LIST OF CHANGES TO THE 2010 PBP SOFTWARE (PRA)

1. REQUIREMENT: *Reinstate the Foreign V/T functionality in section C of the PBP*
   SOURCE: Internal
   PBP SCREEN/CATEGORY: C-Visitor/Travel – Foreign
   DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_09_12.5
   Page(s): 48-57
   CITATION: 42 CFR 422.256
   REASON WHY CHANGE IS NEEDED: To allow for standard data entry fields of foreign V/T benefit. In CY 2009, this had to be entered as a non-Standard benefit.
   IMPACT ON BURDEN: Decrease in burden

2. REQUIREMENT: *Add the following question: "Do you charge the Medicare-defined cost shares?" to the Section C (OON) Inpatient Hospital and SNF screens.*
   SOURCE: Internal
   PBP SCREEN/CATEGORY: Section C – OON – Inpatient – Base 1 Screen
   DOCUMENT AND PAGE NUMBER:
   PBP_2010_screenshots_sec_c_2008_09_12.5.doc
   Page(s): 4, 5, 8
   CITATION: 42 CFR 422.256
   REASON WHY CHANGE IS NEEDED: Since the Medicare-defined hospital cost-sharing isn't released until September, this allows organizations to indicate the amount they are offering in June with the PBP deadline, without having to submit a plan correction in September.
   IMPACT ON BURDEN: Decrease in burden

3. REQUIREMENT: *Add minimum and maximum coinsurance data entry fields for Part B Chemo drugs and other Part B drugs*
   SOURCE: Internal
   PBP SCREEN/CATEGORY: Section B – 15 – Medicare Part B Prescription Drugs – Base 1 Screen
   DOCUMENT AND PAGE NUMBER:
   PBP_screenshots_sec_b_2008_09_12.doc
   Page(s): 174-175
   CITATION: 42 CFR 422.256
   REASON WHY CHANGE IS NEEDED: Needed to capture the full range of drug cost-sharing. In CY 2009, only one amount was captured, meaning that the full cost sharing could only be accurately reflected in the notes.
   IMPACT ON BURDEN: Minimal increase in burden

4. REQUIREMENT: Wording change to PBP_C_CSR_OUTPT_GROUP_NUM:
   Indicate how many groups you offer for reduced cost sharing when members voluntarily pre-authorize. (excluding Inpatient Hospital Services) (Optional):

SOURCE: Internal
PBP SCREEN/CATEGORY: Section C – Cost Share Reduction – Groups – Group Screen
DOCUMENT AND PAGE NUMBER:
PBP_2010_screenshots_sec_c_2008_09_12.5.doc
Page(s): 33
CITATION: 42 CFR 422.254
REASON WHY CHANGE IS NEEDED: Since this screen will be enabled for PFFS contracts, the language needed to be modified to be applicable to both PFFS and RPPO plan types.
IMPACT ON BURDEN: None

5. REQUIREMENT: *Add 'Non-preferred Generics' to the pick list for description of Gap coverage.*
SOURCE: Internal
PBP SCREEN/CATEGORY: Rx-Basic/Enhanced Alternative
DOCUMENT AND PAGE NUMBER:
PBP_screenshots_Medicare_Rx_Drugs_2008_19_12
Page(s): 19
CITATION: 42 CFR 423.272
REASON WHY CHANGE IS NEEDED: To be more descriptive of type of Gap Coverage being offered.
IMPACT ON BURDEN: None

6. REQUIREMENT: *For HMOPOS plans - need to require that they answer "yes" to the question "Do you offer a POS option?" If they aren't offering POS, then the org should be a regular HMO.*
SOURCE: Internal
PBP SCREEN/CATEGORY: C-POS
DOCUMENT AND PAGE NUMBER:
PBP_2010_screenshots_sec_c_2008_09_12.5.doc
Page(s): 29
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: Needed as an edit rule so organizations select the correct plan types when creating plans.
IMPACT ON BURDEN: None

7. REQUIREMENT: Label Added:
Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.
(MRX_TIER_LBL_INSTR)

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your

keyboard.
(MRX_GEN_LOC_INSTR)
SOURCE: Internal
PBP SCREEN/CATEGORY: Rx-General Screens/ Multiple
DOCUMENT AND PAGE NUMBER:
PBP_screenshots_Medicare_Rx_Drugs_2008_19_12
Page(s): 6, 15, 22, and 28
CITATION: 42 CFR 423.272
REASON WHY CHANGE IS NEEDED: This is an area of confusion for organizations, so CMS has added on-screen labels to help with data entry.
IMPACT ON BURDEN: Decreased burden

8. REQUIREMENT: *There is a requirement to add the following question on Service Category 7a - PCP Base 2 screen: "Do you Offer In-Area Network Urgent Care Services?"*
   SOURCE: Internal
   PBP SCREEN/CATEGORY: Section B – 7a – Primary Care Physician – Base 2 Screen
   DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3
   Page(s): 57e
   CITATION: 42 CFR 422.256
   REASON WHY CHANGE IS NEEDED: Since the In-Area Network Urgent Care is an optional benefit, CMS needed to further clarify if an organization was choosing to offer this benefit.
   IMPACT ON BURDEN: minimal increase.

9. REQUIREMENT: *There is a requirement to add a Notes field at the end of each set of Optional Supplemental - Out-of-Network screens.*
   SOURCE: Industry
   PBP SCREEN/CATEGORY: Section D – Optional Supplemental – Out-of-Network - 7b – Chiropractic Services Screen, Section D – Optional Supplemental – Out-of-Network - 7f – Podiatry Services Screen, Section D – Optional Supplemental – Out-of-Network - 10b – Transportation Services Screen, Section D – Optional Supplemental – Out-of-Network - 16a – Preventive Dental Services Screen, Section D – Optional Supplemental – Out-of-Network - 16b – Comprehensive Dental Services Screen, Section D – Optional Supplemental – Out-of-Network - 17a – Eye Exams Screen, Section D – Optional Supplemental – Out-of-Network - 17b – Eye Wear Screen, Section D – Optional Supplemental – Out-of-Network - 18a – Hearing Exams Screen, Section D – Optional Supplemental – Out-of-Network – Step up
   DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_d_2008_12_11
   Page(s): 29, 33, 37, 45, 54, 58, 65, 71, 77
   CITATION: 42 CFR 422.256
   REASON WHY CHANGE IS NEEDED: To allow organizations more flexibility in describing their optional supplemental benefit design.
   IMPACT ON BURDEN: None

10. REQUIREMENT: *There is a requirement to include B-14a Health Ed/Wellness in the plan-level max enrollee out-of-pocket limit Medicare picklists because there are benefits (e.g., smoking cessation) that are covered by Medicare.*

    Note: B-14a should also remain in the non-Medicare picklists (similar to dental, vision and hearing cats that contain primarily non-Medicare benefits).
    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section D – Max Enrollee Cost Limit (Combined) – Base 1 Screen, Section D – Max Enrollee Cost Limit (Combined) – Base 2 Screen, Section D – Max Enrollee cost Limit (In-Network) Screen, Section D – Max Enrollee Cost Limit (Out-of-Network) Screen, Section D – Max Enrollee Cost Limit (Non-Network) Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_d_2008_12_11 Page(s): 10, 11, 12, 13, 14
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: Since the Medicare-Covered smoking cessation benefit can be found in PBP category B-14a, this PBP service category must now be present in Medicare picklists.
    IMPACT ON BURDEN: Minimal Burden for those plans with enrollee out-of-pocket limits.

