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TO: Medicare-Medicaid Plans

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SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2016

The purpose of this memorandum is to provide an overview of the general requirements of, and enhancements to, the plan benefit package (PBP) software for Medicare-Medicaid Plans (MMPs) for contract year (CY) 2016. In addition to changes made to further accommodate more integrated benefit data entry by MMPs in previous cycles, CMS has made minor modifications to the PBP software for CY 2016 specifically impacting MMPs.

On April 10, 2015, CMS released the CY 2016 PBP software in HPMS. As articulated in our February 23, 2015 HPMS guidance memorandum for Medicare-Medicaid Plans (MMPs), "Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2016," MMPs will use the PBP software to annually submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits.

All PBP submissions for CY 2016 are due **no later than June 1, 2015 (11:59pm PT)**. MMPs are required to complete the following as part of a complete bid submission:

- Service Area Verification
- Plan Crosswalk (NOTE: This is only for renewing contracts in CY2016)
- Formulary Crosswalk
- PBP Submission

After submission of the bid, MMPs are also required to submit the Additional Demonstration Drug (ADD) file by 12:00 p.m. on June 5, 2015).

Data Entry for Medical and Other Non-Drug Services

Plan Type

MMPs must define themselves as either a Health Maintenance Organization (HMO) or a Health Maintenance Organization Point-of-Service (HMOPOS) plan in the 2016 Bid Submission Module in HPMS. POS benefits are optional; however, if a plan is an HMOPOS plan type, at least one benefit must be offered under mandatory supplemental point-of-service benefit and indicated in section C of the PBP.

Medicare Benefits

Because MMPs must provide all Medicare Parts A and B services at \$0 cost sharing to enrollees, all Medicare-required benefit cost-sharing, deductible, and maximum out-of-pocket data fields in section B of the PBP will include validations to ensure that no cost-sharing can be entered for those services.

Medicaid and Demonstration-Specific Benefits

Section B-13h of the PBP software allows for data entry of Medicaid and demonstration-specific benefit categories that cannot be accommodated elsewhere in the PBP. MMPs will have 14 pre-defined Medicaid service categories, plus 23 (versus 18 in CY 2015) additional blank “other” categories, for which they can enter data about maximum plan benefit coverage, cost sharing, authorization, and referral requirements. In addition, if an MMP needs additional blank “other” categories, three are available in sections B-13d, e, and f of the PBP.

Integration of Medicare and Medicaid Benefits

MMPs should integrate Medicare and Medicaid benefits as much as possible within the existing PBP benefit categories. Medicaid wrap-around benefits should not be described in a separate section of the PBP as the Medicare benefits are described. For example, Medicaid wrap-around benefits (such as unlimited inpatient days) should be displayed as supplemental (non-Medicare) benefits in sections B-1a (Inpatient Hospital Acute-Base 1, Base 5, Base 6, Base 10, and Base 11 screens) and B-2 (Skilled Nursing Facility – Base 1, Base 6, and Base 7 screens), respectively. MMPs will have the opportunity in section D of the PBP to indicate whether any supplemental (non-Medicare) benefits entered in section B of the PBP are: (1) Medicaid (or demonstration-required) benefits, or (2) plan-covered supplemental benefits.

Supplemental Benefits

All supplemental (non-Medicare) benefits must be mandatory benefits. Optional benefits will not be permitted, as enforced by exit and/or other validation rules.

Over-the-counter (OTC) drug and pharmacy benefits may not be included in section B-13b of the PBP if they are required to be included in the MMP’s benefit package under the integrated

formulary submission. OTC drugs and products required to be covered under the Medicaid drug benefit must be included on one or more formulary tiers in the Rx section of the PBP. Section B-13b of the PBP should only be used for OTC drugs and items that are included as a plan-covered supplemental benefit beyond the Medicaid-required OTC pharmacy benefit.

MMPs are permitted to bundle Part D home infusion drugs with home infusion supplies and administration costs just as Medicare Advantage plans are permitted to do as a supplemental benefit under Part C. Section B-15 will allow plans to indicate that they bundle home infusion drugs with supplies and administrative services in this way (though we note that plans that do this will be required to submit a Home Infusion supplemental drug file by 12 p.m. ET on June 5, 2015). Alternatively, MMPs may indicate that home infusion supplies and administration are paid for under the Medicaid benefit; in this case, MMPs will not submit a supplemental Home Infusion drug file and should indicate they do NOT bundle home infusion drugs under Section B-15 of the PBP software.

