DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

DATE: April 11, 2016

TO: Medicare-Medicaid Plans

FROM: Lindsay Barnette
Director, Models, Demonstrations, and Analysis Group, Medicare-Medicaid Coordination Office

Kathryn Coleman
Director, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare

Jennifer R, Shapiro
Acting Director, Medicare Drug Benefit and C&D Data Group, Center for Medicare

SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2017

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) 2017. 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 2017 specifically impacting MMPs.

On April 8, 2016, CMS released the CY 2017 PBP software in HPMS. MMPs will use the PBP software to annually submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits.

As stated in the CY 2017 Final Call Letter, all PBPs for CY 2017 must be submitted **no later than 11:59 p.m. PDT on June 6, 2016**. 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 CY 2017)
- Formulary Crosswalk
- PBP Submission

After submission of the bid, MMPs are also required to submit the Additional Demonstration Drug (ADD) file and any other supplemental formulary files by **11:59 a.m. EDT on June 10, 2016**.

**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 2017 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 benefits 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 have 14 pre-defined Medicaid service categories, plus 38 (versus 23 in CY 2016) 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 11:59 a.m. EDT on June 10, 2016). 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 2017 PBP Enhancements (Sections A, B, and D)***

Among enhancements to MMP-specific fields in the PBP software for CY 2017 are the following:

- **Section A**
  - Disabled standard bid questions for Sections B, C, and D (Section A-5 screen)

- **Section B**
  - Disabled inpatient hospital benefit period questions for 1a, Inpatient Hospital Acute; 1b, Inpatient Hospital Psychiatric; and 2, Skilled Nursing Facility

  - Increased character limits from 72 to 144 when entering the "Other" service category title for 6, Home Health; 7c, Occupational Therapy; 7i, Physical Therapy and Speech Therapy; 11a, Durable Medical Equipment; 11b, Prosthetics/Orthotics/Medical Equipment; and 13h, Additional Services

  - Edited unit limits from "Other, describe" to "Items/Other, describe" for 6, Home Health, Personal Care Services, Other 1, and Other 2 and for 13h, Additional Services

  - Added 15 "Other" blank service categories to 13h, Additional Services

- **Section D**
  - Removed "Optional" from the requirement for including all benefits covered under Medicaid and all plan-covered supplemental benefits

## 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 2017 MMP tier models can be found in Appendix A. The CY 2017 tier models have been changed from CY 2016 to reflect the requirements for generic tier labeling. MMPs should refer to the CY 2016 Final Call Letter for more information.

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 tier 5, 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.

### *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 (Initial Coverage Limit) 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 2017 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 $3.30.
    - 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 $8.25.
    - 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 $8.25.
- 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 Section Rx Data Entry Requirements***

There are additional data entry requirements in the PBP software for MMPs 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 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 2017 PBP software continues to allow MMPs to enable this option and enter the MOOP amount.

***CY 2017 PBP Enhancements (Section Rx)***

Two updates have been made to Section Rx requirements:

- Ensured that MMPs must select an exceptions tier that includes Part D drugs (Part D Only or Part D and non-Medicare covered drug combination tier)

- Deleted the two Maximum Enrollee Out-of-Pocket cost questions on the pre-ICL screen

**PBP Notes**

The notes fields in Sections B, C and D of the PBP have a 3,000 character limit, except for Section B-14c, which has a 1,000 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 have the ability to copy their CY 2016 PBPs to prepopulate their CY 2017 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 2017 PBPs closely follow the CY 2016 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, some fields and service elements have been updated in B-14c for Nutritional/Dietary Benefit, Fitness Benefit, Counseling Services, Medical Nutrition Therapy, and Alternative Therapies for CY 2017.

## CMS-State Joint Review

CMS and the states will jointly review the PBPs. CMS ensures that all Medicare Parts A, B, and D benefits have been adequately captured, and the states 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 Medicaid and demonstration-specific benefits for CY 2017. Each state releases guidance to its MMPs beginning in mid-April 2016 to ensure that MMPs have ample time to prepare their PBP submissions by June 6, 2016.

## PBP Corrections

CMS has provided additional flexibility to MMPs with respect to PBP corrections after the time of final PBP approval. This flexibility has been necessary to make accommodations, including but not limited to mid-year legislative changes to Medicaid benefits, as well as the timing of payment rate finalization.

The following policies apply to MMP changes to PBPs:

- CMS will consider 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 2016. This opportunity, if approved, 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.

- Rate-related PBP corrections to supplemental benefits are permissible during the Center for Medicare's annual correction window in September 2016 (see the calendar in the CY 2017 Final Call Letter for more information), 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.

- Any PBP corrections after the Center for Medicare's annual correction window in September 2016 will be considered on a case-by-case basis. PBP corrections due to plan error will be subject to compliance action, regardless of whether they are positive or negative changes.

## Training and Resources for More Information

For additional information, MMPs should complete the CY 2017 PBP online training module, released by CMS on April 8, 2016. MMPs will need to register and log in to access the training. The registration link is: https://webinar.cms.hhs.gov/e2yp5jqwbl9/event/registration.html, and

the log in link is https://webinar.cms.hhs.gov/e2yp5jqwbl9/event/login.html. MMPs should also consult the HPMS Bid User's Manual at the following pathway in HPMS: Plan Bids > Bid Submission > Contract Year 2017 > 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

| | | CY 2017 Tier Model Medicare/Medicaid Plans | | | | | |
|---|---|---|---|---|---|---|---|
| **2017 Tier Structure** | **2017 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 | 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 | Generic | Preferred Brand | Non-Preferred Brand | ---- | ---- |
| 4 tier | B | Generic | Preferred Brand | Non-Preferred Brand | Non-Medicare Rx/OTC | ---- | ---- |
| 4 tier | C | Preferred Generic | 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 | Generic | Preferred Brand | Non-Preferred Brand | Non-Medicare RX/OTC | ---- |
| 5 tier | B | $0 Drugs | Preferred Generic | Generic | Brand | Non-Medicare RX/OTC | ---- |
| 5 tier | C | $0 Drugs | 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 | Generic | Brand | Non-Medicare Rx Drugs | Non-Medicare OTC | ---- |
| | | | | | | | |
| 6 tier | A | $0 Drugs | Preferred Generic | Generic | Brand | Non-Medicare Rx Drugs | Non-Medicare OTC |
| 6 tier | B | $0 Drugs | Generic | Preferred Brand | Non-Preferred Brand | Non-Medicare Rx Drugs | Non-Medicare OTC |
| 6 tier | C | Preferred Generic | Generic | Preferred Brand | Non-Preferred Brand | Non-Medicare Rx Drugs | Non-Medicare OTC |
| 6 tier | D | $0 Drugs | Preferred Generic | Generic | Preferred Brand | Non-Preferred Brand | Non-Medicare Rx/OTC |