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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 8, 2020

TO: All Organization Types and Stakeholders

FROM: Kathryn A. Coleman
Director

SUBJECT: Final Contract Year 2021 Part C Benefits Review and Evaluation

This memorandum includes final bid and operational instructions for Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans, for Contract Year (CY) 2021. Statutory cites in this memorandum are to the Social Security Act (the Act) and regulatory cites are to 42 C.F.R. parts 417 and 422 unless otherwise noted.

CMS issued this HPMS memorandum in draft form to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2021 (HPMS memorandum titled "Contract Year 2021 Part C Benefits Review and Evaluation", issued February 6, 2020). As part of providing final guidance for CY 2021 benefits review and evaluation for MA organizations to use in developing and submitting their CY 2021 bids, this document summarizes and responds to the issues and concerns raised by commenters.

Overview of CY 2021 Part C Benefits Review

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

Medicare-Medicaid Plans in a capitated model under the Medicare-Medicaid Financial Alignment Initiative are not subject to the review criteria summarized in Table 1 below and benefit review information for these plans will be provided separately.

CMS makes all of the necessary tools and information available to MA organizations in advance of the bid submission deadline, and therefore expects all MA organizations to submit their best, accurate, and complete bid(s) on or before Monday, June 1, 2020 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).

CMS addressed several of the regulations and standards on which instructions are provided in the proposed rule titled, "Medicare and Medicaid Programs; Contract Year 2021 and 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 (CMS-4190-P)," (the NPRM), published in the Federal Register on February 18, 2020 (85 FR 9002). In light of the NPRM, we reiterate that this memorandum applies only to CY 2021. Table 1 below displays key MA bid review criteria and identifies the criteria used to review the bids of the various plan types identified in the column headings.

Table 1: Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans
Low Enrollment 42 C.F.R. §422.510(a)(4)(xv)	Yes	Yes	No	No
Total Beneficiary Cost Section 1854(a)(5)(C)(ii) of the Act 42 C.F.R. § 422.254(a)(4) and 422.256(a)	Yes	No	No	No
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
PMPM Actuarial Equivalent Cost Sharing 42 C.F.R. § 422.254(b)(4) and 422.100(f)(2) and (f)(6)	Yes	Yes	No	Yes
Service Category Cost Sharing[1] 42 C.F.R. §§417.454(e), 422.100(f) and 422.100(j)	Yes	Yes	Yes	Yes
Part C Optional Supplemental Benefits Section 1852(a)(3) and 42 C.F.R. §§ 422.100(f) and 422.102	Yes	Yes	No	No

[1] Section 1876 Cost Plans and MA plans may 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)). In addition, MA plans may not charge enrollees higher costs sharing than is charged under Original Medicare for: (i) COVID-19 testing and COVID-19 testing-related services identified in section 1833(cc)(1) for which payment would be payable under a specified outpatient payment provision described in section 1833(cc)(2) during the period from March 18, 2020 through to the end of the emergency period described in section 1135(g)(1)(B); and (ii) a COVID-19 vaccine and its administration described in section 1861(s)(10)(A). These changes regarding coverage of COVID-19 testing, testing-related services, and vaccination are pursuant to amendments to section 1852 of the Act made by the Families First Coronavirus Response Act (P.L. 116-127) and the CARES Act (P.L. 116-136).

CMS interprets and applies the regulatory and statutory standards for service category cost sharing standards and amounts, PMPM Actuarial Equivalence factors, and TBC thresholds for CY 2021 and provides information on these in each applicable section below. 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.

Maximum Out-of-Pocket (MOOP) Limits

The information discussed in this section applies only to CY 2021 bid submissions.

Under 42 C.F.R. §§ 422.100(f)(4) and (5) and 422.101(d)(2) and (3), 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 do not exceed the annual limits set by CMS. In setting these limits under these regulations, CMS uses Medicare Fee-for-Service (FFS) data to strike a balance between limiting maximum beneficiary out-of-pocket costs and potential changes in premium, benefits, and cost sharing, with the goal of ensuring beneficiary access to affordable and sustainable benefit packages. The regulations addressing MOOP limits were originally adopted in 2010 rulemaking. This standard for setting the MOOP limits was adopted in the final rule Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-F) (83 Fed. Reg. 16440 (Apr. 16, 2018)) and is applicable for 2021.

Currently, local and regional PPO plans are required to have two MOOP limits consistent with maximum thresholds established by CMS using the regulation standard, including (a) an in-network and (b) a catastrophic (combined) limit that includes both in-network and out-of-network items and services covered under Parts A and B. HMO-POS plans may offer out-of-network benefits as supplemental benefits, but are not required to have these services contribute to the in-network MOOP limit or to a combined in- and out-of-network MOOP limit. Although the MOOP limits apply to Parts A and B benefits, an MA organization can apply the MOOP limit to supplemental benefits as well. MA organizations are responsible for tracking out-of-pocket spending incurred by the enrollee (i.e., cost sharing includes deductibles, coinsurance, and copayments, pursuant to § 422.2) and to alert enrollees and contracted providers when the MOOP limit is reached.