11. REQUIREMENT: *There is a requirement to add PBP Section B20 Prescription Drugs to the Section C Visitor/Travel benefit subcategories for Cost plans without Medicare Part D benefits.*

    SOURCE: Industry
    PBP SCREEN/CATEGORY: Section C – POS – General – Base 1 Screen, Section C – POS – General – Base 3 Screen, Section C – V/T – General –U.S. – Base 1 Screen, Section C – V/T – General –U.S. – Base 2 Screen, Section C – V/T – General – Foreign – Base 1 Screen, Section C – V/T – General – Foreign – Base 2 Screen, Section C – V/T – General – Foreign – Base 3 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3 Page(s): 13, 15, 39, 40, 50, 51, 52
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To allow plans greater flexibility to indicate the service categories that apply to the Visitor/Travel benefit.
    IMPACT ON BURDEN: Minimal Burden for those plans that have B-20 enabled. No burden for all other plan types.

12. REQUIREMENT: *There is a requirement to create a separate Section C Cost Share Reduction section for PFFS plans.*

    Added new variable: Do you offer cost sharing for members that pre-notify for services? (PFFS Only)

    SOURCE: Internal

PBP SCREEN/CATEGORY: Section C – Cost Share Reduction – General – Base 1 Screen
DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11 Page(s): 27
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: PFFS plans may offer reduced cost sharing for members that pre-notify for services. CMS needs to capture this data in the PBP so it can be review by CMS as well as alert beneficiaries to these benefits.
IMPACT ON BURDEN: Minimal Burden for PFFS plans.

13. REQUIREMENT: *There is a requirement to add the following question to the Section C (**POS**) Inpatient Hospital and SNF screens after both Coinsurance and Copayment Yes/No fields:*

    "Do you charge the Medicare-defined cost shares?

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section C – POS – Inpatient – Base 2 Screen, Section C – POS – Inpatient – Base 3 Screen, Section C – POS – Inpatient – Base 4 Screen, Section C – POS – Inpatient – Base 5 Screen, Section C – POS – SNF – Base 1 Screen, Section C – POS – SNF – Base 2 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11 Page(s): 18, 19, 20, 21, 22, 23
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: Since the Medicare-defined hospital cost-sharing isn't released until September, this allows organizations to indicate they are offering the Medicare defined amount in June with the PBP deadline, without having to submit a plan correction in September.
    IMPACT ON BURDEN: Decrease in burden

14. REQUIREMENT: *There is a requirement to add the following question to the Section C (V/T - US) Inpatient Hospital and SNF screens after both Coinsurance and Copayment Yes/No fields:*

    "Do you charge the Medicare-defined cost shares?"

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section C – V/T – Inpatient – U.S. – Base 1 Screen, Section C – V/T – Inpatient – U.S. – Base 2 Screen, Section C – V/T – Inpatient – U.S. – Base 3 Screen, Section C – V/T – Inpatient – U.S. – Base 4 Screen, Section C – V/T – SNF – U.S. – Base 1 Screen, Section C – V/T – SNF – U.S. – Base 2 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11 Page(s): 42, 43, 44, 45, 46, 47,
    CITATION: 42 CFR 422.256

REASON WHY CHANGE IS NEEDED: Since the Medicare-defined hospital cost-sharing isn't released until September, this allows organizations to indicate they are offering the Medicare defined amount in June with the PBP deadline, without having to submit a plan correction in September.
IMPACT ON BURDEN: Decrease in burden

15. REQUIREMENT: *There is a requirement to add the following question to the Section C (CSR) Inpatient Hospital and SNF screens after both Coinsurance and Copayment Yes/No fields:*

    "Do you charge the Medicare-defined cost shares?"

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section C – Cost Share Reduction – Inpatient – Base 2 Screen, Section C – Cost Share Reduction – Inpatient – Base 3 Screen, Section C – Cost Share Reduction – Inpatient – Base 4 Screen, Section C – Cost Share Reduction – SNF – Base 1 Screen, Section C – Cost Share Reduction – SNF – Base 2 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11 Page(s): 30, 31, 32, 33, 34
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: Since the Medicare-defined hospital cost-sharing isn't released until September, this allows organizations to indicate they are offering the Medicare defined amount in June with the PBP deadline, without having to submit a plan correction in September.
    IMPACT ON BURDEN: Decrease in burden

16. REQUIREMENT: *There is a requirement to add the following question to the Section C (V/T - Foreign) Inpatient Hospital and SNF screens after both Coinsurance and Copayment Yes/No fields:*

    "Do you charge the Medicare-defined cost shares?"

