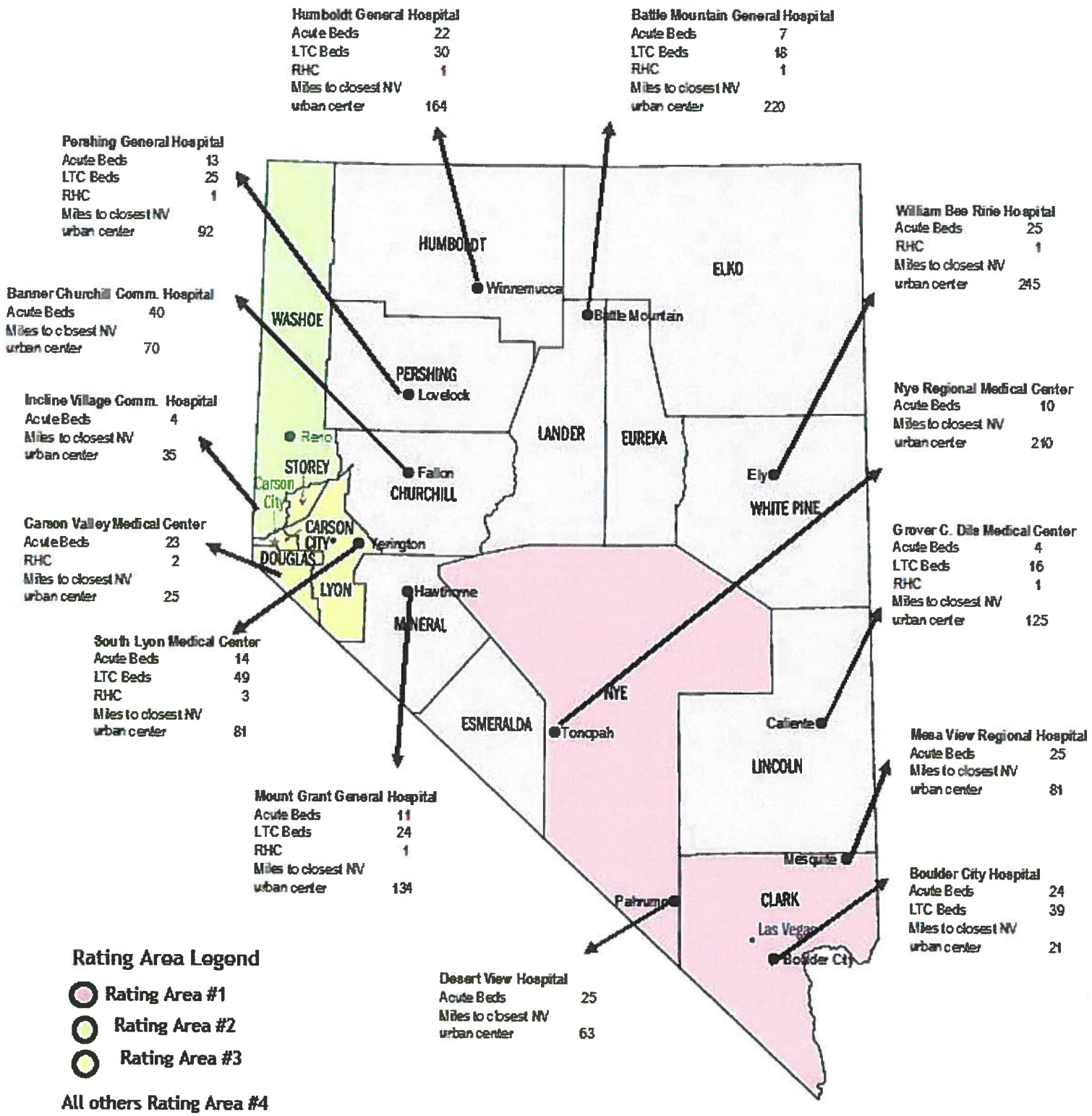


Population Served: 261,000

Total Area Served: 95,431 square miles

Nevada Rural Hospital Partners * 4600 Kietzke Lane * Suite I-209 * Reno * Nevada * 89502 * 775-827-4770

NRHP 2015 Consortium Map - Rating Area Designation



DISTANCE GUIDELINES
Medicare – Advocates Nonparticipating Review Clarification

Effective Date: January 1, 2013
Last Change: July 21, 2014
Applicable Plans: Medicare

SelectHealth Member Advocates use distance as part of the criteria considered during a nonparticipating review. Using distance as a guideline for nonparticipating review ensures that SelectHealth members will have appropriate access to the care they need without being required to travel to a participating provider when there isn't one near their home.

Distance guidelines are considered from the member's address of record in Facets, and should always be determined using mapquest.com to gauge the exact distance to the nearest participating provider. If the nearest participating provider is further than the required distance for the member to travel, then a service approval can be allowed based on distance alone. If there is a participating provider within the required distance who can provide the service requested, then the member will be required to travel to the participating provider's office and cannot receive a service approval. All possible specialties that are able to provide the requested services need to be considered within the required distance.

SelectHealth Advantage Distance Guidelines for members in an Urban County:

- The member will be required to travel no more than **10** miles to a participating Primary Care Physician.
- The member will be required to travel no more than **20** miles to a participating Secondary Care Physician.

SelectHealth Advantage Distance Guidelines for members in a Rural County:

- The member will be required to travel no more than **20** miles to a participating Primary Care Physician.
- The member will be required to travel no more than **50** miles to a participating Secondary Care Physician

SelectHealth Advantage distance guidelines for members anywhere in the state of Idaho:

- The member will be required to travel no more than **40** miles to a participating Primary Care or Secondary Care Physician.

Primary Care Physician/Provider (PCP)

A general practitioner is a physician who attends to common medical problems, provides preventive care, and health maintenance. SelectHealth has classified the

following types of providers, their associated physician assistants, and nurse practitioners, as PCPs:

- Family Practice
- Geriatrics
- Internal Medicine

Secondary Care Physician/Provider (SCP)

A secondary care provider is a provider who has specialized in a specific area of medicine (e.g. orthopedics, cardiology, mental health). SelectHealth has classified any provider type who is *not* identified as a Primary Care provider as a secondary care provider or SCP.

When the Network affiliation process is unable to assist the member the distance policy will help a member receive the needed care.

Note: Distance guidelines do not apply to super specialists, rare procedures, or out-of-state SelectHealth Medical Director.

Super Specialist

A Super Specialist is a provider who gives highly specialized care not generally available in any given area. Typically these specialists are located only in urban areas, large facilities, or academic centers and limit their practice to a certain subspecialty that requires additional formal training.

For super specialists, the entire plan service area is considered the distance limitation for applying the Service Approval criteria. As such, members may be required to drive farther than anticipated to receive service from a Super Specialist if failed access is not approved based on other criteria. The following providers are currently considered Super Specialists for the purpose of failed access determination:

- Nephrologist
- Neuro-Ophthalmology
- Neuro-Otology
- Occuloplastic Surgeons
- Sub-specialty Orthopedists very specialized in one area, such as hand, foot etc.
- Pediatric Specialist
- Reproductive Endocrinology for conditions other than infertility
- Special Clinics for rare conditions (Typically located at University of Utah or PCMC)
- Spine Surgeons
- Vascular Surgeons
- Infectious Disease/AIDS
- Cardiovascular and Thoracic Surgeon

Super Specialty Services

Super Specialty Services are defined as services that are considered highly specialized care not generally available in any given area. Typically, these services are located only in urban areas, large facilities or academic centers and are typically provided by a super specialist provider.

Distance from a member's residence is not used as part of the criteria in determining Service Approvals for Super Specialty Services. As such, members may be required to drive farther than anticipated to receive a Super Specialty Service if a Service Approval is not allowed based on other criteria.

- Ambulatory EEG (24 to 72 hours);
- Cochlear Implants;
- Hip Arthroscopy;
- Hyperbaric oxygen therapy;
- Intracranial or other neurosurgical procedures;
- Open MRI or other specialized MRI requests;
- Other specialized diagnostics;
- Pain Pumps;
- Spinal Cord Stimulator;
- Transplant services
- Gamma Knife services
- High dose brachytherapy
- Intensity Modulated Radiation Therapy (IMRT)
- Etc.

NHA
Nevada Hospital Association

5190 Neil Rd. • Ste. 400 • Reno, NV 89502
775-827-0184 • Fax 775-827-0190

July 15, 2015

Nevada Department of Insurance
1818 East College Parkway
Carson City, NV 89706

The Nevada Hospital Association (NHA) appreciates the leadership and effort of the Nevada Division of Insurance (DOI) to ensure that Nevada's network adequacy regulations protect consumers' access to high quality and affordable health care. The NHA is dedicated to representing the interests of our member hospitals, including general acute care, long-term acute care, rehabilitation and psychiatric hospitals, located in both urban and rural settings all of whom furnish vital health care to Nevadans.

In response to the discussion at the June 11, 2015, Commissioner's Advisory Committee on Health Care and Insurance meeting, regarding the latest draft of the Adequacy of Network Regulations dated June 3, 2015 (LCB File No. R049-14), the following are issues that the NHA would like to see addressed or clarified:

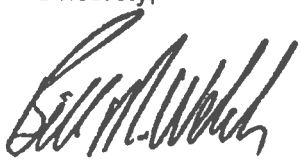
Section 4, subsection 3: Are hospitals, emergency rooms and trauma services included in the network adequacy standards? As the NHA has stated in previous comments provided in the development of these regulations, section 4 subsection 3 (a) and (b) do not include emergency room and/or trauma care on either list for determining an adequate network. Are these services not considered part of an adequate network? Aren't services such as these the primary reason for the DOI's needed over site of an adequate network? We believe the carrier has the responsibility to protect the patient when seeking emergency care as defined in NRS 695G.170. Proximity is often the key to good outcomes when a patient is seeking medically necessary emergent care.

Section 12, subsection 3: For purposes of protecting the consumer in the event a payer network is deemed deficient or inadequate, this subsection was intended to not require prior authorization if a member sought health care services from a non-participating provider in an emergent/urgent situation. "Medically necessary emergency services" as defined in Section 2, subsection 12 references the definition in NRS 695G.170 which covers serious injury/bodily impartment. In the circumstance of an inadequate network, it would seem reasonable that a person with a broken arm should be able to seek treatment in an emergency room and that service should be covered as though it was provided in network. We believe the definition in the CMS Manual for Medicare Managed Care for Emergency and Urgently Needed Services (Section 20.2) would be more appropriate (see attached) and would allow services that don't generally require authorization to be accessed directly if needed in the event of a deficient or inadequate network.

We hope that you will take into consideration the comments included in this letter. The NHA also supports comments provided by Nevada Rural Hospital Partners (NRHP) on behalf of our joint rural hospital members regarding these proposed regulations.

We look forward to working with the Division and other stakeholders to assure that the adopted network adequacy regulations are effective in providing the patient with timely access to care and protection against financial risk related healthcare decisions out of their control.

Sincerely,



Bill M. Welch
President/CEO

CMS Manual System

Pub. 100-16 Medicare Managed Care

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

Transmittal 97

Date: May 20, 2011

SUBJECT: Chapter 4, "Benefits and Beneficiary Protections"

I. SUMMARY OF CHANGES: The CMS Final Rule, 4144-F was published in the Federal Register (76) on April 5, 2011. This manual update mainly incorporates these regulatory guidances into the manual chapter. This manual update incorporates other recently published changes, such as Call Letter guidance and cost-sharing guidance. We also added guidance and strengthened our beneficiary protections in specific areas such as transplants.

NEW / REVISED MATERIAL = EFFECTIVE DATE: May 20, 2011
IMPLEMENTATION DATE: May 20, 2011

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Contents
R	4/10.2/ Basic Rule
R	4/10.5/ Part D Rules for MA Plans
R	4/10.6/ Anti-Discrimination Requirements
R	4/10.8/ Confidentiality and Accuracy of Enrollee Records
R	4/10.9/ Benefit Requirements
R	4/10.10/ Uniformity
R	4/10.11/ Caps on Enrollee Financial Responsibility
R	4/10.13/ Clinical Trials
R	4/10.14/ Provider Qualifications
R	4/10.15/ Drugs that are Covered Under Part B Original Medicare
R	4/10.18/ Access to Screening Mammography and Influenza Vaccine
R	4/10.19/ Return to Home Skilled Nursing Facility (SNF)
R	4/10.21/ Therapy Caps and Exceptions
R	4/10.22/ Balance Billing
R	4/10.24/ In-network Preventive Services
R	4/20.1/ Ambulance Services
R	4/20.2/ Definitions of Emergency and Urgently Needed Services

R	4/20.4/ Stabilization of an Emergency Medical Condition
R	4/20.5/ Limit on Enrollee Charges for Emergency Services
R	4/20.7/ Services of Non–contracting Providers and Suppliers
R	4/30.1/ Definition of Supplemental Benefit
R	4/30.2/ Anti-Discrimination Requirements
R	4/30.3/ Examples
R	4/30.4/ Transportation Benefits
R	4/30.5/ Meals
R	4/30.8/ Supplemental Benefits Extending Original Medicare Benefits
R	4/30.9/ Benefits During Disasters and Catastrophic Events
R	4/40.4/ Benefit Status
R	4/40.9/ CMS Table of OTC Items
R	4/50.1/ Guidance on Acceptable Cost-Sharing
R	4/50.2/ Total Beneficiary Cost-sharing (TBC)
N	4/50.3/ Cost-Sharing Rules for RPPOs
R	4/60.1/ Definition
R	4/60.2/ Examples of VAIS
R	4/60.3/ Additional VAIS Requirements
R	4/70.4/ Content of Enrollee Information and Other MA Obligations
R	4/80.6/ Sources for Obtaining Information
R	4/90.2/ Multi-Year Benefits
R	4/100.1/ HMO Point of Service (POS)
R	4/100.6/ PPO Out-of-Network Coverage
R	4/100.7/ The Visitor / Travel (V/T) Program
R	4/110.3/ Access for Emergency, Urgently Needed Services and Dialysis
R	4/110.4/ Access and Plan Type
R	4/120.1/ General Rule
R	4/130.1/ Basic Rule
R	4/130.3/ Medicare Benefits Secondary to Group Health Plans (GHPs) and Large Group Health Plans (LGHPs) and in settlements
R	4/130.6/ Collecting From GHPs and LGHPs
R	4/140.1/ Introduction
R	4/140.6/ Renewal Plan with a Service Area Reduction and No Other MA Options Available
R	4/140.7/ Renewal Plan with a Service Area Reduction When the MAO will Offer Another PBP in the Reduced Portion of the Service Area
R	4/140.9/ Crosswalk Table Summary
R	4/160/ Meaningful Plan Differences

III. FUNDING: No additional funding is currently provided by CMS; contractor activities are to be carried out within their own FY 2010 and/or future operating budgets determined by the organizations.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

Table of Contents
(Rev.97, Issued: 05-20-11)

Transmittals for Chapter 4

50.2 - Total Beneficiary Cost-sharing (TBC)

50.3 – Cost-Sharing Rules for RPPOs

60.1 - Definition

60.2 – Examples of VAIS

60.3 – Additional VAIS Requirements

70.4 – Content of Enrollee Information and Other MA Obligations

80.6 – Sources for Obtaining Information

90.2 – Multi-Year Benefits

100.1– HMO Point of Service (POS)

100.6 – PPO Out-of-Network Coverage

100.7 – The Visitor / Travel (V/T) Program

110.3 – Access for Emergency, Urgently Needed Services and Dialysis

110.4 – Access and Plan Type

120.1 – General Rule

130.1 – Basic Rule

130.3 – Medicare Benefits Secondary to Group Health Plans (GHPs) and Large Group Health Plans (LGHPs) *and in Settlements*

130.6 – Collecting From GHPs and LGHPs

140.1 – Introduction

140.6 *Renewal Plan with a Service Area Reduction and No Other MA Options Available*

140.7 *Renewal Plan with a Service Area Reduction When the MAO will Offer Another PBP in the Reduced Portion of the Service Area*

140.9 – Crosswalk Table Summary

160 – Meaningful Plan Differences

10.2 - Basic Rule
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An MA organization (MAO) offering an MA plan must provide enrollees in that plan with all Original Medicare-covered services except in the four circumstances described in the next paragraph. The MAO must provide Part A and Part B services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered Part B enrollee. The MAO fulfills its obligation of providing Original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying on behalf of enrollees for the benefits. *The following requirements apply with respect to the rule that MAOs must cover the costs of Original Medicare benefits:*

- *Benefits: MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services;*

- *Access: MA enrollees must have access to all medically necessary Parts A and B services.* However, MA plans are not required to provide MA enrollees the *identical access to providers as is provided under Original Medicare (refer to accessibility rules for MA plans in section 110 of this chapter).*

- *Cost-sharing: Cost-sharing imposed for Original Medicare benefits is subject to the restrictions in section 50.1 and annual guidance issued by CMS. For services not subject to restrictions in section 50.1, MA plans may impose cost-sharing for a particular item or service that is above or below the Original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries as specified in section 30.2;*

- *Billing: MA plans need not follow fee-for-service (FFS) billing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail. MA plans may not require enrollees to pay providers – whether contracted or not – for Original Medicare services and then be reimbursed by the plan. See section 20.7 for rules governing payment amounts to non-contracted providers for Original Medicare non-emergent services; and*

- *Non-contracted providers (including suppliers): MAOs may negotiate payment rates with their contracted providers and need not follow FFS payment rates. However, in the absence of a mutual agreement between the non-contracted provider and the MAO to receive less than the Original Medicare rate, non-contracted providers must accept the Original Medicare rate as payment in full. For further information on payment to non-contracted providers see Section 100, "Special Rules for Services Furnished by Non-Contract Providers," of Chapter 6, "Relationships with Providers," of this manual. Additional useful information on*

payment requirements by MAOs to non-network providers may be found in the "MA Payment Guide for Out-of-network Payments," at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

- *DMEPOS Competitive bid program: On January 1, 2011, the FFS Medicare payment amount for DMEPOS competitive bid items furnished in Competitive Bidding Areas (CBAs) was reduced below the fee schedule payment. The new program only affects certain geographic areas and certain categories of DMEPOS; exceptions may apply. For the latest guidance refer to information at http://www.cms.gov/DMEPOSCompetitiveBid/. The new program will affect MA payments in those situations when an MA plan is only required to pay at least the FFS rate, for example, when reimbursing non-contracting suppliers. MAOs must disclose information on the new program to their plan members. MAOs should advise enrollees how the DMEPOS competitive bidding program will affect them and what they should do if they need to change suppliers, for example, in cases where a member's current supplier is not one of the "Medicare contract suppliers" under the DMEPOS competitive bidding program and they cannot be grandfathered under the DMEPOS competitive bidding program.*

The following circumstances are exceptions to the rule that MAOs must cover the costs of Original Medicare benefits:

- Hospice: Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. *However, an MA enrollee who has elected hospice and requires medical treatment for a non-hospice condition can do one of the following:*

  (1) Use plan providers and services. In such a case, the enrollee only pays plan allowed cost-sharing, and the provider would directly bill FFS for Parts A and B services); or

  (2) Use non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the enrollee would pay the total FFS allowed cost-sharing.

- Inpatient hospital stay during which enrollment ends: For the types of hospitals mentioned at 42 CFR 422.318(a), the MAO must continue to cover an inpatient hospital stay of a non-plan enrollee if the individual was an enrollee at the beginning of the inpatient hospital stay. *Note that:*

  - *Incurred non-inpatient services are paid by Original Medicare or the new MAO the enrollee joined as of the effective date of the new coverage;*

  - *Enrollee cost-sharing for the inpatient hospital stay is based on the cost-sharing amounts as of the entry date into the hospital;*

- *If the enrollee was in a SNF in December in an MAO that does not require a prior qualifying 3-day hospital stay and then joined Original Medicare on January 1st, the enrollee may continue staying in the SNF (if medically required) without a three-day qualifying hospital stay.*

- Clinical trials: Original Medicare pays for the costs of routine services provided to an MA enrollee who joins a *qualifying* clinical trial. MA plans pay the enrollee the difference between fee-for-service cost-sharing incurred for *qualifying* clinical trial items and services and the MA plan's in-network cost-sharing for the same category of items and services. *For further information on coverage and payment of clinical trials in MA plans, see section 10.13 of this chapter.*

In addition to providing Original Medicare benefits, to the extent applicable, the MAO also furnishes, arranges, or pays for supplemental benefits and prescription drug benefits to the extent they are covered under the plan.

CMS reviews and approves an MAO's coverage of benefits by ensuring compliance with requirements described in this manual, including this chapter, Chapter 7, "Payments to Medicare+Choice Organizations" Chapter 8, "Payments to Medicare Advantage Organizations," and other CMS instructions, such as the guidance contained in the annual Call Letter.

10.5 - Part D Rules for MA Plans

(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

As provided in 42 CFR 422.4(c), an MAO cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MAO in that same service area includes Part D prescription drug coverage. Part D prescription drug coverage is defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual. This rule requiring that at least one MA plan be offered in an area with Part D coverage applies only to coordinated care plans. For more information about this rule, refer to section 20.4.4 of Chapter 5 of the Prescription Drug Benefit Manual.

Regardless of whether an MAO offers a coordinated care plan in the area with Part D benefits, all Special Needs plans (SNPs) are required to include Part D prescription drug coverage (see the definition of SNPs in 42 CFR 422.2).

The guidance provided in this section only applies to the provision of Part D prescription drug benefits. For guidance governing OTC (Over-the-Counter) drug benefits, see section 40 of this chapter.

