CHAPTER 4: PLAN BENEFIT PACKAGE SECTION B

PURPOSE OF SECTION B

Section B collects information at the Service Category level about the specific Medicare Part A and Part B and supplemental benefits being offered by a plan. This information includes benefit description, maximum plan-benefit coverage, Maximum Out-of-Pocket (MOOP) costs for enrollees, coinsurance, deductible, copayments, authorizations, and referrals. A "Notes" field is also provided to enter additional information relevant to benefit design not captured in the data entry fields. Use the "Notes" field only if the benefits entered in the standard data entry field do not fully reflect the benefit being offered.

Note: Section B is not applicable for Fallback, National Programs of All-Inclusive Care for the Elderly, Prescription Drug Plan (PDP), and Medical Savings Account (MSA) plan types. Any enhanced benefits offered by MSA plans must be designated as Optional Supplemental Benefits and described in "Section D—Optional Supplemental Benefit Packages."

NEW FOR 2021

The following is a summary of changes to the Contract Year (CY) 2021 Plan Benefit Package (PBP) that impact Section B.

B-4: Emergency/Urgently Needed Services:

Service Category B4 has been renamed to "Emergency/Urgently Needed Services" and the Benefit B4a has been renamed to "Emergency/Post-Stabilization Services." The "Indicate Maximum per visit amount" question has had the cost sharing validation implemented.

B-7: Health Care Professional Services:

B-7j: Additional Telehealth:

The B7j Additional Telehealth Benefits question has been revised to read "Select the Medicare-covered benefits that may have Additional Telehealth Benefits available."

B-7k: Opioid Treatment Program Services:

Service Category B7k has been renamed to "Opioid Treatment Program Services."

B-13: Other Supplemental Services

The notes for B13d, B13e, B13f and B13g (when they are applicable) will now be required when the benefits in these sections are offered.

B-14: Preventive and Other Defined Supplemental Services

B-14c: Other Defined Supplemental Benefits:

1. A mandatory question has been added to indicate type of Fitness Benefit offered for the B14c4 Fitness Benefit category.
2. The B14c8 benefit category name has been changed to "Home and Bathroom Safety Devices and Modifications."

B-15: Medicare Part B Rx Drugs

1. "Medicare Part B Chemotherapy Drugs" has been changed to "Medicare Part B Chemotherapy/Radiation Drugs."

B-19: VBID/MA Uniformity Flexibility/SSBCI

1. An option for VBID plans to offer a VBID Hospice benefit has been added. Screens to capture these benefits have been added in B19c.
2. A screen for VBID plans to outline the components of their Wellness and Health Care Planning programs offered to enrollees has been added.
3. On the B19a and B19b Package Information screens, the prerequisite question option has been changed "participation in a wellness or care management program" to "participation in a care management program."
4. New VBID Rewards and Incentives screens have been added.
5. An on-screen label has been added instructing users to go to Section Rx to enter VBID Part D Rewards and Incentives.
6. The list of other VBID interventions (in addition to wellness and health care planning) for selection in B19a and B19b has been revised to "Value-Based Design Flexibilities by Condition or Socioeconomic Status" and "Medicare Advantage Rewards and Incentives Programs." "Telehealth Networks" has been removed from the list of interventions.
7. The notes fields required for VBID packages offering Medicare Advantage Rewards and Incentives Programs or Telehealth Networks have been removed.
8. The 19a and 19b VBID Disease State screens have been renamed to be VBID Target Population screens. The questions on these screens have been updated to separate chronic condition(s) from socioeconomic status in specifying targeting methodology and to gather additional information on disease state requirements as well as estimated enrollees to be targeted and engaged to receive model benefits. The questions "Does the enrollee need to have all diseases selected to qualify? Y/N" and "Does the enrollee need to have a combination of diseases selected to qualify? Y/N" have been added to these screens for all VBID packages.

9. In Section B19b, 13i the benefit “Transitional/Temporary Supports” has been renamed “General Supports for Living.”
10. In Section 19b, PPO plans are required to select "Yes" to the question "Do the benefits in this package apply to OON/POS?"

B-20: Prescription Drugs

1. "Medicare Part B Chemotherapy Drugs" has been changed to "Medicare Part B Chemotherapy/Radiation Drugs.”

OTHER DEFINED SUPPLEMENTAL BENEFITS

PLAN BENEFIT PACKAGE SERVICE CATEGORIES AND BENEFITS

There are 20 Service Categories, which are further disaggregated into 57 subcategories, which enables users to describe plan benefits in greater detail.

Note: Users are encouraged to read the Service Category descriptions that are provided on the first screen of each Service Category. While entering data for a particular service category, the user can click the Help tab at the top of the PBP screen and select “Category Description” to view the description.

There is also an additional 20th category that is available only to cost plans not offering the Medicare Part D benefit. This 20th Service Category enables users to describe the cost plan’s enhanced drug benefits. This data entry is listed in category B-20.

For reference, below is a detailed list of the PBP Service Categories, with the respective Medicare-covered and enhanced benefit options.

PLAN BENEFIT PACKAGE 2021 SERVICE CATEGORIES AND BENEFITS

Service Category Title		Service Categories		Benefits
01	**Inpatient Hospital Services**	#1a	Inpatient Hospital-Acute	Medicare-covered stay
				Additional Days
				Non-Medicare-covered Stay
				Upgrades
		#1b	Inpatient Hospital-Psychiatric	Medicare-covered stay
				Additional Days
				Non-Medicare-covered Stay
02	**Skilled Nursing Facility (SNF)**	#2	SNF	Medicare-covered stay
				Additional days beyond Medicare-covered
				Non-Medicare-covered stay (MMP Only)
03	**Cardiac and Pulmonary Rehabilitation Services**	#3	Cardiac and Pulmonary Rehabilitation Services	Medicare-covered Cardiac Rehabilitation Services
				Medicare-covered Intensive Cardiac Rehabilitation Services
				Medicare-covered Pulmonary Rehabilitation Services
				Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
				Additional Cardiac Rehabilitation Services
				Additional Intensive Cardiac Rehabilitation Services
				Additional Pulmonary Rehabilitation Services
				Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
04	**Emergency/Urgently Needed Services**	#4a	Emergency/Post-Stabilization Services	Medicare-covered Benefits
		#4b	Urgently Needed Services	Medicare-covered Benefits

		#4c	Worldwide Emergency/Urgent Coverage	Worldwide Emergency Coverage
				Worldwide Urgent Coverage
				Worldwide Emergency Transportation
05	**Partial Hospitalization**	#5	Partial Hospitalization	Medicare-covered Benefits
06	**Home Health Services**	#6	Home Health Services	Medicare-covered Benefits
			Home Health Services – MMP	Additional Hours of Care
				Personal Care Services
				Other 1
				Other 2
07	**Health Care Professional Services**	#7a	Primary Care Physician Services	Medicare-covered Benefits
		#7b	Chiropractic Services	Medicare-covered Benefits
				Routine Care
				Other
		#7c	Occupational Therapy Services	Medicare-covered Benefits
			Occupational Therapy Services – MMP	Non-Medicare Occupational Therapy Service
		#7d	Physician Specialist Services	Medicare-covered Benefits
		#7e	Mental Health Specialty Services	Medicare-covered Individual Sessions
				Medicare-covered Group Sessions
		#7f	Podiatry Services	Medicare-covered Podiatry Services
				Routine Foot Care
		#7g	Other Health Care Professional	Medicare-covered Benefits

		#7h	Psychiatric Services	Medicare-covered Individual Sessions
				Medicare-covered Group Sessions
		#7i	PT and SP Services	Medicare-covered Benefits
			PT and ST – MMP	Other 1
				Other 2
		#7j	Additional Telehealth Services	Medicare-covered Visits
		#7k	Opioid Treatment Program Services	Medicare-covered Benefits
08	**Outpatient Procedures, Tests, Labs & Radiology Services**	#8a	Outpatient Diagnostic Procs/Tests/Lab Services	Medicare-covered Diagnostic Procedures/Tests
				Medicare-covered Lab Services
		#8b	Outpatient Diag/Therapeutic Rad Services	Medicare-covered Diagnostic Radiological Services
				Medicare-covered Therapeutic Radiological Services
				Medicare-covered X-Ray Services
09	**Outpatient Services**	#9a	Outpatient Hospital Services	Medicare-covered Outpatient Hospital Services
				Medicare-covered Observation Services
		#9b	ASC Services	Medicare-covered Benefits
		#9c	Outpatient Substance Abuse	Medicare-covered Individual Sessions
				Medicare-covered Group Sessions
		#9d	Outpatient Blood Services	Medicare-covered Benefits
				Three (3) Pint Deductible Waived
10	**Ambulance/Transportation Services**	#10a	Ambulance Services	Medicare-covered Ground Ambulance Services

				Medicare-covered Air Ambulance Services
		#10b	Transportation Services	Plan-approved Location
				Any Health-related Location
11	**DME, Prosthetics and Medical & Diabetic Supplies**	#11a	DME	Medicare-covered Benefits
			DME – MMP	Durable Medical Equipment for use outside the home
				Other 1
				Other 2
		#11b	Prosthetics/Medical Supplies	Medicare-covered Prosthetic Devices
				Medicare-covered Medical Supplies
			Prosthetics/Medical Supplies – MMP	Non-Medicare covered Prosthetics/Medical Supplies
		#11c	Diabetic Supplies and Services	Medicare-covered Diabetic Supplies
				Medicare-covered Diabetic Therapeutic Shoes or Inserts
12	**Dialysis Services**	#12	Dialysis Services	Medicare-covered Benefits
13	**Other Supplemental Services**	#13a	Acupuncture	Number of Treatments
		#13b	OTC Items	OTC Items
		#13c	Meal Benefit	Meal Benefit
		#13d	Other 1	"Name of Service (Optional)"
		#13e	Other 2	"Name of Service (Optional)"
		#13f	Other 3	"Name of Service (Optional)"
		#13g	Dual Eligible SNPs with Highly Integrated Services[1]	"Name of Service (Optional)"
		#13h	Additional Services[2]	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

				Tobacco Cessation Counseling for Pregnant Women
				Freestanding Birth Center Services
				Respiratory Care Services
				Family Planning Services
				Nursing Home Services
				Home and Community Based Services
				Personal Care Services
				Self-Directed Personal Assistance Services
				Private Duty Nursing Services
				Case Management (Long Term Care)
				Institution for Mental Disease Services for Individuals 65 or Older
				Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
				Case Management
				Other 1 through 38
		#13i	Non-Primarily Health Related Benefits (for SSBCI and VBID 19b packages only)	Food and Produce
				Meals (beyond limited basis)
				Pest Control
				Transportation for Non-Medical Needs
				Indoor Air Quality Equipment and Services
				Social Needs Benefit
				Complimentary Therapies

				Services Supporting Self-Direction
				Structural Home Modifications
				General Supports for Living
				Other 1 through 5
14	**Preventive and Other Defined Supplemental Services**	#14a	Medicare-covered Zero Dollar Preventive Services	Medicare-covered Benefits
		#14b	Annual Physical Exam	Annual Physical Exam
		#14c	Other Defined Supplemental Benefits	Health Education
				Nutritional/Dietary Benefit
				Additional Sessions of Smoking and Tobacco Cessation Counseling
				Fitness Benefit
				Enhanced Disease Management[4]
				Telemonitoring Services
				Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)
				Home and Bathroom Safety Devices and Modifications
				Counseling Services
				In-Home Safety Assessment
				Personal Emergency Response System (PERS)
				Medical Nutrition Therapy (MNT)
				Post discharge In-home Medication Reconciliation
				Re-admission Prevention
				Wigs for Hair Loss Related to Chemotherapy

				Weight Management Programs
				Alternative Therapies
				Therapeutic Massage
				Adult Day Health Services
				Home-Based Palliative Care
				In-Home Support Services
				Support for Caregivers of Enrollees
		#14d	Kidney Disease Education Services	Medicare-covered Benefits
		#14e	Other Medicare-covered Preventive Services	Medicare-covered Glaucoma screening
				Medicare-covered Diabetes Self-Management Training
				Medicare-covered Barium Enemas
				Medicare-covered Digital Rectal Exams
				Medicare-covered EKG following Welcome Visit
				Other Medicare-covered Preventive Services (Optional)
15	**Medicare Part B Prescription (Rx) Drugs**	#15	Medicare Part B Rx Drugs	Medicare Part B Chemotherapy/Radiation Drugs
				Other Medicare Part B Drugs
			Home Infusion Bundled Services	Home Infusion Bundled Services
16	**Dental**	#16a	Preventive Dental	Oral Exams
				Prophylaxis (Cleaning)
				Fluoride Treatment
				Dental X-Rays

		#16b	Comprehensive Dental	Medicare-covered Benefits
				Non-routine Services
				Diagnostic Services
				Restorative Services
				Endodontics
				Periodontics
				Extractions
				Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
17	**Eye Exams/Eyewear**	#17a	Eye Exams	Medicare-covered Benefits
				Routine Eye Exams
				Other
		#17b	Eyewear	Medicare-covered Benefits
				Contact lenses
				Eyeglasses (lenses and frames)
				Eyeglass lenses
				Eyeglass frames
				Upgrades
18	**Hearing Exams/Hearing Aids**	#18a	Hearing Exams	Medicare-covered Benefits
				Routine Hearing Exams
				Fitting/Evaluation for Hearing Aid
		#18b	Hearing Aids	Hearing Aids (all types)
				Hearing Aids - Inner Ear
				Hearing Aids - Outer Ear
				Hearing Aids - Over the Ear

19	**VBID/MA Uniformity Flexibility/Special Supplemental Benefits for the Chronically Ill (SSBCI)**	#19a	Reduced Cost Sharing for VBID/UF/SSBCI	Reduced Cost Sharing for VBID/UF/SSBCI
		#19b	Additional Benefits for VBID/UF/SSBCI	Additional Benefits for VBID/UF/SSBCI
		#19c	VBID Hospice	VBID Hospice
20	**Prescription Drugs[3]**	#20	Outpatient Drugs	Medicare Part B Chemotherapy/Radiation Drugs
				Other Medicare Part B Drugs
				Drug Groups 1-5
				Home Infusion Bundled Services

1. D-SNPs only
2. MMPs only
3. Cost plans only
4. Not available for C-SNPs

STATUTORY BENEFIT CATEGORIES

Within the above Service Categories, three types of statutory benefit categories exist: Medicare-covered, Mandatory Supplemental, and Optional Supplemental.

- Medicare-covered
  - Health services required by statute or covered under the legal authority of the Secretary of the Department of Health and Human Services.
- Mandatory Supplemental
  - Non-Medicare-covered benefits offered by the plan that must be purchased by all enrollees at the same cost and are purchased by the enrollee with the selection of plan.
- Optional Supplemental
  - Non-Medicare-covered benefits the plan may choose to offer enrollees for an additional premium.

If a plan's optional supplemental benefits package includes a step-up benefit for which there are no special step-up screens in Section D, the user must describe these step-up benefits in the corresponding "Notes" field of the Section B category for this optional supplemental benefit. Step-up benefits are discussed in Chapter 6.

IMPORTANT POINTS TO REMEMBER BEFORE ENTERING DATA

There are several important points to keep in mind when entering data in Section B.

1. The sections of the PBP are highly interdependent, especially Section B. Data entered in one section can impact the data entry variables for another section. For example, specifying a benefit as "Optional" in Section B will force the user to include that benefit in an Optional Supplemental Benefit Package when completing Section D.

   What may potentially confuse a user is the impact on the status of Section D when the user makes changes to Section B after completing data entry for Section D. To clarify, if the user previously completed data entry for Section D, but then made changes to Section B, the status for Section D will automatically change to "Incomplete." The PBP tool has been designed to require the user to make the necessary changes to Section D in such an instance.

   If a user makes a change to Section B in error, reopening Section B and correcting the error will not automatically change the Section D status back to "Complete." In this case, the user should reopen Section D and exit with validation in order to change the status back to "Complete." The checks for data-entry completion are only performed on exiting a certain section.

