

# CY 2013 PBP/Formulary List of Changes

## CY 2013 PBP Changes

### General

1. The PBP has been updated, so that if a plan indicates it is filing a standard bid for any of the following questions within Section A that corresponding sections status will display as "Complete" instead of "N/A:" "Is your organization filing a standard bid for Section B of the PBP?", "Is your organization filing a standard bid for Section C of the PBP?", and "Is your organization filing a standard bid for Section D of the PBP?"

SOURCE: Industry

PBP SCREEN/CATEGORY: Section A-5, PBP Management Screen for Sections B, C, and D

DOCUMENT: PBP\_2013\_screenshots\_section\_a\_2011\_12\_08.pdf

PAGE(s): 5

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: Information will be generating for these sections in the SB, so "Complete" is more accurate than "N/A"

IMPACT ON BURDEN: No Impact

2. The Notes fields throughout the PBP have been updated to only accept up to 3000 characters, adding a validation that checks for invalid formatting, making sure the notes fields only include ascii text characters, and adding the following label "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." These validations have also been added during the upload process for the same fields.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section A-2 Screen, Section A-6 Screen,

1a Inpatient Hospital-Acute – Base 12 Screen, 1a Inpatient Hospital-Acute (B-Only) – Base 4 Screen, 1b Inpatient Hospital Psychiatric – Base 12 Screen, 1b Inpatient Hospital Psychiatric (B Only) – Base 5 Screen, 2 Skilled Nursing Facility – Base 7 Screen, 2 Skilled Nursing Facility (B Only) – Base 4 Screen, 3 Cardiac and Pulmonary Rehabilitation Services – Base 4 Screen, 4a Emergency Care – Base 4 Screen, 4b Urgently Needed Care – Base 3 Screen, 5 Partial Hospitalization – Base 2 Screen, 6 Home Health Services – Base 3 Screen, 7a Primary Care Physician Services – Base 2 Screen, 7b Chiropractic Services – Base 4 Screen, 7c Occupational Therapy Services – Base 2 Screen, 7d Physician Specialist Services – Base 2 Screen, 7e Mental Health Specialty Services – Base 3 Screen, 7f Podiatry Services – Base 3 Screen, 7g Other Health Care Professional – Base 2 Screen, 7h Psychiatric Services – Base 3 Screen, 7i Physical Therapy and Speech Pathology Services – Base 2 Screen, 8a Outpatient Drug Diagnostic Procedures/Tests/Lab Services – Base 4 Screen, 8b Outpatient Diagnostic/Therapeutic Radiological Services – Base 3 Screen, 9a Outpatient Hospital Services – Base 3 Screen, 9b Ambulatory Surgical Center Services – Base 3 Screen, 9c Outpatient Substance Abuse – Base 3 Screen, 9d Outpatient Blood Services – Base 2 Screen, 10a Ambulance Services – Base 2 Screen, 10b Transportation Services – Base 3 Screen, 11a Durable Medical Equipment – Base 2 Screen, 11b Prosthetics/Medical Supplies – Base 3 Screen, 11c Diabetic Supplies and Services – Base 2 Screen, 12 – End-Stage Renal Disease – Base 2 Screen, 13a Acupuncture – Base 3 Screen, 13b Over The Counter Drugs – Base 3 Screen, 13c Meal Benefit – Base 3 Screen, 13d Other 1 – Base 3 Screen, 13e Other 2 – Base 3 Screen, 13f Other 3 – Base 3 Screen, 13g High Quality Special Needs Plan – Base 3 Screen, 14a Medicare-covered Preventive Services Screen, 14b Supplemental Preventive Health Services – Base 3 Screen, 14c Supplemental Education/Wellness Programs – Base 5 Screen, 14d Kidney Disease Education Services – Base 3 Screen, 14e Diabetes Self-Management Training – Base 3 Screen, 15 Medicare Part B Rx Drugs – Notes (Optional) Screen, 16a Preventive Dental – Base 5 Screen, 16b Comprehensive Dental – Base 6 Screen, 17a Eye Exams – Base 3 Screen, 17b Eye Wear – Base 6 Screen, 18a Hearing Exams – Base 4 Screen, 18b

# CY 2013 PBP/Formulary List of Changes

Hearing Aids – Base 5 Screen, 20 Outpatient Drugs – Notes (Optional) Screen, OON - General- Notes Screen, POS – General - Notes Screen, V/T – General - US Screen, Section D - Notes Screen, Optional Supplemental – Label and Premium Screen, Optional Supplemental – OON Stepup Screen, Optional Supplemental – OON Optional Screen, Step Up #7b Chiropractic Services – Base 4 Screen, Step Up #7f Podiatry Services – Base 3 Screen, Step Up #10b Transportation Services – Base 3 Screen, Step Up #16a Preventive Dental – Base 5 Screen, Step Up #16b Comprehensive Dental – Base 6 Screen, Step Up #17a Eye Exams – Base 3 Screen, Step Up #17b Eye Wear – Base 6 Screen, Step Up #18a Hearing Exams – Base 4 Screen, Step Up #18b Hearing Aids – Base 5 Screen, Medicare Rx - Notes Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_a\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): PBP\_2013\_screenshots\_section\_a\_2011\_12\_08.pdf: 2, 6;

PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf: 12, 16, 28, 33, 40, 44, 48, 52, 55, 57, 60, 62, 66, 68, 70, 73, 76, 78, 81, 83, 87, 90, 93, 96, 99, 101, 103, 106, 108, 111, 113, 115, 118, 121, 124, 127, 130, 133, 136, 137, 140, 145, 148, 151, 154, 160, 166, 169, 175, 179, 184, 189;

PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf: 3, 18, 29;

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf: 19, 21, 23-24, 28, 31, 34, 39, 45, 48, 54, 58, 64;

PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf: 49

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: If characters other than the ascii characters were entered in the PBP notes fields the data was not properly uploading into the HPMS data tables. The change will also decrease the amount of duplicative information entered in the notes fields.

