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

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 20, 2022

TO: All Organization Types and Stakeholders

FROM: Kathryn A. Coleman
Director

SUBJECT: Final Contract Year 2023 Part C Benefits Review and Evaluation

This memorandum[1] includes final bid and operational instructions for Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans. Statutory cites in this memo are to the Social Security Act (the Act) and regulatory cites are to 42 C.F.R. parts 417 and 422 unless otherwise noted.

CMS issued a preliminary HPMS memorandum to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2023 (HPMS memorandum titled "Preliminary Contract Year 2023 Part C Benefits Review and Evaluation," issued March 3, 2022). Our memo addressed low enrollment and optional supplemental benefit policies which are consistent with past years. We also discussed application of the total beneficiary cost (TBC) evaluation and the increase in the change threshold for CY 2023 based on the updated OOPC model. We received no comments and are finalizing the CY 2023 policies. As suggested in stakeholder comments from last year, CMS is including administrative information regarding the TBC calculation, benefit policies and updates to plan benefit package software as an appendix to this document (rather than a separate HPMS memorandum).

Please note that CMS published a final rule with comment period titled, "Contract Year (CY) 2023 Medicare Advantage (MA) Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards Final Rule with Comment Period (CMS-4190-FC4)", which appeared in the Federal Register on April 14, 2022 at https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards. In this final rule with comment period, CMS is addressing two remaining proposals from the February 2020 proposed rule (85 FR 9002): (1) Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services (§§ 422.100 and 422.101) and (2) Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing (§§ 422.100 and 422.113).

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

We strongly encourage MA organizations to review the final rule with comment period in its entirety. Final CY 2023 MOOP and other cost sharing limits are in the following tables in the final rule:

- **Maximum Out-of-Pocket (MOOP) Limits--** Table 5: Final Contract Year 2023 MOOP Limits by Plan Type (Page 22318)
- **PMPM Actuarial Equivalent Cost Sharing--** Table 27: Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing for Contract Year 2023 (Page 22398)
- **Service Category Cost Sharing--** Table 28: Final Contract Year 2023 In-network Service Category Cost Sharing Limits Using Projections of 2017-2021 Medicare FFS Data (Pages 22400-22401)

MA organizations with benefit designs using a coinsurance or copayment amount for which CMS does not have an established threshold for non-discriminatory cost sharing (e.g., coinsurance for Inpatient or copayment for DME) must submit documentation with their initial bid that clearly demonstrates how the coinsurance or copayment amount satisfies the regulatory requirements for each applicable plan.

As discussed in the April 2022 FC, § 422.100(f)(6)(i), (iii)(B), and (j)(1)(ii) identify the data MA organizations may use to develop supporting documentation for the cost sharing included in their PBP(s). Section II.B.5.a. of the April 2022 FC addresses how MA plans should prepare and submit supporting documentation for the service category or for a reasonable group of benefits using this data, if necessary. In brief, MA organizations may include information for multiple plans in one set of documentation, but calculations must be presented for each plan individually (or plan segment, if applicable). In addition, the MA organization's calculations and documentation must reflect cost sharing amounts that combines the enrollee's entire cost sharing responsibility as a single, total copayment per § 422.100(f)(9), even if the MA plan has contract arrangements involving separate payments to facilities and professional providers. This documentation must be identified separately from other supporting documentation submitted as part of the BPT. The documentation must be submitted for each plan through the supporting documentation upload section titled "Cost-Sharing Justification" in HPMS. The upload will be available to all MA plan types (both employer and individual market), but not for stand-alone PDPs. The link for uploading cost sharing justification files will be located at Plan Bids > Bid Submission > CY 2023 > Upload > Cost-Sharing Justification.

Overview of Contract Year (CY) 2023 Part C Benefits Review

Portions of this memorandum apply to section 1876 Cost Plans and MA plans (including EGWPs, Dual-Eligible Special Needs Plans (D-SNPs), Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs)).

Medicare-Medicaid Plans in a capitated model under the Medicare-Medicaid Financial Alignment Initiative are not subject to the review criteria summarized in the table below and benefit review information for these plans will be provided separately.

