

CY 2017 PBP/Formulary List of Changes

CY 2017 PBP Changes

PBP Section A

1. The question, "Under this plan, has the state agreed to cover all Medicare premiums and coinsurance for enrollees in your Full Benefit Dual Eligible SNP, including any that either do not have eligibility for, or have not enrolled in the QMB program?" has been updated to, "Under this D-SNP, has the state agreed to cover all Medicare premiums and coinsurance for enrollees in your D-SNP?" on the Section A-2 screen.

Note:

All D-SNPs must answer this question.

If the user selects "Yes," the plan will be classified as a \$0 Cost Share D-SNP.

If the user selects "No," the plan will be classified as a Non-\$0 Cost Share D-SNP.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section A-2

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_a_and_upload_2015_12_04.docx

PAGE(S): pg. 2

CITATION: (Release 2, 16594)

REASON WHY CHANGE IS NEEDED: To eliminate the 5 D-SNP subtypes for 2017, because they do not appear to be meaningful as they are not reflective of what the state is offering. There will still be a distinction between \$0 D-SNPs and Non-\$0 D-SNPs.

IMPACT BURDEN: No impact

2. If a plan selects "Yes" to the question, "Is your organization filing a standard bid for Section B of the PBP?" on the Section A-5 screen, then the following questions on the Section A-6 screen will be disabled:

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software.)

Select the benefits that have tiered cost sharing.

Select the Medicare-covered benefits that have tiered cost sharing.

Select the Non-Medicare-covered benefits that have tiered cost sharing.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section A-5, Section A-6

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_a_and_upload_2015_12_04.docx

PAGE(S): pgs. 5, 6

CITATION: (Release 1, 16120; Release 2, 16120)

REASON WHY CHANGE IS NEEDED: These questions are not applicable for plans filing a standard bid for Section B.

IMPACT BURDEN: Lessens impact

3. The following standard bid questions have been disabled for MMP plans on the Section A-5 and Section A-6 screens:

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?

Is your organization filing a standard bid for Section D of the PBP?

SOURCE: Internal

PBP SCREEN/CATEGORY: Section A-5, Section A-6

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_a_and_upload_2015_12_04.docx

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PAGE(S): pgs. 5, 6

CITATION: (Release 1, 15050)

REASON WHY CHANGE IS NEEDED: These questions are not applicable to MMPs.

IMPACT BURDEN: Lessens impact

PBP Section B

B-1: Inpatient Hospital Services

1. On the B-1a: Inpatient Hospital-Acute – Base 2 screen, the question, "Do you charge cost sharing on the day of discharge?" has been added for plans that select anything other than "Original Medicare" for the question, "What is your inpatient hospital benefit period?"

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-1a: Inpatient Hospital-Acute – Base 2

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 2

CITATION: (Release 2, 16696)

REASON WHY CHANGE IS NEEDED: There is no standard for plans not using Original Medicare benefit periods as to whether they charge cost sharing on the day of discharge, which did not allow for an accurate assessment of those plans' benefits.

IMPACT BURDEN: Low impact

2. On the B-1b Inpatient Hospital Psychiatric – Base 2 screen, the question, "Do you charge cost sharing on the day of discharge?" has been added for plans that select anything other than "Original Medicare" for the question, "What is your inpatient hospital benefit period?"

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-1b Inpatient Hospital Psychiatric – Base 2

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 18

CITATION: (Release 2, 16696)

REASON WHY CHANGE IS NEEDED: There is no standard for plans not using Original Medicare benefit periods as to whether they charge cost sharing on the day of discharge, which did not allow for an accurate assessment of those plans' benefits.

IMPACT BURDEN: Low impact

B-2: Skilled Nursing Facility (SNF)

1. On the B-2: SNF – Base 2 screen, the question, "Do you charge cost sharing on the day of discharge?" has been added for plans that select anything other than "Original Medicare" for the question, "What is your inpatient hospital benefit period?"

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-2: SNF – Base 2

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 35

CITATION: (Release 2, 16696)

REASON WHY CHANGE IS NEEDED: There is no standard for plans not using Original Medicare benefit periods as to whether they charge cost sharing on the day of discharge, which did not allow for an accurate assessment of those plans' benefits.

IMPACT BURDEN: Low impact

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B-4: Emergency Care/Urgently Needed Services

1. The following question has been added to the B-4a: Emergency Care – Base 1 screen for plans entering coinsurance:

- Indicate the maximum per visit amount.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-4a: Emergency Care – Base 1

DOCUMENT: Appendix_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 52

CITATION: (Release 2, 17534)

REASON WHY CHANGE IS NEEDED: To ensure that the maximum per-visit amount does not exceed the maximum copayment amount for this benefit.

IMPACT BURDEN: Low impact

2. The following question has been added to the B-4a: Emergency Care – Base 2 screen for plans entering cost sharing:

- Does the Emergency Care cost sharing count towards any plan level deductible?

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-4a: Emergency Care – Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 53

CITATION: (Release 2, 17530)

REASON WHY CHANGE IS NEEDED: A plan may choose to apply the Emergency Care cost toward the deductible or not.

IMPACT BURDEN: Low impact

3. The following question has been added to the B-4b: Urgently Needed Services – Base 1 screen for plans entering a coinsurance:

- Indicate the maximum per visit amount.

SOURCE: Internal

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

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 54

CITATION: (Release 2, 17534)

REASON WHY CHANGE IS NEEDED: To ensure that the maximum per-visit amount does not exceed the maximum copayment amount for this benefit.

IMPACT BURDEN: Low impact

4. The following question has been added to the B-4b: Urgently Needed Services – Base 2 screen for plans entering cost sharing:

- Does the Urgently Needed Services cost sharing count towards any plan level deductible?

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-4b: Urgently Needed Services – Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 55

CITATION: (Release 2, 17530)

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REASON WHY CHANGE IS NEEDED: A plan may choose to apply Urgently Needed Services cost towards the deductible or not.

IMPACT BURDEN: Low impact

5. The following question has been added to the B-4c: Worldwide emergency/Urgent Coverage–Base 1 screen:

- Does this benefit include emergency transportation? If yes, describe it in the notes.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-4c: Worldwide emergency/Urgent Coverage –Base 1

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 57

CITATION: (Release 2, 17535)

REASON WHY CHANGE IS NEEDED: To allow plans the flexibility to offer emergency transportation during travel in foreign countries as part of Worldwide Services.

IMPACT BURDEN: Low impact

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

1. The following question has been added to the B-8a: Outpatient Diagnostic Procedures/Tests/Lab Services–Base 3 screen:

- If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – B-8a: Outpatient Diagnostic Procedures/Tests/Lab Services –Base 3

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 97

CITATION: (Release 2, 17546)

REASON WHY CHANGE IS NEEDED: To allow plans the flexibility to indicate that the beneficiary will only pay for one service if they receive more than one service at the same time.

IMPACT BURDEN: Low impact

2. The following question has been added to the B-8b: Outpatient Diagnostic/Therapeutic Radiology Services–Base 2 screen:

- If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – B-8b: Outpatient Diag/Therapeutic Rad Services –Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 99

CITATION: (Release 2, 17546)

REASON WHY CHANGE IS NEEDED: To allow plans the flexibility to indicate that the beneficiary will only pay for one service if they receive more than one service at the same time.

IMPACT BURDEN: Low impact

B-13: Other Supplemental Services

1. The following question has been added on the B-13b: OTC Items - Base 1 screen:

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- Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Note: This question will be enabled if a plan selects every month, three months, or six months for the Maximum Plan Benefit Coverage periodicity.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-13b: OTC Items - Base 1

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 133

CITATION: (Release 2, 17545)

REASON WHY CHANGE IS NEEDED: To allow plans to indicate whether any unused maximum plan amounts carry forward to the next period (e.g. a quarterly maximum may or may not carry forward to the next quarter).

IMPACT BURDEN: Low impact

2. Fifteen additional “Other” services have been added to Section B-13h: Additional Services.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-13h: Additional Services – Base 1, Base 3, B-13h: Additional Services – Bases 12-17, B-13h: Additional Services – Bases 20-22, B-13h: Additional Services – Bases 24-27, B-13h: Additional Services – Bases 29-30, B-13h: Additional Services – Bases 34-37

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pgs 151, 153, 162-167, 170-172, 174-177, 179-180, 184-187

CITATION: (Release 2, 17145)

REASON WHY CHANGE IS NEEDED: There are Medicare-Medicaid Plans that offer more separate additional services than the PBP Additional Services category could accommodate.

IMPACT BURDEN: Low impact

B-14: Preventive and Other Defined Supplemental Services

1. A note is no longer required when “Nutritional/Dietary Benefit” is offered In B-14c: Eligible Supplemental Benefits as Defined in Chapter 4.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1, B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 7

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pgs. 192, 198

CITATION: (Release 2, 17532)

REASON WHY CHANGE IS NEEDED: The PBP collects enough information for a Nutrition/Dietary benefit.

IMPACT BURDEN: Lessens impact

2. The following questions have been added for Counseling Services on the B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1 screen:

- Is this benefit unlimited for Counseling Services?
- Indicate number of visits for Counseling Services:
- Indicate setting for Counseling Services:
- Indicate duration of sessions (in minutes):

SOURCE: Internal

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PBP SCREEN/CATEGORY: Section B – B-14c: Eligible Supplemental Benefits as Defined in Chapter 4– Base 1

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 192

CITATION: (Release 2, 17527)

REASON WHY CHANGE IS NEEDED: To allow for more accurate information to be collected in the PBP.

IMPACT BURDEN: Low impact

3. On the B-14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 2 screen, the questions for the Re-admission Prevention have been updated to the following:

- What does your Re-admission Prevention benefit include (check all that apply):
- Enter name of Service.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-14c Eligible Supplemental Benefits as Defined in Chapter 4- Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 193

CITATION: (Release 2, 17529)

REASON WHY CHANGE IS NEEDED: To allow a plan the flexibility to offer a portion of the Re-admission Prevention benefit.

IMPACT BURDEN: No impact

4. The question, “Indicate number of visits offered for Alternative Therapies” has been added on the B-14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 2 screen.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-14c: Eligible Supplemental Benefits as Defined in Chapter 4– Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 193

CITATION: (Release 2, 17541)

REASON WHY CHANGE IS NEEDED: To allow for more accurate information to be collected in the PBP.

IMPACT BURDEN: Low impact

5. B-14e: Other Medicare-covered Preventive Services has been updated to include the following benefits:

- Glaucoma Screening
- Diabetes Self-Management Training
- Five additional “Other” Medicare-covered Preventive Services.

Note: Each of these benefits includes individual Maximum Enrollee Out-of-Pocket (MOOP) Cost, Coinsurance, Deductible, Copayment, Authorization, Referral, and Notes fields.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-14e: Other Medicare-covered Preventive Services – Bases 1-7

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pgs. 204-210

CITATION: (Release 2, 17526)

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REASON WHY CHANGE IS NEEDED: To allow a plan to accurately depict the cost of Glaucoma screening and any other Medicare-covered preventive services that are not automatically zero cost to the beneficiary, and to minimize any issues in the plan's Out-of-Pocket Cost calculations.

IMPACT BURDEN: No impact

B-18: Hearing Exams/Hearing Aids

1. On the B-18b Hearing Aids - Base 2 screen, the note "Please describe whether the Maximum Plan Benefit Coverage amount is per ear, or for both ears combined, in the Notes field" has been replaced with the question, "Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?"

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – B-18b Hearing Aids - Base 2

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx

PAGE(S): pg. 240

CITATION: (Release 2, 17543)

REASON WHY CHANGE IS NEEDED: To allow plans to indicate whether the maximum applies per hearing aid or for 2 hearing aids combined.

IMPACT BURDEN: No impact

B-19: Value Based Insurance Design (VBID Only)

1. B-19: Value Based Insurance Design (VBID) has been added as a new category in the PBP for plans that offer a VBID. The following 2 new service categories will collect cost sharing information for VBIDs:

- B-19a: VBID Cost Sharing Reductions
- B-19b: VBID - Additional Benefits

SOURCE: Internal

PBP SCREEN/CATEGORY: Section B – B-19: Value Based Insurance Design (VBID Only), all pages

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_b_VBID_2015_12_04.docx

PAGE(S): pgs. 1-104

CITATION: (Release 2, 17387, 17388)

REASON WHY CHANGE IS NEEDED: To accommodate the new VBID demonstrations.

IMPACT BURDEN: Medium impact

PBP Section D

1. If a PPO plan offers a benefit as a mandatory supplemental benefit in Section B, it will be allowed to charge a separate deductible for mandatory supplemental benefits in Section D.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section D – Plan Deductible LPPO/RPPO Bases 2-6.

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_d_2015_12_04.docx

PAGE(S): pgs. 2-6

CITATION: (Release 2, 17592)

REASON WHY CHANGE IS NEEDED: To allow PPO plans the ability to charge a separate deductible for mandatory supplemental benefits.

IMPACT BURDEN: Low impact

2. If an HMOPOS plan has an Optional benefit for one of the following categories, an Optional Supplemental – OON Stepup screen for that associated benefit will be enabled:

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- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b: Transportation Services
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear
- 18a: Hearing Exams
- 18b: Hearing Aids

SOURCE: Industry

PBP SCREEN/CATEGORY: Section D – Optional Supplemental – OON Stepup #7b Chiropractic Services, Optional Supplemental – OON Stepup #7f Podiatry Services, Optional Supplemental – OON Stepup #10b Transportation Services, Optional Supplemental – OON Stepup #16a Preventive Dental, Optional Supplemental – OON Stepup #16b Comprehensive Dental, Optional Supplemental – OON Stepup #17a Eye Exams, Optional Supplemental – OON Stepup #17b Eyewear, Optional Supplemental – OON Stepup #18a Hearing Exams, Optional Supplemental – OON Stepup #18b Hearing Aids.

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_d_2015_12_04.docx

PAGE(S): pg. 28 (generic screen – identical for all service categories)

CITATION: (Release 1, 16340)

REASON WHY CHANGE IS NEEDED: To allow HMOPOS plans the ability to include a POS cost for any optional benefits.

IMPACT BURDEN: Low Impact

3. A picklist with all applicable Optional Supplemental benefits and the following question have been added in Section D on the Optional Supplemental - Label and Premium screen following the question, "Is there an enrollee deductible for this package?":

- Select the benefits to which the deductible applies.
Note: The plan will only be allowed to select benefits in this picklist that are included in that specific Optional Supplemental package.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section D – Optional Supplemental-Label and Premium

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_d_2015_12_04.docx

PAGE(S): pg. 27

CITATION: (Release 2, 17547)

REASON WHY CHANGE IS NEEDED: To allow PPO plans to charge a separate deductible for optional supplemental benefits.

IMPACT BURDEN: Low impact

PBP Section Rx

1. The following questions have been added to the Medicare Rx General 3 screen:

- Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?
- What is the lower level cost sharing Formulary Exceptions Tier?

SOURCE: Industry

PBP SCREEN/CATEGORY: Section Rx – Medicare Rx General 3

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

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PAGE(S): pg. 3

CITATION: (Release 2, 17326)

REASON WHY CHANGE IS NEEDED: to allow plans the ability to include a second less expensive cost sharing tier for generic drugs.

