CMS 2011 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN
SPRING CONFERENCE
APRIL 12-13, 2011 | MARRIOTT HUNT VALLEY INN | BALTIMORE, MD

Sara Silver
Division of Plan Data
CMS

Today we're going to go through the overview of the PBP changes, so just a reminder: this is very high level. These are some of your bigger impact PBP changes. So, you've heard a lot of discussion about all of the benefit changes this year and benefit policy. And here's the application of those different benefit policies in the software and different edit rules and changes. So, we're going to go through PBP changes. Lucia is going to go through some of the high level SB changes, and of course a list of contacts. If you have any questions, again please feel free to contact us. And the sooner you contact us, the better. The closer we get to that June 6th deadline, things get pretty crazy.

I do want to just say this is a high level overview. If you go to the HPMS bid submission Webpage, you will see that we have approximately 50 pages of changes. So, we can't do that in a, you know, 30-minute presentation here today. But there are a lot of changes, and that goes through the very gory details of all of the changes.

So, the first set of changes are in Section A of the PBP software. And again, a lot of those changes and comments we have received through our lessons learned process through the industry. So again, I always want to strongly encourage people to submit comments to CMS. We review all of the comments that you submit, and this is, you know, a prime example of the changes that we take from industry and that we apply to our software in our practices.

So, we're providing organizations the opportunity to indicate for Section B, Section C, and Section D of the software if you were planning on submitting a standard bid or essentially a Fee-For-Service Bid by answering "yes" or "no" to a question in Section A of the software. So, this is asked separately for each section, so you can answer "yes" that you're offering the standard bid for Section B of the software, but not for Sections C or D. And essentially by answering the question "yes" in the PBP software, the rest of the questions will be disabled to you in that applicable section of the software because we already know the benefit design that you plan on offering. For example, this may be very helpful for people submitting employer plan bids because this will ensure that you're complying with CMS cost share standards, and it will help to alleviate some of the data entry burden that you have.

So, we've outlined here what you're essentially saying the benefit package is by answering "yes" to these questions. So, if you answer "yes" that you're offering a standard benefit in Section B, you're offering the fee-for-service cost sharing for inpatient hospital and SNF, Skilled Nursing Facility, zero percent coinsurance for home health and preventive services, 40 percent coinsurance for outpatient mental health care, and 20 percent coinsurance for all other benefits.

In Section C, this is going to be enabled, depending on your plan type, which sections are going to be enabled to you in Section C. So, if you're a PPO, for example, and you have out-of-network screens enabled to you, you can answer in Section A that for Section C you're filing a standard bid, and then you're going to be offering the cost share that's outlined on the screen, which is very similar to what you would have indicated in Section B of the software. Also, the U.S. visitor travel benefit would not be offered if you're indicating that you're offering the standard bid.

Something worth noting with all of these, if you have any modifications to what is on the standard bid, you have to answer "no" to the standard bid question and complete all of the data entry in the PBP. So, it's an all or nothing type of question.

CMS 2011 Medicare Advantage And Prescription Drug Plan

So again, in Section C, if you're an HMO POS offering the point of service benefit, this is what we'd automatically fill out if you indicate that you are offering the standard bid. You're offering the POS benefit as a mandatory supplemental benefit, and it includes all categories. And again, the cost sharing is very similar to what you saw in Section B for your in-network cost sharing.

Section D, if you indicate that you're offering a standard bid, what this means is that you're offering the Medicare-defined Part B deductible amount and that that deductible does not apply to inpatient, SNF, home health, and preventive services. So, that's what that benefit would be. The Max Enrollee Cost Limit, we're applying the mandatory maximum out-of-pocket limit. And again, if you're like a PPO and you have an out-of-network benefit, we would have the $10,000 catastrophic coverage limit. And you would not be offering any Max Plan benefit coverage amounts. So again, those are your big changes in Section A of the software.

Moving on to Section B, so here are your cost share limits. And I'm not going to go over these limits, but the purpose of me showing this here is that we're enforcing edit rules in the PBP software this year, that you will not be able to submit your bid unless you comply with these cost share standards. So, you will receive error messages when you're trying to exit and validate the applicable sections if you're not meeting these standards. We are applying the standards that are different between the voluntary and mandatory moot, so we will be looking at that data entry as well. So, this should help you with your bid submission, kind of help you ensure that you're submitting a big that's something that CMS can improve. So, I'll just scroll through those. So again, and I think Dale had all of those in his presentation. And they are in the call letter and the additional standards will also be in that policy memo that Dale spoke about earlier today.

Section 3 of the PBP software previously was the CORF benefit. But we've actually removed this data entry screen from the software. And the reason is because it's really not a Medicare defined benefit, it's a place for specific services, and we already collect the cost sharing for the services in other sections of the PBP software. So it was in some ways duplicate data entry for some organizations. Instead, we've moved the cardiac rehabilitation services here, and we've expanded the data entry, so there's more comprehensive data entry for the section.