CMS makes all of the necessary tools and information available to MA organizations in advance of the bid submission deadline, and therefore expects all MA organizations to submit their best,

accurate, and complete bid(s) on or before Monday, June 6, 2022 at 11:59 PM PDT. Any organization whose bid fails the Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, Total Beneficiary Cost (TBC), and/or Optional Supplemental Benefit requirements and evaluation standards at any time prior to final approval may receive a compliance notice, even if the organization is allowed to correct the deficiency. The severity of compliance notice may depend on the type and/or severity of error(s).

The table below displays key MA bid review criteria and identifies the criteria used to review the bids of the various plan types identified in the column headings.

Table 1: Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-EGWP (Excluding Dual Eligible SNPs)	Applies to Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to EGWP Plans[1]
Low Enrollment § 422.510(a)(4)(xv)	Yes	Yes	No	No
Total Beneficiary Cost Sec. 1854(a)(5)(C)(ii) of the Act; §§ 422.254(a)(4) and 422.256(a)	Yes	No	No	No
Maximum Out-of-Pocket (MOOP) Limits §§422.100(f)(4) and (5) and 422.101(d)(2) and (3)	Yes	Yes	No	Yes
PMPM Actuarial Equivalent Cost Sharing §§ 422.254(b)(4) and 422.100(f)(2), (f)(6), (f)(7), and (j)(2)	Yes	Yes	No	Yes
Service Category Cost Sharing §§ 417.454(e), 422.100(f) and 422.100(j)	Yes	Yes	Yes[2]	Yes
Part C Optional Supplemental Benefits §§ 422.100(f) and 422.102	Yes	Yes	No	No

[1]Employer Group Waiver Plans (EGWP) exclusively enroll only members of group health plans sponsored by employers, labor organizations, and/or trustees of funds established by established by one or more employers or labor organizations to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations.

[2]Section 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (§ 417.454(e)). Additional cost sharing requirements apply to MA plans under §§ 422.100(f) and (j).

In this memo, CMS interprets and applies certain regulatory and statutory standards and provides additional information on topics related to CY 2023 bids. Consistent with prior years, MA organizations also must address other requirements in their bids, such as the medical loss ratio, and are expected to do so independently of our requirements for benefits and bid review. Therefore, CMS is not making specific adjustments or allowances for these changes in the benefits review requirements.

Plans with Low Enrollment

At the end of March, CMS notified MA organizations that operate non-SNP plans that have fewer than 500 enrollees and SNP plans that have fewer than 100 enrollees and have been in existence for three or more years as of March 2022 (three annual election periods) of CMS's decision not to renew these plans under § 422.510(a)(4)(xv). Plans with low enrollment operating in service areas that do not have a sufficient number of competing options of the same plan type (such that the low enrollment plan still represents a viable plan option for beneficiaries), as determined by CMS, did not receive this notification. Please note that § 422.514 is a minimum enrollment requirement that is applied at the contract level as part of the MA application process and is independent of this plan-level requirement in § 422.510(a)(4)(xv).

Upon receipt of the notification, organizations had to either (1) confirm each of the low enrollment plans identified by CMS would be eliminated or consolidated with another of the organization's plans for CY 2023, or (2) provide a justification to CMS for renewal. If CMS finds that the low enrollment justification is insufficient, CMS instructed the organization to eliminate or consolidate the plan. Instructions and the timeframe for submitting justifications will be provided in CMS's notification to the organization. These requirements do not apply to Section 1876 cost plans, EGWPs, or Medical Savings Account (MSA) plans.

CMS recognizes there may be certain factors, such as the specific populations served by and geographic location of the plan that led to a plan's low enrollment. SNPs, for example, may justifiably have low enrollments because they focus on a subset of enrollees with certain medical conditions or status. CMS will consider this information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. MA organizations should follow CMS renewal/non-renewal guidance (see section 50 of Chapter 16B of the Medicare Managed Care Manual[2]) to determine whether a low enrollment plan may be consolidated with another plan(s). Additional guidance regarding renewal options for 2023 will also be issued in April through a separate HPMS memorandum titled: "Information about Renewal Options for 2023". CMS will continue to evaluate and implement low enrollment requirements on an annual basis.

