



MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 12, 2018

TO: Medicare Advantage Organizations
Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2019 Medicare Advantage Bid Review and Operations Guidance

Introduction

The purpose of this memorandum is to provide Medicare Advantage Organizations (MAO), and where specified, Section 1876 Cost Plans the following: detailed operational guidance to support plans in their bid development; highlight key benefit policies; and review of the contract year (CY) 2019 Plan Benefit Package (PBP) software for bid submission.

Guidance in this memorandum references the CY 2019 Final Call Letter (specifically Section II, Part C) issued on April 2, 2018, Chapter 4 of the Medicare Managed Care Manual (MMCM), and the bid submission module in the Health Plan Management System (HPMS). CMS recommends MAOs and other Medicare health plans review these resources in addition to this memorandum to develop CY 2019 bids. Bids are due to CMS on or before **Monday, June 4, 2018 at 11:59 PM Pacific Daylight Time**.

Additional guidance related to the reinterpretation of the “primarily health related” supplemental benefit definition and the uniformity requirement in the MA regulations at §422.100(d) will be issued in the near future. CMS will respond to related questions submitted by organizations at that time.

Guidance related to the Medicare-Medicaid Plans (MMP) may be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html> and in the HPMS Memorandum titled “Applicability of Contract Year (CY) 2019 Final Call Letter Provisions to Medicare-Medicaid Plans (MMPs)” issued on April 3, 2018.

For information about the Medicare Advantage Value-Based Insurance Design Model Test (MA-VBID), please visit: <http://innovation.cms.gov/initiatives/vbid/>.

Bid Review

The following chart displays key MA bid review criteria and identifies which criteria are used in reviewing the bids of plan types described in the column headings, and if guidance is also provided in the CY 2019 Final Call Letter. As noted in the final rule (CMS-4182-F), CMS eliminated the requirement that MA plans offered by the same organization in the same county comply with the meaningful difference requirement beginning with CY 2019 MA bid submissions.

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNP)	Applies to Non-Employer Dual Eligible SNP	Applies to 1876 Cost Plans	Applies to Employer Plans	Described in Call Letter or this HPMS Memo
Total Beneficiary Cost (TBC) section 1854(a)(5)(C)(ii) of the Act 42 C.F.R. §422.254	Yes	No	No	No	Both
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	Both
PMPM Actuarial Equivalent Cost Sharing 42 C.F.R. §422.254(b)(4), §422.100(f)(2) and (f)(6)	Yes	Yes	No	Yes	Call Letter
Service Category Cost Sharing 42 C.F.R. §417.454(e), §422.100(f) and §422.100(j)	Yes	Yes	Yes ¹	Yes	Call Letter

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNP)	Applies to Non-Employer Dual Eligible SNP	Applies to 1876 Cost Plans	Applies to Employer Plans	Described in Call Letter or this HPMS Memo
Part C Optional Supplemental Benefits 42 C.F.R. §422.100(f)	Yes	Yes	No	No	Call Letter

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)).

CMS has interpreted and applied the regulatory standards for service category cost sharing standards and amounts, PMPM Actuarial Equivalence factors, and Total Beneficiary Cost (TBC) requirements for CY 2019 and has provided guidance on these requirements in each applicable section below. Consistent with last year, MAOs also must address other requirements in their bids, such as the medical loss ratio requirements and health insurance providers' fee, and are expected to do so independently of our requirements for benefits or 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 CY 2019 Final Call Letter, CMS will exercise its authority under section 1854(a)(5)(C)(ii) of the Act to deny MAO bids, on a case-by-case basis, if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next through the use of the TBC standard. A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs (OOPC).

The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By limiting excessive increases in the TBC from one year to the next, CMS is able to make sure enrollees who continue enrollment in the same plan are not exposed to significant cost increases. As in past years, CMS will evaluate TBC for non-employer plans (excluding D-SNPs and MSAs). In addition, Chronic Condition Special Needs Plans for End Stage Renal Disease (ESRD) Requiring Dialysis will not be subject to the TBC evaluation for CY 2019. The OOPC model used for the TBC evaluation does not effectively address ESRD SNP enrollees 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 large benefit or premium changes (while taking into consideration payment changes) are identified during bid review.