One of the big changes is really for the Preventive Services Section though. We've revised Section 14 completely, and we've moved all Medicare covered- well in-network Medicare covered zero cost sharing preventive services, so it's all in one section. And you are attesting that you are complying with CMS's standards. Last year's plans, we worked with you throughout the summer. And, you know, there was some confusion, and understandably so, because you had to figure out which categories we were talking about that you had to enter zero cost sharing to say that you were offering the Medicare-covered services at zero cost sharing. So, we've removed that complexity from your data entry, moved them all together in one section, and it's an attestation.

So, as a result, the rest of the data entry on these screens has been modified. We have that attestation be 14a. We have a supplemental preventive health benefit, supplemental education and wellness program. We've added separate data entry for kidney disease education services and the diabetes health management training.

So, here's just a list of Medicare-covered services. Again, this is outlined in other documentation that is available to you. This will all be listed in the PBP software, so you know what you're attesting to.

Okay, the Supplemental Preventive Health services, something that we want to point out, this section is really only for entering data that you're offering additional immunizations. So, we have an on-screen note there to make sure that you're only indicating that you're only offering additional immunizations. There are some other check boxes that will be available to you, but CMS does not think you should be, you know, indicating those benefits, just the other immunization section. So, here's the list of everything that's outlined there and, as we said, just the other immunizations.

Kidney Disease Education Services, we now have that broken out into its separate data entry categories, so you can enter your minimum and maximum cost share amounts in this section. We've also renamed the diabetes monitoring section, and we've moved the section, as applicable, because we've modified all the categories in B-14.

CMS 2011 Medicare Advantage And Prescription Drug Plan

Okay, Section C, really two main changes. The Out-Of-Network, again this came from a comment through lessons learned. We're now going to allow organizations to enter a maximum benefit coverage amount for non-Medicare benefits out-of-network. Previously, you didn't have the option to enter that. So, if you have a supplemental dental benefit and you're a PPO and you want to have a maximum amount of $500 on that benefit out-of-network, you now have the ability to enter that in the out-of-network section.

Also, for the Visitor Travel, you'll notice that the data entry is significantly reduced. You only have two questions that are actually available to you. You can indicate if you're offering the U.S. Visitor Travel program, and you can indicate if it's a mandatory or optional benefit. And the reason why this has been done, and I believe this is actually outlined in the 2011 call letter, was because of the access and availability requirements that if you're offering a U.S. Visitor Travel program, then you have to offer those benefits at your in-network cost-sharing amounts. So, we've already collected your in-network cost sharing amounts in Section B of the PBP tool. We don't need to collect it again in Section C, so we've removed the additional cost sharing data entry screens for the Visitor Travel benefit.

Section D changes, we've made some modifications to the picklists in Section D so you can more completely indicate the benefits that you're offering. So we've updated the non-Medicare, or the supplemental picklists. So you can pick any category that has any supplemental component. Before you could only select categories that only had a supplemental component, so we've expanded the list. And we have edit rules around that list to ensure you're not picking a benefit category that you're not offering a supplemental benefit offering.

Also, on the deductible screen, we have a new edit rule that you cannot select B-14a, which is your zero cost-sharing preventive services benefit as a part of your combined, or your in-network deductible. And the reason for this is you're attesting that you're offering it at zero cost-sharing. You can't have a deductible with these preventive service benefits. So again, we're preventing you from trying to indicate a benefit that CMS will not approve.

Here are the maximum out-of-pocket amounts. We have with the voluntary/mandatory. Dale went through this, I believe, earlier in the day. But these are edit rules in the system. So again, you won't be able to upload a bid unless you're indicating one of these voluntary or mandatory amounts. So, we're trying to help you with your data entry process to make sure that what you upload is complete and complies with CMS's standards. That's just the second half.

So, some of the Rx changes, and again these are just some of the high level changes. Supplemental formulary files, I think you've heard several times that it's due June 13th. We have on-screen notes in the plan benefit package software indicating this due date. So, just another reminder about that deadline.

We've also made some modifications. I'm not sure if anyone here is from Puerto Rico and participates in the Platino Program, but you can only have a basic Part D offering. So that's the defined standard actuarially equivalent and basic alternative Part D types. You may not offer an enhanced alternative drug type.

And this is just kind of reiterating the policy of what you need to enter and be sure that this complies with CMS's standards. There are not edit rules in the software about this sixth tier, but please be sure when you're doing this data entry that you're complying with the standards that are outlined in the call letter, and that if you do indicate a sixth tier, it's only for the reason that CMS has already identified.

Okay, and this is just allowing organizations to enter excluded drug information. So, if you're indicating Medicare-defined cost sharing in other parts of the PBP software, you have much more limited data entry. But we're still going to allow you to define your excluded drug cost sharing separately, because it may be different than what you're offering for your Medicare Part D drugs.