Table I: Part D Prescription Drug Coverage by Plan Type

Plan Type	Regional or Local MA Plan?	Must offer Part D?	Can an enrollee elect a PDP?
MA Coordinated Care Plan (CCP)			
HMO, Point of Service (HMO-POS), Provider Sponsored Organization (PSO)	Local	Yes, unless another non-SNP MA plan offered by the same organization in the same service area includes required prescription drug coverage under Part D (42 CFR 422.104(f)(3)). See footnote 1 for details.	No
PPO	Either	Yes, unless another non-SNP MA plan offered by the same organization in the same service area includes required prescription drug coverage under Part D (42 CFR 422.104(f)(3)). See footnote 1 for details.	No
Special Needs Plan (SNP)	Either	Yes, required	No
Private Fee-for-Service (PFFS) plan	Local	No	Yes, provided the PFFS plan does not offer Part D coverage.
MA Medical Savings Account (MSA) Plan	Local	Not permitted	Yes
Section **1876 Cost Plans**			
Cost plan offering qualified Part D prescription drug coverage	NA	No, but Part D coverage can be offered as an optional supplemental benefit	Yes
Cost plan offering non-qualified prescription drug coverage	NA	No. The cost plan cannot offer both Part D coverage and non-qualified prescription drug coverage.	Yes
Section **1833 HCPP (Health Care Pre-payment Plan)**	NA	No	Yes
PACE Programs (Program for the All inclusive Care of the Elderly)	NA	Yes[2]	No

Notes to Table I:

1. See section 20.4.4 of Chapter 5 of the Prescription Drug Benefit manual located at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage for the definition of required drug coverage.

2. PACE Providers offering PACE Programs, as defined in section 1894 of the Act generally have elected to provide Part D coverage in order to receive payment for the prescription drug coverage that they are statutorily required to provide.

10.6 – Anti-Discrimination Requirements
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An MA plan may not deny, limit, or condition enrollment to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

- Claims experience;
- Receipt of health care;
- Medical history and medical condition including physical and mental illness;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of domestic violence; and
- Disability.

Additionally, an MAO *must*:

- Comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008; *and*
- Ensure that its MA plans have procedures in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

However, *in certain cases, an MAO may deny enrollment based on medical status*. There are three situations where enrollment may be denied based on the presence or absence of a medical condition:

- In a SNP, to a person who does not fulfill the eligibility criteria for enrollment in the SNP;

- *To a person with end-stage renal disease (ESRD),* under the circumstances mentioned in section 20.2 of Chapter 2 of this manual, "Enrollment and Disenrollment" located at http://www.cms.hhs.gov/Manuals/IOM/, Publication 100-16; and

- *To a person receiving hospice benefits prior to completing an enrollment request for an MSA plan. Refer to* section 20.*10* of Chapter 2 of this manual, "Enrollment and Disenrollment" located at http://www.cms.hhs.gov/Manuals/IOM/, Publication 100-16.

The following websites contain useful information about discrimination:

- *http://www.eeoc.gov/policy/adea.html, and*

- *http://www.ada.gov/.*

10.8 – Confidentiality and Accuracy of Enrollee Records
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

With respect to confidentiality and accuracy of enrollee records, for any medical records or other health and enrollment information it maintains with respect to enrollees, an MAO must establish procedures to:

- Abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. The MAO must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify:

  - For what purposes the information will be used within the organization; and

  - To whom and for what purposes it will disclose the information outside the organization;

- Ensure that medical information is released only in accordance with applicable Federal or state law or pursuant to court orders or subpoenas;

- Maintain the records and information in an accurate and timely manner; and

- Ensure timely access by enrollees to the records and information that pertain to them.

For purposes of CMS audits of risk adjustment data, upon which health status

adjustments to CMS capitation payments to MAOs are based, and for the purposes set forth below, network providers *and* deemed contracting providers *(of PFFS plans) must be required* under *their contracts or the plan's Terms and Conditions of Payment* to provide medical records requested by the MAO.

Purposes for which medical records from providers are used by MAOs include:

- Advance determinations of coverage;
- Plan coverage;
- Medical necessity;
- Proper billing;
- Quality reporting;
- Fraud and abuse investigations; and
- Plan initiated internal risk adjustment validation.

To encourage providers to submit member medical records to the plan an MAO may choose to facilitate the process by sending staff to assist in the record collection or by reimbursing providers for the costs associated with furnishing the records. MAOs are prohibited from using medical record reviews to delay payments to providers. Both required and voluntary provision of medical records must be consistent with HIPAA privacy *statute and regulations (http://www.hhs.gov/ocr/privacy/)*

10.9 - Benefit Requirements
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

All benefits offered by any MA plan, independent of plan type, must:

- Be priced in the bid; the plan incurred bid-priced cost should not be solely administrative;
- Fulfill requirements in section 30.1 and 30.2, such as anti-*discrimination*; and
- Be specified in the appropriate marketing vehicles as indicated in the Medicare Marketing Guidelines located at http://www.cms.hhs.gov/Manuals/Downloads/mc86c03.pdf.

All plans, independent of plan type:

- Must offer basic benefits as described in section 10.3;

- May only offer supplemental benefits that are directly health-related, that is, health care services or items whose primary purpose is to prevent, cure, or diminish *an* actual or *expected* illness or injury (See section 30.1); and

- Must provide in a timely manner a written advance coverage determination to enrollees and non-contract or deemed providers who request this information. A written advance coverage determination is a determination by the plan prior to *provision of* a service confirming whether that service is both medically necessary and a plan-covered service and in consequence will be paid for by the MA plan (see 42 CFR 422.566). All MA plans should provide in their member materials clear explanations of the process for requesting a written advance coverage determination

- Local PPO, RPPO, PFFS, and MSA plans may not establish prior notification rules under which an enrollee is charged lower cost-sharing when either the enrollee or the provider notifies the plan before a service is furnished (42 CFR 422.4(a)(1)(v), (a)(2), and (a)(3)).

10.10 - Uniformity
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The following rules apply to any MA plan, independent of plan type:

- An MAO offering an MA plan must offer all plan benefits uniformly to all enrollees residing in the service area of the plan;

- An MAO offering an MA plan must offer it at a uniform premium, with uniform benefits and cost-sharing throughout the plan's service area or segment of service area when such segments have been approved, to all Medicare beneficiaries with Parts A and B of Medicare (See section 20 of Chapter 1 of this manual, "General Provisions," for the definition of segment);

- The uniform premium requirement prohibits plans from offering nominal discounts to those enrollees electing to pay premiums electronically.

- All plans must offer to, but may not require of, their enrollees the option of:

  - Having their premiums deducted from their Social Security check or benefit;

  - Having their premiums paid by an electronic transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); and

  - Paying their premium by check.

The following guidance applies to benefit package designs that include tiered cost-sharing of medical benefits:

- *On a limited basis, a plan may tier cost-sharing of medical benefits based on service category – for example, inpatient hospital services – provided:*
    - *The plan fully discloses tiered cost-sharing amounts and requirements to enrollees and plan providers;*
    - *The services at each tier of cost-sharing are equally accessible to all plan enrollees; and*
    - *All beneficiaries are charged the same amount for the same service with the same provider.*
- *Tiered cost-sharing of medical benefits may not be based on the provider group an enrollee selects within an MA plan. For example, if an MA plan offers access to two or more physician groups, it may not require different cost-sharing based on the physician group the member selects upon enrollment. Basing a plan's cost-sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan and, therefore, conflicts with the uniformity of premium and cost-sharing requirement (see 42 CFR 422.100(d)(2)).*
- *The cost-sharing amount for post-stabilization services must be the same or lower for non-plan providers as for plan providers.*
- *CMS does not classify the following differential cost-sharing as prohibited tiering when the variation in cost-sharing is based on:*
    - *Facility settings for furnishing some services, such as diagnostic imaging services;*
    - *In-network versus out-of-network services, as explained in sections 100.1 and 110.4; and*
    - *DME and Part B drugs, as explained in section 50.1.*

10.11 - Caps on Enrollee Financial Responsibility
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Although MAOs have certain rights of collections, in *the* instances *described below*, the enrollee is "held harmless," that is, the enrollee is protected by a limit on his/her financial responsibility:

1) Limitations on Enrollee Liability: CMS considers a contracted plan provider an agent of the MAO offering the plan. Consequently, the services and referrals s/he

gives are considered plan-approved unless notice is provided that the services will not be covered. An enrollee who receives a service or item from a contracted plan provider or a provider referred by a contracted plan provider is therefore held harmless and need not pay more than the plan-allowed cost-sharing (e.g., coinsurance, copays and deductibles). The enrollee is held harmless independent of whether:

- The service is otherwise plan covered;
- The enrollee was advised of the need for a referral; and
- The referral was properly done.

Also note that the MAO cannot retroactively overturn the decision by a contracted provider to provide the service or item or refer the enrollee to another provider.

2) No balance billing: As indicated in Section 10.22, an enrollee *is responsible for paying* non-contracted providers *only* the plan-allowed cost-sharing *for covered services*. The MAO, not the enrollee, is obligated to pay balance billing *when it is allowed under Medicare rules*. Furthermore, if an enrollee inadvertently paid balance billing, the MAO must refund the balance billing amount to the enrollee.

3) No reimbursement relationship: A plan may not require a beneficiary to pay a contracted provider and then receive reimbursement.

4) Provider-enrollee relationships: Providers are frequently called upon to give advice, as an enrollee may need services and procedures that are not provided or covered by the plan. A *plan* provider who refers a patient to *another* provider for a non-covered service must ensure that the enrollee is aware of his or her obligation to pay in full for such non-covered services. Similarly, a network provider who *furnishes* a non-covered service (for example, *a* service *that* is not part of the plan benefit package) should clearly advise the enrollee prior to *furnishing the* service of the enrollee's responsibility to pay the full cost of the service. For the requirements for issuance of notices of non-coverage see Chapter 13 of this manual located at http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf.

Missed Appointment Charges: MAOs may charge "administrative fees" to enrollees for missed appointments with contracting providers and for not paying *required cost-sharing* at the time of service with a contracting provider. Under the MA program such charges are allowable *only* if the charge is priced in the bid and documentation submitted with the bid clearly shows these charges are priced in the bid. Furthermore, these additional charges must be clearly outlined in the notes section of the PBP and be included in the Evidence of Coverage.

If the MAO itself does not charge an administrative fee for missed appointments then any individual provider – whether or not that provider contracts with the plan - may still charge a fee for missed appointments, provided such fees apply uniformly and at the same amount to all Medicare and non-Medicare patients.

10.13 – *Clinical Trials*
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. The Clinical Trial National Coverage Determination (NCD) defines what routine costs means and also clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Refer to the Medicare Clinical Trial Policies page at http://www.cms.gov/ClinicalTrialPolicies/ for more information.

MA plans pay the enrollee the difference between Original Medicare cost-sharing incurred for qualified clinical trial items and services and the MA plan's in-network cost-sharing for the same category of items and services. This cost-sharing reduction requirement applies to all qualifying clinical trials. MAOs cannot choose the clinical trials or clinical trial items and services to which this policy applies. The MAO owes this difference even if the member has not yet paid the clinical trial provider. Additionally, the member's in-network cost-sharing portion must also be included in the plan's out-of-pocket maximum calculation.

To be eligible for reimbursement, beneficiaries (or providers acting on their behalf) must notify their plan that they have received qualified clinical trial services and provide documentation of the cost-sharing incurred, such as a Medicare Summary Notice (MSN). MAOs are also permitted to seek MA member FFS cost-sharing information directly from clinical trial providers.

MA plan enrollees are free to participate in any qualifying clinical trial that is open to beneficiaries in Original Medicare. If an MAO conducts its own clinical trial, the MAO can explain to its enrollees the benefits of participating in its clinical trial; however, the MAO may not require pre-authorization for a Medicare qualified clinical trial not sponsored by the plan, nor may it create impediments to an enrollee's use of a non-plan clinical trial, even if the MAO believes it is sponsoring a clinical trial of a similar nature. Examples of impediments include, but are not limited to, requiring enrollees to pay the original Medicare cost-sharing amount for routine care services before being compensated for the difference by the MAO or unduly delaying any required cost-sharing refund. The enrollee has final choice on which, if any, clinical trial to participate in. However, an MA plan can request, but not require, enrollees to pre-notify the plan when they are participating in clinical trials.

CMS's current clinical trial policy (July 2007 NCD) and information about clinical trials may be found on the CMS website at http://www.cms.gov/ClinicalTrialPolicies/ and in

the Clinical Trial NCD located in the NCD manual, Part 4, section 310, http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf. The clinical trial policy contains detailed information about the qualification process. Clinical trials that do not automatically qualify under the clinical trial policy are subject to local review and coverage by the MACs. MAOs may contact the clinical trial provider or the MAC for information about qualification and payment for clinical trial items and services. Category B IDE study and clinical trial claims processing instructions for both FFS and managed care enrollees (including required modifiers used to denote IDE studies and clinical trial items and services), are located in Pub. 100-4, the Medicare Claims Processing Manual in chapter 32, sections 68 and 69. http://www.cms.gov/manuals/downloads/clm104c32.pdf. In addition, the National Institutes of Health sponsors a website called Clinicaltrials.gov, which serves as a registry and public database for clinical trials. http://www.clinicaltrials.gov/

10.14 - Provider Qualifications
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Basic benefits must be furnished through providers meeting requirements that are specified in 42 CFR 422.204(b)(3) and discussed more fully in Chapter 6 *of this manual, "Relationships with Providers" which may be found at http://www.cms.gov/manuals/downloads/mc86c06.pdf.* In the case of providers meeting the definition of "provider of services" (a hospital, critical access hospital, SNF, comprehensive outpatient rehabilitation facility, home health agency, or other institutional providers), the provider must have a provider agreement with CMS. Supplemental benefits, defined in section 10.3, do not need to be provided through Medicare providers.

10.15 - Drugs that are Covered Under Part B Original Medicare
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

For this subsection, the term "drug" means "drug or biological." Drugs that are covered under Medicare Part B are governed by the Original Medicare regulations and local coverage decisions. For more coverage details, see the Medicare Benefits Policy Manual Publication 100-02, Chapter 15, Section 50 "Drugs and Biologicals" and the Medicare Claims Processing Manual, Publication 100-04, Chapter 17, and sections of the Manual referenced therein.

The following broad categories of drugs may be covered under Medicare Part B – subject to coverage requirements as well as regulatory and statutory limitations. *Note* that these examples are illustrative and not a comprehensive list.

- Injectable drugs that have been determined by Medicare Administrative Contractors (MACs) to be "not usually self-administered" and that are administered incident to physician services. For further information, see the Medicare Policy Benefits Manual Publication 100-02, Chapter 15, Section 50.2 and 50.3.

- Drugs that the MA enrollee takes through durable medical equipment (such as nebulizers) that were authorized by the enrollee's MA plan;

- Drugs covered under the statute, including but not limited to:

    - Certain vaccines (pneumococcal, hepatitis B (high or intermediate risk only) influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition). For further details, see section 50.4.4.2 of Chapter 15 of the Medicare Benefit Policy Manual: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf .

    Certain oral anti-cancer drugs and anti-nausea drugs;

    - Hemophilia clotting factors;

    - Immunosuppressive drugs;

    - Some antigens;

    - Intravenous immune globulin administered in the home for the treatment of primary immune deficiency;

    - Injectable drugs used for the treatment of osteoporosis in limited situations; and

    - Certain drugs, including erythropoietin, administered during the treatment of end stage renal disease.

If an MA enrollee wishes to receive a "not usually self-administered" drug in a physician's office, then the MAO must cover the drug and the service of administering the drug. MAOs may not determine whether it was reasonable and necessary for the patient to choose to have his or her drug administered incident to physician services. MAOs can continue to make determinations concerning the appropriateness of a drug to treat a patient's condition and the appropriateness of the intravenous or injection form, as opposed to the oral form of the drug.

Injectable drugs that the applicable MAC has determined are not usually self-administered, but that members purchase at a pharmacy and administer at home, may only be offered by MAOs as a Part D benefit, and cannot be offered as a Part C supplemental benefit. However, MA enrollees always have the option of receiving the Medicare-covered benefit, i.e., administration of the covered drug, in a physician's office from the physician's stock of drugs.

Some drugs are covered under either Part B or Part D depending on the circumstances. For clarification on coverage under Part B versus Part D, see Appendix C of Chapter 6 of the Part D Prescription Drug Benefit Manual located at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/R2PDBv2.pdf. It is critical to understand when a drug is covered under Part B or Part D in order to ensure that Part C and Part D bids properly reflect appropriate coverage under either Part B or Part D.

10.18 – *Access to* Screening Mammography *and* Influenza Vaccine
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Enrollees of an MAO may directly access (through self-referral to any plan participating provider) in-network screening mammography and influenza vaccine.

10.19 - Return to Home Skilled Nursing Facility (SNF)
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An MA plan must provide coverage *through a home SNF (defined at 42 CFR 422.133(b))* of post-hospital extended care services to enrollees *who resided in* a nursing facility prior to *the hospitalization, provided:*

- The enrollee elects to receive the coverage through the home SNF; *and*
- *The home SNF either has a contract with the MAO or agrees to accept substantially similar payment under the same terms and conditions that apply to similar nursing facilities that do contract with the MAO.*

This requirement also applies if the MAO *offers* SNF care *without requiring* a prior qualifying hospital stay.

The post-hospital extended care scope of services, cost-sharing, and access to coverage provided by the home SNF must be no less favorable to the enrollee than post-hospital extended care services coverage that would be provided to the enrollee by a SNF that would be otherwise covered under the MA plan (42 CFR 422.133(c)). In particular, in a PPO, in-network cost-sharing applies.

10.21 - Therapy Caps and Exceptions
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Certain services are exempted from Original Medicare *caps for* rehabilitation services. Complete details can be found in section 10.2 of chapter 5 of publication 100-04, the Medicare Claims Processing Manual, at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

10.22 – Balance Billing
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The guidance in this section applies to HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), and RPPOs (Regional PPOs).

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO, is that they do not pay more than plan-allowed cost-sharing. *Providers who* are permitted to balance bill must obtain this balance billing from the MAO.

Note: Under Original Medicare rules, *an Original Medicare participating provider (hereinafter referred to as* a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. The MACs post lists of participating providers. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. *An Original Medicare* non-participating provider (*hereinafter referred to as a non-participating, or non-par, provider*) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS *5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of *MA-plan* non-contracting and *Original-Medicare* non-participating providers are listed below by type of provider.

- Contracted provider. There is no balance billing paid by either the plan or the enrollee.

- Non-contracting, participating provider. There is no balance billing paid by either the plan or the enrollee;

- Non-contracting, non-participating provider. The MAO owes the non-contracting, non-participating (non-par) provider the difference between the member's cost-sharing *and* the *Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider*. The enrollee only pays plan-allowed cost-sharing, which equals:

    - The copay amount, if the MAO uses a copay *for its cost-sharing; or*

    - *The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance* method for its cost-sharing.

- *MA-plan* non-contracting, non-participating DME supplier. The MAO owes the non-contracting non-participating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or

- *The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing.* Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in "MA Payment Guide for Out-of-network Payments," at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

MA plans must clearly communicate to enrollees through the Evidence of Coverage (EOC) and Summary of Benefits (SB) their cost-sharing obligations as well as their lack of obligation to pay above allowed plan cost-sharing whether the payments go to the provider bill or to balance billing.

10.24 – In-network Preventive Services
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

MAOs are required to offer all Medicare preventive services *that are covered at zero cost-sharing under Original Medicare* at zero cost-sharing. *CMS will provide annual guidance to MAOs on which Medicare preventive services must be covered at zero cost-sharing for the following contract year.*

MAOs may not charge for facility fees, professional services, or physician office visits if the only service(s) provided during the visit is a *preventive service that is covered at zero cost-sharing under Original Medicare*. However, if during provision of the preventive service, additional non-preventive services are furnished, then the plan's cost-sharing standards apply.

The following CMS publications provide valuable information for plans:

- Your Medicare Benefits, http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf, which contains a list of Medicare covered preventive services furnished by Original Medicare. As noted in the publication, the preventive status of certain services is dependent on referrals. For example, as explained in these publications, *abdominal aortic aneurysm screening* is covered as a preventive service only when referral is made as a result of the one-time "Welcome to Medicare" physical exam.

- Medicare and You, http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

In addition, the Affordable Care Act of 2010 established a new Medicare covered preventive service, the "*annual wellness visit.*" Information about this benefit *may be found at http://www.medicare.gov/navigation/manage-your-health/preventive-services/medicare-physical-exam.aspx*.

20.1 – Ambulance *Services*
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The MAO is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, when *either an emergency situation exists as defined in section 20.2*, or other means of transportation would endanger the beneficiary's health. *The enrollee is financially responsible for plan-allowed cost-sharing*. Medicare rules on coverage for ambulance services are set forth at 42 CFR 410.40. For Original Medicare coverage rules for ambulance services, *refer to* chapter 10 of the Medicare Benefit Policy Manual, publication 100-02, located at http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf.

20.2 – Definitions of Emergency and Urgently Needed Services
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Urgently-needed services are covered services that:

- Are not emergency services as defined in this section;
- Are provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area, or the plan network is otherwise not available; and

- Are medically necessary and immediately required, meaning that:
    - The urgently needed services are a result of an unforeseen illness, injury, or condition; and
    - Given the circumstances, it was not reasonable to obtain the services through the MA plan's participating provider network.

Note that under unusual and extraordinary circumstances, services may be considered urgently-needed services when the enrollee is in the service or continuation area, but the organization's provider network is temporarily unavailable or inaccessible.