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section C – V/T – Inpatient – Foreign – Base 1 Screen, Section C – V/T – Inpatient – Foreign – Base 2 Screen, Section C – V/T – Inpatient – Foreign – Base 3 Screen, Section C – V/T – Inpatient – Foreign – Base 4 Screen, Section C – V/T – SNF – Foreign – Base 1 Screen, Section C – V/T – SNF – Foreign – Base 2 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11 Page(s): 54, 55, 56, 57, 58, 59
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: Since the Medicare-defined hospital cost-sharing isn't released until September, this allows organizations to indicate they are offering the Medicare defined amount in June with the PBP deadline, without having to submit a plan correction in September.

IMPACT ON BURDEN: Decrease in burden

17. REQUIREMENT: *There is a requirement to provide an on-screen label indicating that a user must edit (and not clear entirely) the currently displayed text in the Benefit Description field in PBP Section B13 to avoid losing previously entered data in the same section.*

    SOURCE: Industry
    PBP SCREEN/CATEGORY: Section B – 13e – Other – Base 1 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3
    Page(s): 130
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To clarify data entry in the "Other" PBP benefits category, and to help users not accidentally delete their data entry.
    IMPACT ON BURDEN: None

18. REQUIREMENT: *There is a requirement to add "Each plan must indicate a specific Tier for their Exceptions Process" and "Is this Tier your Exceptions Tier" to PBP Section Rx General screens Pre-ICL.*

    Only one tier per plan may be indicated as the Exceptions Tier.

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Medicare Prescription Drugs Section – Alternative – Pre-ICL Label Screen, Medicare Prescription Drugs Section – Alternative – Gap Tier Label
    DOCUMENT AND PAGE NUMBER:
    PBP_2010_screenshots_Medicare_Rx_Drugs_2008_12_11_v3
    Page(s): 14, 21
    CITATION: 42 CFR 423.265
    REASON WHY CHANGE IS NEEDED: To help clarify for CMS and beneficiaries the cost sharing a beneficiary will be expected to pay for drugs obtained through the exceptions process.
    IMPACT ON BURDEN: Minimal.

19. REQUIREMENT: *There is a requirement to modify the Section D Max ENR OOP Cost Limit Screen service category picklist to reflect exclusions (rather than inclusions) in OOP Max for both Medicare-Covered (A/B) services and Non-Medicare-Covered services.*

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section D – Max Enrollee Cost Limit (Combined) – Base 1 Screen, Section D – Max Enrollee Cost Limit (Combined) – Base 2 Screen, Section D – Max Enrollee cost Limit (In-Network) Screen, Section D – Max Enrollee Cost Limit (Out-of-Network) Screen, Section D – Max Enrollee Cost Limit (Non-Network) Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_d_2008_12_11

Page(s): 10, 11, 12, 13, 14
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: To show CMS and beneficiaries the categories being excluded from the Out-of-Pocket Max instead of what is included. This is an easier format for CMS to review and beneficiaries to understand.
IMPACT ON BURDEN: None

20. REQUIREMENT: *There is a requirement to add a question specifying whether or not PBP Section C Visitor/Travel uses the same cost sharing as Section B. If not, this should then enable the cost share fields in the Visitor/Travel section.*

    SOURCE: Industry
    PBP SCREEN/CATEGORY: Section C – V/T – Inpatient – U.S. – Base 1 Screen, Section C – V/T – SNF – U.S. – Base 1 Screen, Section C – V/T – Inpatient – Foreign – Base 1 Screen, Section C – V/T – SNF – Foreign – Base 1 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_c_2008_12_11
    Page(s): 42, 46, 54, 58
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: If the Visitor/Travel cost sharing is the same for the categories as was entered in Section B of the PBP, than no further data entry is required.
    IMPACT ON BURDEN: Decreases burden.