IMPACT ON BURDEN: Low Impact

3. 14a has been updated in the Section C and D picklists from: “Medicare-covered Zero Cost-Sharing Preventive Services” to “Medicare-covered Preventive Services.”

SOURCE: Industry

PBP SCREEN/CATEGORY: Section C: OON – General – Base 2 Screen, OON – Groups – Base 1 Screen, POS – General – Base 1 Screen, POS – General – Base 2 Screen, POS – General – Base 4 Screen, POS – General – Base 5 Screen, POS – Groups – Base 1 Screen; and Section D: Plan Deductible (Combined) – Base 1 Screen, Plan Deductible (Combined) – Base 2 Screen, Plan Deductible (In-Network) Screen, Plan Deductible (RPPO-Differential Deductible) – Base 1 Screen, Plan Deductible (Out-of-Network) Screen, Plan Deductible (Non-Network) Screen, Maximum Enrollee Cost Limit (Combined) – Base 1 Screen, Maximum Enrollee Cost Limit (Combined) – Base 2 Screen, Maximum Enrollee Cost Limit (In-Network) Screen, Maximum Enrollee Cost Limit (Out-of-Network) Screen, Maximum Enrollee Cost Limit (Non-Network) Screen, Maximum Plan Benefit Coverage Screen, Maximum Plan Benefit Coverage (Non-Network) Screen, PFFS Billing Screen, Optional Supplemental – Service Categories Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf

PAGE(s): PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf: 2, 11, 13-14, 16-17, 27;

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf: 1- 4, 7-15, 17, 22

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: Plans do not have to offer the Medicare-covered Preventive Services at zero cost share Out-of-Network or in POS, therefore the picklist names have been updated to lessen confusion.

IMPACT ON BURDEN: No Impact

# CY 2013 PBP/Formulary List of Changes

4. The supplemental file upload date has been updated to "Friday, June 8, 2012 at 12:00pm EST."

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B: 15 Home Infusion Bundled Services Screen, 20 Home Infusion Bundled Services Screen; Section Rx: Medicare Rx General 2 Screen, Alternative – Enhanced Alternative Characteristics Screen, Alternative – Tier Coverage – Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf: 155, 200;

PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf: 2, 24, 37

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To reflect the 2013 deadline.

IMPACT ON BURDEN: No Impact

## **PBP Section A**

1. The following questions have been added on the Section A-5 screen for Sections B and C and will be enabled for the appropriate section if a plan chooses it offers a standard bid: "Do any of these services require prior authorization?" and "Do any of these services require referrals?" If "Yes" is selected to either the Authorization or Referral question, the PBP will enable Authorization and Referral category picklists for each standard bid question. The picklists will only contain categories that have referral/authorization questions available elsewhere in the PBP.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section A-5 Screen,

DOCUMENT: PBP\_2013\_screenshots\_section\_a\_2011\_12\_08.pdf

PAGE(s): 5

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To give plans the opportunity to select they offer a standard bid, even if they require authorization or a referral.

IMPACT ON BURDEN: Lessen Impact

## **PBP Section B**

1. The following PBP service category question has been updated from "Do you offer any Mandatory or Optional Supplemental Benefits?" to a question that includes the name of the Supplemental benefit the plan may or may not choose for each section where this is applicable. (Release 4, 5424)

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B: 1a Inpatient Hospital-Acute – Base 1 Screen, 1b Inpatient Hospital Psychiatric – Base 1 Screen, 2 Skilled Nursing Facility – Base 1 Screen, 3 Cardiac and Pulmonary Rehabilitation Services – Base 1 Screen, 4a Emergency Care – Base 1 Screen, 7b Chiropractic Services – Base 1 Screen, 7f Podiatry Services – Base 1 Screen, 9d Outpatient Blood Services – Base 1 Screen, 10b Transportation Services – Base 1 Screen, 13a Acupuncture – Base 1 Screen, 14b Annual Physical Exam – Base 1 Screen, 14c Supplemental Education/Wellness Programs – Base 1 Screen, 16a Preventive Dental – Base 1 Screen, 16b Comprehensive Dental – Base 1 Screen, 17a Eye Exams – Base 1 Screen, 17b Eye Wear – Base 1 Screen, 18a Hearing Exams – Base 1 Screen, 18b Hearing Aids – Base 1 Screen, 20 Outpatient Drugs – Base 1 Screen; Section D: Step Up #7b Chiropractic Services – Base 1, Step Up #7f Podiatry Services – Base 1 Screen, Step Up #10b Transportation Services – Base 1 Screen, Step Up #16a Preventive Dental – Base 1 Screen, Step Up #16b Comprehensive Dental – Base 1 Screen, Step Up #17a Eye Exams – Base 1 Screen, Step Up #17b Eye Wear – Base 1 Screen, Step Up #18a Hearing Exams – Base 1 Screen, Step Up #18b Hearing Aids – Base 1 Screen,

# CY 2013 PBP/Formulary List of Changes

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf;

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf

PAGE(s): PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf: 1, 17, 34, 45, 49, 63, 74, 100, 104, 116, 138, 141, 156, 161, 167, 170, 176, 180, 185; PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf: 25, 29, 32, 35, 40, 46, 49, 55, 60

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To make data entry uniform throughout the PBP software.

