CY 2018 PBP/MTMP/Formulary List of Changes

CY 2018 PBP Changes

PBP Section A

1. The question, "Indicate CY 2018 total estimated monthly Medicare membership for this plan:" on the Section A-2 screen has been updated to "Indicate CY2018 total projected member months for this plan:" In addition, the question has been updated as follows:

- The character length for the text box has been expanded from 9 to 10 characters.
- The following pop-up message has been added when a user enters this field:
  "Please confirm that you are entering projected member months because this question has changed from previous years."
- This field is required for all plans that are not required to submit a BPT.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section A-2
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_a_and_upload_2016_12_12.pdf
PAGE(S): pg. 2
CITATION: (Release 1, Requirement 20329, & Release 2, Requirement 20861)
REASON WHY CHANGE IS NEEDED: To accommodate a larger number and to clarify the question.
IMPACT BURDEN: No impact

2. If a plan selects "Yes" to the standard bid questions on the Section A-5 or A-6 screens, the following pop-up has been added:

- "You have chosen to offer a standard bid. This option requires the PBP to auto-populate a large number of PBP fields with standard values, an internal operation that can take up to several minutes, depending on the particular configuration of your computer or network. During this time, you may be unable to continue data entry, and performance on a network setup may be adversely affected, especially for any users currently logged in. Please allow additional time to complete this operation properly upon Exit (with Validation) from Section A."

  HPMS recommends that plans with the PBP software installed on their networks complete any Standard Bid data entry off the network first, then add data to the network environment."

SOURCE: Industry
PBP SCREEN/CATEGORY: Section A-5, Section A-6
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_a_and_upload_2016_12_12.pdf
PAGE(S): pg. 5, 6.
CITATION: (Release 2, Requirement 21189)
REASON WHY CHANGE IS NEEDED: To inform plans that they should NOT perform a standard bid from a network drive and that they should allow some time for the PBP to populate data when filling out a standard bid.
IMPACT BURDEN: Low impact

PBP Section B

1. The authorization questions in Section B have been updated from "Enrollee must receive Authorization from one or more of the following:" with five selection options to "Is authorization required?" with "Yes/No" responses.

SOURCE: Industry

PBP SCREEN/CATEGORY: Section B – B-1a: Inpatient Hospital-Acute – Base 12, B-1b: Inpatient Hospital Psychiatric – Base 12, B-1b: Inpatient Hospital Psychiatric (B Only) – Base 4, B-2: SNF – Base 10, B-2: SNF (B-Only) – Base 4, B-3: Cardiac and Pulmonary Rehabilitation Services – Base 4, B-5: Partial Hospitalization – Base 2, B-6: Home Health Services – Base 3, B-6: Home Health Services – MMP – Base 3, B-7b: Chiropractic Services – Base 2, B-7c: Occupational Therapy Services - Base 2, B-7c: Occupational Therapy Services – MMP - Base 2, B-7d: Physician Specialist Services – Base 2, B-7e: Mental Health Specialty Services – Base 3, B-7f: Podiatry Services – Base 3, B-7g: Other Health Care Professional – Base 2, B-7h: Psychiatric Services – Base 3, B-7i: PT and SP Services – Base 2, B-7i: PT and ST – MMP – Base 2, B-8a: Outpatient Diag Procs/Tests/Lab Services – Base 4, B-8b: Outpatient Diag/Therapeutic Rad Services – Base 3, B-9a: Outpatient Hospital Services – Base 2, B-9b: ASC Services – Base 2, B-9c: Outpatient Substance Abuse – Base 3, B-9d: Outpatient Blood Services – Base 2, B-10a: Ambulance Services – Base 2, B-10b: Transportation Services – Base 3, B-11a: DME – Base 2, B-11a: DME – MMP – Base 2, B-11b: Prosthetics/Medical Supplies – Base 3, B-11b: Prosthetics/Medical Supplies – MMP - Base 1, B-11c: Diabetic Supplies and Services – Base 2, B-12 Dialysis Services – Base 2, B-13a: Acupuncture – Base 2, B-13c: Meal Benefit – Base 2, B-13d: Other 1 – Base 2, B-13e: Other 2 – Base 2, B-13f: Other 3 – Base 2, B-13g: Dual Eligible SNPs with Highly Integrated Services – Base 2, B-13h: Additional Services – Base 30, B-14a: Medicare-covered Zero Dollar Preventive Services, B-14b: Annual Physical Exam – Base 3, B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 9, B-14d: Kidney Disease Education Services – Base 2, B-14e: Other Medicare-covered Preventive Services – Base 3, B-15: Medicare Part B Rx Drugs – Base 2, B-16a: Preventive Dental – Base 5, B-16b: Comprehensive Dental – Base 6, B-17a: Eye Exams – Base 3, B-17b: Eyewear – Base 6, B-18a: Hearing Exams – Base 3, B-18b: Hearing Aids – Base 5, B-20: Outpatient Drugs – Base 4; Section B-19 VBID Benefits - 19A-1a: Inpatient Hospital-Acute – Base 12, 19A-1b: Inpatient Hospital Psychiatric – Base 12, 19A-2: SNF – Base 10; 19B-1a: Inpatient Hospital-Acute – Base 12, 19B-1b: Inpatient Hospital Psychiatric – Base 4, 19B-2: SNF – Base 10, 19B-3: Cardiac and Pulmonary rehabilitation Services – Base 4, 19B-7b: Chiropractic Services – Base 2, 19B-7f: Podiatry Services – Base 3, 19B-9d: Outpatient Blood Services – Base 2, 19B-10b: Transportation Services – Base 3, 19B-13a: Acupuncture – Base 2, 19B-13c: Meal Benefit – Base 2, 19B-13d: Other 1 – Base 2, 19B-13e: Other 2 – Base 2, 19B-13f: Other 3 – Base 2, 19B-14b: Annual Physical Exam – Base 3, 19B-14c: Eligible Supplemental benefits as Defined in Chapter 4 – Base 9, 19B-16a: Preventive Dental – Base 5, 19B-16b: Comprehensive Dental – Base 6, 19B-17a: Eye Exams – Base 3, 19B-17b: Eyewear – Base 6, 19B-18a: Hearing Exams – Base 3, 19B-18b: Hearing Aids – Base 5.
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
APPENDIX_C_PBP_2018_screenshots_section_b_ VBID_2016_12_12.pdf
PAGE(S): Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf: pg. 12, 28, 32, 43, 47, 51, 61, 64, 67, 71, 74, 76, 78, 81, 84, 86, 89, 91, 93, 97, 100, 102, 105, 109, 111, 113, 116, 118, 120, 123, 124, 126, 128, 130, 136, 139, 142, 145, 148, 179-180, 183, 192, 196, 200, 203, 210, 216, 219, 225, 228, 234, 238; Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ VBID_2016_12_12.pdf: pg. 32, 44, 54, 71, 83, 93, 97, 102, 106, 108, 111, 113, 119, 122, 125, 128, 132, 141, 148, 154, 157, 163, 166, 172.
CITATION: (Release 2, Requirement 21010, 18680)
REASON WHY CHANGE IS NEEDED: The data from the authorization source are not necessary.
IMPACT BURDEN: Lessons burden