MA plans taking advantage of our new flexible approach to Part C uniformity and/or participating in the Value-Based Insurance Design (VBID) model test will be subject to the TBC evaluation for CY 2019; however, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered as part of Part C uniformity flexibility or 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, 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.

CMS will continue to incorporate the technical and payment adjustments described below and expects organizations to address other factors, such as coding intensity changes, risk adjustment model changes, and payment of the health insurance providers' fee independently of our TBC requirement. 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 MAOs that the Office of the Actuary extends flexibility on margin requirements so MAOs can satisfy the TBC requirement.

In mid-April 2018, as in past years, CMS will provide plan specific CY 2019 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 (\$22.00 for CY 2019).
- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

CMS is increasing the TBC change threshold, for most plans, from \$34.00 PMPM to \$36.00 PMPM in CY 2019 to provide flexibility in addressing medical and pharmacy inflation and benefit design and formulary changes. Therefore, a plan experiencing a net increase in adjustments must have an effective TBC change amount below the \$36.00 PMPM threshold to avoid denial of the bid under section 1854(a)(5)(C)(ii). Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the \$36.00 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 2019, the TBC change evaluation will be applied as follows for these specific situations:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than \$36.00 PMPM will have a TBC change threshold of \$0.00 PMPM (i.e., -1 times the TBC change limit of \$36.00 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 -\$36.00 PMPM will have a TBC change threshold of \$72.00 PMPM (i.e., 2 times TBC change limit of \$36.00 PMPM) plus applicable technical adjustments. That is, plans are not allowed to make changes that result in greater than \$72.00 worth of decreased benefits or increased premiums.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than -\$36.00 PMPM will have a TBC change threshold of \$72.00 PMPM (i.e., 2 times TBC change limit of \$36.00) plus applicable technical adjustments.
- Plans not accounted for in the three specific situations above are evaluated at the \$36.00 PMPM limit, similar to CY 2018.

CMS will maintain the TBC evaluation used during CY 2018 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 2018 plan will be compared independently to the CY 2019 plan.
- Segmenting an existing plan: TBC for each CY 2019 segmented plan will be compared independently to the CY 2018 non-segmented plan.
- Consolidating/crosswalking previously segmented plans: TBC of each existing CY 2018 segmented plan will be compared independently to the non-segmented CY 2019 plan.
- Consolidating/crosswalking segmented plans into other segmented plans: TBC of the existing CY 2018 segmented plan will be compared independently to the segmented CY 2019 plan.

If CMS provides an opportunity to correct CY 2019 TBC issues following the submission deadline, the MAO cannot change its formulary (e.g., adding drugs, etc.) as a means to satisfy

this requirement. The formulary review process has multiple stages and making changes that are unrelated to CMS’s 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 MAO 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 bid and contract. To avoid TBC issues, MAOs are strongly encouraged to make sure all Part C and Part D benefit and formulary changes are considered as part of their TBC evaluation prior to submitting their final bids and formularies to CMS. We make all of the necessary tools and information available to MAOs in advance of the bid submission deadline, and therefore expect all MAOs to submit bids that satisfy CMS requirements.

The plan-specific data elements that CMS will post on HPMS in mid-April 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 \$36.00 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. Section 1876 Cost Plans will be included in the HPMS posting so organizations can review their applicable information to implement the enrollment conversion requirements associated with the cost contract transition.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2018 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 2019 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

Steps	Item	Item	Description
	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 2018 (\$109.00) and the amount for CY 2019 (\$131.00)	Value is \$22.00 for all plans
	L	Impact of changes in OOPC Model between CY 2018 and CY 2019	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 \$36.00 PMPM