21. REQUIREMENT: *There is a requirement to modify Section B Category 12 to include Minimum and Maximum fields for Coinsurance and Copayment.*
    SOURCE: Industry
    PBP SCREEN/CATEGORY: Section B – 12 – Renal Dialysis – Base 1 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3
    Page(s): 117
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: Needed to capture the full range of cost-sharing. In CY 2009, only one amount was captured, meaning that the full cost sharing could only be accurately reflected in the notes.
    IMPACT ON BURDEN: Minimal increase in burden

22. REQUIREMENT: *There is a requirement to modify PBP Section B-13 C to be "Part C OTC Drugs." This category requires the standard "Big 8" questions:*

    -Enhanced (Mandatory or Optional Supplemental) benefits
    -Maximum Plan Benefit Coverage
    -Maximum Enrollee Out-of-Pocket costs
    -Coinsurance
    -Deductible
    -Copayments
    -Authorization

-Referral

This category may be both Optional and Mandatory and impacts picklist fields in both PBP Sections C and D. This change will also necessitate new language for the Summary of Benefits.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 13c – Part-C OTC Drugs – Base 1 Screen, Section B – 13c – Part-C OTC Drugs – Base 2 Screen, Section B – 13c – Part-C OTC Drugs – Base 3 Screen
DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3 Page(s): 124, 125, 126
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: Standardizing the data entry for Part C Over-the-counter drugs.
IMPACT ON BURDEN: Decrease in burden due to standardization.

23. REQUIREMENT: *There is a requirement to add phone extensions to Section A. They will be pre-populated from HPMS.*
    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section A – A-3 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_a_2008_12_11 Page(s): 3
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To display the phone number extensions in the summary of benefit introductions.
    IMPACT ON BURDEN: No impact.

24. REQUIREMENT: *There is a requirement to add the following label on all Section D Maximum Enrollee Out-of-Pocket Screen screens:*

    "CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is $xxxx."

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section D – Max Enrollee Cost Limit (Combined) – Base 1 Screen, Section D – Max Enrollee Cost Limit (Combined) – Base 2 Screen, Section D – Max Enrollee cost Limit (In-Network) Screen, Section D – Max Enrollee Cost Limit (Out-of-Network) Screen, Section D – Max Enrollee Cost Limit (Non-Network) Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_d_2008_12_11 Page(s): 10, 11, 12, 13, 14
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To alert users to the CMS recommended out-of-pocket maximum, as is discussed in the Call Letter.
    IMPACT ON BURDEN: No impact.

25. REQUIREMENT: *There is a requirement to add the following question if user selects either 3-month retail/mail order supply, or other supply (greater than 34 days):*

    "Are all of the drugs on this tier available at the extended day(s) supply?"

    There is a requirement to add the following on-screen label: "Select Yes if you chose a 3-month supply at the In-Network Retail Pharmacy and/or you have an other day supply greater than your one month supply."

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Medicare Prescription Drugs Section – Actuarially Equivalent – Pre-ICL Tier Location Screen, Medicare Prescription Drugs Section – Alternative – Pre-ICL Locations Screen, Medicare Prescription Drugs Section – Alternative – Gap Tier Locations Screen, Medicare Prescription Drugs Section – General Location/Supply
    DOCUMENT AND PAGE NUMBER:
    PBP_2010_screenshots_Medicare_Rx_Drugs_2008_12_11_v3
    Page(s): 6, 15, 23, 29
    CITATION: 42 CFR 423.265
    REASON WHY CHANGE IS NEEDED: To alert CMS and beneficiaries if all drugs or only a subset of drugs on a given tier are available at the extended day supply.
    IMPACT ON BURDEN: Minimal increase in burden.

26. REQUIREMENT: *There is a requirement to remove the GENERAL Max plan benefit coverage question, and create SEPARATE benefit level max plan benefit coverage questions for contacts, eye glasses, eye glass lenses, eye glass frames, and upgrades.*

    These changes apply to both Section B and Section D - Opt Supp Step-up screens.

    SOURCE: External
    PBP SCREEN/CATEGORY: Section B – 17b – Eye Wear – Base 3 Screen, Section B – 17b – Eye Wear – Base 4 Screen; Section D – Step-Up – 17b – Eye Wear – Base 4 Screen, Section D – Step-Up – 17b – Eye Wear – Base 5 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3; PBP_2010_screenshots_sec_d_2008_12_11
    Page(s): 194, 195; 62, 63
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To allow organizations greater flexibility when creating their benefit structures.
    IMPACT ON BURDEN: Reduced Impact as plans no longer have to indicate this information in the notes section of the PBP.

27. REQUIREMENT: *There is a requirement enhance the brand-only deductible screen to identify which Tiers do NOT apply to the deductible. The deductible screens shall be updated as follows:*

Does the deductible apply to all tiers?
Yes (end of questions)
No (continue answering questions below)

- Is the tier cost share during the deductible phase the same as the Pre-ICL cost sharing for all locations?
Yes (answer question #1 below)
No (answer question #2 below)

1. Please indicate each tier for which the deductible will not apply (please note that the deductible will not apply to any of the drugs on each tier selected)
o Tier 1
o Tier 2
o Tier 3
o Tier 4 (etc - depending on the number of tiers the plan has)

2. Indicate the type of cost sharing structure for this tier(s) until the deductible is reached.
o Coinsurance
o Copayment
o Greater of Coinsurance and Copayment
o Lesser of Coinsurance and Copayment

Enter Coinsurance:
Enter Copayment:

To which tier(s) does this cost share apply? (please note that this cost share will be applied to all drugs on the tier(s) selected.
o Tier 1
o Tier 2
o Tier 3
o Tier 4 (etc - depending on the number of tiers a plan has
SOURCE: Internal
PBP SCREEN/CATEGORY: Medicare Prescription Drugs Section – Alternative – Deductible Screen
DOCUMENT AND PAGE NUMBER:
PBP_2010_screenshots_Medicare_Rx_Drugs_2008_12_11_v3
Page(s): 12
CITATION: 42 CFR 423.265
REASON WHY CHANGE IS NEEDED: To allow organizations greater flexibility to apply the deductible at the tier-level.
IMPACT ON BURDEN: Minimal increase in burden.

28. REQUIREMENT: *There is a requirement to remove Custodial Care as an enhanced benefit under the B6 - Home Health service category.*
    SOURCE: Industry
    PBP SCREEN/CATEGORY: Section B – 6 –Home Health – Base 1 Screen, Section B – 6 –Home Health – Base 2 Screen, Section B – 6 –Home Health – Base 3 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3 Page(s): 52, 53, 54
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: CMS does not consider Custodial Care an enhanced benefit.
    IMPACT ON BURDEN: Reduced Burden

29. REQUIREMENT: *There's a requirement to modify the Gap Coverage and Partial Tier Gap Coverage description:*

    -Does this include all formulary drugs? (Y/N)
    If Yes, than the below questions would be disabled.

    -Does this include generics? (Y/N)
    (Radio buttons - PBP users can only select one generic type)
    -All
    -Many
    -Some
    -Few
    -None

    -Does this include brand drugs (Y/N)
    (Radio buttons - PBP users can only select one)
    -All
    -Many
    -Some
    -Few
    -None

    An on-screen label shall also be added:
    Proposed Gap Description Note for CY 2010 PBP:

    CY 2010 gap coverage descriptions should be indicated as follows: Generic and 'Brand' products are classified according to the drug type labels assigned by Part D sponsors on approved Part D formulary files. A product is defined by its distinct: drug type label, dosage form, route of administration, and gap coverage status. Gap coverage status is determined at the tier level or by using partial tier drug lists. Please note that if the plan's formulary utilizes a specialty tier, the drugs sitting on that tier are included in this analysis.