The following example is an illustration of urgently-needed services:

> Example: A beneficiary has been under the care of a dermatologist for many years for a chronic skin condition. However, while the member was out of the service area, the condition flared up and the beneficiary needed to see a local doctor.
>
> The required services are urgently-needed and, therefore, the plan is obligated to provide for them. Even though the enrollee was aware of the chronic skin condition, the flare up was unforeseen. Although the flare-up is not a medical emergency, it does require immediate medical attention, and it was unreasonable for the enrollee to return to the service area. Therefore, the plan *is financially responsible for the urgently-needed* medical care.

20.4 – Stabilization of an Emergency Medical Condition
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MAO. *Refer to section* 20.6 below for the MAO's obligations regarding services provided following stabilization. Chapter 13 of this manual, "MA Beneficiary Grievances, Organization Determinations, and Appeals," addresses the enrollee's right to request a Quality Improvement Organization review *of* hospital discharges to a lower level of care. For transfers from one inpatient setting to another inpatient setting, an enrollee, or person authorized to act on his or her behalf, who disagrees with the decision and believes the enrollee cannot safely be transferred, can request that the organization pay for continued out-of-network services. If the MAO declines to pay for the services, appeal rights are available to the enrollee.

20.5 - Limit on Enrollee Charges for Emergency Services
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Enrollees' charges for emergency department services cannot exceed the lesser of the following amounts:

- *The limit for emergency service cost-sharing that is published by CMS in its annual guidance*;

- What the enrollee would be charged in-network if s/he obtained the services through the MAO (refer to Table *VI* in section 110.4).

20.7 - Services of Non-contracting Providers and Suppliers
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An MAO must make timely and reasonable payment to, or on behalf of, the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MAO to provide services covered by the MA plan:

- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the beneficiary's health, as provided in section 20.1 of this chapter;

- Emergency and urgently needed services under the circumstances described in section 20.2 of this chapter;

- Maintenance and post-stabilization care services under the circumstances described in section 20.6 of this chapter;

- Medically necessary dialysis from any qualified provider selected by an enrollee when the enrollee is temporarily absent from the plan's service area and cannot reasonably access the plan's contracted dialysis providers. An MA plan cannot require prior authorization or notification for these services. However, the MA plan *may* provide medical advice and recommend that the enrollee use a qualified dialysis provider *if the enrollee voluntarily requests such advice because (s)he will be out of area*. The MA plan must clearly inform the beneficiary that the plan will pay for care from any qualified dialysis provider the beneficiary may independently select. Furthermore, the cost-sharing for out-of-network medically necessary dialysis may not exceed the cost-sharing for in-network dialysis; and

- Services for which coverage has been denied by the MAO and found (upon appeal under subpart M of 42 CFR Part 422) to be services the enrollee was entitled to have furnished, or paid for, by the MAO.

An MA plan (and an MA MSA plan, after the annual deductible has been met) offered by an MAO generally satisfies its requirements of providing basic benefits with respect to benefits for services furnished by a non-contracting provider if that MA plan provides payment in an amount the provider would have been entitled to collect under Original Medicare (see section 10.22 for guidance on balance billing).

30.1 – Definition of Supplemental Benefit

(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

In order for an item or service to be classified as a supplemental benefit, the following three conditions must be met:

(1) Primarily health related: The item or service must be directly health related; that is, the primary purpose of the item or service is to prevent, cure or diminish an illness or injury that is actually present or expected to occur in the future. If the primary purpose of the item or service is comfort, cosmetic or daily maintenance, then it may not be classified as a health benefit.

The primary purpose of an item or service is determined either by 1) national typical usages of most people using the item or service, or by 2) community patterns of care. See the examples below and Table II in section 30.3 for illustrative examples.

(2) Cost requirement: The MA plan must incur a non-zero direct medical cost in providing the benefit. If the MA plan only incurs an administrative cost, this cost requirement is not met. Note: The MAO must properly price all items in its submitted bid including administrative and medical cost components.

(3) Classification: The proposed benefit must be correctly classified as a supplemental benefit that is not furnished by Original Medicare. In reviewing whether this classification requirement is met it is important to emphasize that under Part A the statute covers any item or service that is considered medically necessary, as requested by a qualified Medicare provider for provision of care, in an institutional setting. Part B coverage is determined by the category to which the item or service belongs.

An item or service that meets the above three conditions may be proposed *as a* supplemental benefit *in a plan's bid and submitted plan benefit package*. Additional requirements governing approval of a proposed *plan* benefit package are *specified* in sections 30.2, 30.3 and 40 of this chapter. The final determination of benefit status is made by CMS during the annual benefit package review, after which the item or service may be called a supplemental benefit and offered as part of an approved *plan* benefit package.

In limited circumstances and for a limited short duration, an item or service that is normally classified as cosmetic, for-comfort or for-maintenance may, in a specific context, be classified as a health benefit provided the provision of the item or service is:

- Based on an underlying illness or hospital stay;
- Consistent with the *community* pattern of delivery of care for this illness; and
- Provided for a limited and short duration, typically two weeks or less.

Supplemental benefits may be provided by doctors, naturopaths, acupuncturists and chiropractors that are State licensed. Supplemental benefits may not be provided by licensed massage therapists (LMTs), since, as explained in section 30.3, an MAO may not offer a massage benefit. However, an MAO may offer a chiropractor visit as a benefit even *when* the chiropractor uses preparatory massages during the visit.

Original Medicare does not provide payment to non-Medicare beneficiaries, except in rare circumstances, for example, living donors of kidney transplants. Consequently, an MAO may not make payments on behalf of non-enrollees, including family members, for Original Medicare benefits in those situations where Original Medicare does not so provide.

Except in the special circumstances described in section 30.4, MAOs are similarly prohibited from providing payments to non-enrollees, including family members, for supplemental benefits. For example, an MA plan is prohibited from providing payments for transportation costs of a living donor in the case of a kidney transplant.

For further examples of benefits, refer to Table II in section 30.3. *MA plans with questions about whether a* proposed benefit *meets the definition of a supplemental benefit should email MABenefitsMailbox@LMI.org. This mailbox will typically be functional after release of MA bid and benefit guidance for the following contract year and for the duration of the bid season.*

30.2 - Anti-Discrimination Requirements
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

CMS reviews and approves MA benefit packages using statutes, regulations, policy guidelines and requirements in this manual, and other CMS instructions to ensure that:

- An MAO provides Medicare-covered services that meet CMS guidelines under Original Medicare;
- An MAO does not offer a cost-sharing structure or plan benefits that:
  - *Conditions eligibility for a supplemental benefit on utilization. For example, a plan may not condition the offering of a gym benefit based on an enrollee meeting minimal gym attendance requirements;*
  - Promote discrimination;
  - Discourage enrollment;
  - Encourage disenrollment;
  - Steer specific subsets of Medicare beneficiaries to particular MA plans (with the exception of SNPs);

- Inhibit access to services;

- Design cost-sharing differentials in such a way as to unduly limit choice or availability to the beneficiary. An MAO:

  - May not, for example, charge higher copays for all providers in the western portion of the county while charging lower co-payments for providers in the eastern portion of the county;

  - As indicated in section 10.10, must clearly disclose any tiered cost-sharing to its enrollees; and

  - May not design a plan with supplemental benefits that only appeal to healthier beneficiaries; *or*

- Benefit designs meet other MA program requirements.

Section 50.1 of this chapter contains general guidance on *acceptable* cost-sharing. The anti-discrimination prohibitions *in this section* apply to both Original Medicare, mandatory supplemental, and optional supplemental benefits.

30.3 - Examples
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Sections 30.1 and 30.2 outline the general theory of supplemental benefits. Many supplemental benefits – for example, vision, hearing, and dental – are standard, well known, and *included* in the widely circulated Medicare & You Handbook. Table II below contains an alphabetized list *other supplemental* benefits. These examples *are based on our experience with annual benefit reviews*. Each example is classified as being, or not being, a potential supplemental benefit. Table II also provides an explanation of the classification based on the guidance provided in sections 30.1 and 30.2. The list of examples in Table II is intended to be illustrative, not exhaustive. Table **II** complements Table *IV*, provided in section 40.9, explaining which over-the-counter (OTC) items *may be offered* as benefits. Although some of the items listed in Table II may not be offered as supplemental benefits under the MA program, they may be offered under appropriate conditions under the Medicaid program to dual eligibles through an arrangement with the State. However, those items may not be included in a plan's *plan benefit package* (PBP) or *bid pricing tool* (BPT).

Table II: Alphabetical list of items *and services* and their potential supplemental benefit status

Item / Service	*May the item be offered as a Supplemental Benefit?*	*Rationale / Reasons / Comments / Further examples.*

Assisted Daily Living (ADL) assistance	No, *ADL services may not be offered as a supplement benefit.*	*The* primary purpose *of ADL assistance* is maintenance.
Batteries	No, *batteries may not be offered as a supplemental benefit* if *they* come by *themselves* (e.g., replacement batteries for hearing aids). Yes, *batteries are allowed as a supplemental benefit* if *they are* factory-packaged with a benefit item – for example, batteries in an original package from the factory with a hearing aid.	The primary purpose of a battery is to provide electrical current, not to cure hearing loss. (The goal and a secondary effect of battery usage is to power the hearing aid to reduce hearing loss; however, benefit status is determined by primary purpose, not by goals or secondary effects.) This example applies generally to add-ons.
Beauty Salon *Services*	No, *beauty salon services may not be offered as a supplemental benefit*.	*The* primary purpose of *beauty salon services are* cosmetic.
Cash	No, *cash may not be offered as a supplemental benefit.*	*There is a* statutory prohibition *on offering cash.*
Contact Lens Cases	No, *contact lens cases are not allowed as a supplemental benefit* if *they are* offered separately *from the contact lens.* Yes, *contact lens cases are allowed as a supplemental benefit* if factory packaged with the contact lens.	See the explanation above under "batteries."
Dentures	Yes, *dentures may be offered as a supplemental benefit.*	The primary purpose of dentures is to address symptoms of lack of teeth.
Educational Materials	Yes, *educational materials may be offered as supplemental benefits*, if the subject of the teaching is itself eligible to be a benefit. No, *educational materials may not be offered as supplemental benefits*, if the	Educational pamphlets on gym exercises, Tai chi, etc. are allowed as benefits, since these items can themselves be allowed as benefits. Educational materials on *subjects such as* home repairs, *which are not*

	subject of the teaching – for example, home repair – is not eligible to be a benefit.	*allowable benefits*, may not be offered as a benefit.
Electronic Monitoring (Notification devices in case of a fall)[1]	Yes, *electronic monitoring devices may be offered as a supplemental benefit.* No, *cell phones are not allowed as a supplemental benefit, even when intended as monitoring devices).*	The primary / sole purpose of electronic monitoring devices is to prevent or cure injury; however. the primary purpose of cell phones is communication. Intent to provide them for monitoring does not change their primary status.
Gym benefit including exercise classes at a gym, such as Tai Chi, yoga and dance classes	Yes, *gym benefits may be offered as a supplemental benefit.*	The primary purpose of a gym benefit is prevention through exercise.
Homemaker services (including maid service)[2]	No, *homemaker services cannot be offered as a supplemental benefit.*	The primary purpose *of homemaker services* is convenience.[3]
Manicures / Pedicures	No, *manicures / pedicures may not be offered as a supplemental benefit.*	*The* primary purpose *of manicures / pedicures* is cosmetic.
Massages	No, *massages by themselves may not be offered as a supplemental benefit.* Note: Chiropractor visits may be covered *as supplemental benefits* (even when preparatory massages are used).	Massages, by themselves, are not benefits (even when offered by a State licensed massage therapist). *A chiropractic visit may be offered as a benefit since the primary purpose of going to a chiropractor is to cure symptoms of diseases or injuries.*
Meals	No, *meals are generally not allowed as benefits.* *Note: Refer to* section 30.5 for exceptional *cases when meals may be offered as a supplemental benefit.*	The primary purpose of meals is maintenance. *Refer to* section 30.5 for *an explanation of when meals may not be offered as a supplemental benefit benefits and the reason.*
Safety devices, shower safety bars and other bathroom safety devices	Yes, *all fall prevention devices in the bathroom may be offered as a supplement benefit.* No, smoke detectors, fire	*We allow all bathroom safety devices whose purpose is fall prevention.* *Fires in homes are not expected events. We do not*

	alarms, fire extinguishers, home assessment, and home repair services such as repair of rugs and stairway rails *may not be offered as a supplemental benefit.*	*allow safety devices to be offered as supplemental benefits outside the bathroom.*
Transportation (Medically necessary transportation[4]	Yes, *medically necessary transportation may be offered as a supplemental benefit.* No, monthly bus or train passes *may not be offered as supplemental benefits.*	The primary purpose of medically necessary transportation (to and from medical appointments) is to treat disease. However, the primary purpose of a monthly bus pass is convenience.

Notes to Table II:

1. Original Medicare covers certain electronic monitoring. The service / item in the table refers to additional electronic monitoring not covered by Original Medicare.

2. Homemaker (or maid) services include such items as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs. In specific circumstances described in the Home Health Manual, Original Medicare covers home health aides for beneficiaries who qualify. Under extremely limited circumstances, a home health aide who has performed his/her duties and has extra time may help out in the performance of household chores. If the Home Health Agency Manual indicates that a particular service is covered under Original Medicare, then the plan must also cover it; however, if the Home Health Agency Manual explicitly indicates that a particular service is not covered under Original Medicare, then an MA plan may not offer it either as an Original Medicare benefit or a supplemental benefit. For further details on the Original Medicare home health aide benefit, see 42 CFR 409.45. The Home Health Agency Manual is located at http://www.cms.gov/Manuals/PBM/list.asp, publication #11.

3. Here, primary purpose is measured by the typical usage of most people: most people employ maid service for purposes of convenience.

4. See section 30.4 for *more detail about* transportation benefits.

See section 30.4 for a full discussion on transportation benefits

30.4 - Transportation Benefits
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

There are situations when transportation may be a covered *supplemental* benefit. The following examples are illustrative (but not exhaustive):

Not covered by Original Medicare: An MA plan may create either a mandatory or optional supplemental transportation benefit *beyond those circumstances, indicated in sections 20.1 where Original Medicare covers transportation.* A typical example is transportation for bariatric surgery. Bariatric surgery is typically not available in every county, and Original Medicare does not cover transportation related to bariatric surgery. Therefore, an MA plan can provide this transportation as a supplemental benefit. If the MAO covers transportation as a supplemental benefit it must be priced in the bid and advertised in appropriate plan disclosure statements.

Original Medicare transplant services: As *explained* in section *10.2, every* MA plan must provide all Original Medicare services *to its enrollees*. For coordinated care plans, *in-network transplant* services may be provided outside of the service area of the plan if the services are accessible and available to enrollees, and the service delivery is consistent with patterns of care for Original Medicare beneficiaries who reside in the same area.

An MA plan, for reasons of cost *(as explained below)*, may wish to provide a required *Original Medicare* transplant *service* at a distant location *(further away than the normal community patterns of care for that service)*, even though *provision of this service is* available locally (*within* the service *area)* consistent with patterns of care for Original Medicare beneficiaries who reside in the *service* area.

The MA *plan's provision of a* transplant service at a distant location, further away than the normal community patterns of care *for transplant services, depends on the local cost of transplants:*

- *If the local providers of transplants, within the normal community patterns of care for transplants, are willing to cover transplants for MA enrollees at the Original Medicare rate then, although the MA plan may also offer transplants at a more distant location, the MA plan must allow enrollees the option of obtaining transplant services locally;*

- *If the local providers of transplants, within the normal community patterns of care for transplants, are not willing to cover transplants for MA enrollees at the Original Medicare rate, then the MA plan must alternatively offer transplants at a more distant location.*

When providing an Original Medicare service at a more distant location, further away than the normal community patterns of care for transplants, the MA plan must ensure that the distant location provides at least the same quality and timeliness of services as at the local providers of this service.

In any circumstance in which an MA plan provides transplant services *at a more distant location,* the MA plan must:

- Provide reasonable transportation for the member and a companion to the distant facility; and

- Provide reasonable accommodations for the member and a companion while present in the distant location for medical care.

The policy in this section is summarized in Table III.

Table III: Provision of Original Medicare transplant services at a distant location and related transportation and lodging.

Do the local providers - within the normal community pattern of care for an Original Medicare transplant services – accept Original Medicare rates for treating MA enrollees?		*May/Must the plan cover transplant services for enrollees who chose to obtain services locally, within the normal community patter of care for this Original Medicare transplant services?*	*May/must the plan provide Original Medicare transplant services at a distant location, further than the normal community patterns of care for Original Medicare transplant services?*	*May/must the plan provide transportation and lodging*
Yes		*Must provide*	*May provide*	*Must provide*
No		*May provide*	*Must provide*	*Must provide*

30.5 – Meals
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

As discussed in section 30.1, all benefits must be primarily health related. While nutritional counseling is a desired aspect of case and/or disease management, the provision of meals, meal vouchers or grocery vouchers to individuals, without an underlying need based on an actual illness, cannot be classified as a health care benefit, because it is not primarily health-care related in nature.

However, as mentioned in section 30.1, in specific non-standard situations, meals may be offered as a supplemental benefit provided the nutritional service is:

1) Based on an underlying illness;

2) Consistent with the normal pattern of delivery of care for this illness, that is, requiring either home delivery of meals, a special diet, or special diet foods; and

3) Offered for a short duration.

Below we provide examples of specific illness situations for which meal benefits may be offered as well as the meaning of the term "short duration."

Non-standard meal benefits may be *offered* to address the following two types of illnesses.

- For a traumatic illness – For example, immediately following surgery, an inpatient hospital stay, or exacerbation of a chronic illness with debilitation (i.e., ulcerative colitis or Crohn's disease with weight loss) or immediately following an acute incident (e.g., pneumonia with weight loss and decompensation). Meals may be offered for a temporary duration, typically a two-week or four-week period, per enrollee per year, provided they are *ordered* by a provider (not a social or case worker). As discussed in 42 CFR 422.112(b)*(3)*, after this temporary duration, the provider should refer the enrollee to community and social services for further meals if needed.

  If an MAO chooses to offer meals for a traumatic illness for four weeks or less, CMS will approve the benefit without further review. However, if the MAO proposes to offer meals for more than four weeks, CMS will request from the MAO justification for this longer duration and will review the proposed benefit to determine if it should be approved.

- For a chronic condition - For example, hypertension, high cholesterol, or diabetes. For a chronic condition meals may be offered, but only if they are:

  - Offered for temporary period, typically for two weeks, per enrollee per year.
  - *Ordered* by a provider (not a social or case worker); and
  - Part of a supervised program designed to transition the enrollee to life style modifications.

  If an MAO chooses to offer meals for a chronic condition for two weeks or less (and the other conditions listed above are fulfilled then) CMS will approve the benefit without further review. However, if the MAO proposes to offer meals for more than two weeks, CMS will request from the MAO justification for this longer duration and will review the proposed benefit to determine if it should be approved.

Social factors by themselves cannot justify classification of a nutritional service as an MA benefit. Social factors include limited income, an inability to pick up meals, poverty, dual eligible status, poor diet – even if measured by recognized survey instruments, or general statements by a provider that improved nutrition would result in better health status.

Note that all MA coordinated care plans are required to "coordinate MA benefits with community and social services generally available in the area served by the MA plan" (422.112(b)(3)). Therefore, CMS encourages plans to:

- Provide links to websites with nutritious diet planning information, such as MyPyramid.gov;

- Provide nutritional tips in their plan newsletters or on their plan websites; or

- Partner with social community services such as "Meals on Wheels".

However, the MA plan may not classify any of these community services as plan benefits. Additionally, an MA plan offering a meal benefit complying with the requirements described in this chapter may not advertise it as a "Meals on Wheels" benefit or use the term "Meals on Wheels" in the name of the benefit. It is important that prospective enrollees not confuse the limited CMS approved meals benefit with the broader services offered under the "Meals on Wheels" program. However, if an MA plan has entered into a contract with "Meals on Wheels" to furnish the approved meals benefit, it may inform its members that the meal benefit under the plan will be delivered by "Meals on Wheels."

30.8 – Supplemental Benefits Extending Original Medicare Benefits
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

In designing supplemental benefits that resemble Original Medicare benefits, four important principles must be observed:

Medical Necessity: All MAOs must cover all medically necessary Original Medicare benefits (section 10.2). An MAO may *only* offer additional coverage, beyond *those* furnished by Original Medicare, as a supplemental benefit, *provided that coverage is medically necessary*.

- *Example*: An MAO may offer additional inpatient hospital days as a supplemental benefit. All Original Medicare manuals may be found in the Internet-only and Paper-based Manual links located at http://www.cms.hhs.gov/Manuals/.

- *Example: An MA plan may not offer home health coverage or home health services beyond that covered by Original Medicare, if the Home Health Agency manual has classified those additional services as not covered by Original Medicare because they are not considered medically necessary. The Home Health Agency Manual is located at* http://www.cms.gov/Manuals/PBM/list.asp, *publication #11*.

Distinct Naming: An MAO should be careful in the selection of terminology describing a supplemental benefit that furnishes coverage beyond that of Original Medicare. For example:

- An MAO offering additional inpatient hospital coverage as a supplemental benefit should preferably refer to this benefit as "extended inpatient hospital

coverage," "additional inpatient hospital *days,"* or similar terms *in order to distinguish the benefit from the Part A benefit the plan is required to provide in its benefit package.*

Enrollee services: An MAO may not offer as a benefit services furnished to a person other than the enrollee (unless Original Medicare specifically allows such services, for example, Original Medicare coverage of a living donor for medical complications arising from a kidney transplant).

