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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: May 6, 2024

TO: All Medicare Advantage Organizations, Section 1876 Cost Plans, and Stakeholders

FROM: Kathryn A. Coleman
Director

SUBJECT: Final Contract Year (CY) 2025 Standards for Part C Benefits, Bid Review and Evaluation

This memorandum includes final bid and operational instructions for Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans. Statutory cites in this memorandum are to the Social Security Act (the Act) and regulatory cites are to 42 C.F.R. Parts 417 and 422 unless otherwise noted. This final memorandum applies only to CY 2025 and applies standards in regulations applicable to CY 2025.

CMS issued a preliminary HPMS memorandum to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2025 (HPMS memorandum titled, "Preliminary Contract Year (CY) 2025 Standards for Part C Benefits, Bid Review, and Evaluation," issued February 21, 2024). In the preliminary memorandum, CMS detailed how the CY 2025 Maximum Out-of-Pocket (MOOP) and cost sharing limits and Total Beneficiary Cost (TBC) thresholds were developed in accordance with §§ 422.100(f) and (j), 422.101(d), 422.254(a)(4), and 422.256(a). We received comments from five organizations in response.

Comments regarding TBC and cost sharing standards are summarized and addressed in detail within those sections of this memorandum. After consideration of the comments, we are finalizing the CY 2025 policies discussed in this memorandum which include revisions to the TBC threshold amount from the preliminary memorandum.

We also received technical comments regarding the Part D Out-of-Pocket Cost (OOPC) model and the Office of the Actuary's (OACT) bidding guidance. We shared these technical comments with the appropriate subject matter experts in CMS and OACT.

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).

CMS annually evaluates available Medicare data and other information to apply MA program requirements in accordance with applicable law (for example, §§ 422.100(f) and (j), 422.101, 422.256). Organizations are afforded the flexibility to design their benefit packages so long as

they satisfy Medicare coverage requirements. We remind organizations that they must also comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age or disability, including section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Overview of CY 2025 Part C Benefits Review

Portions of this memorandum apply to Section 1876 Cost Plans as well as 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.

Table 1 displays key MA bid review criteria by plan type.

Table 1: Applicable Bid Review Criteria by Plan Type

Bid Review Criteria	Applies to Non-EGWP (Excluding Dual Eligible SNPs)	Applies to Dual Eligible SNPs	Applies to Section 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
Part C Optional Supplemental Benefits §§ 422.100(f) and 422.102	Yes	Yes	No	No
Part C MOOP Limits §§422.100(f)(4) and (5) and 422.101(d)(2) and (3)	Yes	Yes	No	Yes
Service Category Cost Sharing §§ 417.454(e), 422.100(f), 422.100(j), and 422.113(b)	Yes	Yes	Yes[2]	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

[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 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 services including chemotherapy drugs and radiation therapy integral to the treatment regimen (including Part B rebatable drugs that are for chemotherapy), skilled nursing care, and renal dialysis services; in addition, cost plans must use Original Medicare cost sharing for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) (§ 417.454(e)). These and additional cost sharing requirements apply to MA plans under section 1852(a)(1)(B) of the Act §§ 422.100(f) and (j).

To facilitate the bid submission process, CMS provides tools and information to MA organizations in advance of the bid submission deadline. All MA organizations are required to submit their best accurate and complete bid(s) on or before Monday, June 3, 2024, at 11:59 PM Pacific Daylight Time. 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).

In this memorandum, CMS interprets and applies certain regulatory and statutory standards and provides additional information on topics related to CY 2025 bids. Consistent with prior years, MA organizations must also 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.

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 MA organizations that appear to have plans with significant increases in cost sharing or decreases in benefits from the prior contract year, including supplemental benefit offerings, to address these concerns.

Plans with Low Enrollment

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 2024 (three annual election periods) of CMS's decision not to renew these plans under § 422.510(a)(4)(xv). Consistent with prior years, 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 the plan-level termination authority in § 422.510(a)(4)(xv).

Upon receipt of this notification, MA organizations either (1) confirmed each of the low enrollment plans identified by CMS will be eliminated or consolidated with another of the organization's plans for CY 2025, or (2) provided a justification to CMS for renewal. If CMS found that the low enrollment justification is insufficient, CMS instructed the organization to eliminate or consolidate the plan. If the MA organization fails to comply with the instructions, CMS will terminate the plan under § 422.510. Instructions and the timeframe for submitting

justifications were 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 the 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 considers this information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. In addition, MA organizations must follow applicable regulations (including § 422.530) and instructions regarding procedures for renewal/non-renewal and consolidations with other plans. CMS will continue to evaluate whether an MA plan has sufficient enrollment to establish that it is a viable independent plan option 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, we apply a TBC evaluation that is designed to protect enrollees from significant increases in cost sharing or decreases in benefits from one year to the next. For 2025, the TBC evaluation will be consistent with the approach used for 2024. This includes using the same TBC change amount of $40.00 PMPM and applying the same methodology for plan-specific adjustments. As in prior years, the plan-specific adjustments include ensuring there is a year-over-year level playing field associated with updates to the Part D defined standard benefit, including benefit changes required under the Inflation Reduction Act.

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 in the PBP (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 increases in cost sharing or decreases in benefits.

Consistent with past years, CMS will use updated versions of the Part C and Part D Out-of-Pocket Cost (OOPC) Models to estimate beneficiary out-of-pocket costs in the TBC calculation for CY 2025 bid evaluation purposes. The Part C OOPC model includes annual utilization updates based on the Medicare Current Beneficiary Survey (MCBS) results. CMS generated updated CY 2024 Part C and Part D Baseline OOPC Model values for organizations and posted these values in HPMS (see HPMS memorandum titled "Contract Year 2024 Part C and Part D Baseline Out-of-Pocket Cost Models" issued December 19, 2023). Please note that the CY 2024 Part C Baseline OOPC model was updated to correct a technical issue on March 14, 2024, but

the model values originally posted in HPMS on December 19, 2023, were and continue to be accurate. MA organizations can view their plan OOPC values in HPMS under: Quality and Performance > Performance Metrics > Reports > Costs > Part C Out-of-Pocket Costs. In addition, the CY 2025 Bid Review OOPC Models were released April 16, 2024[1] (see HPMS memorandum titled "Contract Year 2025 Bid Review Out-of-Pocket (OOPC) Models). Note that CMS is also planning an annual refresh of the Part D Bid Review OOPC model to reflect updates in the May Formulary Reference File (FRF) consistent with this past year.

As in past years, for 2025, CMS will not evaluate TBC for EGWPs, MSA plans, D-SNPs, and C-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. D-SNP PBP data entry does not include the additional state benefits and cost sharing relief that dually eligible beneficiaries will have in that plan. These factors prevent the TBC evaluation (which uses PBP data) from reflecting the full benefit and cost sharing package available to enrollees in EGWPs and D-SNPs. MSA plans have unique benefit designs that include a medical savings account for purposes of paying for Part A and B benefits costs before the enrollee meets the deductible and a requirement to pay 100 percent of the costs for Part A and B benefits after the enrollee meets the deductible. 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 OOPC model cohort includes beneficiaries with and without ESRD and these plans potentially experience larger increases and/or decreases in payment amounts. These ESRD C-SNPs are subject to all other MA standards and CMS will contact plans if we identify large benefit or premium changes (while taking into consideration certain payment changes) during bid review.