Generic:
'All': 100% of generic drugs are covered through the gap
'Many': 65% to 100% of generic drugs are covered through the gap
'Some': 10% to 65 % of generic drugs are covered through the gap
'Few': 0% to 10% of generic drugs are covered through the gap (and must also be 15 products covered through the gap

Brand:
'All': 100% of generic drugs are covered through the gap
'Many': 65% to 100% of generic drugs are covered through the gap
'Some': 10% to 65 % of generic drugs are covered through the gap
'Few': 0% to 10% of generic drugs are covered through the gap (and must also be 15 products covered through the gap

'All Formulary Drugs': 100% of 'Generic' and 100% of 'Brand' products (either by covering all drug products in the gap or by having no initial coverage limit).
CMS reserves the right to change these thresholds.

SOURCE: Internal
PBP SCREEN/CATEGORY: Medicare Prescription Drugs Section – Alternative – ICL Screen, Medicare Prescription Drugs Section – Alternative – Gap Coverage Screen
DOCUMENT AND PAGE NUMBER:
PBP_2010_screenshots_Medicare_Rx_Drugs_2008_12_11_v3
Page(s): 19, 20
CITATION: 42 CFR 423.265
REASON WHY CHANGE IS NEEDED: To create greater consistency between the PBP gap coverage indication and the Medicare.gov tools as well as provide users with greater clarity with the gap coverage indications.
IMPACT ON BURDEN: No Impact.

30. REQUIREMENT: *There is a requirement to make the following changes to the Home Infusion screens under Service Category B15:*

    Change the following sentence from: 'Does the plan provide Part D home infusion drugs as a supplemental benefit under Part C?' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory a supplemental benefit under Part C?'

    Change the note below the sentence above to make sure it is changed consistent with the language above (add the 'part of a bundled service as a mandatory" language).

    Add a note under the first note stating: 'If you select `Yes' to `Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory a supplemental benefit under Part C?', you must ensure that your benefit includes not only the home infusion drug, but also any services and supplies associated with the home infusion drug's administration.'

Everywhere else where we refer to 'Home Infusion drugs' on the PBP screenshot, instead change the reference to 'Home Infusion bundled services'.

SOURCE: Internal
PBP SCREEN/CATEGORY: B – 15 – Part C Home Infusion drugs
DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3 Page(s): 175
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: To provide organizations further clarity to the bundled Home Infusion Drug Benefit.
IMPACT ON BURDEN: None

31. REQUIREMENT: *There is a requirement to add an on-screen label for B13-E "Other" Service Category:*

    "Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, respite, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13C."

    SOURCE: Internal
    PBP SCREEN/CATEGORY: Section B – 13e – Other – Base 1 Screen
    DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_b_2008_12_11_v3 Page(s): 130
    CITATION: 42 CFR 422.256
    REASON WHY CHANGE IS NEEDED: To provide organizations further clarity on what is allowable in the "other" service category sections.
    IMPACT ON BURDEN: None

32. REQUIREMENT: *There is a requirement to add a new screen in Section D to collect differential category-level deductibles for Regional PPOs only. The new screen should be placed after the In-network deductible screens:*

    The new screen after the In-Network Deductible screens should include the following fields:

    "Do you have differential service category-level deductibles in addition to your In-Network Plan-level Deductible?" Yes/No

    "Select all of the Service Categories to which the differential deductibles apply:"

    For each service category selected above, "Indicate Differential Deductible Amount for:"

    There is an edit rule that validates the sum of all In-Network differential deductibles match the total plan level deductible.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section D – Plan Deductible (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 1, Section D – Plan Deductible (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 2, Section D – Plan Deductible (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 3
DOCUMENT AND PAGE NUMBER: PBP_2010_screenshots_sec_d_2008_12_11 Page(s): 4, 5, 6
CITATION: 42 CFR 422.256
REASON WHY CHANGE IS NEEDED: To provide RPPOs standard data entry if they choose to have a differential deductible by service category.
IMPACT ON BURDEN: Reduced burden by creating standardized data entry.

