Appendix B: PBP 2008 Changes

PBP Section A

1. (**POLICY)** For PFFS, ESRD I, MSA, and MSA Demo organizations, the network indication entered in HPMS will be downloaded and displayed on screen A-1.

2. (**LESSONS LEARNED COMMENTS)**The following Special Needs Plan Type information has been added to the information downloaded from HPMS, and has been displayed on screen A-2:
   - Percentage: Exclusive or Disproportionate
   - Population: All Duals or Full Duals
   - Chronic or Disabling Conditions

3. **(BENEFICIARY ED COMMENTS)** The Online Provider Directory Web Address field has been added to the information downloaded from HPMS, and has been displayed on screen A-3.

PBP Section B

1. **(POLICY/CALL LETTER)** Section B has been disabled for Standard MSA plans. Any enhanced benefits offered by MSA plans must be designated as Optional Supplemental benefits and described in Section D – Optional Supplemental Benefit packages.

2. **(POLICY/CALL LETTER)** A validation rule has been added to ensure that any enhanced benefits offered by MSA Demo plans must be designated as Optional Supplemental benefits.

3. **(POLICY GUIDANCE)**A validation rule has been added to Section B ensuring that Regional PPO plans do not enter any category-level deductibles.

B-1a/B-1b: Inpatient Hospital

1. **(LESSONS LEARNED)**A question has been added under Coinsurance and Copayment allowing the plan to indicate that it charges the Medicare-defined cost shares.
   - If the plan selects this option, then the cost share questions for the Medicare-covered stay, Medicare-covered day intervals, and Lifetime reserve day intervals has been disabled.

2. **(DEMONSTRATION PROGRAM POLICY)** The optional questions for PFFS plans only will also be enabled for ESRD I plans.

B-2: SNF

1. **(LESSONS LEARNED)** A question has been added under Coinsurance and Copayment allowing the plan to indicate that it charges the Medicare-defined cost shares.
    - If the plan selects this option, then the cost share questions for the Medicare-covered stay and Medicare-covered day intervals has been disabled.

2. (**DEMONSTRATION POLICY)** The optional questions for PFFS plans only will also be enabled for ESRD I plans.

B-4a: Emergency

1. **(CMS POLICY)**A series of questions has been added allowing the plan to specify a maximum plan benefit coverage limit for Worldwide coverage, if Worldwide coverage is offered as an enhanced benefit.
2. **(CMS SUBREG GUIDANCE)**The ER plan level deductible field has been modified to have check-boxes instead of radio buttons.
    - There is an edit rule that 'combined' must be mutually exclusive from 'In-network only' or 'Out-of-Network only'.
3. **(CMS SUBREG GUIDANCE)** The following question has been added: "Does ER cost sharing count towards any plan-level deductibles?" Yes/No
    - (If Yes) Indicate the plan-level deductibles where ER cost sharing counts:
        - In-Network only
        - Out-of-Network only
        - Combined (In-Network and Out-of-Network)

B-4b: Urgently Needed Services

1. **(POLICY)**The title of this category has been revised from 'Urgent Care'.

2. (**REGULATORY GUIDANCE)** The following Label has been added on the Base 1 screen:

    This screen should be used to describe the urgently needed services benefit. *Urgently needed services* means covered services that are not emergency services provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition; and it was not reasonable given the circumstance to obtain the services through the organization offering the MA plan (CFR 422.113(b)(1)(iii).

3. (**REGULATORY GUIDANCE)** Worldwide coverage has been removed as an enhanced benefit.

B-7a: PCP

1. (**TECHNICAL)** The following Label has been added on the Base 1 screen:
   If your plan offers in-network coverage such as through walk-in clinics or urgent care clinics during regular hours or after hours, then this benefit should be included in this category. If cost sharing for this benefit is not the same as primary care, reflect the cost sharing in the range.