As described in the exhibit above, CMS will provide, through the HPMS posting, CY 2018 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of Part B premium (full premium or partial as a result of a Part B premium buy-down). Based on the CMS release of Statistical Analysis Software (SAS) files in early April, MAOs will be able to calculate their plan-specific CY 2019 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2019 (Item E). Premium (net of rebates) can be found in the Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The *Unadjusted* TBC Change between CY 2018 and CY 2019 (Item G) is the difference between CY 2019 Total TBC (Item F) and CY 2018 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 \$36.00 PMPM	Maximized at \$36.00
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -\$36.00 PMPM	Minimized at -\$36.00
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -\$36.00 PMPM	Minimized at -\$36.00
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 2018 and CY 2019 (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 \$36.00 PMPM will likely be accepted. CMS also reminds MAOs that the Office of the Actuary extends flexibility on margin requirements so MAOs can satisfy the TBC requirement. Under 42 C.F.R. §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.

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 2019 rebate minus the CY 2018 rebate. The CY 2018 Bid Amount and Benchmark are taken from the CY 2018 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2018 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2019 ratebook. The CY 2019 Benchmark is the weighted average of county-specific payment rates using the CY 2019 ratebook and projected enrollment from the CY 2018 BPT. The rebate percentage is dependent on the plan's Quality Bonus Payment (QBP) rating for each year. The rebate is calculated as the Benchmark minus the Bid Amount (if the Bid Amount is less than the Benchmark the difference is multiplied by the rebate percentage).

Illustrative Calculation Examples

Bid ID	2018 Values					2019 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	1,059.30	\$1,006	50%	(\$52.97)	(\$2.97)	(\$2.97)	\$38.97
Plan 002	3	\$1,000	\$1,050	50%	\$25.00	3	1,059.30	\$1,112	50%	\$26.48	\$1.48	\$1.48	\$34.52
Plan 003	3	\$1,000	\$1,300	50%	\$150.00	3.5	1,059.30	\$1,377	65%	\$206.56	\$56.56	\$36.00	\$0.00
Plan 004	3.5	\$1,000	\$1,300	65%	\$195.00	3	1,059.30	\$1,377	50%	\$158.90	(\$36.11)	(\$36.00)	\$72.00
Plan 005	3.5	\$1,000	\$1,300	65%	\$195.00	4	1,059.30	\$1,442	65%	\$248.81	\$53.81	\$36.00	\$0.00
Plan 006	4	\$1,200	\$1,365	65%	\$107.25	3.5	1,271.16	\$1,378	65%	\$69.25	(\$38.00)	(\$36.00)	\$72.00
Plan 007	2.5	\$1,000	\$1,300	50%	\$150.00	2.5	1,059.30	\$1,250	50%	\$95.35	(\$54.65)	(\$36.00)	\$72.00

Note: Slight variances in numbers are due to rounding.

Illustrative Calculation Descriptions

- a. Plans 001 through 004 have benchmark growth of 5.93%.
- 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 \$36.
- e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -\$36.
- f. Plan 005 has benchmark growth of 5.93% plus 5.0% to simulate gaining a bonus payment; therefore the payment adjustment is maximized at \$36.
- g. Plan 006 has benchmark growth of 5.93% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -\$36.
- h. Plan 007 has a 2019 star rating below 3.0; therefore the payment adjustment is minimized at -\$36.

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

Modified TBC Evaluation for Cost Plan Conversions

CMS provided information in the CY 2019 Final Call Letter about cost plan entities that must complete the transition to MA by CY 2019 in order to deem their cost enrollees into an affiliated MA plan offered by the organization under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) cost transition requirements. In addition, CMS released guidance on the requirements of the cost plan transition which is available at the following link:

<https://www.cms.gov/Medicare/Health-Plans/MedicareCostPlans/index.html>.