IMPACT ON BURDEN: No Impact

2. The cost sharing questions within Section B have been updated for categories where more than one benefit is offered. A new parent question asking "Is there an enrollee Coinsurance?" has been added. If the answer to this question is "Yes" a new child question has been added that reads: "Select the benefit(s) that have a Coinsurance (Select all that apply)." Individual Coinsurance Minimum/Maximum questions will become enabled for the benefits that the user selects. The copayment questions have been updated in the same layout as the coinsurance questions.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B: 3 Cardiac and Pulmonary Rehabilitation Services – Base 2 Screen, 3 Cardiac and Pulmonary Rehabilitation Services – Base 3 Screen, 7b Chiropractic Services – Base 2 Screen, 7b Chiropractic Services – Base 3 Screen, 7e Mental Health Specialty Services – Base 2 Screen, 7f Podiatry Services – Base 2 Screen, 7h Psychiatric Services – Base 2 Screen, 8a Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 2 Screen, 8a Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 3 Screen, 8b Outpatient Diagnostic and Therapeutic Radiological Services – Base 1 Screen, 8b Outpatient Diagnostic and Therapeutic Radiological Services – Base 2 Screen, 9c Outpatient Substance Abuse – Base 2 Screen, 11b Prosthetics and Medical Supplies – Base 1 Screen, 11b Prosthetics and Medical Supplies – Base 2 Screen, 11c Diabetes Supplies and Services – Base 1 Screen, 11c Diabetes Supplies and Services – Base 2 Screen, 15 Medicare Part B Rx Drugs – Base 1 Screen, 15 Medicare Part B Rx Drugs – Base 2 Screen, 16a Preventive Dental – Base 3 Screen, 16a Preventive Dental – Base 4 Screen, 16b Comprehensive Dental – Base 4 Screen, 16b Comprehensive Dental – Base 5 Screen, 17a Eye Exams – Base 2 Screen, 17b Eye Wear – Base 4 Screen, 17b Eye Wear – Base 5 Screen, 18a Hearing Exams – Base 2 Screen, 18a Hearing Exams – Base 3 Screen, 18b Hearing Aids – Base 3 Screen, 18b Hearing Aids – Base 4 Screen, 20 Outpatient Drugs – Base 3 Screen, 20 Outpatient Drugs – Base 4 Screen; Section D: Step Up #7b Chiropractic Services – Base 2 Screen, Step Up #7b Chiropractic Services – Base 3 Screen, Step Up #7f Podiatry Services – Base 2 Screen, Step Up #16a Preventive Dental – Base 3 Screen, Step Up #16a Preventive Dental – Base 4 Screen, Step Up #16b Comprehensive Dental – Base 4 Screen, Step Up #16b Comprehensive Dental – Base 5 Screen, Step Up #17a Eye Exams – Base 2 Screen, Step Up #17b Eye Wear – Base 4 Screen, Step Up #17b Eye Wear – Base 5 Screen, Step Up #18a Hearing Exams – Base 2 Screen, Step Up #18a Hearing Exams – Base 3 Screen, Step Up #18b Hearing Aids – Base 3 Screen, Step Up #18b Hearing Aids – Base 4 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf

PAGE(s): PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf: 46-47, 63-64, 72, 75, 80, 85-86, 88-89, 98, 109-110, 112-113, 152-153, 158-159, 164-165, 168, 173-174, 177-178, 182-183, 187-188;

PBP\_2013\_screenshots\_section\_d\_2011\_12\_08.pdf: 26-27, 30, 37-38, 43-44, 47, 52-53, 56-57, 62-63

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To eliminate confusion to plan users when the cost share structure is coinsurance for a given service, and copayment for another.

IMPACT ON BURDEN: Low Impact

# CY 2013 PBP/Formulary List of Changes

3. The question "Indicate whether a separate physician/professional service cost share applies" has been updated with the options: "Sometimes" and "No" wherever applicable within the PBP.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B: 8a Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 3 Screen, 8b Outpatient Diagnostic and Therapeutic Radiological Services – Base 2 Screen, 14e Diabetes Self-Management Training - Base 2, 17a Eye Exams - Base 3, OON – Groups – Base 2 Screen, POS – Groups – Base 2 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf,

PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf,

PAGE(s): PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf 86, 89, 150, 169;

PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf: 12, 28

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The only applicable answers to that question are "Sometimes" or "No."

IMPACT ON BURDEN: Low Impact

## **B-1: Inpatient Hospital Services**

1. Plans that offer both Part A and Part B will be allowed to have up to three hospital cost share tiers for In-Network Medicare-covered benefits within B-1a and B-1b. (Release 4, 5414)

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B - 1A - Inpatient Hospital-Acute – Base 2 Screen, Section B – 1B - Inpatient Hospital Psychiatric – Base 2 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 2, 3, 4, 18, 19, 20

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow greater flexibility to plans when defining their Inpatient Acute and Psychiatric Hospital benefits. This new data entry reflects industry trends.

IMPACT ON BURDEN: Medium Impact for plans that offer hospital cost share tiers. Low impact for plans that do not offer hospital cost share tiers.

## **B-4: Emergency Care/Urgently Needed Services and B-7: Health Care Professional Services**

1. All PFFS plans will have Urgently Needed Care enabled for data entry.

SOURCE: Policy

PBP SCREEN/CATEGORY: B-4b

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 53-55

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: All Urgently Needed Care Services are now in B-4b instead of having some in B-7a, therefore all plans need access to B-4b.