IMPACT BURDEN: Low impact

2. The Medicare Rx - Tier Model screen has been updated to allow the user to select the Tier Model in a table format, instead of using radio buttons.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Medicare Rx – Tier Model (for each model type), Medicare Rx – Medicare-Medicaid Formulary Tier Model (for each model type)

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 4-13

CITATION: (Release 1, 16495; Release 2, 16495)

REASON WHY CHANGE IS NEEDED: When a plan utilized the 125% zoom screen windows feature, the Tier Model selections did not align with the radio buttons.

IMPACT BURDEN: No impact

3. The tier models have been updated to reflect the addition of the “Non-Preferred Drug” tier label and the removal of the “Non-Preferred Generic”.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Medicare Rx – Tier Model, Medicare Rx – Medicare-Medicaid Formulary Tier Model, Actuarially Equivalent – Tier Type and Cost Share Structure – Pre-ICL, Actuarially Equivalent – Tier Type – Post-OOP Threshold, Alternative – Tier Type and Cost Share Structure – Pre-ICL, Alternative – Medicare-Medicaid Tier Type – Pre-ICL, Alternative – Tier Type and Cost Share Structure – Gap, Alternative – Tier Type Post-OOP Threshold

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 4-13, 17, 27, 32, 42, 51, 62

CITATION: (Release 2, 14762)

REASON WHY CHANGE IS NEEDED: The Tier Models have been updated to more closely reflect the structure Part D Sponsors use when creating drug benefit packages.

IMPACT BURDEN: No impact

4. If a plan has a deductible and selects "No" to the question, "Does the deductible apply to all tiers?," the plan will be prevented a from selecting all tiers for the question, "Indicate each tier for which the deductible will NOT apply."

SOURCE: Industry

PBP SCREEN/CATEGORY: Section Rx – Alternative – Deductible

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pg. 29

CITATION: (Release 1, 15049; Release 2, 15049)

REASON WHY CHANGE IS NEEDED: A plan should not be able to select all tiers for this question if it is only intended to apply to a subset of tiers.

IMPACT BURDEN: No impact

5. A validation has been added that will prevent a plan from entering cost sharing (other than \$0) for any "Vaccines (\$0 cost sharing)" tiers.

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SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Actuarially Equivalent – Retail Pharmacy Copayment and Coinsurance – Pre-ICL, Actuarially Equivalent – Mail Order Copayment and Coinsurance – Pre-ICL, Actuarially Equivalent – OON and LTC Copayment and Coinsurance – Pre-ICL, Actuarially Equivalent – Tier Cost Sharing – Post-OOP Threshold, Alternative – Retail Pharmacy Copayment and Coinsurance – Pre-ICL, Alternative – Mail Order Copayment and Coinsurance – Pre-ICL, Alternative – OON and LTC Copayment and Coinsurance – Pre-ICL, Alternative – Medicare-Medicaid Copayment – Pre-ICL, Alternative – Retail Pharmacy Copayment and Coinsurance – Gap, Alternative – Mail Order Copayment and Coinsurance – Gap, Alternative – OON and LTC Copayment and Coinsurance – Gap, Alternative – Tier Cost Sharing Post-OOP Threshold, and Alternative – Tier Type and Tier Cost Sharing Post-OOP Medicare and Medicaid.

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 22-24, 28, 37-39, 47, 57-59, 63, 65

CITATION: (Release 2, 15066)

REASON WHY CHANGE IS NEEDED: Previously, there was no validation preventing plans that selected a vaccines tier (\$0 cost sharing) from entering cost sharing other than zero for that tier.

IMPACT BURDEN: No impact

6. A Clear button has been added to the Daily Copayment Amount Cost Sharing screens that will allow a user to clear all Daily Copay values previously entered on that screen.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Actuarially Equivalent – Daily Copayment Amount Cost Sharing – Pre-ICL, Alternative – Daily Copayment Amount Cost Sharing – Pre-ICL, Alternative – Medicare-Medicaid Daily Copayment Amount Cost Sharing, Alternative – Daily Copayment Amount Cost Sharing – Gap

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 25, 40, 48, 60

CITATION: (Release 2, 15032)

REASON WHY CHANGE IS NEEDED: To allow a plan the ability to clear all of the daily copay values at once instead of one at a time.