As indicated in the HPMS memo titled, “Implementation of the Cost Contract Plan Transition Requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),” issued December 7, 2015, CMS will apply a modified TBC calculation as described below for converting cost plans:

- Cost plan contracts that are transitioning to MA for CY 2019 must have submitted a CY 2018 Plan Benefit Package (PBP) to CMS in order to be evaluated for deemed enrollment.
- Each predecessor cost plan’s PBP will be compared to the successor MA plan’s PBP, based on the CMS plan crosswalk and/or contract consolidation process.
- For purposes of the modified TBC calculation, technical adjustments will be included in the calculation, but payment adjustments will be excluded. The TBC change between the converting cost plan and the MA plan must not exceed \$36.00 PMPM.
- Predecessor cost plans that include a Part D benefit must include a Part D benefit in its successor MA plan **and** predecessor cost plans that do not include a Part D benefit must not include a Part D benefit in its successor MA plan. Cost plans that offer Part D benefits through an affiliated stand-alone Prescription Drug Plan will be evaluated based on only medical benefits for both the predecessor cost plan and successor MA plan (i.e., Part D benefits will not be included in the evaluation).
- The TBC evaluation is based on in-network services and mandatory supplemental benefits entered into the PBP as described in the OOPC methodology documentation. NOTE: Out-of-network and optional supplemental benefits are **excluded** from the OOPC model.
- Cost plan contractors must review available resources and prepare to use the necessary information and tools provided by CMS so that conversion bids submitted by the first

Monday in June satisfy TBC requirements and continue to satisfy this requirement following the rebate reallocation period in late July and/or early August.

- CMS expects to communicate with organizations in late June and following the rebate reallocation period in mid-August if their MA bid does not satisfy enrollment conversion requirements in section 1851(c)(4) of the Act or MA contracting standards. Please note that MA bids that do not satisfy the modified TBC requirement will not be approved by CMS for 2019 MA plan offerings.
- CMS does not expect to make any exceptions to this evaluation process based on unique situations and/or characteristics of specific predecessor cost plans or successor MA plans.
- Successor MA plan bids must satisfy all CMS requirements as any other MA plan bid.

Maximum Out-of-Pocket (MOOP) Limits

As codified at 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 spending that do not exceed the annual maximum amounts set by CMS. The MOOP applies to Parts A and B services. However, an MAO may apply the MOOP to supplemental benefits at its option.

For CY 2019, we continue to encourage organizations to establish the lower, voluntary MOOP thresholds. MAOs adopting voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits. Plans are responsible for tracking enrolled beneficiaries' out-of-pocket spending and to alert beneficiaries and plan providers when the spending limit is reached.

The CY 2019 Final Call Letter identifies MOOP requirements by plan type. The following chart identifies the required MOOP amounts by plan type, including all Parts A and B services, for the CY 2019 PBP:

CY 2019 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

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 Call Letter) for which cost sharing appears discriminatory. For additional guidance, 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 2019 Part C Benefit Policy

MA-PD Offerings

Each MAO must ensure that if it is offering a MA-only (i.e., no Part D coverage) coordinated care plan, it also offers at least one MA-PD plan in each county covered by the MAO's service area. (This evaluation of whether an MA-PD is offered to satisfy 42 C.F.R. §422.4(c) is done using the legal entity identified as the MAO.) Pursuant to §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 qualified Part D prescription drug coverage meeting the requirements of §423.104. Additional guidance is also provided in Chapter 4, section 10 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. If a legal entity uploads an EGWP or SNP plan, in addition to MA-only plan that is neither a SNP or EGWP in the same upload package, the legal entity must complete the attestation for the MA-only plans.

Medical Services Performed in Multiple Health Care Settings

CMS is continuing its efforts to avoid duplication of medical services categories in the PBP. CMS is also providing guidance on properly placing services performed in different health care settings (e.g., physician office, outpatient hospital, and free standing facility) in the appropriate service category to correctly complete data entry within the PBP.

CMS aims to improve transparency and streamline data entry so cost sharing associated with those PBP service categories reflects the services provided across a variety of healthcare settings. 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 service. The cost sharing for a particular service must be in that PBP category, 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, cost sharing for these services should only appear in PBP Service Category 3 (Cardiac and Pulmonary Rehabilitation Services), using the minimum/maximum data fields. Plans should describe the cost sharing 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.