B-1: Inpatient Hospital Services

1. The question, "Is the Coinsurance structure for Upgrades the same as the Coinsurance structure for the Medicare-covered stay?" has been added to the B-1a: Inpatient Hospital – Acute - Base 6 screen.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-1a: Inpatient Hospital–Acute – Base 6
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 6

CITATION: (Release 2, Requirement 18631)
REASON WHY CHANGE IS NEEDED: To accommodate plans that offer an upgrade with the same cost structure as their Medicare-covered stay.
IMPACT BURDEN: Low impact

2. The question, “Is the Copayment structure for Upgrades the same as the Copayment structure for the Medicare-covered stay?” has been added to the B-1a: Inpatient Hospital–Acute - Base 12 screen.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-1a: Inpatient Hospital–Acute – Base 12
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 12
CITATION: (Release 2, Requirement 18631)
REASON WHY CHANGE IS NEEDED: To accommodate plans that offer an upgrade with the same cost structure as their Medicare-covered stay.
IMPACT BURDEN: Low impact

3. The benefit period question has been updated as follows:

- The question, "What is your inpatient hospital benefit period?" has been updated to “What is your Inpatient Hospital-Acute benefit period?”
- The “Per Admission" response has been updated to "Per Admission or Per Stay."
- Moved from the B-1a: Inpatient Hospital–Acute - Base 2 screen to the Base 12 screen.
- Will be disabled if a plan indicates it has no cost sharing for the Medicare-covered services.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-1a: Inpatient Hospital–Acute – Base 12
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 12
CITATION: (Release 2, Requirement 20859, 21373, 21427)
REASON WHY CHANGE IS NEEDED: So that plans with no cost sharing do not have to specify an irrelevant benefit period, and to clarify the type of inpatient hospital benefit and the type of benefit period for plans that do have cost sharing.
IMPACT BURDEN: Lessens impact

4. The benefit period question on the B-1b: Inpatient Hospital Psychiatric - Base 12 screen has been updated as follows:

- The question has been updated from "What is your inpatient hospital benefit period?" to “What is your Inpatient Hospital Psychiatric benefit period?”
- The “Per Admission" response has been updated to "Per Admission or Per Stay."
- The question has been moved from the Base 2 screen to the Base 12 screen.
- The question will be disabled if a plan indicates they have no cost sharing for the Medicare-covered services.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-1b: Inpatient Hospital Psychiatric – Base 12
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 28
CITATION: (Release 2, Requirement 20859, 21373, 21427)

