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: May 19, 2020

TO: Medicare Advantage Organizations and Part D Sponsors

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2021 Part C Bidding and Benefits Instructions Related to COVID-19

This memorandum provides Medicare Advantage (MA) organizations with Contract Year (CY) 2021 Part C Bid Pricing Tool (BPT) and Plan Benefit Package (PBP) instructions related to COVID-19.

CMS issued an HPMS Memorandum titled "Information Related to Coronavirus Disease 2019 - COVID-19" on April 21, 2020 (revised from March 10, 2020) that informed MA organizations and Part D sponsors of the obligations and permissible flexibilities related to the declarations of disaster and public health emergency resulting from the COVID-19 pandemic. CMS is not able to determine if COVID-19 emergency orders will continue through all or part of CY 2021.

The following information summarizes how MA organizations may prepare their CY 2021 BPT and PBP, based on obligations and permissible flexibilities discussed in the MA sections of the April 21, 2020 HPMS memorandum. Specifically, these instructions address how MA organizations may prepare their CY 2021 BPT and PBP given (1) required coverage and special requirements for MA plans related to COVID-19 or during a COVID-19 federal or state public health emergency; and (2) benefits and flexibilities that are permissive for MA plans to have in place for affected enrollees during a federal or state public health emergency. The discussion below will refer to "affected enrollees" as those MA plan enrollees who are living in geographic areas while subject to a public health emergency declaration for all or part of CY 2021 (i.e., a plan's entire service area may or may not be affected by a public health emergency declaration).

1. Required Coverage and Special Requirements[1]

The required coverage and special requirements are collectively referred to herein as "required actions." The required actions include:

(a) Coverage of the COVID-19 testing and specified COVID-19 testing-related services without cost-sharing on or after March 18, 2020 and during the public health emergency described in section 1135(g)(1);

[1] This section aligns with the "Special Requirements" section of the April 21, 2020 HPMS memo.

(b) Coverage of the COVID-19 testing and specified COVID-19 testing-related services without prior authorization or other utilization management on or after March 18, 2020 and during the public health emergency described in section 1135(g)(1);
(c) Coverage and requirements in accordance with 42 C.F.R. § 422.100(m), such as coverage of out-of-network services with in-network cost sharing; and
(d) Coverage of the COVID-19 vaccine and its administration without cost sharing.

COVID-19 testing and specified testing-related services must be covered without cost-sharing and without imposing prior authorization or other utilization management requirements for the period beginning on or after March 18, 2020 and through to the end of the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act (PHSA), including any renewal of such declaration pursuant to section 319 of the PHSA. That specific public health emergency was declared by Secretary Azar on January 31, 2020, entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus.' The specified COVID-19 testing related services that are subject to these requirements are those services described in section 1833(cc)(1) of the Act for which payment would be payable under a specified outpatient payment provision described in section 1833(cc)(2) of the Act.

Projected costs applicable to required actions must be included in the BPT. MA organizations must also include support for these projected costs in supporting documentation for their bids. The PBP should reflect cost sharing used uniformly by the MA plan for plan enrollees during the entire CY 2021 **as if the Secretary's declaration under the PHSA is not in effect**. If the MA plan will cover COVID-19 testing and specified testing-related services without cost sharing uniformly for plan enrollees for the entire CY 2021 regardless whether there is a declaration under PHSA section 319 in place, the BPT and PBP must be completed using standard CMS instructions (e.g., PBP service category B8a would be completed with a $0 minimum range).

Special requirements for coverage and cost sharing in accordance with 42 C.F.R. § 422.100(m), such as out-of-network services with in-network cost sharing, are required when a declaration of disaster or public health emergency described in § 422.100(m)(2) is in place and for so long as described in § 422.100(m)(3). Projected costs applicable to required actions must be included in the BPT. MA organizations must also include support for these projected costs in supporting documentation for their bids. In completing the PBP, the MA organization should assume that the coverage and cost-sharing requirements of § 422.100(m) are not in place and the PBP should reflect cost sharing used uniformly by the MA plan for plan enrollees during the entire CY 2021. If the MA plan will cover out-of-network services at in-network cost sharing (and/or other coverage parameters imposed by § 422.100(m)) for the entire CY 2021 regardless whether § 422.100(m) requires it, the BPT and PBP must be completed using standard CMS instructions.