IMPACT BURDEN: Lessens impact

7. A validation has been added where if a plan offers coinsurance for the specialty tier (and only the specialty tier), the Average Expected Cost sharing Attestation on the Medicare Rx - Attestations Screen will be not be mandatory.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Medicare Rx – Tier Model (for each model type), Medicare Rx – Medicare-Medicaid Formulary Tier Model (for each model type), Medicare Rx - Attestations

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 4-13, 67

CITATION: (Release 1, 16428; Release 2, 16428)

REASON WHY CHANGE IS NEEDED: Plans that have coinsurance only on their Specialty tier should not be required to attest to an Average Expected Coinsurance Dollar Amount because the Specialty tier is exempt from the rule requiring an Average Expected Coinsurance Dollar Amount.

IMPACT BURDEN: Lessens impact

8. The following question has been added to the Retail Pharmacy Location Supply screen:

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- Which drugs that are limited to a 1-month supply for the first fill are available at an extended day supply?

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Actuarially Equivalent – Retail Pharmacy Location Supply – Pre-ICL, Alternative – Retail Pharmacy Location Supply – Pre-ICL, Alternative – Medicare-Medicaid Retail Pharmacy Location Supply – Pre-ICL, Alternative – Retail Pharmacy Location Supply – Gap

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 19, 34, 44, 54

CITATION: (Release 2, 17714)

REASON WHY CHANGE IS NEEDED: To allow a plan the flexibility to offer some drugs on a tier at an extended day supply without including all drugs on that tier at an extended day supply.

IMPACT BURDEN: Low impact

9. A validation has been added to the Location Supply screens that requires the user to enter the same day supply value for the retail pharmacy locations for all tiers. For example, if a plan has a one month retail supply, it would not be able to enter a day supply value of 30 for Tier 1, 31 for tier 2 and 32 for Tier 3.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx – Actuarially Equivalent – Retail Pharmacy Location Supply – Pre-ICL, Actuarially Equivalent – Retail Pharmacy Location Supply – Pre-ICL, Actuarially Equivalent – OON and LTC Location Supply – Pre-ICL, Alternative – Retail Pharmacy Location Supply – Pre-ICL, Alternative – Mail Order Location Supply – Pre-ICL, Alternative – OON – LTC Location Supply – Pre-ICL, Alternative – Medicare-Medicaid Retail Pharmacy Location Supply – Pre-ICL, Alternative – Medicare-Medicaid Mail Order Location Supply – Pre-ICL, Alternative – Medicare-Medicaid OON and LTC Location Supply – Pre-ICL, Alternative – Retail Pharmacy Location Supply – Gap, Alternative – Mail Order Location Supply – Gap, Alternative – OON and LTC Location Supply – Gap

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pgs. 19-21, 34-36, 44-46, 54-56

CITATION: (Release 2, 15299)

REASON WHY CHANGE IS NEEDED: To ensure consistency in the day supply value within a given location type across tiers.

IMPACT BURDEN: No impact

PBP Section Rx (MMP Only)

1. The following questions and on screen note have been removed from the Alternative - Pre-ICL Medicare-Medicaid screen:

- Is there an annual Maximum Enrollee Out-of-Pocket Cost?
- Indicate the Maximum Enrollee Out-of-Pocket Cost Amount:
- The annual Maximum Enrollee OOP Cost field is only meant to capture any State-required limit on total drug spending for both Medicare and Medicaid-covered drugs. MMPs may not enter the OOP Threshold or Total Covered Part D Spending at OOP Threshold amounts here.
- MMPs may not enter the OOP Threshold or Total Covered Part D Spending at OOP Threshold amounts here. The annual Maximum Enrollee OOP Cost field is only meant to capture any State-required limit on total drug spending for both Medicare and Medicaid-covered drugs.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx (MMP Only) – Alternative - Pre-ICL Medicare-Medicaid

CY 2017 PBP/Formulary List of Changes

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx

PAGE(S): pg. 41

CITATION: (Release 2, 17143)

REASON WHY CHANGE IS NEEDED: No MMPs used the MOOP fields, and they caused confusion with the MOOP limit.