REASON WHY CHANGE IS NEEDED: So that plans with no cost sharing do not have to specify an irrelevant benefit period, and to clarify the type of inpatient hospital benefit and the type of benefit period for plans that do have cost sharing.
IMPACT BURDEN: Lessens impact

B-2: Skilled Nursing Facility (SNF)

1. The "Indicate coinsurance/copayment for the Medicare-covered per stay" and "Is there and enrollee deductible" questions have been disabled in Section B-2: SNF.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-2: SNF, Bases 2-3, Bases 6-7.
DOCUMENT: Appendix_C_APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 35-36, 39-40
CITATION: (Release 2, Requirement 20851)
REASON WHY CHANGE IS NEEDED: To ensure that plans adhere to the cost-sharing standard of $0 for the first 20 days for Medicare-covered SNF.
IMPACT BURDEN: Lessens impact

2. The question, "What is your SNF benefit period?" has been updated as follows:

- The “Per Admission" response has been updated to "Per Admission or Per Stay."
- The question has been moved from the B-2: SNF - Base 2 screen to the Base 10 screen.
- The question will be disabled if a plan indicates it has no cost sharing for the Medicare-covered services.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B2: SNF – Base 10
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 43
CITATION: (Release 2, Requirement 20859, 21373)
REASON WHY CHANGE IS NEEDED: So that plans with no cost sharing do not have to specify an irrelevant benefit period, and to clarify the type of benefit period for plans that do have cost sharing.
IMPACT BURDEN: Lessens impact

3. A validation has been added to B-2: SNF that prevents plans from entering cost sharing for the first 20 days of SNF.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-2: SNF – Bases 2-3, 6-7.
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 35-35, 39-40
CITATION: (Release 2, Requirement 21368)
REASON WHY CHANGE IS NEEDED: To ensure that plans adhere to the cost-sharing standard of $0 for the first 20 days for Medicare-covered SNF.
IMPACT BURDEN: Lessens impact

B-3: Cardiac and Pulmonary Rehabilitation Services

1. The question, "Is a referral required?" has been added to the B-3: Cardiac and Pulmonary Rehabilitation Services - Base 4 screen.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – B3: Cardiac and Pulmonary Rehabilitation Services - Base 4
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 51
CITATION: (Release 2, Requirement 18680)
REASON WHY CHANGE IS NEEDED: To capture referral information for these services, consistent with other service categories.
IMPACT BURDEN: Low impact

B-4: Emergency Care/Urgently Needed Services

1. The question, "Indicate the maximum per visit amount:" on the B-4a: Emergency Care - Base 1 screen is optional for Cost Plans.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – B-4a: Emergency Care – Base 1
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 52
CITATION: (Release 2, Requirement 20710)
REASON WHY CHANGE IS NEEDED: The maximum cost-sharing amounts do not apply to Cost Plans.
IMPACT BURDEN: Lessens impact

2. The enhanced benefits in B-4c: Worldwide Emergency/Urgent Coverage have been split into the following three separate benefits:

- Worldwide Emergency Coverage
- Worldwide Urgent Coverage
- Worldwide Emergency Transportation

Note: Separate coverage type, coinsurance, copayment, and hospital waiver questions have been added for each specific benefit.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – B-4c: Worldwide Emergency/Urgent Coverage, Bases 1-2
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 57-58
CITATION: (Release 2, Requirements 18652, 20865)
REASON WHY CHANGE IS NEEDED: To allow for a more accurate data collection of the Worldwide Emergency/Urgent Coverage benefit.
IMPACT BURDEN: Medium impact

B-6: Home Health Services (MMP Only)

1. If a plan selects "Items/Other, Describe" for the question, “Indicate units a limit will be provided in for…” on the B-6: Home Health Services (MMP Only) - Base 1 or Base 2 screens, the corresponding question, "Indicate numerical limit on the services provided for..." will be enabled.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-6: Home Health Services (MMP Only) – Bases 1-2
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 65-66
CITATION: (Release 2, Requirement 20332)
REASON WHY CHANGE IS NEEDED: To make the information collected for that selection consistent with all other options.
IMPACT BURDEN: Low impact

B-7: Health Care Professional Services

1. The enhanced benefit "Routine Care/Other" has been separated into "Routine Care" and "Other" in B-7b: Chiropractic Services, with the following updates:

- A new text field, "Enter name of Other Service" has been added to the B-7b: Chiropractic Services - Base 1 screen and will be enabled if a plan selects "Other."
- Separate limit and cost sharing questions have been added for each benefit.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-7b: Chiropractic Services – Bases 1-2
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 70-71
CITATION: (Release 2, Requirement 17531)
REASON WHY CHANGE IS NEEDED: To allow plans to provide more accurate information for the enhanced benefit(s) offered.
IMPACT BURDEN: Medium impact