B-8a: Outpatient Diagnostic Procedures and Tests and Lab Services

1. (**TECHNICAL)** The title of this category has been revised from 'Outpatient Clinical/ Diagnostic/ Therapeutic Radiological Lab Services'.

2. (**TECHNICAL)** The service category description has been revised.

3. (**POLICY GUIDANCE)** The Medicare benefit description has been revised. The Medicare-covered benefits for this category will now include the Medicare covered benefit for cardiovascular screenings that test for cholesterol, high-density lipoprotein, and triglyceride levels in the blood. Medicare covers these tests once every five years. (Moved from 13a: Blood)

4. (**LESSONS LEARNED)**The Coinsurance and Copayment fields have been revised:
   - Clinical/Diagnostic Medicare Covered benefits has been changed to Medicare Covered Diagnostic Procedures/Tests.
   - Therapeutic Medicare Covered Benefits has been moved from this category to 8b.
   - Cost share fields have been added for Lab Services.

B-8b: Outpatient Diagnostic and Therapeutic Radiological Services

1. (**TECHNICAL)** The title of this category has been revised from 'Outpatient X-Rays'.

2. (**TECHNICAL)** The service category description has been revised.

3. (**LESSONS LEARNED)** The Medicare benefit description has been revised.

4. (**LESSONS LEARNED/POLICY GUIDANCE)** The Coinsurance and Copayment fields have been revised:
   - Medicare Covered Benefits has been split into two fields: Medicare Covered X-Ray services, and Other Medicare Covered Diagnostic Radiological services.

- Medicare Covered Therapeutic Radiological Services has been moved to this category from 8a.

B-10a: Ambulance

1. (**LESSONS LEARNED)** The Medicare-covered cost share fields (Coinsurance and Copayment) have been revised to allow for a Minimum/Maximum range for the Medicare-covered benefit.

B-11a: DME; B-11b: Prosthetics/Medical Supplies

1. **(DEMONSTRATION POLICY)** The optional questions for PFFS plans only will also be enabled for ESRD I plans.

B-13a: Blood

1. (**POLICY GUIDANCE)** The Medicare covered benefit for cardiovascular screenings has been removed from the Medicare benefit description for this category and placed in the Medicare benefit description for 8a: Clinical/Diagnostic/Therapeutic Lab Services.

B-14c: Physical Exams (**LESSONS LEARNED BOTH #1 AND #2)**

1. The title of this category has been revised from 'Routine Physicals'.

2. The enhanced benefit wording has been changed from 'Number of Visits' to 'Routine Exams'.

B-14j: Nutrition Therapy for Diabetes and Renal Disease

1. (**TECHNICAL CHANGE, LESSONS LEARNED)** A new category has been added for CY 2008 that covers the Medicare Part B benefit for medical nutrition therapy services for people who have diabetes or renal disease. *Prior to 2008, there was a pop-up message displayed upon entering B-14: Preventive Services directing the plan to describe this information in the Notes section of 14i: Diabetes Monitoring. This message has been removed.

2. (**LESSONS LEARNED)**This benefit includes (1) an initial nutrition and lifestyle assessment, (2) nutrition counseling, (3) Information regarding managing lifestyle factors that affect diet, and (4) Follow-up visits to monitor progress in managing diet. The benefit does not include meals, food or nutritional supplements.

B-15: Medicare Part B Rx Drugs

1. (**LESSONS LEARNED, CMS POLICY CLARIFICATION)** Cost share fields (Coinsurance, Copayment, and Deductible) have been added for Part B covered chemotherapy drugs.

B-18a: Hearing Exams

1. (**LESSONS LEARNED)** The Medicare-covered cost share fields (Coinsurance and Copayment) have been revised to allow for a Minimum/Maximum range for the Medicare-covered benefit.

