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

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 20, 2020

TO: Medicare Advantage Organizations
Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2021 Medicare Advantage Bid Review and Operational Instructions

This memorandum provides Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans operational instructions on bid development and submission; highlights benefit policies; and reviews the contract year (CY) 2021 Plan Benefit Package (PBP) software.

CMS recommends organizations reference the following list of documents in conjunction with this memorandum as they develop CY 2021 bids.

- Final rule, CMS-4185-F, titled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" published on April 16, 2019;
- CY 2020 Final Call Letter (specifically Section II, Part C) issued on April 1, 2019;
- Chapter 4 of the Medicare Managed Care Manual (MMCM);
- HPMS Memo titled "Final Contract Year 2021 Part C Benefits Review and Evaluation" issued on April 8, 2020;
- Contract Year (CY) 2021 Final Part D Bidding Instructions issued on February 6, 2020;
- Bid Submission User Manual in the Health Plan Management System (HPMS).

Bids are due to CMS on or before **Monday, June 1, 2020, at 11:59 PM PDT**.

The table below displays the applicable bid review criteria by MA plan type. The column titled "Document References" refer to the following: (1) This HPMS Memorandum, (2) The HPMS Memo titled "Final Contract Year 2021 Part C Benefits Review and Evaluation" issued on April 8, 2020, and (3) the CY 2020 Final Call Letter issued April 1, 2019.

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	**Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)**	**Applies to Non-Employer Dual Eligible SNPs**	**Applies to 1876 Cost Plans**	**Applies to Employer Plans**	**Document References** *(see descriptions above)*
Total Beneficiary Cost (TBC) Section 1854(a)(5)(C)(ii) of the Act, and 42 C.F.R. §§422.254(a)(4) and 422.256(a)	Yes	No	No	No	1 and 2
Maximum Out-of-Pocket (MOOP) Limits 42 C.F.R. §422.100(f)(4) and (5) and §422.101(d)(2) and (3)	Yes	Yes	No	Yes	1 and 2
PMPM Actuarial Equivalent Cost Sharing Section 1852(a)(1)(B) of the Act; 42 C.F.R. §422.254(b)(4), §422.100(f)(2)	Yes	Yes	No	Yes	2
Service Category Cost Sharing[1] 42 C.F.R. §417.454(e), §422.100(f) and §422.100(j)	Yes	Yes	Yes	Yes	2
Part C Optional Supplemental Benefits Section 1852(a)(3) and 42 C.F.R. §422.100(f)	Yes	Yes	No	No	2 and 3

[1]Section 1876 Cost Plans and MA plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 C.F.R. §§417.454(e) and 422.100(j)). In addition, MA plans may not charge enrollees higher costs sharing than is charged under Original Medicare for: (i) COVID-19 testing and COVID-19 testing-related services identified in section 1833(cc)(1) for which payment would be payable under a specified outpatient payment provision described in section 1833(cc)(2) during the period from March 18, 2020 through to the end of the emergency period described in section 1135(g)(1)(B); and (ii) a COVID-19 vaccine and its administration described in section 1861(s)(10)(A). These changes regarding coverage of COVID-19 testing, testing-related services, and vaccination are pursuant to amendments to section 1852 of the Act made by the Families First Coronavirus Response Act (P.L. 116-127) and the CARES Act (P.L. 116-136).

Consistent with prior years, MA organizations also must address other requirements in their bids, such as the medical loss ratio, and are expected to do so independently of our requirements for benefits and bid review. Therefore, CMS is not making specific adjustments or allowances for these changes in the benefits review requirements.

Total Beneficiary Cost (TBC)

As stated in the HPMS memo titled "Final Contract Year 2021 Part C Benefits Review and Evaluation" issued April 8, 2020, CMS is not obligated to accept every bid submitted and is authorized to deny a plan bid if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. In exercising this authority, we will be using the same TBC evaluation as in past years to calculate the TBC change amount as described below. In applying the TBC evaluation, plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and a MAO may be requested to provide a justification or change its bid(s). A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs (OOPC). The methodology for developing the CY 2021 out-of-pocket costs (OOPC) model is consistent with last year's methodology.