2. The combined benefits in B-7b: Chiropractic Services have been updated as follows:

- The question, “Select the enhanced benefits that are included in the combined benefit (Select all that apply):” has been added to the B-7b: Chiropractic Services -Base 1 screen.
- Alternative Therapies (in 14c: Eligible Supplemental Benefits as Defined in Chapter 4) has been added as one of the benefits to include in a combined benefit with Acupuncture and/or Chiropractic.
- If a plan indicates it is offering combined benefits, at least two of the benefits from 7b: Chiropractic – Routine Care, 7b: Chiropractic – Other, 13a: Acupuncture, and 14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Alternative Therapies will either need to have the same maximum benefit amount or have the same number of visits entered.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-7b: Chiropractic Services – Base 1, B-13a: Acupuncture – Base 1, 14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Bases 2, 4
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 70, 129, 185, 187
CITATION: (Release 2, Requirement 20866)
REASON WHY CHANGE IS NEEDED: To allow plans more flexibility when offering a combined benefit.
IMPACT BURDEN: Medium impact

B-13: Other Supplemental Services

1. If a plan selects, "Items/Other, Describe" for the question, “Indicate units a limit will be provided in for…” on the B-13h: Additional Services (MMP Only) - Base 3 through 18 screens, the corresponding "Indicate numerical limit on the services provided for..." question will be enabled.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-13h: Additional Services (MMP Only) – Bases 3-18
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 152-167
CITATION: (Release 2, Requirement 20332)
REASON WHY CHANGE IS NEEDED: To make the information collected for that selection consistent with all other options.
IMPACT BURDEN: Low impact

2. The combined benefits in B-13a: Acupuncture have been updated as follows:

- Alternative Therapies (in 14c: Eligible Supplemental Benefits as Defined in Chapter 4) has been added as one of the benefits to include in a combined benefit with Acupuncture and/or Chiropractic.
- If a plan indicates it is offering combined benefits, at least two of the benefits from 7b: Chiropractic – Routine Care, 7b: Chiropractic – Other, 13a: Acupuncture, and 14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Alternative Therapies will either need to have the same maximum benefit amount or have the same number of visits entered.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-7b: Chiropractic Services – Base 1, B-13a: Acupuncture – Base 1, 14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Bases 2, 4
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 70, 129, 185, 187
CITATION: (Release 2, Requirement 20866)
REASON WHY CHANGE IS NEEDED: To allow plans more flexibility when offering a combined benefit.
IMPACT BURDEN: Medium impact

B-14: Preventive and Other Defined Supplemental Services

1. The question, “Select the type of Remote Access Technologies offered (Select all that apply):” has been added to the B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Base 1 screen, with the option to select Web/Phone based technologies and/or a Nursing Hotline.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 184
CITATION: (Release 2, Requirement 20868)
REASON WHY CHANGE IS NEEDED: To allow plans to provide more specific information on the type of Remote Access Technologies offered.
IMPACT BURDEN: Low impact

2. The question, "Is this benefit unlimited for Alternative Therapies?" has been added to 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_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 185
CITATION: (Release 2, Requirement 18722)
REASON WHY CHANGE IS NEEDED: To allow a plan to accurately offer an unlimited benefit.
IMPACT BURDEN: Low impact

3. Separate maximum out-of-pocket cost questions have been added for every benefit in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 to the B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Base 5 and 6 screens.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Bases 5-6
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 188-189
CITATION: (Release 2, Requirement 18658)
REASON WHY CHANGE IS NEEDED: To provide more accurate information on any service-specific MOOPs.
IMPACT BURDEN: Medium impact

4. The combined benefits in B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 have been updated as follows:

- Alternative Therapies has been added as one of the combined benefits with Acupuncture and/or Chiropractic.
- The following questions have been added for the Alternative Therapies benefit on the B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Base 2 screen:
    - “Do you offer a combined Acupuncture/Alternative Therapies/Chiropractor Services benefit?”
    - "Is this benefit unlimited for Alternative Therapies?"
- If a plan indicates it is offering combined benefits, at least two of the benefits from 7b: Chiropractic – Routine Care, 7b: Chiropractic – Other, 13a: Acupuncture, and 14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Alternative Therapies will either need to have the same maximum benefit amount or have the same number of visits entered.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B – B-7b: Chiropractic Services – Base 1, B-13a: Acupuncture – Base 1, 14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Bases 2, 4
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 70, 129, 185, 187
CITATION: (Release 2, Requirement 20866)
REASON WHY CHANGE IS NEEDED: To allow plans more flexibility when offering a combined benefit.
IMPACT BURDEN: Medium impact

5. The question, “Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline) Notes” on the B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 - Base 10 screen has been split into “Remote Access Technologies (Web/Phone based technologies) Notes” and “Remote Access Technologies (Nursing Hotline) Notes.”

