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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 14, 2023

TO: All Organization Types and Stakeholders

FROM: Kathryn A. Coleman
Director

SUBJECT: Final Contract Year (CY) 2024 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 memo are to the Social Security Act (the Act) and regulatory cites are to 42 C.F.R. parts 417 and 422 unless otherwise noted. This final memorandum applies only to CY 2024 and applies standards in regulations applicable to CY 2024.

CMS issued a preliminary HPMS memorandum to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2024 (HPMS memorandum titled, "Preliminary Contract Year (CY) 2024 Standards for Part C Benefits, Bid Review, and Evaluation," issued February 24, 2023). We only received comments from two organizations regarding the Total Beneficiary Cost (TBC) evaluation (addressed in that section) and are finalizing the CY 2024 policies discussed in this memorandum. 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 recently released a final rule titled, "Medicare Program; Contract Year 2024 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", which was issued on April 5, 2023 (referred to as the April 2023 final rule) and is available online at: https://www.federalregister.gov/public-inspection/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program. The provisions in the April 2023 final rule do not affect the specific guidance in this final memorandum. The final rule makes important changes to several Medicare Advantage regulations applicable to CY 2024. MA organizations should review the final rule in preparing their bids for CY 2024.

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 benefits, 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 Contract Year (CY) 2024 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.

CMS provides tools and information to MA organizations in advance of the bid submission deadline, and therefore expects all MA organizations to submit their best accurate and complete bid(s) on or before Monday, June 5, 2023 at 11:59 PM PDT. Any organization whose bid fails the Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, Total Beneficiary Cost (TBC), and/or Optional Supplemental Benefit requirements and evaluation standards at any time prior to final approval may receive a compliance notice, even if the organization is allowed to correct the deficiency. The severity of compliance notice may depend on the type and/or severity of error(s).

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

Table 1: Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-EGWP (Excluding Dual Eligible SNPs)	Applies to Dual Eligible SNPs	Applies to 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
Maximum Out-of-Pocket (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, as finalized in the April 2023 final rule, 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)). Additional cost sharing requirements apply to MA plans under §§ 422.100(f) and (j).

In this memo, CMS interprets and applies certain regulatory and statutory standards and provides additional information on topics related to CY 2024 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.

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 2023 (three annual election periods) of CMS's decision not to renew these plans under § 422.510(a)(4)(xv). However, 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 requirement in § 422.510(a)(4)(xv).

Upon receipt of this notification, 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 2024, or (2) provided a justification to CMS for renewal. If CMS finds that the low enrollment justification is insufficient, CMS will instruct 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 will be provided in CMS's notification to the organization. These requirements do not apply to Section 1876 cost plans, EGWPs, or Medical Savings Account (MSA) plans.

CMS recognizes there may be certain factors, such as the specific populations served by and 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 will consider this information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. MA organizations must follow applicable regulations (including § 422.530) and instructions regarding procedures for renewal/non-renewal and consolidations with other plans. Medicare Advantage organizations should follow applicable regulations and instructions regarding renewal/non-renewal and consolidations with other plans. CMS will continue to evaluate and implement low enrollment requirements on an annual basis.

Total Beneficiary Cost (TBC)

Under section 1854(a)(5)(C)(ii) of the Act, CMS is not obligated to accept every bid submitted and is authorized to deny a plan bid if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. In exercising this authority, we will use the same TBC evaluation as in past years to calculate the TBC change amount as described below. In applying the TBC evaluation, plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s). MA organizations are strongly encouraged to use the available tools and TBC information in developing and preparing their bids.

A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. By reviewing excessive increases in the TBC from one year to the next, CMS is able to make sure enrollees who

continue enrollment in the same plan are not exposed to significant cost increases.

CMS will use 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 bid evaluation purposes with CY 2024 bid submissions. The Part D OOPC model has been updated to incorporate potential formulary alternatives and formulary exceptions (see HPMS memorandum titled "Proposed Part D Out-of-Pocket Cost Model Updates" issued November 25, 2022). The Part C OOPC model includes annual utilization updates related to the Medicare Current Beneficiary Survey (MCBS). CMS generated updated CY 2023 Part C and Part D Baseline OOPC Model values for organizations and posted these values in HPMS (see HPMS memorandum titled "Contract Year 2023 Part C and Part D Baseline Out-of-Pocket Cost Models" issued January 13, 2023). MA organization OOPC values can be viewed in HPMS under: Quality and Performance > Performance Metrics > Reports > Costs > Part C Out-of-Pocket Costs. In addition, the CY 2024 Bid Review OOPC Models will be released prior to the bid deadline. Note that CMS intends to release an annual refresh of the Part D Bid Review OOPC model to reflect updates in the May Formulary Reference File (FRF) (see HPMS memorandum titled "Draft Contract Year (CY) 2024 Part D Bidding Instructions" issued January 30, 2023).

