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

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: May 12, 2021

TO: Medicare Advantage Organizations
Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Contract Year 2022 Medicare Advantage Technical Instructions

This memorandum provides Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans technical instructions on bid development and submission; highlights benefit policies; and reviews the contract year (CY) 2022 Plan Benefit Package (PBP) software.

CMS recommends organizations reference the following documents in conjunction with this memorandum as they develop CY 2022 bids:

- Final rule, "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," which appeared in the Federal Register on June 2, 2020 (referred to as the June 2020 Final Rule)
- Final rule, "Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," which appeared in the Federal Register on January 19, 2021 (referred to as the January 2021 Final Rule)
- HPMS Memo titled "Final Contract Year 2022 Part C Benefits Review and Evaluation" which is expected to be issued in May 2021
- Contract Year (CY) 2022 Final Part D Bidding Instructions issued on January 19, 2021
- CY 2020 Final Call Letter (specifically Section II, Part C) issued on April 1, 2019
- Chapter 4 of the Medicare Managed Care Manual (MMCM)
- Bid Submission User Manual in the Health Plan Management System (HPMS).

Bids are due to CMS on or before **Monday, June 7, 2021, at 11:59 PM PDT**.

The table below displays the applicable bid review criteria by MA plan type. The column titled "Document References" refer to the following: (1) This HPMS Memorandum, (2) The HPMS Memo titled "Final Contract Year 2022 Part C Benefits Review and Evaluation" which is expected to be issued in May 2021, and (3) the CY 2020 Final Call Letter issued April 1, 2019.

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	**Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)**	**Applies to Non-Employer Dual Eligible SNPs**	**Applies to 1876 Cost Plans**	**Applies to Employer Plans**	**Document References** *(see descriptions above)*
Total Beneficiary Cost (TBC) Section 1854(a)(5)(C)(ii) of the Act, and 42 C.F.R. §§422.254(a)(4) and 422.256(a)	Yes	No	No	No	1 and 2
Maximum Out-of-Pocket (MOOP) Limits 42 C.F.R. §422.100(f)(4) and (5) and §422.101(d)(2) and (3)	Yes	Yes	No	Yes	1 and 2
PMPM Actuarial Equivalent Cost Sharing Section 1852(a)(1)(B) of the Act; 42 C.F.R. §422.254(b)(4), §422.100(f)(2)	Yes	Yes	No	Yes	2
Service Category Cost Sharing[1] Section 1852(a)(1)(B) of the Act; 42 C.F.R. §417.454(e), §422.100(f) and §422.100(j)	Yes	Yes	Yes	Yes	2
Part C Optional Supplemental Benefits Section 1852(a)(3) and 42 C.F.R. §422.100(f)	Yes	Yes	No	No	2 and 3

[1] Section 1876 Cost Plans and MA plans must not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 C.F.R. §§ 417.454(e) and 422.100(j)). MA plans (by statute) must not charge enrollees higher cost sharing than is charged under Original Medicare for a COVID-19 vaccine and its administration. In addition, Section 1876 Cost Plans (by regulation) must not charge enrollees higher cost sharing than is charged under Original Medicare for a COVID-19 vaccine and its administration for the duration of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Act.

Consistent with prior years, MA organizations also must address other requirements in their bids, such as the medical loss ratio, and are expected to do so independently of our requirements for benefits and bid review. Therefore, CMS is not making specific adjustments or allowances for these changes in the benefits review requirements.

Total Beneficiary Cost (TBC)

CMS is not obligated to accept every bid submitted and is authorized to deny a plan bid if CMS determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. *See* section 1854(a)(6)(B) of the Act and 42 C.F.R. § 422.256. In exercising this authority, we will be using the same TBC evaluation methodology as in past years, with a modification to the evaluation in calculating the TBC change amount. For CY 2022, CMS will include the Cash or Monetary Rebate component of the Value-Based Insurance Design (VBID) in the TBC evaluation, but will continue to exclude other benefits and cost sharing reductions entered in Section B-19 of the PBP from the TBC evaluation. 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 a MAO may be requested to provide a justification or change its bid(s). MAOs 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 methodology for developing the CY 2022 out-of-pocket costs (OOPC) model is generally consistent with last year's methodology. For more information, please reference the HPMS memorandum dated December 31, 2020 titled "CY 2021 Baseline Out-of-Pocket Cost (OOPC) Model". In addition, the CY 2022 Bid Review OOPC Model will be released in April 2021. We note that the impact of copayment reductions for the Part D Senior Savings Model will be incorporated into both the CY 2021 baseline and CY 2022 bid review OOPC models. As a result, CMS will not make any special considerations for MA-PD plans providing the Part D Senior Savings Model benefit in CY 2022.

The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By reviewing excessive increases in the TBC from one year to the next, CMS is able to make sure enrollees who continue enrollment in the same plan are not exposed to significant cost increases. As in past years, CMS will not evaluate TBC for EGWPs, D-SNPs, SNPs for End Stage Renal Disease (ESRD) Requiring Dialysis, and MSA plans. EGWP benefit packages are negotiated arrangements between employer groups and MA organizations so we believe that the employer would have taken these costs into account in making such plans available. D-SNP benefits entered into the plan benefit package do not include state benefits and cost sharing relief, which means that a TBC evaluation would not be based on the full benefit and cost sharing package available to enrollees. SNPs for ESRD Requiring Dialysis are not effectively addressed by the OOPC model used for the TBC evaluation and these plans potentially experience larger increases and/or decreases in payment amounts. ESRD SNPs are subject to all other MA standards and CMS will contact plans if CMS identifies large benefit or premium changes (while taking into consideration payment changes) during bid review. Finally, MSAs have unique benefit designs that include a medical savings account for purposes of paying costs below the deductible.

MA plans offering Part C supplemental benefits that take advantage of the flexibility in the uniformity requirements, offering Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or participate in the VBID model test will be subject to the TBC evaluation for CY 2022. However, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered under Part C uniformity flexibility, SSBCI, or as part of the VBID model test will be excluded from the TBC calculation. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan. As noted above, CMS will include the Cash or Monetary Rebate component of the Value-Based Insurance Design (VBID) in the TBC evaluation, but will continue to exclude other benefits and cost sharing reductions entered in Section B-19 of the PBP from the TBC evaluation.

Under 42 C.F.R. § 422.256, CMS reserves the right to further examine and negotiate changes to a plan bid even if a plan's TBC is within the given amount. This approach not only protects enrollees from significant increases in cost sharing or decreases in benefits, but also confirms enrollees have access to viable and sustainable MA plan offerings.

As in past years using the TBC evaluation, CMS will incorporate the technical and payment adjustments described below and expects organizations to address other factors, such as coding intensity changes, and risk adjustment model changes, independently of our TBC standard. As such, plans are expected to anticipate and manage changes in payment and other factors to minimize changes in benefit and cost sharing over time. CMS also reminds MA organizations that the OACT extends flexibility on margin requirements in bid review so MA organizations can satisfy the TBC standard.

In April 2021, as in past years, CMS expects to provide plan specific CY 2022 TBC values. In doing so, CMS will 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 ($148.50).
- Payment Adjustments: (1) county benchmark and (2) quality bonus payment and/or rebate percentages.

The TBC evaluation is applied by determining whether the out-of-pocket costs projected for an enrollee using the CY 2022 bid exceeds the out-of-pocket costs projected for an enrollee under the CY 2021 bid by more than a set threshold amount. A plan experiencing a net increase in the technical and payment adjustments may have an effective TBC change amount that is below the PMPM threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the PMPM threshold. The PMPM threshold amount will be set in the HPMS Memo titled "Final Contract Year 2022 Part C Benefits Review and Evaluation" which is expected to be issued in May 2021. In order to provide MA organizations with important information about how the TBC evaluation is performed with sufficient time for organizations to use that information in planning their bids, we are furnishing detailed explanations of the mechanics of the TBC evaluation in this memo. **The descriptions below use a $39.00 PMPM for illustrative purposes only.**

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 continue to apply the TBC evaluation differently for the following specific situations:

1. Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than the TBC change threshold (i.e., $39.00 PMPM) will have a TBC change threshold of $0.00 PMPM plus applicable technical adjustments.
2. Plans with a decrease in quality bonus payments and/or rebate percentage, that are below the lower limit payment adjustment amount (i.e., -$39.00 PMPM) will have a TBC change threshold of 2 times the TBC change threshold (i.e., $78.00 PMPM) plus applicable technical adjustments. That is, plans should not make changes that result in greater than $78.00 worth of decreased benefits or increased premiums.
3. Plans with a star rating below 3.0 and an overall payment adjustment amount that are below the lower limit payment adjustment (i.e.,−$39.00 PMPM) will have a TBC change threshold of 2 times the TBC change threshold (i.e., $78.00) plus applicable technical adjustments.
4. Plans not accounted for in the three specific situations above are evaluated at the TBC change threshold (i.e., $39.00 PMPM).