Note: If "Web/Phone based technologies" is selected for the question, "Select the type of Remote Access Technologies offered (Select all that apply)," the notes field for "Web/Phone based technologies" will be mandatory.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-14c: Eligible Supplemental Benefits as Defined in Chapter 4 – Base 10
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 193
CITATION: (Release 2, Requirement 20868)
REASON WHY CHANGE IS NEEDED: To allow plans to provide more specific information about the type of Remote Access Technologies being offered.
IMPACT BURDEN: Low impact

6. The benefits in B-14e: Other Medicare-covered Preventive Services have been updated by replacing the five "Medicare-covered Other" benefits with a single "Other Medicare-covered Preventive Services" benefit.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-14e: Other Medicare-covered Preventive Services – Bases 1-4
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 198-201
CITATION: (Release 2, Requirement 20819)
REASON WHY CHANGE IS NEEDED: To reduce the burden on plans of filling in data for multiple specific Preventive Services.
IMPACT BURDEN: Low impact

B-16: Dental

1. The enhanced benefit, "Periodontics/Endodontics/Extractions," in B-16b: Comprehensive Dental, has been separated into "Periodontics," "Endodontics," and "Extractions" with separate limit and cost sharing questions for each benefit.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-16b: Comprehensive Dental – Bases 1-5
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 211-215
CITATION: (Release 2, Requirement 20728)
REASON WHY CHANGE IS NEEDED: To allow plans to provide more accurate information for the enhanced benefit(s) offered.
IMPACT BURDEN: Medium impact

B-17: Eye Exams/Eyewear

1. The enhanced benefit "Routine Eye Exams/Other," in B-17a: Eye Exams, has been separated into "Routine Eye Exams" and "Other" with the following updates:

- A new text field, "Enter name of Other Service:" has been added to the B-17a: Eye Exams - Base 1 screen and will be enabled if a plan selects "Other."
- Separate limit and cost sharing questions have been added for each benefit.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-17a: Eye Exams – Bases 1-2

DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 217-218
CITATION: (Release 2, Requirement 17533)
REASON WHY CHANGE IS NEEDED: To allow plans to provide more accurate information for the enhanced benefit(s) offered.
IMPACT BURDEN: Medium impact

B-18: Hearing Exams/Hearing Aids

1. The response, "one single ear" has been added to the question, "Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?" on the B-18b: Hearing Aids - Base 2 screen.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B - B-18b: Hearing Aids – Base 2
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
PAGE(S): pg. 231
CITATION: (Release 2, Requirement 20854)
REASON WHY CHANGE IS NEEDED: To accommodate plans that limit their maximum plan benefit coverage to one ear.
IMPACT BURDEN: Low impact

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

1. The following two targeted clinical conditions have been added to the disease states in 19: Value Based Insurance Design:

- Rheumatoid Arthritis
- Dementia

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19a: Reduced Cost Sharing for VBIDs – Base 1, 19b: Additional Benefits for VBIDs – Base 1
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf
PAGE(S): pg. 2, 56
CITATION: (Release 2, Requirement 20807)
REASON WHY CHANGE IS NEEDED: To reflect the expansion of the disease states that qualify for the VBID Model Test.
IMPACT BURDEN: Low impact

2. The question, “Does your VBID cost reduction cover all or some Specialists under 7d: Physician Specialist Services?” has been added on the 19a Reduced Cost Sharing for VBIDS – Base 1 screen.

If a plan selects, “Some Specialists” for the question, “Does your VBID cost reduction cover all or some Specialists under 7d: Physician Specialist Services?” the plan will fill out the reduced cost for these specific specialists on the 19a Reduced Cost Sharing for VBIDS – Base 15 through Base 17 screens. The questions on these screens will be enabled based on the following data entry.

- If a plan selects 7d: Physician Specialist Services for reduced coinsurance on the Base 3 screen, then the picklist on the Base 15 screen, “Select all Specialists with a reduced coinsurance” will become

enabled. The corresponding min/max coinsurance variables will be enabled based on the plan's picklist selection.

- If a plan selects 7d: Physician Specialist Services for reduced deductible on the Base 8 screen, then the picklist "Select all Specialists with a reduced deductible" will become enabled on the Base 16 screen. The corresponding deductible variables will be enabled based on the plan's picklist selection.
- If a plan selects 7d: Physician Specialist Services for reduced copayment on the Base 10 screen, then the picklist "Select all Specialists with a reduced copayment" will become enabled on the Base 17 screen. The corresponding copayment min/max will be enabled based on the plan's picklist selection

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19a: VBID Cost Sharing for VBIDs, Base 1, 3, 8, 10, 15-17
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf
PAGE(S): pg. 2, 4, 9, 11, 16-18
CITATION: (Release 2, 20809)
REASON WHY CHANGE IS NEEDED: To enable plans to specify a reduction on cost for a specific specialty type.
IMPACT BURDEN: Medium impact

