CY 2015 PBP/Formulary List of Changes

CY 2015 PBP Changes

PBP Section B

B-4: Emergency Care/Urgently Needed Services

1. The following questions have been removed from Section B4a and B4b: "Is there an enrollee Deductible," "Indicate Deductible amount," "Does ER cost sharing count towards any plan level deductible," and "Indicate the plan-level Deductibles where ER cost sharing counts."
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 4A – Emergency Care – Base 1 Screen, Section B – 4B – Urgently Needed Care – Base 2 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 49, 52
CITATION: (2015 Requirements, 9436)
REASON WHY CHANGE IS NEEDED: To align the benefit design data collection with how policy defines how Emergency Care and Urgently Needed Care Room cost sharing aligns with any plan level deductibles.
IMPACT ON BURDEN: Lessens Burden

2. The following question has been added on the B4c – Base 1 screen: "Is the service-specific Maximum Plan Benefit Coverage amount unlimited?"
SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – 4C – Worldwide Emergency Coverage – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 54
CITATION: (2015 Requirements, 10499)
REASON WHY CHANGE IS NEEDED: To allow plan users to have an unlimited amount covered towards Worldwide Emergency Services.
IMPACT ON BURDEN: Low Impact

B-7: Health Care Professional Services

1. The following question has been removed from the B7c – Base 1 screen: "Do you apply the Medicare coverage limit?"
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 7C – Occupational Therapy Services – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 71
CITATION: (2015 Requirements, 8918)
REASON WHY CHANGE IS NEEDED: Per Medicare policy this question is no longer valid.
IMPACT ON BURDEN: Lessens Burden

2. The cost sharing questions have been updated so that a plan can enter a minimum and maximum coinsurance and/or copayment for all benefits in B7c: Occupational Therapy Services and B7i: PT and SP Services.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 7C – Occupational Therapy Services – Base 1 Screen, 7C – Occupational Therapy Services – MMP – Base 1 Screen, 7I – PT and SP Services – Base 1 Screen

DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 71, 73, 88
CITATION: (2015 Requirements, 10503)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the cost sharing for these service categories.
IMPACT ON BURDEN: Low Impact

3. A validation has been added preventing plans from entering a copayment greater than $60 in B7c: Occupational Therapy Services and B7i: PT and SP Services.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 7C – Occupational Therapy Services – Base 1 Screen, 7I – PT and SP Services – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 71, 73
CITATION: (2015 Requirements, 10525)
REASON WHY CHANGE IS NEEDED: To align the PBP data collection with the Medicare policy defined limit.
IMPACT ON BURDEN: Low Impact

B-13: Other Supplemental Services

1. The following questions have been added on the B13c – Base 1 screen: "How many weeks does your Meal Benefit last," and "What is the maximum number of meals the benefit provides?"
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 13C – Meal Benefit – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 133
CITATION: (2015 Requirements, 10508)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT ON BURDEN: Low Impact

2. Five additional "Other" services have been added to Section B13h: Additional Services.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 1 Screen, 13H – Additional Services – Base 2 Screen, 13H – Additional Services – Base 9 Screen, 13H – Additional Services – Base 10 Screen, 13H – Additional Services – Base 11 Screen, 13H – Additional Services – Base 14 Screen, 13H – Additional Services – Base 15 Screen, 13H – Additional Services – Base 16 Screen, 13H – Additional Services – Base 17 Screen, 13H – Additional Services – Base 18 Screen, 13H – Additional Services – Base 19 Screen, 13H – Additional Services – Base 20 Screen, 13H – Additional Services – Base 24 Screen, 13H – Additional Services – Base 25 Screen, 13H – Additional Services – Base 26 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 148-149, 156-157, 158, 161-167, 171-173
CITATION: (2015 Requirements, 10513)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define MMP benefits offered as part of the benefit package.
IMPACT ON BURDEN: Low Impact

3. The following limit questions have been added for all benefits on the B13h – Base 2 through Base 10 screens: "Is there a limit on the services provided," "Select Non-Medicare Home Health Services where limit applies," "Indicate units a limit will be provided," "Indicate numerical limit on the services provided," and "Select limit on services periodicity."
SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 2 Screen, 13H – Additional Services – Base 3 Screen, 13H – Additional Services – Base 4 Screen, 13H – Additional Services – Base 5 Screen, 13H – Additional Services – Base 6 Screen, 13H – Additional Services – Base 7 Screen, 13H – Additional Services – Base 8 Screen, 13H – Additional Services – Base 9 Screen, 13H – Additional Services – Base 10 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 149-157
CITATION: (2015 Requirements, 10496)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT ON BURDEN: Low Impact

4. The following questions have been added for all benefits on the Section B13h – Base 15 through Base 16 screens: "Is a beneficiary receiving this benefit subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount")," "Minimum monthly payment amount," and "Maximum monthly payment amount."
SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 15 Screen, 13H – Additional Services – Base 16 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 162-163
CITATION: (2015 Requirements, 10507)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT ON BURDEN: Low Impact

5. The following waiver question has been added for all benefits on the B13 – Base 15 screen: "Does any service require qualification for and enrollment in a state-operated waiver program?"
SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 15 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 162
CITATION: (2015 Requirements, 10505)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT ON BURDEN: Low Impact

6. An "Additional Notes (Optional)" field has been added to the B13h – Base 26 screen.
SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 26 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 173
CITATION: (2015 Requirements, 10511)

REASON WHY CHANGE IS NEEDED: To allow more opportunity for plan users to clarify the benefits being offered.
IMPACT ON BURDEN: Low Impact

7. Both the "Notes (Optional)" and "Additional Notes (Optional)" fields on the B13h – Base 26 screen have a 3000 character limit.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 13H – Additional Services – Base 26 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 173
CITATION: (2015 Requirements, 10458, 10511)
REASON WHY CHANGE IS NEEDED: To align these notes fields with the others provided in Section B. It will also correct an error some users experienced when attempting to review the notes on HPMS upon uploading their bids.
IMPACT BURDEN: Low Impact

B-14: Preventive and Other Defined Supplemental Services

1. The following services have been added to Section B14c: Eligible Supplemental Benefits as Defined in Chapter 4: "Bathroom Safety Devices," "Counseling Services," "In-Home Safety Assessment," "Personal Emergency Response System (PERS)," "Additional sessions of Medical Nutrition Therapy (MNT)," "Post discharge In-home Medication Reconciliation," "Re-admission Prevention," and "Wigs for Hair Loss Related to Chemotherapy".
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 2 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 3 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 4 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 5 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 6 Screen, 14C Eligible Supplemental Benefits as Defined in Chapter 4 – Base 7 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGES(s): 178-184
CITATION: (2015 Requirements, 10500)
REASON WHY CHANGE IS NEEDED: To allow more robust benefit categories to be offered and collected in a standardized method.
IMPACT BURDEN: Low Impact

B-16: Dental

1. The following questions have been added to the B16a – Base 5 screen: "Enrollee must receive Authorization from one or more of the following," and "Is a referral required for Preventive Dental Services?"
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 16A Preventive Dental– Base 5 screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGES(s): 199
CITATION: (2015 Requirements, 10501)

REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT BURDEN: Low Impact

B-17: Eye Exams/Eyewear

1. The following questions have been added to the B17a – Base 3 screen and the B17b – Base 6 screen: "Enrollee must receive Authorization from one or more of the following," and "Is a referral required for Eye Exams?"
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 17A Preventive Dental– Base 3 screen, 17B Eyewear – Base 6
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGES(s): 208, 214
CITATION: (2015 Requirements, 10501)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT BURDEN: Low Impact