During this past year's bid review (CY 2024), CMS received feedback from MA organizations indicating the TBC evaluation does not effectively measure changes in costs for beneficiaries enrolled in an I-SNP. Organizations suggested that a high percentage of dually eligible enrollees may be enrolled in I-SNPs and cost sharing and benefit improvements may not provide value for dually eligible enrollees since dually eligible individuals generally face zero out of pocket costs and receive benefits through Medicaid in addition to Medicare benefits. In addition, I-SNPs may have higher costs than other types of plans resulting in greater payment changes from one year to the next as compared to non-I-SNP MA plans. CMS considered these suggestions regarding the TBC evaluation for I-SNPs when developing the preliminary version of this CY 2025 memorandum, including capping payment changes, incorporating a risk adjustment factor, applying a different TBC change threshold for I-SNPs, and/or not applying the TBC evaluation to all or some I-SNPs. As a result of our analysis, we did not identify a compelling reason to change our long-standing policy of applying the TBC evaluation to I-SNPs and reflected this policy in the preliminary version of this CY 2025 memorandum.

In response to the "Preliminary CY2025 Standards for Part C Benefits, Bid Review and Evaluation" memorandum ("preliminary memorandum"), commenters requested CMS exempt either all or some I-SNPs (e.g., plans with a very high percentage of dually eligible enrollees) from the TBC evaluation. One organization recommended that if CMS decides to continue subjecting I-SNPs to the TBC evaluation that CMS should exclude the Part D benefit and

[1] A subsequent HPMS email titled "Release of Updated Contract Year 2025 Part C Bid Review OOPC Model" was released May 2, 2024, announcing an update to the Part C OOPC model.

premium changes because those changes will largely be due to changes in the standard Part D benefit design. Commenters stated that: (1) the TBC evaluation does not consider Medicaid benefits and cost sharing relief experienced by dually eligible beneficiaries, (2) applying the TBC evaluation to plans with a very high percentage of dually eligible enrollees will not reflect the ultimate benefits that most beneficiaries in those plans receive, and (3) exempting I-SNPs (all or a subset) would be consistent with CMS exempting D-SNPs from the TBC requirements. A commenter indicated that complying with the TBC evaluation when county benchmarks or star ratings change significantly can lead to administrative burdens for I-SNPs, especially for smaller, less sophisticated plans that have limited capabilities to customize their claims processing systems. The commenter requested that if the TBC evaluation is applied to I-SNPs that plans with original Medicare cost sharing be exempted.

After considering the comments, CMS will continue to apply the TBC evaluation to I-SNPs in evaluating CY 2025 bids. We do not believe that changing the TBC evaluation to exempt I-SNPs would be in the best interests of the MA program or its enrollees. Unlike D-SNPs, I-SNPs enroll dually eligible and non-dually eligible enrollees and the percentage of non-dually eligible enrollees as a percent of total enrollment in individual I-SNPs varies widely. The TBC evaluation is an important protection for non-dually eligible enrollees who might otherwise face increases in cost sharing or decreases in benefits from one year to the next. Moreover, excluding Part D from the TBC calculation for I-SNPs would be inconsistent with the requirement that both Part C and Part D benefits and premiums be included in the analysis to effectively measure changes in benefits and premiums from one year to the next from the beneficiary's perspective. In addition, we note that some non-SNPs and C-SNPs may also have higher percentages of dually eligible enrollees and are subject to the TBC evaluation. In addition, CMS believes that maintaining the consistency in the application of our well-established TBC evaluation is important so all MA organizations can plan and prepare bids properly.

Consistent with last year, 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 2025. However, the TBC calculation excludes benefits and cost sharing reductions entered in the VBID, MA Uniformity, and SSBCI sections of the PBP. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan.

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 ensures enrollees have access to viable and sustainable MA plan offerings.

CMS will continue to incorporate the technical and payment adjustments described below into the TBC evaluation and expects organizations to address other factors, such as Medicare Advantage payment policy changes, independently of our TBC standard. As such, plans are expected to 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 gain/loss margin requirements so MA organizations can satisfy the TBC standard.

In the preliminary memo, we stated that, as in past years, CMS will provide plan specific CY 2025 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 ($174.70).[2]
- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

As discussed previously, the updated Part C and D OOPC Models are being used to evaluate year-to-year TBC changes with CY 2025 bid submissions. The unweighted average for plans subject to the TBC evaluation, using the 2023 Baseline OOPC models, is about $395 per member per month (PMPM), compared to about $379 PMPM using the updated baseline OOPC models (a decrease of about $16 PMPM as illustrated in Table 2 below).

In the preliminary memorandum, CMS indicated that the TBC threshold for the CY 2025 bid evaluation would be $38.00 PMPM or 10% of the $379.06 Total Beneficiary Cost for the CY 2024 Updated Baseline OOPC Models, rounded to the nearest dollar, in Table 2. We note that the year-to-year change in the Part B premium amount is accounted for in the technical adjustments discussed previously.

Table 2: TBC Comparison Between CY 2023 and 2024 Baseline OOPC Models
(Unweighted Per Member Per Month Averages)

Item	2023 Baseline OOPC Models	2024 Updated Baseline OOPC Models	Difference
Part C OOPC	$119.79	$115.21	($4.58)
Part D OOPC	$96.54	$93.91	($2.63)
Part B Premium[1]	$157.96	$150.05	($7.91)
Plan Premium (Parts C&D)	$20.94	$19.90	($1.04)
Total Beneficiary Cost[2]	$395.23	$379.06	($16.17)

[1]This average includes plan-specific reductions in Part B premium.
[2]Totals may not equal sum of individual components due to rounding.

Several commenters requested CMS modify the CY 2025 TBC calculations directly or indirectly by changing the approach to technical adjustments or increase the TBC change threshold because of the impact of IRA-related Part D benefit redesign and other payment changes that will be discussed in more detail in the following paragraphs. One of these commenters also asked CMS to clarify if the 2025 Part D Bid Review OOPC tool will consider the "greater of" logic that applies to an enhanced alternative plan when accumulating the $2,000 Part D out of pocket limit as referenced in the "Draft CY 2025 Part D Redesign Program Instructions".[3] The commenter believes it is material and important for the OOPC tool to use the "greater of" logic. We confirm the CY 2025 Part D Bid Review OOPC tool does use the "greater of" logic when accumulating the $2,000 Part D annual out of pocket threshold for enhanced alternative plans.

[2] The CY 2025 Part B premium buy-down is limited to the dollar amount of the CY 2024 Part B premium.
[3] Draft CY 2025 Part D Redesign Program Instructions, published January 31, 2024, and Final CY 2025 Part D Program Instructions, published April 1, 2024, available at: https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements.

A commenter indicated the payment adjustments applicable to the adjusted TBC calculations are not treated consistently and that this can result in unreasonable situations for plans where county benchmarks have increased relative to the national average (i.e., a favorable rebasing impact), compared to plans experiencing a change in quality bonus payments or rebate percentages which are capped at a certain dollar amount (i.e., plan situation). Consistent with past years, we believe it is reasonable to cap changes in payment or rebate percentages to mitigate the impact on plan designs. However, we do not believe it is necessary to place a cap on the benchmark payment adjustment for evaluation purposes and have concerns that doing so could potentially impact bid integrity. For example, MA organization bid projections related to risk score could potentially be adjusted to obtain a TBC payment adjustment cap.

An organization recommended CMS consider an alternate approach to the Part B Premium adjustment factor that would result in adding $1.00 PMPM to the TBC change threshold. The commenter indicated that this would address the unique situation of having the maximum Part B premium in the Bid Pricing Tool decrease between 2023 and 2024 and then increase in 2025, such as due to the anticipated spending for a new Part B drug. We believe the existing approach to the TBC calculation and Part B premium adjustment factor best protects enrollees who continue enrollment in the same plan from significant increases in cost sharing or decreases in benefits for purposes of the TBC evaluation. Therefore, we are not making the recommended change.