CMS will maintain the TBC evaluation used during CY 2022 for consolidating or crosswalking plans. Each individual plan being consolidated/crosswalked into another plan must meet the TBC requirement on its own merit. Therefore, the TBC adjustment factors for each plan being consolidated/crosswalked will be part of the calculation as if the plan were continuing. For example, Plan A is being consolidated/crosswalked into Plan B. Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B. Plan B's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan B. The following describes how the TBC evaluation will be conducted for organizations that consolidate/crosswalk or segment plans from one year to the next:

- Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2021 plan will be compared independently to the CY 2022 plan.

- Segmenting an existing plan: TBC for each CY 2022 segmented plan will be compared independently to the CY 2021 non-segmented plan.

- Consolidating/crosswalking previously segmented plans: TBC of each existing CY 2021 segmented plan will be compared independently to the non-segmented CY 2022 plan.

- Consolidating/crosswalking segmented plans into other segmented plans: TBC of the existing CY 2021 segmented plan will be compared independently to the segmented CY 2022 plan.

If CMS provides the MA organization an opportunity to address CY 2022 TBC issues following the bid submission deadline, the MA organization may not be permitted to change its formulary (e.g., adding drugs, etc.) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS identified formulary review concerns negatively affects the formulary and bid review process. For example, portions of the annual formulary review process are based on outlier analyses. If an MA organization were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition,

significant formulary changes will necessitate additional CMS review, outside of the normal review stages, and may jeopardize the approval of a sponsor's formulary and could affect approval of its contract.

The plan-specific data elements that CMS posts on HPMS for purposes of the TBC evaluation are shown in the following table. This information may be accessed in HPMS by selecting: Quality and Performance > Performance Metrics > 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 PMPM TBC change threshold **(in this illustration, the TBC change threshold is $39.00 PMPM)**. 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 2021 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 2022 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 2021 ($144.60) and the amount for CY 2022 ($148.50)	Value is $3.90 for all plans

Steps	Item	Item	Description
	L	Impact of changes in OOPC Model between CY 2021 and CY 2022	Plan-specific value will be provided by CMS through an HPMS posting
Evaluation	M	Adjusted TBC Change	Calculation: G + J - K - L Plan is likely to pass the TBC evaluation if M is less than or equal to $39.00 PMPM

* CMS will include the Cash or Monetary Rebate component of the Value-Based Insurance Design (VBID) in the TBC evaluation for CY 2022, but will continue to exclude other benefits and cost sharing reductions entered in Section B-19 of the PBP from the TBC evaluation. The table above and information provided by CMS does not include the Cash or Monetary Rebate as a separate line item for CY 2021 and/or CY 2022. Affected MA plans must incorporate the impact of the Cash or Monetary Rebate into their calculations independently.

As described in the table above, CMS will provide, through the HPMS posting, CY 2021 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 2021 BPT. Based on the CMS release of Statistical Analysis Software (SAS) files in early April, MA organizations will be able to calculate their plan-specific CY 2022 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2022 (Item E). Premium (net of rebates) can be found in the CY 2022 Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14. As noted above for CY 2022, CMS will include the Cash or Monetary Rebate component of the Value-Based Insurance Design (VBID) in the TBC evaluation, but will continue to exclude other benefits and cost sharing reductions entered in Section B-19 of the PBP from the TBC evaluation.

The *Unadjusted* TBC Change between CY 2021 and CY 2022 (Item G) is the difference between CY 2022 Total TBC (Item F) and CY 2021 Total TBC (Item C) , i.e., G = F - C. The *Adjusted* TBC Change amount (Item M) reflects the impact of the payment adjustment and technical adjustments. CMS will provide payment adjustment information through the HPMS posting. The Gross Payment Adjustment (Item H) accounts for changes in county benchmark, and quality bonus payment and/or rebate percentages. The Plan Situation (Item I) defines whether the TBC calculation will be modified with an alternative Payment Adjustment based on the Plan Situation (Item J) to account for changes in the quality bonus payment and/or rebate percentage or star rating as indicated in the following table:

Plan Situation (Item I)	Payment Adjustment Based on the Plan Situation (Item J)
Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount (Item H) greater than $39.00 PMPM	Maximized at $39.00
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -$39.00 PMPM	Minimized at -$39.00
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -$39.00 PMPM	Minimized at -$39.00
Plans that are not accounted for in the three categories above	Same as Gross Payment Adjustment

The HPMS posting will also provide Technical Adjustments, including Part B premium adjustment (Item K) and the Impact of Changes in the OOPC model between CY 2021 and CY 2022 (Item L). It should be noted, however, these elements impact TBC in different directions, i.e., M = G + J - K - L.