As explained in the April 2018 final rule (82 FR 16486 – 87), adopting the current regulation that we are applying here, CMS sets the MOOP limits using an analysis of Medicare FFS data by the Office of the Actuary (OACT) and the 95th and 85th percentiles of projected beneficiary out-of-pocket spending for the year for which the MOOP limits are being set; CMS applies the regulatory standard using this information. Because of the limits on MA eligibility and enrollment for beneficiaries with diagnoses of End Stage Renal Disease (ESRD), CMS has not traditionally used out-of-pocket spending data for beneficiaries with diagnoses of ESRD in this process. With the changes by the 21st Century Cures Act ("Cures Act") in MA eligibility and enrollment for beneficiaries with diagnoses of ESRD, we believe it is appropriate to begin

incorporating cost data for beneficiaries with diagnoses of ESRD into how MOOP limits are set under §§ 422.100 and 422.101.

Section 17006 of the Cures Act amended section 1851(a) of the Act to allow Medicare beneficiaries with diagnoses of ESRD to enroll in MA plans on the same terms as other Medicare beneficiaries, beginning January 1, 2021, when the law had previously limited eligibility and enrollment for ESRD beneficiaries. Beneficiaries with diagnoses of ESRD typically incur higher costs than the average beneficiary; CMS establishes separate payment rates to MA plans for ESRD beneficiaries that reflect this. We expect that more beneficiaries with diagnoses of ESRD will elect enrollment in MA plans in 2021 in light of how the eligibility and enrollment restrictions have been lifted.

Because of the change in eligibility requirements for MA plans regarding beneficiaries with diagnoses of ESRD, we believe that it is appropriate that the data we use to set the MOOP limits also reflect the out-of-pocket expenditures of such beneficiaries so that the data set used to set the MOOP limits better reflects the beneficiaries enrolled in the MA program. To ensure the MOOP limits take into account out-of-pocket costs for beneficiaries with diagnoses of ESRD, we plan on a multiyear transition from our current practice under §§ 422.100(f) and 422.101(d) of excluding all costs incurred by beneficiaries with diagnoses of ESRD to including all related costs into the Medicare FFS data that is used to set the MOOP limits beginning with CY 2021. The term "ESRD cost differential" refers to the difference between: (1) projected out-of-pocket costs for beneficiaries using Medicare FFS data excluding the costs incurred by beneficiaries with ESRD diagnoses for contract year 2021 and (2) the projected out-of-pocket costs for all beneficiaries using Medicare FFS data (including the costs incurred by beneficiaries with ESRD diagnoses). Excluding all the ESRD cost differential might serve to limit MA enrollee costs, but would not be consistent with ensuring access to affordable and sustainable benefit packages because MA plans will have to cover costs for beneficiaries with diagnoses of ESRD, who typically incur higher health care costs. As beneficiaries with diagnoses of ESRD enroll in MA plans and incur greater costs, MA plans will have to cover higher costs when ESRD enrollees meet the MOOP limit and incur more costs past the MOOP threshold than non-ESRD enrollees are projected to do. In covering higher costs, MA plans would likely have to increase premiums for all enrollees or would not be able to continue to offer viable benefit designs. Those outcomes are not consistent with the standard CMS uses to set the MOOP limit under §§ 422.100(f) and 422.101(d).

As shown in Table 2 below, using Medicare FFS data excluding costs incurred by beneficiaries with diagnoses of ESRD, the 95th percentile is projected to be $7,175 in CY 2021, compared to $8,174 when costs incurred by beneficiaries with diagnoses of ESRD are included, a difference of $999. For CY 2021, CMS is factoring in 40% of that difference ($399.60) and add it to the projected 95th percentile without ESRD costs ($7,175), which equals $7,574.60 (rounded to $7,550).

Table 2: MOOP Limit and Medicare FFS Beneficiary Costs

MOOP Limit	Percentile	Medicare FFS Beneficiary Costs				In-Network MOOP Limit
		Excluding ESRD	Including ESRD	Difference	40% of Difference	
Mandatory	95th	$7,175	$8,174	$999	$399.60	$7,550
Voluntary	85th	$3,360	$3,537	$177	$70.80	$3,450

CMS developed this approach in consultation with the OACT to take into account the likely increase in enrollment of beneficiaries with diagnoses of ESRD in the MA program while ensuring that there is not a significant and sudden shift in the MOOP limits. Under §§ 422.100(f) and 422.101(d), MOOP limits must be set to strike a balance between limiting maximum beneficiary out-of-pocket costs and potential changes in premium, benefits, and cost sharing, with the goal of ensuring beneficiary access to affordable and sustainable benefit packages. A sudden and significant shift in the MOOP limits – which would happen if the MOOP limits were increased by 100% of the cost difference in one year – is not consistent with limiting beneficiary costs. MA organizations have been aware of the program change to allow Medicare beneficiaries with diagnoses of ESRD to enroll in MA since the Cures Act was enacted in December 2016. As such, CMS expects MA organizations have planned and prepared for this upcoming program change as they have conducted business activities, such as defining plan benefits, provider contracting with network providers, developing case management programs, and making reinsurance arrangements. We do not expect 100 percent of Medicare beneficiaries with diagnoses of ESRD will enroll in the MA program in CY 2021 and as such, CMS is not planning to integrate 100 percent of the costs in CY 2021. Further, transitioning to including the costs incurred by beneficiaries with diagnoses of ESRD in the process for setting the MOOP limits is more consistent with how MOOP limits must be set to strike the balance required by the regulations. In the NPRM, we proposed a transition schedule that aligns with how the standard in the current regulations permits CMS to incorporate these additional costs into the data used to set the MOOP.