CY 2016 PBP Enhancements (Sections B and D)

Among the major enhancements to the MMP-specific fields in the PBP software for CY 2016 are the following:

- **Section B-13h: Additional Services**
 - Five additional “other” service categories have been added
 - The following questions have been added for all benefits in the Base 2 through Base 10 screens:
 - New unit option for benefit limits: Other
 - New Periodicity Options for benefit limits: Every Session/Visit, Every Pregnancy, and Every Lifetime
 - Addition of a validation rule to prevent a plan from entering both “Sessions and “Visits” for unit and “Every Session/Visit” for periodicity.
 - Updates to the Minimum and Maximum Patient Pay Amount fields on the B-13h: Additional Services – Base 17 screen to make them optional.
- **Section D**
 - The following MMP picklists have been updated to include every individual enhanced benefit on the MMP – Medicaid/plan covered cost sharing screen:
 - Select all of the benefits that are covered under Medicaid (Optional):

- Select all of the benefits that are plan-covered supplemental benefits (i.e., services not covered by Medicare or Medicaid) (Optional):

Data Entry for Drug Coverage

Tier Models

Data entry for MMPs' drug benefits should be integrated to reflect a formulary combining both Medicare Part D and Medicaid-required prescription and OTC drugs and products. A table summarizing the CY 2016 MMP tier models can be found in Appendix A. The CY 2016 tier models are unchanged from CY 2015.

MMPs may select a formulary tier model consisting of 2 to 6 tiers. Part D drugs may be included on any tier without a tier label that indicates it is "Non-Medicare" – i.e., tiers up to and including the 5th tier, depending on the formulary model selected. For formulary models with 3 to 6 tiers, non-Part D drugs may be included only on tiers 3 to 6. For 2-tier formulary designs, both tiers must include Part D drugs and at least one tier must contain both Part D and non-Part D drugs. A 2-tier formulary model cannot include a tier with only non-Part D drugs.

MMPs should refer to the CY 2016 Final Call Letter for more information about changes in the requirements for generic tier labeling. Although these tier changes will not be reflected in the PBP software and HPMS for CY 2016, MMPs must ensure that the generic tier labels in their CY 2016 beneficiary materials are consistent with these new requirements.

Part D Drug Cost Sharing Reductions

We encourage MMPs to reduce cost-sharing for some or all Part D drugs to \$0 where it is not otherwise required by the demonstration state in which they operate. Reducing beneficiary cost sharing for prescription drugs has the potential for improving medication adherence for a particularly vulnerable population, and improved adherence has been linked to improved health outcomes and reduced overall health care expenditures, often through reduced inpatient hospital days and emergency department visits.

For tiers with Part D drugs, MMPs have the flexibility to reduce cost-sharing for all enrollees below the statutory low-income subsidy (LIS) maximum copayment amounts for brands and/or generics. This flexibility is described in our September 20, 2012, HPMS memorandum entitled, "Waiver of Part D Low-Income Subsidy Cost-sharing Amounts by Medicare-Medicaid Plans and Operational Impacts for Prescription Drug Event Data and Plan Benefit Package Submissions," which is posted at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/Part_D_Cost_Sharing_Guidance.pdf.

Drug Cost-Sharing Requirements

For cost-sharing before the out-of-pocket threshold, MMPs will have a cost sharing screen (the Alternative- Medicare-Medicaid Copayment – Pre-ICL screen) that will allow for data entry of cost-sharing amounts (a minimum and maximum copayment) instead of the cost sharing screens other Part D plans use. MMPs will have the ability to designate their tiers as no cost-share tiers or as cost-share tiers. The no cost-sharing option applies to all tiers, whereas the cost-share tiers option allows the user to enter specific cost sharing amounts for each tier. Cost-share tiers can also be designated as low-income subsidy (LIS) cost-share tiers (in which case MMPs will not need to enter cost sharing data, because the standard LIS cost sharing maximums for CY 2016 will be assumed and the copayment fields will be disabled for these tiers).

The following validations related to the tier content continue to be applicable to copayment fields on the Alternative – Medicare-Medicaid Copayment – Pre-ICL screen when the plan selects cost-share tiers.

- When a tier only includes Medicare Part D drugs, plans may enter copayment minimum and maximum amounts reflecting one of the following options for each Part D only tier:
 - For tiers with only Medicare Part D generic drugs: The minimum copayment amount that can be entered is \$0 and the maximum copayment amount that can be entered is \$2.95.
 - For tiers with only Medicare Part D brand drugs: The minimum copayment amount that can be entered is \$0 and the maximum copayment amount that can be entered is \$7.40.
 - For tiers with only Medicare Part D brand and generic drugs: The minimum copayment amount that can be entered is \$0 and the maximum copayment amount that can be entered is \$7.40.
- When a tier includes both Medicare Part D and non-Part D drugs, plans must enter copayment minimum and maximum of \$0.
- For tiers with only non-Part D drugs: There are no minimum or maximum cost-sharing validations, unless a tier contains non-Part D drugs and the plan indicated on the Alternative -Medicare-Medicaid Pre-ICL Threshold screen that LIS cost-sharing applies to this tier. In that case, the PBP will assign the LIS cost-sharing standards described above to the tier and the plan will not be responsible for cost-sharing data entry on these tiers. (Please note that the fact that there is no minimum or maximum cost-sharing validation does not mean there are no state specific cost sharing requirements that must also be met as part of the PBP review and approval process. MMPs should refer to their state's PBP guidance for more information on cost-sharing requirements for Medicaid-covered drugs.)