- *Example. Other than the Original Medicare respite benefit, an MA plan may not offer as a supplemental benefit other types of caregiver or custodial support (whether to SNF or non-SNF enrollees). However, an MAO may, and is even encouraged to, advise in plan newsletters or other similar vehicles of services to assist caregivers in obtaining relief provided the plan does not refer to these services as benefits. For information on the Original Medicare respite benefit see publication 100-02, The Medicare Benefit Policy Manual, Chapter 9, section 40.2.2. The list of manual links may be found at* http://www.cms.hhs.gov/Manuals/IOM/list.asp.

Marketing Requirements: An MAO, in its *marketing materials* and PBP *descriptions* of Original Medicare benefits, should not single out specific aspects of the benefit. For example, it suffices for an MAO to state that it offers "ESRD services;" it need not further mention that "living donor expenses" are covered since "ESRD services" specifically includes "living donor expenses" and it would be misleading from a marketing perspective to single out *only* one aspect of the benefit.

- *Example: While an MAO must offer "Occupational Therapy," it should not in its marketing materials single out any particular aspect of this coverage, such as massage therapy, and indicate that it offers "massage therapy" as a benefit. Similarly, although an MAO may offer "chiropractic visits" as a benefit, the description of the benefit should be "chiropractic visits" without use of the word "massage," even though the chiropractor may use preparatory massage therapy during the visit.*

- *Example: Although an MAO must offer in the PBP "ESRD services"* it may not specifically mention "living donor coverage," as this is already included in the Original Medicare benefit, and separately identifying it could imply that it is a supplemental benefit.

30.9 - Benefits during Disasters and Catastrophic Events
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

If, in addition to a Presidential declaration of a disaster or emergency under the Stafford Act or National Emergencies Act, the Secretary of Health and Human Services declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary of Health and Human Services has the right to exercise her waiver authority

under Section 1135 of the Social Security Act. If the Secretary exercises her Section 1135 waiver authority, detailed guidance and requirements for MA plans-- including timeframes associated with those requirements -- for MA plans will be posted on the Department of Health and Human Services (DHHS) website, (http://www.dhhs.gov/) and the CMS web site (http://www.cms.hhs.gov/). In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – MA plans are expected to:

1. Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare certified facilities);

2. Waive in full, requirements for *gatekeeper referrals where applicable*;

3. Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts;

4. Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, plans should resume normal operations 30 days from the initial declaration.

CMS still reserves the right to assess each disaster or emergency on a case-by-case basis and issue further guidance supplementing or modifying the above guidance.

During emergencies or disasters in which the Secretary has invoked his or her authority under Section 1135, information about the waivers is posted on the Department of Health and Human Services (DHHS) website. The CMS web site also will provide detailed guidance for MA plans in the event of a disaster or emergency in which the Secretary's 1135 waiver authority is being exercised. During these disasters and emergencies, MA plans should check these web sites frequently.

If the President has declared a major disaster, or the Secretary of DHHS has declared a public health emergency, then MA plans must follow the guidance in Chapter 5 of the Prescription Drug Benefit Manual, Section 50.12, regarding refills of Part D medications. The Prescription Drug Benefit Manual may be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage.

40.4 - Benefit Status

(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

As indicated in the introduction to this section, not all OTC items may be offered as benefits. More specifically:

- If a plan is offering items under its Part D utilization management protocols, then the items it may offer are discussed in section 60.2 of Chapter 7 of the Part D Prescription Drug Benefit Manual as described in section 40.2 above; and

- If the plan is offering a Part C OTC supplemental benefit consisting of either a few items or a packaged benefit, and independent of payment method, then the plan may only cover items belonging to the categories listed in the eligible and dual-purpose item sections of Table *IV* in section 40.9. This table was created based on the guidance in sections 30.1 and 30.3 which discussed the definition of benefit. Items belonging to categories in the non-eligible portion of Table IV may not be offered as a Part C supplemental benefit. Should a plan wish to include on its OTC list categories of items not listed as eligible or dual purpose which are not found on Table IV, it must first obtain permission from CMS.

We emphasize that this table outlines categories of items rather than individual items. As a simple example, since cough medicines are listed as an eligible category of OTC items a plan not using a catalog delivery method that chooses to offer cough medicines as a Part C OTC supplemental benefit may not choose to cover only specified items and brands. Once the plan chooses to cover cough medicines, it must cover all cough medicines.

Table *IV* contains:

- Eligible OTC Items: Certain OTC items may always be offered;

- Non-Eligible OTC Items: Certain items may never be offered; and

- Dual Purpose OTC Items: Certain items may be offered after appropriate conversations with the enrollee's personal provider who orally recommends the OTC item for a specific diagnosable condition.

Among the items that may be offered as benefits, only certain items are typically electronically linked to a debit card. In the remainder of this chapter we will use the phrases "admissible OTC item" or "permissible OTC item" to refer to an OTC item that is classified as either eligible or dual-purpose in Table *IV* in section 40.9.

40.9 - CMS Table of OTC Items

(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Table *IV* below *includes* a detailed list of items. The items are presented by category. The following principles will facilitate correct usage of the list:

- Categories vs. items: As indicated in section 40.4, Table *IV* below lists categories of items. MA plans should not steer enrollees to particular brands of items. For example, if an MA plan does not deliver its OTC benefit though a catalog, and its Part C OTC list includes headache medications such as Excedrin, it must cover all brands of headache medications;

- Categories not on the list: Each plan must publish, on its plan website, or in catalogs or other marketing materials, the list of categories of items, or in the case of delivery by a catalog payment method, the list of items, that a plan enrollee may purchase. The plan list need not be identical with the list below however the plan list may not include as eligible, any items marked non-eligible. Should the plan wish to include on its own list categories of items not listed as eligible or dual purpose which are not found on the list below they must first obtain permission from CMS;

- Three eligibility categories: The list has three types of items. The type is listed in the first column:

    - The purchase of eligible items, if listed on the plan OTC list, are covered by the plan;

    - The plan OTC list must include non-eligible items. Enrollees must be instructed that non-eligible items, if purchased, will not be covered by the plan;

    - The purchase of dual purpose items, if listed on the plan OTC list, are covered by the plan but the plan must, in their marketing materials, advise enrollees that prior to purchase the enrollee must have appropriate conversations with his/her personal provider who orally recommends the OTC item for a specific diagnosable condition. CMS does not require written recommendations. However, MAOs may require written recommendations for purchase of dual purpose or eligible items.

- Debit card linkages: If the plan provides a packaged Part C OTC benefit paid by a debit card then it should be aware of differences between its own plan Part C OTC list and the official list of items electronically linked to the debit card. The following three examples illustrate the situations that plans must formulate instructions for:

    - Dual Purpose: Many electronically linked cards may not allow purchase of dual-eligible items. Consequently the plan must explicitly provide instructions to enrollees on how to purchase such dual-eligible items, for example vitamins and minerals;

- Acne / Sunscreen: Certain items – for example, acne treatment or sunscreen lotion– are classified as eligible on the CMS list, but are classified as dual-purpose or non-eligible on some electronic debit cards. In this case (should the plan for example, wish to cover acne treatment or sunscreen lotion), the plan must notify the enrollee that acne treatment or sunscreen lotion may only be purchased through a catalog or direct reimbursement after a mail-in of receipts; and

- Baby Items: Many electronically linked cards allow purchase of baby items. The plan must explicitly notify enrollees that they may only purchase items on the plan list, even if other items are prohibited, and even if they are electronically linked to the plan debit card. As indicated in the last section, it is the plan's responsibility to ensure that the debit card is properly used.

- Part B/D: As indicated above several of the items in the table, under certain circumstances, may be covered under Part B or Part D.

Table IV: Eligibility *Status* of OTC *Items*.

Eligible?	Category	Sub-categories	Exceptions
Dual Purpose	Minerals	Includes both multi-vitamins, individual vitamins and minerals.	
Dual Purpose	Vitamins	Includes both multi-vitamins, individual vitamins and minerals.	
Dual Purpose	Items used to assist in weight loss		
Dual Purpose	Diagnostic Equipment	Equipment diagnosing: blood pressure, cholesterol, diabetes, colorectal screenings, HIV, etc.	Thermometers are classified as eligible not dual *purpose*; scales are non-eligible; pregnancy diagnosis items are non-eligible *(See footnote #4)*
Dual Purpose	Hormone replacement	Phytohormone, natural progesterone, DHEA	
Dual Purpose	Weight loss items	Phentermine, FucoThin, Alli, Hoodia	All OTC foods, such as protein shakes, even if heavily supplemented by nutrients, may not be offered as an OTC benefit

Eligible?	Category	Sub-categories	Exceptions
Eligible	Fiber supplements		Items which are primarily food with fiber added.
Eligible	First Aid supplies	Includes: Bandages, dressings, non-sport tapes.	Flashlights are non-eligible.
Eligible	Incontinence supplies.		
Eligible	Medicines, ointments and sprays with active medical ingredients that cure, diminish or remove symptoms.	For examples see footnote #1.	Homeopathic and alternative medicines including botanicals, herbals, probiotics, and neutraceuticals are non-eligible. For further exceptions see footnote #2.
Eligible	Sunscreen lotion		
Eligible	Support items	Compression hosiery, rib belts, braces, orthopedic supports.	Arch and insoles are non-eligible.
Eligible	Teeth / denture -related items / Mouth care	Toothbrushes, toothpaste, floss, denture adhesives, gum problems	Mouthwashes, bad breath items, and teeth-whiteners are non-eligible.
Non-eligible	Alternative medicines	Includes botanicals, herbals, probiotics and neutraceuticals.	
Non-eligible	Baby items		
Non-eligible	Contraceptives		
Non-eligible	Convenience (non medical) items	Scales, fans, magnifying glasses, ear plugs, foot insoles, gloves.	
Non-eligible	Cosmetics	For examples see footnote #3.	Sun-tan lotions are eligible. Medicated soaps, hand sanitizers, therapeutic shampoos, shampoos to fight dandruff are non-eligible.
Non-eligible	Food product or supplements	Sugar / salt supplements, energy bars, liquid energizers, protein bars,	Fiber products are eligible unless they are primarily foods

Eligible?	Category	Sub-categories	Exceptions
		power drinks, ensure, glucema.	with fiber added.
Non-eligible	Replacement items, attachments, peripherals.	Includes: Hearing aid batteries, contact-lens' containers, etc. when not factory packaged with the original item.	

Notes to Table *IV*:

1. Each item in the following alphabetized list is either a medicine, ointment or spray, or a condition which is addressed by a medicine, ointment or spray: acid, acne, allergy, analgesics (which reduce pain, inflammation), anti-arthritics, antibiotics, antiradicals, anti-diarrheas, anti-fungals, anti-gas, anti-histamines, anti-inflammatory, anti-insect, anti-itch, anti-parasitic, antiseptics, antipyretics(fever reducing), arthritis, asthma, blood clotting, bruises, burns, calluses, corns, colds, cold sores, cough, diabetes, flu, decongestants, dermatitis, eczema, digestive aids, ear drops, expectorants (mucus), eye drops, gastro-intestinal, hay fever, headaches, hemorrhoidal, incontinence, influenza, laxatives, (medicated) lactose intolerance products, lice, (medicated) lip products, menopausal, menstrual, sinus, motion sickness, nasal, osteoporosis, pain, psoriasis, pediculicide, rash, respiratory scars, sleep, smoking, snoring, sore throat, stomach, travel sickness, steroids, sunscreen, thrush, wart, worms, wounds, etc.

2. The following are not eligible: Baby medicines, contraceptives, dehydration drink, dry skin lotions (e.g. eucerin, aquaphor), hair-loss products, lactaid milk (because it is a food not a medicine), and shampoos to fight dandruff. Certain smoking cessation may be Part B. Certain diabetic supplies may be Part B or Part D. For the status of food supplements see Table *IV*.

3. Antiperspirants, chap stick, deodorants, facial cleansers, feminine products, grooming devices, hair conditioners, hair removal, hair bleaches, moisturizers, perfumes, shampoos, shaving and men's grooming, and soaps.

4. *For certain very specific diseases – for example, congestive heart failure or liver disease – daily or weekly weight fluctuations may indicate fluid buildup and affect medical treatment or medication. For these limited diseases, the MA plan will cover the purchase of scales as a supplemental, Part C, OTC item, provided the enrollee has discussed the purchase with his/her personal provider who orally recommends the purchase due to the specific disease. Similarly, purchase of OTC early-diagnosis pregnancy items are covered by the plan if the enrollee's personal provider orally recommends these diagnostic items for a specific disease or condition where early diagnosis affects medical treatment or medication. We*

recommend that MA plans indicate these exceptions in their own OTC lists by using footnotes rather than table entries because scales or pregnancy diagnosis items are not generally dual purpose except in rare cases.

50.1 – Guidance on Acceptable Cost-sharing
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

CMS, in its annual bid review of proposed plan packages, applies five categories of cost-sharing standards whose requirements are detailed below in items (1) through (5). Organizations should note that benefit design and cost-sharing amounts approved for a previous contract year will not be automatically acceptable for the following contract year because a separate, distinct review is conducted each contract year. Throughout this section, the term "cost-sharing" refers to co-payments, coinsurances and deductibles (42 CFR 422.2)

The five categories of cost-sharing standards are the following:

1. Maximum Out-of-Pocket (MOOP) and Catastrophic Limits. To ensure that MAO cost-sharing does not discourage enrollment of higher cost individuals, and to provide for transparent plan benefit designs that permit beneficiaries to better predict their out-of-pocket costs, all local MA plans (employer and non-employer) – including HMOs, HMOPOS, local PPO (LPPO), and PFFS plans – are subject to a mandatory maximum out-of-pocket (MOOP) limit on enrollee cost-sharing that includes costs for all Parts A and B services. The mandatory MOOP amount is set annually by CMS.

   Note: For any dual eligible enrollee, MA plans must count toward the MOOP limit only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost-sharing and not the cost-sharing amounts for services the plan has established in its plan benefit package. Effectively, this means that, for dual eligible enrollees who are not responsible for paying the Medicare Parts A and B cost-sharing, the MOOP limit will rarely be reached. However, plans must still track out-of-pocket spending for these enrollees.

   In addition, as provided at 42 CFR 422.100(f)(5), *both RPPO and* LPPO plans are required to have a "catastrophic" limit inclusive of both in- and out-of-network cost-sharing for all Parts A and B services, the dollar amount of which is set annually by CMS. All cost-sharing (i.e., deductibles, coinsurance, and co-payments) for Parts A and B services must be included in plans' MOOPs. Organizations must track enrollee out-of-pocket costs and should notify enrollees when they reach, or are near, a mandatory MOOP, a voluntary MOOP, or a catastrophic limit.

   CMS may also annually establish a lower, voluntary MOOP limit. MAOs that adopt the lower voluntary MOOP limit will have more flexibility in establishing cost-sharing amounts for Parts A and B services than those that do not elect the voluntary

MOOP. Table V below summarizes MOOP and catastrophic limit rules for various MA plan types.

Table V: Summary of MOOP and catastrophic limits by plan type.

Plan Type	Mandatory MOOP Limit(In-network Parts A/B Services)		Voluntary MOOP Limit (In-network Parts A/B services)		Catastrophic Limit (In and Out-of-network Parts A/B Services)	
	Required?	Who sets the maximum amount?	Required?	Who sets the maximum amount?	Required?	Who sets amount?
HMO, HMOPOS [(i)], PFFS [(ii)]	Yes, unless plan adopts voluntary MOOP limit	CMS	No, if plan adopts mandatory MOOP limit	CMS	Not applicable.	CMS
Local PPO *and Regional PPO*	Yes, unless plan adopts voluntary MOOP limit	CMS	No, if plan adopts mandatory MOOP limit	CMS	Yes	CMS

Notes to Table V:

(i). In addition to the Original Medicare MOOP and catastrophic limits discussed in this section, an HMOPOS plan may set a separate *limit* on *cost-sharing for* the services furnished by its POS benefit that limits plan liability for the POS benefit during the contract year (Section 100.1).

(ii). MOOP limits apply to all PFFS plans – whether non-network, partial network, or full network.

2. Per Member Per Month (PMPM) Actuarial Equivalent (AE) Cost-sharing Maximums. The actuarially estimated total MA cost-sharing for Parts A and B services must not exceed cost-sharing for those services in Original Medicare. MAOs should refer to annually published guidance regarding the application of this requirement to particular service categories. Note that CMS applies this requirement separately to inpatient, SNF, home health service, DME, and Part B drugs.

3. Service Category Cost-sharing Standards. As provided under 42 CFR 422.100(f)(6), MA plan cost-sharing for Parts A and B services specified by CMS must not exceed levels annually determined by CMS to be discriminatory. In addition, under Section 1852(a)(1)(B)(iii) of the Act (as amended by the Affordable Care Act) the cost-sharing charged by MA plans for chemotherapy administration services, renal dialysis services, and skilled nursing services for which cost-sharing would apply under

original Medicare (after the first 20 days) may not exceed the cost-sharing for those services under Parts A and B.

4. Discriminatory Pattern Analysis. In addition to the other specific cost-sharing requirements enumerated in this section, CMS may also perform *an* additional general discriminatory pattern analysis to ensure that discriminatory benefit designs are identified and corrected.

5. Individual service requirements: CMS has several cost-sharing requirements which apply to individual services. Several of these requirements are referenced elsewhere in this chapter, including the cost-sharing requirements for in-network preventive services (section 10.24), emergency care (section 20.5), and out-of-network dialysis (section 110.3). Additionally, the following cost-sharing requirements for individual services must be adhered to:

   - The 50% cap on Original Medicare services: In order for an Original Medicare in-network or out-of-network item or service *category* to be considered a *plan* benefit, *plans may not just pay a stipend, that is, less than 50% of the contracted (or Medicare allowable rate); rather,* cost-sharing for that service cannot exceed 50% of the total MA plan financial liability for this benefit. *Consequently:*

     - *If a plan uses a coinsurance method of cost-sharing, then the coinsurance for an in-network or out-of-network service category cannot exceed 50%;*

     - *If a plan uses a copay method of cost-sharing, then the copay for an out-of-network Original Medicare service category cannot exceed 50% of the average Medicare rate in that area;*

     - *If a plan uses a copay method of cost-sharing, then the copay for an in-network Original Medicare service category cannot exceed 50% of the average contracted rate of that service. For example, if the plan's service area consists of two counties with equal frequency of utilization with contracted rates for a particular service of $90 and $110 in the two counties, then the plan may uniformly charge no more than a $50 copay for that service category; and*

     - *This 50% cap is in addition to any other caps. Thus, for those service categories subject to fee-for-service cost-sharing limits (e.g. 20% coinsurance) the plan may not charge more than the fee-for-service cost-sharing limit..*

   - Part B drugs: No dollar limits can be placed on the provision of Part B drugs covered under Original Medicare unless the Medicare statute imposes the limit on Original Medicare coverage, it is specified in a national or applicable

local coverage determination, or CMS imposes a dollar limit. (See section 80.2 of this chapter for more detailed guidance on the obligation of plans to follow local coverage determination

In addition to the five categories of cost-sharing standards listed above in bullets (1) through (5), MA organizations are subject to the following additional guidance on cost-sharing:

- Deductibles: While high deductibles are required for MSA plans, CMS will closely scrutinize high deductibles in other plan types.

- Use of Coinsurance vs. Co-payments: In our annual review of plan cost-sharing, we will monitor both co-payment amounts and coinsurance percentages. Although MAOs have the flexibility to establish cost-sharing amounts as co-payments or coinsurance, organizations should keep in mind when designing their cost-sharing that enrollees generally find co-payment amounts more predictable and less confusing than coinsurance.

- Organizations may, in certain situations, use co-payments for services that have CMS cost-sharing standards based on Original Medicare coinsurance levels. In those situations, the plan may charge a co-payment that is actuarially equivalent, based on the expected distribution of costs, to the coinsurance standard;

- Plans may not use different co-payment amounts that are based on the cumulative number of visits (e.g., cost-sharing of $5 for visits 1 through 5, and $10 for visits 6 and greater); and

- Plans may use a stratified co-payment arrangement for DME and/or Part B drugs provided that: (1) for each strata, the co-payment amount is no greater than the CMS coinsurance requirement for the lower limit of the strata, and (2) the number of co-payment strata does not exceed four. The following example complies with CMS standards.

Cost Range For service	Co-payment
• $0 - $199	$0
• $200 - $499	$40
• $500 - $999	$100
• $1000 and above	$200

50.2 – Total Beneficiary Cost-Sharing (TBC)
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

As provided under section 1854(a)(5)(C)(ii) of the Affordable Care Act, and regulations at 42 CFR 422.256(a), CMS may deny bids on a case-by-case basis, if CMS determines that a bid proposes too significant an increase in cost-sharing or decrease in benefits from one plan year to the next. CMS uses the Total Beneficiary Cost (TBC) metric as a

means of evaluating changes in plan benefits from one year to the next, and evaluating whether such changes impose significant increases in cost-sharing or decreases in benefits. 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 the change in the TBC from one year to the next, CMS is able to ensure that beneficiaries are not exposed to significant cost increases from one plan year to the next.

TBC is the sum of plan-specific premium and estimated beneficiary out-of-pocket costs. For those plans that include a Part B premium buy-down as part of their benefit package, this sum of plan-specific premium and estimated beneficiary out of pocket costs is then adjusted by applying a factor to account for the Part B premium buy-down. Information on the TBC metric for the following contract year will be provided in annual guidance issued by CMS.

50.3 - Cost-Sharing Rules for RPPOs
(Rev.*97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11.*)

As specified in section 50.1, MA regional PPO (RPPO) plans are required to establish a MOOP limit for in-network cost-sharing and a catastrophic limit inclusive of both in- and out-of-network cost-sharing for Parts A and B services. Table V in section 50.1 summarizes MOOP and catastrophic limit rules for various MA plan types, including RPPOs.