A commenter acknowledged that CMS used 10% of the total baseline TBC value, which was the approach first mentioned in the CY 2012 Call Letter, to set the $38.00 PMPM TBC threshold specified in the preliminary memorandum for CY 2025. The organization then requested that CMS provide additional information and the details used to set the 10% TBC change threshold. We note, at the time of the CY 2012 Call Letter, the 10% increase value was established using actuarial and policy judgement based on CMS's bid review experience from previous years and after considering comments received on the CY 2012 Draft Call Letter. In addition, CMS discussed the TBC evaluation in the CY 2012 final rule (76 FR 21432, 21450-51). As noted by the commenter, CMS has adjusted the TBC change threshold related to policy changes in previous years. For example, CMS increased the TBC change threshold for most plans in CY 2021 to account for changes in ESRD enrollment policy resulting from the 21st Century Cures Act and to provide greater flexibility in navigating related MOOP limit changes at the time.

A commenter suggested CMS use a forward-looking approach in setting the TBC change threshold each year that accounts for anticipated changes in the Part C MOOP limits and cost sharing standards. We note the Part C MOOP and cost sharing limits are maximum limits based on Medicare FFS costs and do not necessarily represent the actual cost sharing experienced by MA enrollees under each MA plan's benefit design. For example, most plan benefit designs have MOOP and cost sharing amounts that are below the published limits. In contrast, the TBC evaluation is based on actual changes in out-of-pocket costs reflected in each MA plan's benefit package and the projected impact of those changes for MA enrollees. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes in the PBP (i.e., cost sharing changes) on plan enrollees.

Commenters suggested alternative approaches in evaluating and setting the TBC change threshold for CY 2025 to address the Part D benefit redesign and other payment challenges (e.g., risk adjustment and normalization for MA-PD plans and PDPs). Examples included removing Part D OOPC and premium from the TBC evaluation for CY 2025, incorporating technical adjustments based on the Part D benefit redesign, and/or increasing the TBC change threshold. A couple commenters indicated that without increases to the $38.00 PMPM TBC threshold (and one commenter also identified changes to the OOPC model), costs could increase for beneficiaries or plans may choose to exit the MA program due to solvency concerns.

The TBC evaluation is designed to protect enrollees from increases in cost sharing or decreases in benefits from one year to the next. The TBC evaluation includes – and we believe that it is necessary that it include – both Part C and Part D benefits and premiums in the analysis to have a better reflection of expected costs for MA enrollees. Specifically, the CY 2025 OOPC models will reflect PBP changes, such as the IRA-related Part D benefit redesign, impacts to the re-structuring of the Part C supplemental dental benefit as described in the appendix of this document, and other, typical model updates of the type that occur each year (e.g., inflation and utilization adjustments). In addition, as in prior years, the TBC calculation incorporates adjustment factors for changes in the OOPC models, plan payments, and Part B premium to account for year over year changes so that CY 2024 and CY 2025 benefits are evaluated on a level playing field against the TBC change threshold. Consistent with past years, MA organizations must address other factors, such as the risk adjustment model, independently of the TBC calculation.

The CY 2024 Part D OOPC model, like previous models, was based on the estimated total gross covered drug costs for applicable beneficiaries. As a result of the Part D benefit redesign, the CY 2025 OOPC model is based on Part D true out-of-pocket costs (TrOOP). The adjustment factor for annual changes in the OOPC model software will account for differences between the CY 2024 and CY 2025 models (assuming the plan uses the same formulary for CY 2025). However, while developing the 2025 Part D OOPC model CMS identified an error in the CY 2024 Part D OOPC model. The error resulted from using the estimated total gross covered drug costs for applicable beneficiaries from the CY 2024 Advance Notice ($13,172.18), rather than the updated value from the CY 2024 Rate Announcement ($12,447.11). The average impact of this error is approximately $0.70 PMPM for applicable MA-PD plans and made the TBC evaluation less challenging for plans during CY 2024 bid review but would make it more challenging for plans in CY 2025 (i.e., the CY 2024 Part D OOPC values were overstated and may require plans to make additional benefit or premium adjustments for CY 2025). As a result, CMS will provide a plan-specific technical correction adjustment (referred to as the "CY 2024 Part D OOPC model correction adjustment" in the Appendix) which decreases a plan's CY 2025 OOPC value for applicable MA-PD plans by the amount that was overstated for that plan in their CY 2024 OOPC value (thus providing more flexibility for plans).

We appreciate all the comments and understand the comments regarding navigating the Part D benefit redesign and payment policy changes for CY 2025. CMS carefully considered the recommendations to change the TBC calculation and increase the TBC change threshold. Based on the comments, CMS is keeping the TBC change threshold at the same level as 2024 ($40.00 PMPM) which is an increase from the proposed $38.00 PMPM to $40.00 PMPM for CY 2025. We believe this TBC change threshold provides MA organizations with reasonable flexibility in

navigating CY 2025 benefit and payment policy changes while protecting beneficiaries from large increases in cost sharing, the intent of TBC. This stability in the TBC change threshold balances our interest to: (1) protect beneficiaries from significant increases in cost sharing or decreases in benefits from the prior year and (2) provide stability to MA organizations that have plans with uncertain or variable impacts to their benefit liabilities due to the CY 2025 payment policy changes and Part D redesign.

We also remind organizations that as described in the 2024 Advance Notice and the July 31, 2023, HPMS memorandum, titled "Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information," under section 1860D-13(a) of the Act, as amended by section 11201 of the IRA, the Base Beneficiary Premium (BBP) for CY 2024 through CY 2029 is equal to the lesser of the prior year's BBP increased by 6 percent, or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted. The Part D premium stabilization provision limits premium increases for people enrolled in Part D.

Plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and a MA organization may be requested to provide a justification or change its bid(s). (See above for a discussion about which MA plans are not subject to the TBC evaluation and below for information about situation-specific adjustments.) 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).

A plan experiencing a net increase in adjustments may have an effective TBC change amount below the $40.00 PMPM threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $40.00 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 for CY 2025 as follows:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $40.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $40.00 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 -$40.00 PMPM will have a TBC change threshold of $80.00 PMPM (i.e., 2 times TBC change limit of $40.00 PMPM) plus applicable technical adjustments. That is, plans should not make changes that result in greater than $80.00 worth of decreased benefits or increased premiums.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$40.00 PMPM will have a TBC change threshold of $80.00 PMPM (i.e., 2 times TBC change limit of $40.00) plus applicable technical adjustments.
- Plans not accounted for in the three specific situations above are evaluated at the $40.00 PMPM limit, similar to the policy in CY 2024 about using the TBC threshold.

If CMS provides the MA organization an opportunity to address CY 2025 TBC issues following the bid submission deadline, the MA organization may not 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.

We reiterate our appreciation of the comments and suggestions received. CMS is finalizing the policies as discussed in this memorandum.

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-EGWP 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 a multi-year projection, but the plan bids submitted each year are evaluated based on that particular plan year. MA plans that offer optional supplemental benefits are still subject to Part 422 regulations (e.g., uniformity requirements, appeals, reporting, etc.).

Part C Maximum Out-of-Pocket Limits & Cost Sharing Standards Overview

Generally, all MA plans must comply with the cost sharing and MOOP limits established using the methodologies in §§ 422.100(f) and (j) and 422.101(d), except for MA MSA plans.[4] MA MSA plans must not cover basic benefits until the plan's deductible has been reached and after the deductible is reached, the MSA plan must cover 100 percent of the costs of basic benefits. See section 1859(b)(3) of the Act and § 422.4(a)(2). In addition to the MOOP and benefit category cost sharing limits, MA plans must comply with the aggregate and service-category specific PMPM actuarially equivalent requirements (§ 422.100(j)(2)). MA EGWPs continue to

[4] Additional detail about the rules CMS follows to set the MOOP and cost sharing limits is available in the final rule with comment period, "Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards Final Rule with Comment Period." Available 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", published April 14, 2022, referred to as the April 2022 final rule.

be subject to all MA regulatory requirements that have not explicitly been waived by CMS, regardless of whether they are affirmatively evaluated as part of bid review or in connection with other reviews.