Total Beneficiary Cost (TBC)

Under section 1854(a)(5)(C)(ii) of the Act, CMS is not obligated to accept every bid submitted and is authorized to deny a plan bid if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. In exercising this authority,

[2] MA organizations should review § 422.530 regarding permissible crosswalks in conjunction with guidance on renewing/nonrenewing MA plans.

we will be using the same TBC evaluation as in past years to calculate the TBC change amount as described below. In applying the TBC evaluation, plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s). MA organizations are strongly encouraged to use the available tools and TBC information in developing and preparing their bids.

A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By reviewing excessive increases in the TBC from one year to the next, CMS is able to make sure enrollees who continue enrollment in the same plan are not exposed to significant cost increases.

CMS will use the updated versions of the Out-of-Pocket Cost (OOPC) Models to estimate beneficiary out-of-pocket costs in the TBC calculation for bid evaluation purposes starting with CY 2023 bid submissions (see HPMS memorandum titled "Enhanced Out-of-Pocket Cost Model Update" issued November 19, 2021 and a subsequent HPMS communication titled "Release of Updated CY 2022 Part D Baseline OOPC Model" issued January 21, 2022). The Part C portion of the OOPC model expands the Medicare Current Beneficiary Survey (MCBS) cohort to include beneficiaries with end-stage renal disease (ESRD), who are now eligible to enroll in MA plans, and survey participants with a missing health status in the OOPC cohort. The Part D portion of the OOPC model replaces MCBS data with a cohort based on a random 0.1% sample of all Part D beneficiaries and their associated Prescription Drug Event (PDE) data to calculate Part D OOPC estimates. CMS has generated updated CY 2022 Part C and Part D Baseline OOPC Model values for organizations and posted these values in HPMS on February 7, 2022. MA organization OOPC values can be viewed in HPMS under: Quality and Performance > Performance Metrics > Reports > Costs > Part C Out-of-Pocket Costs. In addition, the CY 2023 Bid Review OOPC Model was released April 8, 2022.

As in past years, CMS will not evaluate TBC for EGWPs, MSA plans, D-SNPs, and SNPs for End Stage Renal Disease (ESRD) Requiring Dialysis. 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. MSAs have unique benefit designs that include a medical savings account for purposes of paying costs before the deductible. 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. Finally, SNPs for the chronic condition of ESRD Requiring Dialysis are not effectively addressed by the OOPC model used for the TBC evaluation because the cohort includes beneficiaries with and without ESRD 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.

MA plans offering Part C supplemental benefits that take advantage of the flexibility in the uniformity requirements under § 422.100(d)(2)(ii), Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or participating in the VBID model test will be subject to the TBC

evaluation for CY 2023; however, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered under Part C uniformity flexibility, SSBCI, or as part of the VBID model test will be excluded from the TBC calculation. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan. The Centers for Medicare and Medicaid Innovation (CMMI) announced the removal of the VBID Model's Cash or Monetary Rebates component beginning in CY 2023 (see HPMS memorandum titled "Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Application Process for Calendar Year (CY) 2023" issued March 1, 2022). This change means that CMS will not test the Cash or Monetary Rebates component as previously anticipated in CY 2023 through CY 2024. As a result, the Cash and Monetary Rebate will be excluded from the TBC evaluation (CY 2022 baseline and CY 2023 bid review) beginning with CY 2023 bids.

Under §§ 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 given amount. This approach not only protects enrollees from significant increases in cost sharing or decreases in benefits, but also confirms enrollees have access to viable and sustainable MA plan offerings.