Table 3 below displays the CY 2021 mandatory and voluntary MOOP limits and the combined (catastrophic) MOOP limits applicable to Local PPOs and Regional PPOs developed under §§ 422.100(f)(4) and (5) and 422.101(d)(2) and (3) as described above. A plan's adoption of a MOOP limit that qualifies as a voluntary MOOP limit ($0 - $3,450) results in greater flexibility for individual service category cost sharing. The possible ranges of the MOOP limit within each plan type are displayed in order to illustrate that MA plans may use MOOP limits that are lower than the CMS-established limits and what MOOP amounts qualify as mandatory and voluntary MOOP limits. As clarified in previous Call Letters, the in-network MOOP amount dictates the combined MOOP range for PPOs (i.e., PPOs are not permitted to offer a combined MOOP amount within the mandatory range while having an in-network MOOP amount within the voluntary range). Consistent with our long standing policy, the combined MOOP limits for PPO plans were calculated by multiplying the in-network amount by 1.5 and rounding to the closest $50 increment (we round down if the number is exactly between two $50 increments). The use of this increase for the combined catastrophic MOOP limits serves to strike an appropriate balance between limiting maximum beneficiary out-of-pocket costs and potential changes in

premium, benefits, and cost sharing, with the goal of ensuring beneficiary access to affordable and sustainable benefit packages.

Table 3: CY 2021 Voluntary and Mandatory MOOP Limits by Plan Type

Plan Type	Voluntary	Mandatory
HMO	$0 - $3,450	$3,451 - $7,550
HMO POS	$0 - $3,450 In-network	$3,451 - $7,550 In-network
Local PPO	$0 - $3,450 In-network and $0 -$5,150 Combined	$3,451 - $7,550 In-network and $3,451 - $11,300 Combined
Regional PPO	$0 - $3,450 In-network and $0 - $5,150 Combined	$3,451 - $7,550 In-network and $3,451 - $11,300 Combined
PFFS (full network)	$0 - $3,450 Combined	$3,451 - $7,550 Combined
PFFS (partial network)	$0 - $3,450 Combined	$3,451 - $7,550 Combined
PFFS (non-network)	$0 - $3,450	$3,451 - $7,550

MA organizations are responsible for tracking out-of-pocket spending incurred by the enrollee (i.e., cost sharing includes deductibles, coinsurance, and copayments, pursuant to § 422.2) and to alert enrollees and contracted providers when the MOOP limit is reached. Although most dually eligible enrollees are not responsible for paying cost sharing, certain D-SNPs (Medicare Non-Zero-Dollar Cost Sharing Plans) enroll dually eligible enrollees who do pay cost sharing. Any dually eligible enrollee exempted from cost sharing who loses his/her Medicaid eligibility may be responsible for cost sharing for the period he/she has lost Medicaid coverage, and remains enrolled in the D-SNP. This also applies to Medicare Zero-Dollar Cost Sharing Plans that apply cost sharing in their Medicare Part A and B benefit package, but enroll only dually eligible individuals who are exempt from cost sharing. D-SNPs have the flexibility to establish zero dollars as the MOOP limit, thereby guaranteeing there is no cost sharing for enrollees, including those who are liable for Medicare cost sharing. Otherwise, if the D-SNP does apply cost sharing for Medicare Part A and B covered benefits, then it must track enrollees' out-of-pocket spending to ensure compliance with §§ 422.100(f) and 422.101(d). It is up to the plan to develop the process and vehicle for doing so.

Based on the two comments received, organizations were supportive of CMS incorporating costs of beneficiaries with diagnoses of ESRD into the methodology used to establish MOOP limits. Two organizations requested that CMS incorporate 50% of the ESRD cost differential into the data used to determine the change in the MOOP limits for CY 2021, rather than 40% of the ESRD cost differential. The commenters requested this change based on the OACT's projection that 50% of the beneficiaries with ESRD anticipated to enroll in MA plans by 2026 will enroll in 2021 which was discussed in the NPRM.

As discussed above, CMS sets the MOOP limits using an analysis of Medicare FFS data by the OACT and the 95th and 85th percentiles of projected beneficiary out-of-pocket spending for the year for which the MOOP limits are being set. The change in the mandatory MOOP limit for CY 2021 reflects two components:

(a) the difference between the existing MOOP limit ($6,700) and the 95th percentile of projected beneficiary costs, using data that excludes costs incurred by beneficiaries with the diagnosis of ESRD ($7,175); and

(b) 40% of the ESRD cost differential, which is the difference between the 95th percentile excluding costs incurred by beneficiaries with the diagnoses of ESRD ($7,175) compared to the 95th percentile including beneficiaries with the diagnosis of ESRD ($8,174), a total difference of $999.

Another way of evaluating the mandatory MOOP limit increase for CY 2021 is to compare the existing MOOP limit of $6,700 to $8,174, which is the 95th percentile of projected beneficiary costs where the data includes all beneficiaries (with and without ESRD). If we had decided to avoid a transition for incorporating the ESRD cost differential and to set the CY 2021 mandatory MOOP at the 95th percentile of projected beneficiary costs where the data includes all beneficiaries (with and without ESRD), the increase from CY 2020 to CY 2021 for the mandatory MOOP limit would be $1,474. From this perspective, the mandatory MOOP limit change from $6,700 to $7,550 represents 58% of that potential increase. That adequately aligns with the OACT projections of approximately 50% of the potential number of beneficiaries with diagnoses of ESRD that will choose MA enrollment doing so in 2021, while also incorporating an increase to keep the MOOP limits at the 95th and 85th percentiles. We believe that a potential increase of over $1,400 in one year is too steep to achieve our goal to strike a balance between limiting maximum beneficiary out of pocket costs and potential changes in premium, benefits, and cost sharing, along with the goal of ensuring beneficiary access to affordable and sustainable benefit packages. In addition, we note that the voluntary MOOP limit is not increasing as much due to the lower percentile, but the vast majority of plans and enrollees have a mandatory MOOP limit for CY 2020.