CMS followed the methodology in §§ 422.100(f) and (j) and 422.101(d) to calculate the CY 2025 MOOP limits and cost sharing standards included in this memorandum.
The calculations supporting the CY 2025 MOOP and cost sharing limits (which were developed consistent with § 422.100(f)(7)) discussed in this memorandum (and the calculations for the CY 2024 MOOP and cost sharing limits) are available for reference at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. The year(s) of Medicare FFS data and trend factors that the OACT used to develop the CY 2025 Medicare FFS data projections are summarized in the footnotes of the CY 2025 calculation file.

Part C Maximum Out–of-Pocket Limits

MA plans must comply with the MOOP limits in Table 3 for CY 2025. CMS followed the methodology in §§ 422.100(f)(4), particularly paragraphs (f)(4)(v) and (f)(4)(vi)(B), and §§ 422.101(d)(2) and (d)(3) to calculate the CY 2025 MOOP limits. This involved basing calculations on Medicare FFS data projections[5] and applying the 10 percent cap on increases from the prior contract year to the in-network mandatory and lower MOOP types, if applicable. The CY 2025 Medicare FFS data projections, as rounded per § 422.100(f)(4)(iii), for the mandatory and lower MOOP limits did not exceed the 10 percent cap on increases. As a result, the CY 2025 in-network MOOP limits in Table 3 reflect the applicable projected Medicare FFS percentiles and the numeric midpoint for the intermediate MOOP type, application of the rounding rules, and 100 percent of ESRD costs (i.e., the ESRD transition ended in CY 2024).

Consistent with prior contract years, the PBP module includes validations to prevent an MA organization from entering MOOP and cost sharing amounts that are above the MOOP and cost sharing limits for the year, while also allowing plans to have MOOP and cost sharing amounts that are not rounded to a whole dollar amount. For example, an HMO plan that establishes an in-network MOOP amount of $4,150.50 will be considered an intermediate MOOP based on PBP validations applied to that plan's data entry (i.e., $4,150.50 exceeds the $4,150 lower MOOP limit in Table 3).

TABLE 3: FINAL CY 2025 PART C MOOP LIMITS BY PLAN TYPE

Plan Type	Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
HMO and HMO POS	$0 to $4,150 In-network	$4,151 to $6,750 In-network	$6,751 to $9,350 In-network
PPO (Local and Regional)	$0 to $4,150 In-network and $0 to $6,200 Combined	$4,151 to $6,750 In-network and $4,151 to $10,100 Combined	$6,751 to $9,350 In-network and $6,751 to $14,000 Combined
PFFS (full, partial, and non-network)	$0 to $4,150	$4,151 to $6,750	$6,751 to $9,350

[5] As defined in § 422.100(f)(4)(i), Medicare FFS data projections include data for beneficiaries with and without diagnoses of ESRD. Per § 422.100(f)(vi)(B), the CY 2025 MOOP limits reflect 100 percent of the ESRD cost differential.

Cost Sharing Standards

On November 7, 2022, CMS issued an HPMS memorandum, "Inflation Reduction Act Changes to Cost Sharing for Part B Drugs for Contract Year 2023 Medicare Advantage and Section 1876 Cost Plans," to provide guidance for CY 2023 on the beneficiary cost sharing protections under section 11101 (Part B drugs with prices increasing faster than inflation) and section 11407 (Monthly cost-sharing cap for insulins furnished under Part B benefit) of the Inflation Reduction Act (IRA, P.L. 117-169), enacted on August 16, 2022. The beneficiary cost sharing protections from these IRA provisions are reflected in the appropriate categories of Part B drug cost sharing limits in Table 4.

Beginning January 1, 2024, Medicare started allowing marriage, family, and mental health counselors to bill independently for their professional services and made changes to payment for certain mental health specialty services, including services involving community health workers and outpatient psychotherapy for crisis services. The OACT does not have sufficient utilization data available for these services to incorporate their costs into the projected weighted average allowed amount for the CY 2025 "mental health specialty services" service category standard used for setting MA cost sharing limits at this time. As a result, the same provider specialties used to set the CY 2024 copayment limits were used to calculate the CY 2025 copayment limits for the "mental health specialty services" service category shown in Table 4, including clinical psychologist, licensed clinical social worker, and psychiatry. MA plans must apply the "mental health specialty services" service category cost sharing limits shown in Table 4 to the specialty services covered during CY 2025. CMS plans to update the data used to inform the calculation of the CY 2026 "mental health specialty services" service category copayment limit to include covered services marriage, family, and mental health counselors and new payment rates for certain mental health specialty services.

Beginning January 1, 2024, Medicare also started covering Intensive Outpatient Program services. This benefit provides the same services as the partial hospitalization program benefit but requires fewer hours of therapy per week (a minimum of 9 hours versus over 20 hours). The OACT does not have sufficient utilization data available for this service type to project a CY 2025 allowed amount for these Intensive Outpatient Program services that is separate from partial hospitalization program services at this time. As a result, the cost sharing limit for partial hospitalization services in Table 4 also apply to the Intensive Outpatient Program services furnished during CY 2025. For CY 2026, CMS expects to set cost sharing limits specific to Intensive Outpatient Program services that are separate from the cost sharing limits appliable to partial hospitalization program services and establish separate data entry for this benefit in the PBP module.

Table 4 below summarizes the standards and maximum permissible cost sharing amounts by MOOP type under § 422.100(f)(6), (f)(7), (f)(8), and (j)(1); CY 2025 bids must reflect enrollee cost sharing for in-network services no greater than the amounts displayed below. These standards will be applied only to in-network Parts A and B services unless otherwise indicated in the table. All standards and cost sharing are inclusive of applicable service category deductibles, copayments, and coinsurance, but do not include plan level deductibles (for example, deductibles that include several service categories). Per § 422.100(f)(9), plan cost sharing (copayments and coinsurance) for basic benefits must reflect the enrollee's entire cost sharing responsibility,

inclusive of professional, facility, or provider setting charges, by combining (or bundling) all applicable fees into the cost sharing amount for that particular service(s) and setting(s) and be clearly reflected as a single, total cost sharing in appropriate materials distributed to beneficiaries for basic benefits.

TABLE 4: FINAL CY 2025 IN-NETWORK SERVICE CATEGORY COST SHARING LIMITS

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
Inpatient Hospital – Acute – 60 days[1]	1a	$4,150	$5,081	$6,012
Inpatient Hospital – Acute – 10 days[1]	1a	$3,327	$2,995	$2,662
Inpatient Hospital – Acute – 6 days[1]	1a	$2,992	$2,693	$2,394
Inpatient Hospital – Acute – 3 days[1]	1a	$2,731	$2,458	$2,185
Inpatient Hospital Psychiatric – 60 days[1]	1b	$4,105	$3,694	$3,284
Inpatient Hospital Psychiatric – 15 days[1]	1b	$2,755	$2,479	$2,204
Inpatient Hospital Psychiatric – 8 days[1]	1b	$2,545	$2,290	$2,036
Skilled Nursing Facility – First 20 Days[3]	2	$20/day	$10/day	$0/day
Skilled Nursing Facility – Days 21 through 100[3]	2	$214/day	$214/day	$214/day
Cardiac Rehabilitation[4]	3	50% / $50	42% / $40	35% / $35
Intensive Cardiac Rehabilitation[4,5]	3	50% / $65	42% / $55	35% / $45
Pulmonary Rehabilitation[4]	3	50% / $35	42% / $30	35% / $25
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)[4]	3	50% / $30	42% / $25	35% /$20
Emergency Services[4,6]	4a	$140	$125	$110
Urgently Needed Services[4,6]	4b	50% / $65	42% / $55	35% / $45
Partial Hospitalization Program[4]	5	50% / $130	42% / $105	35% / $80
Home Health[2]	6a	20% / $50[4]	$0	$0
Primary Care Physician[4]	7a	50% / $60	42% / $50	35% / $40
Chiropractic Care[4]	7b	50% / $20	42% / $20	35% / $15
Occupational Therapy[4]	7c	50% / $55	42% / $45	35% / $35
Physician Specialist[4]	7d	50% / $85	42% / $70	35% / $55
Mental Health Specialty Services[4]	7e	50% / $75	42% / $60	35% / $50
Psychiatric Services[4]	7h	50% / $70	42% / $60	35% / $45
Physical Therapy and Speech-language Pathology[4]	7i	50% / $80	42% / $65	35% / $50
Therapeutic Radiological Services[2,4]	8b	20% / $80	20% / $80	20% / $80
DME-Equipment	11a	50%	50%	20%[2,4]
DME-Prosthetics	11b	50%	50%	20%[2,4]
DME-Medical Supplies	11b	50%	50%	20%[2,4]
DME-Diabetes Monitoring Supplies[7]	11c	50%	50%	20%[2,4]
DME-Diabetic Shoes or Inserts	11c	50% / $30	50% / $30	20% / $10[2,4]
Dialysis Services[2,4]	12	20% / $55	20% / $55	20% / $55
Part B Drugs-Insulin[8]	15	$35	$35	$35
Part B Drugs-Chemotherapy/Radiation[2,4,9]	15	20% / $275	20% / $275	20% / $275
Part B Drugs-Other[2,4,9]	15	20% / $275	20% / $275	20% / $275