Supplemental Benefits that Extend or Are Offered in Conjunction with Parts A and B Services

CMS is clarifying that all MA plans are required to offer all Parts A and B items and services (except hospice) as a basic benefit. Supplemental benefits only include benefits beyond what is offered in Original Medicare. Some supplemental benefit items and services may "add-on" to or be provided in conjunction with some basic benefits (e.g., additional inpatient days, counseling services, enhanced disease management, remote access technologies, and telemonitoring services).

Original Medicare pays for chronic care management (CCM) services for patients with multiple chronic conditions. As a result, plans offering a telemonitoring supplemental benefit may only consider the telemonitoring unit and other services unrelated to CCM services as a supplemental

benefit. A related supplemental benefit may also include additional CCM or an extension of these services to a broader population of individuals than those for whom Original Medicare would pay for the CCM services. Parts A and B services and supplemental benefit items and services must be included in the appropriate PBP service categories.

PPO Caps for Supplemental Benefits

CMS is clarifying PPO plans must enter in 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 guidance applies to mandatory and optional supplemental benefits. MAOs 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.

Rewards and Incentives

Rewards and incentives are not considered plan benefits or eligible supplemental benefits. Rewards and incentives are programs plans may offer consistent with regulations at 42 C.F.R. §422.134 and guidance in Chapter 4, Section 100 of the MMCM. Rewards and Incentives Programs should not be included in CY 2019 PBPs. However, the cost of any Rewards and Incentives Program must be included in the BPT as a non-benefit expense.

CY 2019 PBP Data Entry Expectations

Most PBP sections do not require a note, particularly when an MA organization provides benefits consistent with the guidance 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 in the notes field.
- Is consistent with guidance in Chapter 4 of the MMCM or additional guidance related to the reinterpretation of the “primarily health related” supplemental benefit definition

and the uniformity requirement in the MA regulations at §422.100(d) that will be issued in the near future:

- If PBP notes are necessary based on Chapter 4 guidance, 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 guidance specific to the benefit in Chapter 4 of the MMCM, 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;
- BPT explanations;
- Terms such as "etc., or misc." in the notes field;
- 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.

B-3: Cardiac and Pulmonary Rehabilitation Services for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD)

As stated in the CY 2019 Final Call Letter, MAOs should account for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) in their bids as a basic benefit and should not include these Medicare-covered items and services as supplemental benefits. For CY 2019, MA plans should include SET for PAD in PBP service category B-3: Cardiac and Pulmonary Rehabilitation Services, and are subject to MA cost sharing guidance (i.e., not Original Medicare coinsurance). These Medicare-covered items and services must not be entered as supplemental benefits.

For PBP data entry, Medicare-covered SET for PAD is placed in the Cardiac and Pulmonary Rehabilitation Services PBP service category B3, under “Medicare-covered Pulmonary Rehabilitation Services” and must include the appropriate range of cost sharing. Also, additional (non-Medicare-covered) SET for PAD services should be included in Additional Pulmonary Rehabilitation Services. Although SET for PAD services are distinctly different from Pulmonary Rehabilitation Services, cost sharing for the two services are similar. CMS will consider creating a separate PBP data entry field for SET for PAD in CY 2020.

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

As stated in the CY 2019 Final Call Letter, Medicare Diabetes Prevention Program (MDPP) services were considered a Medicare Part B covered service beginning April 1, 2018. We want to ensure that MA plans are aware that while they must cover MDPP services in accordance with the MDPP regulations, they may also offer additional similar services as a supplemental benefit. For example, although MDPP services cannot be provided only remotely or in a 100% virtual format under current regulations to satisfy the Part B coverage requirement (and thus to be a basic benefit when covered by an MA plan), an MA plan may offer similar services in a virtual format as a supplemental benefit under Remote Access Technologies (Web/Phone-based technologies) within PBP section B-14c: Eligible Supplemental Benefits as Defined in Chapter 4.

Special Needs Plans Serving Dual Eligible Enrollees (D-SNP)

CMS expects MAOs 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 Part 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 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 CMS may appropriately account for the Medicare benefit package.