2. If a plan's optional supplemental benefits package includes a step-up benefit for which there are no special step-up screens in Section D, the user must describe these step-up benefits in the corresponding "Notes" field of the Section B category for this optional supplemental benefit.
3. Regional LPPO and RPPO plans are not permitted to enter any Service Category-level deductibles.
4. If a plan offers tiering for a benefit, that benefit must include a range of cost sharing.
5. If a plan enters a cost-sharing range for any service, a description of this cost-sharing range must be included in the "Notes" field for that specific Service Category. As appropriate, provide a brief description of the different cost sharing levels included in ranges in the data field. For example, minimum, maximum and cost sharing amounts that fall in between for some highly utilized services (if applicable).
6. The cost sharing validations will be enforced against the In-Network MOOP selection for Preferred Provider Organization (PPO) and Health Maintenance Organization-Point of Service (HMO-POS) plans.
7. The cost sharing validations will be enforced against the Combined MOOP selection for Network Private Fee-for-Service (PFFS) plans.

8. If a plan offers a $0 MOOP, the user must select "No" for the deductible questions for all Section B categories.
9. If an MMP offers a supplemental benefit, it must be offered as a Mandatory Supplemental benefit.
10. MMPs may not include service-specific MOOPs, coinsurances, deductibles, or copayments for Medicare-covered services.

ENTER SECTION B

STEP 1

To begin data entry, **Select a Contract**, and double-click or press the spacebar on a plan on the **PBP Management Screen** (Table 4-1).

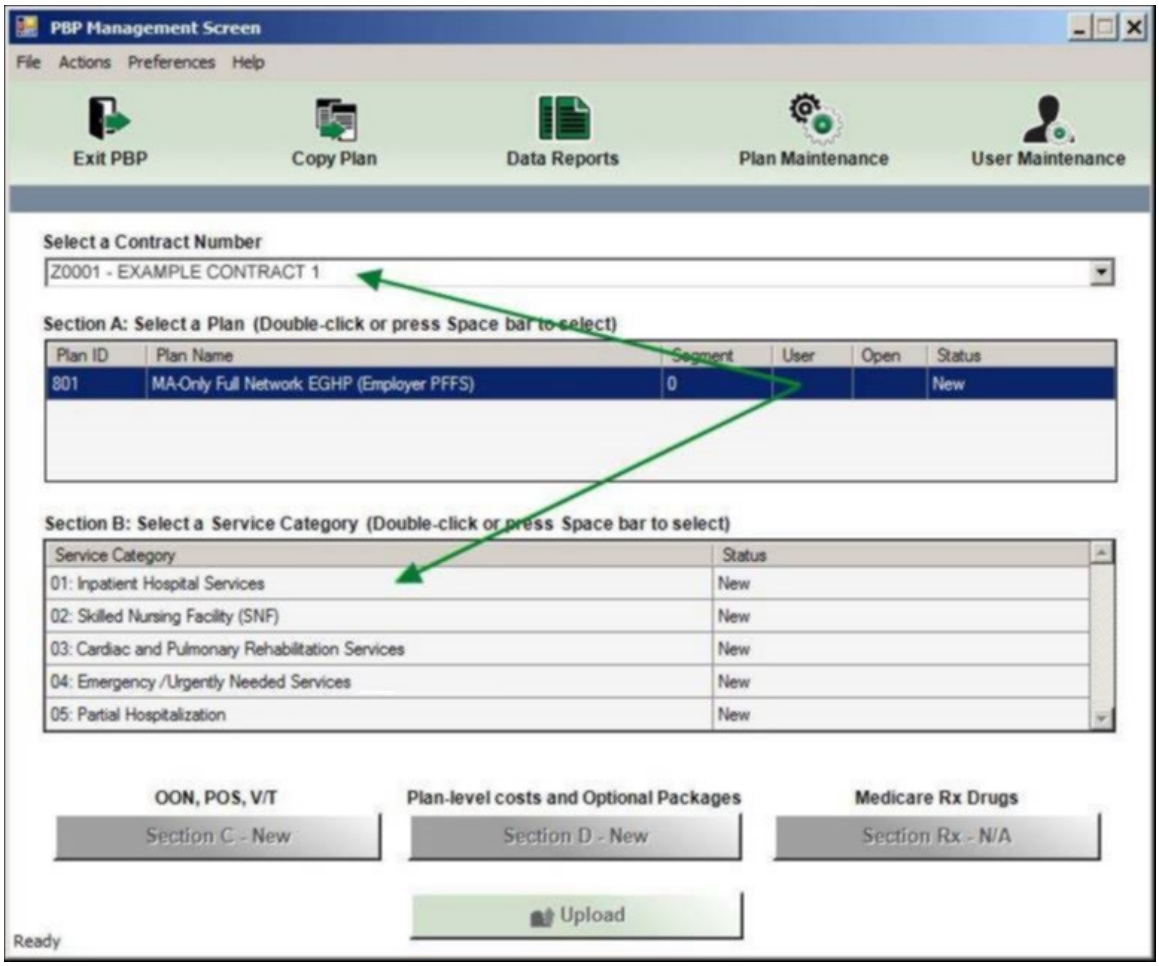
STEP 2

Complete Section A and exit with validation. It is strongly recommended (but not required) that users complete Section B of the PBP before completing Sections C and/or D.

STEP 3

Double-click or press the space bar on a service category under **Section B: Select a Service Category**.

Table 4-1



SERVICE CATEGORY #1: INPATIENT HOSPITAL SERVICES

Includes the following subcategories:

- B1a: Inpatient Hospital–Acute (B1a)
- B1b: Inpatient Psychiatric Hospital (B1b)

There are 12 data entry screens associated with each of the above subcategories.

Notes:

- Plans offering both Part A and Part B can have up to three hospital cost-share tiers for In-Network Medicare-covered benefits and/or Additional Days. If a plan is offering hospital cost-share tiers, it must follow the guidelines below:
  - The Medicare-covered benefit and Additional Days can be tiered independently of each other (i.e., the user can tier one without tiering the other).

- If both Medicare-covered benefit and Additional Days are tiered, the plan must offer the same number of tiers for the Medicare-covered benefit and Additional Days.
- A plan cannot offer more than one tier with Medicare-defined standard cost sharing. Tiers must be entered in ascending or descending order of cost.

- Medicare covers the Inpatient Substance Abuse benefit under both the B1a: Inpatient Hospital–Acute and B1b: Inpatient Hospital Psychiatric benefit categories. Use either subcategory to describe this benefit in the PBP, and include a note that it is covered under both.
- The following Cost-Share Limitations must be followed in B1a: Inpatient Hospital–Acute.

  If offering the MOOP at the Voluntary amount, cost shares for B1a: Inpatient Hospital–Acute will be limited as follows:

  - Voluntary MOOP:
    - B1a: Inpatient Hospital–Acute—10 Days – $ 2,783
    - B1a: Inpatient Hospital–Acute—6 Days – $ 2,524

  If offering the MOOP at the Mandatory amount, cost shares for B1a: Inpatient Hospital–Acute will be limited as follows:

  - Mandatory MOOP:
    - B1a: Inpatient Hospital–Acute—60 Days – $ 4,816
    - B1a: Inpatient Hospital–Acute—10 Days – $ 2,226
    - B1a: Inpatient Hospital–Acute—6 Days – $ 2,019

The following Cost-Share Limitations must be followed in B1b: Inpatient Hospital Psychiatric.

If offering the MOOP at the Voluntary amount, cost shares for B1b: Inpatient Hospital Psychiatric will be limited as follows:

- Voluntary MOOP:
  - B1b: Inpatient Hospital Psychiatric—60 Days – $ 3,408
  - B1b: Inpatient Hospital Psychiatric—15 Days – $ 2,339

If offering the MOOP at the Mandatory amount, cost shares for Inpatient Hospital Psychiatric will be limited as follows.

- Mandatory MOOP:
  - B1b: Inpatient Hospital Psychiatric—60 Days – $ 2,726
  - B1b: Inpatient Hospital Psychiatric—15 Days – $ 1,871

- The following description of the Inpatient Hospital screens does not apply to Part B-only plans. The Part B-only plans will enter data on different data entry

screens associated with each subcategory. However, the instructions below for "How to enter cost sharing per day and per stay" do apply to Part B-only plans.

BASE 1 THROUGH 3 SCREENS

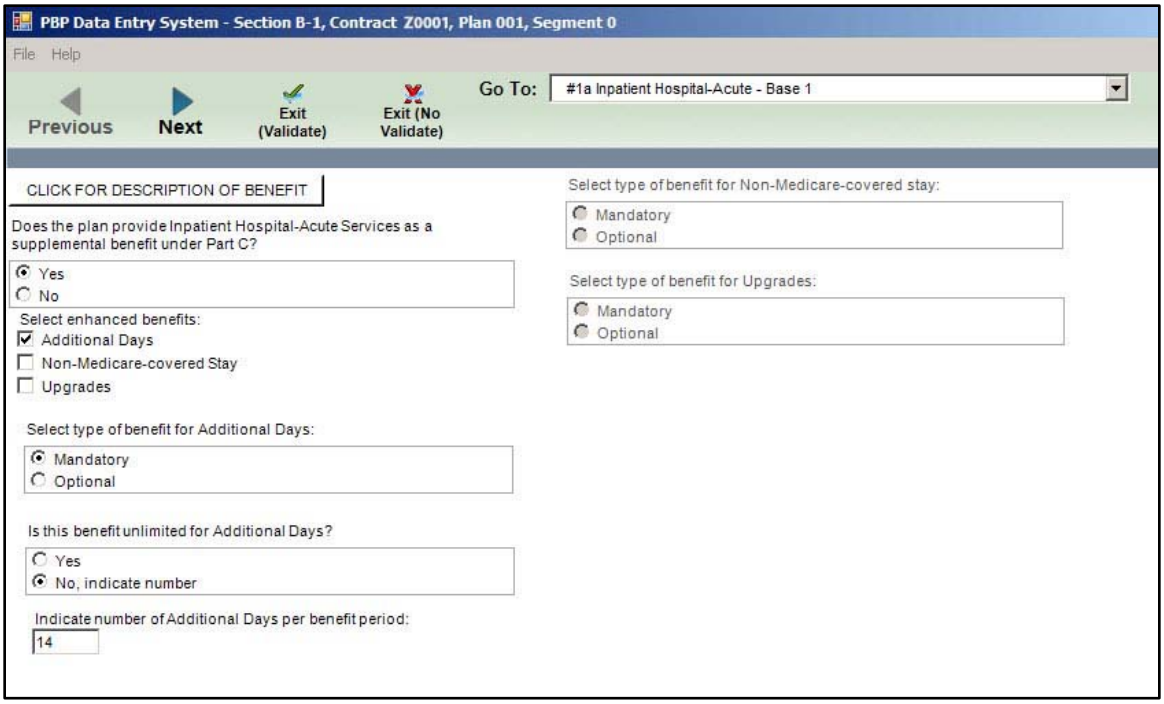
On the Base 1 screen, the plan will indicate whether it will provide B1a: Inpatient Hospital–Acute (or B1b: Inpatient Hospital Psychiatric) items as a supplemental benefit under Part C (Table 4-2), and if these benefits are offered as a Mandatory or Optional supplemental benefit.

On the Base 2 screen, the plan will indicate whether its Medicare-covered cost sharing varies by the hospital in which the enrollee receives care. If the response to this question is "Yes," the plan then specifies the number of tiers offered by the plan (up to three). The remainder of the Base 2 and 3 screens include cost-sharing questions for up to three Medicare-covered hospital cost-share tiers. Tables 4-2 and 4-3 show screens for the B1a: Inpatient Hospital–Acute subcategory; the B1b: Inpatient Hospital Psychiatric screens are similar.

The response to each question on the base screens determines which remaining questions will be enabled or disabled in the remainder of the PBP subsection. For example, on the Base 2 screen, if a user indicates that the plan charges Medicare-defined cost shares for Tier 1, the cost-share questions on the Base 2 and subsequent base screens for the Medicare-covered stay, Medicare-covered day intervals, and Lifetime Reserve Day intervals for Tier 1 will be disabled.

If a user indicates that the plan charges the Medicare-defined cost shares for any particular tier, the user cannot enter a separate deductible amount for that tier. The Medicare deductible is included in the Medicare-defined cost-share indication. Also, if a user selects Medicare-defined cost shares for coinsurance and/or copayment for all tiers, the user must select "No" for Deductible in the Service Category.

Table 4-2



HOW TO ENTER COST SHARING PER STAY AND PER DAY

Coinsurance and copayment amounts may be entered on a stay and/or a per day basis. To enter amounts for both a stay and a per day basis, simply enter cost-sharing amounts in both the coinsurance/copayment per stay variable and in the coinsurance/copayment per day variable (Table 4-3).

A warning message will appear whenever a stay amount and a per day amount are the same value. For example, if a Medicare Advantage (MA) plan charges $500 per stay and $100 per day for days 1–5, the beneficiary is charged $500 for each entry to the hospital and $100 for each day during the 1- to 5-day period. Thus, if a beneficiary goes to the hospital for 5 days, the beneficiary will pay $1,000, or $500 + ($100 x 5). An MA plan is permitted to charge a per stay amount and a per day amount. However, the Centers for Medicare & Medicaid Services (CMS) has observed that this is a common data entry error, so the PBP includes a warning message as an alert when a user enters per stay and per day data (Table 4-4). Users will still be able to exit with validation if they receive this warning message.

Note: The validations are similar for the service category B2: Skilled Nursing Facility (SNF) for per stay and per day cost sharing.