[1] All MA plans are required to establish cost sharing that complies with these limits calculated under § 422.100(f)(6)(iv) and does not exceed either the plan's MOOP limit or overall cost sharing for inpatient benefits in original Medicare on a per member per month actuarially equivalent basis. For the inpatient hospital cost sharing limits calculated per § 422.100(f)(6)(iv), the inpatient hospital acute 60-day length of stay cost sharing limit for the lower MOOP type exceeded the lower MOOP limit in Table 3. Therefore, CMS capped the CY 2025 cost sharing limit for the inpatient hospital acute 60-day length of stay at the lower MOOP limit.

[2] Section 1876 Cost Plans (per § 417.545(e)(1) and (2)) and MA plans (per § 422.100(j)(1)(i)(A) and (B)) may not charge enrollees higher cost sharing than is charged under original Medicare for Part B chemotherapy administration services, including chemotherapy drugs and radiation therapy integral to the treatment regimen, and renal dialysis services. MA plans (per § 422.100(j)(1)(i)(F)) may not charge enrollees higher cost sharing than is charged under Original Medicare for "Part B drugs – Other." MA plans that establish a lower MOOP amount may charge cost

sharing for home health (provided it does not exceed 20% coinsurance or an actuarially equivalent copayment), while plans with an intermediate or mandatory MOOP amount must not charge higher cost sharing than in original Medicare (per § 422.100(j)(1)(i)(D)). MA plans that establish a mandatory MOOP amount may also not charge enrollees higher cost sharing than is charged under original Medicare for specific DME service categories (per § 422.100(j)(1)(i)(E)).

[3] Section 1876 Cost Plans (per § 417.454(e)(3)) may not charge enrollees higher cost sharing than is charged under original Medicare for skilled nursing care. MA plans (per § 422.100(j)(1)(i)(C)) with a mandatory MOOP may not charge enrollees for the first 20 days of a skilled nursing facility (SNF) stay because their cost sharing cannot exceed cost sharing that is charged under original Medicare for these services. MA plans that establish a lower or intermediate MOOP limit may have cost sharing for the first 20 days of a SNF stay (§ 422.100(j)(1)(i)(C)). The per-day cost sharing for days 21 through 100 must not be greater than one eighth of the projected (or actual) Part A deductible amount, per § 422.100(j)(1)(i)(C)*(1)*. The SNF copayment limit for days 21 through 100 is based on 1/8th of the projected Part A deductible for 2025. Total cost sharing for the overall SNF benefit must not be greater than the actuarially equivalent cost sharing in original Medicare, pursuant to section 1852(a)(1)(B) of the Act, and § 422.100(j)(1)(i)(C).

[4] Cost sharing limits for these service categories (and for the DME service categories for MA plans with the mandatory MOOP type) are subject to the multiyear transition schedules finalized in §§ 422.100(f)(6)(iii), (f)(8), (j)(1)(ii), and 422.113(b)(2)(v).

[5] The copayment limit set for the intensive cardiac rehabilitation service category reflects application of the "lesser of" requirement in § 422.100(f)(8); the actuarially equivalent value to the coinsurance limit for CY 2025 is less than the value resulting from the actuarially equivalent copayment transition (after application of the rounding rules in § 422.100(f)(6)(ii)).

[6] The dollar amount for Emergency Services and Urgently Needed Services included in the table represents the maximum cost sharing permitted per visit (copayment or coinsurance) and the cost sharing limit applies regardless of whether the services are received inside or outside the MA organization, per § 422.113(b)(2)(i), (v), and (vi). Emergency and Urgently Needed Services benefits are not subject to plan level deductible amount and/or out-of-network providers. In addition, the cost sharing limit for Urgently Needed Services is based on the limits specified for professional services in § 422.100(f)(6)(iii) (which includes being subject to the transition limits in § 422.100(f)(8)), per § 422.113(b)(2)(vi).

[7] CMS did not set a copayment limit for "DME – diabetes monitoring supplies" based on large variations in cost from year-to-year due to the monitoring supplies PBP service category including items with high and very low costs together. CMS is considering separating this category into two categories in a future contract year to address this issue.

[8] The "Part B Drugs – Insulin" service category cost sharing limit applies to insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). The dollar amount for included in the table represents the maximum cost sharing permitted for a one-month's supply of Part B insulin (copayment or coinsurance). The "Part B Drugs – Insulin" benefit is not subject to a service category or plan level deductible.

[9] For Part B rebatable drugs, MA plans (for Part B rebatable drugs in the "Part B Drugs – Chemotherapy/Radiation Drugs" and "Part B Drugs – Other" service categories) and Section 1876 Cost Plans (for Part B rebatable drugs in the "Part B Drugs – Chemotherapy/Radiation Drugs" category) must comply with the lower coinsurance limit used in Original Medicare for the applicable quarter, based on the identification of Part B rebatable drugs for which specific cost sharing limits apply in original Medicare per IRA section 11101. To comply with this requirement, plans must ensure their in-network cost sharing does not exceed the adjusted Medicare coinsurance for the Part B drugs identified in the quarterly pricing files (e.g., the Average Sales Price (ASP) files). The Medicare coinsurance adjustment may change quarterly or not apply in a subsequent quarter.

NOTE: For MA plans that use: (1) coinsurance for inpatient hospital acute and psychiatric or SNF plan benefits or (2) copayment for DME service categories for which CMS does not have a set copayment limit, MA organizations must submit documentation with their initial bid that clearly demonstrates how these amounts satisfy the regulatory requirements for each applicable plan. This is because CMS does not have an established coinsurance limit for the inpatient hospital or SNF benefits under § 422.100 and has not set a copayment limit for all service categories of DME. In addition, for MA plans that use a coinsurance or copayment amount for other service categories for which CMS does not have an established limit on cost sharing under §§ 422.100 or 422.113, the MA organization must submit this documentation upon request by

CMS. This documentation may include information for multiple plans and must be identified separately from other supporting documentation submitted as part of the bid pricing tool (BPT) as required by OACT bidding guidance.[6] The documentation must be submitted for each PBP through the supporting documentation upload section titled "Cost-Sharing Justification" in HPMS. The upload will be available to all MA plan types (EGWP 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 2025 > Upload > Cost-Sharing Justification.