IMPACT BURDEN: Lessens impact

PBP Section Rx (VBID Only)

1. New Section Rx VBID screens have been added to Section Rx for plans that offer a VBID.

SOURCE: Internal

PBP SCREEN/CATEGORY: Section Rx (VBID Only) – all pages

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_Rx_VBID_2015_12_04.docx

PAGE(S): pgs. 1-26

CITATION: (Release 2, 17201)

REASON WHY CHANGE IS NEEDED: To accommodate the new VBID demonstrations.

IMPACT BURDEN: Medium impact

508 Compliance

1. The PBP has been updated to be more compatible with the Job Access With Speech (JAWS) software.

SOURCE: Internal

PBP SCREEN/CATEGORY: All screens

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_a_and_upload_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_b_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_b_VBID_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_c_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_d_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_Rx_2015_12_04.docx,

APPENDIX_C_CY2017_PBP_screenshots_section_Rx_VBID_2015_12_04.docx

PAGE(S): All pages

CITATION: (Release 1, 16241, 15909, 16181, 16082, 16083, 16081)

REASON WHY CHANGE IS NEEDED: The order in which JAWS read questions, buttons, picklists, and other screen features was potentially confusing to the user.

IMPACT BURDEN: Lessens impact

Upload

1. The Summary of Benefits (SB) has been removed from the PBP software, therefore a user will no longer need to Review and Verify the SB.

SOURCE: Internal

PBP SCREEN/CATEGORY: PBP Plan Upload

DOCUMENT: APPENDIX_C_CY2017_PBP_screenshots_section_a_and_upload_2015_12_04.docx,

PAGE(S): 8

CITATION: (Release 1, 16427, 16516, 16535)

REASON WHY CHANGE IS NEEDED: The SB has been removed entirely from the Bid Process

IMPACT BURDEN: Lessens impact

CY 2017 Formulary Changes

CY 2017 PBP/Formulary List of Changes

1. CMS will collect a new supplemental file containing RxCUIs for the drugs not available at an extended day's supply under the Part D plan's benefit.

SOURCE: CMS, Internal

DOCUMENT: Not available at this time.

PAGE(S): N/A

CITATION: 42 CFR 423.120

REASON WHY CHANGE IS NEEDED: Bene protection – if not all drugs are covered at the extended day supply, the bene currently does not know which drugs are and are not covered at the extended day supply (e.g., 60 days).

IMPACT BURDEN: Medium Impact

CY 2017 MTMP Changes

1. A Plan user must provide 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 (\$3,507). When selecting "Other" or "Formula", include the specific thresholds or formula selected for Specific Threshold and Frequency on the /edit/EditPageA_3.asp (Incurred Cost for Covered Part D Drugs) page.

SOURCE: CMS, Internal

DOCUMENT: Appendix_C_CY2017_MTMP_screenshots_PRA_09102015.pdf

PAGE(S): 1

CITATION: Lessons Learned

REASON WHY CHANGE IS NEEDED: To meet the business needs

IMPACT BURDEN: No Impact

2. A Plan user may select Delivery of a copy of beneficiary CMR summary for Specific Prescriber Interventions under the Recipient of Interventions on the /edit/EditPageD.asp (Resources) page.

SOURCE: CMS, Internal

DOCUMENT: Appendix_C_CY2017_MTMP_screenshots_PRA_09102015.pdf

PAGE(S): 1-2

CITATION: Lessons Learned

REASON WHY CHANGE IS NEEDED: To meet the business needs

IMPACT BURDEN: No Impact