Table 4-3

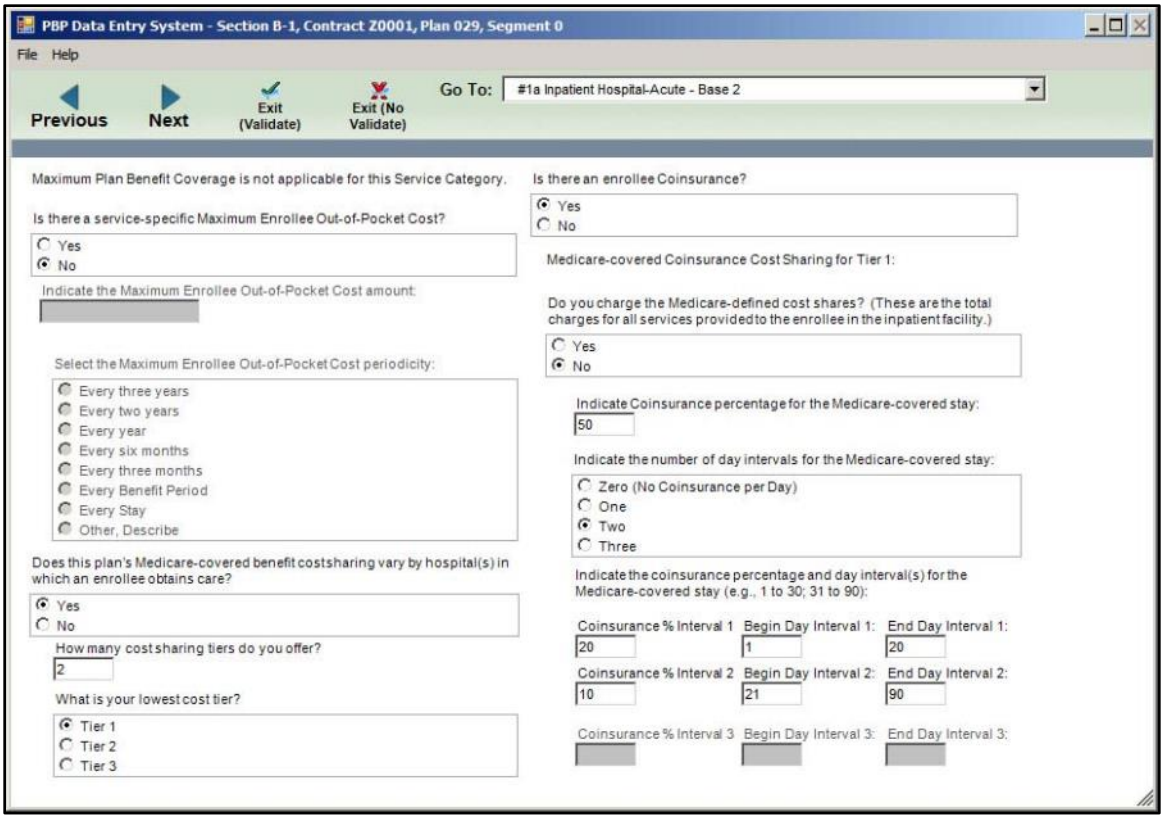
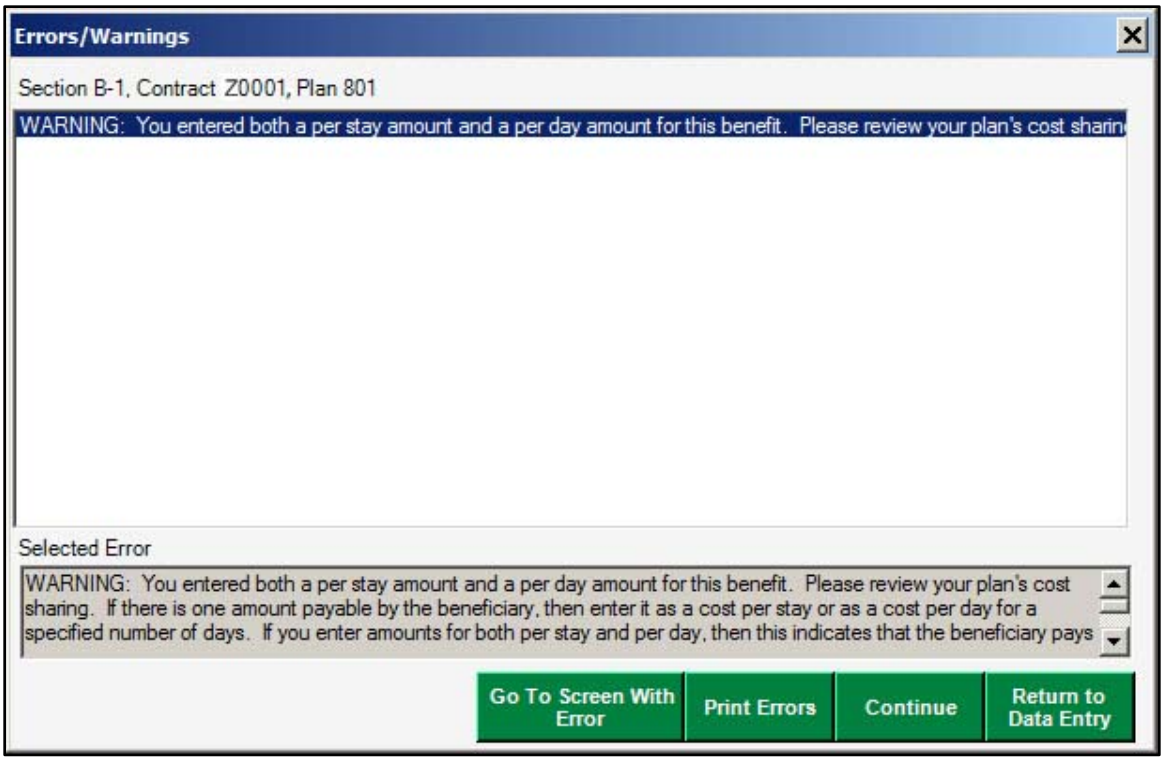


Table 4-4



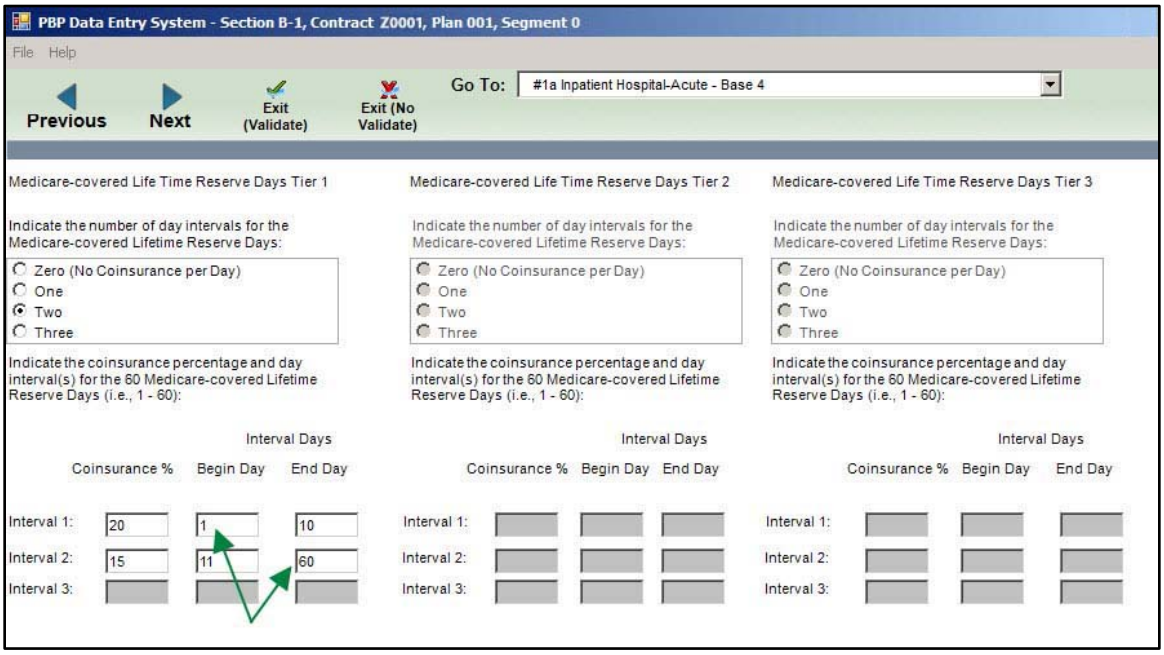
BASE 4 THROUGH 12 SCREENS

On the Base 4 through 12 screens, many questions will be enabled based on how questions were answered on prior base screens. Always review the screen carefully to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will display when exiting with validation.

HOW TO ENTER MEDICARE-COVERED LIFE TIME RESERVE DAYS

Users must explicitly price the 60 Life Time Reserve Days covered by Medicare. The PBP requires users to enter a start day equal to "1" in the first interval, and an end day equal to "60" in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost-share structure. If the plan selects "Zero" for "Indicate the number of day intervals for the Medicare-covered Life Time Reserve Days," the plan is choosing to cover the 60 Medicare-covered Life Time Reserve Days at $0 cost sharing. See Table 4-5 for an example of how to enter data for Medicare-covered Life Time Reserve Days.

Table 4-5

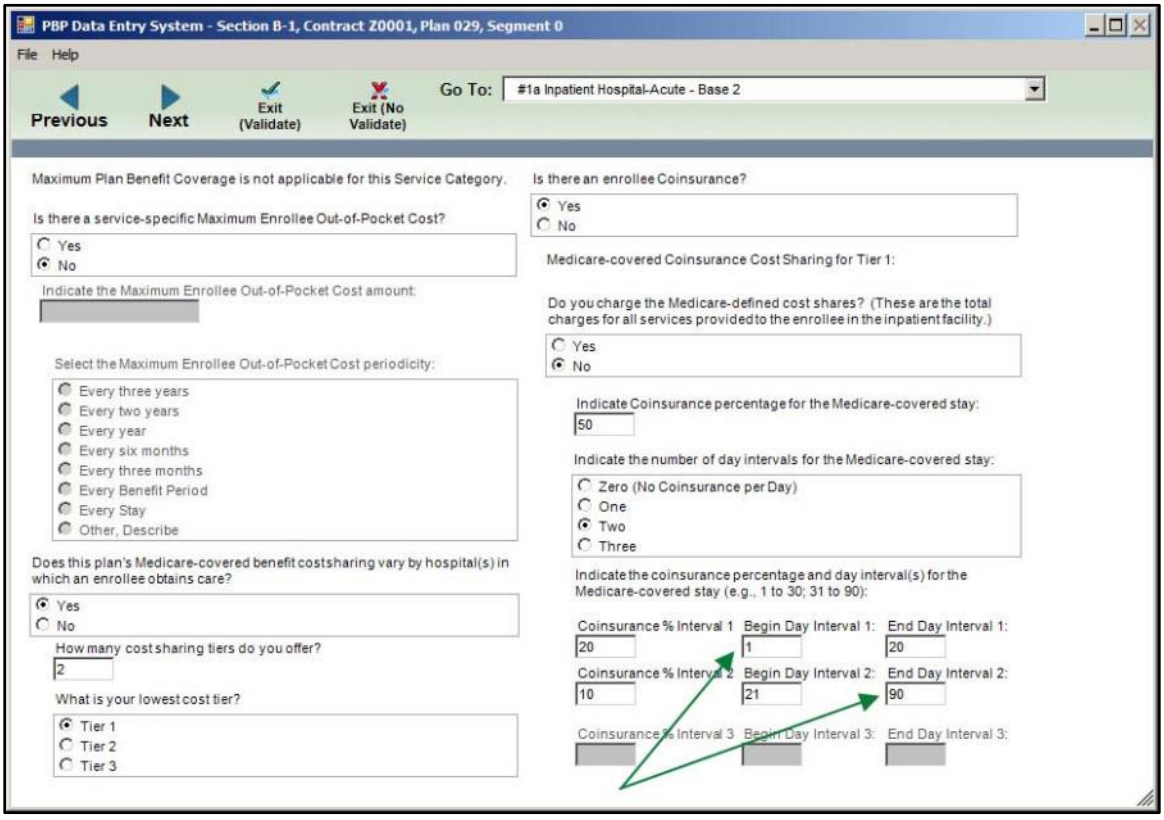


HOW TO ENTER COST SHARING PER DAY

If a plan has a per day cost structure for Medicare-covered stays, users must explicitly price the 90 days covered by Medicare during a benefit period. To ensure this pricing structure, the PBP requires users to enter a start day equal to "1" in the first interval, and an end day equal to "90" in the last interval.

Note: Enter the end day in the first, second, or third interval, depending upon the plan's cost-sharing structure (Table 4-6).

Table 4-6



HOW TO ENTER COST SHARING FOR NON-MEDICARE-COVERED ADDITIONAL DAYS

Additional Days are defined as days covered by the plan after the Medicare-covered 90-days-per-benefit period. Additional Days always begin at day 91. The number of Additional Days offered on the Base 1 screen determines the end day. If a plan offers three tiers for Additional Days, then the tiers must go in ascending or descending order of cost.

Example: If 14 Additional Days per benefit period are offered at 20% coinsurance, the cost-share structure should specify Additional Days 91 through 104 (Tables 4-7A and 4-7B).

On the Base 5 screen, the plan will indicate whether its Additional Days cost sharing varies among hospitals in which the enrollee receives care. If the response to this question is "Yes," the plan specifies the number of tiers offered by the plan (up to three). If the plan has tiering for Medicare-covered benefit and Additional Days, the plan must offer the same number of tiers for the Medicare-covered benefit and Additional Days, and the lowest cost tier must be the same for both. The remainder of the Base 5 and 6 screens

include cost-sharing questions for Additional Days for up to three cost-sharing tiers (similar to the Medicare-covered hospital cost-sharing screens).

Table 4-7A

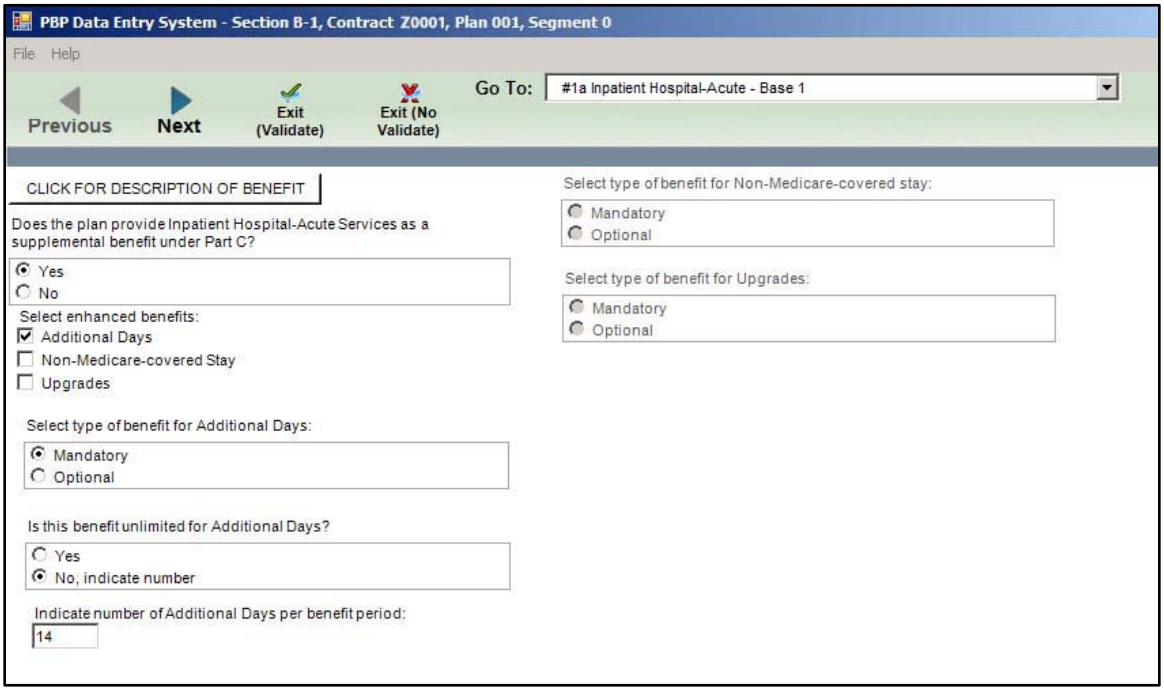
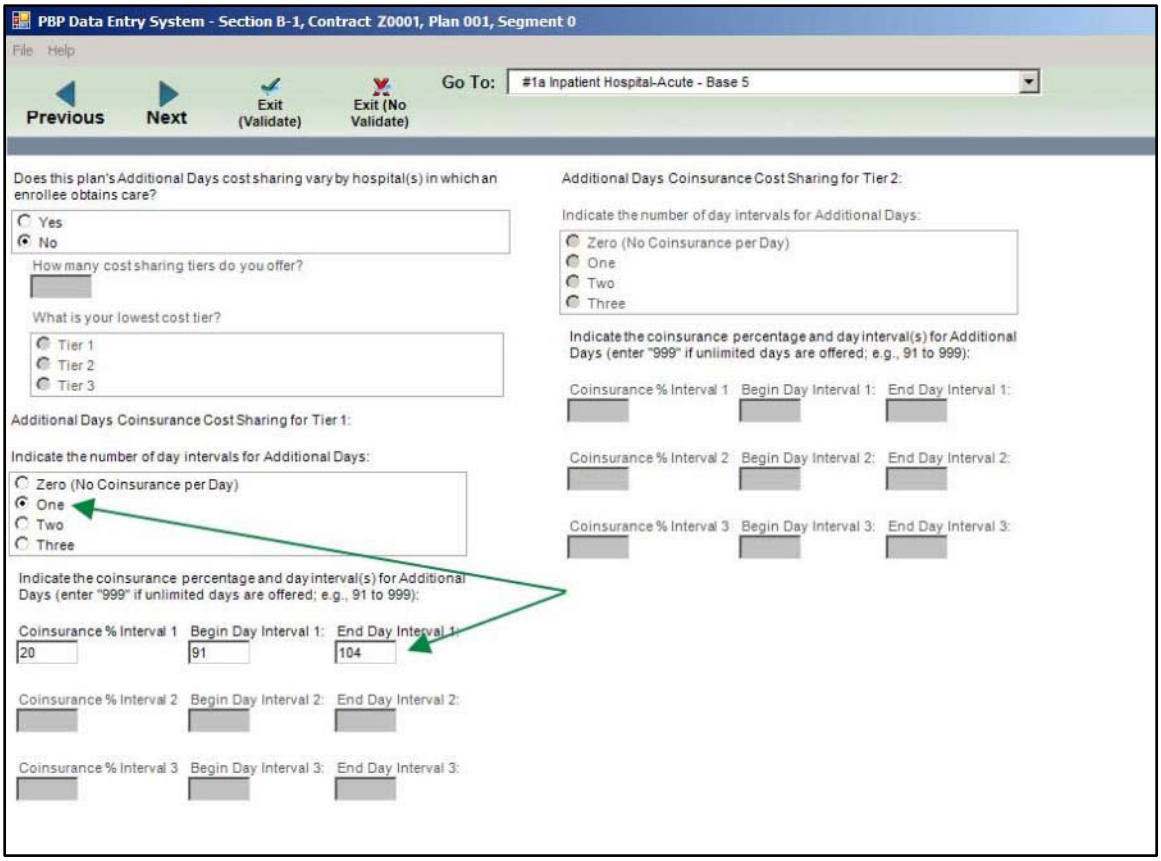


