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 18, 2019

TO: Medicare Advantage Organizations
Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2020 Medicare Advantage Bid Review and Operations Guidance

This memorandum provides Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans operational guidance on bid development and submission; highlights benefit policies; and reviews the contract year (CY) 2020 Plan Benefit Package (PBP) software.

Guidance in this memorandum references the CY 2020 Final Call Letter (specifically Section II, Part C) issued on April 1, 2019; Chapter 4 of the Medicare Managed Care Manual (MMCM); the 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]"; and the bid submission module in the Health Plan Management System (HPMS). CMS recommends organizations review these documents in conjunction with this memorandum as they develop CY 2020 bids.

Bids are due to CMS on or before **Monday, June 3, 2019 at 11:59 PM Pacific**.

The following table displays the applicable bid review criteria by MA plan type:

Applicable Bid Review Criteria by Plan Type

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans	Described in Call Letter or this HPMS Memo
Total Beneficiary Cost (TBC) Section 1854(a)(5)(C)(ii) of the Act, and 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 Section 1852(a)(1)(B) of the Act; 42 C.F.R. §422.254(b)(4), §422.100(f)(2)	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[1]	Yes[1]	Yes[1]	Yes[1]	Call Letter
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 TBC requirements for CY 2020 and provided guidance on these requirements in the CY2020 Final Call Letter issued on April 1, 2019. Consistent with last year, MA organizations 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 2020 Final Call Letter, CMS will exercise its authority under section 1854(a)(5)(C)(ii) of the Act to deny MA organization 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 methodology for developing the CY 2020 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 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 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 CMS adopted last year in applying the uniformity requirements ("Part C uniformity flexibility") and/or participating in the Value-Based Insurance Design (VBID) model test will be subject to the TBC evaluation for CY 2020; however, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered under Part C uniformity flexibility 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, 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 MA

organizations that the Office of the Actuary extends flexibility on margin requirements so MA organizations can satisfy the TBC requirement.

In mid-April 2019, as in past years, CMS will provide plan specific CY 2020 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 ($135.50).

- 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 remain at $36.00 PMPM in CY 2020. 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 2020, 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 $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 2019.

CMS will maintain the TBC evaluation used during CY 2019 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 2019 plan will be compared independently to the CY 2020 plan.

- Segmenting an existing plan: TBC for each CY 2020 segmented plan will be compared independently to the CY 2019 non-segmented plan.

- Consolidating/crosswalking previously segmented plans: TBC of each existing CY 2019 segmented plan will be compared independently to the non-segmented CY 2020 plan.

- Consolidating/crosswalking segmented plans into other segmented plans: TBC of the existing CY 2019 segmented plan will be compared independently to the segmented CY 2020 plan.

If CMS provides the MA organization an opportunity to correct CY 2020 TBC issues following the bid submission deadline, the MA organization 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 identified formulary review concerns 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 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.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2019 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 2020 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 2019 ($131.00) and the amount for CY 2020 ($135.50)	Value is $4.50 for all plans
	L	Impact of changes in OOPC Model between CY 2019 and CY 2020	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 2019 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 2020 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2020 (Item E). Premium (net of rebates) can be found in the CY 2020 Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The *Unadjusted* TBC Change between CY 2019 and CY 2020 (Item G) is the difference between CY 2020 Total TBC (Item F) and CY 2019 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 2019 and CY 2020 (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 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. 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.

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 2020 rebate minus the CY 2019 rebate. The CY 2019 Bid Amount and Benchmark are taken from the CY 2019 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2019 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2020 ratebook. The CY 2020 Benchmark is the weighted average of county-specific payment rates using the CY 2020 ratebook and projected enrollment from the CY 2019 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	2019 Values					2020 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	1,057.90	$1,005	50%	($52.90)	($2.89)	($2.89)	$38.90
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,057.90	$1,111	50%	$26.45	$1.45	$1.45	$34.55
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,057.90	$1,375	65%	$206.29	$56.29	$36.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,057.90	$1,375	50%	$158.69	($36.32)	($36.00)	$72.00
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,057.90	$1,440	65%	$248.54	$53.54	$36.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,269.48	$1,376	65%	$69.10	($38.15)	($36.00)	$72.00
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,057.90	$1,250	50%	$96.05	($53.95)	($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 5.79%.

