DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: April 13, 2020

TO: Medicare-Medicaid Plans

FROM: Lindsay P. Barnette
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SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2021

The purpose of this memorandum is to provide an overview of enhancements to the plan benefit package (PBP) software for Medicare-Medicaid Plans (MMPs) for contract year (CY) 2021 and to direct MMPs to CY 2017 guidance that remains unchanged for CY 2021.

For information that remains unchanged for CY 2021, MMPs should refer to the following sections and subsections in the CMS memorandum titled "Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2017," dated April 11, 2016, and issued through the Health Plan Management System (HPMS):

- Data Entry for Medical and Other Non-Drug Services
    - Plan Type
    - Medicare Benefits
    - Medicaid and Demonstration-Specific Benefits
    - Integration of Medicare and Medicaid Benefits
    - Supplemental Benefits

- Data Entry for Drug Coverage
    - Tier Models
    - Part D Drug Cost Sharing Reductions
    - Drug Cost-Sharing Requirements (subsection remains unchanged except for updated low income subsidy (LIS) cost-sharing amounts stated later in this memorandum)
    - MMP-Specific Section Rx Data Entry Requirements

- PBP Notes

- Plan Copy Feature

In addition to changes made to further accommodate more integrated benefit data entry by MMPs in previous cycles, CMS has made modifications to the PBP software for CY 2021 that impact MMPs.

On April 10, 2020, CMS released the CY 2021 PBP software in the Health Plan Management System (HPMS). MMPs use the PBP software to annually submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits.

All PBPs for CY 2021 must be submitted **no later than 11:59 p.m. PDT on June 1, 2020**. MMPs are required to complete the following as part of a complete bid submission:

- Service Area Verification
- Plan Crosswalk (NOTE: This is only for renewing contracts in CY 2021.)
- Formulary Submission
- Formulary Crosswalk
- PBP Submission

After submission of the bid, MMPs are also required to submit the Additional Demonstration Drug (ADD) file and any other supplemental formulary files **by 11:59 a.m. EDT on June 5, 2020**.

Data Entry for Medical and Other Non-Drug Services

CY 2021 PBP Enhancements (Sections A, B, C, D, and Rx)

No enhancements to MMP-specific fields in the PBP software for CY 2021 appear in Sections A and C. The following enhancements appear in Section B:

- All Note fields require at least one alphanumeric character.
- 4c, Worldwide Emergency/Urgent Coverage; 13a, Acupuncture; 14c, Other Defined Supplemental Benefits; 16a, Preventive Dental; and 18b, Hearing Aids, have disabled Note fields unless the plan selects “Yes” to offer a supplemental benefit.
- 4, Emergency/Urgently Needed Services; 4a, Emergency/Post-Stabilization Services; 7k, Opioid Treatment Program Services; 14c8, Home and Bathroom Safety Devices and Modifications; and 15, Medicare Part B Chemotherapy/Radiation Drugs, have updated service category or benefit titles.
- 7j, Additional Telehealth Services, has been revised. If the plan selects “Yes” to indicate that it offers an Additional Telehealth benefit for Part B services, the plan is then

instructed to select from a picklist “the Medicare-covered benefits that **may** have Additional Telehealth Benefits available.”

- 13d, Other 1; 13e, Other 2; and 13f, Other 3, require a Note if the plan offers the benefit.

- 14c4, Fitness Benefit, now requires the plan to indicate the benefit type: Physical Fitness, Memory Fitness, or Activity Tracker. The plan must select at least one type and may select all types that apply.

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Section D includes two new questions. “Do you offer Reductions in Cost Sharing?” relates to reduced cost sharing for Medicare Parts A and B and/or supplemental benefits. “Do you offer Combined Supplemental Benefits with uniform cost sharing?” relates to plans that offer groups of supplemental benefits with uniform cost sharing. Since MMP cost sharing has already been reduced to $0 in almost all of these cases and MMP supplemental benefits are typically not grouped, plans will usually select “No” in response to each question.

In addition, Section Rx no longer contains validations that require the number of days in a three-month retail supply to be the same across all drug tiers. However, the range of a three-month supply must still be between 90 and 102 days, inclusive. Although a variety of revisions were made to improve readability and navigation throughout this section, none of those changes affect the plan’s data entry.