In addition to the applicable cost-sharing requirements listed in section 50.1, RPPOs must provide for the following:

(1) Single deductible: If an MA Regional PPO (RPPO) wishes, in one of its plan packages, to offer a deductible for Original Medicare services, either in-network or out-of-network, then the RPPO may:

- Offer a single combined deductible for all Original Medicare services, whether in-network or out-of-network;
- Offer separate deductibles for specific Original Medicare in-network services, provided the RPPO also offers a single combined deductible for all Original Medicare services, both in- and out-of-network, towards which the separate deductibles for specific in-network Original Medicare services count; and
- Not offer a separate deductible for out-of-network Original Medicare services.
- Exempt for specific items or services from the deductible - that is, the RPPO may choose to always cover specific items or services at plan cost-sharing levels whether or not the deductible has been met.

If the RPPO wishes to apply a deductible to supplemental services then the RPPO may either:

- Include supplemental services in the single combined deductible;
- Establish separate deductibles for supplemental benefits in addition to the single deductible for Original Medicare services; or
- Have a deductible for supplemental services but have no deductibles for any Original Medicare services.

The examples below illustrate the policies described above.

- Example 1: An RPPO has a single combined deductible of $1,000. The plan limits the amount of the deductible that will apply to in-network inpatient hospital services to $500, and the amount that will apply to in-network physician services to $100. It also exempts application of the deductible to all preventive services (including immunizations) – whether they are received in- or out-of-network – and to all home health services (in- and out-of-network).

- The example complies with the RPPO deductible guidance because it:
  - Uses a single combined deductible;
  - Differentiates the applicability of this single deductible for two in-network services (Inpatient hospital and physician services);
  - Does not differentiate the single deductible for out-of-network services; and
  - Exempts preventive and home-health services from the deductible.

- Example 2a: An RPPO may not have both a $500 deductible for out-of-network physician services and a $1,000 deductible for in- and out-of network inpatient hospital services because:
  - The RPPO does not have the right to establish a separate out-of-network deductible; and also
  - The RPPO failed to establish a single-combined deductible.

- Example 2b: An RPPO may have a single combined deductible of $1,500 that it applies to the aggregate costs of all in-network and out-of-network Original Medicare services. The RPPO may specify that only $500 of the total deductible amount will be for in-network inpatient hospital services.

- This example complies with the guidance because the RPPO met its requirement of a single deductible and exercised its right to differentiate for specific in-network services. In this case, a beneficiary could meet the deductible by spending $500 on an in-network hospital and the remaining $1,000 on an out-of-network SNF. The beneficiary could also meet the single deductible by spending $1,500 on an out-of-network inpatient hospital stay.

- Example 3a: An RPPO may not have a single deductible of $3,000 with a $1,000 cap on Part A services (in- and out-of network) because the RPPO created a differentiation in the deductible that applies to out-of-network services, since the $1,000 cap on Part A services applies to all Part A services both in- and out-of network.

- Example 3b: An RPPO may have a single deductible of $3,000 with a $1,000 cap on specific in-network Part A services because the RPPO meets its requirements of a single deductible and differentiated for specific in-network services without affecting out-of-network services.

Additionally, an enrollee can meet the deductible by spending $3,000 out-of-network. The enrollee can also meet the deductible by spending $1,000 in-network on Part A services and $2,000 on out-of-network services, or by spending $1,000 on in-network Part A services, $1500 on in-network Part B services and $500 on out-of-network services.

(2) In-Network catastrophic limit: RPPOs are required to provide a catastrophic limit on beneficiary out-of-pocket expenditures for Original Medicare in-network benefits;

(3) Total catastrophic limit: RPPOs are required to provide an additional catastrophic limit on beneficiary out-of-pocket expenditures for Original Medicare in-network and out-of-network benefits. This second out-of-pocket catastrophic limit, which would apply to both Original Medicare in-network and out-of-network benefits, may be higher than the in-network catastrophic limit, but may not increase that limit.

The examples below illustrate the policy above:

- Example 1: A plan may not have a $1,000 limit on in-network out of pocket expenditures and a $2,000 limit on out-of-network out of pocket expenditures; however

- Example 2: A plan may have a $1,000 limit in in-network out-of-pocket expenditures and a combined in-network/out-of network limit of $3,000.

  In this example the enrollee may meet the limit by spending $1,000 in-network and $2,000 out-of-network or by spending $3,000 out-of-network.

(4) Tracking of deductible and catastrophic limits and notification: RPPOs are required to:

- Track the deductible (if any) and catastrophic limits of incurred out-of-pocket beneficiary costs for Original Medicare-covered services; and

- Notify members and health care providers when the deductible (if any) or a limit has been reached; and

(5) Out-of-network Reimbursement: RPPOs are required to provide reimbursement for all plan-covered benefits, regardless of whether those benefits are provided within the network of contracted providers.

60.1 - Definition
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Value-Added Items and Services (VAIS) are non-benefit items and services provided to an MAO's enrollees *for which* the *cost, if any, incurred by the plan in providing the item or service is solely administrative.* VAIS may not be funded with Medicare program dollars. *A cost is not automatically classified as solely administrative simply because it is either minimal or non-medical; rather, the cost, if any, is classified as solely administrative if the cost only covers clerical items or equipment and supplies related to communication (such as phone and postage), or database administration (such as verifying enrollment or tracking usage).*

Since VAIS may be of value to some beneficiaries and may be commonly available to commercial enrollees, *we allow MA plans to offer VAIS provided that the notification to the beneficiaries about the* VAIS *follows* specific marketing guidelines. For details, see *sections* 110 and 170 of the Medicare Marketing Guidelines located at http://www.cms.hhs.gov/ManagedCareMarketing/Downloads/R91MCM.pdf.

Note that this definition does not require that VAIS be health-related. A VAIS is not a benefit since no direct medical or pharmaceutical cost is incurred to the MAO in providing the VAIS.

60.2 - Examples of VAIS
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The following are some examples of permissible and non-permissible VAIS:

- Example 1: An MA plan offers an in-network vision-exam benefit (for which it incurs a direct medical cost). The MA plan also offers a 5% discount on a vision-exam out-of-network. Enrollees are instructed to pay for the vision-exam out-of-network and receive a 5% discount. The discount is covered by the vision-exam center to broaden its market. Consequently, the MA plan does not incur a direct medical cost as a result of this discount. The MA plan may incur administrative

costs related to negotiating the discount, notifying members, and verifying eligibility.

Since the plan does not incur a direct medical cost in providing the vision exam out-of-network, the discount may not be classified as a benefit. The plan may offer the discount on out-of-network vision exams as a VAIS. However, since the out-of-network vision exam is not a benefit it may not be advertised on the Medicare Options Compare site nor mentioned in the PBP. Other restrictions on advertising apply.

Similarly, if the plan offered a vision-exam benefit and the *vision* center providing the vision-exam provided a 10% discount on glasses purchased by those enrollees obtaining vision exams, the discount on glasses is a VAIS, not a benefit; it may not be advertised on the Medicare Options Compare site nor mentioned in the PBP.

- Example 2: An MA plan wishes to offer free groceries with vouchers to its enrollees.

  Such grocery vouchers could not be offered as VAIS if the plan pays costs for the vouchers provided. *Although the cost is minimal,* the cost is not solely administrative, since the MA plan is paying for vouchers.

60.3 - Additional VAIS Requirements
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

VAIS is not a benefit; therefore, it:

- May not be priced in the bid;
- May not be offered to non-plan members, for example, dependents and spouses of plan members; and
- Is not reviewed during the annual review of plan benefit package design. While VAIS are not typically the subject of CMS site visits, CMS reserves the option to review VAIS, either during an ordinary or special monitoring visit, especially if problems or complaints arise.

Organizations offering VAIS must:

- Offer it for the entire contract year;
- Offer it uniformly to all plan members;
- Maintain the privacy and confidentiality of enrollee records in accordance with all applicable statues and regulations;

- Comply with all applicable HIPAA laws. For information on HIPAA, see http://www.hhs.gov/ocr/privacy/. In particular, an MAO may not directly contact Medicare beneficiaries if a VAIS item or service is not directly health related. This prohibition on contact includes the prohibition on distributing names, addresses, or information about the individual enrollees for commercial purposes. If the organization or sponsor uses a third party to administer VAIS that is not directly health related, the organization or sponsor is ultimately responsible for adhering to and complying with these confidentiality requirements; and

- Comply with all *applicable* relevant fraud and abuse laws, including the anti-kickback statute and prohibition on inducements to beneficiaries.

70.4 - Content of Enrollee Information and Other MA Obligations
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The written information provided to enrollees must, at a minimum, include a description of the MAO's written policies on advance directives including an explanation of the following:

- That the organization cannot refuse care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

- The right to file a complaint about an organization's noncompliance with advance directive requirements, and where to file the complaint;

- That the plan must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

- That the MAO is required to comply with State law (See section 70.3 for details);

- That the MAO must educate its staff about its policies and procedures for advance directives; and

- That the MAO must provide for community education regarding advance directives.

If the MAO cannot implement an advance directive as a matter of conscience, it must issue a clear and precise written statement of this limitation. The statement must include information that:

- Explains the differences between institution-wide objections based on conscience and those that may be raised by individual physicians;

- Identifies the State legal authority permitting such objection; and

- Describes the range of medical conditions or procedures affected by the conscience objection.

Section 40 of the Medicare Marketing Guidelines, http://www.cms.gov/manuals/downloads/mc86c03.pdf includes additional marketing requirements.

80.6 - Sources for Obtaining Information
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

In an effort to make the coverage process more transparent, understandable, and predictable, CMS has redesigned its Medicare coverage process. Part of the redesign includes using the Internet to provide information about how NCDs are made and the progress of each issue under coverage review. The following Internet resources provide valuable information:

- **The Medicare Coverage Homepage**, located at http://www.cms.hhs.gov/center/coverage.asp has links that:
  - Provide a listing of all NCDs;
  - *Provide a listing of all National Coverage Analyses (NCAs);*
  - *Provide an index of Local Coverage Determinations (LCDs);*
  - *Enable users to subscribe to the CMS Coverage Listserv and receive weekly notifications when national coverage documents are updated, such as national coverage analyses (NCAs) and national coverage determinations (NCDs). Listserv subscribers also receive special updates, including CMS announcements of new topics opened for national decision, posting of decision memos, and posting of final technology assessment (TA) reports; and*
  - Enable users to search the database.

  Both pending and closed coverage determinations are listed. For each coverage topic CMS provides a staff name and e-mail link so interested individuals can use the Internet to send questions and provide feedback.

- **The Medicare NCDs Manual, Publication 100-03**, accessible at http://www.cms.hhs.gov/Manuals/IOM/list.asp, is the primary record of Medicare national coverage policies, and includes a discussion of the circumstances under which items and services are covered.

- **Program Transmittals and Program Memoranda**, transmit CMS' new policies and procedures on new coverage determinations and Medicare benefits. Links to the

    - **Program Transmittals** can be found at http://www.cms.hhs.gov/transmittals/01_overview.asp; and

    - **Program Memoranda** can be found at http://www.cms.hhs.gov/transmittals/CMSPM/List.asp.

Medicare Internet-Only Manuals, located at http://www.cms.hhs.gov/Manuals/IOM/list.asp. These manuals present information on Medicare coverage of items and services. Changes to these manuals are released through Program Memoranda and Program Transmittals.

90.2 - Multi-Year Benefits
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Supplemental multi-year benefits are services that are provided to a plan's Medicare enrollees over a period exceeding one year. *For example, it is permissible for a plan to cover one new pair of eyeglasses every two years. We understand that some benefits are appropriately offered over multiple years, but encourage plans to limit offerings to one contract year where possible.*

100.1 - HMO Point Of Service (POS)
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Under a POS option, an HMO coordinated care plan permits enrollees to obtain specified items and services from non-network providers, *whether inside the authorized service area or outside*. The HMO plan may:

- Include a POS option as a mandatory or optional supplemental benefit;

- Require or waive prior authorization rules for POS;

- Require that enrollees pay higher cost-sharing for POS services;

- Establish a cap on the dollar amount of services that will be covered under the POS option;

- Restrict the set of plan-covered services available under the POS option; and

- *Specify the provider group(s) that will furnish the POS benefit to enrollees.* Plans which allow a POS benefit to be used by enrollees to access plan contract providers without prior authorization or referral must separately track and report

in-network POS utilization. Plan enrollees have the right to inquire from the plan how close they are to the monetary cap on POS services.

Plans offering a POS benefit must establish an annual maximum dollar cap on enrollees' financial liability for POS benefits, and must calculate and disclose the maximum out-of-pocket expense an enrollee could incur. The reason for requiring a cap on enrollee financial liability is to ensure that beneficiaries are aware in advance of the *plan's maximum contribution for POS benefits, after which the beneficiary assumes full liability.*

Example: A plan may offer a POS benefit with a $5,000 annual maximum on aggregate costs, and require a 20 percent coinsurance from the beneficiary using the POS benefit. Once the $5,000 aggregate POS annual maximum is reached, the beneficiary has paid the out-of-pocket maximum of $1,000 and the plan has contributed $4,000 of the $5,000 aggregate annual maximum for the POS benefit. At this point, the plan has no further obligation to cover services for the beneficiary under the POS benefit *and the beneficiary is 100% liable for all future costs.*

100.6 - PPO Out-of-Network Coverage
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)
PPOs must furnish all services in-network and out-of-network but may charge higher cost-sharing for plan covered services obtained out-of-network. The following rules apply to PPO coverage outside the service:

- MAOs must provide reimbursement for all plan-covered medically necessary services received from non-contracted providers without prior authorization requirements. However, both enrollees and providers have the right to request a prior written advance determination of coverage from the plan prior to receiving services.

- PPO plans offering an optional supplemental benefit must offer the same benefit in-network and out-of-network.

- PPO plans wishing to cap the dollar value of supplemental benefits must use the same cap for both in-network and out-of-network benefits.

- As provided in section 10.9, PPO plans are prohibited from establishing prior notification rules under which an enrollee is charged lower cost-sharing when either the enrollee or the provider notifies the plan before a service is furnished.

- The out-of-network requirement for PPOs applies to the entire United States and its territories. For example, a PPO with a service area in Puerto Rico must *cover all plan* benefits *furnished* to its enrollees on the mainland. An MAO wishing to furnish all plan-covered services outside its service area but only in certain geographic locations should offer an HMOPOS plan.

100.7 - The Visitor/Travel (V/T) Program
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Under plan enrollment rules, MA plans that do not offer a visitor / travel (V/T) supplemental benefit must disenroll *current* enrollees who are *temporarily* absent from the plan's service area for *more than* six *consecutive* months. However, MA plans that offer a visitor / travel benefit may retain enrollees temporarily out of their service area but within the United States or its territories for up to twelve months (42 CFR 422.74(d)(4)(iii)). *See section 50.2.1 of Chapter 2, "Medicare Advantage Enrollment and Disenrollment," of the Medicare Managed Care Manual located at* http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp *for further details.*

The specific requirements for the V/T benefit are as follows:

- The 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 be available to all plan enrollees who are temporarily in the designated geographic areas where the V/T benefit is offered;
- V/T benefits may not be offered outside the United States and its territories;
- The V/T benefit must furnish all plan covered services in its designated V/T 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;
- An MAO that is not able to form a network of direct contracted providers to furnish supplemental benefits in an area in which it offers a V/T benefit may, with CMS approval, allow its enrollees to obtain plan covered services from non-contracted providers, *but at in-network cost-sharing*, as long as the plan can ensure that its members have access to providers willing to furnish services in that area;

110.3 - Access for Emergency, Urgently Needed Services and Dialysis
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

As explained in section 20, all plan types must provide emergency, urgently-needed and medically necessary dialysis. However, these three situations have slightly different rules for cost-sharing and access:

- Cost-sharing:

- Emergency: As indicated in section 20.5, cost-sharing is capped at the lesser of 1) *the limit for emergency service cost-sharing that is published by CMS in its annual guidance, and 2)* the in-network plan cost-sharing for that service in a non-emergency situation.

- Urgently Needed services: There are no *special* restrictions on cost-sharing; *rather, urgently needed services are subject to the same cost sharing requirements that apply to all other plan-covered services.*

- Medically necessary dialysis: The cost-sharing for out-of-network (OON), out of service area, medically necessary dialysis cannot exceed the in-network (IN) cost-sharing (see section 20.7 for further details).

- Access:

  - Emergency and medically necessary dialysis: Plans must provide access both IN and OON.

  - Urgently needed services: As explained in section 20, urgently needed services, only apply OON (or IN when normal access is temporarily unavailable).

- Gatekeeper:

  - Emergency and urgently needed services: Plans are prohibited from requiring *prior* authorization.

  - Medically necessary dialysis: A *coordinated care* plan may use a gatekeeper in-network, but is prohibited from using a gatekeeper out-of-network.

110.4 - Access and Plan Type
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

In the past decade a variety of statutes have created flexibility in the Medicare program by providing a variety of plan types that MAOs may offer. Some of the newly created plan types may allow provision of services out-of-network and some plan types may allow provision of services without a gatekeeper. Table *VI* below summarizes important access attributes of several plan types.

Table VI: Plan Type and Access attributes for non-emergent non-urgent-care service

Plan Type	Is a gatekeeper[1] allowed?	Is a network required?	Must benefits be provided IN and OON?	May Cost-sharing requirements differ IN/OON
HMO	Optional	Must contract[2]	Must provide IN; may provide OON	No, except for HMOPOS
PPO, RPPO	Optional, *In-network (IN), Prohibited Out-of-network (OON)*	Must contract[2]	Must provide both IN/OON	May have higher cost-sharing OON
MSA and PFFS	Prohibited	May use full, partial, or non-network model	Must provide both IN/OON	May have higher cost-sharing OON

Notes to Table VI:

1. *A gatekeeper, when allowed, is typically, but not necessarily, a PCP. The primary purpose of a gatekeeper, when allowed, is to comply with plan requirements for medically necessarily referrals to in-network specialists. Prior authorization is never allowed OON in a PFFS or MSA plan.*

2. Although an RPPO must contract with a network it may, upon obtaining a waiver from CMS, only contract with a network in part of its service area (42 CFR 422.112(a)(1)(ii))

120.1 - General Rule
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

(42 CFR 422.106(a)(2)) An MAO may contract with employers or State Medicaid Agencies to *pay for* benefits that complement those that an employee or retiree receives under an MA plan. Some examples of complementary benefits include the following:

- The employer *or* State Medicaid Agency pays, or is financially responsible, for some, or all, of the MA plan's basic premiums, supplemental premiums, or cost-sharing;

- The employer, State Medicaid Agency provides other employer-sponsored (or State-sponsored) services that may require additional premium and cost-sharing; and

- The employer, the State Medicaid Agency purchases a non-Part D drug benefit from the MAO.

These complementary benefits *may* not *be classified* as *MA* benefits *and are therefore not regulated* by *CMS. However,* the MAO *must comply with all State regulations governing such benefits.*

130.1 - Basic Rule
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

CMS does not pay for services to the extent that there is a third party that is required to be the primary payer. The principles on cost-sharing that are discussed below may not apply in circumstances where CMS has granted an employer group waiver. (See the chapter of this manual entitled, "Premiums and Cost-sharing," for further discussion.)

This section only discusses collections related to Part C benefits. Special rules apply *to* the collection of cost-sharing related to Part D benefits offered in an MA-PD plan. *These special rules may be found in sections 50.13 and 60, as well as in Appendix E, section 30, and sections 50.6, 50.7 and 50.11 of Chapter 14, "Coordination of Benefits," of the Prescription Drug Benefit Manual, located at* http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter14.pdf.

130.3 - Medicare Benefits Secondary to Group Health Plans (GHPs) and Large Group Health Plans (LGHPs) *and in Settlements*
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

Secondary payer status can arise both from settlements as well as other insurance plans.

In the case of other insurance plans, secondary payer status may, in certain circumstances, depend on:

- Whether the entitlement to Medicare is because of age or disability;
- Who is the primary beneficiary of the other insurance plan; or
- The size (number of employees) of the sponsoring employer group.

Specifically, but not exclusively, an MAO is the secondary payer in the following situations:

- When the MA plan has an MA enrollee who is 65 years or older, and
    - Who is covered by a Group Health Plan (GHP) because of either:
        - Current employment, or

        - Current employment of a spouse of any age; and

    - The employer that sponsors or contributes to the GHP plan employs 20 or more employees;

- When the MA plan has an MA enrollee who is disabled, and

    - Who is covered by a Large Group Health Plan (LGHP) because of either:

        - Current employment, or

        - A family member's current employment, and

    - The employer that sponsors or contributes to the LGHP plan employs 100 or more employees; or

- During the first 30 months of eligibility or entitlement to Medicare for an MA enrollee whose entitlement to Medicare is solely on the basis of ESRD and group health plan coverage (including a retirement plan). This provision applies regardless of the number of employees and the enrollee's employment status.

Secondary payer status can also happen because of settlements. In this case, the MAO is the secondary payer for an MA enrollee when:

- The proceeds from the enrollee's workers' compensation settlement are available; and

- The proceeds from the enrollee's no-fault or liability settlement is available.

Medicare does not pay at all for services covered by a primary GHP. In the case of the presence of workers comp, no-fault and liability insurance (including self-insurance), Medicare makes conditional payments if the other insurance does not pay promptly. These conditional payments are subject to recovery when and if the other insurance does make payment. However, if an MA enrollee illegally did not own auto insurance the MAO cannot withhold primary payment on the grounds that the enrollee should have owned this insurance because it is a state requirement. MAOs cannot withhold primary payment unless there is a reasonable expectation that another insurer will actually promptly pay primary to Medicare.