Table 4-7B

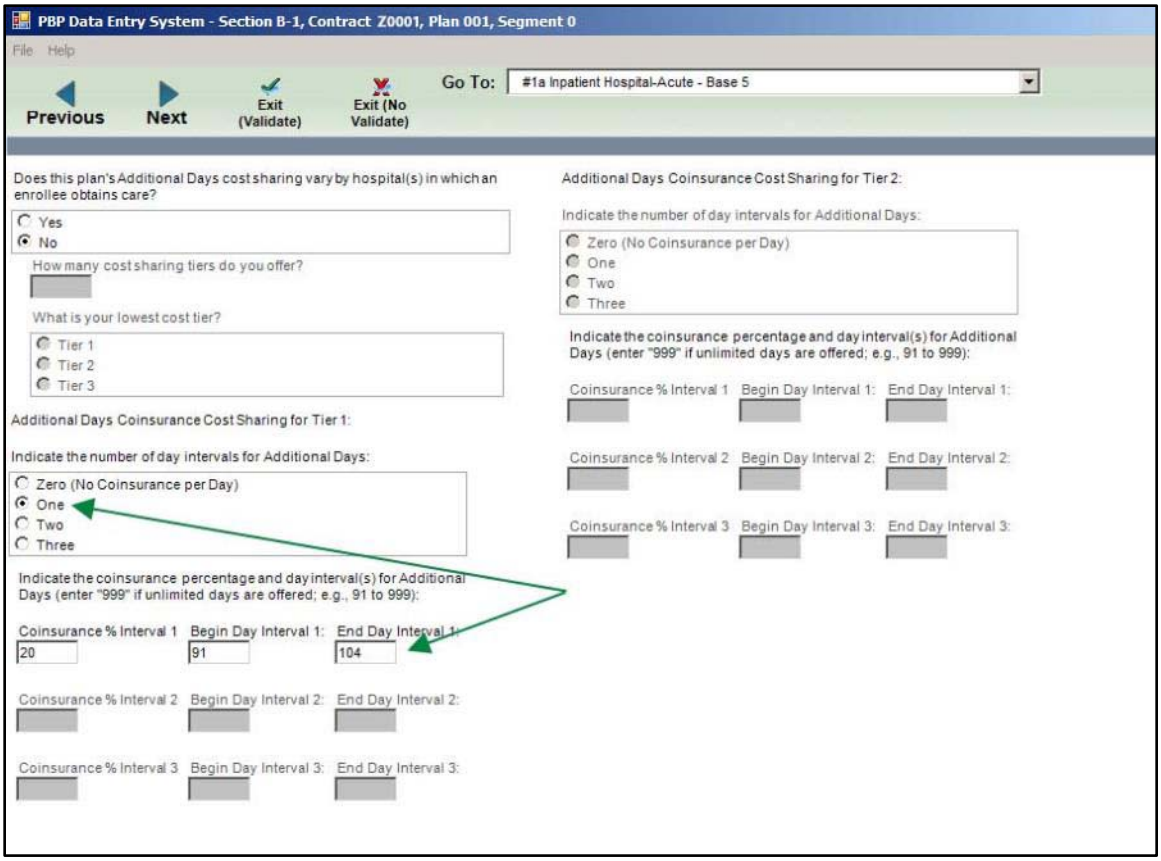


If an unlimited number of Additional Days are offered, use "999" to notate the end day of the pricing structure.

HOW TO ENTER COST SHARING FOR NON-MEDICARE-COVERED STAYS

A Non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare-coverage guidelines, or one provided in a facility not certified by Medicare. To indicate that the plan covers Non-Medicare-covered stays, select the appropriate option on the Base 1 screen (Table 4-8).

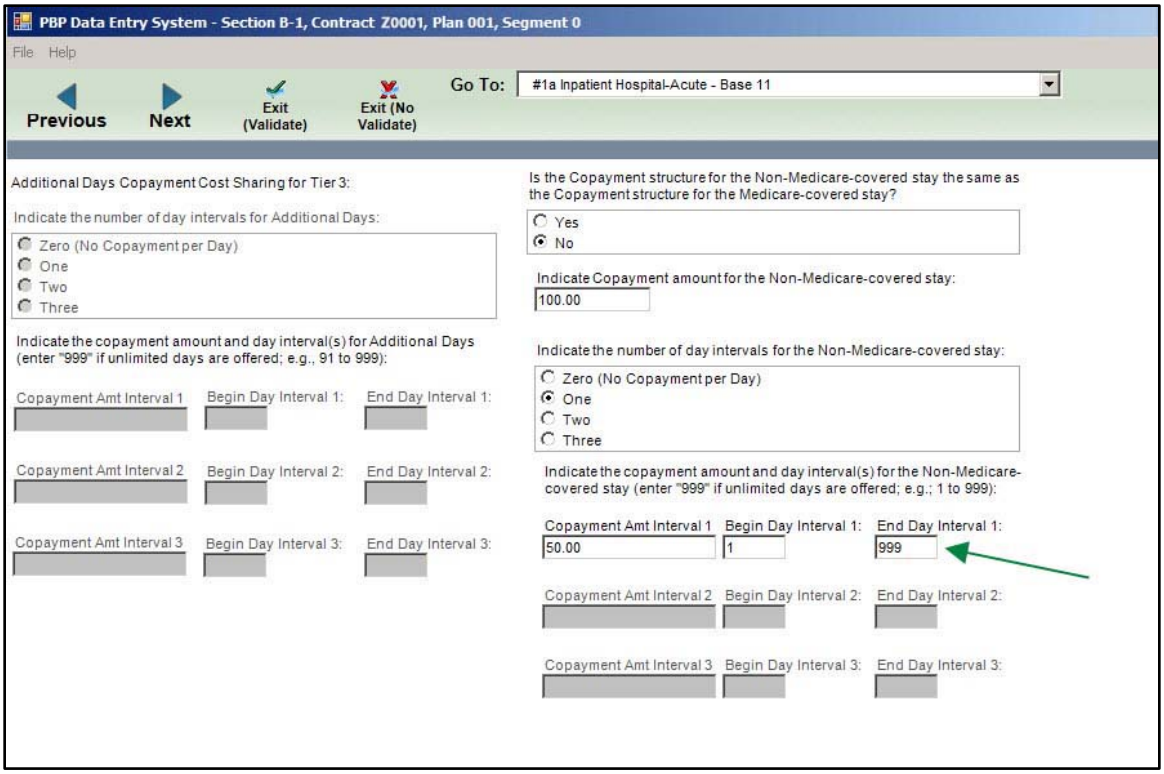
Table 4-8



If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost-share interval must be day 1, and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the Non-Medicare-covered stay if a per day cost-share structure exists.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered stay, declare one interval, and enter $50 for days 1 through 999 (Table 4-9).

Table 4-9



If the Medicare-covered cost sharing and Non-Medicare-covered cost sharing are the same, first indicate that Non-Medicare-covered stays are covered (Table 4-8), and then indicate that there is an enrollee Coinsurance (Copayment) (Table 4-10A). This will enable the Base 6 question "Is the Coinsurance (Copayment) structure for the Non-Medicare-covered stay the same as the Coinsurance (Copayment) structure for the Medicare-covered stay?" Answer "Yes" to this question (Table 4-10B).

Table 4-10A

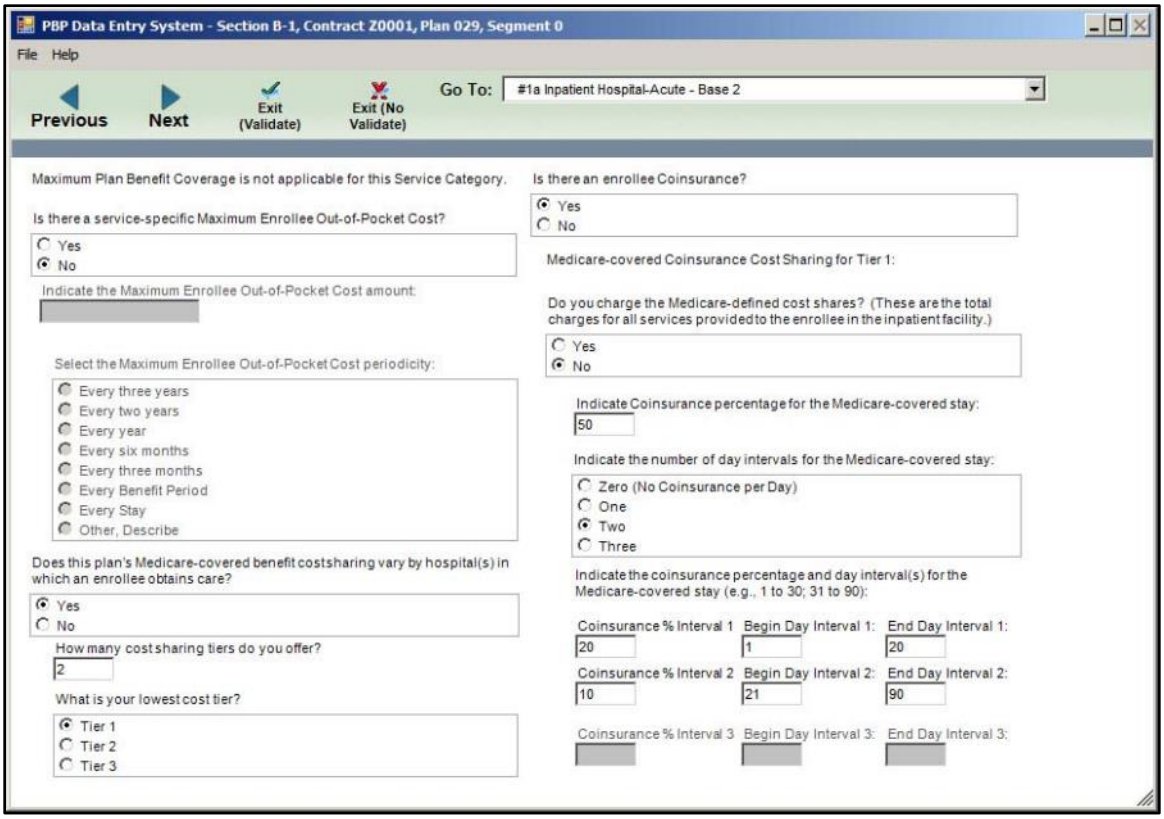
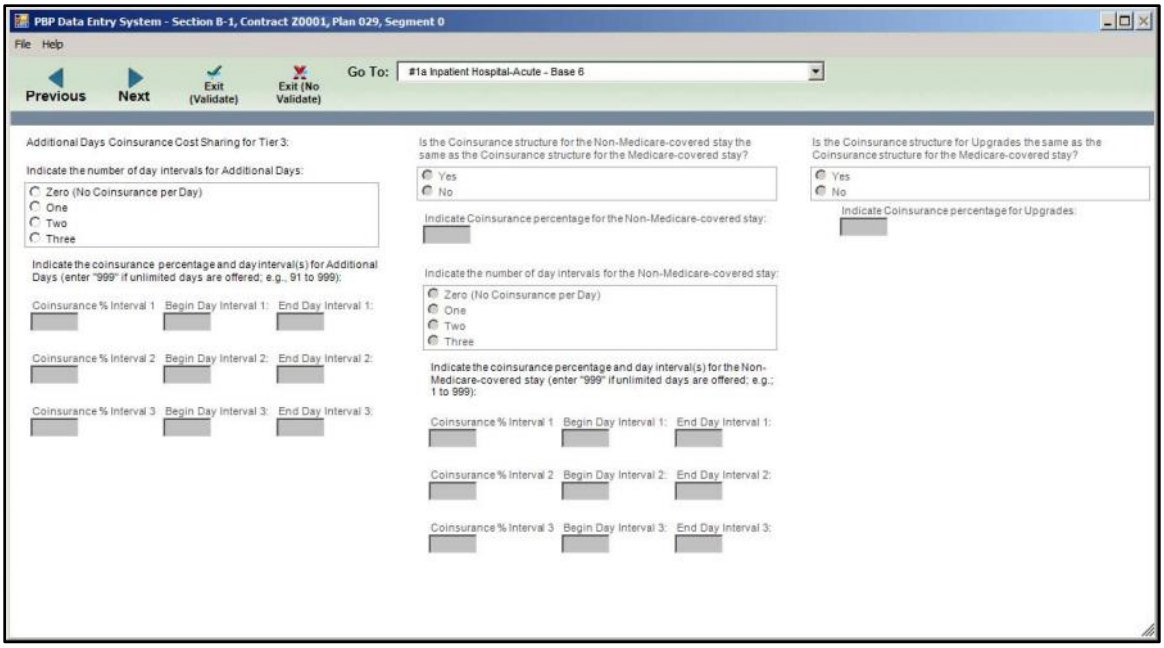


Table 4-10B

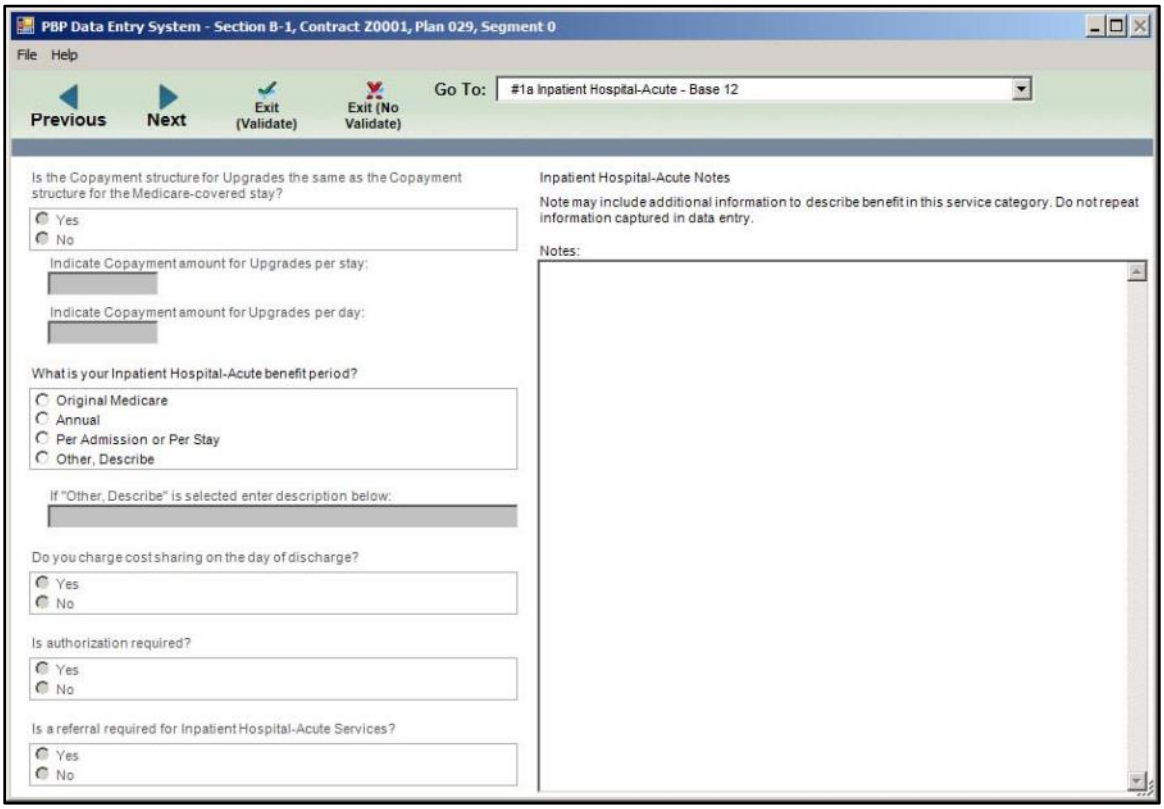


HOW TO ENTER BENEFIT PERIOD

On Base screen 12 (Table 4-10C), plans must indicate whether their inpatient hospital benefit period is the same as Original Medicare, Annual, Per Admission or Per Stay, or

Other benefit period. If plans select anything other than Original Medicare, the question "Do you charge cost sharing on the day of discharge?" will be enabled. If Other, Describe is selected, the text box for a description of the benefit period will be enabled.