In this illustrative scenario, plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $39.00 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 2022 rebate minus the CY 2021 rebate. The CY 2021 Bid Amount and Benchmark are taken from the CY 2021 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2021 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2022 ratebook. The CY 2022 Benchmark is the weighted average of county-specific payment rates using the CY 2022 ratebook and projected enrollment from the CY 2021 BPT. The rebate percentage is dependent on the plan's Quality Bonus Payment (QBP) rating for each year. The rebate is calculated as the amount by which the Benchmark exceeds the Bid Amount, multiplied by the rebate percentage.

Illustrative Calculation Examples

Bid ID	2021 Values					2022 Values					Rebate Difference	Payment Adj.	TBC Threshold
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*			
Plan 001	3	$1,000	$950	50%	**$50.00***	3	1,063.00	$1,010	50%	**$53.15***	($3.15)	($3.15)	$42.15
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,063.00	$1,116	50%	$26.57	$1.57	$1.57	$37.43
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,063.00	$1,382	65%	$207.29	$57.28	$39.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,063.00	$1,382	50%	$159.45	($35.55)	($35.55)	$74.55
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,063.00	$1,447	65%	$249.54	$54.54	$39.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,275.60	$1,383	65%	$69.64	($37.61)	($37.61)	$76.61
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,063.00	$1,250	50%	$93.50	($56.50)	($39.00)	$78.00

* Indicates that the amount is a premium.

Note: Slight variances in numbers are due to rounding.

Illustrative Calculation Descriptions

a. Plans 001 through 004 have benchmark and bid growth of 6.3%.

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 the enrollee as a Part C or 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 $39.

e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -$39.

f. Plan 005 has benchmark growth of 6.3% plus 5 percentage point increase in calculating the benchmark to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $39.

g. Plan 006 has benchmark growth of 6.3% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$39.

h. Plan 007 has a 2022 star rating below 3.0; therefore the payment adjustment is minimized at -$39.

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

Maximum Out-of-Pocket (MOOP) Limits

All MA plans, including employer group plans and SNPs, must establish limits on enrollee out-of-pocket cost sharing (i.e., deductibles, coinsurance, and copayments) for Parts A and B services that are consistent with the MOOP limits set under 42 C.F.R. § 422.100(f)(4) and (5), and § 422.101(d)(2) and (3). Details on the MOOP limits for CY 2022 are available in the HPMS Memo titled "Final Contract Year 2022 Part C Benefits Review and Evaluation" which is expected to be released in May 2021. For CY 2022, we continue to encourage organizations to establish the lower, voluntary MOOP thresholds. MA organizations adopting voluntary MOOP amounts will have more flexibility in establishing cost sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP limits. In order to ensure that enrollees are not charged cost sharing in excess of the MOOP consistent with §§ 422.100(f) and 422.101(d), MA organizations must track out-of-pocket spending incurred by the enrollee (i.e., cost sharing includes deductibles, coinsurance, and copayments pursuant to § 422.2) and alert enrollees and contracted providers when the MOOP limit is reached.

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 2022 PBP Options for Entering MOOP Amounts by Plan Type

Plan Type	**Required MOOP Amounts**	**Plan also may choose to enter in the PBP:**
HMO	In-network	"In-network" is only option available in the PBP
HMO with Optional Supp. Point of Service (POS)	In-network	"In-network" is only option available in the PBP
HMO with Mandatory Supp. POS	In-network	"No" or enter amounts for "Combined" and/or "Out-of-Network" as applicable
Local Preferred Provider Organization (LPPO)	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
Regional Preferred Provider Organization (RPPO)	In-network and Combined	"No" or enter an amount for "Out-of-Network" as applicable
PFFS (full network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (partial network)	Combined	"No" or enter amounts for "In-Network" and/or "Out-of-Network" as applicable
PFFS (non-network)	General	"General" is the only option available in the PBP

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. This review includes cost sharing for specific services that are not specifically addressed here or in the HPMS Memo titled "Final Contract Year 2022 Part C Benefits Review and Evaluation" which is expected to be issued in May 2021. CMS will evaluate whether cost sharing levels are defined or administered in a manner that may discriminate against sicker or higher-cost beneficiaries and may also evaluate the impact of benefit design on beneficiary health status and/or certain disease states. CMS will contact plans to discuss any issues that are identified as a result of these analyses and seek correction or adjustment of the bid as necessary. Additional guidance is provided in MMCM, Chapter 4, Section 50.1.