PBP Section C

1. (**LESSONS LEARNED)** Out-of-Network (OON) benefits (Regional and Local PPOs only):
    - The following Label has been added: "NOTE: Plans must describe cost sharing for all Out-of-Network (OON) benefits."
    - The following Exit Message has been added: "Local PPO and Regional PPO plans must describe cost sharing for all Out-of-Network benefits. The In-Network cost sharing applies if no Out-of-Network cost sharing is described."

2. (**LESSONS LEARNED)**POS option (HMOPOS, PSO, CCRC Demo, and ESRD II Demo plans only):
    - The following questions has been added to this section:
        - POS Enrollee Out-of-Pocket Maximum amount
        - POS Deductible
    - In addition to the cost share questions for Inpatient Hospital and Outpatient services, the following questions has been added:
        - Inpatient Hospital Maximum Plan benefit coverage amount
        - Inpatient Hospital Deductible amount
        - Group Maximum Plan benefit coverage amount
        - Group Deductible

3. (**LESSONS LEARNED/ POLICY GUIDANCE)** Visitor/Travel Program:
    - This section has been available for PPO plans.
    - This section will NOT be available for PFFS and ESRD I Demo plans.

PBP Section D

1. (**LESSONS LEARNED)** The plan–level Deductible amount question(s) has been revised as follows:
    - For each plan-level Deductible, the following question has been added: "Do you charge the Medicare Part B Deductible amount?" Yes/No

2. (**LESSONS LEARNED, CMS POLICY, ENHANCEMENT OF SOFTWARE)**
For each plan-level Deductible, the plan may separately select the Medicare-covered and Non-Medicare covered benefits that apply
    - Combined (In-Network and Out-of-Network) Deductible:
        - Select the benefits that apply to the Combined Deductible:
            - In-Network Medicare-covered benefits
                - Does the Combined Deductible apply to all In-Network Medicare-covered plan services
                    - (If No) Select all of the In-Network Medicare-covered Service Categories to which the Combined Deductible applies: *picklist*
            - In-Network Non-Medicare covered benefits
                - Does the Combined Deductible apply to all In-Network Non-Medicare-covered plan services
                    - (If No) Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies: *picklist*
            - Out-of-Network Medicare-covered benefits
                - Does the Combined Deductible apply to all Out-of-Network Medicare-covered plan services
                    - (If No) Select all of the Out-of-Network Medicare-covered Service Categories to which the Combined Deductible applies: *picklist*
            - Out-of-Network Non-Medicare covered benefits
                - Does the Combined Deductible apply to all Out-of-Network Non-Medicare-covered plan services
                    - (If No) Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies: *picklist*

      Note: The Combined Deductible questions has been enabled only for Local PPOs, Regional PPOs, Network PFFS, and ESRD I Demo plans; as well as HMOPOS, PSO, CCRC Demo, and ESRD II Demo plans: ONLY if POS is Mandatory
    - In-Network Deductible
        - Select the benefits that apply to the In-Network Deductible:
            - In-Network Medicare-covered benefits
                - Does the In-Network Deductible apply to all In-Network Medicare-covered plan services
                    - (If No) Select all of the In-Network Medicare-covered Service Categories to which the In-Network Deductible applies: *picklist*
            - In-Network Non-Medicare covered benefits
                - Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services

- (If No) Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Deductible applies: *picklist*

Note: The In-Network Deductible questions will NOT be enabled for RPPOs

- Out-of-Network Deductible
  - Select the benefits that apply to the Out-of-Network Deductible:
    - Out-of-Network Medicare-covered benefits
      - Does the Out-of-Network Deductible apply to all Out-of-Network Medicare-covered plan services
        - (If No) Select all of the Out-of-Network Medicare-covered Service Categories to which the Out-of-Network Deductible applies: *picklist*
    - Out-of-Network Non-Medicare covered benefits
      - Does the Out-of-Network Deductible apply to all Out-of-Network Non-Medicare-covered plan services
        - (If No) Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Deductible applies: *picklist*