Table 4-10C



SERVICE CATEGORY #2: SKILLED NURSING FACILITY

Includes the following category:

- B2: SNF

There are 10 data entry screens associated with this Service Category.

Notes:

- The following cost-sharing limitations must be followed in B2: SNF:

  If offering the MOOP at the Voluntary amount, cost shares for SNF will be limited as follows:

  - Voluntary MOOP:
    - B2: SNF—First 20 days – $20/day
    - B2: SNF—Days 21-100 – $184/day

If offering the MOOP at the Mandatory amount, cost shares for B2: SNF will be limited as follows:

- Mandatory MOOP:
  - B2: SNF—First 20 days – $0/day
  - B2: SNF—Days 21-100 – $184/day

If coinsurance is entered, the cost share will be calculated as a percentage of $518 per day.

For cost plans, cost sharing must be $0 for the first 20 days, and they may not enter a deductible.

- If a plan switches from both Part A and Part B coverage to Part B-only coverage, it will lose data previously entered in the PBP for the SNF benefit (since the data entry screens for Part B-only plans are different).
- Plans that offer both Part A and Part B can have up to three hospital cost-share tiers for In-Network Medicare-covered benefits and/or Additional Days enhanced benefit. If a plan is offering hospital cost-share tiers, then the plan:
  - Cannot offer more than one tier with Medicare-covered standard cost sharing.
  - Enter tiers in ascending or descending order of cost.
  - The Additional Days benefit for each tier must have the same maximum number of days; however, the number of intervals and how days are spread across an interval can vary from tier to tier.
- If the Medicare-covered services are also tiered, the Medicare-covered benefit and Additional Days must include the same number of tiers, and the lowest cost tier must be the same for both. The following description of the SNF screens does not apply to Part B-only plans. Part B-only plans will enter different data on four data entry screens associated with this category.

BASE 1 THROUGH 3 SCREENS

On the Base 1 screen, the plan will indicate whether it will provide SNF Services as a supplemental benefit under Part C (Table 4-11), and whether these benefits are offered as a Mandatory or Optional supplemental benefit.

On the Base 2 screen, the plan will indicate whether its Medicare-covered cost sharing varies by the SNF in which the enrollee receives care. If the response is "Yes," the plan then specifies the number of tiers offered (up to three). The remainder of the Base 2 and 3 screens include cost-sharing questions for up to three Medicare-covered SNF cost-share tiers. Tables 4 –11 and 4–12 show the screens for the B2: SNF category.

The response to each question on the base screens determines which remaining questions will be either enabled or disabled throughout the remainder of the PBP subsection. For

example, on the Base 2 screen, if a user indicates that the plan charges Medicare-defined cost shares for Tier 1, the cost-share questions on the Base 2 and subsequent base screens for the Medicare-covered stay and Medicare-covered day intervals for Tier 1 will be disabled.

If a user indicates that the plan charges the Medicare-defined cost shares for any particular tier, the user cannot enter a separate deductible amount for that tier. The Medicare deductible is included with the Medicare-defined cost-share indication. Also, if a user selects Medicare-defined cost shares for coinsurance and/or copayment for all tiers, the user must select "No" for Deductible in the Service Category.

Table 4-11

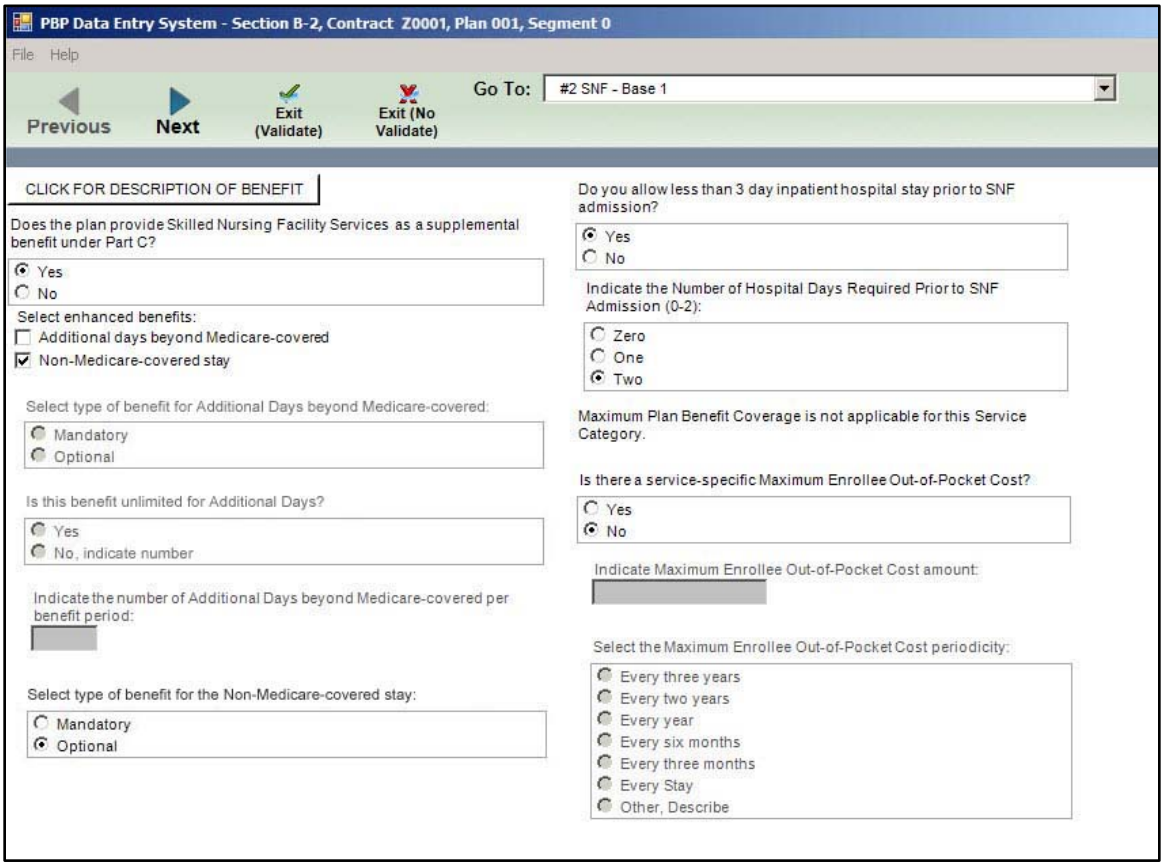
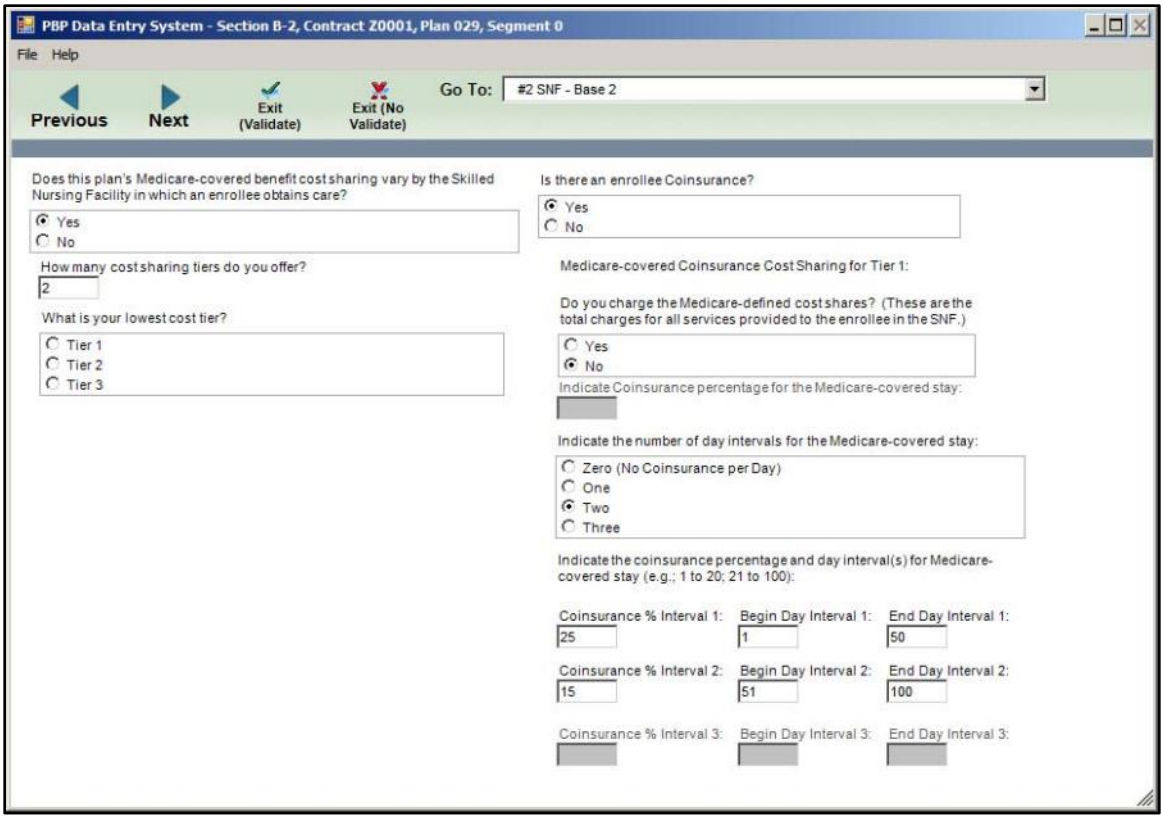


Table 4-12



BASE 4 THROUGH 10 SCREENS

On the Base 4 through 10 screens, many questions will be enabled based on how questions were answered on the prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

If a user indicates that the plan charges the Medicare-defined cost shares, the user cannot enter a separate deductible amount. The Medicare deductible is included with the Medicare-defined cost-shares indication. Also, if a user selects Medicare-defined cost shares for Coinsurance (Copayment), the user must select "No" for deductible in this Service Category.

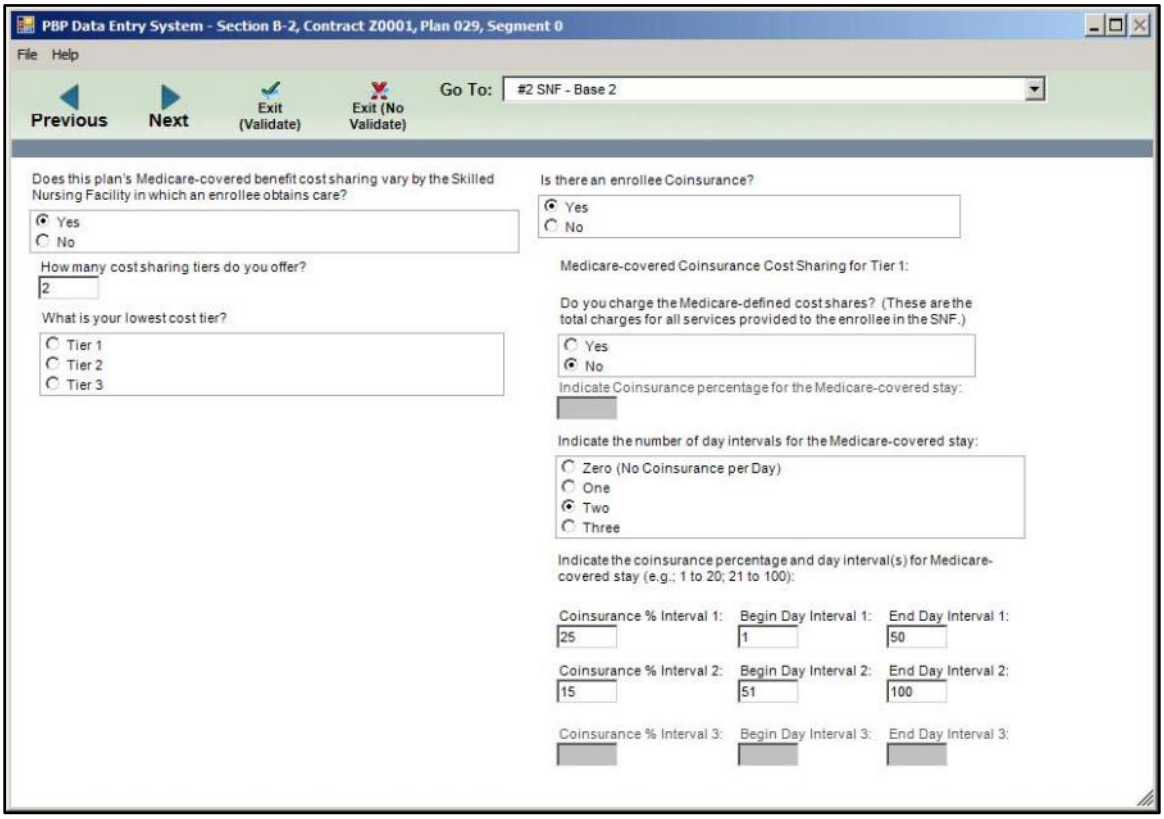
Note: Cost plans may not enter a deductible.

HOW TO ENTER COST SHARING FOR MEDICARE-COVERED STAYS

Coinsurance (Copayment) amounts for Medicare-covered stays may be entered on a stay and/or a per day basis.

As shown in Table 4-13, if a plan has a per day cost structure for Medicare-covered stays, the user must explicitly price the 100 days covered by Medicare during a benefit period. To ensure this pricing structure, the PBP requires that the user enter, at a minimum, a start day equal to "1" in the first interval, and an end day equal to "100" in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Table 4-13



Note: It is allowable to charge a per stay amount and a per day amount. However, since a combined per day and per stay data entry is a commonly observed data entry error in the PBP, a warning message will display as an alert when entering per stay and per day data. See Table 4-4 (while this table is for Inpatient Hospital–Acute Services, the error is similar for SNF Services). The user will still be able to exit with validation if this warning message is received.

HOW TO ENTER COST SHARING FOR NON-MEDICARE-COVERED ADDITIONAL DAYS

Additional Days are defined as days covered after the Medicare-covered 100-days-per-benefit period. Additional Days for SNF start at day 101. The number of Additional Days offered on the Base 1 screen determines the end day.

