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

PLAN OVERSIGHT & ACCOUNTABILITY GROUP

MEMORANDUM

DATE: August 3, 2007

TO: All Current and Prospective Medicare Advantage, Prescription Drug Plans, PACE, 1876 Cost Plan Sponsors, and Demonstration Organizations

FROM: Cynthia E. Moreno, Director

SUBJECT: CY 2008 Plan Benefit Package Software Patch #5 Deployed to HPMS

The Contract Year (CY) 2008 Plan Benefit Package (PBP) software has been updated and is on now available on the Health Plan Management System (HPMS). **The download and installation of PBP software patch #5 is mandatory for all plan types except for standalone PDP contracts (S numbers) and employer-direct contracts (E numbers)**.

Note: Please remember that PBP software patch #4 remains mandatory for standalone PDP contracts and employer-direct contracts.

All required plans **must** perform the following steps for PBP software patch #5:

- Download software patch #5 to your local PBP software;
- Open PBP Section A for each plan and exit with validation in order for the patch to be applied; and
- Complete the standard pre-upload steps and reupload your plans to HPMS.

It is critical that all impacted organization reupload these plans in order to ensure that your Summary of Benefit (SB) sentences are accurately reflected in the HPMS SB Report (which is used for marketing review) as well as on Medicare Options Compare (MOC).

Users should log into HPMS and select Plan Bids > Bid Submission > Contract Year 2008 > Download. Please see the PBP Enhancement Download page for complete instructions on how to install the enhancement.

To verify that you have the most recent PBP software enhancements, users should ensure that your PBP/SB version information matches the version information below:

Version Information:
PBP Version ID: 2008.06
PBP Version Date: 08/03/2007
Dictionary Date: 08/03/2007
SB MDB Version: 2008.06

NOTE: If you downloaded the PBP 2008 software and forwarded it to other users in your organization, please make sure that these other users receive and install the PBP 2008 software patch.

Thank you for your patience as we continue to improve the PBP software for 2008. If you have any questions about this e-mail, please contact the HPMS Help Desk at either 1-800-220-2028 or hpms@cms.hhs.gov.

PBP Software Patch #5 – Released on 8/3/2007

The PBP software patch #5 released on 8/3/2007 addresses the following software changes and bug fixes. Please note that a complete list of software modifications will be listed on HPMS.

Important Note: All PBP software patches are cumulative in nature. As a result, PBP software patch #5 contains all of the modifications described in this section as well as those modifications that were part of the four previous software patches. If you did not download software patches #1, #2, #3, or #4 you only need to download software patch #5.

Plan Copy Feature

- Using the plan copy feature, the Section C OON Notes section, PBP_C_OON_NOTES has been fixed to copy correctly.

Plan Exit Error

- Error message was generating when exiting an incomplete Section D with validation. Error has been resolved.

Footnotes to Selected Sentences for Original Medicare

- The footnotes that appeared in the Original Medicare column were removed from the display in the 2008 SB as part of the CMS process to simplify the sentences. These same footnotes will no longer generate on the SB report available on the HPMS for consistency.

Modifications to the SNP Sentences for All Dual Eligible Plans

- All SNP sentences for Medicare-covered benefits (excluding Part D) for the Dual Eligible plans (except for those with the Population of $0 Cost Share) have been modified. In previous versions of the PBP2008, the sentences read:

  > $0 to $___ where the blank was the amount of the cost sharing provided by the plans.

  As per direction from CMS, the "to" has been replaced with "or".

  Note that the SB crosswalk documentation was modified to reflect these changes.

- For the SB29 (Part D), the cost-sharing sentences under the Defined Standard plan type have been revised. The relevant sentences are as follows:

  > **Dual Eligible Exclusive OR Disproportionate Full Dual OR All Dual OR Medicaid Subset OR Disproportionate $0 Cost Share**
  > In-Network
  > $0 or $56 yearly deductible (amount depends on your income and institutional status.)*

Dual Eligible Exclusive $0 Cost Share
Initial Coverage
$0 or $1.05 copay for generic drugs (including brand drugs treated as generic) and $0 or $3.10 copay for all other drugs (amount depends on your income and institutional status).*

Dual Eligible Exclusive OR Disproportionate Full Dual OR All Dual OR Medicaid Subset OR Disproportionate $0 Cost Share
Initial Coverage
Depending on your income and institutional status, you pay either $0 to $2.25 copay, or 15% coinsurance for generic drugs (including brand drugs treated as generic). You pay either $0 to $5.60 copay, or 15% coinsurance for all other drugs.*

Dual Eligible Exclusive $0 Cost Share [NO CHANGE]
Catastrophic Coverage
After your yearly out-of-pocket drug costs reach $4,050 you pay a $0 copay.*