PBP Section C

POS

1. 8a1: Medicare-covered Diagnostic Procedures/Tests and 8a2: Medicare-covered Laboratory Services have been combined into the following single picklist item in the POS Medicare-covered referral picklist: 8a: Outpatient Diag/Procs/Test/Lab Services
SOURCE: Internal
PBP SCREEN/CATEGORY: Section C – POS – General – Base 4
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_c_2013_12_19.doc
PAGES(s): 16
CITATION: (2015 Requirements, 9699)
REASON WHY CHANGE IS NEEDED: To provide consistency with the In-Network and Point of Service referral choices.
IMPACT BURDEN: Low Impact

2. The following questions have been added to the POS – General – Base 6 screen: "Does this POS benefit service the United States and its territories? If no, please briefly describe geographic limitations," and "Does this POS benefit include all practitioners who are state-licensed or state-certified to furnish the services? If no, please briefly describe provider limitations." (Release 4, 10497)
SOURCE: Internal
PBP SCREEN/CATEGORY: Section C – POS – General – Base 6
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_c_2013_12_19.doc
PAGES(s): 18
CITATION: (2015 Requirements, 10497)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT BURDEN: Low Impact

PBP Section D

1. The following service categories have been removed from all LPPO differential deductible picklists and/or questions on the Plan Deductible LPPO/RPPO screens: “4a: Emergency Care,” and “4b: Urgently Needed Care.”
SOURCE: Internal
PBP SCREEN/CATEGORY: Section D – Plan Deductible LPPO/RPPO Base 3, Plan Deductible LPPO/RPPO Base 3
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_d_2013_11_20.docx
PAGES(s): 3, 4
CITATION: (2015 Requirements, 9436)
REASON WHY CHANGE IS NEEDED: To align the benefit design data collection with how policy defines how Emergency Care and Urgently Needed Care Room cost sharing aligns with any plan level deductibles.
These options are no longer valid.
IMPACT BURDEN: Low Impact

PBP Section Rx

1. The following updates have been made throughout Section Rx:
    - “In-Network Retail” has been updated to “Standard Retail Cost-Sharing.”
    - “In-Network Preferred/Non-Preferred” has been updated to “Preferred Retail Cost-Sharing” and “Standard Retail Cost-Sharing.”

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare Rx General 1 Screen, Actuarially Equivalent – Tier Locations – Pre-ICL Screen, Actuarially Equivalent – Retail Pharmacy Location Supply – Pre-ICL Screen, Actuarially Equivalent – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Deductible Screen, Alternative – Tier Locations – Pre-ICL Screen, Alternative – Retail Pharmacy Location Supply – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Medicare-Medicaid Tier Locations – Pre-ICL Screen, Alternative – Medicare-Medicaid Retail Pharmacy Location Supply – Pre-ICL Screen, Alternative – Medicare-Medicaid Copayment – Pre-ICL Screen, Alternative – Tier Locations – Gap Screen, Alternative – Retail Pharmacy Location Supply – Gap Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Gap Screen, Defined Standard – Locations and Location Supply Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 1, 18-19, 22, 28, 32-33, 36, 41-42, 45, 50-51, 54, 62
CITATION: (2015 Requirements, 10534)
REASON WHY CHANGE IS NEEDED: Updates the data collection to match the changes in Medicare Policy.
IMPACT BURDEN: No Impact

2. The following question has been removed from the Medicare Rx General 1 screen: “Does this plan offer national prescription coverage?”
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare Rx General 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 1
CITATION: (2015 Requirements, 8456)
REASON WHY CHANGE IS NEEDED: This question no longer needs to be asked.

IMPACT BURDEN: Lessens Burden

3. The following question has been added to the Medicare Rx General 2 screen: "Does plan utilize ceiling pricing?"
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare Rx General 2 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 2
CITATION: (2015 Requirements, 8259)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT BURDEN: Low Impact

4. The following cost sharing validations have been added for the Retail two and three month cost-sharing fields:

- If the plan offers both two and three month cost sharing, then the two and three month copay may be no greater than three times the one month copay amount.
- If the plan offers both two and three month cost sharing, then the cost sharing must be identical to one another.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Actuarially Equivalent – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL Screen, Alternative – Retail Pharmacy Copayment and Coinsurance – Gap Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 22, 36, 54
CITATION: (2015 Requirements, 8034, & 10534)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects updated CMS policy.
IMPACT BURDEN: Low Impact