For cost-sharing after the out-of-pocket threshold, MMPs will have the dedicated Alternative - Medicare-Medicaid Post-OOP Threshold screen on which an MMP can select either no cost-sharing or cost-share tiers. The no cost-sharing option applies to all tiers, whereas the cost-share tiers option allows the user to enter specific cost-sharing amounts for each tier. The following validations related to the tier content continue to be applied in the Alternative-Medicare-Medicaid Post-OOP Threshold screen:

- If the MMP chooses cost-share tiers and has a Part D-only tier, then the minimum and maximum copayment must equal \$0 for that tier.
- If the MMP chooses cost-share tiers and has a tier that includes both Part D and non-Part D drugs, then the minimum and maximum copayment must equal \$0 for that tier.

If the MMP chooses cost-share tiers and has a tier that includes only non-Part D drugs, then there will be no limit on the minimum or maximum copayment amount for that tier. (Please note that the fact that there is no minimum or maximum cost-sharing validation does not mean there are no state specific cost sharing requirements that must also be met as part of the PBP review and approval process.)

MMP-Specific Rx Section Data Entry Requirements

Since CY 2014, we have included additional data entry requirements for MMPs in order to represent the drug benefit as an MMP enrollee will experience it (i.e., full gap coverage, an integrated formulary, and all cost sharing protections afforded to Medicare-Medicaid enrollees). These include:

- Requiring that all MMPs select the Enhanced Alternative plan type in the Medicare-Rx-General screen.
- Requiring that all MMPs select “no deductible” in the Alternative – Deductible screen
- Requiring MMPs to select “Yes” for the question “Do you offer reduced Part D cost sharing as part of your supplemental Part D benefit?” on the Alternative – Enhanced Alternative Characteristics screen.
- Requiring MMPs to select all of the following options for the question “Indicate the area(s) throughout the Part D benefit where the reduced Part D cost sharing is reflected (select all that apply)” on the Alternative – Enhanced Alternative Characteristics screen:
 - “Reduced deductible,” “Reduced pre-ICL cost shares,” “Raised ICL,” “and Reduced post-threshold cost shares”
- Requiring MMPs to select “No ICL (Full Gap Coverage)” to the question “Do you apply the Medicare-defined Part D Standard Initial Coverage Limit (ICL) Amount?” on the Alternative – ICL screen.

- Requiring MMPs to select “Yes” for the question “Do you offer additional cost-sharing reductions in the coverage gap?” on the Alternative – Enhanced Alternative Characteristics screen.
- Disabling all excluded drug supplemental drug file questions, since MMPs will submit all non-Part D drugs on a single supplemental drug file, the Additional Demonstration Drug (ADD) file.
- Since Part D cost-sharing cannot exceed LIS statutory cost sharing maximums for Medicare-Medicaid enrollees:
 - MMP data entry for Standard/Preferred Retail Cost-Sharing is disabled on all pharmacy location screens;
 - MMP data entry for Standard/Preferred Mail Order Cost-Sharing is disabled on all pharmacy location screens;
 - Extended day supply cost sharing cannot exceed the one-month cost sharing amounts; and
 - MMPs may not select “Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable” for out-of-network cost-sharing on the Alternative-Deductible screen.

In addition, if a state wishes to require plans to apply a maximum out-of-pocket (MOOP) limit for all pharmacy spending, the CY 2016 PBP software continues to allow MMPs to enable this option and enter the MOOP amount.

CY 2016 PBP Enhancements (Rx Section)

A Daily Copayment Amount Cost Sharing screen has been added for MMPs that will include the following:

- Copayment amount for one month, daily supply amount for one month, and daily copay amount for Retail, Mail Order, and LTC.
- The Daily Copay amount will be calculated (based on the maximum copayment entered) when a plan selects the Calculate Daily Copay Amount button, and can be edited to a lower amount.
- A pop up screen with the Daily Copay Instructions will generate when a plan selects the Daily Copay Instructions button. It is important that plans read the Daily Copay Instructions before making edits to the Daily Copay amount.