CMS received a comment requesting that we provide clarity on the supporting documentation required when a plan establishes a copayment or coinsurance for a service category (in Table 4 or PBP categories that are not listed in Table 4) for which CMS has not set a copayment or coinsurance limit, respectively. The commenter also specifically requested CMS clarify if: (1) MA organizations must provide supporting documentation for all service categories where the plan has established a copayment and CMS has not set a copayment limit and (2) if this supporting documentation is required for in-network basic benefits subject to the 50% coinsurance cap in § 422.100(f)(6)(i).

We appreciate the comment. The April 2022 final rule[7] includes a detailed discussion of cost sharing justification requirements in section II.B. and particularly on pages 22338 through 22346. MA organizations must develop and maintain documentation that demonstrates how plan cost sharing satisfies the requirements in § 422.100(f)(6)(i), (iii), and (j)(1). While we may not require documentation demonstrating the calculation of every cost sharing amount (coinsurance and copayment) used by an MA plan, consistent with prior years, CMS will direct MA organizations through annual guidance (such as HPMS memoranda or bid instructions) on whether cost sharing supporting documentation must be submitted with their initial bid or submitted upon request (as part of bid review or general oversight) depending on the service category. We have updated the “note” underneath Table 4 in this memorandum to be clear on this point.

In brief, the plan’s copayment supporting documentation must demonstrate:

- How the MA organization calculated the plan’s estimated total financial liability for the benefit for that contract year (or the average Medicare FFS allowable amount for the service area for benefits subject to § 422.100(f)(6)(i) and (j)(1));
- The percentage the copayment represents of the plan’s estimated total financial liability for the benefit for that contract year (or the average Medicare FFS allowable amount for the service area for benefits subject to § 422.100(f)(6)(i) and (j)(1)); and
- How the cost sharing does not exceed, as applicable, an actuarially equivalent amount to the 50 percent estimated total MA plan financial liability requirement (established at § 422.100(f)(6)(i)), the range of cost sharing requirement based on the type of MOOP limit (established at paragraph (f)(6)(iii)), and cost sharing under original Medicare (established at § 422.100(j)(1) and (2)).

[6]The annual OACT MA bidding guidance may be accessed from CMS’s page on Bid Forms & Instructions from the website: https://www.cms.gov/ Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Forms-Instructions.
[7]“Contract Year (CY) 2023 Medicare Advantage (MA) Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards Final Rule with Comment Period.” Available 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

Table 11 in the April 2022 final rule (on page 22346) provides an illustration of one way an MA organization can approach developing and summarizing supporting documentation that addresses the three components described previously for some select service categories. We expect MA organizations to also include any necessary payment, cost, and/or utilization data or assumptions that are not shown in Table 11. Requiring supporting documentation as described in this memorandum and in the April 2022 final rule protects enrollees from high cost sharing (generally and in relation to specific service categories) by ensuring that MA plan cost sharing amounts (coinsurance and copayments) satisfy cost sharing requirements in various scenarios.

Per Member Per Month Actuarial Equivalent Cost Sharing Limits

Per § 422.100(j)(2), CMS will separately evaluate the PMPM actuarial value of the cost sharing used by each MA plan for the following service categories: Inpatient, Skilled Nursing Facility (SNF), Durable Medical Equipment (DME), and Part B drugs (including biologics). Whether in aggregate, or on a service-specific basis, this evaluation is done by comparing two values in the plan's BPT. In essence, CMS determines plan compliance by comparing the actuarial value of a plan's PMPM cost sharing for the benefit category to the estimated actuarial value of original Medicare cost sharing for the same benefit category.

For CY 2025, a plan's PMPM cost sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) will be compared to Medicare covered actuarially equivalent cost sharing (BPT Worksheet 4, Section IIA, column n). For Inpatient hospital and SNF services, the Medicare actuarially equivalent cost sharing values, unlike plan cost sharing values, do not include Part B cost sharing. Therefore, an adjustment factor is applied to these Medicare actuarially equivalent values to incorporate Part B cost sharing and to make the comparison valid. These adjustment factors for Inpatient and Skilled Nursing Facility in column #4 of Table 5 (Part B Adjustment Factor to Incorporate Part B Cost Sharing) have been updated for CY 2025. Once the comparison amounts have been determined, CMS can evaluate excess cost sharing. Excess cost sharing is the difference (if positive) between the plan cost sharing amount (column #1 in Table 5) and the comparison amount in column #5 of Table 5 (which reflects an estimated original Medicare cost sharing which is weighted based on the plan's projected county enrollment). This evaluation process remains consistent with prior years and § 422.100(j)(2). Table 5 uses illustrative values to demonstrate the mechanics of this determination for CY 2025.

TABLE 5: ILLUSTRATIVE COMPARISON OF SERVICE-LEVEL ACTUARIAL EQUIVALENT COSTS TO IDENTIFY EXCESSIVE COST SHARING FOR CY 2025

	#1	#2	#3	#4	#5	#6	#7
BPT Benefit Category	**PMPM Plan Cost Sharing (Parts A&B)** ***(BPT Col. l)***	**Medicare FFS Allowed Amount** ***(BPT Col. m)***	**Medicare FFS Actuarially Equivalent Cost Sharing** ***(BPT Col. n)*** [1]	**Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on Medicare FFS Data Projections)**	**Comparison Amount**[2] ***(#3 × #4)***	**Excess Cost Sharing (#1 − #5, min of $0)**	**Pass/Fail**
Inpatient	$33.49	$331.06	$25.30	1.318	$33.35	$0.14	Fail
SNF	$10.83	$58.19	$9.89	1.069	$10.57	$0.26	Fail
DME	$3.00	$11.37	$2.65	1	$2.65	$0.35	Fail
Part B-Rx	$0.06	$1.42	$0.33	1	$0.33	$0.00	Pass

[1] PMPM values in column #3 for Inpatient and SNF only reflect Part A FFS actuarial equivalent cost sharing for that service category.

[2] Estimated original Medicare cost sharing weighted based on the plan's projected county enrollment.

Conclusion

The policies described in this memorandum will be used in the evaluation of CY 2025 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) 2025 Plan Benefit Package (PBP) data entry instructions 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 in the TBC section of this memo.

For CY 2025 bids, CMS will maintain the process used in prior years for consolidating or crosswalking plans when conducting the TBC evaluation. 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 2024 plan will be compared independently to the CY 2025 plan.
- Segmenting an existing plan: TBC for each CY 2025 segmented plan will be compared independently to the CY 2024 non-segmented plan.
- Consolidating/crosswalking previously segmented plans into one non-segmented plan: TBC of each existing CY 2024 segmented plan will be compared independently to the non-segmented CY 2025 plan.
- Consolidating/crosswalking segmented plans into other segmented plans: TBC of each existing CY 2024 segmented plan will be compared independently to the segmented CY 2025 plan.

If CMS provides the MA organization an opportunity to address CY 2025 TBC issues following the bid submission deadline, the MA organization may not 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 table below. 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 $40.00 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 2024 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 2025 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 2024 ($164.90) and the amount for CY 2025 ($174.70)	Value is $9.80 for all plans
	L	Impact of changes in OOPC Model between CY 2024 and CY 2025	Plan-specific value will be provided by CMS through an HPMS posting

Steps	Item	Item	Description
	LL	CY 2024 Part D OOPC model correction adjustment	Plan-specific correction for the CY 2024 Part D OOPC model, previously discussed in the "Total Beneficiary Cost (TBC)" section.
Evaluation	M	Adjusted TBC Change	Calculation: G + J - K - L + LL Plan is likely to pass the TBC evaluation if M is less than or equal to $40.00 PMPM

As described in the table above, CMS will provide, through the HPMS posting, CY 2024 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 2024 BPT. MA organizations will be able to calculate their plan-specific CY 2025 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2025 (Item E). Premium (net of rebates) can be found in the CY 2025BPT, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The Unadjusted TBC Change between CY 2024 and CY 2025 (Item G) is the difference between CY 2025 Total TBC (Item F) and CY 2024 Total TBC (Item C), i.e., G = F - C. The Adjusted TBC Change amount (Item M) reflects the impact of the payment adjustment, technical adjustments, and the CY 2024 Part D OOPC model correction adjustment. 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 $40.00 PMPM	Maximized at $40.00 PMPM
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -$40.00 PMPM	Minimized at -$40.00 PMPM
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -$40.00 PMPM	Minimized at -$40.00 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 2024 and CY 2025 (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.[8] The formula for applying the adjustments to calculate the Adjusted TBC Change amount is represented as follows: M = G + J - K - L + LL. In this illustrative scenario, plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $40.00 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 2025 rebate minus the CY 2024 rebate. The CY 2024 Bid Amount and Benchmark are taken from the plan-submitted CY 2024 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2024 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2024 ratebook. The CY 2025 Benchmark is the weighted average of county-specific payment rates using the CY 2025 ratebook and projected enrollment from the CY 2024 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.