As in past years, for 2024, 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. MSAs have unique benefit designs that include a medical savings account for purposes of paying costs before the deductible. D-SNP benefits entered into the plan benefit package do not include state benefits and cost sharing relief for dually eligible beneficiaries, which means that a TBC evaluation would not be based on the full benefit and cost sharing package available to enrollees. Finally, SNPs for the chronic condition of ESRD requiring dialysis are not effectively addressed by the OOPC model used for the TBC evaluation because the 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 CMS identifies large benefit or premium changes (while taking into consideration payment changes) during bid review.

MA plans offering Part C supplemental benefits that take advantage of the flexibility in the uniformity requirements under § 422.100(d)(2)(ii), Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or participating in the VBID model test will be subject to the TBC evaluation for CY 2024; however, benefits and cost sharing reductions (entered in the VBID, MA Uniformity, SSBCI section 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.

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 that have been used in the past 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 margin requirements so MA organizations can satisfy the TBC standard.

In April 2023, as in past years, CMS will provide plan-specific CY 2024 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 ($164.90).
- 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 2024 bid submissions. The unweighted average for plans subject to the TBC evaluation, using the 2023 Bid Review OOPC models, is about $407 per member per month (PMPM), compared to about $395 PMPM using the updated OOPC models (a decrease of about $12 PMPM as illustrated in Table 2 below). Consistent with application of the TBC evaluation, as discussed in the CY 2012 Final Call Letter,[1] CMS is setting the TBC change threshold for bid evaluation purposes at $40.00 PMPM or about 10% of the $395.23 Total Beneficiary Cost for the CY 2023 Updated Baseline OOPC Models in the table below. CMS provides the tools for MA organizations to plan for these changes and prepare their bids in a manner to satisfy the TBC evaluation. 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 OOPC Models
(Unweighted Per Member Per Month Averages)

Item	2023 Bid Review OOPC Models	2023 Updated Baseline OOPC Models	Difference
Part C OOPC	$118.27	$119.79	$1.52
Part D OOPC	109.74	96.54	($13.20)
Part B Premium	157.96	157.96	$0.00
Plan Premium	20.94	20.94	$0.00
Total Beneficiary Cost	$406.91	$395.23	($11.68)

Plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s) as part of bid negotiation. A plan experiencing a net increase in

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

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 as follows.

For CY 2024, the TBC change evaluation will be treated differently for the following specific situations:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $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 PMPM limit, similar to the policy in CY 2023 about using the TBC threshold.

If CMS provides the MA organization an opportunity to address CY 2024 TBC issues following the bid submission deadline, the MA organization may not be permitted to change its formulary (e.g., adding drugs, etc.) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS identified formulary review concerns negatively affects the formulary and bid review process. For example, portions of the annual formulary review process are based on outlier analyses. If an MA organization were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition, significant formulary changes will necessitate additional CMS review, outside of the normal review stages, and may jeopardize the approval of a sponsor's formulary and could affect approval of its contract.

CMS is providing detailed TBC information and examples of how the TBC evaluation will be applied to consolidating or crosswalking plans prior to bid submission in the appendix of this document.

CMS received comments from two organizations regarding the Total Beneficiary Cost (TBC) evaluation. Both organizations were concerned that CMS has historically not accounted for changes in the CMS hierarchal condition categories (CMS-HCC) risk adjustment model in the TBC calculation, while proposing to lower the TBC change threshold by one dollar per member per month for CY 2024. The concerned organizations noted that a recent study, based on the CY 2024 Advance Notice, indicates that plan rebates would decrease significantly due to the proposed changes to the CMS risk adjustment model for CY 2024. Commenters stated that this would result in an estimated increase in plan premium and/or benefit reduction. One organization

also expects the impact to be greater for plans with larger concentrations of members with certain conditions impacted by the risk model changes.