CY 2022 Part C Benefit Policy

Consistent with 42 CFR § 422.254, MA bids must include certain information about the benefits and cost sharing as well as the actuarial basis for the bids. This document provides information and instructions on these topics.

MA Uniformity Flexibility Targeted Conditions

Consistent with 42 CFR § 422.100(d)(2), MA organizations may offer supplemental benefits, including reductions in cost sharing, that are tied to disease state or health status in a manner that ensures that similarly situated individuals are treated uniformly; there must be some nexus between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state. Such benefits are identified as an MA Uniformity Flexibility package in the PBP. MA organizations must clearly identify the clinical categories and must briefly describe them in section B-19 of the PBP. CMS adopted § 422.100(d)(2) in the recent final rule that appeared in the Federal Register on January 19, 2021; MA organizations are strongly encouraged to review that final rule for additional guidance on § 422.100(d)(2).

In an HPMS memo that predated the recent final rule (an HPMS memo titled, "Reinterpretation of the Uniformity Requirement" issued April 27, 2018), CMS identified the International Statistical Classification of Diseases and Related Health Problems, also known as ICD-10 codes, as means to formally define the targeted conditions, or a subset of diagnoses within the targeted conditions. However, MA organizations may use other means to identify that the health status or disease state that is tied to the supplemental benefits so long as the means to identify eligible enrollees ensures that similarly situated individuals are treated uniformly. MA organizations must identify in their bids when and how they are offering supplemental benefits using the flexibility described in § 422.100(d)(2) by briefly describing the criteria for eligibility based on health status or disease state in the PBP in the general notes field in section B-19a and/or 19b. In addition, MA organizations must maintain detailed

internal documentation necessary to address potential beneficiary appeals, complaints, and/or general oversight activities performed by CMS. *See* 42 CFR § 422.504(d).
MA plans participating in the MA VBID model test have broader ability to target benefits for certain categories of enrollees.

Additional Telehealth Benefits

For CY 2022, Additional Telehealth Benefits - Part B services and cost sharing continues to be entered in B-7j of the PBP and may not be referenced under B-14c: Remote Access Technologies.

Under § 422.135 MA organizations have the ability to provide "additional telehealth benefits" to enrollees and treat them as basic benefits for purposes of bid submission and payment by CMS. Additional telehealth benefits are limited to services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act, and that have been identified for the applicable year as clinically appropriate to furnish through electronic exchange when the physician or practitioner providing the service is not in the same location as the enrollee.

An MA plan must meet the requirements of 42 CFR 422.135 in order for the benefits to be considered additional telehealth benefits that are treated as basic benefits. If the MA plan fails to comply with the requirements of 42 CFR 422.135, then the MA plan may not treat the benefits provided through electronic exchange as additional telehealth benefits, but may treat them as supplemental benefits as described in 42 CFR 422.102, subject to CMS approval. These supplemental benefits should be entered in B-14c: Remote Access Technologies.

MA plans must indicate in the PBP service category B-7j if they are offering additional telehealth benefits through network providers for Part B services and select the service categories where additional telehealth benefits may be offered. Cost sharing should be entered as a range in B-7j and encompass all service categories selected. Consistent with 42 CFR § 422.135(f), MA plans offering additional telehealth benefits may maintain different cost sharing for the specified Part B service(s) furnished through an in-person visit and the specified Part B service(s) furnished through electronic exchange.

MA-PD Offerings

Pursuant to § 422.4(c), an MA organization cannot offer an MA coordinated care plan in an area unless that plan or another plan offered by the MA organization in that same service area includes qualified Part D prescription drug coverage meeting the requirements of § 423.104. That is, each MA organization (defined as the legal entity that signs the MA contract for the CMS evaluation) must ensure that if it is offering a MA-only coordinated care plan (i.e., no Part D coverage), it also offers at least one MA-PD plan in each county covered by the MA organization's service area(s). Additional information is also provided in Chapter 4, Section 10.15 of the MMCM. Because of the limitations on their enrollment, SNPs and EGWPs offered by the same organization in the same service area do not satisfy this requirement for non-SNPs. The legal entity must complete the attestation for all MA-only plans.