Anticipated plan costs for vaccines for COVID-19 must be included in the Part C bid as a Medicare-covered service. Section 3713 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) specifies that a COVID-19 vaccine and its administration will be covered under Medicare Part B without cost sharing and requires MA plans to do the same with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

Under section 1852(a)(5) and § 422.109, CMS pays for certain changes in Medicare benefits with significant costs through Medicare FFS until the costs for the new benefits are factored into the MA payment benchmarks. The Office of the Actuary performs that significant cost assessment, based on thresholds defined in regulation, once the benefit becomes available in Medicare FFS, and a Medicare FFS price is determined for the service. The significant cost criteria include an estimated impact of a particular legislative change representing at least 0.1 percent of the national average per capita costs. The CARES Act specifies coverage for a COVID-19 vaccine by Medicare Part B without cost sharing. This legislative change would trigger a significant cost assessment for a COVID-19 vaccine. A significant cost assessment cannot be performed until more details are known about the actual indications and pricing of a potential COVID-19 vaccine. Based on the criteria, a potential vaccine will either be determined to meet the significant cost assessment threshold or be expected to have smaller than a 0.1 percent effect on overall Medicare spending. Either way, it is expected that MA organizations will not be responsible for significant costs associated with a potential COVID-19 vaccine in CY 2021.

MA organizations must include their best estimate of their anticipated costs for vaccine coverage in their CY 2021 bid submissions. MA organizations must also include support for these projected costs in supporting documentation for their MA bids. The PBP does not require data entry for these potential future changes to Original Medicare as part of the bid submission.

2. Permissive Actions[2]

MA plans are permitted to provide coverage of certain supplemental benefits only for affected enrollees during a public health emergency as described in this section but must include information explaining and supporting the additional coverage properly in its BPT and PBP.

Permissive Actions for Additional Telehealth Benefits provided only to affected enrollees during a public health emergency (e.g., specific provider specialist services) are considered Medicare-covered benefits for purposes of completing the BPT. We note that any reductions in cost sharing below the applicable Medicare Part B cost sharing for the additional telehealth benefits (if the additional telehealth benefits were furnished in person) would be included in the BPT as a supplemental benefit. Also, MA organizations must comply with § 422.135 and § 422.254 in identifying permissible additional telehealth benefits and including them in the BPT for basic benefits. Plans providing additional telehealth benefits to only affected enrollees during a COVID-19 public health emergency should enter the benefits and cost sharing in PBP service category "B7j: Additional Telehealth Services" and describe limitations in the notes field.

If the plan's covered services and cost sharing are provided uniformly to plan enrollees during the entire CY 2021 without regard to whether a public health emergency is in place, the BPT and PBP must be completed using standard CMS instructions.

Permissive Actions for Supplemental Benefits (reduced cost sharing or additional benefits) provided to only affected enrollees during a public health emergency must be accounted for in the BPT and included in PBP service category "B13f: Other." An MA plan may cover one benefit or a package of benefits for only affected enrollees during a public health emergency.

[2] This section aligns with the "Permissive Actions" section of the April 21, 2020 HPMS memo.

Examples include additional meals, medical transportation benefits, or reduced cost sharing related to the treatment of COVID-19 for primary care, specialty care, additional telehealth, and/or hospital care. However, in order to limit coverage to only affected enrollees during a COVID-19 public health emergency, the supplemental benefits must meet all requirements for supplemental benefits, be provided uniformly to affected enrollees, and address issues or medical needs raised by the COVID-19 outbreak, such as covering meal delivery or medical transportation services to accommodate the efforts to promote social distancing during the COVID-19 public health emergency.