CMS will continue to incorporate the technical and payment adjustments described below and expect organizations to address other factors, such as coding intensity changes, and risk adjustment model changes independently of our TBC standard. As such, plans are expected to anticipate and manage changes in payment and other factors to minimize changes in benefit and cost sharing over time. CMS also reminds MA organizations that the OACT extends flexibility on margin requirements so MA organizations can satisfy the TBC standard.
As in past years, CMS is providing plan specific CY 2023 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 ($170.10).
- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

As discussed previously, the OOPC Models (both baseline and bid review) are being used to evaluate year to year TBC changes beginning in CY 2023. The TBC using the previous OOPC model is about $371 per member per month (PMPM) compared to about $406 PMPM using the Enhanced OOPC model (an increase of about $35 PMPM as illustrated in Table 2 below). Consistent with application of the TBC evaluation, as discussed in the CY 2012 Final Call Letter,[3] CMS is setting the TBC change threshold for bid evaluation purposes at $41.00 PMPM or about a 10% increase from CY 2022 to CY 2023. CMS has provided the tools necessary for MA organizations to plan for these changes and prepare their bids in a manner to satisfy the TBC evaluation.

[3] See https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf, pages 128-129.

Table 2: TBC Comparison Between CY 2022 Baseline OOPC Models
(Unweighted Per Member Per Month Averages)

Item	Previous OOPC Model	Enhanced OOPC Model	Difference
Part C OOPC	$102.20	$125.73	$23.53
Part D OOPC	102.68	114.28	11.60
Part B Premium	140.90	140.90	0.00
Plan Premium	25.19	25.19	0.00
Total Beneficiary Cost	$370.97	$406.10	$35.13

Plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s) as part of bid negotiation. A plan experiencing a net increase in adjustments may have an effective TBC change amount below the $41.00 PMPM threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $41.00 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 2023, 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 $41.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $41.00 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 -$41.00 PMPM will have a TBC change threshold of $82.00 PMPM (i.e., 2 times TBC change limit of $41.00 PMPM) plus applicable technical adjustments. That is, plans should not make changes that result in greater than $82.00 worth of decreased benefits or increased premiums.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$41.00 PMPM will have a TBC change threshold of $82.00 PMPM (i.e., 2 times TBC change limit of $41.00) plus applicable technical adjustments.
- Plans not accounted for in the three specific situations above are evaluated at the $41 PMPM limit, similar to the policy in CY 2022 about using the TBC threshold.

If CMS provides the MA organization an opportunity to address CY 2023 TBC issues following the bid submission deadline, the MA organization may not be permitted to change its formulary (e.g., adding drugs, etc.) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS identified formulary review 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.
CMS is providing detailed TBC information and examples of how the TBC evaluation will be applied to consolidating or crosswalking plans prior to bid submission in the appendix of this document.

Part C Optional Supplemental Benefits
As part of our evaluation to ensure a plan's bid and benefits do not discriminate against enrollees with specific (or high cost) health needs, CMS will review non-employer MA plans' bid submissions to verify that enrollees electing optional supplemental benefits are receiving reasonable value at the MA contract level. CMS considers plan designs for optional supplemental benefits to be non-discriminatory when the total value of the optional supplemental benefits offered by all plans under the contract meet the following thresholds: (a) the enrollment weighted contract-level projected gain/loss margin, as measured by a percent of premium, is no greater than 15% and (b) the sum of the enrollment-weighted contract-level projected gain/loss margin and non-benefit expenses, as measured by a percent of premium, is no greater than 30%. CMS understands some supplemental benefits are based on multi-year projections, but the plan bids submitted each year are evaluated based on that particular plan year.

CMS will monitor and address potential concerns as part of our existing authority to review and approve bids. CMS will monitor to ensure organizations are not engaging in activities that are discriminatory or potentially misleading or confusing to Medicare beneficiaries. CMS will communicate and work with organizations that appear to have significant increases in cost sharing or decreases in benefits, raising and discussing with such MA organizations any concerns.

Conclusion
The policies described in this memo will be used in the evaluation of CY 2023 bids submitted by MA organizations. Unless otherwise noted in an applicable final rule, this document, or other specific guidance, CMS will continue existing policies and instructions regarding bid submission from the prior year. A more complete discussion of such existing and continuing policies is available in the Final CY 2020 Call Letter (found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf). For example, the policies regarding incomplete and inaccurate bid submissions and plan corrections are discussed on pages 163-166 of the CY 2020 Call Letter.