  Note: The Out-of-Network Deductible questions has been enabled only for Local PPOs, Network PFFS, and ESRD I Demo plans; as well as HMOPOS, PSO, CCRC Demo, and ESRD II Demo plans: ONLY if POS is Mandatory; NOT RPPOs
- The Deductible Type field (Medicare only; Enhanced only; All benefits) has been removed.
- Service category 4a: Emergency Care has been removed from all Deductible picklists.
- Service category 4b: Urgently Needed Services has been removed from all In-Network picklists

3. (**LESSONS LEARNED, CMS POLICY, ENHANCEMENT OF SOFTWARE)** The plan–level Enrollee Out-of-Pocket cost question(s) has been revised to allow the plan to separately select the Medicare-covered and Non-Medicare covered benefits that apply.

   Note: For RPPOs, all A/B services must be included in the enrollee out-of-pocket cap [catastrophic] amount.
   - Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket cost:
     - Select the benefits that apply to the Combined Maximum Enrollee Out-of-Pocket cost:
       - In-Network Medicare-covered benefits
         - Does the Combined Maximum Enrollee Out-of-Pocket cost apply to all In-Network Medicare-covered plan services
           - (If No) Select all of the In-Network Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket cost applies: *picklist*

- In-Network Non-Medicare covered benefits
  - Does the Combined Maximum Enrollee Out-of-Pocket cost apply to all In-Network Non-Medicare-covered plan services
    - (If No) Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket cost applies: *picklist*
- Out-of-Network Medicare-covered benefits
  - Does the Combined Maximum Enrollee Out-of-Pocket cost apply to all Out-of-Network Medicare-covered plan services
    - (If No) Select all of the Out-of-Network Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket cost applies: *picklist*
- Out-of-Network Non-Medicare covered benefits
  - Does the Combined Maximum Enrollee Out-of-Pocket cost apply to all Out-of-Network Non-Medicare-covered plan services
    - (If No) Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket cost applies: *picklist*

Note: The Combined Maximum Enrollee Out-of-Pocket cost questions has been enabled only for Local and Regional PPOs, Network PFFS, and ESRD I Demo plans; as well as, HMOPOS, PSO, CCRC Demo, and ESRD II Demo plans: ONLY if POS is Mandatory

- In-Network Maximum Enrollee Out-of-Pocket cost
  - Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:
    - In-Network Medicare-covered benefits
      - Does the In-Network Maximum Enrollee Out-of-Pocket cost apply to all In-Network Medicare-covered plan services
        - (If No) Select all of the In-Network Medicare-covered Service Categories to which the In-Network Maximum Enrollee Out-of-Pocket cost applies: *picklist*
    - In-Network Non-Medicare covered benefits
      - Does the In-Network Maximum Enrollee Out-of-Pocket cost apply to all In-Network Non-Medicare-covered plan services
        - (If No) Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Maximum Enrollee Out-of-Pocket cost applies: *picklist*
- Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount
  - Select the benefits that apply to the Out-of-Network Maximum Enrollee Out-of-Pocket cost:
    - Out-of-Network Medicare-covered benefits
      - Does the Out-of-Network Maximum Enrollee Out-of-Pocket cost apply to all Out-of-Network Medicare-covered plan services

        - (If No) Select all of the Out-of-Network Medicare-covered Service Categories to which the Out-of-Network Maximum Enrollee Out-of-Pocket cost applies: *picklist*
    - Out-of-Network Non-Medicare covered benefits
        - Does the Out-of-Network Maximum Enrollee Out-of-Pocket cost apply to all Out-of-Network Non-Medicare-covered plan services
            - (If No) Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Maximum Enrollee Out-of-Pocket cost applies: *picklist*

    Note: The Out-of-Network Maximum Enrollee Out-of-Pocket cost questions has been enabled only for Local PPOs, Regional PPOs, Network PFFS, and ESRD I Demo plans; as well as HMOPOS, PSO, CCRC Demo, and ESRD II Demo plans: ONLY if POS is Mandatory
  - The Enrollee Out-of-Pocket Type field (Medicare only; Enhanced only; All benefits) has been removed.
  - Service category 4b: Urgently Needed Services has been removed from all In-Network picklists

4. (**CMS POLICY, LESSONS LEARNED)**The plan–level Maximum Plan Benefit Coverage amount question(s) has been revised to allow the plan to separately select the In-Network Non-Medicare-covered and Out-of-Network Non-Medicare covered benefits that apply.