IMPACT ON BURDEN: Medium Impact for PFFS plans, No Impact for all other plan types.

2. The label on the 4b-Base 1 screen has been updated to: "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

# CY 2013 PBP/Formulary List of Changes

given the circumstance to obtain the services through the organization offering the MA plan (CFR 422.113(b)(1)(iii).”

SOURCE: Policy

PBP SCREEN/CATEGORY: B-4b Section B – 4B – Urgently Needed Care – Base 1 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 53

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: All Urgently Needed Care Services are now in B-4b instead of having some in B-7a, the label change was made to accommodate this.

IMPACT ON BURDEN: No Impact

3. The In-Area Network Urgent Care Services questions have been removed from B-7a. All Urgent Care Services will be located entirely within B-4b.

SOURCE: Internal

PBP SCREEN/CATEGORY: B-7a, B-4b, B – 4B – Urgently Needed Care – Base 1 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 53

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: This more accurately reflects how Urgent Care Services are offered through Medicare.

IMPACT ON BURDEN: Lessens Impact

4. The following label has been added: “If you have entered a range of cost sharing, you must describe the reason for this range.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – 4B – Urgently Needed Care – Base 3 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 55

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To instruct plans that CMS will require more information when reviewing their benefit design if they have indicated a range of cost sharing.

IMPACT ON BURDEN: No Impact

## **B-8: Outpatient Procedures, Tests, Labs & Radiology Services**

1. Notes fields have been added for each individual sub-service offered within B-8a and B-8b.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – 8A– Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services– Base 4 Screen, Section B – 8B– Outpatient Diagnostic and Therapeutic Radiological Services – Base 3 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 87, 90

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow users to more clearly define what service a note refers to.

IMPACT ON BURDEN: Lessen Impact if the user has notes for the different sub-services offered. No Impact if they do not.

## **B-9: Outpatient Services**

1. The title of Section B9 has been updated from “Outpatient Hospital Services” to “Outpatient Services.”

# CY 2013 PBP/Formulary List of Changes

SOURCE: Internal

PBP SCREEN/CATEGORY: B-9

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 91-101

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: All of the services within B-9 are not administered through a Hospital.

IMPACT ON BURDEN: No Impact

## **B-11: DME, Prosthetics, and Medical & Diabetic Supplies**

1. The following question has been added to the 11a – Base 2 screen: “Are there preferred vendors/manufacturers for DME?”

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – 11A–Durable Medical Equipment– Base 2 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 108

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow plans to indicate if they are offering cost share differences based upon the vendor or manufacturer of DME items.

IMPACT ON BURDEN: Low Impact

2. The following question has been added to the 11c – Base 2 screen: “Do you limit diabetic supplies and services to those from specified manufacturers?”

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – 11C–Diabetic Supplies and Services– Base 2 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 113

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow plans to limit diabetic supplies and services from specified manufacturers.

IMPACT ON BURDEN: Low Impact

## **B-13: Other Supplemental Services**

1. The following label has been added to the Other Base 1 screens: “If providing a supplemental benefit, enter a descriptive title. “Other” is not an acceptable title.”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – 13D–Other 1– Base 1 Screen, Section B – 13E–Other 2– Base 1 Screen, Section B – 13F–Other 3– Base 1 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 125, 128, 131

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To clarify the data entry CMS requires from the plans.

IMPACT ON BURDEN: No Impact

2. 13f: Other 3 has been added as a new category in the PBP. It mirrors the updated format of Section B13d and B13e.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B - 13f Other 3

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

# CY 2013 PBP/Formulary List of Changes

PAGE(s): 131-133

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow plans to enter an additional "Other" category in which to describe benefits offered.

IMPACT ON BURDEN: Low Impact

3. 13g: High Quality SNP Benefit has been added as a new category in the PBP. This section will be for High Quality SNP plans and the format of the screens will be based upon the Other 1, 2, and 3 screens. This section will be enabled for all SNP plans and these plans are not required to complete the Other 1, 2, and 3.

SOURCE: Policy

PBP SCREEN/CATEGORY: B-13g High Quality Special Needs Plan

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 134-136

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To accommodate the entry of benefits that is specific to the services offered by High Quality SNP plans.

IMPACT ON BURDEN: Low Impact

## **B-14: Preventive Services**

1. 14a Medicare-covered Zero Cost-Sharing Preventive Services, has been updated by removing and replacing the \$0 cost sharing preventive services with an attestation that reads "I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing;" adding a note that reads "Plans cannot impose authorization and referral requirements for those services not permitted to have authorization or referral, e.g. mammography;" adding an authorization question that reads "Enrollee must receive Authorization from one or more of the following;" adding a referral question that reads "Is a referral required;" and adding a notes field.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B - 14A-Medicare-covered Preventive Services

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 137

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The PBP software is made available before the final list of Preventive Services will be determined for 2013.

IMPACT ON BURDEN: No Impact

2. B-14b has been updated by changing the title for B14b from "Supplemental Preventive Health Services" to "Annual Physical Exam;" deleting all supplemental benefits except for "Additional Physical Exams" which has been updated to "Annual Physical Exam;" and removing all the periodicity questions.

SOURCE: Policy

PBP SCREEN/CATEGORY: 14B-Annual Physical Exam

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 138-140

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The supplemental benefits that were previously in B-14b are automatically covered under the Medicare-covered Zero Cost-Sharing Preventive Services except for an Annual Physical Exam.