We appreciate the comments and suggestions and are finalizing the MOOP limits stated in Table 3 above because we believe the mandatory MOOP limit change from $6,700 to $7,550 (an increase of $850 or nearly 13%) strikes an appropriate balance between limiting maximum beneficiary out-of-pocket costs and potential changes in premium, benefits, and cost sharing, while ensuring beneficiary access to affordable and sustainable benefit packages.

Per Member Per Month (PMPM) Cost Sharing Limits to Address Actuarial Equivalent (AE) Cost Sharing Limits and Anti-Discrimination Standards

Total MA cost sharing for Parts A and B services must not exceed cost sharing for those services in Original Medicare on an actuarially equivalent basis[1] and must not be discriminatory. In order to ensure that cost sharing is consistent with both 42 C.F.R. §§ 422.254(b)(4) and 422.100(f)(2) and (6), CMS evaluates actuarial equivalent cost sharing limits on a per member per month (PMPM) basis separately in the following service categories for CY 2021: Inpatient, Skilled Nursing Facility (SNF), Durable Medical Equipment (DME), and Part B drugs.

Whether in aggregate, or on a service-specific basis, excess cost sharing is identified by comparing two values found in Worksheet 4 of the BPT. Specifically, a plan's PMPM cost

[1] MA plans may establish lower cost sharing as a mandatory supplemental benefit. See 42 C.F.R. §§ 422.2 (definition of mandatory supplemental benefit) and 422.102(a)(4).

sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) is compared to Original Medicare Actuarially Equivalent (AE) Cost Sharing (BPT Worksheet 4, Section IIA, column n). For Inpatient services, the Original Medicare AE cost sharing values, unlike plan cost sharing values, do not include Part B cost sharing. Therefore, an adjustment factor is applied to these Original Medicare AE values to incorporate Part B cost sharing and to make the comparison valid. Please note that factors for Inpatient and Skilled Nursing Facility in column #4 of Table 4 below (Part B Adjustment Factor to Incorporate Part B Cost Sharing) have been updated for CY 2021.

Once the comparison amounts have been determined, excess cost sharing can be identified. Excess cost sharing is the difference (if positive) between the plan cost sharing amount (column #1) and the comparison amount (column #5). Table 4 below uses illustrative values to demonstrate the mechanics of this determination.

Table 4: Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing

	#1	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**
BPT Benefit Category	**PMPM Plan Cost Sharing (Parts A&B)** ***(BPT Col. l)***	**Original Medicare Allowed** ***(BPT Col. m)***	**Original Medicare AE Cost sharing** ***(BPT Col. n)*** [1]	**Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on FFS data)**	**Comparison Amount** ***(#3 × #4)***	**Excess Cost Sharing (#1 − #5, min of $0)**	**Pass/Fail**
Inpatient	$33.49	$331.06	$25.30	1.367	$34.58	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.073	$10.61	$0.22	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 Skilled Nursing Facility only reflect Part A fee-for-service actuarial equivalent cost sharing for that service category.

NOTE: Beginning in CY 2017, CMS waived the requirement for MA employer plans (EGWPs) to submit a Bid Pricing Tool (BPT), which affects our ability to evaluate EGWPs on the PMPM Actuarial Equivalent Cost Sharing standards discussed in this section. MA EGWPs continue to be subject to all unwaived MA regulatory requirements regardless of whether they are affirmatively evaluated as part of bid review or in connection with other reviews.

A commenter asked if CMS made any adjustments to the calculation/methodology used to compare PMPM plan cost sharing to adjusted Original Medicare actuarial equivalence cost sharing to account for beneficiaries with diagnoses of ESRD being permitted to enroll in the MA program beginning in CY 2021. We note the PMPM actuarial equivalence factors included in

Table 4 for Inpatient and SNF benefit categories have historically included costs from beneficiaries with diagnoses of ESRD. Although beneficiaries with ESRD diagnoses may enroll in MA plans beginning in CY 2021, ESRD utilization and payment information is different when compared to other enrollees and will continue to be excluded from the primary pricing sections of the MA BPT. Additionally, the FFS Medicare Actuarial Equivalent Cost Sharing Factors in (column K) WS 4 of the MA BPT are calculated excluding ESRD utilization and payment information. Therefore, removing beneficiaries with ESRD diagnoses from the development of the adjustment factors that account for physician allowed costs and cost sharing for Inpatient and SNF is an appropriate correction to the methodology and calculations. This change is not expected to have a material impact on plans in meeting the Inpatient and SNF cost sharing thresholds and is consistent with how information is collected in the BPT. As indicated in the *Instructions for Completing the Medicare Advantage Bid Pricing Tools:* "The benchmarks calculated in the MA BPT exclude enrollees in ESRD status, as does the projection of bid expenditures…. In order to account for the projected marginal costs (or savings) of bid enrollees in ESRD status, the BPT allows for an adjustment that is allocated across ESRD and non-ESRD bid members (including out-of-area members)." Information in Table 4 above has been updated from the February 6, 2020 memorandum to reflect the changes discussed above. We also note that the PMPM actuarial equivalence evaluation (Table 4) is separate from evaluating the Part C cost sharing standards (Table 5). Both evaluations are used to prevent benefit designs that discriminate against and discourage enrollment by beneficiaries with a health status that requires those services. The PMPM actuarial equivalence evaluation uses BPT data in four service categories (Inpatient, SNF, DME, and Part B drugs) in a manner consistent with the BPT data collection that excludes ESRD costs. Part C service category cost sharing standards for inpatient scenarios are based on enrollee cost sharing entered in the PBP and includes costs from all beneficiaries, including those with diagnoses of ESRD, as discussed in the Part C Cost Sharing Standards section below.