130.6 - Collecting From GHPs and LGHPs
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

When an MAO is the secondary payer to an employer/union group health plan, the coordination of benefits occurs in the aggregate through the bid process. This process

results in a co-payment as part of the MA plan benefit package for which every enrollee is liable. Therefore, there is no coordination of benefits on a beneficiary-specific basis that would relieve an MA enrollee with employer/union group health plan coverage of his or her cost-sharing obligation under the MA plan. As a result, the MA enrollee remains liable for payment of the MA plan's cost-sharing regardless of whether Medicare is primary or secondary. However, under 42 CFR 422.504(g) which addresses beneficiary financial protection contained in the contract between the MAO and CMS, the MAO is responsible for relieving the beneficiary of responsibility for payment of health care costs other than the MA cost-sharing, and therefore, the MAO must relieve the enrollee of his or her liability under the terms of the employer/union group health plan.

Example: If the employer/union group health plan (the primary payer) has a co-payment of $20 and the MA plan has a co-payment of $10 for a plan-covered service that the beneficiary properly received (following all plan requirements), the beneficiary cannot be liable for paying more than the MA's co-payment of $10. The MAO must *hold harmless* the beneficiary of the liability for any amount in excess of the MA plan co-payment of $10.

140.1 - Introduction
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The guidance in this section specifically applies to non-SNP HMOs, HMOPOS and PPOs. CMS does not permit plan renewals across product types. For example:

- An MA-only plan cannot be renewed as, or consolidated into, an MA-PD plan (and vice versa);
- Health Maintenance Organization (HMO) plans cannot renew as, or consolidate into, a Preferred Provider Organization (PPO) plans (and vice versa);
- HMO plans or PPO plans cannot renew as, or consolidate into, Private-Fee-for-Service (PFFS) plans (and vice versa);
- Special Needs Plans (SNPs) cannot renew as, or consolidate into, non-SNP MA plans (and vice versa); and
- Section 1876 cost contract plans cannot renew as, or consolidate into, MA plans (and vice versa).

With limited exceptions specified in annual renewal and non-renewal guidance by CMS, we will not permit consolidation of PBPs across contracts, independent of plan type.

As a result of business decisions, or pre- or post-bid discussions with CMS, MAOs may choose to change their current year offerings for the following contract year. Each year, current MAOs must indicate Plan Benefit Package

(PBP) renewal and non-renewal decisions and delineate, for enrollment purposes, the relationships between PBPs offered under each of their contracts for the coming contract year. MAOs must also adhere to certain notification requirements, some of which are indicated below. Most renewal options must be completed in the HPMS Crosswalk, but there are limited exceptions to this requirement.

The renewal and non-renewal guidance presented in this section facilitates the opportunity for beneficiaries to make active enrollment elections that best fit their particular needs. Annual renewals and non-renewals options should simultaneously protect previously made enrollment choices of beneficiaries as well as foster future beneficiary access and choice.

Table *VII*, in section 140.9, presents all permissible renewal and non-renewal options for MAOs with HMO, HMOPOS, PPO, and RPPO plan types, including their method of effectuation, systems enrollment activities, enrollment procedures, and required beneficiary notifications. Each renewal/non-renewal option presented in Table VII includes, where applicable, instructions and important deadlines which MAOs should carefully adhere to in order to ensure smooth year-to-year transitions.

If a renewal or non-renewal scenario is not explicitly presented in Table VII or described in sections 140.2-140.8 below, or is not specified in annual CMS guidance as a renewal or non-renewal scenario that CMS may approve contingent upon receipt of specific information from an MAO, it is not a permissible renewal option for an MAO.

140.6 *Renewal Plan with a Service Area Reduction and No Other MA Options Available*

(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

An MAO offering a local MA plan may reduce the service area of a current contract year's PBP. This is known as a service area reduction, or SAR. An MAO renewing a plan with a SAR must retain the renewed PBP's ID number in the HPMS Plan Crosswalk so that current enrollees in the renewal portion of the service area remain enrolled in the same plan in the following contract year. Current enrollees in the renewal portion of the service area will not be required to take any enrollment action, and the MAO will not submit enrollment transactions in MARx for these current members. Current enrollees in the renewal portion of the service area must receive a standard ANOC notifying them of any changes to the renewing plan.

Current plan enrollees in reduced service areas will be disenrolled at the end of the current contract year. These individuals affected by the SAR will need to elect another plan. The MAO will submit disenrollment transactions to CMS.

The MAO will send a termination notice to enrollees in the reduced portion of the service area that includes notification of special election period (SEP) and Medigap guaranteed

issue rights. Only when there are no other MA options in the reduced service area, the MAO may offer current enrollees in the reduced portion of the service area the option of remaining enrolled in the renewal plan consistent with CMS continuation area policy as provided under 42 CFR 422.74(b)(3)(ii). If an MAO elects to offer current enrollees in the reduced service area the option of remaining enrolled in the renewal plan, the MAO may provide additional information, in addition to the termination notice, about the option to remain enrolled in the plan for the following contract year. However, no specific plan information for the following contract year can be shared with any beneficiaries prior to October 1 of the current contract year. Any current enrollees in the reduced portion of the service area who wish to continue their enrollment must complete an enrollment request.

140.7 *Renewal Plan with a Service Area Reduction When the MAO will Offer Another PBP in the Reduced Portion of the Service Area*
(Rev. **97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11***)*

An MAO offering a local MA plan may elect to reduce the service area of a current contract year's PBP and make the reduced area part of a new or renewal MA PBP service area in the following contract year. An MAO renewing a plan with a SAR must retain the renewed PBP's ID number in the HPMS Plan Crosswalk so that current enrollees in the renewal portion of the service area remain enrolled in the same plan in the following contract year.

Current enrollees in the renewal portion of the service area will not be required to take any enrollment action, and the MAO will not submit enrollment transactions to MARx for these current members. These individuals must receive a standard ANOC notifying them of any changes to the renewing plan.

Current enrollees in the reduced portion of the service area must be disenrolled, and the MAO must submit disenrollment transactions to MARx for these individuals. The MAO will send a termination notice to current enrollees in the reduced portion of the service area that includes notification of special election period (SEP) and Medigap guaranteed issue rights. If the MAO offers one or more MA plans in the reduced portion of the service area, it may offer current enrollees in the reduced portion of the service area the option of enrolling in that plan (or those plans). However, no specific plan information for the following contract year can be shared with any beneficiaries prior to October 1 of the current contract year. Any current enrollees in the reduced portion of the service area who wish to enroll in another MA plan offered by the same organization in the reduced service area must complete an enrollment request, and the organization must submit enrollment transactions to MARx for those members.

140.9 - Crosswalk Table Summary
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The following table summarizes the guidance from sections 140.2 – 140.8.

Table VII: *Guidance* for plan renewals

Section	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
140.2	New Plan (PBP) Added	An MAO creates a new plan benefit package (PBP).	**HPMS Plan Crosswalk Definition:** A new plan added for the following contract year that is not linked to a current contract year plan. **HPMS Plan Crosswalk Designation:** New Plan	The MAO **must submit enrollment transactions** for the following contract year.	New enrollees must complete an enrollment request.	None.
140.3	Renewal Plan	An MAO continues to offer a current contract year MA PBP in the following contract year and retains all of the same service area. **The same PBP ID number must be retained** in order for all current enrollees to remain in the same MA PBP in the following contract year.	**HPMS Plan Crosswalk Definition:** A plan in the following contract year that links to a current contract year plan and retains all of its plan service area from the current contract year. The following contract year plan must retain the same plan ID as the current contract year plan. **HPMS Plan Crosswalk Designation:** Renewal Plan	**The renewal PBP ID must remain the same** so that current enrollees will remain in the same PBP ID. The MAO **does not submit enrollment transactions** for current enrollees.	No enrollment request for current enrollees to remain enrolled in the renewal PBP in the following contract year. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

Section	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
140.4	Consolidated Renewal Plan	An MAO ***combines one or more whole MA PBPs*** of the same type offered in the current contract year into a single renewal PBP so that all current enrollees in combined PBP are offered the same benefits in the following contract year. The MAO must designate which of the renewal PBP IDs will be retained in the following contract year after consolidation. CMS will not allow for consolidations across contracts (with limited exceptions for some renewal options, as described elsewhere in this guidance). Only whole PBPs may be consolidated; a current contract year PBP may not be split among different PBPs in the following contract year. **Note:** If an MAO reduces a service area when consolidating PBP, it must follow the rules for a renewal plan with SAR described elsewhere in this guidance.	**HPMS Plan Crosswalk Definition:** *One or more current contract year plans that consolidate into one plan for the following contract year. The plan ID for the following contract year must be the same as one of the consolidating current contract year plan IDs.* **HPMS Plan Crosswalk Designation:** Consolidated Renewal Plan	**The MAO's designated renewal PBP ID must remain the same** so that CMS can consolidate enrollees into the designated renewal PBP ID in CMS systems. The MAO **does not submit enrollment transactions** for current enrollees. The MAO may have to submit 4Rx data for individuals whose PBP number changed.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in the following contract year. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

Section	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
140.5	Renewal Plan with an SAE	**This option is available to local MA plans only.** An MAO continues to offer a current contract year local MA PBP in the following contract year and retains all of the same PBP service area, but also adds one or more new service areas. **The same PBP ID number must be retained** in order for all current enrollees to remain in the same MA PBP in the following contract year.	**HPMS Plan Crosswalk Definition:** A following contract year plan that links to a current contract year plan and retains all of its plan service area from the current contract year, but also adds one or more new counties. The following year contract plan must retain the same plan ID as the current contract year plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with an SAE **Note:** If the following contract year plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR.	**The renewal PBP ID must remain the same** so that current enrollees in the remaining in the service area will remain in the same PBP ID. The MAO **does not submit enrollment transactions** for current contract year enrollees. The MAO submits enrollment transactions for new enrollees.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in the following contract year. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

Section	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
140.6	Renewal Plan with a SAR and no other MA options availabl e	***This option is available to local MA plans only.*** *An MAO reduces the service area of a current contract year MA PBP and the reduced service area is not contained in another MA PBP offered by the same organization or any other MAO.* *The MAO **may offer** the option to individuals in the reduced portion of the service area for the following contract year to enroll in its remaining PBP if no other MA plans are available (see 42 CFR 422.74(b)(3)(ii)).* ***Note:** One renewal plan with a SAR may have counties that should follow the guidance provided in 5a, and other counties in the SAR that should follow the guidance provided under 5b (i.e., the guidance provided in 5a and 5b may both apply to a single plan).*	***HPMS Plan Crosswalk Definition:*** *A following contract year plan that links to a current contract year plan and only retains a portion of its plan service area. The following contract year plan must retain the same plan ID as the current contract year plan.* ***HPMS Plan Crosswalk Designation:*** *Renewal Plan with a SAR* ***Note:** If the following contract year plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR*	*The MAO **must submit disenrollment transactions** for individuals residing in the reduced portion of the service area for whom it does not collect an enrollment request.* *The MAO **does not submit enrollment transactions** for current enrollees in the renewal portion of the service area.*	*Enrollees impacted by the SAR need to complete an enrollment request if the MAO offers the option of continued enrollment (see 42 CFR 422.74(b) (3) (ii)).*	*The MAO sends a termination notice to current enrollees in the reduced service area that includes notification of SEP and guaranteed issue Medigap rights.* *The MAO may also provide affected enrollees additional information, in addition to the termination notice, about the option to remain enrolled in the plan if the MAO elects to offer enrollment to enrollees in the reduced portion of the service area.* *Current enrollees in the renewal portion of the service area receive the*

Section	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
140.7	Renewal Plan with a SAR when the MAO will offer another PBP in the reduced portion of the service area	**This option is available to local MA plans only.** An MAO reduces the service area of a current contract year MA PBP and the reduced service area is part of a new or renewal PBP offered by that MAO in the following contract year. The MAO **may market** to enrollees in the reduced service area any other PBP offered in the reduced service area for the following contract year. Affected enrollees who elect to enroll in another MA plan offered in the reduced service area must submit an enrollment request. **Note:** One renewal plan with a SAR may have counties that should follow the guidance provided in 5a and other counties in the SAR that should follow the guidance provided under 5b (i.e., the guidance provided in 5a and 5b may both apply to a single plan).	**HPMS Plan Crosswalk Definition:** A following year contract plan that links to a current contract year plan and only retains a portion of its plan service area. The following contract year plan must retain the same plan ID as the current contract year plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR **Note:** If the following contract year plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR.	The MAO **must submit transactions to disenroll individuals** residing in the reduced portion of the service area. The MAO **submits enrollment transactions** to enroll beneficiaries who have requested enrollment in other PBP offered in the reduced service area.	Enrollees impacted by the SAR **need to complete enrollment requests** if they elect to enroll in another PBP (plan) in the same organization or a different MA plan.	The MAO sends a termination notice to current enrollees in the reduced portion of the service area that includes notification of SEP and guaranteed issue Medigap rights. The MAO may also provide additional information, in addition to the termination notice, including instructions on how to complete an enrollment request to switch to another PBP offered by the same organization. Current enrollees in the renewal portion of the service area receive the standard

Section	**Activity**	**Guidelines**	**HPMS Plan Crosswalk**	**Systems Enrollment Activities**	**Enrollment Procedures**	**Beneficiary Notifications**
140.8	Terminated Plan (Non-Renewal)	An MAO terminates the offering of a current contract year PBP.	**HPMS Plan Crosswalk Definition:** A current contract year plan that is no longer offered in the following contract year. **HPMS Plan Crosswalk Designation:** Terminated Plan.	The MAO **does not submit disenrollment transactions**. If the terminated enrollee elects to enroll in another MA plan with the same or any other MAO, that organization **must submit enrollment transactions** to enroll the beneficiary.	Terminated enrollees must complete an enrollment request if they choose to enroll in another PBP, even in the same organization.	Terminated enrollees are sent a termination notice that includes notification of SEP and guaranteed issue Medigap rights.

160 – Meaningful Plan Differences
(Rev. 97, Issued: 05-20-11, Effective: 05-20-11, Implementation: 05-20-11)

The guidance in this section applies to non-employer MA and MA-PD plans of all types. CMS reserves the right to extend the guidance in this section to employer plans in future years.

As provided under 42 CFR 422.254(a)(5) and 422.256(b)(4)(i), CMS annually reviews bids to ensure that an MAO's plans in a given service area are meaningfully different from one another in terms of key benefits or plan characteristics. The criteria CMS may use include:

- Cost-sharing;
- *Mandatory supplemental* benefits offered;
- Plan type; and
- Premiums.

CMS annually publishes guidelines to assist MAOs in creating plan designs and plan cost structures in a given area with meaningful differences. MAOs offering more than one plan in a given service area should ensure that beneficiaries can easily identify the differences in costs and benefits between the plans. Beneficiaries should be able, for example, to determine which plan provides the highest value at the lowest cost based on their needs. Plan bids that CMS determines are not meaningfully different as determined during the annual *CMS* review will not be approved by CMS. *CMS will not approve bids that it determines are not meaningfully different from one another. MAOs will have to withdraw or consolidate such offerings.*

Although the specific guidelines and criteria for meaningful differences may change annually, CMS has considered the presence of any of the following characteristics to represent meaningful differences among plans offered by an MAO in a service area:

- Part D benefit. The plan offers a Part D benefit.
- SNP status. The plan is a SNP that serves a unique population; or
- Distinct plan types. Plans offered are of distinctly different types (e.g., HMO, local PPO, RPPO, PFFS plans).

Example: An MAO offers three plans in a service area with the characteristics listed below. Since each plan differs from the other two plans by one of the characteristics described above, this MAO is considered to be offering plans with meaningful differences; no further tests need be done.

- Non SNP, MA-only;
- Non SNP, MA-PD; and
- SNP, MA-PD.

If an MAO offers two plans in a given service area that either both cover drugs, have the same SNP status, and are of the same plan type, then CMS conducts further tests based on other criteria, such as cost-sharing or benefits, to determine if the two plans are meaningfully different from one another.

20.2 – Definitions of Emergency and Urgently Needed Services

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

• Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

• Serious impairment to bodily functions; or

• Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

• Furnished by a provider qualified to furnish emergency services; and

• Needed to evaluate or treat an emergency medical condition.

Urgently needed services are covered services that:

• Are not emergency services as defined in this section but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;

• Are provided when (A) the enrollee is temporarily absent from the plan's service (or, if applicable, continuation) area and therefore, he/she cannot obtain the needed service from a network provider; or (B) when the enrollee is in the service or continuation area but the network is temporarily unavailable or inaccessible; and

• Given the circumstances, it was not reasonable, for the enrollee to wait to obtain the needed services from his/her regular plan provider after the enrollee returns to the service area or the network becomes available.

An MA organization may choose to cover non-emergency services outside the network at higher cost-sharing.

20.3 – MAO Responsibilities for Coverage of Emergency Services

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

The MAO must inform enrollees of their right to call 911 and:

• No materials furnished to enrollees, including wallet card instructions, may contain instructions to seek prior authorization for emergency or urgently needed services; and

• No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the enrollee has been stabilized.

The MAO is financially responsible for emergency services and urgently needed services:

• Regardless of whether services are obtained within or outside the plan's authorized service area and/or network (if applicable);

• Regardless of whether there is prior authorization for the services;

• If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis; and

• Whenever a plan provider - a provider with whom the MAO has a written contract to furnish plan covered services to its enrollees - or other plan representative instructs an enrollee to seek emergency services within or outside the plan.

The MAO is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, if the attending physician is treating a fracture, the plan is not responsible for any costs connected with a biopsy of skin lesions performed while treating the facture.

20.4 – Stabilization of an Emergency Medical Condition

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MAO. Refer to Section 20.5 below for the MAO's obligations regarding services provided following stabilization. Chapter 13 of the Medicare Managed Care Manual, "MA Beneficiary Grievances, Organization Determinations, and Appeals," addresses the enrollee's right to request a Quality Improvement Organization review of hospital discharges to a lower level of care. For transfers from one inpatient setting to another inpatient setting, an enrollee or person authorized to act on his or her behalf who disagrees with the decision and believes the enrollee cannot safely be transferred may request that the organization pay for continued out-of-network services. If the MAO declines to pay for the services, appeal rights are available to the enrollee.

July 16, 2015

Mr. Scott Kipper
Commissioner, Nevada Division of Insurance
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

Re: Regulation R049-14, Network Adequacy

Dear Commissioner Kipper:

On behalf of the more than 13,500 U.S. members of the American Academy of Dermatology Association ("Academy"), we appreciate the opportunity to comment on proposed draft regulations that would establish network adequacy requirements. We support the Nevada Division of Insurance's ("Division") decision to amend the November draft proposal of Regulation R049-14, which included several provisions of significant concern to the Academy. We recognize the Division's attempt to address the concerns of the Academy and other physician organizations. To strengthen this version and ensure patients have adequate access to the care they need, the Academy requests the following amendments:

Section 2.11 details the definition of "Material Change" to a network. In addition, this section is referenced in Section 6.3 to provide carriers an ability to meet the network adequacy threshold for specialists when 10 or less specialists with a geographic service area, through the utilization of essential community providers. While the AADA acknowledges the role of essential community providers in patient care, the specialized training a dermatologist receives to identify and diagnose skin diseases, including melanoma and non-melanoma skin cancer, cannot be easily mitigated by a non-specialist.

Understanding that the intent of this provision is to ensure patients in rural regions have adequate access, the Academy recommends the Division decrease the threshold of 5 specialists.

The AADA supports the existing criteria, with an amendment to provision (b) of Section 2.11 and also recommends the Commissioner consider including an additional subsection:

Section 2.11

11. A "material change" in a network plan is any change, or combination of changes taking effect within 30 days of each other, that:
    (a) For specialties or categories of health care with more than 10 providers, affects network plan capacity by more than 10 percent in any single specialty or category of health care for which a benefit is offered;
    (b) For specialties or categories of health care with ~~10~~ 5 or fewer providers, affects network plan capacity by more

American Academy of Dermatology
Excellence in Dermatology™

1445 New York Ave., NW,
Suite 800
Washington, DC 20005-2134

Main: 202.842.3555
Fax: 202.842.4355
Website: www.aad.org

than 20 percent in any single specialty or category of health care for which a benefit is offered: or

(c) Does not meet the standards as provided for in section 4 of this regulation.

(d) A change in network that could cause the coverage to change the actuarial value of a plan, due to a change in benefit design that modifies the recipient's benefits, including but not limited to, physician network or drug coverages.

Section 4.3 provides the specialties that carriers must include to ensure network adequacy. The proposed language would limit the Division's evaluation of provider access primarily to the general specialty for most specialties; however, adequate access to subspecialties should also be ensured where deemed appropriate. Dermatology has several sub-specialties, including Mohs Micrographic Surgery and Pediatric Dermatology, which without adequate access, care could be delayed or deferred. This could result in higher costs for patients needing access to these subspecialists.

In previous recommendations the Academy has recommended replacing the *and* in provision a with an *or* in order to ensure patients have adequate access to needed care that could only be provided by specialists and subspecialists; however, the Division has consistently opposed this recommendation due to the resulting breadth of specialties and subspecialties. Therefore, the Academy requests that the Division consider additional specialty or subspecialty categories for evaluation based on the needs of the population when determining the requisite categories of providers for evaluation by changing Section 4.3 to read:

3. Unless otherwise approved in writing by the Commissioner, the specialties and categories of health care providers referenced in subsections 1 and 2 of this section shall be those specialties and categories of health care that:
   (a) Appear as options on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; and
   (b) Are offered as a certification by:
      (1) Member Boards within the American Board of Medical Specialties; or
      (2) The American Osteopathic Association; and
      (3) Any additional specialty or subspecialty deemed appropriate by the commissioner

Section 6.3 provides the carrier an ability to meet network adequacy standards when an inadequate number of specialists practice in a geographic service area. As discussed earlier, the Academy understands the intent of this provision is to ensure patients in rural regions have adequate access to care, but believes the threshold is currently too high. In addition to lowering the threshold, the Academy believes carriers should be required to ensure that at least 60 percent are trained in the specialty.