D-SNP "Look-alikes"

CMS adopted new contracting limitations for certain types of MA plans at 42 CFR § 422.514(d) in the June 2020 Final Rule (CMS-4190-F1) to stop the spread of "D-SNP look-alikes." As we discussed in that final rule, 85 FR 33805-33820, D-SNP look-alikes, which are MA plans that have levels of dual eligible enrollment that are virtually indistinguishable from those of D–SNPs and far above those of the typical MA plan, are an obstacle to full implementation of integration and other requirements for D-SNPs. In accordance with 42 CFR 422.514, CMS will not enter into a contract:

- Starting for contract year 2022 and subsequent years, for a new MA plan – other than a SNP – that projects in its bid that 80 percent or more of the plan's total enrollment will be entitled to Medicaid, or
- Starting for contract year 2023 and subsequent years, for a renewing MA plan – other than a SNP – that has actual January enrollment of the current year of 80 percent or more of enrollees who are entitled to Medicaid unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.

This contract limitation only applies in states where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as Medicare-Medicaid Plans (MMPs). The limit on new D–SNP lookalikes precludes CMS from entering into a contract for a D–SNP look-alike for 2022 and subsequent years.

PPO Caps for Supplemental Benefits

For any supplemental benefit (mandatory or optional) with a dollar value cap on coverage, a PPO plan that caps the dollar value of supplemental benefits must enter into the PBP the same maximum plan benefit coverage amount (i.e., cap/dollar amount) for both in-network and out-of-network **or** as a combined maximum benefit amount. MA organizations are expected to accurately enter the maximum benefit coverage amount, cost sharing data, and provide a brief description of the benefit in the PBP notes field. Information provided in the PBP notes field must not contradict the maximum plan benefit coverage amount entered in the PBP.

CY 2022 Part C PBP Data Entry Expectations

Using appropriate benefit categories

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

An accurate bid will have cost sharing amounts entered for a particular service in a manner that reflects the cost sharing charged across ALL possible healthcare settings (e.g., physician office, outpatient hospital, and free-standing facility) and is not duplicated in multiple PBP locations. For

example, Diagnostic Services can be administered in a number of health care settings including outpatient hospitals, free-standing facilities, or a physician's office. Instead of having these services appear in multiple PBP service categories, the range of cost sharing for these services should only appear in PBP Service Category B-8. The note must explain the cost sharing range associated with the various places of service. The cost sharing for these services should NOT be duplicated in PBP category B-9: Outpatient Hospital. Similarly, Medicare-covered preventive services should only be entered in PBP category B-14a or 14e and should not be duplicated in PBP category B-9. Plans that duplicate the cost sharing entry based on the place of service instead of the service category in the PBP will be asked to correct its bid submission.

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

PBP Notes

Most PBP sections do not require a note, particularly when an MA organization provides benefits consistent with the descriptions for a particular benefit in Chapter 4 of the MMCM; 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 relevant information that is necessary for and 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. Describe any tiered cost sharing amounts.
When "Other, describe" is selected in the PBP	Briefly describe the "other" item and confirm it does not conflict with the selections available.
13c: Meals	<u>Meals provided for a limited period of time:</u> <u>Post inpatient hospitalization/surgery</u> Include the number of meals and/or days covered for each event and the number of events applicable for the year. <u>Chronic condition</u>

Category/Circumstance	Information required in the note
	Include the chronic conditions eligible for the meal benefit and the number of meals and/or days covered for each chronic condition. Other medical condition Include a brief description for "other" medical conditions that require the enrollee to remain at home for a period of time and the number of meals and/or days provided for the other medical conditions.
13def: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another defined category in the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c4: Fitness Benefit	Physical fitness: Include a brief description of the services covered. The mention of a gym membership, or a nationally recognized program is sufficient. Otherwise, a description of the type of physical fitness must be included, while making sure it does not include social events or requirements for attendance or performance. Memory fitness: Include a description of the type of brain/memory exercises offered. Activity Tracker If the plan only offers an activity tracker, the note does not need to include any details other than "activity tracker."
14c6: Telemonitoring	Include the condition(s) being monitored and briefly explain the monitoring process (i.e., the frequency of data collection, the device used, and the physician's involvement).
14c7: Remote Access Technologies	Web/Phone-based Technologies Include a description of the technology used and the services provided. Do not use the term "telehealth." Ensure that only supplemental benefits are included (Part B services should be included in 7j.) Nursing Hotline No note is required.