5. (**REGULATORY GUIDANCE- MEDICARE BENEFITS)**The Medicare benefits picklist will exclude the following categories only:
   - 10b: Transportation
   - 13b: Acupuncture
   - 13c: Other
   - 13d: Other
   - 13e: Other
   - 14a: Health Ed/Wellness
   - 16a: Preventive Dental
   - 18b: Hearing Aids

6. (**REGULATORY GUIDANCE- MEDICARE BENEFITS)** The Non-Medicare benefits picklist will include only the following categories:
   - 10b: Transportation
   - 13b: Acupuncture
   - 13c: Other
   - 13d: Other
   - 13e: Other
   - 14a: Health Ed/Wellness

- 16a: Preventive Dental
- 16b: Non-Medicare Comprehensive Dental
- 17a: Non-Medicare Eye Exams
- 17b: Non-Medicare Eye Wear
- 18a: Non-Medicare Hearing Exams
- 18b: Hearing Aids

7. (**REGULATORY GUIDANCE- MEDICARE BENEFITS)**The following questions has been added for PFFS and ESRD I Demo plans only:
   - Do you permit balance billing? Yes/No
   - What category of providers do you allow to balance bill? *(picklist)*
   - Enter Minimum percentage for balance billing: __%
   - Enter Maximum percentage for balance billing: __%

   Note: Percentages cannot be greater than 15.
   - The following label has been added: "Balance Billing is a percentage of plan payment rate provider may collect."

8. (**REGULATORY GUIDANCE- MEDICARE BENEFITS)** The following question(s) has been added for Standard MSA plans. These plans will be defaulted to Yes and no data entry for these sections are required.
   - Does permitted balance billing count toward the plan Deductible? Yes
   - Is permitted balance billing paid by the plan after the Deductible is met? Yes

9. (**REGULATORY GUIDANCE- MEDICARE BENEFITS)** The following question(s) has been added for MSA Demo plans. These plans will be defaulted to Yes and no data entry for these sections are required.
   - Does permitted balance billing count toward the plan Deductible? Yes
   - Is permitted balance billing paid by the plan after the Deductible is met? Yes
   - Does permitted balance billing count toward the Out-of-Pocket Maximum after the Deductible is met? Yes
   - Is permitted balance billing paid by the plan after the Out-of-Pocket Maximum is met? Yes

10. (**NEW MEDICARE BENEFIT IN CY2007 – ENHANCEMENT TO SOFTWARE)** The following question(s) has been added for MSA Demo plans:
    - Do you offer Medicare covered preventive services before the Deductible is met at reduced cost sharing? Yes/No
    - (If Yes) Indicate the Medicare covered preventive services offered before the Deductible is met:
      - Bone Mass Measurement
      - Cardiovascular Screenings
      - Colorectal Cancer Screenings
      - Diabetes Screenings
      - Immunizations
      - Glaucoma Tests

        - Screening Mammograms
        - Pap Test and Pelvic Exam
        - Physical Exam
        - Prostate Cancer Screening
        - Smoking Cessation
    - Do the Medicare covered preventive services offered before the Deductible is met have the same cost shares that are described in Section B for the Medicare covered services after the Deductible is met? Yes/No