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 5.79% plus 5.0% to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $36.

g. Plan 006 has benchmark growth of 5.79% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$36.

h. Plan 007 has a 2020 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 began in April and provide organizations with the opportunity to ask technical questions related to this calculation.

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 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 regulation, 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. This standard was adopted in the recent 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 setting limits on enrollee out-of-pocket costs for plan years beginning January 1, 2020.

For CY 2020, 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. 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 2020 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 2020 PBP:

CY 2020 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 2020 Part C Benefit Policy

MA-PD Offerings

Each MA organization 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 MA organization'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 MA organization.) 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. Additional guidance is

also provided in Chapter 4, section 10 of the MMCM. Each SNP must offer Part D coverage. 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.

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 B-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 Benefits

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 treated as an Original Medicare basic benefit. 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). Supplemental benefit services might include services that do not meet the requirements for MA additional telehealth benefits, such as out-of-network services furnished by a non-contracted provider through electronic exchange (see § 422.135(d)), or services furnished by a provider through electronic exchange that are not currently covered by Part B when furnished in-person. These MA supplemental telehealth benefits may be offered as remote access technologies or telemonitoring in the PBP.

Original Medicare pays for chronic care management (CCM) services for patients with multiple chronic conditions. A 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

Consistent with Chapter 4, § 110.4 of the MMCM, CMS is clarifying PPO plans that cap the dollar value of supplemental benefits 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. 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.

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 Part C supplemental benefits; additional guidance is in 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 guidance for bid submission and limit any PBP notes to service category 19.

CY 2020 Part C 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, additional guidance 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), or Special Supplemental Benefits for the Chronically Ill (SSBCI) guidance:

- 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 or other benefits guidance, 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." 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.

Employer Group Waiver Plans

MA employer plans must complete and submit the MA portion of the Plan Benefit Package (PBP) in accordance with CMS requirements. Organizations should make a good faith effort in projecting CY 2020 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 1876 Cost Plan organizations: "Indicate CY 2020 total projected member months for this plan."

Additional Telehealth[1]

For CY 2020, MA organizations will have the ability to include "additional telehealth benefits" (telehealth benefits beyond what Part B pays) in their bids for the basic Medicare benefits. MA additional telehealth benefits are services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of that Act, and that have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange when the physician (as defined in section 1861(r) of the Act) or practitioner (described in section 1842(b)(18)(C) of the Act) providing the service is not in the same location as the enrollee (see § 422.135(a)).

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. An MA plan furnishing additional telehealth benefits may only do so using contracted providers (see § 422.135(d)). Unlike the requirement for all other plan covered benefits, PPOs are not required to furnish their MA additional telehealth benefits out-of-network. PPO and HMO-POS plans may cover non-contracted, out-of-network Part B services delivered through electronic exchange as supplemental benefits under Remote Access Technologies in Section C of the PBP (see § 422.135(d)). Additional Telehealth should be entered in B-7j of the PBP and may not be referenced under B14c: Remote Access Technologies.

Telemonitoring

CMS is also expanding the definition of the primarily health related telemonitoring supplemental benefit (PBP category B14c) to include smart phones and tablets provided the benefit is offered in accordance with Chapter 4 of the Medicare Managed Care Manual and is configured with only primarily health related applications.

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. However, CMS is clarifying that Part B premium buy-down is permitted for D-SNPs in cases (and for enrollees) where the Medicaid benefit in the applicable state does not include payment of the Part B premium.

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 CMS may appropriately account for the Medicare benefit package.

[1] See 42 CFR § 422.135, as amended in the final rule published in the Federal Register on [April 16, 2019], effective January 1, 2020.

CY 2020 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 guidance. 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 2020 Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2020 > Plan Benefit Reports > Service Category Report).