Appendix

This appendix provides Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans, with technical instructions on bid development and submission; details steps in evaluating changes in Total Beneficiary Cost (TBC); highlights important benefit policies; and reviews the contract year (CY) 2023 Plan Benefit Package (PBP) software updates as CMS has done in prior years.

Total Beneficiary Cost (TBC)

This section provides additional information for calculating the TBC for each MA plan, as discussed on pages 4 to 7 of this memo.

For CY 2023 bids, CMS will maintain the TBC evaluation used in prior years 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, if Plan A is being consolidated/crosswalked into Plan B: (i) Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B and (ii) 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 and/or segment plans from one year to the next:

- Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2022 plan will be compared independently to the CY 2023 plan.

- Segmenting an existing plan: TBC for each CY 2023 segmented plan will be compared independently to the CY 2022 non-segmented plan.

- Consolidating/crosswalking previously segmented plans into one non-segmented plan: TBC of each existing CY 2022 segmented plan will be compared independently to the non-segmented CY 2023 plan.

- Consolidating/crosswalking segmented plans into other segmented plans: TBC of each existing CY 2022 segmented plan will be compared independently to the segmented CY 2023 plan.

As in prior years, if CMS provides an MA organization an opportunity to address CY 2023 TBC issues following the bid submission deadline, the MA organization may not be permitted to change its formulary (e.g., adding drugs, etc.) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS identified formulary review 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.

The plan-specific data elements that CMS posts on HPMS for purposes of the TBC evaluation are shown in the following table. This information may be accessed in HPMS by selecting: Quality and Performance > Performance Metrics > Reports > Costs > Part C Total Beneficiary Costs. 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 the $41.00 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. Please see pages 5 to 7 of this memo for discussion about the updated Part C and Part D Out-of-Pocket Cost (OOPC) Models to estimate beneficiary out-of-pocket costs in the TBC calculation for bid evaluation purposes that will be used starting with CY 2023 bid submissions.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2022 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 2023 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		

Steps	Item	Item	Description
	K	Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2022 ($148.50) and the amount for CY 2023 ($170.10)	Value is $21.60 for all plans
	L	Impact of changes in OOPC Model between CY 2022 and CY 2023	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 $41.00 PMPM

As described in the table above, CMS will provide, through the HPMS posting, CY 2022 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 CY 2022 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 2023 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2023 (Item E). Premium (net of rebates) can be found in the CY 2023 BPT, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The *Unadjusted* TBC Change between CY 2022 and CY 2023 (Item G) is the difference between CY 2023 Total TBC (Item F) and CY 2022 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 PBP-specific 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 $41.00 PMPM	Maximized at $41.00 PMPM
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -$41.00 PMPM	Minimized at -$41.00 PMPM

Plan Situation (Item I)	Payment Adjustment Based on the Plan Situation (Item J)
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -$41.00 PMPM	Minimized at -$41.00 PMPM
Plans that are not accounted for in the three categories above	Same as Gross Payment Adjustment

The HPMS posting also provides Technical Adjustments, including Part B premium adjustment (Item K) and the Impact of Changes in the OOPC model between CY 2022 and CY 2023 (Item L). The Adjusted TBC Change amount (Item M) is calculated by first adding to the Unadjusted TBC Change (Item G) the Payment Adjustment Based on Plan Situation (Item J), then subtracting Item K and Item L.[4] The formula for applying the adjustments to calculate the Adjusted TBC Change amount is represented as follows: M = G + J - K - L.
In this illustrative scenario, plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $41.00 PMPM will have passed the TBC evaluation. CMS also reminds MA organizations that the Office of the Actuary extends flexibility on margin requirements so MA organizations can satisfy the TBC requirement. As noted above, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the required amount.

Illustrative Calculation for Payment Adjustments

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table provides examples of how the payment adjustment is calculated. The Payment Adjustment is the CY 2023 rebate minus the CY 2022 rebate. The CY 2022 Bid Amount and Benchmark are taken from the plan-submitted CY 2022 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2022 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2023 ratebook. The CY 2023 Benchmark is the weighted average of county-specific payment rates using the CY 2023 ratebook and projected enrollment from the CY 2022 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.