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 reviewing excessive increases in the TBC from one year to the next, CMS is able to make sure enrollees who continue enrollment in the same plan are not exposed to significant cost increases. As in past years, CMS will not evaluate TBC for EGWPs, D-SNPs, SNPs for End Stage Renal Disease (ESRD) Requiring Dialysis, and MSA plans. EGWP benefit packages are negotiated arrangements between employer groups and MA organizations so we believe that the employer would have taken these costs into account in making such plans available. D-SNP benefits entered into the plan benefit package do not include state benefits and cost sharing relief, which means that a TBC evaluation would not be based on the full benefit and cost sharing package available to enrollees. SNPs for ESRD Requiring Dialysis are not effectively addressed by the OOPC model used for the TBC evaluation and these plans potentially experience larger increases and/or decreases in payment amounts. ESRD SNPs are subject to all other MA standards and CMS will contact plans if CMS identifies large benefit or premium changes (while taking into consideration payment changes) during bid review. Finally, MSAs have unique benefit designs that includes a medical savings account for purposes of paying costs below the deductible.

MA plans offering Part C supplemental benefits that take advantage of the flexibility in the uniformity requirements, that offer Special Supplemental Benefits for the Chronically Ill (SSBCI), and/or that are participating in the Value-Based Insurance Design (VBID) model test will be subject to the TBC evaluation for CY 2021; however, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered under Part C uniformity flexibility, as SSBCI, or as part of the VBID model test will be excluded from the TBC calculation. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan.

Under 42 C.F.R. §§ 422.254 and 422.256, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the required amount. This approach not only protects enrollees from significant increases in cost sharing or decreases in benefits, but also confirms enrollees have access to viable and sustainable MA plan offerings.

CMS will continue to incorporate the technical and payment adjustments described below and expect organizations to address other factors, such as coding intensity changes and risk adjustment model changes independently of our TBC standard. As such, plans are expected to anticipate and manage changes in payment and other factors to minimize changes in benefit and cost sharing over time. CMS also reminds MA organizations that the Office of the Actuary extends flexibility on margin requirements so MA organizations can satisfy the TBC requirement.

In mid-April 2020, as in past years, CMS will provide plan specific CY 2021 TBC values and incorporate the following adjustments in the TBC calculation to account for changes from one year to the next:

- Technical Adjustments: (1) annual changes in OOPC model software and (2) maximum Part B premium buy-down amount change in the bid pricing tool ($144.60).

- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

The TBC change threshold for most plans, as discussed below, will increase to $39.00 PMPM in CY 2021. Therefore, a plan experiencing a net increase in adjustments must have an effective TBC change amount below the $39.00 PMPM threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $39.00 PMPM threshold. In an effort to support plans that received increased quality compensation and experience large payment adjustments, along with holding plans accountable for lower quality, CMS will apply the TBC evaluation as follows.

For CY 2021, the TBC change evaluation will be treated differently for the following specific situations:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $39.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $39.00 PMPM) plus applicable technical adjustments.

- Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount less than -$39.00 PMPM will have a TBC change threshold of $78.00 PMPM (i.e., 2 times TBC change limit of $39.00 PMPM) plus applicable technical adjustments. That is, plans are not allowed to make changes that result in greater than $78.00 worth of decreased benefits or increased premiums.

- Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$39.00 PMPM will have a TBC change threshold of $78.00 PMPM (i.e., 2 times TBC change limit of $39.00) plus applicable technical adjustments.

- Plans not accounted for in the three specific situations above are evaluated at the $39.00 PMPM limit, similar to the policy in CY 2020 about using the TBC threshold.

CMS will maintain the TBC evaluation used during CY 2020 for consolidating or crosswalking plans. Each individual plan being consolidated/crosswalked into another plan must meet the TBC requirement on its own merit. Therefore, the TBC adjustment factors for each plan being consolidated/crosswalked will be part of the calculation as if the plan were continuing. For example, Plan A is being consolidated/crosswalked into Plan B. Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B. Plan B's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan B. The following describes how the TBC evaluation will be conducted for organizations that consolidate/crosswalk or segment plans from one year to the next:

- Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2020 plan will be compared independently to the CY 2021 plan.

- Segmenting an existing plan: TBC for each CY 2021 segmented plan will be compared independently to the CY 2020 non-segmented plan.

- Consolidating/crosswalking previously segmented plans: TBC of each existing CY 2020 segmented plan will be compared independently to the non-segmented CY 2021 plan.

- Consolidating/crosswalking segmented plans into other segmented plans: TBC of the existing CY 2020 segmented plan will be compared independently to the segmented CY 2021 plan.

If CMS provides the MA organization an opportunity to correct CY 2021 TBC issues, following the bid submission deadline, the MA organization may not be permitted to change its formulary (e.g., adding drugs, etc.) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS identified formulary review negatively affects the formulary and bid review process. For example, portions of the annual formulary review process are based on outlier analyses. If an MA organization were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition, significant formulary changes will necessitate additional CMS review, outside of the normal review stages, and may jeopardize the approval of a sponsor's formulary and could affect approval of its contract. To avoid TBC issues, MA organizations are strongly encouraged to make sure all Part C and Part D benefit and formulary changes are considered as part of their own internal TBC review prior to submitting their final bids and formularies to CMS. We make all of the necessary tools and information available to MA organizations in advance of the bid submission deadline, and therefore expect all MA organizations to submit bids that satisfy CMS requirements.