We appreciate the comments we received. The TBC change threshold is being maintained at approximately 10% of the CY 2023 baseline TBC amount (the sum of plan premium, Part B premium, and OOPC), which reflects changes in the OOPC model as discussed earlier in this memorandum. The decrease in the TBC amount due to the OOPC model changes results in the TBC change threshold decreasing from $41 PMPM to $40 PMPM for CY 2024. The TBC calculation also includes a payment adjustment factor to account for changes in the quality bonus payment and/or rebate percentage (see Appendix, items H through J in the table titled "Plan-Specific TBC Calculation"). For example, if a plan has a reduction in its star rating, we estimate that the plan will have a lower rebate and the dollar amount difference between that estimated rebate and the prior year actual rebate will be directly applied to their TBC value. Consistent with past years, MA organizations must address other factors, such as the risk adjustment model, independently of the TBC calculation. Please refer to the "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" issued by CMS on March 31, 2023 for more discussion about the risk adjustment model.

One of the commenters is concerned about the Part B premium adjustment factor that is applied as part of the TBC calculation. The Bid Pricing Tool allows plans to reduce the Part B premium for enrollees up to the previous year's published Part B premium amount. CMS published the 2023 Part B premium amount of $164.90 in September 2022. Several CY 2023 plans submitted bids in June 2022 with the maximum Part B premium reduction amount of $170.10 based on the previous year's Part B premium (i.e., 2022). The commenter believes those plans are being penalized by the negative adjustment factor (i.e., $164.90 less $170.10, or negative $5.20) because the decrease is outside of the MA organization's control and does not affect enrollee costs. The commenter recommended plans in this situation receive an adjustment factor of $0.

We acknowledge the concern expressed by the commenter and note that the TBC calculation evaluates changes between the CY 2023 and CY 2024 bid submissions. Consistent with past years, the purpose of the TBC evaluation is to compare the current year's bid to the previous year's bid, considering all available rebate dollars used in the bids from one year to the next.

We appreciate the comments and suggestions received and are 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.).

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

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

This memorandum contains the final MOOP and cost sharing limits for CY 2024. In the HPMS memorandum titled, "Preliminary Contract Year 2024 Standards for Part C Benefits, Bid Review and Evaluation" dated February 24, 2023[2], CMS detailed how the MOOP and cost sharing limits were developed in accordance with §§ 422.100(f) and (j) and 422.101(d). We received no comments about the MOOP and cost sharing standards and are finalizing as described in the preliminary memorandum for CY 2024.

The final rule with comment period titled, "Contract Year (CY) 2023 Medicare Advantage (MA) Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards Final Rule with Comment Period (CMS-4190-FC4" (April 2022 final rule)[3] amended §§ 422.100 and 422.101 to establish the methodologies for setting annual maximum out-of-pocket (MOOP) and other cost sharing limits for MA plans. Generally, all MA plans must comply with the MOOP and cost sharing limits established using the methodologies set by the April 2022 final rule, except for MA MSA plans. MA MSA plans must not cover basic benefits until the plan's deductible has been reached and after the deductible is reached, the plan must cover 100 percent of the costs of basic benefits. See section 1859(b)(3) of the Act and § 422.4(a)(2). MA plans must comply with both the aggregate and service-category specific PMPM actuarially equivalent requirements (§ 422.100(j)(2)). MA EGWPs continue to 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 finalized in the April 2022 final rule to calculate the contract year 2024 MOOP limits and cost sharing standards included in this memorandum. The calculations supporting the CY 2024 MOOP and cost sharing limits discussed in this memorandum are available for reference at: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats. The year(s) of Medicare FFS data and trend factors that CMS used to calculate CY 2024 MOOP and cost sharing limits are summarized in the footnotes of the calculation file.

Maximum Out–of-Pocket Limits

Table 3 below summarizes the in-network and total catastrophic (combined MOOP) limits, MA

[2] HPMS memorandum may be accessed at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly

[3] https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards

plans must comply with the final MOOP limits included in Table 3 for CY 2024. CMS followed the methodology in §§ 422.100(f)(4), specifically paragraphs (f)(4)(v) and (f)(4)(vi)(B), and 422.101(d)(2) and (d)(3) to calculate the CY 2024 MOOP limits. This involved basing calculations on Medicare FFS data projections[4] and applying the 10 percent cap on increases from the prior contract year to the in-network mandatory and lower MOOP types. The contract year 2024 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 contract year 2024 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 ends in CY 2024).