Section 8.1.a details the criteria the Commissioner will evaluate when determining the availability of providers within the network. Recent guidance provided by CMS indicates plans cannot meet network adequacy requirements by including physicians who do not accept new patients. As a result, inclusion of the following provision to 8.1.a would provide consistent guidance:

1. In determining whether a network plan is adequate, the Commissioner may, but is not limited to, consider:
    (a) The relative availability of health care providers in the geographic service area covered by the network plan, including, without limitation, the:
        (1) Operating hours, or their equivalent, of available health care providers; and/or
        (2) Established patterns of care;
        (3) Physician accepting new patients

Inclusion of this provision ensures patients retain access to a network of physicians who are available to provide care.

Section 8.1.b appears to put the burden to justify network inclusion or exclusion on the provider, whereas frequently the determination for inclusion or exclusion from network is made by the carrier. We recommend amending section 8.1.b as follows:

> (b) "The ability of a health care provider within the travel standards provided pursuant to section 4 of this regulation to enter into a contract with carrier"

Section 8.1.d indicates that the Commissioner can evaluate the offering of telemedicine or telehealth services offered to supplement or provide an alternative to in-person care in the network plan. While the Academy recognizes that teledermatology is a viable option to deliver high-quality care to patients in some circumstances, particularly in rural regions, a patient's choice to have access to in-person dermatology services should be preserved. It is recommended that the Commissioner clarify that a carrier cannot mitigate an inadequate network through the inclusion of telemedicine services in areas with an adequate amount of specialists.

Section 9 requires a carrier to monitor its network to assess its clinical capacity to ensure adequate access if provided to their beneficiaries. The Academy requests clarification of the metrics the Commissioner will require plans measure when determining the adequacy of its network.

Section 12.2.b protects patients by ensuring they retain access to care when a material change occurs. The Academy believes that plans should be prohibited from making a material change during the benefit year. Patients select a plan during open season based on numerous factors, including coverage of prescribed drugs and in-network physicians. Patients, especially those with chronic conditions, frequently choose their network based on the provider network available to them during the plan selection period. Once a patient selects a plan the patient is locked into the plan for the full year. The Academy believes that if a plan terminates a physician from its network "without cause", all subscribers should retain access to that physician until the next benefit year when subscribers are able to select a new plan that meets their needs. Terminating access to a physician mid-year "without cause" could negatively impact a patient's ability to receive care from a physician with whom the patient may already have a relationship or the patient will need during the benefit year. With limited exceptions, plans should be required to maintain consistent coverage throughout the benefit year.

If the Division elects to permit carriers to terminate patients' access to their physicians, carriers should be required to provide a transition period. The Academy recommends patients with chronic conditions receiving care from a provider who was terminated "without cause" receive an additional ninety (90) days to receive care after the termination takes effect, or until treatment concludes, whichever is

less. As previously mentioned, patients with chronic conditions will frequently choose a plan if the provider network includes a physician with whom the patient has an existing relationship from previous appointments. The Academy reinforces its position that patients should not lose access to a physician if a plan terminates the physician "without cause" during the benefit year.

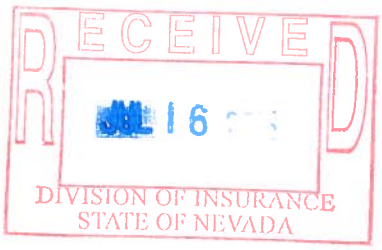
Conclusion

I commend the Nevada Division of Insurance for its effort to ensure the citizens of Nevada have access to needed health care services in a timely fashion and urge the Division to include the proposed amendments described above. Should you have any questions, please contact David W. Brewster, Assistant Director for Practice Advocacy at dbrewster@aad.org or (202) 842-3555 or Lisa Albany, Associate Director for State Advocacy at lalbany@aad.org or (202)712-2615.

Sincerely,

Mark Lebwohl, MD

Mark Lebwohl, MD, FAAD
President
American Academy of Dermatology Association



p @]

On behalf of Aetna I am submitting the following comments on the most recent draft of LCB File No. R049-14:

Section 4.1.: On or before the first Tuesday in January of each year, but no earlier than December 1 of the preceding year, the Commissioner will make available a preliminary list of the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties and categories of health care. Interested parties may submit comments concerning the preliminary list to the Commissioner no later than January 20 of the applicable year.

Additional clarification is requested regarding the basis the Commissioner will use to determine "the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties of health care."

Sec. 10. ***1. A carrier shall update its health care provider directory at least once a month. Any updates to a health care provider directory shall indicate those health care providers which have left the network plan or are no longer accepting new patients.***

Aetna updates its provider directories on a real time basis, as changes are received. Online directories are refreshed 6 days per week (no updates on Sunday). Printed directories are generated once per year. We do show in our directories providers no longer accepting new patients

Aetna does not routinely survey network provider offices or solicit them for updates. In some cases providers fail to notify Aetna of address changes, closed practices, relocation, death of the provider, etc. We do show in our directories providers no longer accepting new patients. However, providers who have left the network are simply not shown in the directory. The internal provider record would show the type of change and when the change was made, but not all information is displayed in the provider directory available to external parties. A requirement to provide these additional changes will require costly system and process changes.

2. A carrier with a material change to its network plan shall:..
(a) Update its health care provider directory within 3 business days of the effective date of the material change in network plan. Any updates to the health care provider directory resulting from a material change to a network plan shall clearly indicate those health care providers:

(1) That have left the network plan since the health care directory was last updated; and
(2) That are not accepting new patients.

As noted above, the names of providers who are no longer in the Aetna network are simply deleted at the next directory update. The absence of the provider signals both that he/she is no longer in the network and, therefore, not accepting new patients. A requirement to add both of these components to the provider directory does not appear to serve a valid purpose as the affected insureds are notified of the changes. We request that these additions not be required.

3. The health care provider directory and each update thereto must:
(b) Be made available in a printed format upon request.

As a national company Aetna's on line directories are a function of corporate-wide programming and we urge the Division to not require a state specific printing requirement. Lists of providers can be printed from Aetna's on line directory at the user's request within certain specifications and the content of these print outs is limited to information about participating providers within a network. We request that the Division include this type of flexibility in the requirement.

Sec. 11. ***1. A carrier shall notify the Commissioner, within 72 hours of the effective date of a material change in its network plan, of:***
(a) ***The effective date of the material change in its network plan; and***
(b) ***A description of the cause and impact of the material change in its network plan.***

Currently, Aetna reports its HMO provider network on a quarterly basis via SERFF. We produce a spreadsheet of previous quarter to current quarter and

verbally report on whether there has been a >30% decrease to any specialty. This change in regulation (and the definition of material impact based on remaining provider availability) may prove burdensome in terms of requiring significant additional resources to comply. We request more specificity in the manner in which the notification is to take place; would it be via an email, certified letter, or SERFF?

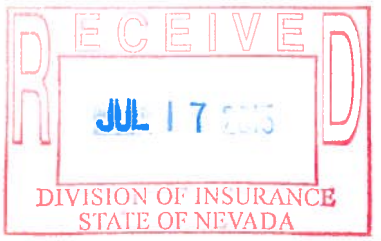
Thank you for your consideration.

Linda Cooper

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org



July 16, 2015

Mark Krueger
Insurance Counsel
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Network Adequacy Proposed Rules – June 3 Draft

Dear Mr. Krueger,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments on the June 3 version of the proposed regulations issued by the Nevada Division of Insurance (Division) on network adequacy.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers.

We appreciate the changes that the Division has made to the proposed regulations and want to express our appreciation for taking into consideration the comments that have been made thus far by health plans and AHIP. While we agree with much of the Division's proposal, we continue to have these remaining concerns:

Changes should be made to provide clarity regarding the applicability of these regulations.

As we understand the proposed definition of "carrier" as written, and the clarifications in Section 15, these regulations would apply to all small group or individual medical plans. We believe these rules should not apply to dental, supplemental, or other HIPAA-excepted benefits insurers. We would appreciate additional clarification to specify that these regulations apply only to comprehensive medical plans and do not apply to dental or vision plans; subjecting dental and vision carriers to these requirements could lead to these plans not meeting the requirements and, as such, having to exit the market, which could lead to higher pricing and a lack of choice for consumers. Section 15 notes the types of coverage the network adequacy provisions do not apply to; we request that a new item 4 be added to this section to include vision or dental plans.

Thus, we recommend:

Section 15.

....

"4. Vision or dental insurance plans."

Additionally, we ask that these regulations acknowledge the "specialty" of a provider when that provider is licensed to perform a general practice and a specialty or more than one specialty. For example, a licensed dentist can provide a variety of services once licensed. A licensed dentist specializing in periodontal or orthodontic services could also perform general dentistry. Carriers should be allowed to count these providers in all categories in which they are licensed to provide services.

We remain concerned with the compressed timeframe of notice of changed standards, and recommend such changes be issued by regulatory notice and review.

We understand the process proposed in Section 4 ties closely to the approach used by the federal Center for Consumer Information and Insurance Oversight (CCIIO) for QHPs in a federally facilitated marketplace (or in this case, a state supported marketplace). However the proposed notice of change for those standards is usually issued in the previous fall, in late November or early December – not January 31. Two additional months is important, since changes to health insurers' networks take time.

For example, the proposed Nevada regulations would require health plans to make changes with little more than 4 months before the date by which individual and small group rate and form filings are required. And since these rules propose to require network information be filed along with those filings, health insurers would have insufficient time to complete any changes.

Health plans require adequate time to respond to any changes in standards regarding network adequacy, especially if it involves additional provider contracting activity. We urge advance notice of proposed changes be issued by regulatory notice and review, so plans can begin early analysis. We also suggest that the network information be permitted to be added later in the rate in form filing process. It could still be added as a requirement for the rates to be approved and meet the intention of the proposed rule; yet this later submission would provide the needed timeframe for health plans' network development.

The proposed requirements for updating a plan's provider directory require significant administrative actions, and rely on the network providers to submit accurate and timely updates.

Section 10 continues to include provider directory requirements with significant administrative impact on health plans. We understand the importance of accurate provider directories, yet we

also note that health plans rely on the information submitted by providers. We request inclusion of hold harmless language for health plans if the information they include in the directory is missing some element, or is incorrect, if it was from information received from the provider that was not full and accurate information.

AHIP will continue to work with the Division to develop these regulations and promote and provide a transparent, value-based health care system. We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org or 971-599-5379.

Sincerely,

Grace Campbell

Grace Campbell
Regional Director

July 16, 2015

(Via e-mail keverett@doi.nv.gov/ mkrueger@doi.nv.gov/ sdummar@doi.nv.gov)

Kimberly Everett
Assistant Chief, Life and Health Section
Nevada Division of Insurance

Mark J. Krueger
Insurance Counsel,
Nevada Division of Insurance

Re: Comments of the Hospital Based Physician Specialty Coalition to the Nevada Department of Insurance on Proposed Revisions to LCB File No-R049-14

Dear Counsel Krueger and Assistant Chief Everett:

The coalition of hospital-based physician specialties has reviewed the proposed regulation LCB File No-R049-14 and found the regulation to be insufficient to ensure that patients enrolled in health plans approved by the Nevada Division of Insurance are able to obtain in-network provision of physician specialist services at in-network facilities and hospitals.

Failure of health plans to establish network adequacy for hospital based specialists will subject patients enrolled in state approved, but inadequate, health plan networks to financial risk for out-of-network payments. When health plans tout that their networks include certain in-network facilities and hospitals, it is grossly misleading to prospective purchasers of these plans when the plan has failed to recruit physicians at these facilities who are essential to the performance of many procedures and treatments a patient should expect to receive and be covered for as an in-network service. Accordingly, these inadequate health plan networks should not be approved by the Division of Insurance as they are misleading consumers and concealing from future patients the potential likelihood of incurring out-of-network physician service costs.

At present, we believe the proposed regulation does not directly address fundamental issues regarding medical specialties identified as being vulnerable to *de minimis* network standards for adequacy. In particular, it is widely known and accepted that many health plans are now creating "narrow" and "ultra-narrow" networks that are ***intentionally*** designed to exclude providers and facilities from plan participation. The result of this intentional design of a benefit plan that is narrowly limited in provider and facility participation is to create network inadequacy and thereby increased potential for balance billing of enrollees by non-participating providers.

Accordingly, we urge two additional provisions to the proposed regulation as **New Sec 4**:

> "A health carrier network shall ensure that for anesthesiology, radiology, pathology, emergency room physicians and hospitalists that there are sufficient numbers of participating providers at each in-network hospital or facility for the delivery of network services."

> "In order to ensure adequacy, accessibility and quality, a health carrier network must have an ongoing plan for providing network adequacy for its covered persons that includes a process to routinely monitor and assess access to physician specialist services in anesthesiology, emergency room care, radiology and pathology/laboratory services. The plan must provide covered persons with timely access and utilization for maintaining quality of care for these services."

We believe the Division of Insurance should specifically scrutinize health plans seeking approval for conformance with this requirement to help ensure that patients enrolled in state approved plans have a reasonable expectation of receiving in-network physician services at in-network health care facilities and hospitals. Furthermore, health carrier networks once approved by the Division, in accordance with the requirement as herein stated, should be responsible for monitoring compliance on an ongoing basis and should be held accountable to the Division of Insurance for providing a plan for such monitoring. We believe both of these recommendations are essential to providing Nevada consumers and patients with high quality health care under the terms of any health plan seeking state approval.

Thank you for your courtesies and consideration of our comments.

Sincerely,

- American College of Emergency Physicians
- American College of Radiology
- College of American Pathologists
- Society of Hospital Medicine

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Nevada Academy of Ophthalmology
An Association of Eye Physicians and Surgeons

July 16, 2015

Nevada Division of Insurance
Acting Commissioner: Amy L. Parks, Esq.
1818 East College Parkway, Suite 103
Carson City, NV 89706

Dear Ms. Parks,

On behalf of the American Academy of Ophthalmology and the Nevada Academy of Ophthalmology, we appreciate the opportunity to provide comments in response to the proposed regulations. The Academy is the world's largest association of eye physicians and surgeons- Eye M.Ds- with 19,000 members in the United States and including more than 100 members in Nevada. We believe the Nevada Division of Insurance (Division) has made significant progress toward establishing a fair and effective process for maintaining adequacy for provider networks; however, we are still concerned about several provisions in the proposed regulation and the impact of those provisions on patients' access to care.

Definition of "Material Change"

Section 2.11 states the changes in a network that are permissible before it triggers a material change. While the Academy is in support of the criteria, we recommend that an additional metric could state:

A change in network that could cause the coverage to fail to meet the actuarial value of a plan, due to a change in benefit design that modifies the recipient's benefits, including but not limited to, physician network or drug coverages.

Required Specialties:

The Academy believes the proposed language limits the Division's evaluation of provider access primarily to the broader specialty designation of most specialties, however, adequate access to subspecialties should also be ensured where appropriate.

The Division should consider additional specialty or subspecialty categories for evaluation based on the needs of the population when determining the requisite categories of providers for evaluation by changing section 4.3 to read:

Unless otherwise approved in writing by the Commissioner, the specialties and categories of healthcare providers referenced in subsections 1 and 2 of this section shall be those specialties and categories of healthcare that:

(a) Appear as options on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; and

(b) Are offered as a certification by:

1. Member Boards within the American Board of Medical Specialties;

or

2. The American Osteopathic Association;

The Academy recommends that the further delineation be added in order to ensure adequate care for chronic conditions and or high risk patients:

3. Subspecialty certification or a certificate of special competence issued by such a board or a nationally recognized accrediting body, or recognized by a regulatory agency;

4. Existence of an American College of Graduate Medical Education (ACGME-accredited residency or subspecialty training program.

The Academy believes it is important to take sub-specialties into consideration. Many retina, glaucoma, and other ophthalmology sub-specialties treat chronic disease and/or high-risk patients. Not having these sub-specialties included in provider networks leave patients with limited or no access to physicians who are adequately trained to and are performing certain services. For example, diabetes is the leading cause of new cases of blindness in adults. This is a growing problem, as the number of people living with diabetes increases, so does the number of people with impaired vision. Diabetes can cause a disease of the eye, known as Diabetic Retinopathy which affects the retina; it is most typically treated by a retina specialist.

The prevalence of primary open-angle glaucoma is three times higher in African Americans and Hispanics of Mexican ancestry compared with non-Hispanics and is the leading cause of blindness within this demographic. Patients with open-angle glaucoma are at significant risk for vision impairment/blindness because they are asymptomatic until late in the disease process, when visual loss and functional impairment are irreversible. General Ophthalmologists often refer their more complex patients to glaucoma specialists when more intensive medical and surgical treatment is required. It is imperative that high-risk patients have access to glaucoma specialists. Without sub-specialties in provider networks, patients will be left without appropriate care for many chronic and blinding illnesses.

Network Adequacy:

Section 8.1 details the criteria the Commissioner will evaluate when determining the availability of providers within the network. Recent guidance provided by CMS indicates plans cannot meet network adequacy requirements by including physicians that do not accept new patients. As a result inclusion of the following provision to 8.1a would provide consistent guidance:

(3) Physician accepting new patients

Contract Negotiations:

Section 8.1 (b) addresses network deficiencies. The burden of contracting with a sufficient number of providers and facilities within its geographic service area lies with the insurance

carrier, as does the responsibility of maintaining a sufficient network. This subsection appears to put the burden to justify network inclusion or exclusion on the provider, whereas most often the determination for inclusion or exclusion from network is made by the carrier. Additionally, as currently worded, the Division may be creating a "race to the bottom", where one provider may accept below market rates which then become the terms and conditions all other providers must accept or be considered not negotiating in "good-faith." The Academy is concerned that as amended, the draft regulation establishes unenforceable standards, and does not consider whether insurers are entering into fair contract negotiations with physicians. We urge the Division to consider developing specific criteria as to how it would measure or evaluate "good faith" negotiations between physicians and insurers. We also recommend amending the language to read:

> *"The ability of a health care provider within the travel standards provided pursuant to section 4 of this regulation to enter into a contract with a carrier."*

Telemedicine:

The Academy recognizes the role of evolving technology in health care, including telemedicine that electronically connects physicians and patients in different locations. The Academy supports delivery of high quality ophthalmological telemedicine as a means of improving quality, access, and cost efficiency of ophthalmological services. The Academy supports policies aimed at validating the value of this technology and fostering appropriate implementation. It is a method to expand the physician-patient relationship beyond the exam room.

Monitoring Network Adequacy:

Section 9 will require a carrier to monitor their network to assess its clinical capacity to ensure adequate access is provided to their beneficiaries. Transparency for patients and the providers who care for them is key to improving health care delivery. Currently the regulations lack clarification of the metrics the Commissioner will require plans to measure in order to determine the network adequacy and this is an important addition that should be included in the final rules.

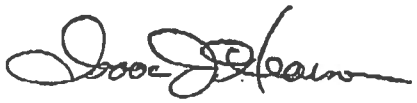
Provider Directories:

Section 10.1 addresses the issue of provider directories. The Academy was very pleased with the addition of a requirement that the directories be updated monthly. Unfortunately, there was no language requiring plans to make any efforts to verify this data. While the Academy was very pleased with the change to the monthly update of the directories, we believe that without a requirement to verify the data, the revision loses much value.

We appreciate the opportunity to comment on the proposed regulations. If you have any questions or need any additional information, please contact Ms. Cherie McNett, AAO Health Policy Director at cmcnett@aaodc.org or via phone 202-737-6662. Again, our Academies would like to thank you for providing us with the opportunity to comment and work with the Division.

Sincerely,

Michael X. Repka, M.D., Medical Director
AAO Government Affairs



Isaac J. Hearne, M.D., President
Nevada Academy of Ophthalmology

Nevada State
Medical Association
Advocates for high quality care since 1875

July 17, 2015

Ms. Amy L. Parks, Esq.
Acting Commissioner
Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Ms. Parks,

The Nevada State Medical Association (NSMA) and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. The comments herein address the draft dated June 3, 2015 that was circulated with the workshop notice.

We are grateful to the staff of the Division of Insurance for your clear re-organization of the original draft of the regulation and the "map" of the sections of each version which made possible an easy comparison. The NSMA and its partners submitted comments to previous drafts, but we note that a number of the issues raised in our previous correspondence and testimony are still not fully addressed in the current language. We have continuing concerns in the areas described below.

Our comments are based on policy adopted at the national level by the American Medical Association, which sets forth the following precepts regarding model network adequacy legislation and regulation. These national policies draw on the experience and expertise of providers from across the country and should be used to guide the discussions surrounding R049-14. Those policies are:

1. Provider networks must include a full range of primary, specialty and subspecialty providers for all covered services for children and adults.
2. Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards. Determinations of network adequacy must be the responsibility of regulators, utilizing strong quantitative and objective measures that take into consideration geographic challenges and the entire range of consumers' health care needs.
3. Appeals processes must be fair, timely, transparent and rarely needed. Policy must make clear that out-of-network arrangements and procedures are not an acceptable alternative to plans having an adequate network.

3660 Baker Lane, Ste. 101
Reno, NV 89509
(775) 825-6788

4. The use of tiered and narrow provider networks and formularies must be regulated. Specific patient protections must be included for networks that are tiered or are limited in scope and number of providers in order to prevent unfair discrimination based on health status.
5. Insurers must be transparent in the design of their provider networks. It is critical that consumers have clear information regarding the design of their plan's provider network.
6. Provider directories must be accurate and up-to-date. Consumers must have access to robust provider directories to enable them to determine which providers are in-network when they purchase their plans, and, in the event their medical needs change, when they need new providers.