The plan-specific data elements that CMS will post on HPMS are shown in the following table. The calculation shown in the table accounts for changes in quality bonus payment and/or rebate percentage or star rating (as described above) so all plans are evaluated against a $39.00 PMPM TBC change threshold. Should there be any changes due to the quality bonus payment appeals process, plan sponsors will be notified of their corresponding revised TBC adjustment factor.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2020 TBC	A	OOPC value	Each of these plan-specific values will be provided by CMS through an HPMS posting
	B	Premium (net of rebates)	
	C	Total TBC	
CY 2021 TBC	D	OOPC value	Plan calculates using OOPC Model Tools
	E	Premium (net of rebates)	Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14
	F	Total TBC	Calculation: D plus E
Apply TBC Adjustments	G	Unadjusted TBC Change	Calculation: F minus C
	Payment adjustments (including county benchmark, quality bonus payment, and/or rebate percentages)		
	H	Gross Payment Adjustment	Plan-specific value will be provided by CMS through an HPMS posting
	I	Plan Situation	CMS determines whether the TBC calculation is modified for each plan to account for changes in quality bonus payment and/or rebate percentage or star rating through an HPMS posting
	J	Payment Adjustment Based on Plan Situation	Plan-specific value will be provided by CMS through an HPMS posting
	Technical Adjustments		
	K	Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2020 ($135.50) and the amount for CY 2021 ($144.60)	Value is $9.10 for all plans
	L	Impact of changes in OOPC Model between CY 2020 and CY 2021	Plan-specific value will be provided by CMS through an HPMS posting
Evaluation	M	Adjusted TBC Change	Calculation: G + J - K - L Plan is likely to pass the TBC evaluation if M is less than or equal to $39.00 PMPM

As described in the table above, CMS will provide, through the HPMS posting, CY 2020 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of plan premium and Part B premium paid by the enrollee as reflected in the BPT. Based on the CMS release of Statistical Analysis Software (SAS) files in early April, MA organizations will be able to calculate their plan-specific CY 2021 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2021 (Item E). Premium (net of rebates) can be found in the CY 2021 Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The *Unadjusted* TBC Change between CY 2020 and CY 2021 (Item G) is the difference between CY 2021 Total TBC (Item F) and CY 2020 Total TBC (Item C) , i.e., G = F - C. The *Adjusted* TBC Change amount (Item M) reflects the impact of the payment adjustment and technical adjustments. CMS will provide payment adjustment information through the HPMS posting. The Gross Payment Adjustment (Item H) accounts for changes in county benchmark, and quality bonus payment and/or rebate percentages. The Plan Situation (Item I) defines whether the TBC calculation will be modified with an alternative Payment Adjustment based on the Plan Situation (Item J) to account for changes in the quality bonus payment and/or rebate percentage or star rating as indicated in the following table:

Plan Situation (Item I)	**Payment Adjustment Based on the Plan Situation (Item J)**
Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount (Item H) greater than $39.00 PMPM	Maximized at $39.00
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -$39.00 PMPM	Minimized at -$39.00
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -$39.00 PMPM	Minimized at -$39.00
Plans that are not accounted for in the three categories above	Same as Gross Payment Adjustment

The HPMS posting will also provide Technical Adjustments, including Part B premium adjustment (Item K) and the Impact of Changes in the OOPC model between CY 2020 and CY 2021 (Item L). It should be noted, however, these elements impact TBC in different directions, i.e., M = G + J - K - L.

Plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $39.00 PMPM will have passed the TBC evaluation. CMS also reminds MA organizations that the Office of the Actuary extends flexibility on margin requirements so MA organizations can satisfy the TBC

requirement. As noted above, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the required amount.

Illustrative Calculation for Payment Adjustments

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table provides examples of how the payment adjustment is calculated. The Payment Adjustment is the CY 2021 rebate minus the CY 2020 rebate. The CY 2020 Bid Amount and Benchmark are taken from the CY 2020 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2020 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2021 ratebook. The CY 2021 Benchmark is the weighted average of county-specific payment rates using the CY 2021 ratebook and projected enrollment from the CY 2020 BPT. The rebate percentage is dependent on the plan's Quality Bonus Payment (QBP) rating for each year. The rebate is calculated as the amount by which the Benchmark exceeds the Bid Amount, multiplied by the rebate percentage.