Category/Circumstance	Information required in the note
14c8: Home and Bathroom Safety Devices	List the devices being offered.
14c16: Weight Management Programs	Include a brief description of the benefit which may include program brand names, if applicable. If programs that typically include meals are offered, the note must state that meals are not covered as meals are a permitted supplemental benefit only when all criteria in § 422.100(c)(2)(ii) are met.
14c17: Alternative Therapies	List the therapies offered and ensure that none should be included in other categories of the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c19: Adult Day Health Services	Briefly describe the benefit being offered.
14c20: Home-Based Palliative Care	Briefly describe the benefit being offered.
14c21: In-Home Support Services	Briefly describe the benefit being offered.
14c22: Support for Caregivers of Enrollees	Describe the benefit being offered for ALL selections made (Respite Care, Caregiver Training, and Other).
19b-13defi: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another category of the PBP. Also confirm the benefit does not duplicate a benefit already indicated in the base plan. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
19b-13i: Non-Primarily Health Related Benefits for the Chronically Ill	Add a brief description for each benefit being offered in the appropriate subcategory. Only add a note that is specific to that particular category. Do NOT duplicate the same note across all categories.
19b-13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)	Briefly describe the benefit and confirm that it does not meet the definition of another PBP category. Also confirm that the benefit does not duplicate one that is already indicated in the base plan. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.

Plans should not include the following in any PBP notes:

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

Home Infusion Supplies

Section 1834(u)(1) of the Social Security Act (the Act), as added by Section 5012 of the 21st Century Cures Act (Pub. L. 144-255), established a new Medicare Home Infusion Therapy (HIT) benefit under Medicare Part B. The Medicare HIT benefit is for coverage of HIT services for certain drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual, through a pump that is a DME item. The HIT benefit category and permanent payment system became effective on January 1, 2021, as required by the 21st Century Cures Act. See the CY 2021 Home Health Prospective Payment System Rate Update Final Rule (85 Fed. Reg. 70298 (Nov. 4, 2020)). The new HIT benefit covers the service component, meaning the professional services, training and education (not otherwise covered under the DME benefit), and monitoring furnished by a qualified HIT supplier needed to administer the home infusion drug in the patient's home. MA plans should include the cost sharing for the drug component of HIT under the B-11a DME benefit category and the professional services based on the provider delivering the service, which could include B-6: Home Health or B-7: Other Healthcare Professional Services. The cost share associated with the home infusion therapy supplies should be entered in the benefit category B-11b: Prosthetics/Medical Supplies.

Opioid Treatment Program Services

In Original Medicare, the Opioid Treatment Program (OTP) benefit does not require any cost sharing from beneficiaries. However, MA plans are permitted to apply cost sharing for services at the OTP provider in their 2022 bids. Only cost sharing for services provided by an OTP provider should be included in PBP service category B7k. In order to meet the requirements of Title XVIII of the Act (that is the Medicare statute) to furnish the OTP basic benefit (see § 422.204(b)(3)), OTPs must be enrolled as providers in Medicare (under section 1866(j)), certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), and accredited by a SAMHSA-approved entity. At this time, CMS has not added any additional requirements for OTPs that CMS determines are necessary for health and safety and

to ensure the effective and efficient furnishing of opioid use disorder treatment services. Cost sharing entered in this service category should not duplicate information in other PBP service categories.

Employer Group Waiver Plans

MA employer plans must complete and submit the MA portion of the PBP in accordance with CMS requirements. Organizations should make a good faith effort in projecting CY 2022 member months for each plan and place the amount in Section A-2 of the PBP. The following question must be completed for all MA and Section 1876 Cost Plan organizations: "Indicate CY 2022 total projected member months for this plan."

Dual Eligible Special Needs Plans (D-SNPs)

CMS expects MA organizations offering D-SNPs to communicate MA and state Medicaid benefits to D-SNP enrollees in a comprehensive and transparent manner. D-SNPs must include Medicare Parts A, B, and D services in their PBP submission, along with approved optional and/or mandatory supplemental benefits. An organization may not be paid twice (under the Medicare program and under the Medicaid program) for furnishing the same benefit. Consistent with 42 CFR § 422.254, the MA bid must cover only the benefits offered under the MA contract (that is, Medicare Parts A, B and D benefits and MA supplemental benefits). Therefore, no Medicaid benefits for which the D-SNP receives Medicaid funds for the same member and for the same contract year may be included in the PBP[1]. For example, if a D-SNP offers a preventive dental benefit for which it receives payment from the State Medicaid Agency, that benefit must not be included in the PBP. A D-SNP PBP can include benefits that are distinct from, and expand upon, a Medicaid-funded benefit—e.g. adding dental services in the PBP that are not covered under the Medicaid-funded preventive dental benefit.