Data Entry for Drug Coverage

Drug Cost-Sharing Requirements

When a tier only includes Medicare Part D drugs, plans may enter copayment minimum and maximum amounts reflecting one of the following options for each Part D only tier:

- For tiers with only Medicare Part D generic drugs: The minimum copayment amount that can be entered is $0 and the maximum copayment amount that can be entered is $3.70.

- For tiers with only Medicare Part D brand drugs: The minimum copayment amount that can be entered is $0 and the maximum copayment amount that can be entered is $9.20.

- For tiers with only Medicare Part D brand and generic drugs: The minimum copayment amount that can be entered is $0 and the maximum copayment amount that can be entered is $9.20.

CMS-State Joint Review

CMS and the states will jointly review the PBPs. CMS ensures that all Medicare Parts A, B, and D benefits have been adequately captured, and the states verify that all Medicaid and demonstration-specific benefits have been adequately captured. The Medicare-Medicaid Coordination Office has been working with all states participating in the capitated financial alignment model to develop guidance for their MMPs on Medicaid and demonstration-specific

benefits for CY 2021. States will begin releasing guidance to their MMPs in mid-April 2020 to ensure that MMPs have ample time to prepare their PBP submissions by June 1, 2020.

PBP Corrections

CMS provides some degree of flexibility to MMPs with respect to PBP revisions after the time of final PBP approval. This flexibility is necessary to accommodate certain mid-year changes unique to MMPs, including but not limited to mid-year legislative changes to Medicaid benefits, as well as the timing of payment rate finalization.

CMS applies the following criteria to MMP requests to change or correct PBPs:

- PBP revisions to add or remove plan-offered supplemental benefits between the time of the release of the National Average Monthly Bid Amount in early August and sign-off of PBPs in HPMS in mid-August 2020 are permissible. This timeframe allows plans to accommodate any approved benefit changes in their required documents (including the Annual Notice of Change, Evidence of Coverage/Member Handbook, and Summary of Benefits) during the Annual Election Period.

- Rate-related PBP corrections are permissible during the Center for Medicare’s annual correction window in September 2020 (see the posted CY 2021 Medicare Parts C and D Annual Calendar in HPMS for more information), but only for purposes of adding supplemental benefits to PBPs. MMPs that elect to correct their PBPs must work with their contract management team on an appropriate member communication strategy (e.g., issuance of corrected or revised information for materials that have already been mailed to members; corrections or updates of hard copy and online versions of other materials for prospective members). We clarify that there will be no compliance penalty for a PBP correction provided an MMP meets these conditions.

- PBP corrections unrelated to rates and supplemental benefits that are requested during the Center for Medicare’s annual correction window in September 2020 (see the posted CY 2021 Medicare Parts C and D Annual Calendar in HPMS for more information) will be considered changes due to plan error. As such, these PBP corrections (or any resultant corrections to MMPs’ Annual Notice of Change and/or Evidence of Coverage/Member Handbook, which must be submitted in HPMS through the errata submission process in the Marketing Module) may be subject to compliance action, regardless of whether they are positive or negative changes.

- Any PBP corrections after the Center for Medicare’s annual correction window in September 2020 will be considered on a case-by-case basis. In cases where a PBP correction is due to a mid-year legislative change to Medicaid benefits (or a benefit change made in a three-way contract amendment) and an MMP’s previously approved PBP submission included a more generous supplemental benefit than the new Medicaid or demonstration benefit, the MMP will be required to continue to provide the more generous supplemental benefit for the remainder of the contract year. PBP corrections (or any resultant corrections to MMPs’ Annual Notice of Change and/or Evidence of

Coverage/Member Handbook, which must be submitted in HPMS through the errata submission process in the Marketing Module) due to plan error may be subject to compliance action, regardless of whether they are positive or negative changes.

Training and Resources for More Information

For additional information and training purposes, MMPs should access PowerPoint presentations and a test version of the PBP software, which will be posted at a later date on https://go.cms.gov/hpms. MMPs should also consult the HPMS Bid User's Manual which will be available at the following pathway in HPMS: Plan Bids > Bid Submission > Contract Year 2021 > View Documentation > Bid Submission User Manual.

Any questions regarding the contents of this memorandum should be directed to the Medicare-Medicaid Coordination Office at MMCOCapsModel@cms.hhs.gov.