Illustrative Calculation Examples

Bid ID	2020 Values					2021 Values					Rebate Difference	Payment Adj.	TBC Threshold
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate			
Plan 001	3	$1,000	$950	50%	($50.00)	3	1,056.20	$1,003	50%	($52.81)	($2.81)	($2.81)	$41.81
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,056.20	$1,109	50%	$26.41	$1.40	$1.40	$37.60
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,056.20	$1,373	65%	$205.96	$55.96	$39.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,056.20	$1,373	50%	$158.43	($36.57)	($36.57)	$75.57
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,056.20	$1,438	65%	$248.21	$53.21	$39.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,267.44	$1,373	65%	$68.91	($38.34)	($38.34)	$77.34
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,056.20	$1,250	50%	$96.90	($53.10)	($39.00)	$78.00

Note: Slight variances in numbers are due to rounding.

Illustrative Calculation Descriptions

a. Plans 001 through 004 have benchmark growth of 5.62%.

b. Plan 001 bid amount is greater than the benchmark in both years; therefore the difference is not multiplied by the rebate percentage.

c. Plan 002 (and plans 003-007) bid amount is less than the benchmark in both years; therefore the difference is multiplied by the rebate percentage.

d. Plan 003 has an increase in rebate percentage; therefore the payment adjustment is maximized at $39.

e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -$39.

f. Plan 005 has benchmark growth of 5.62% plus 5.0% to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $39.

g. Plan 006 has benchmark growth of 5.62% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$39.

h. Plan 007 has a 2021 star rating below 3.0; therefore the payment adjustment is minimized at -$39.

We encourage organizations to participate in Actuarial User Group Calls conducted by the Office of the Actuary. These calls began in April and provide organizations with the opportunity to ask technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

Under 42 C.F.R. §422.100(f)(4) and (5), and §422.101(d)(2) and (3), all MA plans, including employer group plans and SNPs, must establish limits on enrollee out-of-pocket cost sharing (i.e., deductibles, coinsurance, and copayments) for Parts A and B services that do not exceed the annual limits set by CMS. In setting these limits under the regulations, CMS uses Medicare Fee-for-Service data to strike a balance between limiting maximum beneficiary out-of-pocket costs and potential changes in premium, benefits, and cost sharing, with the goal of ensuring beneficiary access to affordable and sustainable benefit packages. The regulations addressing MOOP limits were originally adopted in 2010 rulemaking. This standard for setting the MOOP limits was adopted in the final rule Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-F) (83 Fed. Reg. 16440 (Apr. 16, 2018)) and is applicable for 2021.

For CY 2021, we continue to encourage organizations to establish the lower, voluntary MOOP thresholds. MA organizations adopting voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits. MA organizations are responsible for tracking out-of-pocket spending incurred by the enrollee (i.e., cost sharing includes deductibles, coinsurance, and copayments pursuant to §422.2) and to alert enrollees and contracted providers when the MOOP limit is reached.

The following chart identifies the required MOOP amounts by plan type, including all Parts A and B services, for the CY 2021 PBP:

CY 2021 PBP Options for Entering MOOP Amounts by Plan Type

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

NOTE: While Section 1876 Cost Plans are not required to have a MOOP, CMS encourages cost plans to consider including one. If cost plans do include a MOOP they must specify in their communications to enrollees how the MOOP is calculated to avoid beneficiary confusion.

Discriminatory Pattern Analysis

CMS will review PBP submissions and evaluate whether they satisfy the applicable cost sharing requirements. CMS may identify cost sharing for specific services (that are not specifically addressed here or in the HPMS Memo titled "Final Contract Year 2021 Part C Benefits Review and Evaluation" issued on April 8, 2020) for which cost sharing appears discriminatory. For additional information, review MMCM, Chapter 4, Section 50.1. CMS will evaluate whether cost sharing levels satisfy MA requirements and are defined or administered in a manner that may discriminate against sicker or higher-cost beneficiaries. These analyses may also evaluate the impact of benefit design on beneficiary health status and/or certain disease states. CMS will contact plans to discuss any issues that are identified as a result of these analyses and seek correction or adjustment of the bid as necessary.

CY 2021 Part C Benefit Policy

Additional Telehealth Benefits

For CY 2021, Additional Telehealth Benefits - Part B services and cost sharing continues to be entered in B-7j of the PBP and may not be referenced under B14c: Remote Access Technologies.

