CY 2011
Plan Benefit Package (PBP)
Software Training
Advanced Users

PBP 2011 Training Agenda

Objective: Focus on CY 2011 Software & Technical Changes

- Describe Key PBP 2011 Software changes

- Describe Key SB 2011 Changes

- Provide List of Contacts

Key PBP 2011 Software Changes

PBP 2011 Section A Changes

Section A

- Read only items will display as text boxes
- A-1
  - The service area will now show in Alphabetical order by state and the counties will be in alphabetical order within each state
- A-2
  - Special Needs Institutional Types have been updated to Institutional, Institutional Equivalent (Living in the Community), and Institutional and Institutional Equivalent

Section A (Continued)

- A-3
  - Pharmacy Web Address has been added (will be populated from HPMS Contract Management)

PBP 2011 Section B Changes

Section B – General

- An edit rule has been implemented that prevents a plan from entering more than 50% coinsurance for any In-Network, Medicare-Covered service category

- ESRD 1 plans
  - All authorization and referral questions for Medicare-covered services have been disabled [B-1 through B-18]

Section B – General

- Separate office visit cost share questions
  - The plan can now indicate the separate office visit cost share amounts in each applicable category
    - Coinsurance Min/Max fields
    - Copayment Min/Max fields

Section B – 13c, 13f, 16b

- B-13c (OTC)

  - The question "Does this cover all of the FSA Feds OTC list?" has been changed to "Does this cover all of the CMS OTC list?"

- B-13f (Other 2)

  - This has been added as a new category; it mirrors the format of B-13e (Other 1)

- B-16b (PCP)

  - "Emergency Services" has been changed to "Non-routine Services"

PBP 2011 Section C Changes

Section C – General

- Cost Share Reduction has been removed

- Foreign Visitor/Travel benefit has been removed

- 13f (Other 2) has been incorporated into the category picklists

- An edit rule has been implemented that prevents a plan from entering more than 50% coinsurance for any OON Medicare-Covered service category

Section C – OON

- A new validation rule ensures that PPOs are required to offer categories 10b, 13b, 13c, 13d, 13e, 13f, 16a, and 18b only if the In-Network benefit is Mandatory

  - These categories are not required to be offered OON if the In-Network benefit is not offered or if it is Optional

- If the plan covers a service category (other than Inpatient Hospital and SNF), that category must be included in a Cost Share Group

  - An error message has been added indicating the benefit is not included in a group

PBP 2011
Section D
Changes

Section D – Plan-level Deductible

- 13f (Other 2) has been incorporated into the category picklists

- Optional Supplemental:
  - A label has been added showing examples that cannot be optional supplemental benefits
  - A Notes field has been added on the Opt Supp Label and Premium screen in case the plan selects 'Other, describe' for the Maximum Plan Benefit Coverage periodicity

PBP 2011
Section Rx
Changes

Section Rx – General 1 Screen

- A maximum of 6 tiers may be described

- A Defined Standard Plan will not enter the number of tiers in the Part D benefit
    - The associated label has been removed

- The Part D Payment Demo questions have been removed

Section Rx – General 1 Screen

- The following questions have been added for all MA-PD Enhanced Alternative (EA) plans:
  - Do you have a basic Part D plan (DS, AE, BA) that provides required prescription drug coverage to beneficiaries in the service area covered by this EA plan?
  - If No, then the following question is enabled
    - Is this plan to be treated as your basic plan, where you have bought down your supplemental part D premium to zero?

Section Rx – General 2 Screen

- An OTC Medication Attestation statement will be enabled when a MA-PD plan answers Yes to 'Do you pay for OTCs under the utilization management program'
  - The user must click on the enabled attestation radio button confirming that there will be no duplicative coverage of OTCs under both Part C and Part D

Section Rx – General 2 Screen (Con't)

- After the user clicks on the attestation, the following question will be enabled:
    - Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?
    - A label has been added for the OTCs Step Therapy protocol

Section Rx – Excluded Drugs and Pre-ICL Screen

- For Enhanced Alternative plans
  - The areas throughout the benefit where the Part D cost sharing is reflected have been modified and now include:
    - Reduced deductible
    - Reduced Pre-ICL cost shares
    - Raised ICL
    - Reduced coverage gap cost shares
    - Reduced post-threshold cost shares

Section Rx – New Edit Rules

- For Specialty Tiers, the 2011 cost share value maximums have been incorporated into an edit rule, based on the plan's deductible amount

  - These rules only apply Pre-ICL

Section Rx – New Edit Rules

- For Enhanced Alternative plans
  - If the plan indicates that it offers reduced post-threshold cost shares, then it cannot select Medicare-defined post threshold cost shares for its cost sharing beyond the Part D annual out-of-pocket cost threshold
  - If the plan indicates that it offers reduced Pre-ICL cost shares, then it cannot select Medicare-defined Part D coinsurance amount for its cost sharing before the ICL is reached
  - If the plan indicates Cost Share Tiers pre-ICL, and selects Coinsurance, then at least one coinsurance amount must be less than 25%

Section Rx – Tiers

- Tier names are now standardized based on the drug type(s) selected in the tier

- Users must select the tier name from a Tier Label Selection list

- A rule will enforce that the label selection matches the drug type choices

- To assist the user, on-screen labels have been added to explain the selection options

Section Rx – Tiers

- If the plan indicates that the Tier Type includes "Part D Drugs Only" or "Both Part D and Excluded Drugs", then the following question will be enabled:

  - Injectable Drug Only Tier?