D-SNPs may credit some or all of the rebate under 42 CFR § 422.266(a) toward reduction of the Medicare Part B premium. The use of rebates toward reduction of the Medicare Part B premium is not limited by a state's Medicare Savings Program.

MA plans offering supplemental benefits that are separately purchased by an employer or union may not be included in the PBP (see § 422.106(a)(2)). This segregation of Medicare-only benefits in the PBP is necessary so that CMS may appropriately account for the Medicare benefit package. *See* section 1854 of the Act and 42 CFR § 422.254.

CY 2022 PBP Updates

Updated Service Category Descriptions

CMS updated the Medicare benefit and service category descriptions within the PBP software and encourages MA organizations to review this information to make sure proposed benefits are consistent with CMS definitions and instructions for the bid. Under 42 CFR § 422.254, MA organizations are responsible for submitting accurate and complete bids that provide all necessary information for bid evaluation. These service category descriptions can be viewed within the PBP software. They can also be viewed in early April under the HPMS "Service Category Report" found in the 2022 Bid

[1] Note that the Medicaid program generally is a secondary payer to Medicare. *See* section 1902(a)(25) of the Act.

Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2022 > Plan Benefit Reports > Service Category Report).

B-7: Health Care Professional Services

The PBP will now require a brief note in all B-7 service categories when both a copay and coinsurance are entered even if the cost sharing entered is $0-$0 or 0%-0%.

B-9a: Outpatient Hospital Services

MA plans indicating a copayment for Outpatient Observation Services in PBP B-9a must select whether the copayment applies "per stay," "per day," or "other." MA plans that select "other" must briefly describe the benefit in the notes field.

B-13c: Meal Benefit

MA plans offering a meal benefit in B-13c must now select in the PBP the type of primarily health related meals benefit offered: immediately following surgery or inpatient hospitalization, for a chronic illness, and/or for a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time. The data entry fields for number of meals and duration of meals benefit have been removed. A note is now required in B-13c. See chart above under ***PBP notes*** for the specific note requirements.

B-14c18: Therapeutic Massage

The PBP has been modified to include new data fields in B-14c18 which require MA Plans to "indicate limit for number of sessions" and "indicate the number of sessions periodicity."

B-14e: Other Medicare-covered Preventive Services

B-14e6 "Other" has been removed as a selection from the PBP as all Medicare-covered Preventive Services are covered under B-14e1-5.

B-19: VBID/MA Uniformity Flexibility/SSBCI

MA plans offering SSBCI packages in B19a and B19b, must now indicate in the PBP the chronic condition(s) to which the benefits apply. A new screen has been added to the PBP where plans must select from a pick list of chronic conditions and/or enter up to five other conditions with an accompanying description.

Section C OON/POS Groups

The PBP will now require a note in Section C OON/POS for each group that includes a coinsurance and/or copayment range.

Section D Reductions in Cost Sharing

"Monthly" has been added as a periodicity selection on the PBP Reductions in Cost Sharing screens.

Section D Maximum Plan Benefit Amount and Combined Benefits

The Max Plan Benefit Amount screens have been removed from Section D of the PBP. MA plans must enter benefits with a combined maximum plan benefit amount on the "Combined Benefits" screens in Section D and must not duplicate the maximum plan benefit amount in the corresponding benefit categories in Section B. Periodicity selections of up to one year have also been added to the "Combined Benefits" screens. Exception: Plans that wish to enter a combined max for 16a/b may continue to indicate the combined max within 16a and 16b but must also enter the maximum plan benefit amount in Section D. Similarly, this rule applies for 17a/b and 18a/b.

Important Administrative Information

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

CMS reminds MA organizations that the OOPC model using SAS software is available on the CMS website. All documentation and instructions associated with running the OOPC model are posted on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html. Prior to uploading a Medicare Advantage plan bid, MA organizations should run their plan benefit structures through the SAS OOPC model to make sure the plan offerings comply with applicable Medicare Advantage 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 memorandums) 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) questions, please submit an email to actuarial-bids@cms.hhs.gov;

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

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

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This guidance document will also appear in https://www.hhs.gov/guidance/ when final.