Under § 422.135 MA organizations have the ability to provide "additional telehealth benefits" to enrollees and treat them as basic benefits for purposes of bid submission and payment by CMS. Additional telehealth benefits are limited to services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act, and that have been identified for the applicable year as clinically appropriate to furnish through electronic exchange when the physician or practitioner providing the service is not in the same location as the enrollee.

An MA plan must meet the requirements of 42 CFR 422.135 in order for the benefits to be considered additional telehealth benefits that are treated as basic benefits. If the MA plan fails to comply with the requirements of 42 CFR 422.135, then the MA plan may not treat the benefits provided through electronic exchange as additional telehealth benefits, but may treat them as supplemental benefits as described in 42 CFR 422.102, subject to CMS approval.

MA plans must indicate in the PBP service category B7j if they are offering additional telehealth benefits through network providers for Part B services and select the service categories where additional telehealth benefits may be offered. Cost sharing should be entered as a range in B7j and encompass all service categories selected. MA plans offering additional telehealth benefits may maintain different cost sharing for the specified Part B service(s) furnished through an in-person visit and the specified Part B service(s) furnished through electronic exchange.

Over the Counter (OTC) Items and Services

In the HPMS Memo titled "Reinterpretation of Primarily Health Related for Supplemental Benefits" issued April 27, 2018, CMS explained its expanded interpretation of the standard that supplemental benefits be "primarily health related." A primarily health related benefit is an item or service that is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization.[1] As a result of this reinterpretation, MA plans can cover a broader array of over-the-counter (OTC) items and services as supplemental benefits. Examples include reading and magnifying glasses, hearing aid batteries, probiotics, herbal supplements, and nutritional drinks/shakes (which are all not covered by Medicare) when the MA organization incurs a non-zero direct medical cost in providing or covering. Chapter 4 of the MMCM contains guidance on coverage of OTC items and services as supplemental benefits but we caution MA organizations that the guidance has not been fully updated to incorporate the reinterpretation of the "primarily health related" standard.

[1] In addition to being primarily health related, an item or service must also be (1) not covered by Medicare (Parts A, B or D) and (2) something for which the MA organization incurs a non-zero direct medical cost in providing or covering.

Acupuncture

Medicare covers acupuncture for chronic low back pain for a specified number of visits when reasonable and necessary for treatment of chronic low back pain. Medicare Advantage plans must provide the Medicare-covered acupuncture benefit specified in National Coverage Determination (NCD) 30.3.3,[2] beginning Jan 29, 2020 (the date of the NCD decision memo) as a basic benefit (i.e., non-supplemental benefit). MA organizations must comply with NCDs in furnishing and covering basic benefits under § 422.101. The Medicare-covered benefit requires that providers meet the educational requirements specified in the NCD. If the MA plan currently offers acupuncture as a supplemental benefit (in PBP B-13a) for CY 2020, the supplemental portion of the benefit would only include services not specified in the NCD. This means that if the MA plan permits acupuncture for conditions other than lower back pain or permits enrollees to go to an acupuncture practitioner with fewer restrictions than specified in the NCD, the plan would continue to treat those services (that would not be covered by Medicare) as a supplemental benefit.

For CY 2021, cost sharing and other parameters for Medicare-covered acupuncture services should be incorporated into the appropriate PBP service categories in B-7. Supplemental acupuncture benefits will continue to be entered in PBP service category B-13a.

MA-PD Offerings

Pursuant to §422.4(c), an MA organization cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MA organization in that same service area includes qualified Part D prescription drug coverage meeting the requirements of §423.104. That is, each MA organization (defined as the legal entity that signs the MA contract for the CMS evaluation) must ensure that if it is offering a MA-only coordinated care plan (i.e., no Part D coverage), it also offers at least one MA-PD plan in each county covered by the MA organization's service area(s). Additional information is also provided in Chapter 4, section 10.15 of the MMCM. A SNP or EGWP plan offered by the same organization in the same service area does not satisfy this requirement for non-SNPs. The legal entity must complete the attestation for all MA-only plans.

PPO Caps for Supplemental Benefits

Consistent with Chapter 4, § 110.4 of the MMCM, CMS is clarifying PPO plans that cap the dollar value of supplemental benefits must enter into the PBP the same maximum plan benefit coverage amount (i.e., cap/dollar amount) for both in-network and out-of-network **or** as a combined maximum benefit amount. This information applies to mandatory and optional supplemental benefits. MA organizations are expected to accurately enter the maximum benefit coverage amount, cost sharing data, and provide a brief description of the benefit in the PBP notes field. Information provided in the PBP notes field must not contradict the maximum plan benefit coverage amount entered in the PBP.

[2] The manual is expected to be updated in the near future to address the NCD.