IMPACT ON BURDEN: Lessens Impact



# CY 2013 PBP/Formulary List of Changes

3. The enhanced benefit “Additional Smoking Cessation” has been updated to “Additional Smoking and Tobacco Use Cessation.”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – 14C–Supplemental Education and Wellness Programs– Base 1 Screen, Section B – 14C–Supplemental Education and Wellness Programs– Base 3 Screen, , Section B – 14C–Supplemental Education and Wellness Programs– Base 4 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_b\_2011\_12\_08.pdf

PAGE(s): 141, 143, 144

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To provide greater clarification of the benefit.

IMPACT ON BURDEN: No Impact

## **PBP Section C**

1. The Section C picklists have been updated so that the Medicare-covered and Non-Medicare-covered benefits are in separated out into two picklists.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section C- OON- General- Base 2 Screen, Section C- OON- Groups- Base 1 Screen, Section C- POS- General- Base 1 Screen, Section C- POS- General- Base 2 Screen, Section C- POS- General- Base 4 Screen, Section C- POS- General- Base 5 Screen, Section C- POS- Groups- Base 1 Screen, OON, POS

DOCUMENT: PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf

PAGE(s): 2, 11, 13, 14, 16, 17, 27

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To allow for more accurate data entry of the benefit design.

IMPACT ON BURDEN: Low Impact

2. Medicare Part B Rx Drugs has been added to the POS picklists.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section C- POS- General- Base 1 Screen, Section C- POS- General- Base 2 Screen, Section C- POS- General- Base 4 Screen, Section C- POS- General- Base 5 Screen, Section C- POS- Groups- Base 1 Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_c\_2011\_12\_08.pdf

PAGE(s): 13, 14, 16, 17, 27

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: Medicare Part B Rx Drugs was not in the POS picklists

IMPACT ON BURDEN: Low Impact

## **PBP Section D**

1. The deductible picklists within Section D have been updated by adding “6: Home Health,” and dividing 8b into the following 3 services “8b1: Diagnostic Radiological Services,” “8b2: Therapeutic Radiological Services,” and “8b3: Outpatient X-Rays”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section D- Plan Deductible (Combined) - Base 1 Screen, Section D- Plan Deductible (Combined) - Base 2 Screen, Section D- Plan Deductible (In-Network) – Screen, Section D- Plan Deductible (RPPO-Differential Deductibles) – Base 1 Screen, Section D- Plan Deductible (Out-Of-Network) – Screen, Section D- Plan Deductible (Non-Network) – Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_d\_2011\_12\_08

PAGE(s): 1, 2, 3, 4, 7, 8

# CY 2013 PBP/Formulary List of Changes

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: Home Health was not in the deductible picklists and 8b was expanded to provide consistency with all of the other picklists throughout the PBP.

IMPACT ON BURDEN: Low Impact

2. The Section D Maximum Out of Pocket picklists have been updated to allow plans to select services that are included in a given MOOP rather than excluded.

SOURCE: Internal

PBP SCREEN/CATEGORY: Max Enrollee Cost Limit (Combined) – Base 1 Screen, Max Enrollee Cost Limit (Combined) – Base 2 Screen, Max Enrollee Cost Limit (In-Network) Screen, Max Enrollee Cost Limit (Out-of-Network) Screen

DOCUMENT: PBP\_2013\_screenshots\_section\_d\_2011\_09\_07.pdf

PAGE(s): 9 - 12

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To simplify data entry for users.

IMPACT ON BURDEN: Lessen Impact

## **PBP Section Rx**

1. The Rx General 1 screen has been updated where some fields have been added, removed, or moved from another screen. The Rx General 1 screen's new order is as follows:

"Does your plan offer a Medicare Prescription drug (Part D) benefit?"

"Select the type of drug benefit:"

"Do you have a basic Part D plan (DS, AE, BA) that provides required prescription drug coverage to beneficiaries in the service area covered by this EA plan?"

"Does this EA plan have a zero dollar Part D supplemental premium that satisfies (for this service area) the regulatory requirement at 42CFR §423.104(f)(3)(i) to provide required prescription drug coverage?"

"Describe the components of your network (select all that apply):"

"A plan should specify both preferred and non-preferred mail order pharmacy locations if it will require different cost sharing amounts at different mail order locations, even if both preferred and non-preferred mail order pharmacies are not currently included in its network."

"Does this plan offer national prescription coverage?"

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Medicare RX General 1-- Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 1

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Low Impact

2. The Rx General 2 screen has been updated where some fields have been added, removed, or moved from another screen. The Rx General 2 screen's new order is as follows:

"Does plan utilize floor pricing?"

"Do you offer a free first fill (i.e. \$0 copayment) for any drugs?"

"Example: If your plan offers a \$0 copayment for the first fill of a Lipitor prescription, you should answer "yes" to "Do you offer a free first fill for any drugs" and indicate the RxCUI for Lipitor in the flat file which will be uploaded through the Formulary Submission Module by Friday, June 8, 2012 at 12:00pm EST."

"Are there quantity limits on certain prescription drugs?"

"Is prior authorization required for certain prescription drugs?"

"Do any drugs in your formulary require a step therapy plan?"

# CY 2013 PBP/Formulary List of Changes

“Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?”

“If you select "Yes" to "Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?", you must indicate these specific medications in a flat file which will be uploaded through the Formulary Submission Module by Friday, June 8, 2012 at 12:00pm EST.”

“OTC Medication Attestation statement”

“Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Medicare RX General 2-- Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 2

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use. The question concerning floor pricing was added to allow further clarification on the benefit design by plans.

IMPACT ON BURDEN: Low Impact

3. The Rx General 3 screen has been updated where some fields have been added, removed, or moved from another screen. The Rx General 3 screen's new order is as follows:

“Indicate number of Tiers in your Part D benefit:”

“Are any of your tiers an excluded drug only tier?”