Another commenter requested clarification on whether CMS extends flexibility if the plan uses Original Medicare cost sharing in the PBP, but does not satisfy the evaluation because of a claims distribution issue that is in the BPT with associated supporting documentation. If cost sharing entered in the PBP satisfies Part C service category cost sharing limits, CMS may extend flexibility when evaluating PMPM actuarial equivalent cost sharing to the extent that the cost sharing is actuarially justifiable based on generally accepted actuarial principles and supporting documentation. We believe that this exception will apply in limited situations, such as when the MA plan uses capitated arrangements with provider groups, operate their own facilities, or other unique arrangements. This flexibility is consistent with current policy and practice.

Part C Cost Sharing Standards

The information discussed in this section applies only to CY 2021 bid submissions.

Under § 422.100(f)(6), which was originally adopted beginning CY 2011, CMS has annually announced maximum cost sharing limits for certain Medicare Part A and B benefits to ensure that an MA plan's coverage of those services is not discriminatory.

The length of stay scenarios used to identify the cost sharing limits are based on utilization patterns from the most recent, complete Medicare data. For each length of stay scenario, CMS, in

consultation with the OACT, projects what Medicare FFS cost sharing would be in the year for which the MA cost sharing limits are being set. The OACT conducts an annual analysis of Medicare FFS data, including projected Part A deductible and Part B costs based on the length of stay and the setting of the inpatient stay (acute or psychiatric), to estimate the inpatient hospital acute and psychiatric cost sharing in Medicare FFS. In accordance with our longstanding policy, CMS compares the cost sharing for an MA enrollee under the plan design for each bid to the projected Medicare FFS cost sharing in each scenario; for MA plans with the mandatory MOOP, the cost sharing limit is 100 percent of the Medicare FFS cost sharing for the applicable scenario and for MA plans using the lower, voluntary MOOP, it is 125 percent of the Medicare FFS cost sharing. If an MA plan's cost sharing exceeds the applicable limit for any of the length of stay scenarios, CMS considers the MA plans' cost sharing as discriminatory under current § 422.100.

In developing the cost sharing projections used for this analysis and evaluation, CMS and the OACT have historically used the most recent, complete Medicare FFS data excluding out-of-pocket costs from beneficiaries with diagnoses of ESRD; CMS excluded the costs from beneficiaries with ESRD because of the limits on MA enrollment by Medicare beneficiaries with diagnoses of ESRD. Section 17006 of the Cures Act has amended the Medicare statute to allow Medicare beneficiaries with diagnoses of ESRD to enroll in MA plans beginning in CY 2021. CMS expects this change will result in Medicare beneficiaries with diagnoses of ESRD beginning to transition to, or choose, MA plans in greater numbers than they do currently.

The OACT conducted an analysis to help determine the impact of including all costs incurred by beneficiaries with diagnoses of ESRD into the most recent, complete Medicare FFS data used to set the standards under § 422.100(f)(6) and found that adding in related ESRD costs affects cost sharing limits for inpatient hospital acute length of stay scenarios. For example, the CY 2021 projection representing 100% of the Medicare FFS cost sharing for the inpatient hospital acute 60 day scenario when based on data that does not include the costs from beneficiaries with diagnoses of ESRD is $4,645, which increases to $5,073 when based on data that includes all of the costs for beneficiaries with diagnoses of ESRD. Based on the OACT analysis, inclusion of costs incurred by beneficiaries with diagnoses of ESRD did not impact inpatient hospital psychiatric standards.

Before the amendments made by the Cures Act are effective, individuals medically determined to have ESRD cannot enroll in a MA plan, subject to limited exceptions. As a result of the Cures Act amendments, CMS expects this change will result in Medicare beneficiaries with diagnoses of ESRD to begin transitioning to or choosing MA plans in greater numbers. Because of these changes, beginning in 2021, it is appropriate to use the costs incurred by beneficiaries with diagnoses of ESRD as part of the data to set the MA cost sharing limits. Even though including these additional costs did not have a substantial impact on all of the cost sharing limits, including the costs for beneficiaries with diagnoses of ESRD provides a fuller picture of what a Medicare beneficiary pays in the various inpatient acute and psychiatric stay scenarios. In comparing what an individual would pay in Medicare FFS to what the individual would pay in an MA plan for these scenarios, CMS is ensuring that individuals who need these inpatient stay benefits are not discriminated against based on those health needs. The cost incurred by beneficiaries with diagnoses of ESRD are relevant in making the comparison and evaluating for discriminatory cost sharing. However, we believe that a transition to using all costs incurred by a beneficiary with a diagnosis of ESRD is appropriate to avoid sudden changes in the cost sharing limits. Although