11. (**LESSONS LEARNED)** Optional Supplemental Packages:
    - This Section has been redesigned. A plan will now Add/Delete an Optional Supplemental Package on the Optional Supplemental Package Management Screen.
    - On the Optional Supplemental – Label and Premium Screen
        - A plan will enter the package description and premium amount
        - A plan may indicate a Maximum Plan Benefit Package Coverage Amount for the package.
    - On the Optional Supplemental – Service Categories Screen
        - The first picklist (on the left) should be used to indicate the service categories included in this package that have optional supplemental benefits that were declared in Section B, Section C – POS, and/or Section C – V/T.
            - All categories with an Optional Supplemental benefit previously declared (in Section B or Section C) must include that service category in at least one package. An edit validation rule has been used to check this.
        - The second picklist should be used to select the other service categories included in this package, i.e., step-up benefits, non-standard benefits, that were not previously declared in Section B, Section C – POS, and/or Section C – V/T.
    - As part of the new optional supplement data entry redesign, plans that offer Out-of-Network benefits will have new data entry screens that collect minimum/maximum optional supplemental OON cost sharing in one or more of the following nine service categories:
        - 7b – Chiropractic Services
        - 7f – Podiatry Services
        - 10a – Ambulance Services
        - 16a – Preventive Dental
        - 16b – Comprehensive Dental
        - 17a – Eye Exams
        - 17b – Eye Wear
        - 18a – Hearing Exams
        - 18b – Hearing Aids
    - Where applicable, plans will still be able to describe detailed cost sharing for step-up benefits in one or more of the following nine service categories:
        - 7b – Chiropractic Services

- 7f – Podiatry Services
- 10a – Ambulance Services
- 16a – Preventive Dental
- 16b – Comprehensive Dental
- 17a – Eye Exams
- 17b – Eye Wear
- 18a – Hearing Exams
- 18b – Hearing Aids

PBP Medicare Prescription Drug (Rx) Section

1. (**REGULATORY GUIDANCE)** The Medicare Part D benefit description has been updated.

2. (**TECHNICAL ISSUE)** For Defined Standard plans, the question 'Indicate number of tiers in your Part D benefit' does not default to '1'; plans should indicate the number of Tiers that matches the number of Tiers in the plan's Formulary.

3. (**CMS GUIDANCE)**Long Term Care Pharmacy has been added to the list of a Network Components and the Location(s) where drugs can be obtained.

4. (**LESSONS LEARNED, LANGUAGE CLARIFICATION)** The In-Network locations have been updated to specify 'Retail' Pharmacy: In-Network Retail Pharmacy; In-Network Preferred/Non-Preferred Retail Pharmacy.

5. (**ON SCREEN CLARIFICATION, LESSONS LEARNED)**The following label has been added on Rx – General Screen 1:
   - Defined Standard plans should indicate the number of tiers contained in the formulary that is associated with their plan even though a defined standard plan only has one cost share of 25% throughout its entire benefit.

6. (**ON SCREEN CLARIFICATION, CMS POLICY)** The following fields have been added on Rx - General Screen 2:
   - The following labels have been added:
     - Scenario 1: If your plan offers a $0 co-pay for the first $100 of any generic prescriptions filled and also offers a $0 co-pay for the first fill of Lipitor prescription, you should answer 'yes' to 'Do you offer free Generics up to a maximum amount' and enter $100 as the monetary amount. You should also answer 'yes' to 'Do you offer a free first fill for any drugs' and indicate the NDC for Lipitor in the flat file which will be uploaded through the Formulary Submission Module on June 5th, 2007.
     - Scenario 2: If your plan offers a $0 co-payment for the first fill of a limited number of generic medications you should only answer 'yes' to the question 'Do you offer a free first fill for any drugs' and indicate these

specific medications in a flat file which will be uploaded through the Formulary Submission Module on June 5th, 2007.

- Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program? (List OTCs in Notes)
- Do you restrict access to any drugs to certain specialty pharmacies?
- Do you offer free Generics up to a maximum amount?
  - (If Yes) Enter maximum amount for free Generics
- Do you offer a free first fill (i.e., $0 copayment) for any drugs?