“Does this include a tier for meaningful benefit offerings such as a \$0 vaccine only tier?”

“What is your formulary exception tier?”

“Each plan must indicate one specific cost-sharing tier from its PBP at which it will adjudicate all non-formulary drugs approved through the formulary exceptions process.”

“Although CMS generally allows Part D sponsors to apply only one level of cost sharing from an existing formulary tier to all approved formulary exceptions, sponsors may also elect to apply a second less expensive level of cost sharing for all approved formulary exceptions for generic drugs, so long as this second level is also associated with an existing formulary tier and is uniformly applied to all approved formulary exceptions for generic drugs.”

“When designating the exceptions tier in a PBP submission, sponsors can enter only one level of cost sharing. Thus, a sponsor that has established a second (less expensive) level of cost sharing should indicate the more expensive cost-sharing tier of the two tiers as its Exceptions Tier.”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Medicare RX General 3-- Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 3

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Low Impact

4. The following two questions have been updated on the Alternative - Deductible screen as follows:

“Is the tier cost share during the deductible phase the same as the Pre-ICL cost sharing for all locations?” has been updated to: “During the deductible phase, is the cost-sharing for drugs to which the deductible does not apply, the same as the Pre-ICL cost-sharing for all locations?” and “Indicate the type of cost sharing structure for this tier(s) until the deductible is reached:” has been update to: “Indicate the type of cost sharing structure for these drugs until the deductible is reached:”

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Alternative - Deductible Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

# CY 2013 PBP/Formulary List of Changes

PAGE(s): 23

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To provide clarification of the benefit design.

IMPACT ON BURDEN: No Impact

5. The Rx tier label selection process has been updated for all plans except DS plans. Each plan will answer the questions "Indicate the number of tiers in your Part D benefit:" where a plan will be able to choose between 2-6 tiers. A new screen will contain the tier model options appropriate for the number of tiers the plan offers.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Medicare RX General 3—Screen, Section RX- Medicare RX – Tier 2 Model Screen, Section RX- Medicare RX – Tier 3 Model Screen, Section RX- Medicare RX – Tier 4 Model Screen, Section RX- Medicare RX – Tier 5 Model Screen, Section RX- Medicare RX – Tier 6 Model Screen,

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 3-7

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To simplify the tier naming data entry to allow plans to more easily comply with the CMS guidance.

IMPACT ON BURDEN: Medium Impact

6. The Pre-ICL tier type screens have been updated so that a plan can enter tier drug information for all tiers on one screen. This screen must be completed by all non-DS plans.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section RX- Actuarially Equivalent – Tier Type and Cost Share Structure – Pre-ICL Screen, Section RX- Alternative- Tier Type and Cost Share Structure – Pre-ICL Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 12, 26

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Lessen Impact

7. The Pre-ICL, Gap Coverage and Post-OOP Threshold screens have been updated to allow data entry of all Tier Location information to be performed on one screen in the PBP, instead of requiring plans to enter this information on tier specific pages.

SOURCE: Internal

PBP SCREEN/CATEGORY: Actuarially Equivalent – Tier Locations – Pre-ICL Screen, Alternative – Tier Locations – Pre-ICL Screen, Alternative – Tier Locations – Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_12\_08.pdf

PAGE(s): 13, 27, 38

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Lessen Impact

8. The following edit rule for the Specialty Tier copay values has been updated. If a plan offers the Medicare defined deductible, then the copay is capped at \$150 for a one month supply, \$300 for a two month supply and \$450 for a three month supply. If a plan offers a reduced deductible, including no deductible, then the copay is capped at \$200 for a one month supply, \$400 for two months and \$600 for a three month supply.

SOURCE: Internal

# CY 2013 PBP/Formulary List of Changes

PBP SCREEN/CATEGORY: Alternative – Deductible Screen, Alternative – Enhanced Alternative Characteristics Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 23, 24, 31, 32, 33

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: Two month supply amounts are new for 2013 and the three month supply cap was needed to ensure plans do not charge a higher copay than allowed.

IMPACT ON BURDEN: No Impact

9. The cost sharing screens have been updated so that a plan can enter cost-sharing for all tiers on one screen for each phase of the benefit. This screen will include all tiers, all locations that apply, coinsurance and copayment amounts, and the associated average expected cost-sharing for the coinsurance tier (based on PDE data).

SOURCE: Internal

PBP SCREEN/CATEGORY: Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Gap Screen, Alternative – Mail Order Copayment and Coinsurance – Gap Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 31, 32, 33, 42, 43, 44

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Lessen Impact

10. A daily copayment field has been added for the one month supply cost sharing screens, with a validation that the daily copayment cannot be higher than the one month supply cost-sharing divided by thirty. A description has also been added in the variable help for this field.

SOURCE: Policy

PBP SCREEN/CATEGORY: Actuarially Equivalent – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Actuarially Equivalent – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Actuarially Equivalent – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Gap Screen, Alternative – Mail Order Copayment and Coinsurance – Gap Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 17, 18, 19, 31, 32, 33, 42, 43, 44

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To accommodate the 2013 policy requiring plans to offer daily drug supplies.

IMPACT ON BURDEN: Low Impact

11. The day supply amounts have been updated so that a plan can enter a one month, two month, and/or three month supply for retail and mail order locations. The “other day supply” will not be available for retail or mail order locations.