5. The following cost sharing validations have been added for the Mail Order 1-Month cost sharing fields:

- The Mail Order 1-Month copay may not be less than the 1-Month Standard Retail Cost sharing amount.
- The Mail Order 1-Month copay may not be greater than three times the 1-Month Standard Retail Cost sharing amount.
- The Mail Order 1-Month coinsurance must be equal to the 1-Month Standard Retail Cost sharing amount.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Section Rx – Actuarially Equivalent – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Gap Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 23, 37, 55
CITATION: (2015 Requirements, 10534)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects updated CMS policy.
IMPACT BURDEN: Low Impact

6. The following cost sharing validations have been added for the Mail Order two and three month cost sharing fields:

- If the plan offers both two and three month cost sharing, then the two and three month copay may be no greater than three times the one month copay amount.
- If the plan offers both two and three month cost sharing, then the cost sharing must be identical to one another.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Section Rx – Actuarially Equivalent – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL Screen, Alternative – Mail Order Copayment and Coinsurance – Gap Screen
DOCUMENT: PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 23, 37, 55
CITATION: (2015 Requirements, 8034, & 10534)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects updated CMS policy.
IMPACT BURDEN: Low Impact

7. The following question on the Alternative – Tier Type and Cost Share Structure – Gap screen will be enabled for all tiers that offer Part D and excluded drugs: "Indicate the type of drugs covered on your tiers."
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Alternative – Tier Type and Cost Share Structure – Gap Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 48
CITATION: (2015 Requirements, 10533)
REASON WHY CHANGE IS NEEDED: To allow a plan to have full Part D Coverage without including excluded drugs in the Gap for a tier that offers both Part D and excluded drugs.
IMPACT BURDEN: Low Impact

8. Non-MMP plans may not enter a coinsurance above 5% for any tier Post-OOP.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Alternative – Tier Cost Sharing Post-OOP Threshold Screen
DOCUMENT: PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 59
CITATION: (2015 Requirements, 9856)
REASON WHY CHANGE IS NEEDED: Ensures the benefit design follows CMS policy.
IMPACT BURDEN: Low Impact

9. Preferred and Non-Preferred data entry fields have been removed from the Defined Standard – Locations and Location Supply screen.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Defined Standard – Locations and Location Supply Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 62
CITATION: (2015 Requirements, 6947)
REASON WHY CHANGE IS NEEDED: To display more accurate data entry options.
IMPACT BURDEN: Lessens Burden

CY 2015 PBP/Formulary List of Changes

MMP Changes exempt from PRA process

PBP General (MMP Changes)

1. The character limit has been increased to 72 characters for the MMP-specific "Other" services in B6: Home Health Services, B7c: Occupational Therapy Services, B7i: PT and ST Services, B11a: DME, 11b: Prosthetics/Medical Supplies, and B13h: Additional Services.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 6 – Home Health Services – MMP – Base 1 Screen, 7C – Occupational Therapy Services – MMP – Base 1 Screen, 7I – PT and ST – MMP – Base 1 Screen, 11A – DME – MMP – Base 1 Screen, 11B – Prosthetics/Medical Supplies – MMP – Base 1 Screen, 13H – Additional Services – Base 1 Screen, 13H – Additional Services – Base 2 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 62, 73, 90, 117, 122, 148, 149
CITATION: (2015 Requirements, 10512)
REASON WHY CHANGE IS NEEDED: To ensure more accurate description of the benefits included.
IMPACT ON BURDEN: Lessens Burden