Example: If 10 Additional Days per benefit period are offered at 20% coinsurance, the cost-share structure should specify Additional Days 101 through 110 (Tables 4-14A and 4-14B).

On the Base 4 screen, the plan will indicate whether its Additional Days cost sharing varies by the SNF in which the enrollee receives care. If the response is "Yes," the user then specifies the number of tiers offered by the plan (up to three). If the plan has tiering for Medicare-covered benefit and Additional Days, both must offer the same number of tiers. The remainder of the Base 4 and 5 screens include cost-sharing questions for Additional Days for up to three SNF cost-share tiers (similar to the Medicare-covered SNF cost-share screens).

Table 4-14A

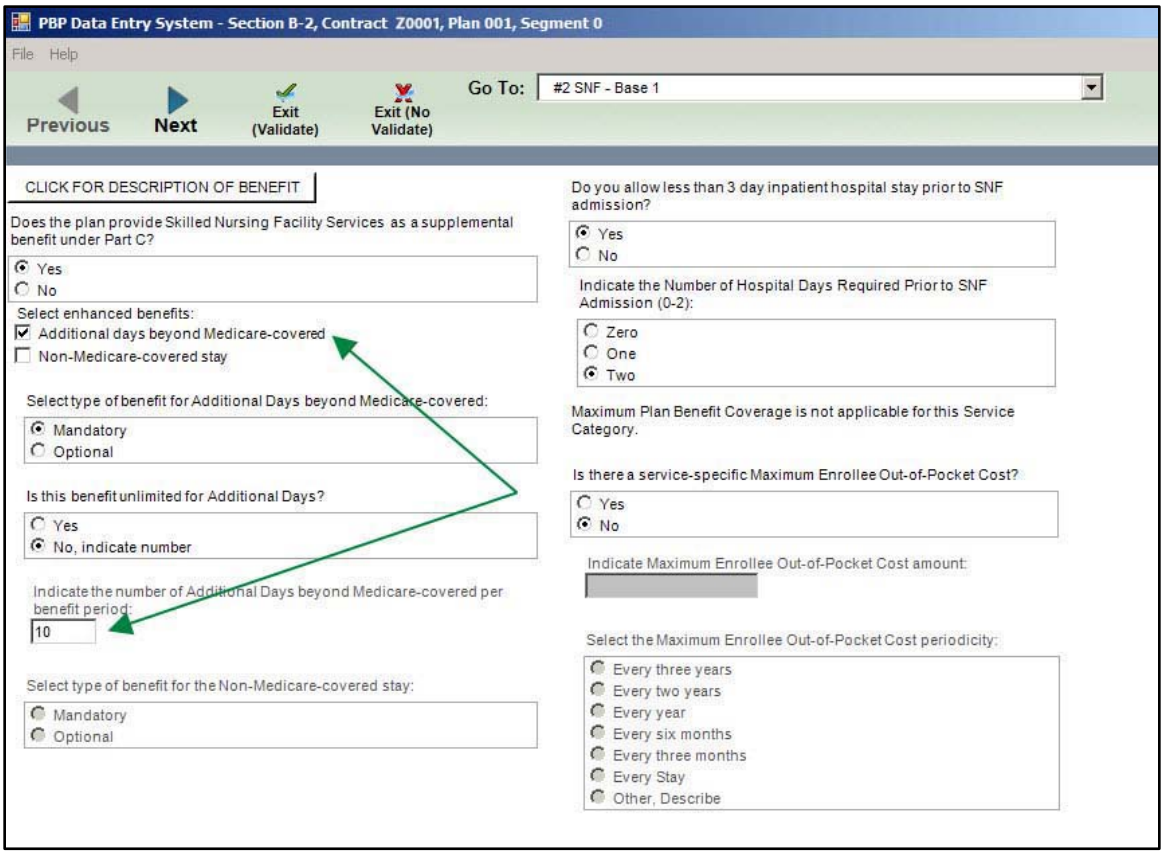
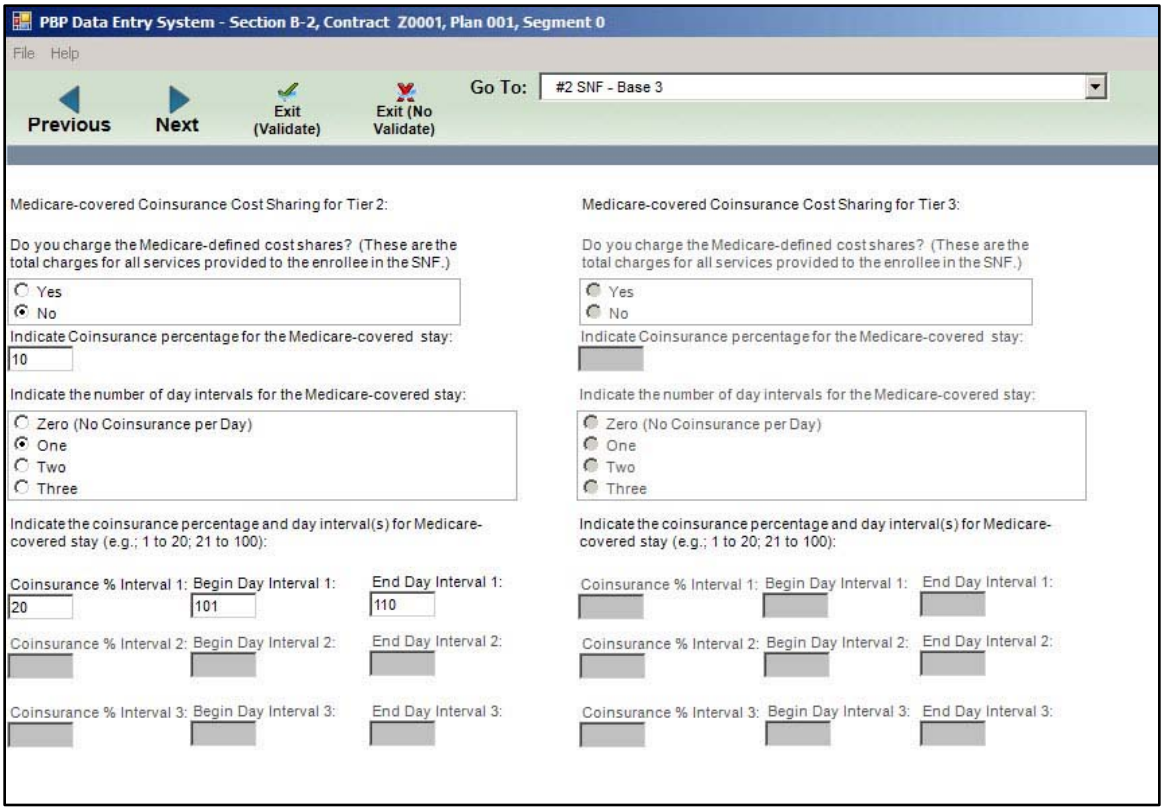


Table 4-14B



If offering an unlimited number of Additional Days, use "999" to notate the end day of the pricing structure.

HOW TO ENTER COST SHARING FOR NON-MEDICARE-COVERED STAYS (MMPS ONLY).

A Non-Medicare-covered stay means Part A benefits have been exhausted, the care is not medically necessary and reasonable according to Medicare coverage guidelines, or the care is provided in a facility not certified by Medicare.

Only MMPs are able to offer cost sharing for Non-Medicare-covered stays. To indicate that the plan covers Non-Medicare-covered stays, select the appropriate option on the Base 1 screen. See Table 4-8 (while this table is for B1a: Inpatient Hospital–Acute Services, data entry is similar for B2: SNF Services). If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost-share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the Non-Medicare-covered stay, if a per day cost-share structure exists.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered stay, the user should declare one interval on the Base 6 screen and enter $50 for days 1 through 999. See Table 4-9 (while this table is for B1a: Inpatient Hospital–Acute Services, data entry is similar for B2: SNF Services).

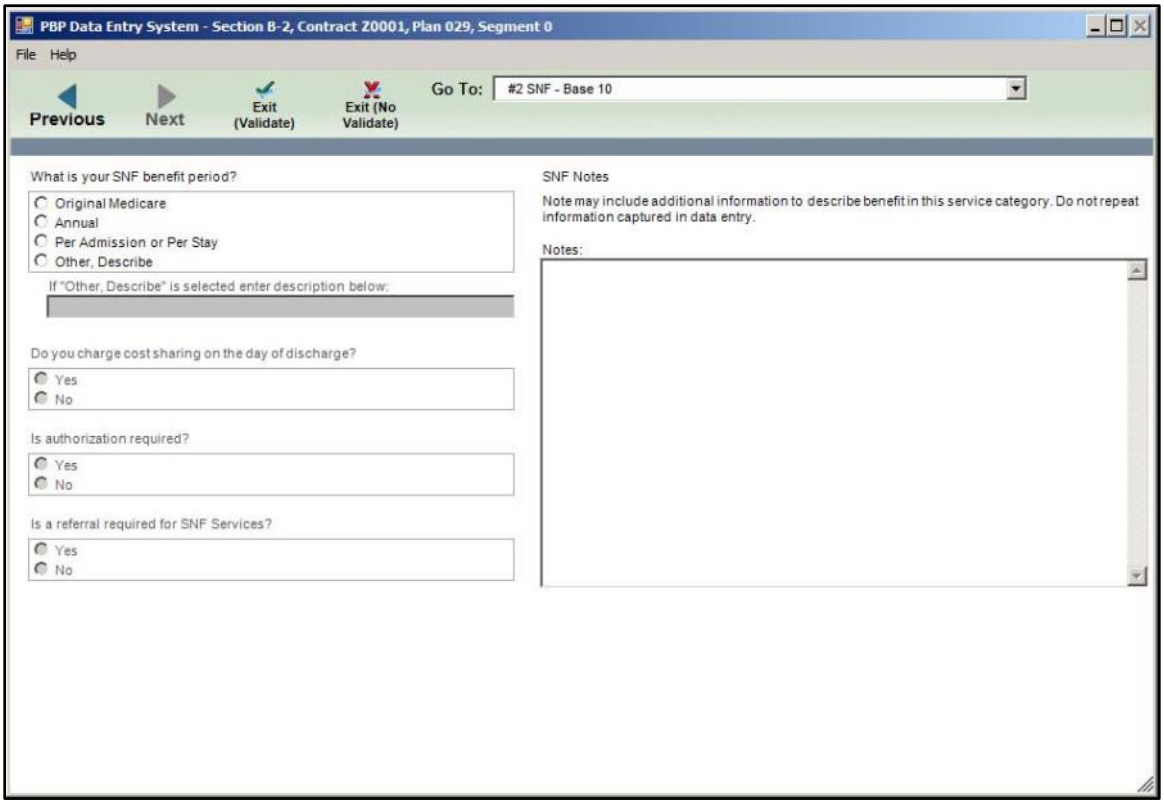
If the Medicare-covered cost sharing and Non-Medicare-covered cost sharing are the same, first indicate that Non-Medicare-covered stays are covered. See Table 4-8 (while this table is for B1a: Inpatient Hospital–Acute Services, data entry is similar for B2: SNF Services). Next, on the Base 2 screen, indicate that there is an enrollee coinsurance. See Table 4-10A (while this table is for B1a: Inpatient Hospital–Acute Services, data entry is similar for B2: SNF Services). This will enable the Base 4 question "Is the Coinsurance (Copayment) structure for the Non-Medicare-covered stay the same as the Coinsurance (Copayment) structure for the Medicare-covered stay?" Answer "Yes" to this question. See Table 4-10B (while this table is for B1a: Inpatient Hospital Acute Services, data entry is similar for B2: SNF Services).

Note: It is allowable to charge a per stay amount and a per day amount. However, since a combined per day and per stay data entry is a commonly observed data entry error on the PBP, a warning message will display as an alert when entering per stay and per day data. See Table 4-4 (while this table is for B1a: Inpatient Hospital Acute Services, the error is similar for B2: SNF Services). The user will still be able to exit with validation if this warning message is received.

HOW TO ENTER BENEFIT PERIOD

On the Base 10 screen (Table 4-14C), plans must indicate whether their inpatient hospital benefit period is the same as Original Medicare, Annual, Per Admission or Per Stay, or Other benefit period. If plans select anything other than Original Medicare, the question, "Do you charge cost sharing on the day of discharge?" will be enabled. If Other, Describe is selected, the text box for a description of the benefit period will be enabled.

Table 4-14C



SERVICE CATEGORY #3: CARDIAC AND PULMONARY REHABILITATION SERVICES

There are four data entry screens associated with this Service Category.

BASE 1 SCREEN

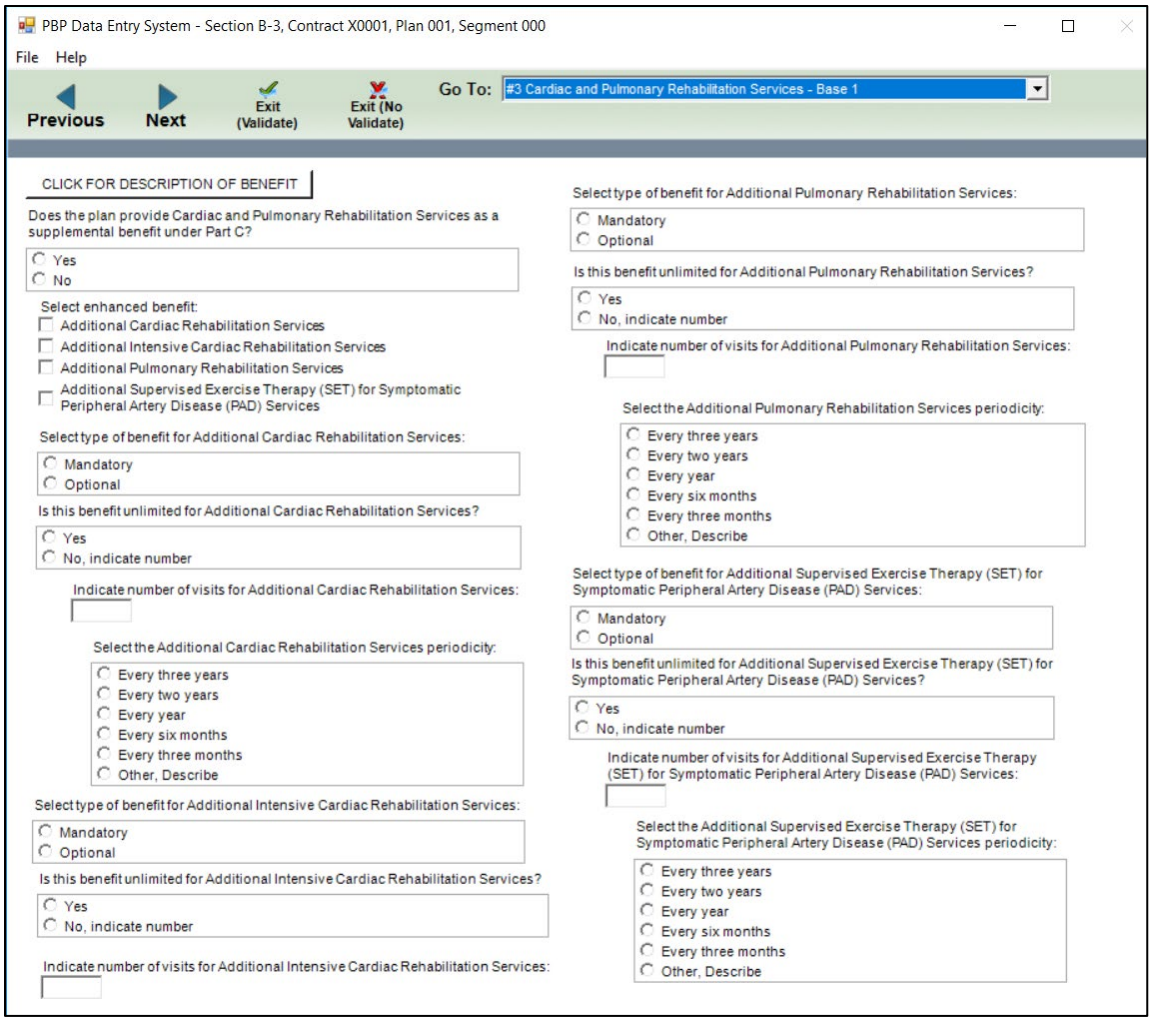
On the Base 1 screen, indicate whether the plan provides any B3: Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C (Table 4-15), and if these benefits are offered as a Mandatory or Optional supplemental benefit.