CMS cannot accurately project the rate at which beneficiaries with diagnoses of ESRD might elect MA enrollment, it seems unlikely that all such beneficiaries would make that transition in the first year. Therefore, for CY 2021, CMS plans to integrate approximately 40 percent of the ESRD cost differential into the projections of beneficiary cost sharing for inpatient hospital acute and psychiatric benefits used in setting the MA cost sharing limits under § 422.100(f)(6) for CY 2021. Consistent with how the term is used in setting MOOP limits (see pages 3 to 8), ESRD cost differential means the difference between (i) projected Medicare FFS costs incurred by beneficiaries with diagnoses of ESRD (reflected in Table 5) and (ii) projected Medicare FFS costs incurred by beneficiaries, excluding beneficiaries with diagnoses of ESRD.

For the other CY 2021 MA cost sharing limits set under § 422.100(f)(6) to ensure that cost sharing is not discriminatory, we plan to use Medicare FFS data that does not include the costs for beneficiaries with diagnoses of ESRD. This is because the analysis indicates that spending patterns for these beneficiaries, as related to how CMS sets the cost sharing limits, for these specific benefit categories are not affected. For example, setting the SNF cost sharing limit for days 21 to 100 only considers the Part A deductible, which is not affected by the costs for beneficiaries with diagnoses of ESRD. CMS establishes cost sharing limits for frequently used professional services, such as primary and specialty care services to guard against MA organizations setting cost sharing amounts in a manner that is potentially discriminatory. We plan to use our current and long standing practice for interpreting and applying the limits on the other MA cost sharing under § 422.100(f)(6), consistent with the final rule published April 16, 2018 (83 FR 16488 through 16490) and the final rule published April 15, 2010 (75 FR 19711 through 19715). This means that the CY 2021 cost sharing limits for various categories of professional services (i.e., the same list as used in the past) were informed by an analysis of Medicare FFS cost and utilization data from the OACT.

In addition, it has been CMS's longstanding policy to afford MA plans greater flexibility in establishing Parts A and B cost sharing when they adopt a lower, voluntary MOOP limit than plans that adopt the higher, mandatory MOOP limit. Table 5 below summarizes the standards and cost sharing amounts by MOOP type (i.e., mandatory or voluntary) that we will not consider discriminatory under § 422.100(f)(6); CY 2021 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. Inpatient and Skilled Nursing Facility (Days 21 through 100) standards have been updated to reflect estimated changes in Original Medicare cost for CY 2021, consistent with our practice in past years. We also note that the CY 2020 service category named "Part B Drugs – Chemotherapy" has changed to "Part B Drugs – Chemotherapy/Radiation" for CY 2021. This is consistent with § 422.100(j)(1), which indicates that chemotherapy administration services includes chemotherapy drugs and radiation therapy integral to the treatment regimen. This clarification reflects how CMS has interpreted and applied the regulatory cost sharing standard for this service category in the past.

Table 5: CY 2021 In-Network Service Category Cost Sharing Requirements

Service Category	PBP Section B data entry field	Voluntary MOOP	Mandatory MOOP
Inpatient Hospital – Acute - 60 days	1a	N/A	$4,816
Inpatient Hospital – Acute - 10 days	1a	$2,783	$2,226
Inpatient Hospital – Acute - 6 days	1a	$2,524	$2,019
Inpatient Hospital Psychiatric - 60 days	1b	$3,408	$2,726
Inpatient Hospital Psychiatric - 15 days	1b	$2,339	$1,871
Skilled Nursing Facility – First 20 Days[1,2]	2	$20/day	$0/day
Skilled Nursing Facility – Days 21 through 100[1,2]	2	$184/d	$184/d
Cardiac Rehabilitation	3	$50	$50
Intensive Cardiac Rehabilitation	3	$100	$100
Pulmonary Rehabilitation	3	$30	$30
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)	3	$30	$30
Emergency/Post Stabilization Services[3]	4a	$120	$90
Urgently Needed Services[3]	4b	$65	$65
Partial Hospitalization	5	$55/day	$55/day
Home Health	6a	20% or $35	0% or $0
Primary Care Physician	7a	$35	$35
Chiropractic Care	7b	$20	$20
Occupational Therapy	7c	$40	$40
Physician Specialist	7d	$50	$50
Psychiatric and Mental Health Specialty Services	7e and 7h	$40	$40
Physical Therapy and Speech-language Pathology	7i	$40	$40
Therapeutic Radiological Services	8b	20% or $60	20% or $60
DME-Equipment	11a	N/A	20%
DME-Prosthetics	11b	N/A	20%
DME-Medical Supplies	11b	N/A	20%
DME-Diabetes Monitoring Supplies	11c	N/A	20% or $10
DME-Diabetic Shoes or Inserts	11c	N/A	20% or $10
Dialysis Services[1]	12	20% or $30	20% or $30
Part B Drugs-Chemotherapy/Radiation[1,4]	15	20% or $75	20% or $75
Part B Drugs-Other	15	20% or $50	20% or $50

[1] MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration including chemotherapy drugs and radiation therapy integral to the treatment regimen, skilled nursing care, and renal dialysis services (42 CFR §§ 417.454(e) and 422.100(j)). In addition, MA plans may not charge enrollees higher costs sharing than is charged under Original Medicare for: (i) COVID-19 testing and COVID-19 testing-related services identified in section 1833(cc)(1) for which payment would be payable under a specified outpatient payment provision described in section 1833(cc)(2) during the period from March 18, 2020 through to the end of the emergency period described in section 1135(g)(1)(B); and (ii) a COVID-19 vaccine and its administration described in section 1861(s)(10)(A).