Dual Eligible Exclusive OR Disproportionate Full Dual OR All Dual OR Medicaid Subset OR Disproportionate $0 Cost Share
Catastrophic Coverage
After your yearly out-of-pocket costs reach $4,050, you pay the following (amount depends on your income and institutional status):

- $0 copay for any drugs; or
- $2.25 copay for generic drugs (including brand drugs treated as generic) and $5.60 copay for all other drugs*

Dual Eligible Exclusive $0 Cost Share
Out-of-Network Initial Coverage
$0 or $1.05 copay for generic drugs (including brand drugs treated as generic) and $0 or $3.10 copay for all other drugs. (Amount depends on your income and institutional status).*

Dual Eligible Exclusive OR Disproportionate Full Dual OR All Dual OR Medicaid Subset OR Disproportionate $0 Cost Share
Out-of-Network Initial Coverage
Depending on your income and institutional status, you pay either $0 to $2.25 copay, or 15% coinsurance for generic drugs (including brand drugs treated as generic). You pay either $0 to $5.60 copay, or 15% coinsurance for all other drugs.*

Dual Eligible Exclusive $0 Cost Share [NO CHANGE]
Out-of-Network Catastrophic Coverage
After your yearly out-of-pocket drug costs reach $4,050 you pay a $0 copay.*

Dual Eligible Exclusive OR Disproportionate Full Dual OR All Dual OR Medicaid Subset
OR Disproportionate $0 Cost Share
Out-of-Network Catastrophic Coverage
After your yearly out-of-pocket costs reach $4,050, you pay the following (amount depends on your income and institutional status):

- $0 copay for any drugs; or
- 2.25 copay for generic drugs (including brand drugs treated as generic) and $5.60 copay for all other drugs*

SB-1 – Premium and Other Important Information

- For both Standard MSAs and MSA demos, if "yes" to "Does permitted balance billing count toward the plan deductible?" then the sentence has been corrected to display as "Balance billing counts towards your plan deductible".

- The sentence "Balance billing doesn't count towards your plan deductible" no longer generates for PFFS plans.

SB-29 – Prescription Drugs for Cost Plans

- The SB has been changed so that Part D Prescription Drug benefits for a Cost Plan DO NOT need to be defined as an Optional Supplemental benefit in Section D. Instead, the cost plan can enter the Part D data like an MA-PD. The Part D benefits will show up in SB 29 (and NOT as an Opt Sup benefit with a premium).

- The specialty cost share description information has been fixed so that it no longer displays both at the beginning and the end for each location and tier level IDs.

- Display of duplicate Generic Tier information with the Coverage Gap information has been removed.

SB-8 – Doctor Office Visits
SB-11 – Outpatient Mental Health Care
SB-12 – Outpatient Substance Abuse Care
SB-13 – Outpatient Surgery/Services
SB-14 – Ambulance Services

- SNP sentence bug was fixed so that the $0 cost sentences display. These $0 cost sentences were not generating when the response to copay/coinsurance questions was “no”.

SB-11 – Outpatient Mental Health Care
SB-12 – Outpatient Substance Abuse Care
SB-24 – Immunizations
SB-26 – Pap Smears and Pelvic Exams
SB-27 – Prostate Cancer Screening Exams
SB-28 – ESRD

- SNP sentence bug was fixed. Sentence was displaying as $0 to $0 copay for each Medicare-covered ... Now displays as $0 for each Medicare-covered …

SB – Point of Service

- POS sentence bug was fixed. The selection of the fifth POS group was not receiving the correct sentences.

- SB sentence bug was fixed where the POS sentences for an optional benefit were generating in the POS section. Fixed so that only the mandatory POS benefit sentences generate in this section.

SB-3 – Inpatient Acute
SB-4 – Inpatient Mental Health
SB-5 – SNF

- Fixed bug in the logic so that the sentence "Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")" generates if there is a YES to either coinsurance or copayment AND YES to "Do you charge the Medicare-Defined cost shares?" in section B-1b. The crosswalk document was also modified. New logic is shown below.

  B-1b
  Is there an enrollee Coinsurance? Yes
  Do you charge the Medicare-defined cost shares? Yes
  AND/OR
  Is there an enrollee Copayment? Yes
  Do you charge the Medicare-defined cost shares? Yes

  AND EQUALS

  B1a
  Is there an enrollee Coinsurance? Yes
  Do you charge the Medicare-defined cost shares? Yes
  AND/OR
  Is there an enrollee Copayment? Yes
  Do you charge the Medicare-defined cost shares? Yes

Opt Sup Label Help (Text Description)

- Fixed the description in the Help screen for the Sect D Opt Sup Label so that the text box displays the Opt Sup label (not the label for the 7b chiropractic variable).