Rewards and Incentives

Rewards and incentives are not plan covered benefits (either basic benefits or supplemental benefits). Rewards and incentives are programs that MA plans may offer consistent with regulations at 42 C.F.R. §422.134 in connection with Part A, Part B or supplemental benefits; additional information is in Chapter 4, Section 100 of the MMCM. The cost of any Rewards and Incentives Program must be included in the BPT as a non-benefit expense. MA plans participating in the VBID demonstration for rewards and incentives must follow VBID instructions for bid submission and limit any PBP notes to service category 19.

CY 2021 Part C PBP Data Entry Expectations

CAR-T

The National Coverage Determination (NCD) requiring coverage of chimeric antigen receptor (CAR) T-cell therapy for certain types of cancer is a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2019 and 2020 only, Medicare Fee-for-Service will pay for CAR T-cell therapy for cancer obtained by beneficiaries enrolled in MA plans when the coverage criteria outlined in the NCD is met. Therefore, for CY 2021, plans must account for these items and services in their bids. MA plans would cover CAR-T services under either inpatient or outpatient, depending upon where the treatment is performed. Labs, Part B drugs, or other services performed in conjunction with the treatment would be covered under the appropriate PBP service category. CAR-T services do not need to be specifically identified in the PBP or notes.

Other Medicare-covered Preventive Services

PBP service category B14e includes an "Other" option in case Original Medicare expands coverage of preventive services with cost sharing during the contract year. The PBP does not include a list of the "Other Medicare-covered Preventive Services" because services may change during the contract year and it is the MA organization's responsibility to monitor and update other Medicare-covered preventive services for which cost sharing may apply. Beginning in CY 2020, PBP service category 14e-Other was updated to add a new "N/A" selection in response to the authorization question in this section. If the plan does not require authorization for "Other Medicare-covered Preventive Services", then "N/A" can be selected.

Medical Services Performed in Multiple Health Care Settings

CMS aims to improve transparency, avoid duplication, and streamline data entry so cost sharing is entered into the appropriate PBP service category and reflects the services provided across a variety of healthcare settings (e.g., physician office, outpatient hospital, and free standing facility). Including the same service in multiple PBP locations may result in inaccurate cost sharing and potentially confusing communication materials.

CMS's expectation is that the PBP service category cost sharing amount is for the particular item or service, regardless of the place of service. For example, Cardiac and Pulmonary Rehabilitation Services can be administered in a number of health care settings including

outpatient hospitals, free-standing facilities, or a physician's office. Instead of having these services appear in multiple PBP service categories, the range of cost sharing (minimum/maximum data fields) for these services should only appear in PBP Service Category B-3 (Cardiac and Pulmonary Rehabilitation Services). In addition, the cost sharing range for diagnostic services in Outpatient Hospital should only be entered in PBP category B-8 rather than PBP category B-9. In each of these examples, plans should describe the cost sharing range associated with the various places of service in the notes field. Plans that continue to enter cost sharing based on the place of service instead of the service category in the PBP will not satisfy CMS requirements and the organization will be asked to correct its bid submission.

Employer Group Waiver Plans

MA employer plans must complete and submit the MA portion of the PBP in accordance with CMS requirements. Organizations should make a good faith effort in projecting CY 2021 member months for each plan and place the amount in Section A-2 of the PBP. The following question must be completed for all MA and Section 1876 Cost Plan organizations: "Indicate CY 2021 total projected member months for this plan."

Dual Eligible Special Needs Plans (D-SNPs)

CMS expects MA organizations offering D-SNPs to communicate MA and state Medicaid benefits to D-SNP enrollees in a comprehensive and transparent manner. D-SNPs must include Medicare Parts A, B, and D services in their PBP submission, along with approved optional and/or mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. For example, if a D-SNP offers a preventive dental benefit for which it receives payment from the State Medicaid Agency, that benefit must not be included in the PBP. D-SNPs may credit some or all of the rebate under 42 CFR § 422.266(a) toward reduction of the Medicare Part B premium. The use of rebates toward reduction of the Medicare Part B premium is not limited by a state's Medicare Savings Program.

MA plans offering supplemental benefits that are separately purchased by an employer or union may not be included in the PBP (see § 422.106(a)(2)). This segregation of Medicare-only benefits in the PBP is necessary so that CMS may appropriately account for the Medicare benefit package and to meet the requirements of section 1854 and § 422.254 regarding bids.