[4] We note that, although we use different mathematical operations to apply the adjustment associated with Item J (i.e., addition) and Item L (i.e., subtraction), either of these Items can cause the TBC to increase or decrease, depending on whether the amount associated with each Item is a positive or negative number. By contrast, Item K, which is subtracted from TBC, is always a positive number, meaning it only causes TBC to decrease.

Illustrative Calculation Examples

Bid ID	2022 Values					2023 Values					Rebate Difference	Payment Adj.	TBC Threshold
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*			
Plan 001	3	$1,000	$950	50%	($50.00)*	3	1,047.50	$995	50%	($52.37)*	($2.37)	($2.37)	$43.37
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,047.50	$1,100	50%	$26.19	$1.19	$1.19	$39.81
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,047.50	$1,362	65%	$204.26	$54.26	$41.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,047.50	$1,362	50%	$157.13	($37.87)	($37.87)	$78.87
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,047.50	$1,427	65%	$246.51	$51.51	$41.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,257.00	$1,362	65%	$67.98	($39.27)	($39.27)	$80.27
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,047.50	$1,250	50%	$101.25	($48.75)	($41.00)	$82.00

*Indicates that the amount is a premium.
Note: Slight variances in numbers are due to rounding.

Illustrative Calculation Descriptions

a. Plans 001 through 004 have benchmark growth of 4.75%.

b. Plan 001 bid amount is greater than the benchmark in both years; therefore the difference is not multiplied by the rebate percentage. The amount by which the bid exceeds the benchmark must be paid by (or on behalf of) the enrollee as the MA premium.

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 $41 PMPM.

e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -$41 PMPM.

f. Plan 005 has benchmark growth of 4.75% plus a quality bonus in the form of a 5 percentage point increase to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $41 PMPM.

g. Plan 006 has benchmark growth of 4.75% less 5.0% to simulate losing a bonus payment[5]; therefore the payment adjustment is minimized at -$41 PMPM.

h. Plan 007 has a 2023 star rating below 3.0; therefore the payment adjustment is minimized at -$41 PMPM.

[5] Loss of the quality bonus payment compared to the prior year generally means that the applicable percentage used in calculating the benchmark in the new year is 5 percentage points lower compared to the applicable percentage used the prior year. See section 1853(n) of the Act and 42 CFR § 422.258(d). The simulation here projects percentage increases to the benchmark rather than recalculation of a new benchmark using a base payment amount and applicable percentage for the next year.

We encourage organizations to participate in Actuarial 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.

Maximum Out-of-Pocket (MOOP) Limits

The following chart identifies how MA plans may enter the MOOP in the PBP and whether the MOOP applies to in-network cost sharing, a combination in-network and out-of-network cost sharing, or both by plan type:

CY 2023 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)	PFFS Amount	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (partial network)	PFFS Amount	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (non-network)	PFFS Amount	"General" is the only option available in the PBP

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

Discriminatory Pattern Analysis

CMS will review PBP submissions and evaluate whether they satisfy the applicable cost sharing requirements, such as those in §§ 422.100 and 422.101, and to ensure that the MA plan does not substantially discourage enrollment by certain MA eligible individuals in violation of the anti-discrimination provisions at sections 1852(b) and 1876(i)(6) of the Act. CMS will evaluate whether cost sharing levels are defined or administered in a manner that may discriminate against sicker or higher-cost beneficiaries and 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. Additional guidance is provided in MMCM, Chapter 4, Section 50.1.

CY 2022 Part C PBP Data Entry Expectations

Using appropriate benefit categories

CMS aims to improve transparency, avoid duplication, and streamline data entry so that all benefits and the corresponding cost sharing are entered into the appropriate PBP service category. In order to ensure that the submitted bid is accurate and complete, MA organizations must enter benefits and cost sharing in a particular category that are compliant with the definition provided for that category. *See* 42 CFR § 422.254(a)(3).