[8] 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.

Illustrative Calculation Examples

Bid ID	2024 Values					2025 Values							
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium *	Rebate Difference	Payment Adj.	TBC Threshold
Plan 001	3	$1,000	$950	50%	($50.00)*	3	1,023.10	$972	50%	($51.16)*	($1.15)	($1.15)	$41.16
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,023.10	$1,074	50%	$25.58	$0.58	$0.58	$39.42
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,023.10	$1,330	65%	$199.50	$49.50	$40.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,023.10	$1,330	50%	$153.47	($41.54)	($40.00)	$80.00
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,023.10	$1,395	65%	$241.75	$46.75	$40.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,227.72	$1,328	65%	$65.36	($41.89)	($40.00)	$80.00
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,023.10	$1,250	50%	$113.45	($36.55)	($36.55)	$76.55

*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 2.31%.
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 $40 PMPM.
e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at −$40 PMPM.
f. Plan 005 has benchmark growth of 2.31% 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 $40 PMPM.
g. Plan 006 has benchmark growth of 2.31% less 5.0% to simulate losing a bonus payment[9]; therefore the payment adjustment is minimized at −$40 PMPM.
h. Plan 007 has a 2025 star rating below 3.0; therefore the payment adjustment is minimized at −$40 PMPM.

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

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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 2025 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	Enter amounts as applicable
PFFS (partial network)	PFFS Amount	Enter amounts 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 the Medicare Managed Care Manual (MMCM), Chapter 4, Section 50.1.

CY 2025 Part C PBP Data Entry Expectations

Updated Medicare Benefit and Service Category Descriptions

CMS updated the PBP Medicare benefit and service category descriptions in HPMS 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 and Medicare benefit descriptions can be viewed under the HPMS Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2025 > Plan Benefit Reports > Service Category Report and Plan Bids > Bid Reports > CY2025 > Plan Benefit Reports > Medicare Benefit Description Report).

Dental Benefit Restructure

The CY 2025 PBP includes several changes to the structure of the service categories in section 16: Dental. The Medicare-covered dental service category has been renumbered to appear as a distinct service category (16a: Medicare Dental Services). Additionally, the non-Medicare covered dental service categories in the PBP (16b: Diagnostic and Preventive Dental, 16c: Comprehensive Dental) have been restructured for CY 2025 to better align with Current Dental Terminology (CDT) code categories. The following chart defines the CDT code categories expected to be represented in each non-Medicare covered dental service category (Note: plans should not include reference to specific CDT codes in the PBP notes).

16b: Diagnostic and Preventive Dental

16b1	Oral Exams	I. Diagnostic (D0100-D0999)
16b2	Dental X-Rays	
16b3	Other Diagnostic Services	
16b4	Prophylaxis (Cleaning)	II. Preventive (D1000-D1999)
16b5	Fluoride Treatment	
16b6	Other Preventive Dental Services	

16c: Comprehensive Dental

16c1	Restorative Services	III. Restorative (D2000-D2999)
16c2	Endodontics	IV. Endodontics (D3000-D3999)
16c3	Periodontics	V. Periodontics (D4000-D4999)
16c4	Prosthodontics, removable	VI. Prosthodontics, removable (D5000-D5899)
16c5	Maxillofacial Prosthetics	VII. Maxillofacial Prosthetics (D5900-D5999)
16c6	Implant Services	VIII. Implant Services (D6000-D6199)
16c7	Prosthodontics, fixed	IX. Prosthodontics, fixed (D6200-D6999)
16c8	Oral and Maxillofacial Surgery	X. Oral and Maxillofacial Surgery (D7000-D7999)
16c9	Orthodontics	XI. Orthodontics (D8000-D8999)
16c10	Adjunctive General Services	XII. Adjunctive General Services (D9000-D9999)

MA organizations should carefully review the service category and Medicare benefit description reports to make sure proposed dental benefits are consistent with CMS definitions and instructions for the bid. MA organizations are reminded that they must not enter any Medicare-covered dental benefits in non-Medicare covered service categories.

Hearing Aids Available Over the Counter (OTC)

MA plans may offer hearing aids available through prescription and/or available OTC as supplemental benefits. The CY 2025 PBP has been modified to include a new service category 18c: OTC Hearing Aids. For CY 2025, CMS's expectation is that prescription hearing aids be included in the 18b: Prescription Hearing Aids service category while OTC Hearing Aids be included in the 18c: OTC Hearing Aids service category only. As a reminder, organizations may offer a single combined maximum plan benefit amount shared between 18c: OTC Hearing Aids and other 13b: OTC benefits by indicating coverage in both service categories and creating a "Combined Supplemental Benefits" package in the PBP.

Using Appropriate Benefit Categories

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.) for that service and is not duplicated in multiple PBP locations. 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 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.

Cost Sharing with a Single Value

The CY 2025 PBP will continue to capture the cost sharing for plans that have the same value for copay/coinsurance minimum and maximum in a different way than in the CY 2023 PBP and previous years. Plans that have the same value for the minimum and maximum copay or coinsurance should select "Yes" rather than "Yes, with a min & max" and enter the single value.

Combined Supplemental Benefits

MA plans must enter benefits with a combined maximum plan benefit amount or benefits with a combined visit limit as a "Combined Supplemental Benefits" package in the PBP. The maximum plan benefit amount should not be duplicated in the corresponding benefit categories in the "Benefit Details" section except as follows:

A. Plans that wish to enter a combined maximum for 16b/c, 17a/b, or 18a/b must indicate the combined maximum in the 16b/c, 17a/b, or 18a/b "Benefit Details" section **and**
B. Must also enter the maximum plan benefit amount in the "Combined Supplemental Benefits" package.

For combined benefits where a **shared maximum benefit amount** applies to **both a base package (service categories 1-18) 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., 13b: Over the Counter benefits and 19b: SSBCI Additional Benefits/13i: Food &

Produce). For combined benefits where the number of visits or trips applies to **both a base package benefit and a SSBCI benefit**, enter the number of visits or trips in the base package benefit and enter 0 for the SSBCI benefit (e.g., 10b: Transportation (primarily health-related) and 19b: SSBCI Additional Benefits/13i: Transportation for non-medical needs).

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 for 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.
Tiering of Cost Sharing for Medical Benefits	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.
13b: OTC	Ensure hearing aids available OTC are not included in the 13b notes. Hearing aids available OTC should be included in the 18c: Hearing Aids service category.
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.

Category/Circumstance	Information required in the note
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/fitness club 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 must not include social events, general use items such as fitness apparel, sneakers, or merchandise or requirements for attendance or performance. Memory fitness: Include a description of the type of brain/memory exercises offered. Puzzles and games are not considered a memory fitness primarily health related supplemental benefit. 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 that are not Medicare-covered or Additional Telehealth Benefits under § 422.135. Do not use the term "telehealth." Ensure that only supplemental benefits are included. Nursing Hotline No note is required.
14c8: Home and Bathroom Safety Devices	List the devices being offered.
14c14: Readmission Prevention	If "meals" is selected, include the number of meals and/or days covered for each event and the number of events applicable for the year. If "other" is selected, include a brief description of the benefit offered.