2. A "Notes (Optional)" field has been added to the B6: Home Health Services, B7c: Occupational Therapy Services, B7i: PT and SP Services, B11a: DME, and B11b: Prosthetics/Medical Supplies MMP screens.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 6 – Home Health Services – MMP – Base 3 Screen, 7C – Occupational Therapy Services – MMP – Base 2 Screen, 7I – PT and ST – MMP – Base 2 Screen, 11A – DME – MMP – Base 2 Screen, 11B – Prosthetics/Medical Supplies – MMP – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 64, 74, 91, 118, 122
CITATION: (2015 Requirements, 10510)
REASON WHY CHANGE IS NEEDED: To provide users with a dedicated notes space for MMP specific benefits.
IMPACT ON BURDEN: Low Impact

B-6: Home Health Services (MMP Only)

1. The following limit questions have been added for all benefits on the B6 – MMP screens: "Is there a limit on the services provided," "Select Non-Medicare Home Health Services where limit applies," "Indicate units a limit will be provided," "Indicate numerical limit on the services provided," and "Select limit on services periodicity."

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 6 – Home Health Services – MMP – Base 1 Screen, 6 – Home Health Services – MMP – Base 1 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 62, 63
CITATION: (2015 Requirements, 10496)
REASON WHY CHANGE IS NEEDED: To allow plan users to limit any additional Home Health Services in the benefit design.
IMPACT ON BURDEN: Low Impact

2. The following waiver question has been added for all benefits on the B6 – MMP – Base 3 screen: "Does any service require qualification for and enrollment in a state-operated waiver program?"

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – 6 – Home Health Services – MMP – Base 3 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_b_2013_12_19.doc
PAGE(s): 64
CITATION: (2015 Requirements, 10505)
REASON WHY CHANGE IS NEEDED: To allow plan users to indicate if the benefit design requires qualification from the state.
IMPACT ON BURDEN: Low Impact

PBP Section Rx (MMP Only)

1. The MMP tier models have been updated.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare Rx – Medicare-Medicaid Formulary Tier Model 2 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 3 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 4 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 5 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 6 Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 9-13
CITATION: (2015 Requirements, 10517)
REASON WHY CHANGE IS NEEDED: To allow plan users to more accurately define the structure of the benefit.
IMPACT BURDEN: Medium Impact

2. The MMP edit rules have been updated as follows for tiers before the Out-of-Pocket Threshold:
    - Tiers that do not include the term "Non-Medicare" in the label must either apply LIS cost sharing or enter $0 copayment.
    - Tiers with the label "$0 drugs" must enter $0 copayment.
    - Tiers that include both Part D and non-Medicare-covered drugs must enter $0 copayment.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare Rx – Medicare-Medicaid Formulary Tier Model 2 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 3 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 4 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 5 Screen, Medicare Rx – Medicare-Medicaid Formulary Tier Model 6 Screen, Alternative – Pre-ICL Medicare-Medicaid Screen, Alternative – Medicare-Medicaid Copayment – Pre-ICL Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 9-13, 39, 45
CITATION: (2015 Requirements, 10517)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects CMS policy.
IMPACT BURDEN: Low Impact

3. The following cost sharing rules have been added for MMP cost sharing tiers:
    - If a tier includes generic drugs only, then the generic LIS cost sharing is the maximum copayment allowed.

- If a tier includes brand drugs only, then the brand LIS cost sharing is the maximum copayment allowed.
- If a tier includes both brand and generic drugs, then the brand LIS cost sharing is the maximum copayment allowed.
- If a tier includes excluded drugs only, then no cost sharing validations exist.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Alternative – Medicare-Medicaid Tier Type – Pre-ICL Screen, Alternative – Pre-ICL Medicare-Medicaid Screen, Alternative – Medicare-Medicaid Copayment – Pre-ICL Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 39, 40, 45
CITATION: (2015 Requirements, 9801)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects CMS policy.
IMPACT BURDEN: Low Impact

4. The MMP edit rules have been updated so that tiers that include both Part D and non-Medicare-covered drugs must enter $0 copayment for Post-Out-of-Pocket Threshold.
SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx – Medicare-Medicaid Tier Type – Pre-ICL Screen, Alternative – Tier Type and Tier Cost Sharing Post-OOP Medicare-Medicaid Screen
DOCUMENT: Appendix_C_PBP_2015_screenshots_section_ Rx_2013_12_19.docx
PAGES(s): 40, 61
CITATION: (2015 Requirements, 10517)
REASON WHY CHANGE IS NEEDED: To ensure that benefit design reflects CMS policy.
IMPACT BURDEN: Low Impact