Note:

If offering the MOOP at the Voluntary or Mandatory amount, cost shares for B3: Cardiac and Pulmonary Rehabilitation Services will be limited as follows:

- Cardiac Rehabilitation: $50
- Intensive Cardiac Rehabilitation: $100
- Pulmonary Rehabilitation: $30
- Supervised Exercise Therapy (SET) for Symptomatic peripheral artery disease (PAD): $30

Table 4-15



BASE 2 THROUGH 4 SCREENS

On the Base 2 through 4 screens, many questions will be enabled based on how the user answered the questions on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #4: EMERGENCY/ URGENTLY NEEDED SERVICES

Includes the following subcategories:

- B4a: Emergency/Post-Stabilization Services
- B4b: Urgently Needed Services

- B4c: Worldwide Emergency/Urgent Coverage

Depending on the subcategory, there are two to three data entry screens associated with each subcategory.

Notes:

If offering the MOOP at the Voluntary amount or at the Mandatory amount, cost shares for B4a: Emergency /Post-Stabilization Services will be limited as follows:

- Voluntary MOOP:
  - B4a: Emergency /Post-Stabilization Services – $ 120
- Mandatory MOOP:
  - B4a: Emergency /Post-Stabilization Services – $ 90

If offering the MOOP at the Voluntary or at the Mandatory amount, cost shares for B4b: Urgently Needed Services will be limited as follows:

- B4b: Urgently Needed Services – $65

BASE SCREENS

On the Base 1 and 2 screens for B4a: Emergency/Post-Stabilization Services and the Base 1 screen for B4b: Urgently Needed Services, answer the questions about whether the plan has a service-specific MOOP cost, whether it charges a coinsurance, and what the maximum per visit amount is. (Table 4-16 and 4-17).

Note: The maximum per visit amount is optional for cost plans.

Table 4-16

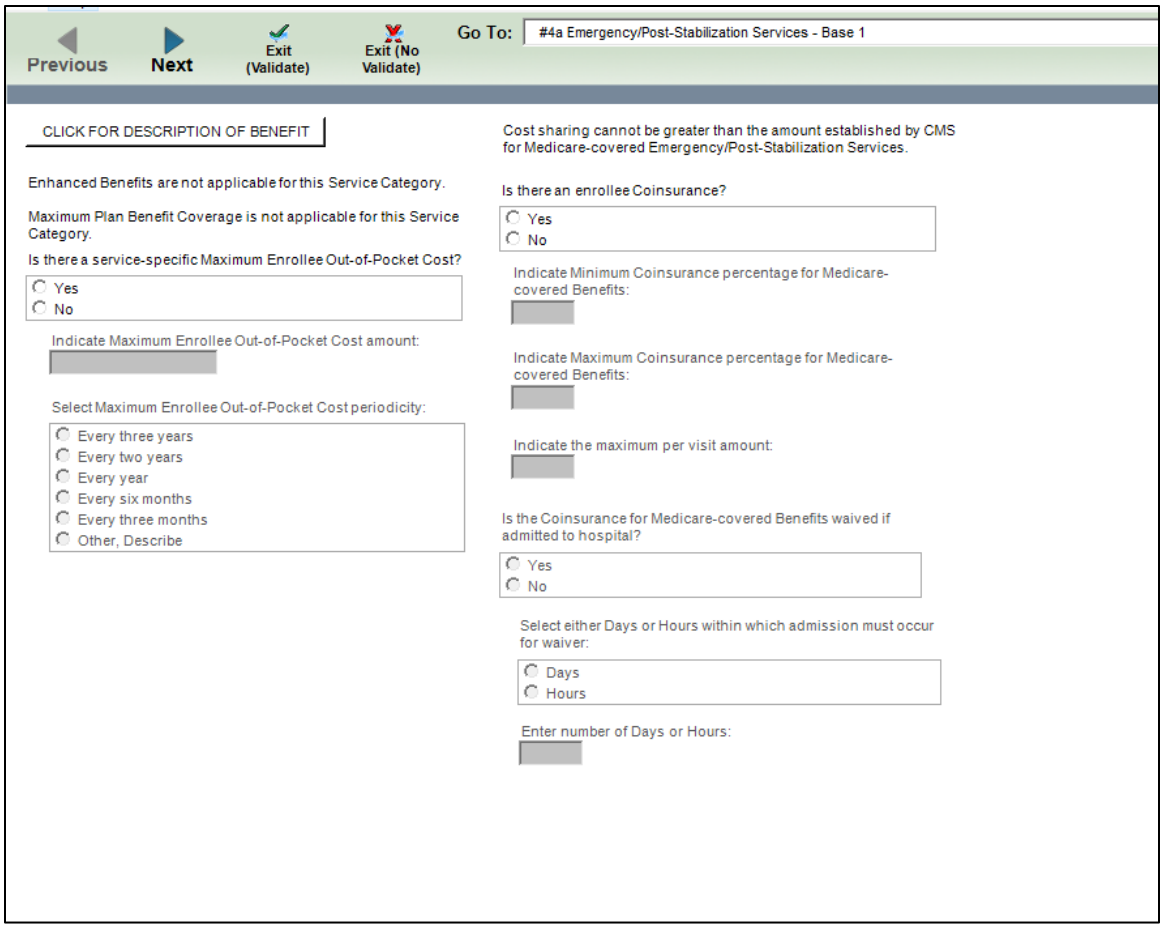
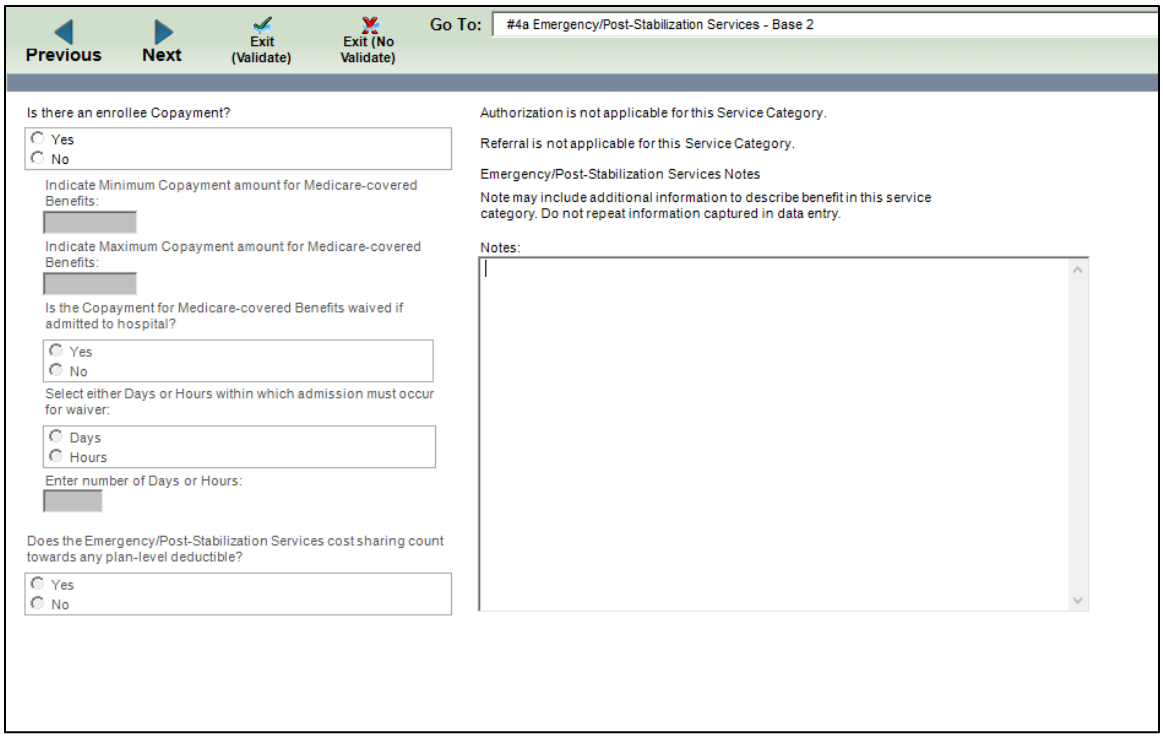
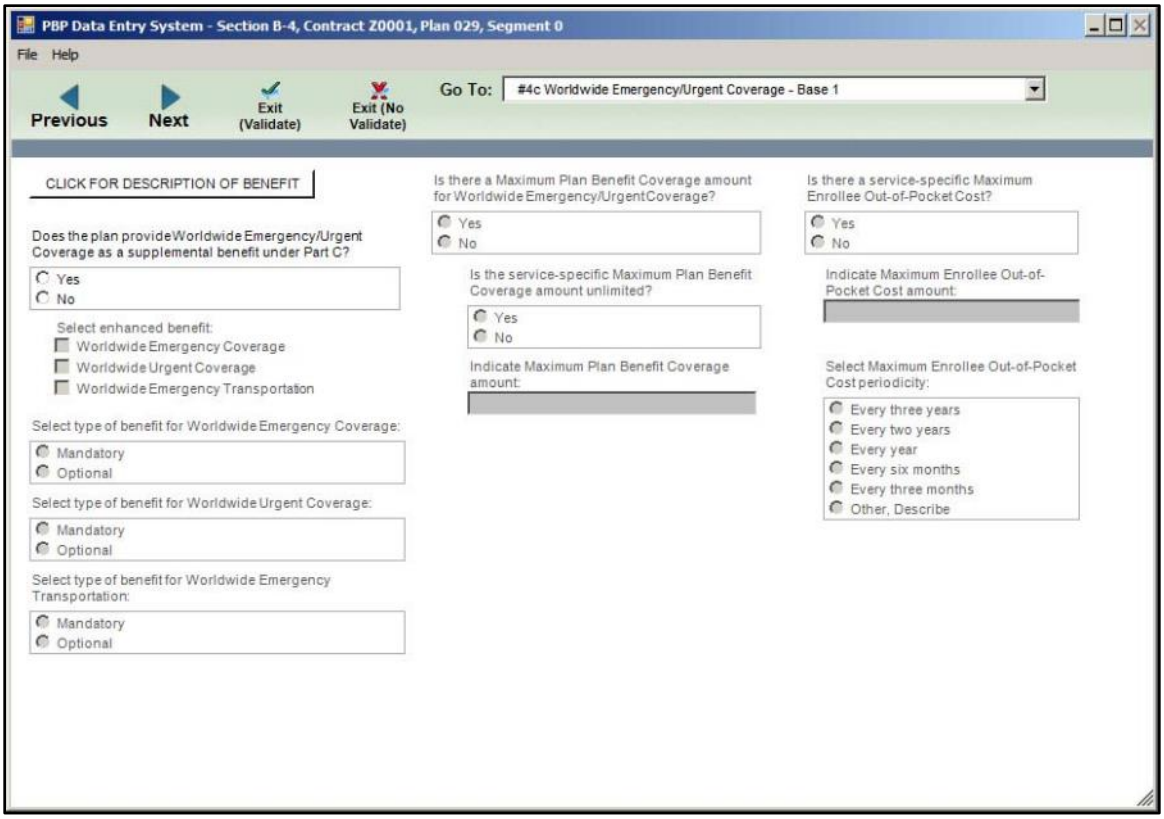

Previous
Next
Exit (Validate)
Exit (No Validate)
Go To:
#4a Emergency/Post-Stabilization Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT
Enhanced Benefits are not applicable for this Service Category.
Maximum Plan Benefit Coverage is not applicable for this Service Category.
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, Describe
Cost sharing cannot be greater than the amount established by CMS for Medicare-covered Emergency/Post-Stabilization Services.
Is there an enrollee Coinsurance?
Yes
No
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:
Indicate the maximum per visit amount:
Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?
Yes
No
Select either Days or Hours within which admission must occur for waiver:
Days
Hours
Enter number of Days or Hours:

Table 4-17



On the Base 1 screen for B4c: Worldwide Emergency/Urgent Coverage, the plan will indicate whether it provides Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C (Table 4-18). Select which of three enhanced benefits it will offer, and whether each of these benefits is offered as a Mandatory or Optional benefit. The plan will also provide information about maximum plan benefit coverage.

Table 4-18



BASE 2 THROUGH 3 SCREENS

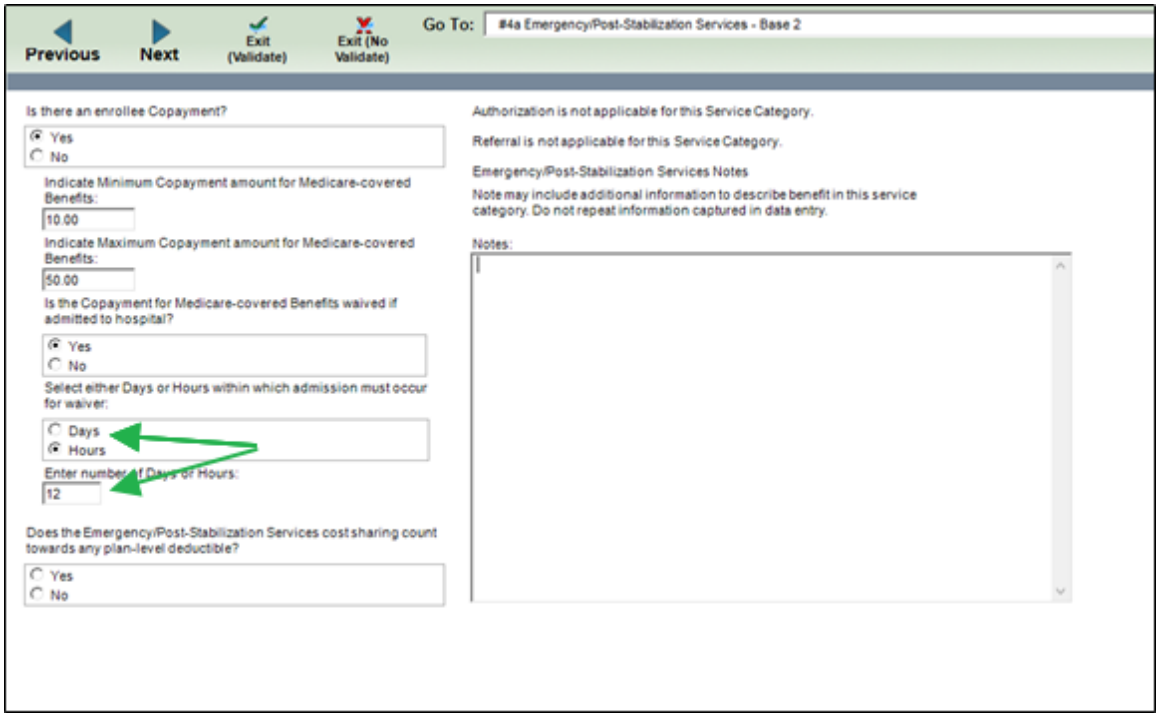
On the Base 2 through 3 screens, many questions will be enabled based on how the questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

On the Base 2 screen for B4a: Emergency/Post-Stabilization Services and B4b: Urgently Needed Services, answer the question on whether the cost sharing counts towards any plan level deductible. If the plan selects "Yes", the plan will be required to enter a plan-level deductible in Section D on the Plan Deductible (In-Network), Plan Deductible (Combined), or the Plan Deductible LPPO/RPPO screens.

