Note: The HPMS Help Desk can be reached at either hpms@cms.hhs.gov or 1-800-220-2028.

PBP/SB FAQs:

1. **Why are MMPs not listed in the PBP plan list for plan copy from the previous year?**

   MMPs are not available in year-to-year plan copy this year. This will be updated for CY2016 so that MMPs will be able to copy a plan from the previous year.

2. **On Section A-6 the question "Is your organization filing a standard bid for Section D of the PBP?" is grayed out for PPO plans. Why can we not answer this question?**

   PPO plans cannot answer the Standard bid question for Section D this year since an LPPO and/or RPPO annual deductible amount entered as either a "Single Deductible" or "Differentially applied to Part A and Part B Medicare services, reflecting Original Medicare payment structure" can both be considered a Standard Bid in Section D. PPO plans DO need to fill out Section D this year.

   If you would like a quicker way to fill out Section D for LPPO and/or RPPO plans, you can do the following:

   - Complete Section D data entry for one of the plans and Exit (validate).
   - Click on "Copy Plan" on the PBP Management Screen.
   - On the PBP Copy plan screen choose the plan that you completed Section D data entry in the picklist on the left in Step 1: Select Source plan and Destination Plan(s).
   - Choose the plan(s) that should have the same Section D data entry in the picklist on the right in Step 1: Select Source plan and Destination Plan(s).
   - Choose Section D in Step 2: Select Copy Type.

   Once these steps have been completed, the Section D data will be completely filled out for those plans.

3. **In the Section B-14c: Eligible Supplemental Benefits Category, there is only one field for maximum plan benefit amount. This does not accurately show the benefits that our plan offers. What are your recommendations for filling out the maximum plan benefit for this category?**

Only one maximum plan benefit amount can be entered for all services in B14c. Please enter the maximum plan benefit amount and then enter additional information in the Notes field to clarify the maximum plan benefit.

4. **If a plan enters a deductible that does not apply to all tiers in Section Rx, then that is not being reflected in the SB.**

   The software is working properly per design. If more clarification is needed, please use the free form text to further describe the split tier deductible in the Initial Coverage section of the SB within Prescription Drug Benefits.

PBP Known Issues:

The following items are PBP issues that can either be addressed with a workaround or by contacting the Help Desk.

1. **In Section B2 – SNF, the PBP is validating against a copay of $156 per day instead of $156.50 per day for days 21 through 100.**

   To work around this issue, please take the following steps:

   - Make sure the Section D Max Cost limit screens have "No" entered for all of the "Is there a Maximum Enrollee Out-of-Pocket Cost" questions. Exit (no validate).
   - Enter all data in Section B2 - SNF, fill out the copay with $156.50, and exit (validate).
   - Enter section D and fill out all screens.

   NOTE: Do NOT re-open Section B-2, or the error message will pop back up.

2. **If a PPO plan covers any benefit up to a certain dollar amount (maximum plan benefit) for "both In-Network and Out-of-Network" services, the Out-of-Network section is forcing the plan to enter a maximum plan benefit that matches the In-Network amount even though it is already covered in the In-Network section for that benefit.**

   To work around this issue, please take the following steps:

   - Enter the maximum plan benefit in the Section B category with "Both In-network and Out-of-Network services" chosen for the question "Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?"

- In section C make sure the benefit category in question is in its own group
- Enter "Yes" for the question "Is there a maximum plan benefit coverage amount for this group?" for the group containing the benefit category
- Enter the same exact Maximum plan benefit amount that was entered in the Section B benefit category.

NOTE: This can happen for any of the following categories: 16a – Preventive Dental, 16b – Comprehensive Dental, 17a – Eye Exams, 17b – Eyewear, 18a – Hearing Exams, 18b – Hearing Aids

3. **The POS section is giving an error message that will not allow a plan to select an authorization and/or referral for certain categories that are not selected on the Base 1 screen even when those categories have been selected.**

   To work around this issue, please contact the Help Desk so that they can assist.

SB Issues:

The following items will be part of the SB HCC Global List. These items are issues in the SB that will be fixed on the HPMS Report and will be automatically approved SB hard copy changes for the local SB. The table below contains the SB category, the affected plan type, the existing sentence that should be changed in the SB, approved text for the new sentence, and a description of the change.

NOTE: This is not the complete SB HCC Global List. This list contains only those items that were identified as of **5/21/2014**.

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change
1	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	PPO	< Medicare-covered "per stay" cost sharing sentence missing >	• In-network: • <*cost sharing*> per stay	If a plan: • has per-stay cost sharing for the Medicare-covered benefit; • offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and • indicates that Non-Medicare-covered stay cost share

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change
					structure is the same as the Medicare-covered stay Then, the Medicare-covered "per stay" cost sharing sentences are not generating.
2	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	HMO, HMOPOS (with optional POS) Non-Network PFFS	< Medicare-covered "per stay" cost sharing sentence missing >	• *<deductible>* • *<cost sharing>* per stay	If a plan: • has per-stay cost sharing for the Medicare-covered benefit; • offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and • indicates that Non-Medicare-covered cost share structure is the same as the Medicare-covered stay Then, the Medicare-covered "per stay" cost sharing sentences are not generating.