Table 3: FINAL CONTRACT YEAR 2024 MOOP LIMITS BY PLAN TYPE

Plan Type	Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
HMO	$0 to $3,850	$3,851 to $6,350	$6,351 to $8,850
HMO POS	$0 to $3,850 In-network	$3,851 to $6,350	$6,351 to $8,850 In-network
Local PPO	$0 to $3,850 In-network and $0 to $5,750 Combined	$3,851 to $6,350 In-network and $3,851 to $9,550 Combined	$6,351 to $8,850 In-network and $6,351 to $13,300 Combined
Regional PPO	$0 to $3,850 In-network and $0 to $5,750 Combined	$3,851 to $6,350 In-network and $3,851 to $9,550 Combined	$6,351 to $8,850 In-network and $6,351 to $13,300 Combined
PFFS (full network)	$0 to $3,850	$3,851 to $6,350	$6,351 to $8,850
PFFS (partial network)	$0 to $3,850	$3,851 to $6,350	$6,351 to $8,850
PFFS (non-network)	$0 to $3,850	$3,851 to $6,350	$6,351 to $8,850

Cost Sharing Standards

Table 4 below summarizes the standards and cost sharing amounts by MOOP type that we will not consider discriminatory under § 422.100(f)(6), (f)(7), (f)(8), and (j)(1); CY 2024 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).

Table 4: FINAL CONTRACT YEAR 2024 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	$3,850	$4,792	$5,734
Inpatient Hospital – Acute - 10 days[1]	1a	$3,167	$2,851	$2,534
Inpatient Hospital – Acute - 6 days[1]	1a	$2,847	$2,563	$2,278

[4] 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 2024 MOOP limits reflect 100 percent of the ESRD cost differential.

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
Inpatient Hospital – Acute - 3 days[1]	1a	$2,600	$2,340	$2,080
Inpatient Hospital Psychiatric - 60 days[1]	1b	$3,850	$3,491	$3,133
Inpatient Hospital Psychiatric - 15 days[1]	1b	$2,622	$2,360	$2,098
Inpatient Hospital Psychiatric - 8 days[1]	1b	$2,421	$2,179	$1,937
Skilled Nursing Facility – First 20 Days[3]	2	$20/day	$10/day	$0/day
Skilled Nursing Facility – Days 21 through 100[3]	2	$203/day	$203/day	$203/day
Cardiac Rehabilitation[4,5]	3	50% / $40	45% / $35	40% / $30
Intensive Cardiac Rehabilitation[4,5]	3	50% / $70	45% / $65	40% / $55
Pulmonary Rehabilitation[4,5]	3	50% / $20	45% / $15	40% / $15
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)[4]	3	50% / $30	45% / $25	40% /$25
Emergency Services[4,6]	4a	$135	$120	$100
Urgently Needed Services[4,6]	4b	50% / $65	45% / $60	40% / $55
Partial Hospitalization[4]	5	50% / $100	45% / $85	40% / $70
Home Health[2]	6a	20% / $45[4]	$0	$0
Primary Care Physician[4]	7a	50% / $50	45% / $40	40% / $35
Chiropractic Care[4]	7b	50% / $20	45% / $20	40% / $15
Occupational Therapy[4]	7c	50% / $50	45% / $45	40% / $40
Physician Specialist[4]	7d	50% / $70	45% / $65	40% / $55
Mental Health Specialty Services[4]	7e	50% / $60	45% / $55	40% / $45
Psychiatric Services[4]	7h	50% / $60	45% / $50	40% / $45
Physical Therapy and Speech-language Pathology[4]	7i	50% / $65	45% / $60	40% / $50
Therapeutic Radiological Services[2,4]	8b	20% / $75	20% / $75	20% / $75
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% / $25	50% / $25	20% / $10[2,4]
Dialysis Services[2,4]	12	20% / $45	20% / $45	20% / $45
Part B Drugs-Insulin[8]	15	$35	$35	$35
Part B Drugs-Chemotherapy/Radiation[2,4,9]	15	20% / $185	20% / $185	20% / $185
Part B Drugs-Other[2,4,9]	15	20% / $205	20% / $205	20% / $205

[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 60 day stays (acute and psychiatric), the inpatient hospital cost sharing limit calculated per § 422.100(f)(6)(iv) exceeded the lower MOOP amount. In those cases, CMS capped the cost sharing limit for those inpatient hospital lengths of stay at the lower MOOP amount.

[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 (§ 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 limit may charge cost sharing for home health, while plans with an intermediate or mandatory MOOP must not charge higher cost sharing than in original Medicare (§ 422.100(j)(1)(i)(D)). MA plans that establish a mandatory MOOP limit may also not charge enrollees higher cost sharing than is charged under original Medicare for specific DME service categories (§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 higher cost sharing than is charged under original Medicare. 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 2024. Total cost sharing for the overall SNF benefit must be 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 these service categories reflect application of the "lesser of" requirement in § 422.100(f)(8); the actuarially equivalent value to the coinsurance limit for contract year 2024 is less than the value resulting from the actuarially equivalent copayment transition (after application of the rounding rules).

[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 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)), as finalized in § 422.113(b)(2)(vi).

[7] CMS did not set an updated copayment limit for "DME – diabetes monitoring supplies" based on potential uncertainty in utilization of Continuous Glucose Monitors (CGM) because of changes to Medicare coverage of CGM (effective July 2021) and new or changed HCPCS codes for this service category (effective April 2022).

[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 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: MA organizations with benefit designs using a coinsurance or copayment amount for which CMS does not have an established limit on cost sharing under §§ 422.100 or 422.113 (e.g., coinsurance for inpatient or copayment for the "DME – Equipment" service category) must submit documentation with their initial bid that clearly demonstrates how the coinsurance or copayment amount satisfies the regulatory requirements for each applicable plan. This documentation may include information for multiple plans and must be identified separately from other supporting documentation submitted as part of the BPT. 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 (both 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 2024 > Upload > Cost-Sharing Justification.

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 compares 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 in order to determine plan compliance.

For CY 2024, 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. CMS annually updates and communicates the Part B adjustment factors prior to bid submission. Please note that 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 contract year 2024. 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 contract year 2024.

Table 5: ILLUSTRATIVE COMPARISON OF SERVICE-LEVEL ACTUARIAL EQUIVALENT COSTS TO IDENTIFY EXCESSIVE COST SHARING FOR CONTRACT YEAR 2024

	#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	1.351	$34.18	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.069	$10.58	$0.25	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 memo will be used in the evaluation of CY 2024 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) 2024 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 on pages 4 to 8 of this memo.

For CY 2024 bids, CMS will maintain the TBC evaluation used in prior years for consolidating or crosswalking plans. Each individual plan being consolidated/crosswalked into another plan must meet the TBC requirement on its own merit. Therefore, the TBC adjustment factors for each plan being consolidated/crosswalked will be part of the calculation as if the plan were continuing. For example, if Plan A is being consolidated/crosswalked into Plan B: (i) Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B and (ii) Plan B's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan B.

The following describes how the TBC evaluation will be conducted for organizations that consolidate/crosswalk and/or segment plans from one year to the next:

- Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2023 plan will be compared independently to the CY 2024 plan.
- Segmenting an existing plan: TBC for each CY 2024 segmented plan will be compared independently to the CY 2023 non-segmented plan.
- Consolidating/crosswalking previously segmented plans into one non-segmented plan: TBC of each existing CY 2023 segmented plan will be compared independently to the non-segmented CY 2024 plan.
- Consolidating/crosswalking segmented plans into other segmented plans: TBC of each existing CY 2023 segmented plan will be compared independently to the segmented CY 2024 plan.

As in prior years, if CMS provides an MA organization an opportunity to address CY 2024 TBC issues following the bid submission deadline, the MA organization may not be permitted to change the formulary (e.g., adding drugs, etc.) used in its MA-PD(s) as a means to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to the concerns that CMS identified in its formulary review 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 offering an MA-PD were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition, significant formulary changes will necessitate additional CMS review, outside of the normal review stages, and may jeopardize the approval of a sponsor's formulary and could affect approval of its contract.