A "primarily health related" supplemental benefit may be provided uniformly to all plan enrollees or tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly based on chronic condition or health status (e.g., COVID-19 related diagnoses). Special supplemental benefits for the chronically ill (SSBCI), including "non-primarily health related" items and services (e.g., food and produce, social needs benefit, non-medical transportation), may be provided to only enrollees who meet the definition of "chronically ill enrollee" in the statute and implementing regulations. We note that SSBCI may only be offered to the chronically ill enrollee if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Plans must clearly describe in the PBP service category "B13f: Other" notes that the supplemental benefit is limited to only affected enrollees during a public health emergency for COVID-19 and describe any limitations (e.g., requirement for COVID-19 related diagnosis, quarantine, or stay at home order). This includes both primarily and non-primarily health related benefits (i.e., SSBCI). If including a non-primarily health related benefit in B13f, the note must specifically identify these items and services are being provided to SSBCI-eligible enrollees. During the course of benefits review, CMS may contact MA organizations to provide supporting documentation to explain how certain benefits are related to COVID-19. CMS notes that this unique supplemental benefit provision is limited to CY 2021 and is restricted to COVID-19 efforts during a public health emergency.

The BPT and PBP are completed using standard CMS instructions if the plan design incorporates supplemental benefits provided uniformly to plan enrollees for the entire CY 2021. MA organizations offering uniformity flexibility benefits or SSBCI benefits for the entire CY 2021 regardless of a public health emergency declaration should enter the information in PBP Section B19. For CY 2021, CMS will also permit plans providing reduced cost sharing or additional supplemental benefits for enrollees with COVID-19-related diagnoses to enter the benefit in PBP service category "B13e: Other" (instead of entering as a uniformity flexibility and/or SSBCI package in PBP service category B19). The benefit, cost sharing, and limitations must be described in the notes field and the title should include "COVID-19."

Supplemental Meals Benefit Clarification: Existing information in Chapter 4 of the Medicare Managed Care Manual provides that meals are a "primarily health related" benefit in PBP service category "B13c: Meals" only in limited situations. CMS is clarifying here that a meals benefit would be considered "primarily health related" for purposes of CMS instructions if provided to enrollees for a limited period of time (e.g., two to six weeks): (1) immediately following surgery or an inpatient hospitalization, (2) for a chronic illness, or (3) for a medical condition or potential medical condition that requires the enrollee to remain at home for a period

of time (e.g., flu, bone fracture, or COVID-19 related diagnosis, quarantine, or stay at home order). Meals may also be provided beyond a limited duration as a "non-primarily health related benefit" (PBP service category B19b/13i) through SSBCI but only for enrollees who meet the definition of "chronically ill enrollee" in the statute and implementing regulations. We note that SSBCI may only be offered to the chronically ill enrollee if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.

Meals (both primarily health related and non-primarily health related through SSBCI) provided to only affected enrollees during a public health emergency must be included in PBP service category "B13f: Other" and include a brief description of the benefit and its limitations in the notes field.

MA organizations offering uniformity flexibility benefits or SSBCI benefits for the entire CY 2021 regardless of a public health emergency declaration should enter the information in PBP Section B19. For CY 2021, CMS will also permit plans providing reduced cost sharing or additional supplemental benefits for enrollees with COVID-19-related diagnoses to enter the benefit in PBP service category "B13e: Other" (instead of entering as a uniformity flexibility and/or SSBCI package in PBP service category B19). The benefit, cost sharing, and limitations must be described in the notes field and the title should include "COVID-19."

To ensure consistency during benefits review, plans must enter the combined maximum number of meals and days the plan covers annually for each qualifying situation. For example, the note must describe the components of the combined total number of meals entered in the PBP, including the number of meals and days covered for each surgery, post-hospitalization event, chronic condition, and medical condition or situation requiring the enrollee to remain at home. In addition, the note should specify any limitations on each qualifying situation such as the number of meals, days or medical conditions.

Marketing and Communications Materials: MA organizations are responsible for clearly identifying in the plan's Evidence of Coverage (EOC) what will and will not be covered. Any limitations on coverage should be clearly noted in the EOC, including the process and/or criteria for determining eligibility to receive a SSBCI. MA organizations may also inform beneficiaries of supplemental benefits, including through marketing and communication materials. When marketing supplemental benefits, MA plan materials must not mislead or misrepresent these benefits to enrollees and must not state that they are guaranteed. We also remind MA organizations that coverage requests from enrollees or providers, including requests for any supplemental benefits, should be treated similar to requests for other benefits furnished by an MA plan. If a request concerning coverage of a discrete item or service submitted to a plan fits within one of the actions defined as an organization determination under 42 C.F.R. § 422.566(b), then the coverage decision is subject to the Subpart M appeals process.