Category/Circumstance	Information required in the note
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, **meals must not be covered** as part of the weight management benefit (because meals are a permitted supplemental benefit only when all criteria in § 422.100(c)(2)(ii) are met) and the note must state that meals are not covered as part of this benefit.
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 such as assistance with ADLs/IADLs. Do not reference companionship as this is not considered a primarily health related supplemental benefit in this category.
14c20: Home-Based Palliative Care	Briefly describe the benefit being offered.
14c21: In-Home Support Services	Briefly describe the benefit being offered such as assistance with ADLs/IADLs. Do not reference companionship as this is not considered a primarily health related supplemental benefit in this category.
14c22: Support for Caregivers of Enrollees	Describe the benefit being offered for ALL selections made (Respite Care, Caregiver Training, and Other).
16b: Diagnostic and Preventive Dental and 16c: Comprehensive Dental	Ensure Medicare-covered dental benefits are not described in the notes for the supplemental dental benefit categories (that is, non-Medicare covered dental benefit categories). While plans may summarize the supplemental dental services covered in the notes fields, plans should not list specific CDT codes covered for each category.
MA Uniformity Flexibility, SSBCI-13def: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another category of the PBP and is primarily health- related. Also confirm the benefit does not duplicate a benefit already indicated in PBP service categories 1-18, 20 (referred to as the base bid). 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/.
SSBCI -13i: Non-Primarily Health Related Special Supplemental Benefits for the Chronically Ill (SSBCI, § 422.102(f))	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.

Category/Circumstance	Information required in the note
SSBCI -13i-O: Non-Primarily Health Related Special Supplemental Benefits for the Chronically Ill (SSBCI, § 422.102(f))), Other	Briefly describe the benefit and confirm that it does not meet the definition of another PBP category. Confirm that the benefit does not duplicate one that is already indicated in the base bid. Also ensure that primarily health-related benefits are entered in 13def, not 13i-O. 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 codes, CDT 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

Other Important Reminders

Special Supplemental Benefits for the Chronically Ill (SSBCI)

The Bipartisan Budget Act of 2018 (Public Law No. 115-123) amended section 1852(a)(3) of the Social Security Act to expand the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees. We refer to these as Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI may include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees, provided that the SSBCI, with respect to the chronically ill enrollee, has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. Examples of items and services that do not meet the 'reasonable expectation' standard and are not permitted as supplemental benefits include: alcohol, tobacco, cannabis products, funeral planning and expenses, life insurance, hospital indemnity insurance, broad membership programs inclusive of multiple unrelated

services and discounts, and procedures that are solely cosmetic in nature and do not extend upon original Medicare coverage (e.g., cosmetic surgery such as facelifts).

Plans are reminded that 42 CFR § 422.102(f)(1)(i)[10] defines a chronically ill enrollee as an individual who:

1) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
2) has a high risk of hospitalization or other adverse health outcomes; and
3) requires intensive care coordination.

All three criteria must be met for an enrollee to be eligible for the SSBCI.

Plans are also responsible for ensuring that for all SSBCI that are items or services and included in its bids for CY 2025, the plan is able to provide a bibliography of evidence supporting the SSBCI and demonstrating through relevant acceptable evidence that each item or service has a reasonable expectation of improving or maintaining the overall health or function of an enrollee, in accordance with § 422.102(f)(3), as amended in the Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024--Remaining Provisions & Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE) final rule ("CY 2025 final rule"). https://www.federalregister.gov/public-inspection/2024-07105/medicare-program-medicare-advantage-and-the-medicare-prescription-drug-benefit-program-for-contract.

An MA plan offering SSBCI must, in accordance with § 422.102(f)(4), as amended in the CY 2025 final rule, do all of the following:

i. Have written policies for determining enrollee eligibility and must document its determination that an enrollee is a chronically ill enrollee based on the definition in § 422.102(f)(1)(i),
ii. Make information and documentation related to determining enrollee eligibility available to CMS upon request,
iii. A. Have and apply written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and document these criteria, and
B. Document the written policies specified in paragraph (iii)(A) and the objective criteria on which the written policies are based,
iv. Document each eligibility determination for an enrollee, whether eligible or ineligible, to receive a specific SSBCI and make this information available to CMS upon request, and
v. Maintain without modification, as it relates to an SSBCI, evidentiary standards for a specific enrollee to be determined eligible for a particular SSBCI, or the specific objective criteria used by a plan as part of SSBCI eligibility determinations for the full coverage year.

[10] See also section 1852(a)(3)(D) of the Act.

Fitness Benefits

Fitness benefits (e.g., fitness center membership, exercise and yoga classes) may be offered by MA plans as supplemental benefits designed to improve or maintain good health. Per CMS regulations at 42 CFR 422.100(c)(2)(ii), CMS defines a mandatory or optional supplemental health care benefit as an item or service (1) not covered by Medicare Parts A, B or D, (2) that is primarily health related, and (3) for which the plan must incur a non-zero direct medical cost. Additionally, per CMS regulations at 42 CFR 422.100(c)(2)(ii)(A), an item or service is considered "primarily health related" if it diagnoses, prevents, or treats an illness or injury; compensates for physical impairments; acts to ameliorate the functional/psychological impact of injuries or health conditions; or reduces avoidable emergency and health care utilization. An item or service that meets all three conditions above may be proposed as a supplemental benefit in a plan's PBP. Further, as stated in the January 2021 Final Rule[11] (86 FR 5971), a supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.

Plans are reminded that items and services included in the PBP under the "Fitness benefit" category must be primarily health related in accordance with the above definition. We also remind plans that a benefit that provides access to permissible fitness activities must be non-transferrable and only available to enrollees, consistent with the plan's coverage criteria (see § 422.100(d)(2)(ii)). MA plans should describe specifically what is included in the supplemental fitness benefit in the 14c4: Fitness Benefits PBP notes field. Examples of fitness related items and services that do not meet the definition of primarily health related include sneakers, athletic clothing or merchandise such as sporting goods, fees related to sport leagues or club sport memberships, competitions, social programs or events, and park passes.

Debit Cards as a Tool in Administering Covered Benefits

MA plans may administer reductions in cost sharing for covered benefits and/or covered supplemental benefits, or combinations of supplemental benefits with a shared maximum benefit amount through a debit card. The PBP must identify the covered benefits or reductions in cost sharing that are facilitated through use of the debit card. Consistent with this, all the items and services for which payment may be made (in the form of a reduction in cost sharing that would otherwise apply for the item or service or in the form of the MA plan's payment of its share of the amount owed to the provider) must meet the requirements to be a supplemental benefit. Plans are reminded that as stated in the 2021 Final Rule (86 FR 5864, p. 5913) they are expected to administer benefits in a manner that ensures the debit card and/or allowance can only be used towards plan-covered items and services. Plans are also reminded that the debit card is not a covered benefit but the mechanism by which the MA plan provides payment to providers for the covered benefit.

Alternative Ambulance Transportation/Non-Transport Supplemental Benefit

Medicare Fee-for-Service covers ambulance transportation when a beneficiary needs to be transported, from a specific location (for example, the beneficiary's home) to a limited number

[11] https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf

of destinations, including a hospital or skilled nursing facility but limited to the locations specified in 42 CFR § 410.40(f), 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 is able to give the beneficiary the care needed. For more information, see 42 CFR §§ 410.40 and 410.4, and Medicare Benefit Policy Manual, Ch. 10.

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 13d,e,f-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 models are 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 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 questions related to the Inflation Reduction Act, please submit an email to IRARebateandNegotiation@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.