# CY 2013 PBP/Formulary List of Changes

SOURCE: Policy

PBP SCREEN/CATEGORY: Actuarially Equivalent – Retail Pharmacy Location Supply – Pre-ICL Screen, Actuarially Equivalent – Mail Order Location Supply – Pre-ICL Screen, Alternative – Retail Pharmacy Location Supply – Pre-ICL Screen, Alternative – Mail Order Location Supply – Pre-ICL Screen, Alternative – Retail Pharmacy Location Supply – Gap Screen, Alternative – Mail Order Location Supply – Gap Screen, General Location and Supply Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 14, 15, 28, 29, 39, 40, 48

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The change reflects how drugs are being offered to beneficiaries.

IMPACT ON BURDEN: Low Impact

12. Long Term Care has been updated by giving the plan an option to divide out generic and brand drug supply when choosing their coinsurance and copayment amounts. Both generic and brand drugs will have a one month supply and other day supply option within Long Term Care.

SOURCE: Policy

PBP SCREEN/CATEGORY: Actuarially Equivalent – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Pre-ICL Screen, Alternative – Out-of-Network and Long Term Care Copayment and Coinsurance – Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 19, 33, 44

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The change reflects how drugs are being offered to beneficiaries.

IMPACT ON BURDEN: Low Impact

13. All prorate cost sharing questions and labels have been removed.

SOURCE: Internal

PBP SCREEN/CATEGORY: Medicare Rx General 3 Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 3

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The need for the prorating of cost sharing questions has been superseded by the new daily supply data entry.

IMPACT ON BURDEN: Lessen Impact

14. If a plan indicates partial tier gap coverage for a tier offering additional gap coverage that contains both generics and brands, a new question has been added to ask whether gap coverage is for brands only, generics only, or for both brands and generics.

SOURCE: Internal

PBP SCREEN/CATEGORY: Alternative – Tier Coverage Gap Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 37

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: To clarify what types of drugs are being covered by additional gap coverage.

IMPACT ON BURDEN: Low Impact

# CY 2013 PBP/Formulary List of Changes

15. The Post OOP Threshold Tier Type information and Cost Share information screens have been updated to allow data entry to be performed on two screens in the PBP, instead of requiring plans to enter this information on tier specific pages.

SOURCE: Internal

PBP SCREEN/CATEGORY: Alternative – Tier Type – Post-OOP Threshold Screen, Alternative – Tier Cost Sharing Post-OOP Threshold Screen

DOCUMENT: PBP\_2013\_screenshots\_Medicare\_RX\_Drugs\_2011\_09\_08.pdf

PAGE(s): 46, 47

CITATION: 42 CFR 423.272

REASON WHY CHANGE IS NEEDED: The entire Rx section was redesigned for ease of use.

IMPACT ON BURDEN: Lessens Impact

## Formulary Changes

1. Change: Excluded Drug File - Add explanatory text for Gap\_Coverage\_YN Field: Response should be 1 (Yes) if drug is in full gap tier.

Source: Industry Feedback (Internal, Policy/Reg Change, Industry, etc)

Document: CY2013 Plan Excluded Drug File Layout 12062011

Page: 1

CITATION: 42 CFR 423.120

Reason why change is needed: Clarification for plans

Impact on Burden to plans: Simplification

2. Change: Prior Authorization Criteria File: Add PA\_Change\_Type

Source: Industry Feedback

Document: CY 2013 Plan Prior Authorization File Layout 12062011

Page: 1

CITATION: 42 CFR 423.120

Reason why change is needed: This change simplifies the formulary submission process by allowing users to upload Prior Authorization Criteria File changes at the same time that the formulary is uploaded, thereby eliminating the requirement to wait for the validation email and then upload the changes from the Revise PA/ST Criteria page.

Impact on Burden to plans: This involves the reformatting of the file to add new fields, and will result in a simplified submission process.

3. Change: Step Therapy Criteria File: Add ST\_Change\_Type

Source: Industry Feedback

Document: CY 2013 Step Therapy File Layout 12062011

Page: 1

CITATION: 42 CFR 423.120

Reason why change is needed: This change simplifies the formulary submission process by allowing users to upload Step Therapy Criteria File changes at the same time that the formulary is uploaded, thereby eliminating the requirement to wait for the validation email and then upload the changes from the Revise PA/ST Criteria page.

Impact on Burden to plans: This involves the reformatting of the file to add new fields, and will result in a simplified submission process.

# CY 2013 PBP/Formulary List of Changes

## MTMP

1. Change: Targeting Criteria page: Select if they offer MTM to all of their enrollees or only to the enrollees who meet their targeting criteria per the CMS requirements.

Source: Legislation

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation: Affordable Care Act, MTM Improvements, Section 10328. Title 42 CFR Part 423, Subpart D (§ 423.153(d))

Reason why change is needed: The Affordable Care Act (ACA) under Section 10328 specified changes to Part D MTM programs. In addition, the ACA further requires that the Secretary, in consultation with relevant stakeholders, develop a standardized format for the CMR action plan and summary. In CMS' final rule, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes," which was published in the Federal Register on April 15, 2011, we revised §423.153(d)(1)(vii) to require standardized action plans and summaries to comply with requirements specified by CMS for the standardized format. Annually, sponsors must submit a MTM program description to CMS for review and approval through HPMS in the MTM Program Submission Module. The changes to the Enter/Edit pages in the MTM Module enable CMS to review the sponsors' MTM programs to ensure that they meet the regulatory requirements. In addition, the information collected will enable CMS to perform analyses of the MTM programs to evaluate improved medication use and reduced adverse events (statutory goals) and identify best practices to further improve the MTM programs offered to Medicare Part D beneficiaries.

