DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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TO: Medicare-Medicaid Plans

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SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2018

The purpose of this memorandum is to provide an overview of enhancements to the plan benefit package (PBP) software for Medicare-Medicaid Plans (MMPs) for contract year (CY) 2018 and to direct MMPs to CY 2017 guidance that remains unchanged for CY 2018.

MMPs should refer to the following sections and subsections in the April 11, 2016 memorandum titled "Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2017" for information that remains unchanged for CY 2018:

- Data Entry for Medical and Other Non-Drug Services
  - Plan Type
  - Medicare Benefits
  - Medicaid and Demonstration-Specific Benefits
  - Integration of Medicare and Medicaid Benefits
  - Supplemental Benefits

- Data Entry for Drug Coverage
  - Tier Models
  - Part D Drug Cost Sharing Reductions
  - Drug Cost-Sharing Requirements (subsection remains unchanged except for updated low income subsidy (LIS) cost-sharing amounts stated later in this memorandum)
  - MMP-Specific Section Rx Data Entry Requirements

- PBP Notes

- Plan Copy Feature

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 2018 specifically impacting MMPs.

On April 7, 2017, CMS released the CY 2018 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 2018 Final Call Letter, all PBPs for CY 2018 must be submitted **no later than 11:59 p.m. PDT on June 5, 2017**. 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 2018)

- 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 9, 2017**.

Data Entry for Medical and Other Non-Drug Services

CY 2018 PBP Enhancements (Sections A, B, D, and Rx)

Among enhancements to MMP-specific fields in the PBP software for CY 2018 are the following:

- **Section A**
    - Updated the question from "Indicate CY 2017 total estimated monthly Medicare membership for this plan" to “Indicate CY2018 total projected member months for this plan” (A-2 screen)

- **Section B**
    - Simplified authorization requirement fields to “Is authorization required? Yes or No” throughout
    - Added Upgrades as a plan-covered supplemental service (1a, Hospital Inpatient Acute)

- Separated services into three distinct options: Worldwide Emergency Coverage, Worldwide Urgent Coverage, and Worldwide Emergency Transportation (4c, Worldwide Emergency/Urgent Coverage)
- Enabled "numerical limits" field when "Items/Other, describe" is selected as units (6, Home Health and 13h, Additional Services)
- Separated Chiropractic Services into two distinct options: Routine Care and Other and added "Alternative Therapies" to combined benefit question with Acupuncture and Chiropractic Services (7b, Chiropractic Services)
- Updated benefit title from “Any location” to “Any health-related location” (10b, Transportation Services)
- Added "Alternative Therapies" to combined benefit question with Acupuncture and Chiropractic Services (13a, Acupuncture)
- Separated Remote Access Technologies into two distinct options: Web/Phone based Technologies and Nursing Hotline (14c, Eligible Supplemental Benefits as defined in Chapter 4)
- Included "Is benefit unlimited?" question to Alternative Therapies and added combined benefit question to Alternative Therapies with Acupuncture and Chiropractic Services (14c, Eligible Supplemental Benefits as defined in Chapter 4)
- Separated services into three distinct options: Medicare-covered Glaucoma Screening, Diabetes Self-management Training, and Other Medicare-covered Preventive Services (14e, Other Medicare-covered Preventive Services)
- Separated services into three distinct options: Endodontics, Periodontics, and Extractions (16b, Comprehensive Dental Services)
- Separated services into two distinct options: Routine Eye Exams and Other and added the question "Is a referral required for Eye Exams?" (17b, Eye Exams)

- **Section D**
  - Updated Medicaid and plan-covered supplemental benefits lists to reflect additional or revised service category descriptions as indicated above in Section B

- **Section Rx**
  - Clarified explanation for appropriate content and added more on-screen information (Notes)

Data Entry for Drug Coverage

Drug Cost-Sharing Requirements

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 $3.35.

- 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 $8.35.

- 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 $8.35.

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 2018. Each state releases guidance to its MMPs beginning in mid-April 2017 to ensure that MMPs have ample time to prepare their PBP submissions by June 5, 2017.

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 accommodate certain mid-year changes unique to MMPs, including but not limited to mid-year legislative changes to Medicaid benefits, as well as the timing of payment rate finalization.

CMS applies the following criteria to MMP requests to change or correct PBPs:

- 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 2017 are permissible. This timeframe allows 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 2017 (see the calendar in the CY 2018 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., corrected or revised information for materials that have already been mailed to members; updates of hard copy and online versions of other materials for prospective

members). We clarify that there will be no compliance penalty for a PBP correction provided an MMP meets these conditions.

- PBP corrections unrelated to rates and supplemental benefits that are requested during the Center for Medicare's annual correction window in September 2017 (see the calendar in the CY 2018 Final Call Letter for more information) will be considered changes due to plan error. As such, these PBP corrections (or any resultant corrections to MMPs' Annual Notice of Change and/or Evidence of Coverage/Member Handbook, which must be submitted in HPMS through the errata submission process in the Marketing Module) may be subject to compliance action, regardless of whether they are positive or negative changes.

- Any PBP corrections after the Center for Medicare's annual correction window in September 2017 will be considered on a case-by-case basis. In cases where a PBP correction is due to a mid-year legislative change to Medicaid benefits (or a benefit change made in a three-way contract amendment) and an MMP's previously approved PBP submission included a more generous supplemental benefit than the new Medicaid or demonstration benefit, the MMP will be required to continue to provide the more generous supplemental benefit for the remainder of the contract year. PBP corrections (or any resultant corrections to MMPs' Annual Notice of Change and/or Evidence of Coverage/Member Handbook, which must be submitted in HPMS through the errata submission process in the Marketing Module) due to plan error may 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 2018 PBP online training module, released by CMS on April 7, 2017. MMPs will need to register and log in to access the training. The registration link is: https://hpmstraining.cms.hhs.gov/e3l11sqo7oa/event/registration.html, and the log in link is https://hpmstraining.cms.hhs.gov/e3l11sqo7oa/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 2018 > 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.