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

DATE: April 19, 2021

TO: Medicare-Medicaid Plans

FROM: Lindsay P. Barnette
Director, Models, Demonstrations, and Analysis Group

SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2022

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) 2022 and to direct MMPs to CY 2017 guidance that remains unchanged for CY 2021.

For information that remains unchanged for CY 2022, MMPs can 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)[1]:

- 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

[1] See the HPMS Memos Archive – Annual (Qtr2 – 2016) on the CMS website at: www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Annual-Items/SysHPMS-Memo-Archive-2016-Qtr2.

- 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 2022 that affect MMPs.

On April 9, 2021, CMS released the CY 2022 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 2022 must be submitted **no later than 11:59 p.m. PDT on June 7, 2021**. In accordance with Article II, Plan Benefit Submission and Review, in the Three-Way Contract, MMPs are required to complete the following items as part of a complete bid submission:

- Service Area Verification
- Plan Crosswalk (NOTE: This is only for renewing contracts in CY 2022.)
- 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 11, 2021**.

Data Entry for Medical and Other Non-Drug Services

CY 2022 PBP Enhancements (Sections A, B, C, D, and Rx)

No enhancements to MMP-specific fields in the PBP software for CY 2022 appear in Sections A and C. The following enhancements appear in Section B:

- 7f, Routine Foot Care and 7i, Non-Medicare Other 1 and 2, includes a Note when an MMP answers "Yes" to the Copayment question and enters a copay amount, even if the amount is $0. (Since these are non-Medicare services, it is possible although unlikely that an MMP will answer "Yes." If an MMP answers "No," entering a Note remains optional.)
- 7b, Chiropractic Services; 13a, Acupuncture; and 14c17, Alternative Therapies, have been updated to eliminate the "combination" benefit questions. (For example, in 7b, "Is your Chiropractic Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?" has been removed.)

- 13c, Meal Benefit, has been updated. ("How many days does your Meal Benefit last?" and "What is the maximum number of meals the benefit provides?" have been removed. "Select the type of primarily health-related meal benefit offered" has been added, and the types are: Immediately following surgery or inpatient hospitalization; For a chronic illness; and For a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time. An MMP that offers the benefit selects at least one type, but may select more than one type, and enters a Note.)

- 14c18, Therapeutic Massage, has been updated to further define the benefit. (An MMP offering the benefit indicates whether it is unlimited or limited and includes the number of sessions and periodicity if the benefit is limited. An MMP selecting "Other, describe" as the periodicity enters a Note.)

- 14c22, Support for Caregivers of Enrollees, has been updated to include types of support. (Support choices are: Respite Care, Caregiver Training, and Other. "Other" is accompanied by a text field. An MMP offering the benefit selects at least one type, but may select more than one type.)

- 14e, Other Medicare-covered Preventive Services, has been updated to remove "Other" as the sixth option.

- 19, MA Uniformity Flexibility/SSBCI, has been updated to indicate chronic conditions for Special Supplemental Benefits for the Chronically Ill (SSBCI) similar to those for disease states in Medicare Advantage (MA) Uniformity Flexibility. (Since Medicaid and supplemental benefits for MMP members are included in other areas of the PBP software, it is possible although unlikely that an MMP will enter benefits in service category 19.)

Section D contains minor updates to Reductions in Cost Sharing and Combined Benefits. Since MMP cost sharing has already been reduced to $0 in almost all of these cases and MMP supplemental benefits are typically not grouped, MMPs usually select "No" in response to questions in these subsections.

Section Rx includes two updates on the Medicare Rx General screens:

- Screen 1 - "Out-of-Network" and "Long-Term Care" are defaults and cannot be de-selected.
- Screen 2 - Questions about prior authorization, step therapy, quantity limits, and indication-based formulary design have been removed as these answers are provided with the formulary submission.

Also, a pop-up window has been added in Section Rx to pre-populate location supply screens by selecting the appropriate pharmacy types and entering the required days' supply. (Use of the pop-up window is not required, and an MMP may still enter or change individual values on each screen if using the pop-up window.)

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 $3.95.[2]

- 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 $9.85.[2]

- 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 $9.85.[2]

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 2022. States will begin releasing guidance to their MMPs in late April 2021 to ensure that MMPs have ample time to prepare their PBP submissions by June 7, 2021.

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 2021 are permissible. This timeframe allows plans to accommodate any approved benefit changes in their required documents (including the

[2] See the HPMS Memos Archive – Weekly (WK 3 Jan 11-15, 2021) on the CMS website at: www.cms.gov/hpms-memos-wk-3-january-11-15-2021/hpms-memos-wk-3-january-11-15-2021.

Annual Notice of Changes, 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 early September 2021 (see the posted CY 2022 Medicare Parts C and D Annual Calendar in HPMS for more information[3]), but only for purposes of adding supplemental benefits to PBPs. MMPs that elect to correct their PBPs should 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 early September 2021 (see the posted CY 2022 Medicare Parts C and D Annual Calendar in HPMS for more information[3]) will be considered changes due to plan error. As such, these PBP corrections (or any resultant corrections to MMPs' Annual Notice of Changes and/or Evidence of Coverage/Member Handbook, which are submitted in HPMS through the errata submission process in the Marketing Review 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 2021 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 Changes and/or Evidence of Coverage/Member Handbook, which are submitted in HPMS through the errata submission process in the Marketing Review 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 may access a test version of the PBP software and corresponding training slides at hpms.cms.gov/public_files/training/pbp2022/PBPDownloads. MMPs may also consult the HPMS Bid User's Manual, which will be available at the following pathway in HPMS: Plan Bids > Bid Submission > Contract Year 2022 > View Documentation > Bid Submission User Manual.

[3] See hpms.cms.gov/app/ng/home/ and scroll down to the "Download the Calendar" link at the bottom of the page on the left.

Please direct any questions regarding the contents of this memorandum to the Medicare-Medicaid Coordination Office at MMCOCapsModel@cms.hhs.gov.