B-3: Cardiac and Pulmonary Rehabilitation Services

For CY 2020, supervised exercise therapy (SET) for peripheral artery disease (PAD) for Medicare and Non-Medicare covered services are listed as separate benefits in Section B-3. Additionally, cost sharing standards were added in section B-3 of the PBP for Cardiac Rehabilitation ($50), Intensive Cardiac Rehabilitation ($100), Pulmonary Rehabilitation ($30), and Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) ($30) services for CY 2020.

B-7 Health Care Professional Services

B-7j: Additional Telehealth

The PBP has been updated to include a new section called B-7j: Additional Telehealth. In this section, plans may include in the basic benefit certain additional telehealth benefits that comply with § 422.135.[2] MA organizations must comply with § 422.135 when offering MA additional telehealth benefits as part of the basic benefits bid. Please note that plans are not required to offer MA additional telehealth benefits.

B-7k: Opioid Treatment Services

The PBP has been updated to include a new section called B-7k: Opioid Treatment Services. Beginning January 1, 2020, opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) are payable as a Medicare Part B benefit. MA Organizations should review the CY 2020 Call Letter and any regulations or guidance issued by CMS specific to this new benefit for additional requirements, guidance, and information about this new Part B benefit. This is a Medicare-covered Part B service and it is mandatory for all plans. Opioid use disorder treatment services include: FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable; substance use counseling; individual and group therapy; toxicology testing; and other items and services that CMS determines appropriate (not to include meals and transportation). The enrollee's entire bundled Part B cost sharing responsibility for Opioid Treatment Services should be entered in section

[2] See 42 CFR § 422.135, as amended in the final rule published in the Federal Register on [April 16, 2019], effective January 1, 2020.

B-7k of the Part C Plan Benefit Package. Consistent with existing Chapter 4, Section 50.1 of the MMCM, Medication Assisted Treatment (MAT) drugs outside of Opioid Treatment Programs (OTPs) that are covered under Part D should not be included in the cost-sharing for this section.

B-10: Ambulance/Transportation Services

B-10b: Transportation Services

The enhanced benefit picklist has been modified from Plan Approved Location to Plan Approved Health-related Location. Rideshare Services has been added as a mode of transportation in the Plan Approved Health-related Location and Any Health-related Location picklists. This benefit includes transportation to health-related locations only. Transportation to non-health related locations can only be provided as a Special Supplemental Benefit for Chronically Ill enrollees and is placed in 19b/13i.

B-13: Other Supplemental Services

B-13c: Meal Benefit

This question has been updated to "Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section." Please note that Meals beyond limited basis can only be provided as a Special Supplemental Benefit for Chronically Ill enrollees and is placed in 19b/13i.

B-14: Preventive and Other Defined Supplemental Benefits

B-14b: Annual Physical Exam

The PBP has been updated to allow SNP plans to select B-14b: Annual Physical Exam as a supplemental benefit (please see CY 2020 Call Letter for more information).

B-14c: Other Defined Supplemental Benefits

Section B-14c has been renamed to Other Defined Supplemental Benefits.
The following supplemental benefits have been added to B-14c: Therapeutic Massage, Adult Day Health Services, Home-Based Palliative Care, In-Home Support Services, and Support for Caregivers of Enrollees.

B-14e: Other Medicare-covered Preventive Services

The PBP has been updated to add a new "N/A" selection in response to the authorization question in this section. If the plan does not offer Other Medicare-covered Preventive Services, then "N/A" can be selected.

B-15: Medicare Part B Rx Drugs

The following question has been added:

Does the plan offer step therapy? Yes or No

Does the benefit step from (select all that apply): Part B to Part B? Part B to Part D? Part D to Part B?

B-19: VBID/MA Uniformity Flexibility/SSBCI

This section has been renamed to B-19: VBID/MA Uniformity Flexibility/SSBCI. It has been updated for MA plans that offer Special Supplemental Benefits for the Chronically Ill (SSBCI) to specify that in this bid. This is the same section in the PBP where MA plans that offer supplemental benefits using Uniformity Flexibility (see guidance in HPMS Memo titled "Reinterpretation of the Uniformity Requirement" issued on April 27, 2018) and/or that are participating in the VBID Model include descriptions of those benefits.

