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

CENTER FOR MEDICARE

DATE: April 11, 2014

TO: Medicare-Medicaid Plans

FROM: Tracey McCutcheon, MHSA, MBA
Acting Director, Medicare Drug Benefit and C&D Data Group

Danielle R. Moon, J.D., M.P.A.
Director, Medicare Drug & Health Plan Contract Administration Group

SUBJECT: Medicare-Medicaid Plan Submission of Plan Benefit Packages for Contract Year 2015

The purpose of this memorandum is to provide an overview of the enhancements to the plan benefit package (PBP) software functionality for Medicare-Medicaid Plans (MMPs) for contract year (CY) 2015. CMS has made additional modifications to the PBP software for CY 2015 in order to accommodate more integrated benefit data entry.

On April 11, 2014, CMS released the CY 2015 PBP software in HPMS. As articulated in our January 13, 2014 and January 14, 2014 HPMS guidance memoranda for Medicare-Medicaid Plans (MMPs), "CY 2015 Capitated Financial Alignment Demonstration Timeline," and "Capitated Financial Alignment Demonstration Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2015," respectively, MMPs will use the PBP software to annually submit a benefit package that integrates Medicare, Medicaid, and demonstration-specific benefits.

All PBP submissions for CY 2015 are due no later than June 2, 2014 (11:59pm PT).

Data Entry for Medical and Other Non-Drug Services

MMPs must define themselves as either a Health Maintenance Organization (HMO) or a Health Maintenance Organization Point-of-Service (HMOPOS) plan in the 2015 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 benefit and indicated in section C of the PBP.

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. In addition, all supplemental (non-Medicare) benefits must be mandatory benefits; optional benefits will not be permitted, as enforced by exit and/or other validation rules.

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 or a waiver of the 3-day inpatient stay for skilled nursing facility stays) 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 and Base 6 screens), respectively. MMPs will have the opportunity in section C 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.

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 will have 14 pre-defined Medicaid service categories, plus 18 (versus 13 in CY 2014) 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.

Over-the-counter (OTC) drug and pharmacy benefits should not be described 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 to indicate 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 so 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 12 p.m. ET on June 6, 2014). 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.

In addition, we have made the following enhancements to the PBP software for CY 2015:

- **Section B-6 (Home Health Services – MMP Screens)**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - The following questions have been added for all benefits in the B6 – MMP Base 1 and 2 screens:
        - Is there a limit on services provided?
        - Select Non-Medicare Home Health Services where limit applies
        - Indicate units a limit will be provided in

        - Indicate numerical limit on the services provided
        - Select limit on services periodicity
    - Addition of the following question: "Does any service require qualification for and enrollment in a state-operated waiver program?"
    - Addition of a "Notes (Optional)" field

- **Section B-7c: Occupational Therapy Services (MMP Screens)**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - Addition of a "Notes (Optional)" field

- **Section B-7i: PT and ST Services (MMP Screens)**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - Addition of a "Notes (Optional)" field

- **Section B-11a: DME (MMP Screens)**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - Addition of a "Notes (Optional)" field

- **Section B-11b: DME (MMP Screens)**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - Addition of a "Notes (Optional)" field

- **Section B-13h: Additional Services**
    - Character limits for MMP-specific blank "other" service categories have been increased to 72 characters.
    - "Services in an Intermediate Care Facility for the Mentally Retarded" has been updated to "Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities."
    - Five additional "other" service categories have been added
    - The following questions have been added for all benefits in the Base 2 through Base 10 screens:
        - Is there a limit on services provided?
        - Select Additional Services where limit applies
        - Indicate units a limit will be provided in
        - Indicate numerical limit on the services provided
        - Select limit on services periodicity

- Addition of the following question: "Does any service require qualification for and enrollment in a state-operated waiver program?"
- Addition of the following questions:
  - Is a beneficiary receiving this amount subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount")?
  - Minimum monthly payment amount
  - Maximum monthly payment amount
- Addition of an additional "Notes (Optional)" field

Data Entry for Drug Coverage

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. In late 2013, we asked MMP to provide comments on enhancements CMS could make to the CY 2014 MMP formulary tier models. Based on those comments, we revised the formulary tier models as described below. A table summarizing the new CY 2015 MMP tier models can be found in Appendix A.

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." For CY 2015, that may include tiers up to and including the 5th tier, 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.

For tiers with Part D drugs, MMPs will have the flexibility to reduce cost-sharing for all enrollees below the statutory low-income subsidy (LIS) maximum copayment amounts for brands and 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.

For cost-sharing before the out-of-pocket threshold, MMPs will have a cost sharing screen (the Alternative- Medicare-Medicaid Copayment – Pre-ICL 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 2015 will be assumed and the copayment fields will be disabled for these tiers).

The following validations related to the tier content have been added to the 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 $2.65.

    - 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 $6.60.

    - 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 $6.60.

- 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.

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 have been added to 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.)

Since CY 2014, we have included additional data entry requirements for MMPs in order 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 enhancements 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 Initial Coverage Limit (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, beginning in CY 2014.

- 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 will be disabled on all pharmacy location screens;

- MMP data entry for Standard/Preferred Mail Order Cost-Sharing will be 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 2015 PBP software will allow MMPs to enable this option and enter the MOOP amount.

PBP Notes

The notes fields in Sections B, C and D of the PBP have a 3,000 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.

CMS-State Joint Review

The PBP review will be conducted jointly between CMS, which will ensure all Medicare Parts A, B, and D benefits have been adequately captured, and the states, which will verify that all Medicaid and demonstration-specific benefits have been adequately captured. The Medicare-Medicaid Coordination Office has requested that all states participating in the Capitated Financial Alignment Demonstration provide their MMPs with guidance on the submission of Medicaid and demonstration-specific benefits for CY 2015, including any requirements to lower Part D cost-sharing below the statutory low-income subsidy cost-sharing amounts and requirements for coverage of non-Part D drugs, by late April 2014. This will ensure that MMPs have ample time to prepare their PBP submissions by June 2, 2014.

We appreciate that flexibility will be needed with respect to the review of PBP submissions, especially in the absence of final state-CMS memoranda of understanding in some states and final payment rate information for CY 2015. To that end, we anticipate that there will be opportunities to resubmit PBPs after CMS and the states have conducted their initial reviews, primarily so that MMPs can modify their supplemental benefits. However, initial reviews by CMS and State staff will begin in early June following the PBP submission deadline, and we expect that the CMS reviews of required Medicare benefits, including Part D benefits, will be completed by late summer 2014.

For additional information, MMPs should complete the CY 2015 PBP online training module, released by CMS on April 11, 2014 and available at: https://hpmstraining.cms.hhs.gov/pbptraining2015/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 2015 > Documentation > Bid User's 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

		CY2015 Tier Model Medicare/Medicaid Plans					
2015 Tier Structure	**2015 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	Non-Preferred 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	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	----	----
4 tier	B	Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC	----	----
4 tier	C	Preferred Generic	Non-Preferred 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	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare RX/OTC	----
5 tier	B	$0 Drugs	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare RX/OTC	----
5 tier	C	$0 Drugs	Preferred 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	Non-Preferred Generic	Brand	Non-Medicare Rx Drugs	Non-Medicare OTC	----
6 tier	A	$0 Drugs	Preferred Generic	Non-Preferred Generic	Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	B	$0 Drugs	Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	C	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx Drugs	Non-Medicare OTC
6 tier	D	$0 Drugs	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Non-Medicare Rx/OTC