Public Interest

NRS 687B.490 confers the authority to the office of the Commissioner to make final determinations on all matters dealing with network adequacy. While exercising this discretion, we believe, the Commissioner must acquire facts and evidence, as referenced in subsection 2(c) of NRS 687B.490, that balance the interests of the insured, the insurance carriers, the health care delivery professionals and the health care facilities.

The magnitude of the Commissioner's decisions is significant, making a transparent and uniform decision-making process both necessary and vital. The regulation must clearly set forth the deliberative process the office of the Commissioner must follow when ascertaining facts and developing findings to support initial determinations of or subsequent changes to network adequacy. That process is not clearly outlined in R049-14.We suggest a new section in R049-14 to read thus:

The Commissioner assures, whenever any determination is being made respecting an insurance product or changes thereto, to be offered to the public, that the insurance product provides for an adequate health care delivery network. In making such a determination respecting an adequate health care delivery network resulting from introduction of an insurance product or changes thereto, the Commissioner must acquire facts and evidence to support findings that the insurance product or changes thereto balances the interests of the insured, the insurance carriers, the health care delivery professionals and the health care facilities and does not negatively impact the health care delivery network.

In addressing the public interest, the Commissioner shall acquire and examine utilization data to support a determination of the adequacy of a health care delivery network. The Commissioner shall consider data, without limitation, showing, on an annual basis:

- *Prior year comparisons against regional and national benchmarks;*
- *Number of hospital admissions for chronic conditions;*
- *Emergency department visits;*
- *Preventive services provided;*
- *Total in-network visits, by specialty;*
- *Total out-of-network visits, by specialty;*
- *Out-of-pocket costs incurred by enrollees;*
- *Out-of-network costs incurred by enrollees;*
- *Percentage of total costs for in-network and out-of-network services;*
- *An evaluation of the quality of assurance standards used by the insurer; and*
- *Results of regular provider surveys to help determine network capacity and accessibility of health care services as well as to solicit providers' perspectives and concerns.*

Developing Standards

We assess that the adoption of certain standards and guidance via a Bulletin, with a truncated process for annually adjusting those standards, is contrary to the requirements outlined in NRS 233B. We respectfully request that the standards be set via the regulatory process.

We have studied the provisions of Bulletin 14-005. Neither that Bulletin nor R049-14 as currently drafted defines the process and criteria that the Commissioner shall use to make critical decisions related to provider-to-patient ratios or time and distance requirements. There is no narrative in the Bulletin that describes the Commissioner's rationale, methodology or calculations.

Sec 4.1 and Sec 4.2 of the draft regulation establish a maximum allowable time of less than a month, after the Commissioner annually issues a preliminary list, for interested parties to submit comments concerning minimum number of providers and the reasonable average travel distance or time by county. This allows only a very limited time for the public, insurance carriers and affected health care providers and facilities to review the preliminary list and make appropriate, informed comments.

In fact, there are now "additional" provider types posted on the DOI website as being added to the "un-validated Network Adequacy Template." Three of those five provider types are not included in Bulletin 14-005.

We would like to point out that the definition of "regulation" in NRS 233B.038 includes:

(a) An agency rule, standard, directive or statement of general applicability which effectuates or interprets law or policy, or describes the organization, procedure or practice requirements of any agency;
(b) A proposed regulation;
(c) The amendment or repeal of a prior regulation; and
(d) The general application by an agency of a written policy, interpretation, process or procedure to determine whether a person is in compliance with a federal or state statute or regulation in order to assess a fine, monetary penalty or monetary interest.

We assess that the adoption of certain standards and guidance via aBulletin, with a truncated process for annually adjusting those standards, is contrary to the requirements outlined in NRS 233B. We respectfully request that the standards be set via the regulatory process.

Contracting with Providers

Sec. 8.1(b) of R049-14 now states that the Commissioner should consider the "ability of a carrier to enter into a contract with health care providers...." We suggest that the language should read:
The Commissioner shall require documentation from carriers of their efforts to negotiate in good faith, under reasonable terms and conditions, with providers and facilities ...."

The concepts of "in good faith" and "reasonable terms and conditions" can be defined by incorporating language from the AMA's model legislation on adequate networks, which includes these concepts:

- **Due Process Protections:** provide providers full opportunity to challenge termination or denial of participation in a health insurance product or panel. Despite the reason for termination or denial of participation, such disruptions impact many of the long-standing patient-physician relationships essential to patient care, and affected providers must be provided a fair process to appeal.

- **Provider Profiling and Network Determination:** require that all profiling programs, including those used to determine tiered or narrow networks, incorporate quality measures and risk adjustment, while providing providers the opportunity to review and appeal their profiles.
- **Provider Choice of Health Insurance Product and Panel:** prevent insurers from requiring a provider who is contracted to be in one network to also be in all of the plans' networks.

Additional language to clarify these concepts includes:
The Commissioner shall collect and evaluate information from insurance carriers regarding the criteria and methodology used to evaluate providers and facilities for network inclusion.
The Commissioner shall require an insurer to make publicly available on its website the criteria and methodology used to evaluate a provider of health care for network inclusion. If the methodology includes cost considerations, it must also incorporate quality data and must provide proper safeguards including, but not limited to risk adjustment and adequate sample size, to ensure the integrity of the data. All quality measurements must take into account practice variation and the ability for patients and providers of health care to determine the best course of treatment.
Further:

As each insurer files its annual attestation of adequacy, the Commissioner shall make such filings available to the public on the DOI website. Each attestation filed by an insurer shall be accompanied by a report from the third party contractor retained by the Division as described in testimony to the Senate Committee on Commerce, Labor and Energy on June 2, 2013 regarding AB 425. This report should include, without limitation:

- *a breakdown of providers by type and number, including health care providers, hospitals, laboratories, diagnostic facilities and other facilities that are contracted to provide services in the network plan; and*
- *whether each provider of health care in the plan network is accepting new patients.*

Complaint Process and Satisfaction Surveys

We acknowledge that the Division currently has a process by which covered persons can file a complaint with the Insurance Commissioner regarding an insurance-related problem. A fully transparent complaint and complaint resolution process is vital to protecting consumers. To that end, we believe that language highlighting this process should be inserted as a new Subsection 2 in Section 3 of the regulation and include the following concepts:

- *In order to assure and monitor that patient access to care is not unduly or unnecessarily delayed or denied, the Commissioner shall accept complaints regarding the adequacy of a network plan from enrolled members of the network plan.*
- *Upon receiving such a complaint, the Commissioner must examine within 15 business days that specific area of a network plan to determine whether the network is adequate or whether significant changes have occurred which may disrupt patient access to care or indicate a deficient network.*
- *The Commissioner shall post on the Division's website all complaints received pursuant to this Section together with findings and the Commissioner's determinations related thereto.*

We also believe the Commissioner should monitor patient satisfaction on an on-going basis. Regulatory language should include the following:
The Commissioner shall monitor established health care delivery networks that the Commissioner has determined to be adequate, requiring reports be made available to the public that show, without limitation, the

following:

- *The results of regular patient surveys conducted for each plan; the results of these should surveys be compared against other network survey results;*
- *The bi-annual results of an insurer's report demonstrating that enrollees have had access to timely and convenient medical care, including all essential health care benefits and emergency services;*
- *The monthly totals of providers of health care accepting new patients for each network, and the total number of providers of health care in each network;*
- *Monthly reports of complaints against insurers relating to network adequacy including steps and measures the insurer and the Commissioner made to resolve the complaints.*

Finally, we believe the reports compiled and posted by the Commissioner should disaggregate the information by carrier.

<u>During a Network Deficiency Period</u>

Section 12 deals with deficiencies in network plans, but questions still arise.

In Sec. 12.1, a carrier is required to "submit a corrective action plan to resolve the deficiency within 60 days after the effective date of the material change...."

- Must the carrier submit the plan within 60 days? Or must the carrier submit a plan whereby the deficiency will be resolved within 60 days?
    - This needs to be clarified and a period of compliance should be enumerated for both the submission and the resolution.
- In either case, how will patients know there is a deficiency awaiting corrective action and that they should contact their plan to make arrangements to receive care from another source, either in or out of network? Notice to patients should be included as part of the corrective action plan.

A related issue exists in Section 7. While this section deals with the Indian Health Service, Sec. 7.2 states that *"nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meets its standards for medical necessity, care management and claim administration or from limiting payment to that amount payable if the health care services were obtained from a health care provider that is part of the network plan."* Does this language indicate that carriers will be allowed to pay only in-network fees? Does this put the burden of paying a "balance bill" on the enrolled patient? If so, carriers must be held responsible to inform their enrolled patients of the potential of incurring significant out-of-pocket expenses.

<u>Telehealth</u>

The topic of telehealth/telemedicine needs to be more completely developed in the draft regulation. During the 2015 session, legislators passed AB 292, dealing with telehealth. The bill:

- Requires insurers to pay for services provided via telehealth in the same amount as if the services were provided in person.
- Requires the Commissioner of Insurance to consider services provided through telehealth when defining insurance network adequacy.

Section 8 of R049-14 lists elements the Commissioner may consider when determining whether a network is adequate.

- In the June 3, 2015 version of the regulation that was attached to the workshop announcement, Sec. 8.1(d) reads "the availability of telehealth services".
- In the June 3, 2015 version that was circulated at the Commissioner's Advisory Committee on Health Care and Insurance, Sec. 8.1(d) reads "the use of telemedicine or telehealth services to supplement or provide an alternative to in-person care in the network plan".

Bulletin 14-005 states several times that "telemedicine may be utilized in order to provide accessible care in **addition to** the above network adequacy ratios and travel standards." (Emphasis added.)
The regulation should clarify that telemedicine services are not part of the metrics in determining adequacy of a network but are seen as an enhancement to an otherwise adequate network. Other clarifications should include whether telemedicine may be part of the determination if every provider in the service is in-network, which should include the originating site, the distant site and all providers who will bill for services.

The Nevada State Medical Association and our partner specialty organizations are pleased to continue the dialogue with the Division of Insurance on the vitally important topic of patient access to quality health care. Many members of the provider community will be available at your upcoming workshops to provide further input.

Sincerely,

Tomas Hinojosa, MD
President
Nevada State Medical Association

Lesley Dickson, MD
Executive Director/State Legislative Representative

Isaac J. Hearne, MD
President
Nevada Academy of Opthalmology

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Cc: Mark Kruger, Division of Insurance
Kim Everett, Division of Insurance

3660 Baker Lane, Ste. 101
Reno, NV 89509
(775) 825-6788

Anthem Blue Cross and Blue Shield
9133 W Russell Road
Las Vegas, Nevada 89148

Anthem

July 15, 2015

Kim Everett
Division of Insurance
1818 E College Parkway, Suite 103
Carson City, NV 89706

Attention: RO-49-15 – June 3, 2015 version

Dear Ms. Everett:

Thank you for the opportunity to provide comments on the proposed network adequacy regulation. We are pleased to provide the following additional comments to the above pending regulation. We do continue to raise concerns about the provider directory update, 72 hour notice requirements and requirements to indicate providers who are either new to or removed from a network, which we detailed in our previous comment letter on the this regulation.

In addition to our previous comments, we recommend the following language be added to the pending regulation as we cannot be held responsible for untimely provider communications to us regarding their required updated information.

- Section 10, Provider Directories:
  - **Anthem proposes the following language be added to Section 10: *Carriers that contract with providers to provide timely updates regarding participation in the network shall not be deemed noncompliant if failure to update the provider directory or report a material change is the result of any provider's failure to provide timely notice to the carrier regarding such change.***
- Section 6 (3)
  - Regarding the write-in procedure for ECPs outlined in the most current "Letter to Issuers in the Federally-facilitated Marketplaces"
    - Comments on the Paper Reduction Act regarding ECPs are due on 8/4/15. The PRA proposes a new approach for collecting data on ECPs directly from providers for the purposes of issuer network development and demonstrating the 30% threshold. The pending rule eliminates carriers' ability to write in contracted provider information. Instead, health plans would rely solely on a CMS list of ECPs which is dependent upon providers reporting their ECP status to CMS
    - Anthem suggests modifying the language to reflect CMS rules in the following manner:
      - ***3. For the purposes of meeting the 30 percent inclusion requirement in subsection 2, a carrier may use an essential community provider***

Anthem Blue Cross and Blue Shield
9133 W Russell Road
Las Vegas, Nevada 89148

Anthem

that does not meet the requirements to be included in any of the categories contained in paragraph (b) of subsection 2 so long as the carrier follows the ~~write-in~~ procedure for essential community providers outlined in the most current "Letter to Issuers in the Federally-facilitated Marketplaces", as issued and updated periodically by CCIIO .

We appreciate the opportunity to continue to provide our perspective on this regulation. If you have any questions, please feel free to contact me at (775) 827-0880 or via email at Tracey.Woods@Anthem.com.

Sincerely,

Tracey Woods
Government Relations Director, Sr.
Anthem, Inc.

Planned Parenthood®
Act. No matter what.

Nevada Advocates for Planned Parenthood Affiliates, Inc.

To: Nevada Division of Insurance

From: Elisa Cafferata, President & CEO, NAPPA

Re: LCB File No. R049-14 Network Adequacy

Date: July 21, 2015

Nevada Advocates for Planned Parenthood Affiliates (NAPPA) is the independent, non-partisan, and nonprofit education, policy and advocacy arm of Planned Parenthood's two affiliates (Mar Monte and the Rocky Mountains) in the state.

Planned Parenthood's three Nevada health centers handle over 48,000 patient visits each year. We offer high quality care at affordable rates, in some cases on a sliding fee scale; many of our patients have nowhere else to go for basic health care. We are proud of our long record of compassionate care -- over 35 years in Nevada -- always affordable, confidential, culturally appropriate, and welcoming to our clients. Thank you for the opportunity to comment on LCB File No. R049-14 Network Adequacy.

- **Access to all Essential Community Providers (ECPs)**
  - Concerns: The proposed rule requires health plans to (1) include at least 30 percent of all available ECPs in the service area (this is consistent with the federal standard); AND (2) include in their networks at least one ECP from each ECP category listed in the regulation. However, in Section 6 sub 2, the regulation lists only 340B providers - e.g., those health centers receiving Title X family planning grants or 340B HIV clinics, FQHCs, 340B family planning providers, and 340B hospitals.
  - This means, under the proposed regulation, plans are not required to include non-340B ECPs in their plan networks. This not only ignores the federal definition of ECP but also undermines access to care, particularly access to rural family planning providers as well as Planned Parenthood health centers.
  - Many Planned Parenthoods do NOT receive Title X grants and do not participate in the 340B program. In fact, none of the Planned Parenthood health centers in Nevada are currently Title X grantees and are not therefore 340B providers. But federal law is very clear that non-340B family planning providers are still considered Essential Community Providers and critical to health care access.
  - ECP federal regulations in 45 CFR 156.235(c) define Essential Community Providers to include "a provider that serves predominantly low-income, medically underserved individuals" which includes:

- (1) a 340B provider;
- (2) a provider described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (these are 340B "look alike" providers that serve the same population as 340B providers but do not participate in 340B); or
- (3) "a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act"

- Recommendations: The Nevada regulation should be consistent with HHS' ECP definition by clarifying that insurers must include in their networks at least one family planning ECP, which may include either 340B or non-340B family planning providers.
- We ask that the proposed rule add a subsection under Section 6(2)(b) specifying that plans must include at least one ECP from each category in the following list, including "a governmental family planning service site or not-for-profit family planning service site whether it receives funding under Title X or not."

- **Essential Community Provider write-in procedure**
  - Concern: Section 6(3) states that, for purposes of meeting the 30 percent ECP inclusion requirement, carriers may use "an essential community provider that does not meet the requirements" as long as the carrier follows the write-in procedure for ECPs outlined in HHS' Letter to Issuers. However, HHS is no longer allowing carriers to use a write-in procedure starting in the 2016 plan year. So this regulation will become out of date and irrelevant in a few months.
  - Recommendation: We ask the Nevada Division of Insurance to eliminate Section 6 (3) and its reference to write- in procedures.

- **Nondiscrimination from plans toward providers of women's health care:**
  - Concern: A policy to stress the federal Essential Community Provider nondiscrimination provision (45 CFR 155.1050) would provide critical protections for women in Nevada. A nondiscrimination provision would make it illegal for NV or the SSHIX to pass a law prohibiting a Marketplace plan (Qualified Health Plan) from contracting with an Essential Community Provider. This was added at the federal level to protect PP from any future attempts in the states to exclude PP from Marketplace plans. Also, a separate ACA provision (section 2706) prohibits group and individual health plans from

discriminating against providers who are acting within the scope of their license or certification. States are tasked with enforcing this policy.

- Recommendation: We recommend that Nevada regulations add a state-level nondiscrimination provision that applies to all carriers (not just QHPs) and protects women's health Essential Community Providers.
- This would protect Nevada women as well as low income patients who are very limited in their options for attaining low cost insurance. The federal guidance is clear; it is not permissible to attempt to exclude or otherwise restrict PP from commercial insurance contracts (both inside and outside the Marketplace).
- The provision could be added to Section 4 and look something like this: *"A carrier who applies to the Commissioner for the issuance of a network plan may not be prohibited or otherwise restricted from contracting with any essential community provider."*

DaVita | HealthCare Partners

July 23, 2015

Ms. Amy L. Parks, Esq.
Acting Commissioner
Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Madam Commissioner:

DaVita Health Care Partners appreciates the opportunity to comment on the June 3, 2015 revision of the November 12, 2014 draft regulation File number R049-14 on network adequacy.

By way of background, DaVita HealthCare Partners serves Nevada through two divisions: (1) Kidney Care and (2) HealthCare Partners Nevada.

DaVita Kidney Care has the privilege of serving 2,372 patients at 25 clinics across the State, in both urban and rural areas of the state. Overall, we employ 635 providers and teammates,

HealthCare Partners Nevada serves approximately 230,000 patients in Southern Nevada, employing 220 total providers divided into 110 Primary Care Providers, 30 hospitalists, 40 specialists and 40 Mid-Level providers. With a focus on primary care, Health Care Partners has medical clinics and specialty care affiliates throughout Las Vegas, North Las Vegas, Henderson, Boulder City, Mesquite and Pahrump, HealthCare Partners Nevada (HCPNV) is committed to delivering the highest quality of care to all our patients.

Ensuring network adequacy, and thereby promoting access to care for our patients is of critical importance to DaVita HealthCare Partners, and for that reason we offer the following comments.

- **We appreciate that with this reorganized draft the Division still intends to publish specific reasonable maximum travel distance, by county, for specialties and categories of care appearing as options on the CMS Network Adequacy Template and recognized medical specialties.**

With respect to kidney care those with end-stage renal disease, also known as kidney failure, cannot live without dialysis – plain and simple. This blood-cleansing, life-sustaining treatment must be provided a minimum of three times a week for 3-4 hours at a time. Each treatment causes patient fatigue and makes it dangerous to operate a vehicle at long distances. Accordingly, most dialysis patients either rely on a friend or loved one for transportation to/from their clinic or utilize public transportation. Requiring a patient to drive a great distance for treatment is simply not viable for these patients. A patient who misses a scheduled treatment can often end up in the emergency room with broader medical concerns. This is why DaVita HCP has participated in these conversations to advocate for reasonable standards with the least amount of travel time for our patients.

- **Transparency is critical for the provider community in how a network is determined to be adequate. We agree that there is a need for clear quantifiable standards on how the Division will evaluate and make that determination.**

We know that the Division is using a third-party contractor to review network data submitted by insurers pursuant to Section 5 of the draft regulation and to verify that the insurer must establish that a network plan submitted has the capacity and geographic diversity of providers to adequately serve the anticipated number of covered persons in the network plan.

Reports from the contractor to the Division about each network should proactively be made available for public review. We would also agree with other comments submitted from the NSMA that the Division should publicly deliberate and release information on how each year's data review will factor into the standards to be promulgated by the Division in the following year.

- **Telehealth standards must be clear, and telehealth alone cannot be used as the alternative to care to establish network adequacy. The Division should tread cautiously in this developing area of care delivery. Telehealth is best used when it promotes access as PART of the continuum of care.**

The Division had previously indicated that telehealth was to be used to supplement a network. In the most recent version of the regulation the language around supplementing was removed in Section 8(1) (d). While the 2015 telehealth bill (AB 292) states that telehealth must be considered by the Commissioner in determining adequacy, it also states that an insurer cannot require a service to be provided by telehealth alone. That would indicate that a network

comprised mostly or entirely of telehealth providers should not be allowed under Nevada law and this regulation. We would like clarification of this point during the regulatory process.

- **We conclude with a question: How will “narrow networks” be defined and permitted under specific standards?**

The Division needs to be vigilant for plan designs that may be employed as a means to discriminate against persons with certain health care needs. The use of specially-crafted narrow networks may dissuade consumers from enrolling in certain plans, in violation of federal nondiscrimination provisions. Does the Division still intend to bar "narrow networks" in all Exchange plans? (Federal Regulations (45 CFR 156.230) require a network, as available to all enrollees, be adequate, which would imply narrow networks will be regulated in some capacity) Will narrow networks be allowed off-Exchange? How will "narrow" be defined? By capacity? By number of providers? By geography?

We appreciate the opportunity to share DaVita Health Care Partners’ comments and recommendations with you. Please do not hesitate to contact me if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

Jeremy Van Haselen

Vice President, State Government Affairs, DaVita
e-mail:jeremy.vanhaselen@davita.com