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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: February 24, 2023

TO: All Organization Types and Stakeholders

FROM: Kathryn A. Coleman
Director

SUBJECT: Preliminary Contract Year 2024 Standards for Part C Benefits, Bid Review and Evaluation

This memorandum includes preliminary 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. Final instructions and guidance are anticipated to be issued in an HPMS memorandum in April 2023. Unless otherwise noted, regulation cites in this memo are to 42 CFR parts 417 and 422.

CMS issued a proposed 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, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications," which appeared in the Federal Register on December 27, 2022, 87 FR 79452 (referred to as the December 2022 Proposed Rule) at https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program. The December 2022 Proposed Rule includes proposals, which, pending finalization, may affect the guidance in this draft memorandum. We have noted specific topics that could be affected where applicable.

CMS is providing interested stakeholders an opportunity to comment on aspects of contract year (CY) 2024 benefits standards, bid evaluation standards and instructions with this memorandum. Comments on this memorandum and related materials may be submitted electronically to: PartCComments@cms.hhs.gov. Please ensure each comment references the memorandum's section title and page number to which the comment pertains (also include tab name and specific item description for any materials related to MOOP and cost sharing calculations). Comments will be made public, so submitters should not include any confidential or personal information. In order to receive consideration prior to finalizing this memorandum in advance of bid submission, comments must be received by 6:00 PM Eastern Standard Time on March 17, 2023. Because of the volume of public comments, we are not able to acknowledge or respond to comments individually.

CMS annually evaluates available Medicare data and other information to apply MA program requirements in accordance with applicable law (for example, §§ 422.100, 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 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 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 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-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 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, cost plans must use Original Medicare cost sharing for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) during the COVID-19 public health emergency (the December 2022 Proposed Rule proposes to extend this protection beyond the COVID-19 public health emergency period) (§ 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

At the end of March, CMS expects to notify 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, will 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 must either (1) confirm 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) provide 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. Additional guidance regarding renewal options for 2024 will also be issued in April through a separate HPMS memorandum titled: "Information about Renewal Options for 2024." 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 intends to 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 is being 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 in April 2023. Note that CMS is also planning 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.[1] 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.

[1] Note that the December 2022 Proposed Rule includes a proposal regarding C-SNPs for ESRD that is proposed for CY 2025.

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 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 mid-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,[2] 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 has provided the tools necessary 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)

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

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 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 expects to provide detailed TBC information and examples of how the TBC evaluation will be applied to consolidating or cross-walking plans prior to bid submission.

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

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 cost sharing and MOOP limits that follow the methodologies set by the April 2022 final rule, except for MA MSA plans because 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). This includes 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. Per § 422.100(f)(7)(iii), this memorandum provides the advance public notice of and announces the available comment period for the projected CY 2024 MOOP limits and cost sharing standards. This memorandum is issued now to allow sufficient time for a comment period, consideration of comments, and issuance of MOOP limits and cost sharing standards for CY 2024 early enough for MA organizations to prepare and submit plan bids. The calculations supporting the CY 2024 MOOP and cost sharing limits discussed in this memorandum are also available for review at: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats. In this memorandum and the related calculation file, we identify and, as necessary, explain substantive differences in calculating MOOP limits and cost sharing standards compared to the methodology used for CY 2023 requirements, such as the conclusion of the ESRD cost transition. If your comment pertains

[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

to the calculation file, please reference the spreadsheet tab name(s), table number(s), and cell number (e.g., cell A1), if applicable.

In developing the projections that CMS uses to determine MOOP and cost sharing limits, the OACT uses actuarial judgement consistent with § 422.100(f)(7) to select the year(s) of Medicare FFS data and to apply trend factors to project the Medicare FFS data (consistent with the most recent Medicare Trustees Report, President's Budget, and changes in statute, regulation, and payment policies). This approach remains consistent with the development of the Medicare FFS data projections used to set CY 2023 MOOP and cost sharing limits. The year(s) of Medicare FFS data and trend factors that CMS uses to calculate CY 2024 MOOP and cost sharing limits are summarized in the footnotes of the calculation file.

Maximum Out–of-Pocket Limits

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: 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

To calculate the CY 2024 inpatient hospital cost sharing limits, CMS followed the methodology in § 422.100(f)(6)(ii)(B), (f)(6)(iv), and (f)(7). CMS used CY 2024 Medicare FFS data projections to calculate the inpatient hospital cost sharing limits, but in two cases, the result

[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.

exceeded the MOOP amount. In those cases, CMS capped the cost sharing limit for the specific inpatient hospital length of stay in Table 4 at the applicable MOOP amount from Table 3.

To calculate the CY 2024 cost sharing limits for professional services and service categories for which cost sharing must not exceed cost sharing under Original Medicare, CMS followed the methodology in § 422.100(f)(6)(iii), (f)(7), (f)(8), and (j)(1). Per § 422.100(f)(8), the copayment limits for 2023 through 2025 for the service categories subject to § 422.100(f)(6)(iii) (professional services that are basic benefits) and § 422.100(j)(1) (basic benefits for which the cost sharing must not exceed Original Medicare cost sharing) are set at an amount that is the lesser of an actuarially equivalent value to the applicable cost sharing standard (from paragraph (f)(6)(iii) or (j)(1)) or the value resulting from the actuarially equivalent copayment transition in § 422.100(f)(8)(ii) for that service category. For CY 2024, the transition to actuarially equivalent copayments continues, with the actuarially equivalent copayment differential in the calculations of copayment limits increasing from 25 percent for CY 2023 to 50 percent for CY 2024 (§ 422.100(f)(8)(i)(B)).

On November 7, 2022, CMS issued an HPMS memorandum, "Inflation Reduction Act Changes to Cost Sharing for Part B Drugs for Contract Year 2023 Medicare Advantage and Section 1876 Cost Plans," to provide guidance for contract year 2023 on the beneficiary cost sharing protections under section 11101 (Part B drugs with prices increasing faster than inflation) and section 11407 (Monthly cost-sharing cap for insulins furnished under Part B benefit) of the Inflation Reduction Act (IRA, P.L. 117-169), enacted on August 16, 2022. CMS took these changes into account in applying the regulatory methodology to set cost sharing limits for different categories of Part B drugs and Table 4 contains updates for contract year 2024 to reflect the beneficiary cost sharing protections from these IRA provisions.

First, a new service category standard – "Part B drugs – insulin" is added in Table 4 to apply the specific original Medicare cost sharing limit for insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) consistent with the November 7, 2022 HPMS memorandum. Prior to the IRA, Part B insulin was subject to the cost sharing limit for "Part B drugs – Other." Consistent with separating out the Part B insulin drugs into its own service category standard, the OACT analyzed the impact on the projections for the "Part B drugs – other" service category (which historically included insulin furnished through a Part B-covered DME pump).

Second, the OACT analyzed the impact of the IRA provisions regarding Part B drugs applicable during contract year 2024 on the projections for the following two service categories: "Part B drugs – other" and "Part B drugs – chemotherapy/radiation drugs." In addition to excluding Part B insulin costs from the Medicare FFS data projections used for the "Part B drugs – other" category, the OACT took into account projections about FFS costs sharing amounts for Part B rebatable drugs based on the applicable IRA provisions for both the "Part B drugs – other" and "Part B drugs – chemotherapy/radiation drugs" categories. Based on the OACT's analysis, the difference in median cost sharing values with and without the impact of the IRA is about $5 for "Part B drugs – chemotherapy/radiation drugs" and $6 for "Part B drugs – Other." Using either projected median cost figure (with or without IRA impacts) and including the application of rounding rules results in the same contract year 2024 copayment limits for both service category standards.

TABLE 4: FINAL CONTRACT YEAR 2024 IN-NETWORK SERVICE CATEGORY COST SHARING LIMITS USING MEDICARE FFS DATA PROJECTIONS

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
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 for 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.