Notes

Most PBP sections do not require a note, particularly when an MA organization provides benefits consistent with instructions in Chapter 4 of the MMCM. When a note is required, organizations must ensure it includes all relevant information necessary for CMS review. This includes ensuring the note:

- Is consistent with the data entry in the corresponding section of the PBP.
- Includes a brief description of the different cost sharing levels included in the data field ranges:

  - Explanation of services included in minimum and maximum cost sharing amounts, and cost sharing for any highly utilized services in between.

  - Explanation of cost sharing associated with various places of service.

- Is consistent with information in Chapter 4 of the MMCM, additional information related to the reinterpretation of the "primarily health related" supplemental benefit definition (see HPMS Memo titled, "Reinterpretation of Primarily Health Related for Supplemental Benefits," issued April 27, 2018), and the uniformity requirement in the MA regulations at §422.100(d) (see HPMS Memo titled "Reinterpretation of the Uniformity Requirement" issued April 27, 2018), and Special Supplemental Benefits for the Chronically Ill (SSBCI) (see HPMS Memo titled: "Implementing Supplemental Benefits for Chronically Ill Enrollees" issued April 24, 2019):

  - If PBP notes are necessary based on Chapter 4 instructions, the note must provide the information as described in Chapter 4.

  - If a plan is offering more extensive services for a particular supplemental benefit, the note should describe only those services over and above what is described in Chapter 4.

  - If there isn't information specific to the benefit in Chapter 4 of the MMCM or other benefits related information, the MAO must enter the benefit being offered in the "Other" category of the PBP (13d, 13e and 13f) and the note must describe the benefit.

Notes should **not** include:

- Detailed ICD-10 codes, CPT codes or extensive lists of every procedure covered by the benefit;

- Names of specific drugs;

- BPT explanations;

- Terms such as "etc." or "misc.";

- Restatements of the PBP question(s);

- Terminology that does not follow the current Chapter 4 definitions (such as "prior authorization" or "referral") or terminology that leaves ambiguity about the benefit coverage parameters;

- References to Medicaid benefits;

- References to Part D benefits (except in Rx PBP Notes section, where applicable);

- References to Model of Care (MOC) requirements.

CY 2021 PBP Updates

Updated Service Category Descriptions

CMS updated the Medicare benefit and service category descriptions within the PBP software and encourages MA organizations to review this information to make sure proposed benefits are consistent with CMS definitions and instructions. These service category descriptions can be viewed within the PBP software. They can also be viewed in early April under the HPMS "Service Category Report" found in the 2021 Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2021 > Plan Benefit Reports > Service Category Report).

B-4: Emergency/Urgently Needed Services

Service Category B4 has been changed from “Emergency Care/Urgently Needed Services” to “Emergency/Urgently Needed Services” and the Benefit B4a has been changed from “Emergency Care/Post-Stabilization Services” to “Emergency/Post-Stabilization Services.” The "Indicate Maximum per visit amount" question now includes a cost sharing validation check. Post-stabilization services are covered services related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in § 422.113(c)(2)(iii), to improve or resolve the enrollee's condition.

B-7: Health Care Professional Services

B-7j: Additional Telehealth

1. The B7j Additional Telehealth Benefits question has been revised to read: “Select the Medicare-covered benefits that may have Additional Telehealth Benefits available.”
2. Consistent with last year, MA plans should continue to enter the cost sharing for Additional Telehealth Benefits as a range in B7j, encompassing all Part B service categories selected and enter a note explaining the range.

B-7k: Opioid Treatment Program Services

1. Service Category B7k has been changed from “Opioid Treatment Services” to “Opioid Treatment Program Services”.
2. In Original Medicare, the Opioid Treatment Program (OTP) benefit does not require any cost sharing from beneficiaries. However, MA plans are permitted to apply cost sharing for services at the OTP provider in their 2021 bids. Only cost sharing for services provided by an OTP provider should be included in PBP service category B7k. In order to meet the requirements of title XVIII to furnish the OTP basic benefit (see § 422.204(b)(3)), OTPs must be enrolled as providers in Medicare (under section 1866(j)), certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), and accredited by a

SAMHSA-approved entity. At this time, CMS has not added any additional requirements for OTPs that CMS determines are necessary for health and safety and to ensure the effective and efficient furnishing of opioid use disorder treatment services. Cost sharing entered in this service category should not duplicate information in other PBP service categories.

B-14: Preventive and Other Defined Supplemental Services

B-14c: Other Defined Supplemental Benefits

1. A mandatory question has been added to indicate type of Fitness Benefit offered for the B14c4 Fitness Benefit category. The plan must select one or more of the following options: Physical Fitness, Memory Fitness, and/or Activity Tracker. The note should briefly describe the benefit being offered.
2. The B14c8 benefit category name has been changed from “Bathroom Safety Devices” to "Home and Bathroom Safety Devices and Modifications.” The note should include the list of devices and/or modifications being offered.