CY 2019 PBP Updates

Updated Service Category Descriptions

CMS updated the Medicare benefit and service category descriptions within the PBP software and encourages MAOs to review this information to make sure proposed benefits are consistent with CMS definitions and guidance. These service category descriptions can be viewed within the PBP software. They can also be viewed in early May under the HPMS "Service Category

Report" found in the 2019 Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2019 > Plan Benefit Reports > Service Category Report).

B-1a: Inpatient Hospital-Acute (B Only) and B-1b: Inpatient Hospital-Psychiatric (B Only)

The following question has been added in B-1a: Inpatient Hospital-Acute (B Only) – base 4 and B-1b: Inpatient Hospital-Psychiatric (B Only) – base 4:

“Do you charge cost sharing on the day of discharge?”

B-4a: Emergency Care/Post-Stabilization Care

The service category name of B-4a has been updated from “B-4a: Emergency Care” to “B-4a: Emergency Care/Post-Stabilization Care” to reflect CMS guidance in the MMCM, Chapter 4, Section 20.5 to 20.5.3.

B-9a: Outpatient Hospital Services

Medicare-covered Outpatient Hospital Services and Medicare-covered Observation Services are now listed as separate benefits in this PBP section. In addition, questions related to cost sharing, deductible, maximum enrollee out-of-pocket cost, authorization, and referral questions are included for each benefit. MA plans that bundle observation with other services (e.g., emergency room visit and outpatient surgery) may include a cost sharing range, enter the appropriate minimum and maximum cost sharing amounts for these services in service category B-9a: Observation Services, and describe the cost sharing arrangement.

B-10a: Ambulance Services

Medicare-covered Ground Ambulance Services and Medicare-covered Air Ambulance Services are now listed as separate benefits in this PBP section. Questions related to cost sharing, deductible, and MOOP costs are included for each benefit.

B-13b: Other OTC Items

The following question and attestation has been added:

“Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?”
Yes/No

If the plan selects “Yes”, then the following NRT attestation will be enabled.

“The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary Drugs.”

The Exit Validation will generate an error message if the attestation is not selected. The attestation is required to ensure compliance with 42 C.F.R. §422.500, which requires that prescription drug coverage by MA plans be provided consistent with Part D requirements, specifically part 423.

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

This PBP section has been updated to allow for separate cost sharing ranges for Remote Access Technologies (Web/Phone based technologies) and Remote Access Technologies (Nursing Hotline).

Cost sharing ranges (i.e., minimum/maximum) can be entered in B-14c – base 7 for coinsurance and B-14c – base 8 for copayment.

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

Enhanced Disease Management has been added as a supplemental benefit in B14-c: Eligible Supplemental Benefits as defined in Chapter 4 for D-SNPs and I-SNPs.

B-14e: Other Medicare-covered Preventive Services

The following selections have been added to B-14e Other Medicare-covered Preventive Services:

Medicare-covered Barium Enemas

Medicare-covered Digital Rectal Exams

Medicare-covered EKG following Welcome Visit

Section C – Out-of-Network (OON)

The following selections have been added to 14e: Other Medicare-covered Preventive Services of Section C OON/POS:

14e1: Glaucoma Screening

14e2: Diabetes Self-Management Training

14e3: Barium Enemas

14e4: Digital Rectal Exams

14e5: EKG following Welcome Visit

Important Administrative Information

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

CMS reminds MAOs that the OOPC model in 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, MAOs should run their plan benefit structures through the SAS OOPC model to make sure the plan offerings comply with all of CMS's 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 and Section 1876 Cost Plan transition policy related questions, please submit to <https://DPAP.lmi.org/DPAPMailbox/>;
- For Medicare Advantage benefits questions, please review available resources (e.g., Call Letter) 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 questions, please submit an email to Marketing@cms.hhs.gov;
- For Part D policy questions about meaningful difference, 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 Advantage Value-Based Insurance Design (MA-VBID) model questions, please submit an email to MAVBID@cms.hhs.gov; or
- For Medicare-Medicaid Program questions, please submit an email to MMCOcapsmodel@cms.hhs.gov.