An accurate bid will have cost sharing amounts entered for a particular service in a manner that reflects the cost sharing charged across ALL possible healthcare settings (e.g., physician's office, outpatient hospital, free-standing facility, etc.) and is not duplicated in multiple PBP locations. For example, Diagnostic Services can be administered in a number of health care settings including outpatient hospitals, free-standing facilities, or a physician's office. Instead of having these services appear in multiple PBP service categories, the range of cost sharing for Diagnostic Services should only appear in PBP Service Category B-8. The MA organization must submit a note on the service category that explains the cost sharing range associated with the various places of service. The cost sharing for these services should NOT be duplicated in PBP category B-9: Outpatient Hospital. Similarly, Medicare-covered preventive services should only be entered in PBP category B-14a or 14e and should not be duplicated in PBP category B-9. Plans that duplicate the cost sharing entry based on the place of service instead of the service category in the PBP will be asked to correct the bid submission.

Benefits for which there is no identified PBP category may be entered in B-13d, e, or f (13-Other). Plans should confirm there is not an appropriate category already provided in the PBP before entering data in 13-Other.

PBP Notes

Most PBP sections do not require a note, particularly when an MA organization provides benefits consistent with the descriptions for a particular benefit in Chapter 4 of the MMCM, HPMS memoranda, and the description of benefits provided in each PBP category; however, if a plan is offering more extensive services for a particular supplemental benefit, the note should describe only those services that are over and above what is described in Chapter 4.

Some benefits and certain PBP categories require additional information to clarify what the MA plan will cover. The table below indicates the specific circumstances and PBP categories that require a note and the information that is necessary for an accurate and complete bid to be submitted for CMS review.

Category/Circumstance	Information required in the note
Cost sharing range (copay range, coinsurance range, both copay and coinsurance charged, tiered cost sharing)	In each category containing a cost sharing range, describe the minimum and maximum cost sharing amount and any highly utilized services in between; include explanations of cost sharing associated with various places of service. When both a copay and coinsurance are charged, indicate when the copay applies versus when the coinsurance applies.

Category/Circumstance	Information required in the note
	Describe any tiered cost sharing amounts.
When "Other, describe" is selected in the PBP	Briefly describe the "other" item and confirm it does not conflict with the selections available.
13c: Meals	Meals provided for a limited period of time: Post inpatient hospitalization/surgery Include the number of meals and/or days covered for each event and the number of events applicable for the year. Chronic condition Include the chronic conditions eligible for the meal benefit and the number of meals and/or days covered for each chronic condition. Other medical condition Include a brief description for "other" medical conditions that require the enrollee to remain at home for a period of time and the number of meals and/or days provided for the other medical conditions.
13def: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another defined category in the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c4: Fitness Benefit	Physical fitness: Include a brief description of the services covered. The mention of a gym membership, or a nationally recognized program, is sufficient. Otherwise, a description of the type of physical fitness benefit must be included. Physical fitness benefits in this category do not include social events or requirements for attendance or performance. Memory fitness: Include a description of the type of brain/memory exercises offered. Activity Tracker If the plan only offers an activity tracker, the note does not need to include any details other than "activity tracker."
14c6: Telemonitoring	Include the condition(s) being monitored and briefly explain the monitoring process (i.e., the frequency of data collection, the device used, and the physician's involvement).
14c7: Remote Access Technologies	Web/Phone-based Technologies Include a description of the technology used and the services provided. Do not use the term "telehealth." Ensure that only supplemental benefits are included Nursing Hotline

Category/Circumstance	Information required in the note
	No note is required.
14c8: Home and Bathroom Safety Devices	List the devices being offered.
14c16: Weight Management Programs	Include a brief description of the benefit which may include program brand names, if applicable. If programs that typically include meals are offered, the note must state that meals are not covered as meals are a permitted supplemental benefit only when all criteria in § 422.100(c)(2)(ii) are met.
14c17: Alternative Therapies	List the therapies offered and ensure that none should be included in other categories of the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c19: Adult Day Health Services	Briefly describe the benefit being offered.
14c20: Home-Based Palliative Care	Briefly describe the benefit being offered.
14c21: In-Home Support Services	Briefly describe the benefit being offered.
14c22: Support for Caregivers of Enrollees	Describe the benefit being offered for ALL selections made (Respite Care, Caregiver Training, and Other).
19b-13def: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another category of the PBP. Also confirm the benefit does not duplicate a benefit already indicated in the base plan. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
19b-13i: Non-Primarily Health Related Benefits for the Chronically Ill	Add a brief description for each benefit being offered in the appropriate subcategory. Only add a note that is specific to that particular category. Do NOT duplicate the same note across all categories.
19b-13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)	Briefly describe the benefit and confirm that it does not meet the definition of another PBP category. Also confirm that the benefit does not duplicate one that is already indicated in the base plan. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.