3	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	HMOPOS (with mandatory POS, Full PFFS Partial PFFS	< Medicare-covered "per stay" cost sharing sentence missing >	• In-network:
				  • *<deductible>*
				  • *<cost sharing>* per stay
					If a plan:
					• has per-stay cost sharing for the Medicare-covered benefit;
					• offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and
					• indicates that Non-Medicare-covered cost share structure is the same as the Medicare-covered stay

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change
					Then, the Medicare-covered "per stay" cost sharing sentences are not generating.
4	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	PPO	< Medicare-covered "per day" cost sharing sentence missing >	• In-network: • *<Up to 3 Intervals for first 90 days><cost sharing>* for days *<Begin Day>* through *<End Day>*	If a plan: • has per-day cost sharing for the Medicare-covered benefit; • offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and • indicates that this cost share structure is the same as the Medicare-covered stay Then, the Medicare-covered "per day" cost sharing sentences are not generating.
5	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	HMO, HMOPOS (with optional POS), non-network PFFS	< Medicare-covered "per day" cost sharing sentence missing >	• *<deductible>* • *<Up to 3 Intervals for first 90 days><cost sharing>* for days *<Begin Day>* through *<End Day>*	If a plan: • has per-day cost sharing for the Medicare-covered benefit; • offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and • indicates that Non-Medicare-covered cost share structure is the same as the Medicare-covered stay Then, the Medicare-covered "per day" cost sharing sentences are not generating.

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change

6	Mental Health Care, Inpatient Hospital Care, Skilled Nursing Facility (SNF)	HMOPOS (with mandatory POS) and Full or Partial Network PFFS	< Medicare-covered "per day" cost sharing sentence missing >	• In-network:
				  • *<deductible>*
				  • *<Up to 3 intervals for first 90 days><cost sharing>* for days *<Begin Day>* through *<End Day*
					If a plan:
					• has per-day cost sharing for the Medicare-covered benefit;
					• offers Non-Medicare-covered stay as a Mandatory Supplemental benefit; and
					• indicates that Non-Medicare-covered cost share structure is the same as the Medicare-covered stay
					Then, the Medicare-covered "per day" cost sharing sentences are not generating.

7	Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	HMO	In this plan, you will pay nothing for Medicare-covered services from in-network providers.	<Delete sentence>	If an HMO plan enters an INN MOOP greater than $0 in Section D, then astray sentence is generating.
8	Optional Benefits	HMO HMOPOS LPPO RPPO Non-Network PFFS	• Eligible Supplemental Benefits as Defined in Chapter 4	• Eligible Supplemental Benefits	If a plan includes 14c: Eligible Supplemental Benefits as Defined in Chapter 4 in any Optional Supplemental Package, then the sentence displays as " "Eligible Supplemental Benefits as Defined in Chapter 4" when it should be

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change
		Partial Network PFFS Full Network PFFS PSO (State License) 1876 Cost			"Eligible Supplemental Benefits". The wording "as Defined in Chapter 4" should be removed.
9	Outpatient Prescription Drugs	D-SNPs	You pay nothing	Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • 1.20 copay; or • $2.65 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $6.60 copay	If a D-SNP selects Defined Standard as its drug benefit type, then, "You pay nothing" is generating under "Initial Coverage" instead of the LIS cost share sentences. "You pay nothing" should be replaced with LIS cost share sentences. This impacts all D-SNPs (both $0 and non-$0 SNPs) that selects DS.
10	Mental Health Care, Inpatient Hospital Care	HMOPOS LPPO RPPO Partial Network PFFS Full Network	<Out-of-Network "per stay" cost sharing sentence missing for Tiers 2 and/or 3>	<Add the Out-of-Network "per stay" cost sharing sentence(s) for Tiers 2 and/or 3>	If a plan has more than one tier for inpatient mental health /hospital care AND offers "per stay" cost sharing in the OON or POS benefit, then the "per stay" cost sharing sentence is not generating for any tiers other than Tier 1.

#	SB category	Plan Types	Existing Sentence	Approved Text	Description of Change
		PFFS PSO (State License)			
11	Optional Benefits	HMO HMOPOS LPPO RPPO Non-Network PFFS Partial Network PFFS Full Network PFFS 1876 Cost PDP All Part D Plans	There is no deductible.	This plan has deductibles for some services.	If a plan has a category level deductible either indicated in Section B or Step-up screens for an Optional Supplemental benefit, but does not have a Package level deductible, then the sentence "There is no deductible" should be replaced with "This plan has deductibles for some services."