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

**CENTER FOR MEDICARE**

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TO: Medicare-Medicaid Plans

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

Cynthia G. Tudor, Ph.D.
Director, Medicare Drug Benefit and C&D Data Group

SUBJECT: Medicare-Medicaid Plan (MMP) Submission of Plan Benefit Packages for CY 2014

The purpose of this memorandum is to provide an overview of the enhanced plan benefit package (PBP) software functionality for Medicare-Medicaid Plans (MMPs) for CY 2014. CMS has made substantial modifications to the PBP software for CY 2014 in order to accommodate more integrated benefit data entry.

On April 5, 2013, CMS released the CY 2014 PBP software in HPMS. As articulated in our January 9, 2013 and January 30, 2013 HPMS guidance memoranda for Medicare-Medicaid Plans (MMPs), "2014 Capitated Financial Alignment Demonstration Timeline," and "Capitated Financial Alignment Demonstration Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2014," 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 2014 are due no later than June 3, 2013 (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 2014 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 new 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 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.

A CY 2014 PBP enhancement for MMPs is the ability to enter supplemental (non-Medicare) benefits for the following service categories: Home Health (section B-6); Occupational Therapy (section B-7C); Physical Therapy and Speech Language Pathology (B-7I); Durable Medical Equipment (section B-11A); and Prosthetics/Medical Supplies (section B-11B).

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 13 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 7, 2013). 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.

**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. MMPs will have new, MMP-specific tier design and cost-share structure screens in the PBP beginning in CY 2014. New MMP tier models were developed for CY2014 based on our experience with the

CY2013 integrated formulary submissions. MMPs may select a formulary tier model consisting of 2 to 6 tiers. Part D drugs may only be included on the first two tiers. For formulary models with 3 to 6 tiers, non-Part D drugs/OTCs may be included only on tiers 3 to 6, with the first two tiers being reserved for Part D drugs only. 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/Downloads/Part_D_Cost_Sharing_Guidance.pdf.

For cost-sharing before the out-of-pocket threshold, MMPs will have a new 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 2014 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 tiers 1 and/or 2 only include 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 $2.55.
    - 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 $6.35.
    - 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 $6.35.

- When tiers 1 and/or 2 include both Medicare Part D and non-Part D drugs, plans may enter copayment minimum and maximum amounts reflecting either one of the following options for each mixed tier:

    - For tiers with a combination of Part D and non-Part D drugs where the LIS cost-sharing does not apply: The minimum copayment amount that can be entered is $0 and there is no maximum copayment validation.

    - For tiers with a combination of Part D and non-Part D drugs where the LIS cost-sharing does apply: No data entry is required in the copayment fields. The PBP will apply the minimum copayment amount of $0 and the maximum copayment amount based on whether the tier includes generic Part D drugs ($2.55), brand Part D drugs ($6.35) or a combination of brand and generic Part D drugs ($6.35).

- 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.

For cost-sharing after the out-of-pocket threshold, MMPs will have a new 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 copayment must equal $0, and there will be no limit on the maximum copayment amount 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.

We have made additional data entry enhancements 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 gap coverage as part of your supplemental benefit?" 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 preferred/non-preferred pharmacy networks 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 "in-network copay/coinsurance plus a differential between the OON billed charge and the in-network 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 2014 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 fields in Section Rx of the PBP have 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 working with CMS to implement a demonstration in 2013 or 2014 provide plans with pending contracts in their states with guidance on the submission of Medicaid and demonstration-specific benefits for CY 2014, 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 mid-April 2013. This will ensure that MMPs have ample time to prepare their PBP submissions by June 3, 2013.

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 and final payment rate information. 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 2013.

For additional information, MMPs should complete the CY 2014 PBP online training module, released by CMS on April 5, 2013 and available at: https://hpmstraining.cms.hhs.gov/pbptraining2014/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 2014 \ 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.