List of Changes to the 2010 Formulary and Supplemental Record Layouts (PRA)

1. Formulary File Record Layout Changes:
   - The NDC field has been replaced with the RxNorm_RxCUI field.

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Formulary File Record Layout 12122008-FINAL
     Page(s): 1-4
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: These changes are needed to the formulary file to utilize RxNorm nomenclature for CY 2010 formularies.
     IMPACT ON BURDEN: Decrease in burden

   NOTE: The following changes were listed in the 60-day PRA comment period for the Formulary File Record Layout. They have been canceled and will not be implemented

   - The Quantity_Limit_Days field has been removed.
   - The Quantity_Limit_Amount field description has been updated to indicate that the amount is based on 31 days.
   - The Step_Therapy_YN field has been added. Valid values are 0 = No or 1 = Yes.
   - The Step_Therapy_Type field has been moved after the Step_Therapy_Step_ Value field. Valid Values are 1 = Step Therapy Applies or 2 = Step Therapy Applies to New Starts Only.
   - The Prior Authorization Group Description field has been removed.

2. Step Therapy Record Layout Changes:
   - The Step Therapy submission has been changed from a Word document format to a text-delimited upload. The new file format includes the following fields:
     - Step_Therapy_Group_Description (100 characters maximum).
     - Step_Therapy_Criteria (4000 characters maximum).

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Step Therapy Record Layout 09182008- FINAL
     Page(s): 1
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: Step Therapy criteria will now be required to be submitted via a tab delimited text file. This will enable HPMS to validate submissions to ensure that every drug requiring step therapy on the formulary file has ST criteria submitted, and vice versa.
     IMPACT ON BURDEN: Increase in burden

3. Gap Coverage, Free First Fill, and Home Infusion Record Layout Changes:
   - The NDC field in the Gap Coverage, Free First Fill, and Home Infusion record layouts has been replaced with RxNorm_RxCUI.

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Gap Coverage File Record Layout 10302008 FINAL; CY 2010 Free First Fill File Record Layout 10302008 FINAL; CY 2010 Home Infusion File Record Layout 10302008 FINAL
     Page(s): 1 of each document (3 documents)
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: This change is necessary in order to be consistent with the formulary file record layout.
     IMPACT ON BURDEN: None

4. Over the Counter Record Layout Changes:
   - All fields have been removed EXCEPT the NDC field.

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Over the Counter Record Layout 09182008 FINAL
     Page(s): 1
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: This change results in elimination of duplicative information..
     IMPACT ON BURDEN: Decrease in Burden

5. Excluded Drug Record Layout Changes:
   - The Drug_Name, Strength, Dosage_Form, and Route_of_Administration fields have been removed.
   - The Prior_Authorization_Description field has been renamed to Prior_Authorization_Criteria.
   - The Step_Therapy_Description field has been renamed to Step_Therapy_Criteria.

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Excluded Drugs Record Layout 12052008
     Page(s): 1-3
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: This change results in elimination of duplicative information and to standardize the review for quantity limit amounts.
     IMPACT ON BURDEN: Decrease in Burden

   NOTE: The following changes were listed in the 60-day PRA comment period for the Excluded Drug Record Layout. They have been canceled and will not be implemented.

   - The description for the Quantity_Limit_Amount field has been updated to indicate that the amount is based on 31 days.
   - The Quantity_Limit_Days field has been removed.

6. Prior Authorization Record Layout Changes:
   - The Drugs field has been removed.
   - The PA_Criteria_Change_Indicator has been added. Valid values are 0 = No and 1 = Yes.

     SOURCE: Internal
     DOCUMENT AND PAGE NUMBER: CY 2010 Prior Authorization Record Layout 12122008
     Page(s): 1, 2
     CITATION: 42 CFR 423.120
     REASON WHY CHANGE IS NEEDED: To remove duplication of data entry.
     IMPACT ON BURDEN: Minimal increase in burden.

   NOTE: The following change was listed in the 60-day PRA comment period for the Prior Authorization Record Layout. It has been canceled and will not be implemented.

   - The Prior_Authorization_Group_Description has been replaced with the RxNorm_RxCUI field.