B-15: Medicare Part B Rx Drugs

"Medicare Part B Chemotherapy Drugs" has been changed to "Medicare Part B Chemotherapy/Radiation Drugs.”

B-19: VBID/MA Uniformity Flexibility/SSBCI

1. On the B19a and B19b Package Information screens, the prerequisite question option has been changed from “participation in a wellness or care management program” to “participation in a care management program.”
2. In Section B19b, 13i the benefit “Transitional/Temporary Supports” has been changed to “General Supports for Living.”
3. In Section 19b, PPO plans are required to select "Yes" to the question "Do the benefits in this package apply to OON/POS?"

B-20: Prescription Drugs (for Section 1876 Cost Plans Only)

"Medicare Part B Chemotherapy Drugs" has been changed to "Medicare Part B Chemotherapy/Radiation Drugs on the B-20: Outpatient Drugs-Base 3 and 4 screens.”

PBP Section C

1. Section C – Plans can no longer select 14e6 Other Medicare Covered Preventive Services in Section C if there is no data entered in Section B14e6. OON benefits can only be offered if they are also offered INN.
2. Section C OON and POS groups– plans are now required to enter a note if a copay and coinsurance is offered OR a range in either copay/coinsurance is entered. This is consistent with our general notes instructions where plans must include a brief description of the different cost sharing levels included in the data field ranges.

PBP Section D

1. New Part C Reductions in Cost Sharing (RICS) screens have been added for plans to enter reduced cost sharing for Parts A and B services and/or supplemental benefits in the base bid (applicable to all enrollees) unlike section 19 (which are benefits offered only to defined populations).

2. New Combined Benefits screens have been added to allow plans to combine supplemental benefits into groups. These screens will allow the plan to offer groups of supplemental benefits together with a single maximum plan benefit amount. Plans may also indicate if the enrollee must pick one or more benefits from a list of supplemental benefits by responding to the following question: "Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?" If the plan offers combined benefits in these screens, the plan must first offer them in Section B. Each benefit may only be offered in one combined supplemental benefit package. Due to this capability, plans will use the plan maximum in section D for the combined benefit and should not enter the plan maximum in each applicable PBP service category in section B. Plans offering packages of combined supplemental benefits should not duplicate the data entry from the Combined Benefits screens on the Max Plan Benefit Coverage screens in section D.

3. Section D – Plans can now select service category 19a or 19b in the Non-Medicare covered picklists to include these services in the plan-level MOOP limit. This allows plans to have the option to apply VBID, MA UF, and SSBCI supplemental benefit cost sharing to the MOOP limit.

Important Administrative Information

MA organizations must regularly update contact information in the HPMS Contract Management module to ensure that communications between CMS and the MA organization includes the correct individuals. In addition, CMS will use the PCT@LMI.org email address to communicate with MA organizations for MA benefits review. Therefore, please ensure your organization's email system can receive emails from this address.

CMS reminds MA organizations that the OOPC model using SAS software is available on the CMS website. All documentation and instructions associated with running the OOPC model are posted on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html. Prior to uploading a Medicare Advantage plan bid, MA organizations should run their plan benefit structures through the SAS OOPC model to make sure the plan offerings comply with all of applicable Medicare Advantage standards.

Questions may be directed to the appropriate mailbox or website as specified below:

- For technical HPMS questions (e.g., PBP download, plan creation, bid upload), please contact the HPMS Help Desk at 1-800-220-2028; hpms@cms.hhs.gov;

- For technical questions about the Out-of-Pocket Cost (OOPC) model, please submit an email to OOPC@cms.hhs.gov;

- For Medicare Advantage policy questions, please submit to https://DPAP.lmi.org/DPAPMailbox/;

- For Medicare Advantage benefits questions, please review available resources (e.g., HPMS memorandums) before submitting questions to https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/;

- For crosswalks, plan consolidation and provider specific plan (PSP) questions, please submit to https://DMAO.lmi.org/DMAOMailbox;

- For marketing or communication material questions, please submit an email to Marketing@cms.hhs.gov;

- For Part D policy questions, please submit an email to PartDBenefits@cms.hhs.gov;

- For technical questions about the Bid Pricing Tool (BPT) questions, please submit an email to actuarial-bids@cms.hhs.gov;

- For Medicare-Medicaid Program questions, please submit an email to MMCOcapsmodel@cms.hhs.gov; or

- For Value-Based Insurance Design (MA-VBID) model questions, please submit an email to vbid@cms.hhs.gov.