[2] MA plans that establish a voluntary MOOP may have cost sharing for the first 20 days of a SNF stay but (1) the per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF cost sharing amount and (2) total cost sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost sharing in Original Medicare. See section 1852(a)(1)(B) of the Act.

[3] Emergency/Post Stabilization and Urgently Needed Services benefits are not subject to plan level deductible amount and/or out-of-network providers. The dollar amount included in the table represents the maximum cost sharing permitted per visit (copayment or coinsurance).

[4] Part B Drugs – Chemotherapy/Radiation cost sharing displayed is for services provided on an outpatient basis and includes administration services.

MA organizations have the option to charge either coinsurance or a copayment for most service category benefits. For example, based on the cost sharing requirements indicated above for Part B Drugs – Chemotherapy/Radiation, a plan can choose to either assign up to a 20 percent coinsurance or $75 copayment to that particular benefit. MA plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration including chemotherapy drugs and radiation therapy integral to the treatment regimen, skilled nursing care, and renal dialysis services (42 C.F.R. § 422.100(j)). In addition, MA plans may not charge enrollees higher costs sharing than is charged under Original Medicare for: (i) COVID-19 testing and COVID-19 testing-related services identified in section 1833(cc)(1) for which payment would be payable under a specified outpatient payment provision described in section 1833(cc)(2) during the period from March 18, 2020 through to the end of the emergency period described in section 1135(g)(1)(B); and (ii) a COVID-19 vaccine and its administration described in section 1861(s)(10)(A). These changes regarding coverage of COVID-19 testing, testing-related services, and vaccination are pursuant to amendments to section 1852 of the Act made by the Families First Coronavirus Response Act (P.L. 116-127) and the CARES Act (P.L. 116-136).

Although CMS has not established a specific service category cost sharing limit for all possible services, CMS has a longstanding interpretation of the anti-discrimination provisions that payment of less than 50 percent of the contracted (or Medicare allowable) rate and use of cost sharing for services that exceeds 50 percent of the total financial liability for the benefit discriminates against enrollees who need those services. If a plan uses a copayment method of cost sharing, then the copayment for an in-network Original Medicare service category cannot exceed 50 percent of the average contracted rate of that service ((CMS-4182-F) (83 Fed. Reg. 16488 through 16490 (Apr. 16, 2018)); Medicare Managed Care Manual, Chapter 4, Section 50.1).

Copayments are expected to reflect specific benefits identified within the PBP service category or a reasonable group of benefits or services provided. Some PBP service categories may identify specific benefits for which a unique copayment would apply (e.g., category 7a includes primary care services), while other categories include a variety of services with different levels of costs which may reasonably have a range of copayments based on groups of similar services (e.g., category 8b includes outpatient diagnostic radiological services).

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

documentation upload section titled "Cost-Sharing Justification" in HPMS. The upload will be available to all MA plan types (both employer and individual market), but not for stand-alone PDPs. The link for uploading cost sharing justification files will be located at Plan Bids > Bid Submission > CY 2021 > Upload > Cost-Sharing Justification.

CMS annually evaluates available Medicare data and other information to apply MA program requirements in accordance with applicable law. Organizations are afforded the flexibility to design their benefits as they see fit so long as they satisfy Medicare coverage requirements. CMS also reminds organizations that they also must comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, national origin, gender, disability, chronic disease, health status, or other prohibited basis 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. This memorandum does not limit application of such anti-discrimination requirements.

Commenters generally supported CMS incorporating costs for beneficiaries with ESRD diagnoses into the methodology used to establish inpatient cost sharing limits. A commenter recommended CMS also incorporate these costs into all specified limits. We note that although this change (to incorporate the ESRD cost differential) does not impact all of the other benefit categories, we proposed changes to the relevant categories (e.g., physician specialties) to take ESRD costs into account in the NPRM beginning in CY 2022. We believe changes for the other service categories in CY 2021 would not provide sufficient planning time for MA organizations and that the applicable regulatory standard is met by our methodology for the CY 2021 cost sharing limits.

A commenter requested that CMS incorporate 50 percent of the ESRD cost differential for 2021, rather than the 40 percent, citing that OACT projects 50 percent of the beneficiaries with ESRD diagnoses anticipated to enroll in the MA program by 2026 will enroll in 2021. We are not making this change in how we are setting the cost sharing limits for CY 2021. As previously discussed in connection with the MOOP limits and how they are calculated (see pages 3-8), we believe that a transition to incorporate costs incurred by beneficiaries with diagnoses of ESRD is appropriate to avoid sudden changes in the cost sharing limits and that incorporating approximately 40 percent of these costs for CY 2021 inpatient cost sharing standards is reasonable and consistent with the approach used for establishing MOOP limits.