Formulary Changes

No changes

MTMP Changes

1. On the CY2015 (Intervention page), a plan user may select a new option by selecting the checkbox for In-person Delivery Method under the Delivery of individualized written summary of Comprehensive Medication Review (CMR) in CMS' standardized format.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 4
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To provide users with the checkbox option to select a method of in-person delivery when applicable for CMR written summary.
   IMPACT BURDEN: No Impact

2. On the CY2015 (Intervention page), a plan user will be required to enter Intervention description for Comprehensive Medication Review (CMR) with summary in Standard Format with a maximum of 4,000 characters.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 4

CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To allow for an intervention description for CMR in a standard text format.
IMPACT BURDEN: Minimal Impact

3. On the CY2015 Intervention page, a plan user will be required to enter Intervention description for Targeted Medication Review (TMR) with a maximum of 4,000 characters.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 4
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To allow for an intervention description for TMR in a standard text format.
   IMPACT BURDEN: Minimal Impact

4. On the CY2015 Intervention page, a plan user is required to enter Intervention description for Prescriber Interventions with a maximum of 4,000 characters.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 5
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To allow for an intervention description for Prescriber Interventions in a standard text format.
   IMPACT BURDEN: Minimal Impact

5. On the CY2015 Intervention Page, a plan user is required to enter Intervention description Other Interventions with a maximum of 4,000 characters.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 5
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To allow for an intervention description for Other Interventions in a standard text format.
   IMPACT BURDEN: Minimal Impact

6. On the CY2015 Resources page, a Plan user may enter up to 5 Name of Disease Management Vendor if Outside personnel and Disease Management Vendor are selected.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 5
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To allow the entry of Outside personnel Disease Management Vendors and/or ‘Other’ Vendors.
   MPACT BURDEN: Minimal Impact

7. On the CY2015 Resources page, a Plan user may select In-house Pharmacists, Local Pharmacists, Physician, Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Physician's Assistant, and up to 10 “Other” fields with information entered for each “Other” field selected for each “Name of Disease Management Vendor” is selected.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf

PAGE(S): 5
CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To provide a method of entering additional Types of Disease Management Vendors and/or 'Other' Vendors.
IMPACT BURDEN: Minimal Impact

8. For 2015, each Disease Management Vendor entered in the CY2015 Resources page will be displayed with a fee table if a Plan user selected the option Fees priced out separately. This will associate a fee table for each "Disease Management Vendor.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 6
   CITATION: Lessons Learned
   REASON WHY CHANGE IS NEEDED: To provide a method for separating out specific fees, billing method, and description when more than one Disease Management Vendor is being submitted.
   IMPACT BURDEN: Minimal Impact

9. On the CY2015/Enter/Edit page, revise edit rules under "Multiple Chronic Conditions" data entry for minimum number of chronic diseases and chronic diseases that apply sections.
   SOURCE: Internal
   DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
   PAGE(S): 1
   CITATION: Pending Regulatory Change
   REASON WHY CHANGE IS NEEDED: To ensure organizations comply with the minimum number of chronic diseases, as defined by regulation.
   IMPACT BURDEN: No impact (selection criteria/pick list is the same)

10. On the CY2015 Enter/Edit page, revise enter/edit rules for minimum number of covered Part D drugs and type of covered Part D drugs that apply sections.
    SOURCE: Internal
    DOCUMENT: Appendix_C_CY2015_MTMP_screenshots_PRA_09102013.pdf
    PAGE(S): 1
    CITATION: Pending Regulatory change
    REASON WHY CHANGE IS NEEDED: To ensure organizations comply with the minimum number of covered Part D drugs and the covered Part D drugs that apply, as defined by the regulation.
    IMPACT BURDEN: No impact (selection criteria/pick list is the same)