3. Questions for Retroactive Reimbursement have been added to the 19a Reduced Cost Sharing for VBIDS – Base 18 screen.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19a: VBID Cost Sharing for VBIDs, Base 18
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf
PAGE(S): pg. 19
CITATION: (Release 2, Requirement 20810)
REASON WHY CHANGE IS NEEDED: To allow a plan to indicate that it is reimbursing cost sharing by check.
IMPACT BURDEN: Low impact

4. The following questions have been added to the 19a Reduced Cost Sharing for VBIDS – Base 18 screen:

"Is there a maximum aggregate amount of reduced cost sharing?"
"Specify the maximum aggregate amount of reduced cost sharing."

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19a: VBID Cost Sharing for VBIDs, Base 18
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf
PAGE(S): pg. 19
CITATION: (Release 2, Requirement 20810)
REASON WHY CHANGE IS NEEDED: To capture the aggregate amount of reduced cost sharing offered by each VBID package in comparison with the plan's non-VBID cost sharing.
IMPACT BURDEN: Low impact

5. Questions for Retroactive Reimbursement have been added to the B-19b: Additional Benefits for VBIDs - Base 3 screen.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19b: Additional Benefits for VBIDs, Base 3
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf

PAGE(S): pg. 58
CITATION: (Release 2, Requirement 20810)
REASON WHY CHANGE IS NEEDED: To allow a plan to indicate that it is reimbursing cost sharing by check.
IMPACT BURDEN: Low impact

6. The following questions have been added to the B-19b: Additional Benefits for VBIDs - Base 3 screen:

- "Is there a maximum aggregate amount of reduced cost sharing?"
- "Specify the maximum aggregate amount of reduced cost sharing."

SOURCE: Internal
PBP SCREEN/CATEGORY: Section B - B-19a: VBID Cost Sharing for VBIDs, Base 3
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_VBID_2016_12_12.pdf
PAGE(S): pg. 58
CITATION: (Release 2, Requirement 20810)
REASON WHY CHANGE IS NEEDED: To capture the aggregate amount of reduced cost sharing offered by each VBID package in comparison with the plan's non-VBID cost sharing.
IMPACT BURDEN: Low impact

PBP Section D

1. The benefits in B-14e: Other Medicare-covered Preventive Services have been broken out in the Section D plan-level picklists as follows:

- 14e1: Glaucoma Screening
- 14e2: Diabetes Self-Management Training
- 14e3: Other Medicare-covered Preventive Services.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section D - Plan Deductible LPPO/RPPO Base 1, Plan Deductible LPPO/RPPO Base 3, Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1, Plan Deductible (In-Network), Plan Deductible (Combined) – Bases 1-2, Plan Deductible (Out-of-Network), Plan Deductible (Non-Network), Max Enrollee Cost Limit (In-Network), Max Enrollee Cost Limit (Combined) – Bases 1-2, Max Enrollee Cost Limit (Out-of-Network), Max Enrollee Cost Limit (Non-Network)
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_d _2016_12_02.pdf
PAGE(S): pg. 1, 3, 7, 9-18.
CITATION: (Release 2, Requirement 19148)
REASON WHY CHANGE IS NEEDED: To allow a plan to include more accurate plan level costs on the preventive services.
IMPACT BURDEN: Low impact

2. If a plan answers "Yes" to the question, "Does the (Emergency Care or Urgently Needed Services) cost sharing count towards any plan level deductible?" on either the B-4a Base 2 screen or the B-4b – Base 2 screen, the plan will be required to enter a plan-level deductible in Section D on the Plan Deductible (In-Network), Plan Deductible (Combined), or the Plan Deductible LPPO/RPPO screens.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section B – B-4b: Urgently Needed Services – Base 2; Section D - Plan Deductible LPPO/RPPO, Bases 1-2; Plan Deductible (In-Network); Plan Deductible (Combined), Bases 1-2

DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf
APPENDIX_C_PBP_2018_screenshots_section_d_ 2016_12_02.pdf
PAGE(S): APPENDIX_C_PBP_2018_screenshots_section_b_ 2016_11_30.pdf: pg. 56;
APPENDIX_C_PBP_2018_screenshots_section_d_ 2016_12_02.pdf: pg. 1-2, 9-11
CITATION: (Release 1, Requirement 18768)
REASON WHY CHANGE IS NEEDED: To ensure a plan enters a plan level deductible in Section D if they select Emergency Care cost sharing counts towards a plan level deductible.
IMPACT BURDEN: Medium impact