Another commenter had concerns that the changes in the Part C cost sharing limit for “Inpatient Hospital Acute--60 Days” would result in a limit that exceeds 100 percent of the Medicare FFS cost sharing for individuals without ESRD, resulting in cost sharing that is no longer actuarially equivalent for the non-ESRD population. We note that the Part C service category standards for inpatient scenarios include projected Part A deductible and Part B costs based on the length of stay using Medicare FFS data. MA plan enrollees with or without ESRD diagnoses receive the same cost sharing based on PBP data entry. The PMPM actuarial equivalence evaluation uses a separate methodology and is based on BPT information.

One commenter expressed concern about how the Emergency/Post-Stabilization Services cost sharing limits include both emergency and post-stabilization costs and asked CMS to clarify what services are included in post-stabilization (e.g., would inpatient services be considered

post-stabilization). We have addressed this concern in the past and the policy reflected in the CY 2021 cost sharing standards here is consistent with past years. CMS responded to a similar comment in the CY 2019 Final Call Letter (issued April 2, 2018) as follows: "Although post-stabilization may encompass a wide variety of services, CMS includes post-stabilization with the emergency category to reflect the services the enrollee receives immediately following stabilization in the emergency department." We note that post-stabilization services do not include inpatient care services. We also direct readers to section 1852 of the Act and § 422.113(c)), which require MA organizations to cover post-stabilization services in specified circumstances. Post-stabilization services are covered services related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in § 422.113(c)(2)(iii), to improve or resolve the enrollee's condition.

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 through the use of the TBC standard. 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 a MA organization may be requested to 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 methodology for developing the CY 2021 out-of-pocket costs (OOPC) model is consistent with last year's methodology. For more information, please reference the HPMS memorandum dated January 24, 2020 titled "CY 2020 Baseline Out-of-Pocket Cost (OOPC) Model". In addition, the CY 2021 Bid Review OOPC Model will be released in April 2020.

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 Medical Savings Account (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 includes 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, Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or participating in the Value-Based Insurance Design (VBID) model test will be subject to the TBC evaluation for CY 2021; 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.

Under 42 C.F.R. § 422.254, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the given amount. This approach not only protects enrollees from significant increases in cost sharing or decreases in benefits, but also confirms enrollees have access to viable and sustainable MA plan offerings.

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

In mid-April 2020, as in past years, CMS will provide plan specific CY 2021 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 ($144.60).
- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

CMS currently excludes beneficiaries with diagnoses of ESRD from the OOPC model used to calculate and evaluate TBC because of the limits on MA enrollment by Medicare beneficiaries with diagnoses of ESRD. As discussed in connection with establishing the MOOP and cost sharing limits, CMS believes that the changes in MA eligibility and enrollment for beneficiaries with diagnoses of ESRD make it appropriate to take into account the costs of beneficiaries with diagnoses of ESRD.

The comments we received generally supported CMS's plan to increase the TBC change threshold. Commenters requested CMS increase the threshold by between $2.00 PMPM and $3.00 PMPM (from the $36.00 PMPM threshold used for evaluating CY 2020 bids) because of additional program costs associated with enrolling beneficiaries with diagnoses of ESRD and related MOOP limit changes. CMS will increase the TBC threshold from the CY 2020 bid evaluation level ($36.00 PMPM) to $39.00 PMPM for most plans in CY 2021 to account for changes in ESRD enrollment policy and provide greater flexibility in navigating related MOOP

limit changes discussed earlier in this memorandum. Plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and a MA organization may be requested to provide a justification or change its bid(s).

Therefore, a plan experiencing a net increase in adjustments may have an effective TBC change amount below the $39.00 PMPM threshold for CY 2021. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $39.00 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 2021, 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 $39.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $39.00 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 -$39.00 PMPM will have a TBC change threshold of $78.00 PMPM (i.e., 2 times TBC change limit of $39.00 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.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$39.00 PMPM will have a TBC change threshold of $78.00 PMPM (i.e., 2 times TBC change limit of $39.00) plus applicable technical adjustments.
- Plans not accounted for in the three specific situations above are evaluated at the $39.00 PMPM limit, similar to the policy in CY 2020 about using the TBC threshold.

If CMS provides the MA organization an opportunity to correct CY 2021 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 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.

In mid-April 2020, CMS will issue the HPMS Memorandum titled "CY 2021 MA Bid Review and Operational Instructions." The memorandum will provide detailed TBC information and examples. Since CMS will maintain the TBC evaluation used during CY 2020 for consolidating or crosswalking plans, the memorandum will also include the operational details of this process.

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.

We received a comment that recommended CMS eliminate the TBC evaluation. CMS discussed eliminating the TBC evaluation in the CY 2019 Draft Call Letter and is continuing to conduct additional research and evaluating potential changes for future years through rulemaking, as applicable. At this time, the current TBC standard will be maintained to evaluate too significant an increase in cost sharing or decrease in benefits from one plan year to the next.

Conclusion

The policies described in this memorandum will be used in the evaluation of CY 2021 bids submitted by MA organizations. Unless otherwise noted in this document, other information or an applicable final rule, the instructions issued in the Final CY 2020 Call Letter applies for CY 2021, which can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf. The following is a non-exhaustive list of CY 2020 Call Letter policies that apply for CY 2021:

- Incomplete and Inaccurate Bid Submissions (pages 163-165)
- Plan Corrections (pages 165-166)
- Plans with Low Enrollment (pages 170-171)
- Part C Optional Supplemental Benefits (page 181)

We note that CMS did not receive any feedback or comments regarding the policies listed above.