PBP Notes

The notes fields in Sections B, C and D of the PBP have a 3,000 character limit. The notes field in Section Rx of the PBP has a 225-character limit. Plans should limit themselves to entering

information in the notes fields only for benefits that the PBP software cannot adequately capture. Plan-entered notes about benefits do not appear in Medicare Plan Finder on www.medicare.gov.

Plan Copy Feature

MMPs now have the ability to copy their CY 2015 PBPs to prepopulate their CY 2016 PBPs. The copy feature will prepopulate all previously approved benefit information *except* any information that appears in B-14c or any new fields or sections. Using the plan copy feature to ensure that the CY 2016 PBPs closely follow the CY 2015 PBPs will expedite the PBP submission and review processes.

In addition to the MMP-specific data entry changes, MMPs should carefully review the non-MMP-specific changes to the PBP software since last year's release. For example, as noted above, there have been significant changes to section B-14c for CY 2016.

CMS-State Joint Review

The PBP review will be conducted jointly between CMS, which will ensure all Medicare Parts A, B, and D benefits have been adequately captured, and the states, which will verify that all Medicaid and demonstration-specific benefits have been adequately captured. The Medicare-Medicaid Coordination Office has been working with all states participating in the Capitated Financial Alignment Demonstration to develop guidance for their MMPs on the submission of Medicaid and demonstration-specific benefits for CY 2016 for release starting in mid-April 2015. This will ensure that MMPs have ample time to prepare their PBP submissions by June 1, 2015.

PBP Corrections

For currently operating MMPs, CMS will approve MMPs' requests to make PBP revisions to add or remove plan-offered supplemental benefits between the time of the release of the National Average Monthly Bid Amount in early August and sign-off of PBPs in HPMS in late August. This will allow plans to accommodate any benefit changes in their required documents (including the Annual Notice of Change, Evidence of Coverage/Member Handbook, and Summary of Benefits) during the Annual Election Period.

For currently operating MMPs, we will allow rate-related PBP corrections to supplemental benefits during the Center for Medicare's annual correction window in September (see CY 2016 Final Call Letter for the exact dates of this window), but only for purposes of adding supplemental benefits to PBPs. MMPs that elect to correct their PBPs must work with their contract management team on an appropriate member communication strategy (e.g., addenda or errata sheets for materials that have already been mailed to members; updates to other materials for current and prospective members). In addition, there will be no compliance penalty for a PBP correction provided an MMP meets these conditions.

For all MMPs, any PBP corrections after the Center for Medicare's annual correction window in September (or, for MMPs with mid-year contract effective dates, the start date of marketing

stipulated in the plan's final readiness report) will be considered on a case-by-case basis. PBP corrections due to plan error will be subject to compliance action.

MMPs should refer to our February 23, 2015 HPMS memorandum, "Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2016," for more information about PBP corrections.

Training and Resources for More Information

For additional information, MMPs should complete the CY 2016 PBP online training module, released by CMS on April 10, 2015 and available at:

<https://hpmstraining.cms.hhs.gov/e3111sqo7oa/event/registration.html>. MMPs should also consult the HPMS Bid User's Manual at the following pathway in HPMS: Plan Bids > Bid Submission > Contract Year 2016 > View Documentation > Bid Submission User Manual.

Any questions regarding the contents of this memorandum should be directed to the Medicare-Medicaid Coordination Office at mmcocapsmodel@cms.hhs.gov.

Appendix A

		CY2016 Tier Model Medicare/Medicaid Plans					
2016 Tier Structure	2016 Option	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
2 tier	A	Generic	Brand	----	----	----	----
3 tier	A	Generic	Preferred Brand	Non-Preferred Brand	----	----	----
3 tier	B	Preferred Generic	Non-Preferred Generic	Brand	----	----	----
3 tier	C	\$0 Drugs	Generic	Brand	----	----	----
3 tier	D	Generic	Brand	Non-Medicare Rx/OTC	----	----	----
3 tier	E	Generic	Brand	Non-Medicare RX Drugs	----	----	----
3 tier	F	Generic	Brand	Non-Medicare OTC	----	----	----
4 tier	A	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	----	----
4 tier	B	Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC	----	----
4 tier	C	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare Rx/OTC	----	----
4 tier	D	\$0 Drugs	Generic	Brand	Non-Medicare Rx/OTC	----	----
4 tier	E	Generic	Brand	Non-Medicare Rx Drugs	Non-Medicare OTC	----	----
5 tier	A	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC	----
5 tier	B	\$0 Drugs	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare Rx/OTC	----
5 tier	C	\$0 Drugs	Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC	----
5 tier	D	Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx Drugs	Non-Medicare OTC	----
5 tier	E	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare Rx Drugs	Non-Medicare OTC	----
6 tier	A	\$0 Drugs	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	B	\$0 Drugs	Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	C	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	D	\$0 Drugs	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC