DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: May 6, 2024

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 2025

The purpose of this memorandum is to provide an overview of changes to the Plan Benefit Package (PBP) submission for Medicare-Medicaid Plans (MMPs) for contract year (CY) 2025 and to direct MMPs to CY 2017 guidance that remains unchanged for CY 2025.

For information that remains unchanged for CY 2025, 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

On May 3, 2024, CMS released the CY 2025 Bid Submission Functionality in HPMS. MMPs will use the Bid Submission Functionality to submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits. CMS released the HPMS memo "Release of the Contract Year (CY) 2025 Bid Submission Functionality in HPMS" dated, May 3, 2024, that addresses the HPMS Bid Submission Functionality. [2].

All PBPs for CY 2025 must be submitted **no later than 11:59 p.m. PDT on June 3, 2024**. 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 2024.)
- 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 7, 2024**.

Data Entry for Medical and Other Non-Drug Services

CY 2025 PBP Enhancements

Benefit Offerings:

A "Select All" checkbox for Out-of-Network (OON) and Point-of-Service (POS) has been added to the Benefit Offerings page so that respondents can easily select all Medicare and/or Non-Medicare service categories to offer as OON/POS.

[2] See the HPMS Memos for week #5 April 29-May 3, 2024 on the CMS website at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly

Benefit Details:

1. **13b –** For Over-the-Counter Items (13b), questions related to Naloxone coverage and cost have been added.
2. **16** – For Dental (16), all Medicare covered dental services have been moved to a redefined parent level category for Medicare-covered Dental Services
3. **(16a) –** all non-Medicare covered dental service sub-categories and questions have been reorganized into Diagnostic and Preventive Dental (16b) or Comprehensive Dental (16c) to better align with Current Dental Terminology.
4. 1**6b2 –** For Dental X-Rays (16b2), the question has been modified to refer to number of x-rays instead of number of visits.

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 $4.90.

- 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 $12.15.

- 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 $12.15.

MMPs can refer to the February 1, 2024, CMS HPMS memo "Contract Year (CY) 2025 Final Part D Bidding Instructions" [3] and the April 3, 2024, HPMS E-mail Message "Correction to Contract Year (CY) 2025 Final Part D Bidding Instructions"[4] for additional information.

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[3] See the HPMS Memo for week 1 February 1-2, 2024 on the CMS website at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-1-february-1-2

[4] See the HPMS Memo for week 1 April 1-5, 2024 on the CMS website at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-1-april-1-5

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 2025. States released guidance to their MMPs in late April 2024 to ensure that MMPs have ample time to submit their PBP submissions by June 3, 2024.

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 late July and sign-off of PBPs in HPMS in mid-August 2024 are permissible. This timeframe allows plans to accommodate any approved benefit changes in their required documents (including the 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 2024 (see the posted CY 2025 Medicare Parts C and D Annual Calendar in HPMS for more information[4]), 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 2024 (see the posted CY 2025 Medicare Parts C and D Annual Calendar in HPMS for more information[4]) 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

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

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 early September 2024 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.

Resources for More Information

MMPs may consult the HPMS Bid User's Manual, which will be available at the following pathway in HPMS: Plan Bids > Bid Submission > CY 2025 > Documentation > View Documentation > Bid Submission User Manual.

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