The plan-specific data elements that CMS posts on HPMS for purposes of the TBC evaluation

are shown in the following table. This information may be accessed in HPMS by selecting: Quality and Performance > Performance Metrics > Reports > Costs > Part C Total Beneficiary Costs. The calculation shown in the table accounts for changes in quality bonus payment and/or rebate percentage or star rating (as described above) so all plans are evaluated against the $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. Please see pages 5 to 6 of this memo for discussion about the updated Part C and Part D Out-of-Pocket Cost (OOPC) Models to estimate beneficiary out-of-pocket costs in the TBC calculation for bid evaluation purposes that will be used starting with CY 2023 bid submissions.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2023 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 2024 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 2023 ($170.10) and the amount for CY 2024 ($164.90)	Negative adjustment or decrease of $5.20 for all plans
	L	Impact of changes in OOPC Model between CY 2023 and CY 2024	Plan-specific value will be provided by CMS through an HPMS posting

Steps	Item	Item	Description
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 $40.00 PMPM

As described in the table above, CMS will provide, through the HPMS posting, CY 2023 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 2023 BPT. MA organizations will be able to calculate their plan-specific CY 2024 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2024 (Item E). Premium (net of rebates) can be found in the CY 2024 BPT, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The Unadjusted TBC Change between CY 2023 and CY 2024 (Item G) is the difference between CY 2024 Total TBC (Item F) and CY 2023 Total TBC (Item C), i.e., G = F - C. The Adjusted TBC Change amount (Item M) reflects the impact of the payment adjustment and technical adjustments. CMS will provide PBP-specific payment adjustment information through the HPMS posting. The Gross Payment Adjustment (Item H) accounts for changes in county benchmark, and quality bonus payment and/or rebate percentages. The Plan Situation (Item I) defines whether the TBC calculation will be modified with an alternative Payment Adjustment based on the Plan Situation (Item J) to account for changes in the quality bonus payment and/or rebate percentage or star rating as indicated in the following table:

Plan Situation (Item I)	Payment Adjustment Based on the Plan Situation (Item J)
Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount (Item H) greater than $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 2023 and CY 2024 (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.[5] The formula for applying the adjustments to calculate the Adjusted TBC Change amount is represented as follows: M = G + J - K - L. In this illustrative scenario, plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $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 2024 rebate minus the CY 2023 rebate. The CY 2023 Bid Amount and Benchmark are taken from the plan-submitted CY 2023 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2023 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2023 ratebook. The CY 2024 Benchmark is the weighted average of county-specific payment rates using the CY 2024 ratebook and projected enrollment from the CY 2023 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	2023 Values					2024 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	1,016.00	$965	50%	($50.80)	($0.80)	($0.80)	$40.80
Plan 002	3	$1,000	$1,050	50%	$25.00	3	1,016.00	$1,067	50%	$25.40	$0.40	$0.40	$39.60
Plan 003	3	$1,000	$1,300	50%	$150.00	3.5	1,016.00	$1,321	65%	$198.12	$48.12	$40.00	$0.00
Plan 004	3.5	$1,000	$1,300	65%	$195.00	3	1,016.00	$1,321	50%	$152.40	($42.60)	($40.00)	$80.00
Plan 005	3.5	$1,000	$1,300	65%	$195.00	4	1,016.00	$1,386	65%	$240.37	$45.37	$40.00	$0.00
Plan 006	4	$1,200	$1,365	65%	$107.25	3.5	1,219.20	$1,319	65%	$64.60	($42.65)	($40.00)	$80.00
Plan 007	2.5	$1,000	$1,300	50%	$150.00	2.5	1,016.00	$1,250	50%	$117.00	($33.00)	($33.00)	$73.00

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

[5] 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 Descriptions

a. Plans 001 through 004 have benchmark growth of 1.6%.
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 1.6% 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 1.6% less 5.0% to simulate losing a bonus payment[6]; therefore the payment adjustment is minimized at −$40 PMPM.
h. Plan 007 has a 2024 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 began in April and provide organizations with the opportunity to ask technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

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

CY 2024 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

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

Plan Type	Required MOOP Amounts	Plan also may choose to enter in the PBP:
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 2024 Part C PBP Data Entry Expectations

Updated Service Category Descriptions

CMS updated the Medicare benefit and service category descriptions within the PBP User Guide and encourages MA organizations to review this information to make sure proposed benefits are consistent with CMS definitions and instructions for the bid. Under 42 CFR § 422.254, MA organizations are responsible for submitting accurate and complete bids that provide all necessary information for bid evaluation. The updated service category descriptions can be viewed in early May under the HPMS Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2024 > Plan Benefit Reports > Service Category Report and Plan Bids > Bid Reports > CY2024 > Plan Benefit Reports > Medicare Benefit Description Report).