Section Rx – Alternative ICL Screen

- The Limited Gap Coverage questions and label have been removed

Section Rx – Alternative Gap Coverage Screen

- The questions for describing the gap coverage for Generic drugs and for Brand drugs, and the associated labels, have been removed

- The following question has been added to identify which tiers are included in gap coverage:

  - Select the tiers that include gap coverage (select all that apply)

- The plan may only enter gap tier information for the tiers selected on this screen. All unselected tiers will be disabled in the subsequent gap tier screens

Section Rx – Gap Tiers

- The following two questions indicating individual tier gap coverage have been removed
  - Is the member cost share for any drugs in this Tier less than 100%?
  - Are all drugs on this tier covered through the gap?

Section Rx – Gap Tiers (Con't)

- A new question indicating tier gap coverage has been added:

  - To what extent are Pre-ICL covered drugs on tier # covered through the gap?

    - All drugs on this tier are covered through the gap (Full Tier Gap Coverage)

    - Some drugs from this tier are covered through the gap (Partial Tier Gap Coverage)

Section Rx – Gap Coverage Screen

File   Help

| <<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** | Alternative - Gap Coverage ▼ |

Do you offer Gap Coverage?

◉ Yes
○ No

Select the tiers that include gap coverage (select all that apply):
☑ Tier 1
☑ Tier 2
☑ Tier 3
☐ Tier 4
☐ Tier 5
☐ Tier 6

- Gap Coverage questions have been revised—only the tiers selected on this screen will be enabled

Section Rx – Gap Tier Screen

File   Help   Tiers

| <<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** | Alternative - Gap Tier Coverage (3) ▾ |

To what extent are any Pre-ICL covered drugs on this tier covered through the gap?

○ All drugs on this tier are covered through the gap (Full Tier Gap Coverage)
◉ Some drugs from this tier are covered through the gap (Partial Tier Gap Coverage)

The gap coverage supplemental file may not include any drugs from a tier that is fully covered in the gap.

Are you offering any excluded drugs as part of your gap coverage?

◉ Yes
○ No

If you select Partial Tier Gap Coverage, you must submit a gap supplemental file for drugs on the partially covered tier with the exception of excluded drugs which cannot be included on the gap supplemental file. The gap supplemental file should be uploaded through the Formulary Submission Module on June 16, 2010.

Does the gap coverage on this tier only include excluded drugs?

○ Yes
○ No

- Gap Tier Coverage questions have been revised and labels have been added.

Section Rx – Notes

- There is a limit of 225 characters in the Rx Notes field

Plan Copy

- The year-to-year plan copy (Prior Year Plan Copy) has been updated based on CY2011 requirements

- Any fields which have been added and/or modified will not be included in the Prior Year Plan Copy functionality. No Section Rx data will be copied from CY2010

SB 2011
Changes

SB – Introductions and Original Medicare Sentences

- SB Introductions
  - All Introductions have been revised

- Original Medicare sentences
  - The $0 cost sharing SNP sentences will generate for the Medicaid Subset $0 cost-sharing SNPs
  - SB-21: Sentences have been added regarding HIV screening

SB – Plan Sentences

- Dual Eligible SNPs
  - The following sentence has been added in SB-1:
    - ** Please consult with your plan about cost sharing when receiving services from out-of-network providers
  - The Out-of-Network cost share sentences for Dual Eligible SNPs have been modified so that if there is a Medicare-covered component to the benefit, then a double asterisk ** has been added to the sentence

SB – Plan Sentences

- Dual Eligible SNPs
  - If the service area is Puerto Rico and the plan indicates that it intends to participate in the Platino program, a sentence will be generated in SB-29 showing the deductible levels and use placeholder cost share amounts until they are determined at a later date
  - For plans that indicate they do NOT intend to participate in the Platino program, the SB-29 cost share sentences will be based on their data entry in PBP – Rx

SB – Plan Sentences

- For sentences that include a list of categories, the PBP category labels will be used instead of the SB category labels

- $0 co-pay sentences will be generated under the Out-of-Network heading, when the plan indicates no Out-of-Network cost-sharing for applicable categories

- The coverage limit sentences have been updated from "$xxx limit for….." to "$xxx plan coverage limit for….."

SB – Plan Sentences

- SB-5: The sentences have been modified if the plan indicates that it allows less than a 3 day hospital stay prior to SNF admission

- SB-8: Sentences will be automatically generated regarding HIV screening

- SB-17: If a plan indicates that the Medicare Coverage Limit applies, then the following sentence will generate under the General heading:

  - There may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits

SB – Plan Sentences

- SB-31 and SB-32: If the plan offers optional supplemental benefits, then a sentence will be generated under the In-Network heading to reference the optional benefit

SB – Plan Sentences

- Plan sentences have been revised in accordance with PBP 2011 data entry changes
  - Example:
    - The separate office visit cost sharing sentences have been modified to accommodate the new cost sharing values (i.e., min/max co-pay and min/max coinsurance) entered in the respective categories

PBP & SB

Contacts

PBP Contact List

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