3. The service category 4c: Worldwide Emergency/Urgent Coverage has been added to the picklist for the question "What category of providers do you permit to balance bill?" on the PFFS Balance Billing screen.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section D - PFFS Balance Billing
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_d_ 2016_12_02.pdf
PAGE(S): pg. 23
CITATION: (Release 2, Requirement 21367)
REASON WHY CHANGE IS NEEDED: To allow PFFS plans that permit providers of Worldwide Emergency/Urgent Coverage to balance bill.
IMPACT BURDEN: Low impact

4. The question, "Do the Optional Supplemental benefits in this package apply to the MOOP for this plan?" has been added to the Optional Supplemental – Label and Premium screen for each Optional Supplemental package.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section D - Optional Supplemental – Label and Premium
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_d_ 2016_12_02.pdf
PAGE(S): pg. 27
CITATION: (Release 2, Requirement 18152)
REASON WHY CHANGE IS NEEDED: To allow plans to designate that the optional supplemental benefit cost sharing applies to the overall Plan MOOP.
IMPACT BURDEN: Low impact

PBP Section Rx

1. The following tier model has been added for plans with three tiers:

- Generic/Preferred Brand/Non-Preferred Drug

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx - Medicare Rx- Tier Model (when a tier includes 3 tiers)
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _2016_12_12.pdf
PAGE(S): pg. 5
CITATION: (Release 2, Requirement 20649)
REASON WHY CHANGE IS NEEDED: To allow plans greater flexibility in the tiers they offer.
IMPACT BURDEN: No impact

2. The following tier models have been added for plans with six tiers:

- Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand/Specialty Tier/Injectable Drugs
- Preferred Generic/Generic/Preferred Brand/Non-Preferred Drug/Injectable Drugs/Specialty Tier
- Preferred Generic/Generic/Preferred Brand/Non-Preferred Drug/Specialty Tier/Injectable Drugs

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx - Medicare Rx- Tier Model (when a tier includes 6 tiers)
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _2016_12_12.pdf
PAGE(S): pg. 8
CITATION: (Release 2, Requirement 20649)
REASON WHY CHANGE IS NEEDED: To allow plans greater flexibility in the tiers they offer.
IMPACT BURDEN: No impact

3. The tier drug type options for the question, "Tier Drug Type(s) (select all that apply):" have been consolidated from Preferred Generic, Non-Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, and Brand to Brand and Generic on the following screens:

- 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 – Tier Type and Cost Share Structure – Gap
- Alternative – Tier Type Post-OOP Threshold

Notes:

- If the tier name contains the word “Brand,” the tier must include a “Brand” drug type. The tier may also include a “Generic” drug type.
- If the tier name contains the word “Generic,” the tier must include a “Generic” drug type. The tier may also include a “Brand” drug type.

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx - 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 – Tier Type and Cost Share Structure – Gap, Alternative – Tier Type Post-OOP Threshold
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _2016_12_12.pdf
PAGE(S): pg. 17, 27, 32, 53, 64
CITATION: (Release 2, Requirement 18811)
REASON WHY CHANGE IS NEEDED: To simplify the tier drug type options.
IMPACT BURDEN: Low impact

4. If a plan’s only tier that includes coinsurance is the specialty tier, the average expected cost sharing attestation on the Medicare Rx – Attestations screen will be disabled.

Note: This only applies to Pre-ICL and Gap cost sharing.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section Rx - Medicare Rx – Attestations
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _2016_12_12.pdf
PAGE(S): pg. 69

CITATION: (Release 2, Requirement 18089)
REASON WHY CHANGE IS NEEDED: To exempt plans for which this attestation is not relevant.
IMPACT BURDEN: Lessens impact

PBP Section Rx (MMP Only)

1. The tier drug type options for the question, "Tier Drug Type(s) (select all that apply):" have been changed from Preferred Generic, Non-Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, and Brand to Brand and Generic on the Alternative – Medicare-Medicaid Tier Type – Pre-ICL screen.

Notes:

- If the tier name contains the word "Brand," the tier must include a "Brand" drug type. The tier may also include a "Generic" drug type.
- If the tier name contains the word "Generic," the tier must include a "Generic" drug type. The tier may also include a "Brand" drug type.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section Rx (MMP Only) - Alternative – Medicare-Medicaid Tier Type – Pre-ICL
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _2016_12_12.pdf
PAGE(S): pg. 43
CITATION: (Release 2, Requirement 21167)
REASON WHY CHANGE IS NEEDED: To simplify the tier drug type options.
IMPACT BURDEN: Low impact

PBP Section Rx (VBID Only)

1. The following two targeted clinical conditions have been added to the disease states on the VBID – Package Setup screen:

- Rheumatoid Arthritis
- Dementia

SOURCE: Internal
PBP SCREEN/CATEGORY: Section Rx (VBID Only) - VBID – Package Setup
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _VBID_2016_12_02.pdf
PAGE(S): pg. 2
CITATION: (Release 2, Requirement 20807)
REASON WHY CHANGE IS NEEDED: To reflect the expansion of the disease states that qualify for the VBID Model Test.
IMPACT BURDEN: Low impact

2. The following questions have been added to the VBID - Package Setup screen in Section Rx:

- "Are you modifying the deductible amount?"
- "Enter the modified Deductible Amount:"

  Note: The first question will be enabled if the plan includes a deductible on the Alternative - Deductible screen. The deductible amount entered must be less than or equal to the deductible amount entered on the Alternative - Deductible screen.