And here are the tier labels. The reason why we wanted to put these here is to also outline what edit rules we have in the software versus which edit rules we do not have in the software. Due to timing issues, we unfortunately do not have these edit rules in the software that your tier labels comply with the tier labels that have been outlined in the call letter. So please use that as a reference when you are completing the PBP software tool.

CMS 2011 Medicare Advantage And Prescription Drug Plan

Something I do what to point out is I think we've gotten a few questions about the drugs being offered on the tier and the tier labels. Some people I think have indicated that the tier labels outlined here aren't tier labels that they can offer. But I think some people are getting the tier labels confused with the drugs actually being covered on the tier. So, all these labels will work. You will be able to exit and validate the PBP software, but there are additional validation rules about the type of drugs being offered on each tier with the whole preferred and non-preferred selections.

Okay, we have some new edit rules. Excluded drug-only tiers must be the highest numbered tier offered. So, if you have a five-tier formulary, and you have an excluded drug tier, it has to be the fifth tier. There is a validation rule that that is required. We have some additional validation rules that if you're indicating you're offering additional generic gap coverage, then the coinsurance cannot be greater than what the defined standard gap, generic gap, coverage amount is. Otherwise, you're really not offering any additional gap coverage. So, we've added those edit rules in there for you.

And there's also a rule that you cannot use duplicative tier names in the software. You'll not be able to validate with that. And we have the requirement that Tier 1 must include the term "generic" in the tier. And it can either be generic or preferred generic, which is outlined on the tier label options chart. Some additional edit rules about generic, and these same rules also apply to brand drugs, if you have at least one tier label, or if you have two or more tier labels that use the term "generic," then you must have one label with "preferred generic" and another label with the "non-preferred generic." And the preferred generic must be a lower tier number than your non-preferred generic tier. Similar rules apply to brand. If you're going to have two brand tiers, one must be "preferred brand" the other "non-preferred brand," and the preferred brand tier must be a lower tier number.

Okay, and with that, I'm going to turn it over to Lucia.

Lucia Patrone: I like this step stool. Good afternoon, everyone. I'm Lucia Patrone. Thank you, Sara. As you can imagine, there have been many changes to the Summary of Benefits for 2012 in order to properly reflect the 2012 changes to the PBP software. So I'm going to briefly go over some of the high level changes that have occurred to the 2012 Summary of Benefits, or, as we call it, the SB. If you have any questions on how a particular scenario would generate in SB, there will also be CMS and PBP representatives around during the conference as well as upstairs in the PBP breakout.

So, we also recommend that you access the PBP to SB crosswalk, which can be found on the HPMS CY2012 bid submission start page under the documentation link. This document provides every SB sentence that will generate based on your PBP data entry.

For CY2012, the SB is revised to include the Medicare covered preventive services that must be offered at zero dollar cost share in one section. And Sara went in to describe those as well. And you can always- we have plenty of resources that you can find that list. But, as a result of these preventive services, the SB categories have been renamed and reordered from SB-22 through the end of the SB.

And the following are the new SB categories from SB-22 on that you can see here. And the three categories of particular note are SB-22, SB-23, and SB-24, which were affected by this renumbering. The following categories on this slide have been removed because of the Medicare-covered preventive services that were covered though SB-22, their enhanced components have been located now to SB-23. And you can see on the screen the list of those services. And SB-22 is now actually a brand new SB category. And it previously resided in SB-17. And now it provides more cost sharing data. And that's SB-22, which is cardiac and pulmonary rehabilitation services. In addition, there's one other change is that in SB-34 there now that covers SB over-the-counter items. Also, to reflect all of the many changes for this year, all of the SB introductions have been updated to reflect the 2012 PBP changes. And an important note for CY2012 SB is that some sentences are only available for the designated plan type and may not be applicable for all plan types.

In all SB introductions, the following sentence under "What are my protections in this plan?" have been updated from 60 to 90 days. And the new question now reads, "If a plan decides not to continue, it must send you a later at least 90 days before your coverage will end." In addition, a couple other items of note are in the PBP Section A-5, as Sara described

CMS 2011 Medicare Advantage And Prescription Drug Plan

referencing the standard bid questions, if a plan selects "yes" to any of the standard bid questions, the appropriate SB sentence will generate as if the data entry was filled out within that particular section in the PBP.

There are also several SB changes that have been updated throughout the document for greater consistency. In SB-1, premium and other important information, the phrase "non-Medicare covered services" now reads as "non-Medicaid supplemental services." The deductible sentences have also been updated, so now they use the word "annual" instead of "yearly." And finally, the MOOP sentences have been updated so that, depending on the MOOP scenario, different text will generate appropriately.

I would also like to just conclude that we have our list of SB and PBP contacts here and that if you're interested in speaking to one of us, either Sara, myself, or another PBP representative, please come up at the conclusion of this session. We're going to be upstairs. If you take the escalators upstairs and hang a right, we're in Ballroom Maryland 4. And we have the PBP set up on some computers there. So if you have particular plan benefit packages or scenarios that you'd like to run past us and see how it would reflect, we'll be there to discuss and also as well for tomorrow.