Plans should not include the following in any PBP notes:

- Authorization and referral protocols (the information entered in the PBP data is sufficient)
- Codes (e.g., ICD-10 codes, CPT/DPT codes)
- Names of specific drugs
- References to the BPT or marketing materials
- Vague terms (e.g., "etc.", "misc.", "extended period of time", "other")
- Restatements of the PBP question(s) or information already indicated in the PBP data fields
- Original Medicare coverage descriptions or guidelines
- Supplemental benefit descriptions from MMCM Chapter 4
- References to state or Medicaid benefits
- References to Part D benefits (except in Rx PBP Notes section, where applicable)
- Value-added Items and Services
- Rewards or incentives
- Phone numbers or websites
- References to Model of Care (MOC) requirements

CY 2023 PBP Updates

Updated Service Category Descriptions

CMS updated the Medicare benefit and service category descriptions within the PBP software and encourages MA organizations to review this information to make sure proposed benefits are consistent with CMS definitions and instructions for the bid. Under 42 CFR § 422.254, MA organizations are responsible for submitting accurate and complete bids that provide all necessary information for bid evaluation. The updated service category descriptions can be viewed within the PBP software. They can be viewed in early April under the HPMS "Service Category Report" found in the 2023 Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2023 > Plan Benefit Reports > Service Category Report).

Section D Maximum Plan Benefit Amount and Combined Benefits

MA plans must enter benefits with a combined maximum plan benefit amount on the "Combined Benefits" screens in Section D and must not duplicate the maximum plan benefit amount in the corresponding benefit categories in Section B. However, there is one exception:

> Plans that wish to enter a combined maximum for B16a/b, 17a/b, or 18a/b must indicate the combined maximum within B16a/b, 17a/b, or 18a/b **and** must also enter the maximum plan benefit amount in Section D.

Note: For combined benefits where a maximum benefit amount applies to both a base package benefit and a SSBCI benefit, enter the maximum benefit amount in the base package benefit and enter $0 in the maximum benefit amount for the SSBCI benefit (e.g., OTC and Food & produce). For combined benefits where the number of visits or trips applies to both a base package benefit and an SSBCI benefit, enter the number of visits or trips in the base package benefit and enter 0

for the SSBCI benefit (e.g., supplemental transportation and transportation for non-medical needs).

Alternative Ambulance Transportation/Non-Transport Supplemental Benefit

Medicare Fee-for-Service covers ambulance transportation when a beneficiary needs to be transported to a limited number of destinations, including a hospital or skilled nursing facility, for emergency services or for other medically-necessary services when transportation in any other vehicle could endanger the beneficiary's health. In some cases, Medicare Fee-for-Service may pay for limited, medically necessary, non-emergency ambulance transportation if the beneficiary has a written order from the doctor stating that ambulance transportation is medically necessary. For example, a beneficiary with End-Stage Renal Disease (ESRD) may need a medically necessary ambulance transport to a facility that furnishes renal dialysis. Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give the beneficiary the care needed.

MA plans may provide a supplemental benefit that covers ambulance services on a broader basis than original Medicare coverage. This could include: (1) transport to an alternative destination appropriate to treat the beneficiary's condition, such as a primary care office, urgent care clinic, or a community mental health center; and (2) initiating and facilitating treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. This type of supplemental benefit should be entered in the PBP at Section B13-Other.

Important Administrative Information

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

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

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

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

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

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

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

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

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

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

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

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

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