NOTE: The Medicare-covered dental service category description has been updated for 2024 and MA organizations are reminded that they must not enter any Medicare-covered benefits in

non-Medicare covered service categories.

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 2024 PBP will capture the cost sharing for plans that have the same value for copay/coinsurance minimum and maximum in a different way than in CY 2023 bids. 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.

Hearing Aids Available Over the Counter (OTC)

MA plans may offer hearing aids available through prescription and/or available OTC as supplemental benefits. For CY 2024, CMS' expectation is that all hearing aids (available either through prescription or OTC) be included in the 18b: Hearing Aids service category only. The PBP includes a new indicator in 18b where plans identify whether or not the hearing aid supplemental benefit includes OTC hearing aids.

Benefits Related to COVID-19

Plans are encouraged to review the HPMS memorandum titled, "Coronavirus Disease 2019 (COVID-19) Related Exercise of Enforcement Discretion Ending May 11, 2023," released on March 24, 2023, for more information.

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 16a/b, 17a/b, or 18a/b must indicate the combined maximum in the 16a/b, 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 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 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 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 18b: 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://mabenefits-mailbox.lmi.org/MABenefitsMailbox/. MA plans should also ensure that there are no benefits specific to a COVID diagnosis included in 13e, as these benefits would be appropriately entered as an MA Uniformity Flexibility package. In addition, CMS' expectation is that no benefits limited to the COVID-19 Public Health Emergency be entered in 13f for CY 2024.
14c4: Fitness Benefit	Physical fitness: Include a brief description of the services covered. The mention of a gym membership, or a nationally recognized program, is sufficient. Otherwise, a description of the type of physical fitness benefit must be included. Physical fitness benefits in this category do not include social events or requirements for attendance or performance. Memory fitness: Include a description of the type of brain/memory exercises offered. Activity Tracker If the plan only offers an activity tracker, the note does not need to include any details other than "activity tracker."
14c6: Telemonitoring	Include the condition(s) being monitored and briefly explain the monitoring process (i.e., the frequency of data collection, the device used, and the physician's involvement).
14c7: Remote Access Technologies	Web/Phone-based Technologies Include a description of the technology used and the services provided. Do not use the term "telehealth." Ensure that only supplemental benefits are included Nursing Hotline No note is required.
14c8: Home and Bathroom Safety Devices	List the devices being offered.

Category/Circumstance	Information required in the note
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.
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.
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).
15-1: Medicare Part B Drugs - Insulin	MA plans with a plan level deductible should indicate in the notes whether the Part B insulin enrollee cost sharing does or does not count towards the plan-level deductible. Part B insulin is not subject to any deductible at the plan or service category level.
16b: 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).
18b: Hearing Aids	MA plans that have cost sharing that varies for prescription vs. OTC hearing aids should describe those differences in the notes.
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/.

Category/Circumstance	Information required in the note
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.
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. Also confirm that the benefit does not duplicate one that is already indicated in 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/.

Plans should **not** include the following in any PBP notes:

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

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. Plans are reminded that 42 CFR § 422.102(f)(1)(i)[7] defines a chronically ill enrollee as an individual who:

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

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.

An MA plan offering SSBCI must, in accordance with § 422.102(f)(3), do all of the following:

(a) 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),
(b) make information and documentation related to determining enrollee eligibility available to CMS upon request,
(c) have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and document these criteria, and
(d) document each determination that an enrollee is eligible to receive an SSBCI and make this information available to CMS upon request.

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 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's 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 model is available on the CMS website. All documentation and instructions associated with running the OOPC model are posted on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug- Coverage/PrescriptionDrugCovGenIn/OOPCResources.html. Prior to uploading an MA plan bid, MA organizations should run their plan benefit structures through the 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/DPAP-Mailbox/;
- For Medicare Advantage benefits questions, please review available resources (e.g., HPMS memoranda) before submitting questions to https://mabenefits-mailbox.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.