Note: The questions for 'free Generics' and 'free first fill for any drugs' will only be enabled for plans with a Basic or Enhanced Alternative benefit.

- Does this plan offer national in-network prescription coverage?
  - Yes (the beneficiary can use this plan to get their prescription drugs in any of the 50 states)
  - No (In-network prescription coverage only in certain areas of the country)

7. **(CMS POLICY, SOFTWARE CLARIFICATION)** The options for 'Indicate the Out-of-Network cost sharing structure for this plan' have been revised as follows"
   - In-Network Coinsurance
   - In-Network Copay plus a differential between the OON billed charge and the In-network allowable
   - In-Network Copay with Limited Days Supply

8. (**TECHNICAL, SOFTWARE EDIT RULES)** The Tier location/supply amounts have been revised as follows:
   - Out-of-Network Pharmacy - three month supply has been removed
   - Out-of-Network Pharmacy – Other day supply must be greater than or equal to 10 days and but less than or equal to 29 days
   - Long Term Care Pharmacy - one month supply has been available. The one month supply cannot be less than 31 or greater than 34 days.

9. **(CMS POLICY, SOFTWARE CLARIFICATION)** The reference-based pricing question has been revised as follows:
   - Do you have reference-based pricing that affects cost sharing for any drugs in this Tier?
   - Reference-based Pricing that affects cost sharing example: Beneficiary pays copayment plus the difference in cost between the brand and its associated generic when the beneficiary chooses the brand name medication.

10. **(CMS SUBREGULATORY GUIDANCE, CALL LETTER)** For plans offering the Enhanced Alternative benefit, the ICL question on the Alternative ICL screen has been revised as follows:
    - Do you apply the Medicare-defined Part D Standard Initial Coverage Limit (ICL) Amount?
      - Yes

- No, enter amount
- No ICL (Full Gap Coverage)

11. **(CMS SUBREGULATORY GUIDANCE, CALL LETTER)** For plans offering the Enhanced Alternative benefit, the following question(s) have been added on the Alternative ICL screen:
    - Do you offer any limited benefit above your ICL?
    - (If Yes) Enter the limited monetary amount
    - A Label has been added: Example: Your plan has an ICL of $2400. You offer $500 in generic coverage post ICL. This is a limited benefit above your ICL.

12. **(CMS SUBREGULATORY GUIDANCE, CALL LETTER)** On the Alternative ICL screen, a label has been added defining Coverage thru the Gap: Gap Coverage Definition: Medicare defines Gap Coverage as coverage of either a tier(s) or specific drugs through the entire gap, (i.e., ICL to catastrophic).

13. **(CMS SUBREGULATORY GUIDANCE, SOFTWARE CLARIFICATION)** The following field has been added to the Alternative ICL Screen:
    - Please Indicate which drug types this limited benefit applies to:
        - Generic
        - Preferred Generic
        - Brand
        - Preferred Brand
        - All formulary Drugs

14. **(NEW CMS SUBREGULATORY POLICY IN CY2008)** The following label has been added to the Alternative- Excluded Drugs and Pre-ICL screen:
    - If you select 'No' (only a limited number of drugs on this tier are covered through the gap), you must indicate these specific medications in a flat file which will be uploaded through the Formulary Submission Module on June 5th, 2007.