SOURCE: Industry
PBP SCREEN/CATEGORY: Section Rx (VBID Only) - VBID – Package Setup
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_Rx _VBID_2016_12_02.pdf
PAGE(S): pg. 2
CITATION: (Release 2, Requirement 18682)
REASON WHY CHANGE IS NEEDED: To allow plans to reduce or eliminate the deductible as an element in its VBID cost reduction.
IMPACT BURDEN: Low impact

Copy Plan

1. If a plan performs a Copy Plan (from Previous Year) of Section A that includes a Standard Bid for any section, the following message has been added:

- The following questions will be set to "No" instead of "Yes" for plan HXXXX-XXX:
  "Is your organization filing a standard bid for Section B, C, or D of the PBP?"

SOURCE: Industry
PBP SCREEN/CATEGORY: Sections A-5 and A-6
DOCUMENT: APPENDIX_C_PBP_2018_screenshots_section_a_and_upload_2015_12_04.pdf
PAGE(S): pg. 4-5
CITATION: (Release 1, Requirement 20287)
REASON WHY CHANGE IS NEEDED: To inform plans that that no section-wide standard bids will be retained when Plan Copy (from Previous Year) is applied.
IMPACT BURDEN: No impact

508 Compliance

1. A pop-up message has been added asking the user if they want to enable 508 Options when the PBP software is opened for the first time.

SOURCE: Internal
PBP SCREEN/CATEGORY: Management Screen
DOCUMENT: N/A
PAGE(S): N/A
CITATION: (Release 1, Requirement 20428)
REASON WHY CHANGE IS NEEDED: To allow the PBP software to give the user feedback upon the selection of a plan in a screen reader environment.
IMPACT BURDEN: Low impact

Technical

1. The "Vertical Screen Data Entry" option has been removed from the PBP software.

SOURCE: Internal
PBP SCREEN/CATEGORY: Management Screen
DOCUMENT: N/A
PAGE(S): N/A
CITATION: (Release 1, Requirement 20334)
REASON WHY CHANGE IS NEEDED: This option was difficult to follow, and could create some data entry errors.
IMPACT BURDEN: Lessens impact

CY 2018 MTMP

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 ($3,919). 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_MTMP_508Screenshots_11222016.pdf
PAGE(S): 1
CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To meet the business needs
IMPACT BURDEN: No Impact

2. Added 5 more outside vendors for MTM, PBM, and Disease Management Vendor for selection on the Resources page.

SOURCE: CMS, Internal
DOCUMENT: APPENDIX_C_MTMP_508Screenshots_11222016.pdf
PAGE(S): 1
CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To meet the business and plan user needs
IMPACT BURDEN: No Impact

3. New section, Data Evaluated for Identifying Chronic Diseases, on the EditPageA_1.asp page.

SOURCE: CMS, Internal
DOCUMENT: APPENDIX_C_MTMP_508Screenshots_11222016.pdf
PAGE(S): 1
CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To meet the business needs
IMPACT BURDEN: No Impact

4. New section, Data Evaluated for Identifying the Number of Covered Drugs, on the EditPageA_2.asp page.

SOURCE: CMS, Internal
DOCUMENT: APPENDIX_C_MTMP_508Screenshots_11222016.pdf
PAGE(S): 1
CITATION: Lessons Learned
REASON WHY CHANGE IS NEEDED: To meet the business needs
IMPACT BURDEN: No Impact

CY 2018 Formulary

1. CMS is proposing additional 2018 Tier Model options.

SOURCE: Internal
DOCUMENT: Appendix_C_Formulary_Proposed_Tier_Models 9-23-16.pdf
PAGE(S): pgs. N/A

CITATION: 42 CFR 423.120
REASON WHY CHANGE IS NEEDED: This will help organizations to more accurately select tier models
IMPACT BURDEN: Lessens impact

2. CMS is removing the drug_type_label field from the 2018 formulary submission file.

SOURCE: Internal
DOCUMENT: Appendix_C_Formulary_Submission_File_Layout.pdf
PAGE(S): N/A
CITATION: 42 CFR 423.120
REASON WHY CHANGE IS NEEDED: The drug type label is not needed for each RxCUI on the formulary file submission. The drug type label is already known based on the RxCUI if the drug is brand or generic. The removal of this field streamlines the data collection process.
IMPACT BURDEN: Lessens impact