IMPACT ON BURDEN: No Impact

2. Change: Beneficiary Interventions page: Select how they deliver the written summary which is required to be delivered after a comprehensive medication review (CMR) such as mail, email, web interface, or other.

Source: Legislation

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 7

Reg Citation: Affordable Care Act, MTM Improvements, Section 10328. Title 42 CFR Part 423, Subpart D (§ 423.153(d))

Reason why change is needed: The Affordable Care Act (ACA) under Section 10328 specified changes to Part D MTM programs. In addition, the ACA further requires that the Secretary, in consultation with relevant stakeholders, develop a standardized format for the CMR action plan and summary. In CMS' final rule, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes," which was published in the Federal Register on April 15, 2011, we revised §423.153(d)(1)(vii) to require standardized action plans and summaries to comply with requirements specified by CMS for the standardized format. Annually, sponsors must submit a MTM program description to CMS for review and approval through HPMS in the MTM Program Submission Module. The changes to the Enter/Edit pages in the MTM Module enable CMS to review the sponsors' MTM programs to ensure that they meet the regulatory requirements. In addition, the information collected will enable CMS to perform analyses of the MTM programs to evaluate improved medication use and reduced adverse events (statutory goals) and identify best practices to further improve the MTM programs offered to Medicare Part D beneficiaries.

IMPACT ON BURDEN: No Impact



# CY 2013 PBP/Formulary List of Changes

3. Change: Resources page: Select which MTM provider provides the CMR such as pharmacist, physician, registered nurse, or other qualified provider.

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 9

Reg Citation: Affordable Care Act, MTM Improvements, Section 10328. Title 42 CFR Part 423, Subpart D (§ 423.153(d))

Reason why change is needed: The Affordable Care Act (ACA) under Section 10328 specified changes to Part D MTM programs. In addition, the ACA further requires that the Secretary, in consultation with relevant stakeholders, develop a standardized format for the CMR action plan and summary. In CMS' final rule, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes," which was published in the Federal Register on April 15, 2011, we revised §423.153(d)(1)(vii) to require standardized action plans and summaries to comply with requirements specified by CMS for the standardized format. Annually, sponsors must submit a MTM program description to CMS for review and approval through HPMS in the MTM Program Submission Module. The changes to the Enter/Edit pages in the MTM Module enable CMS to review the sponsors' MTM programs to ensure that they meet the regulatory requirements. In addition, the information collected will enable CMS to perform analyses of the MTM programs to evaluate improved medication use and reduced adverse events (statutory goals) and identify best practices to further improve the MTM programs offered to Medicare Part D beneficiaries.

IMPACT ON BURDEN: No Impact

4. Change: The MTMP Enter/Edit: Multiple Chronic Diseases Screen shall display a new core disease, "Core: Alzheimer's disease" in the Chronic Disease column before the "CORE: Bone Disease-Arthritis-Osteoporosis" on the Specific chronic diseases table.

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 2

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

5. Change: The MTMP Enter/Edit: Multiple Chronic Diseases Screen shall display a new core disease, "Core: End-stage renal disease requiring dialysis" in the Chronic Disease column after the "Core: Dyslipidemia" on the Specific chronic diseases table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 2

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

6. Change: The MTMP Enter/Edit: Multiple Chronic Diseases Screen shall remove the text, "mellitus" for the disease "CORE: Diabetes mellitus" in the Chronic Disease column on the Specific chronic diseases table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 2

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

# CY 2013 PBP/Formulary List of Changes

7. Change: The MTMP Enter/Edit: Multiple Covered Part D Drugs Screen shall display a new drug, “Antiarrhythmics” in the Part D Drug Class column after the “Angiotensin II receptor blockers (ARBs)” on the Specific Part D drug classes apply table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

8. Change: The MTMP Enter/Edit: Multiple Covered Part D Drugs Screen shall display a new drug, “Anticonvulsants” in the Part D Drug Class column after the “Anticoagulants” on the Specific Part D drug classes apply table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

9. Change: The MTMP Enter/Edit: Multiple Covered Part D Drugs Screen shall display a new drug, “Antiplatelets” in the Part D Drug Class column after the “Antineoplastics” on the Specific Part D drug classes apply table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

10. Change: The MTMP Enter/Edit: Multiple Covered Part D Drugs Screen shall display a new drug, “Bisphosphonates” in the Part D Drug Class column after the “Beta-blockers” on the Specific Part D drug classes apply table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

11. Change: The MTMP Enter/Edit: Multiple Covered Part D Drugs Screen shall display a new drug, “Inhaled corticosteroids” in the Part D Drug Class column after the “Diuretics” on the Specific Part D drug classes apply table

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 3

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

12. Change: The MTMP Enter/Edit: Incurred Cost for Covered Part D Drugs shall remove the text description under the title “Incurred Cost for Covered Part D Drugs”, and display the text, “Provide

# CY 2013 PBP/Formulary List of Changes

description of the analytical procedure used to determine if the total annual cost of a beneficiary's covered Part D drugs is likely to equal or exceed the specified annual cost threshold. When selecting "Other" or "Formula", include the specific thresholds or formula." in bold

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 4

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact

13. Change: The MTMP Enter/Edit: Incurred Cost for Covered Part D Drugs shall remove the text, "Incurred one-fourth of specified annual cost threshold in previous quarter" and display the text, "Incurred one-fourth of specified annual cost threshold in previous three months" for the first selection under the Specific Threshold and Frequency

Document: Appendix\_C\_MTMP screenshots\_12132011

Page: 4

Reg Citation:

Reason why change is needed: To better serve users.

IMPACT ON BURDEN: No Impact