15. **(CMS SUBREGULATORY GUIDANCE, SOFTWARE ENHANCEMENT)** On the Alternative ICL screen, if the plan indicates that it offers Gap Coverage, then the following question has been enabled:
    - In general, describe the full Gap Coverage your plan offers:
        - All Generics
        - All Preferred Generics
        - Only Select Generics
        - All Brands
        - All Preferred Brands

- Only Select Brands
- All Drugs on your Formulary

16. **(CMS SUBREGULATORY GUIDANCE, SOFTWARE CLARIFICATION)** For plans with an Enhanced Alternative benefit that offer gap coverage, if the plan selects 'Yes' for "Is the member cost share for any drugs in this Tier less than 100%?," then the following question has been enabled on the Gap Tier Coverage screen:
    - Select the drug types in this Tier that are covered in the Gap:
        - All Generics
        - All Preferred Generics
        - All Non-Preferred Generics
        - Only Select Generics
        - All Brands
        - All Preferred Brands
        - All Non-Preferred Brands
        - Only Select Brands

17. **(CMS SUBREGULATORY GUIDANCE, SOFTWARE CLARIFICATION)** The following labels have been added on the Gap Tier Coverage screen:
    - Gap Coverage Definition: Medicare defines Gap Coverage as coverage of either a tier(s) or specific drugs through the entire gap, (i.e., ICL to catastrophic).
    - If Tier 1 contains all of your plan's generics plus a few brand medications, you should choose "All Generics" and "Only Select Brands"; if your plan is covering a subset of medications from Tier 1 and they are generics, you should choose "Only Select Generics."
    - Example 1: Tier 1 is indicated as a generic tier and is covered in its entirety through the gap. Tier 4 is a specialty tier and contains a few drugs that are technically generic (e.g. ribavirin) but not being treated as generic. None of the medications on Tier 4 are covered through the gap. The plan would select it covers "All Generics" through the gap since it is covering all drugs that are being treated as generic Pre-ICL.
    - Example 2: Tier 1 contains all designated generics and a low percentage of brand name medications. Tier 1 is covered through the entire gap. The plan would indicate that it covers "All Generics" and "Only Select Brands" through the gap.

18. (**TECHNICAL)** No more than one Tier may be identified as a Specialty Tier; i.e., Specialty Tier: 'Yes'.

19. (**TECHNICAL, CMS GUIDANCE)**The Out-of-Network Pharmacy location and the Long-Term Care Pharmacy location are not required to be selected in the Gap Tiers.

20. **(CMS SUBREGULATORY GUIDANCE, SOFTWARE CLARIFICATION)** The following question has been added to the Alternative Gap Tier Coverage Screen: “Are all drugs on this tier covered through the gap?”

21. (**CMS POLICY GUIDANCE)** Stand-alone 800-series PDPs (Direct PDPs and EGWP PDPs) are only required to complete section A in the PBP. All 800-series MA-PDs (EGWP MA-PDs) are still required to complete all Sections of the PBP except the Rx Section. All 800-series plans do not need to complete the Part D BPT for CY2008 bids. The MA BPT is still required for applicable 800-series plans.

CY 2008 Formulary File Format Changes

1. (**UPDATE BASED ON PBP UPDATED)**The "Drug_Type_Label_Value" sample field values were changed to the following: 1 = Generic, 2 = Preferred Generic, 3 = Non-Preferred Generic, 4 = Brand, 5 = Preferred Brand, 6 = Non-Preferred Brand. This field is always required.

2. (**TECHNICAL, CMS POLICY)**The "Therapeutic_Category_Name" field is now required for all formulary models.

3. (**TECHNICAL, CMS POLICY)** The "Therapeutic_Class_Name" field is now required for all formulary models.

4. (**CMS POLICY, ADDITIONAL BENEFIT CLARIFICATION)** The "Step_Therapy_YN" field was changed to require the capture of step one level drugs.

5. (**TECHNICAL)** The "Step_Therapy_Type_Group_Step_X" field range of valid values was changed from 2 to 99 to 1 to 99.

6. (**CMS SUBREGULATORY POLICY)** A new field, "Specialty_Pharmacy_YN", has been added. It is required. Valid values are 1 = Yes or 0 = No.

7. (**CMS SUBREGULATORY POLICY)** A new field, "PA_Group_Description", has been added. This field shall consist of 100 characters and shall required if the Prior_Authorization_YN field = 1 (Y).