Beginning in CY 2020, plans offering MA Uniformity Packages are no longer required to enter separate packages for individual disease states if the benefits are the same. When entering MA Uniformity Flexibility benefit packages, create a separate package for each unique benefit offering, or combination of benefit offerings. MA Uniformity Flexibility packages may be targeted to single or multiple clinical condition groups. When entering an SSBCI benefit package, include all reduced cost sharing SSBCI benefits in a single package in section B19a and all additional SSBCI benefits in a single package in B19b. All SSBCI offered by the MA plan must comply with section 1852(a)(3)(D) of the Act and CMS guidance.

The following questions have been added for all MA Uniformity Flexibility packages in 19a and 19b:

> Does the enrollee need to have all diseases selected to qualify? Yes or No
>
> Does the enrollee have to have a combination of diseases selected to qualify? Yes or No

When entering the MA Uniformity Flexibility/SSBCI minimum and maximum cost sharing for a service category, list only the cost sharing that would apply to enrollees qualifying for the benefit package. Cost sharing ranges should reflect only the services within the service category or specialty selected that are eligible for reduced cost sharing. If the plan reimburses the enrollee for the reduced cost sharing after the service(s) has been rendered, the cost sharing range should represent what the enrollee pays after reimbursement, and the note should describe the benefit and any limitations. If there is a maximum aggregate amount of reduced cost sharing, the cost sharing entered should reflect only the costs paid by the enrollee prior to reaching the maximum aggregate amount of reduced cost sharing. Consistent with Chapter 4, Section 50.1 of the MMCM, MA plans may not use different cost sharing amounts that are based on the cumulative

number of visits (e.g., cost sharing of $5 for visits 1-5 and cost sharing of $10 for visits 6 and greater); however, plans are permitted to limit the maximum aggregate dollar amount of reduced cost sharing.

PPO plans offering additional supplemental benefits must offer the benefits both in-and out-of-network, though higher cost sharing for out-of-network benefits is permitted. As stated in the HPMS Memo titled "Reinterpretation of the Uniformity Requirement" issued on April 27, 2018, plans can reduce cost sharing and deductible requirements for enrollees diagnosed with a targeted health status or disease state. However, PPO plans are not required to extend the reduction in cost sharing to out-of-network benefits. This policy also applies to SSBCI benefits.

13i: Non-Primarily Health Related Benefits and 13i-O: Other Non-Primarily Health Related Benefits

The PBP has been updated to include a new benefit entry for plans offering a SSBCI package in Section B-19b. Plans have the ability to select 13i: Non-Primarily Health Related Benefits for the Chronically Ill and 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other). Section 13i includes Food and Produce, Meals (beyond limited basis), Pest Control, Transportation for Non-Medical Needs, Indoor Air Quality Equipment and Services, Social Needs Benefit, Complementary Therapies, Services Supporting Self-Direction, Structural Home Modifications, and Transitional Supports. Section 13i-O includes up to five other categories to be defined by the plan. All SSBCI offered by the MA plan must comply with section 1852(a)(3)(D) of the Act and CMS guidance.

14c1: Health Education, 14c5: Enhanced Disease Management, and 14c12: Medical Nutrition Therapy

The PBP software has been updated to remove restrictions on which Supplemental Benefits can be included in a 19b package for Uniformity Flexibility plans. All Uniformity Flexibility plans will now be able to offer 14c1: Health Education, 14c12: Medical Nutrition Therapy, and 14c5: Enhanced Disease Management. As stated in the CY 2019 Final Call Letter issued April 2, 2018, the enhanced disease management supplemental benefit will not be made available to Chronic Condition SNPs (C-SNPs) as it is not necessary. C-SNPs must already have comprehensive targeted disease management elements (beyond the enhanced disease management supplemental benefit requirements) in order to receive the special C-SNP designation and marketing and enrollment accommodations.

Important Administrative Information

MA organizations must update contact information in the HPMS Contract Management module to ensure that communication 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 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, MA organizations 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 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 Value-Based Insurance Design (MA-VBID) model questions, please submit an email to VBID@cms.hhs.gov; or

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