Note: The PBP allows the plan to indicate whether the plan waives the Coinsurance (Copayment) for emergency or urgently needed services if a beneficiary is admitted to the hospital. As shown in Table 4-18, if the cost share is waived, the question "Is the Coinsurance (Copayment) for Medicare-covered Benefits waived if admitted to hospital?" should be answered with "Yes," and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, select "hours" and enter the number "0" for the number of hours in which admittance must occur for the cost sharing

to be waived. See the "Inpatient Hospital Care" section of this booklet for other costs. The urgently needed service sentence is similar.

Table 4-19



SERVICE CATEGORY #5: PARTIAL HOSPITALIZATION

Includes the following category:

- B5: Partial Hospitalization

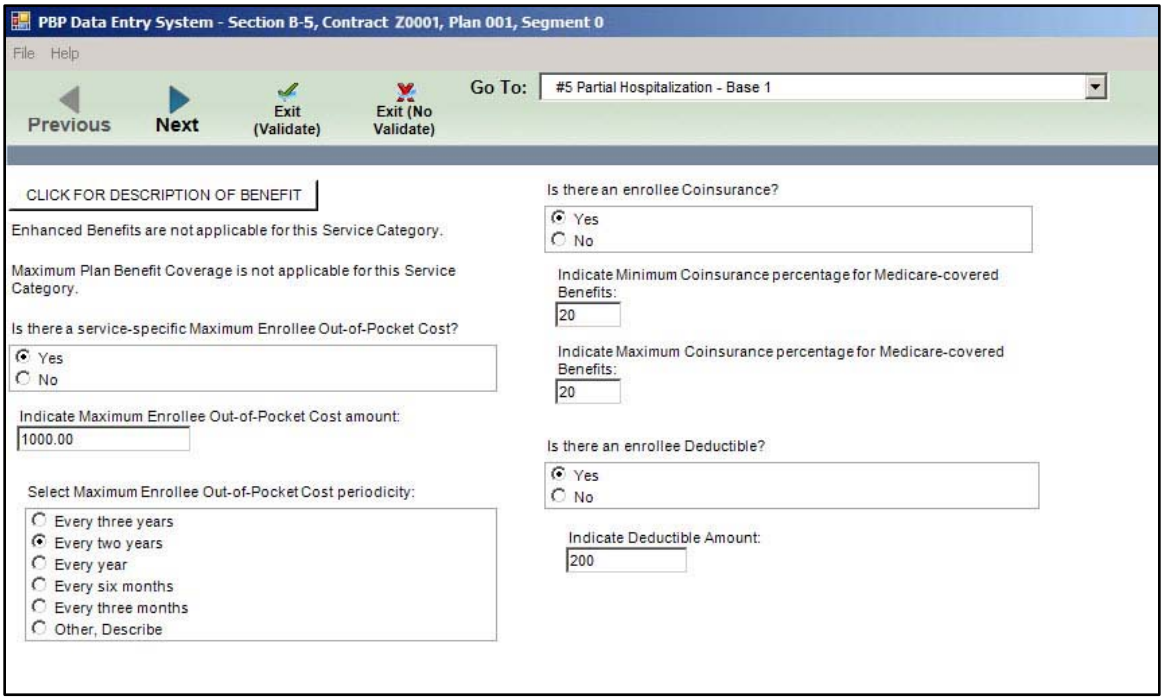
There are two data entry screens associated with this Service Category.

Note: If Copayment is entered, it may not be greater than $55.

BASE 1 SCREEN

On the Base 1 screen, answer three questions (Table 4-20) about whether the plan has a service-specific MOOP cost and whether it charges a coinsurance and/or a deductible. The response to these questions will dictate which subsequent questions are enabled on this screen.

Table 4-20



BASE 2 SCREEN

On the Base 2 screen, answer three questions about whether the plan charges a copayment, requires authorization, and requires a referral.

SERVICE CATEGORY #6: HOME HEALTH SERVICES

Includes the following category:

- B6: Home Health Services

There are three data entry screens associated with this Service Category.

Notes:

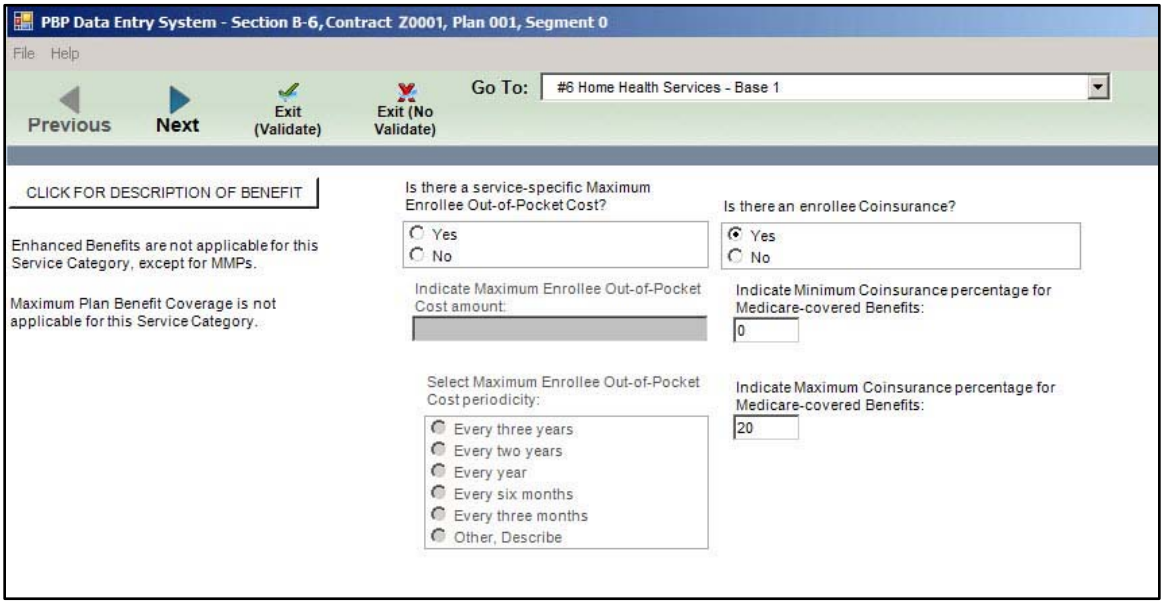
- If offering the MOOP at the Voluntary amount, cost shares for B6: Home Health Services will be limited to 20% or a $35 copayment.
- If offering the MOOP at the Mandatory amount, cost shares for B6: Home Health Services will be limited to $0.

BASE 1 SCREEN

On the Base 1 screen, the plan will answer two questions about whether there is a service-specific MOOP cost and whether it charges a coinsurance (Table 4-21). The

response to these questions will dictate which subsequent questions are enabled on this screen.

Table 4-21



BASE 2 AND 3 SCREENS

On the Base 2 and 3 screens, the plan will answer questions about whether it charges a deductible and/or a copayment, requires authorization, and requires a referral.

ADDITIONAL MMP SCREENS

MMPs have three extra data entry screens. These screens have data entry for the plan to enter up to two supplemental services (offered as either a Medicaid or plan benefit). On these additional screens, MMPs will provide information about cost sharing and any limits applied to the services, and indicate whether any service requires qualification for and enrollment in a state-operated waiver program.

SERVICE CATEGORY #7: HEALTH CARE PROFESSIONAL SERVICES

Includes the following subcategories:

- B7a: Primary Care Physician Services
- B7b: Chiropractic Services
- B7c: Occupational Therapy Services
- B7d: Physician Specialist Services

- B7e: Mental Health Specialty Services
- B7f: Podiatry Services
- B7g: Other Health Care Professional
- B7h: Psychiatric Services
- B7i: Physical Therapy and Speech-Language Pathology Services
- B7j: Additional Telehealth Services (Optional)
- B7k: Opioid Treatment Program Services

Depending on the subcategory, there are two to four data entry screens associated with the subsection.

Notes:

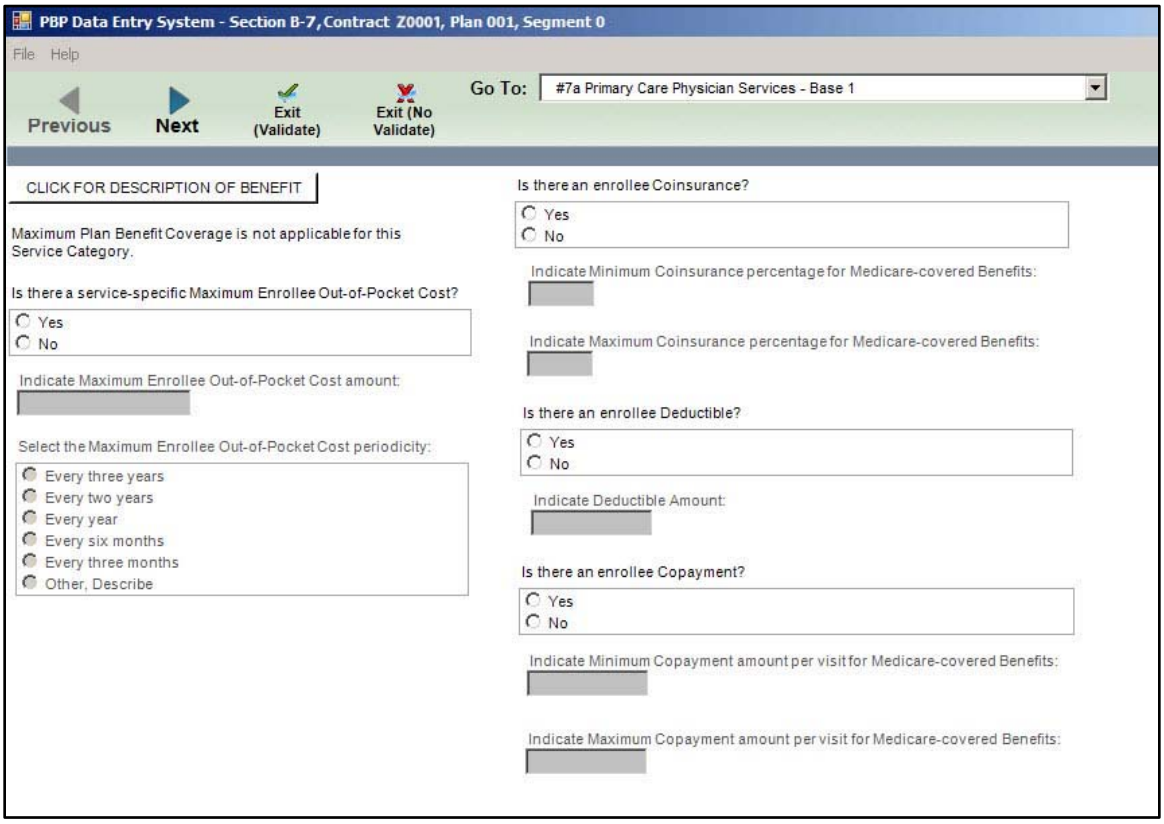
- Medicare-covered B7b: Chiropractic Services includes only Manual Manipulation of the Spine to Correct Subluxation. Other chiropractic services offered, such as routine care, will be classified as either Mandatory or Optional Supplemental benefits.
- The B7b: Chiropractic Services, B13a: Acupuncture, and Alternative Therapies (located in 14c: Other defined supplemental benefits) benefits may be combined. If they are combined, they must include matching maximum plan-benefit amounts and periodicity, or limits. If enhanced benefits are offered, all benefits must be either Mandatory or Optional. If the enhanced benefits are Optional, all sections included in the combined benefit must be included in the same Optional Supplemental Package.
- MMPs have two extra data entry screens associated with B7c: Occupational Therapy Services. The screens enable the plan to enter information about a supplemental service (offered as either a Medicaid or plan benefit).
- Medicare-covered B7f: Podiatry Services includes only medically necessary and reasonable foot care. Other podiatry services offered, such as routine care, will be classified as either Mandatory or Optional Supplemental benefits.
- MMPs have two extra data entry screens associated with B7i: PT and SP Services. These screens enable the plan to enter information about up to two supplemental services (offered as either a Medicaid or plan benefit).
- B7j Additional Telehealth Services is an optional Medicare-covered benefit. These screens enable the plan to select the Medicare-covered Part B service categories where Additional Telehealth may apply.

BASE 1 SCREEN

Depending on the subcategory, on the Base 1 screen, the plan will indicate whether it provides services as a supplemental benefit under Part C, and cost sharing (see Table 4-

22 (while this table is for Primary Care Physician Services, the screen is similar for other subsections in this Service Category). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-22



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and a "Notes" field. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #8: OUTPATIENT PROCEDURES, TESTS, LABS AND RADIOLOGY SERVICES

Includes the following subcategories:

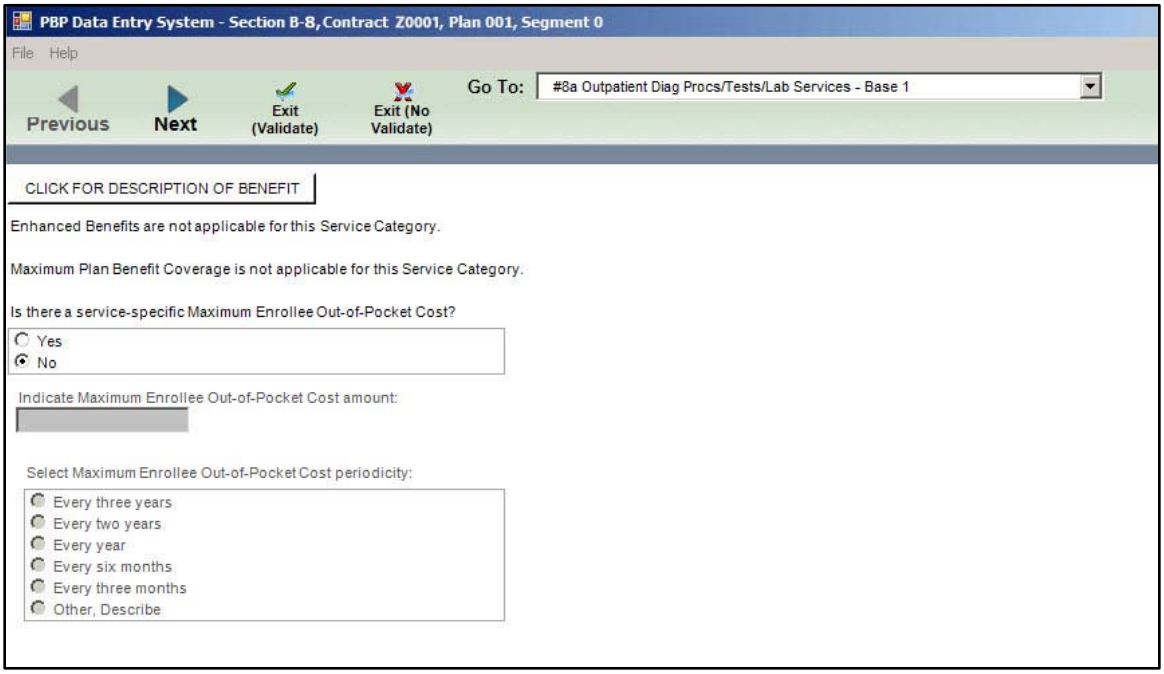
- B8a: Outpatient Diagnostic Procedures, Tests, and Lab Services
- B8b: Outpatient Diagnostic and Therapeutic Radiological Services

Depending on the subcategory, there are three to four data entry screens associated with the subsection.

BASE 1 SCREEN

On the Base 1 screen, the plan will answer the question regarding whether it has a service-specific MOOP cost (Table 4-23). In the case of B8b: Outpatient Diagnostic and Therapeutic Radiological Services, the plan will also indicate whether it charges a coinsurance. The responses to these questions will dictate which subsequent questions are enabled on this screen.

Table 4-23



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #9: OUTPATIENT SERVICES

Includes the following subcategories:

- B9a: Outpatient Hospital Services

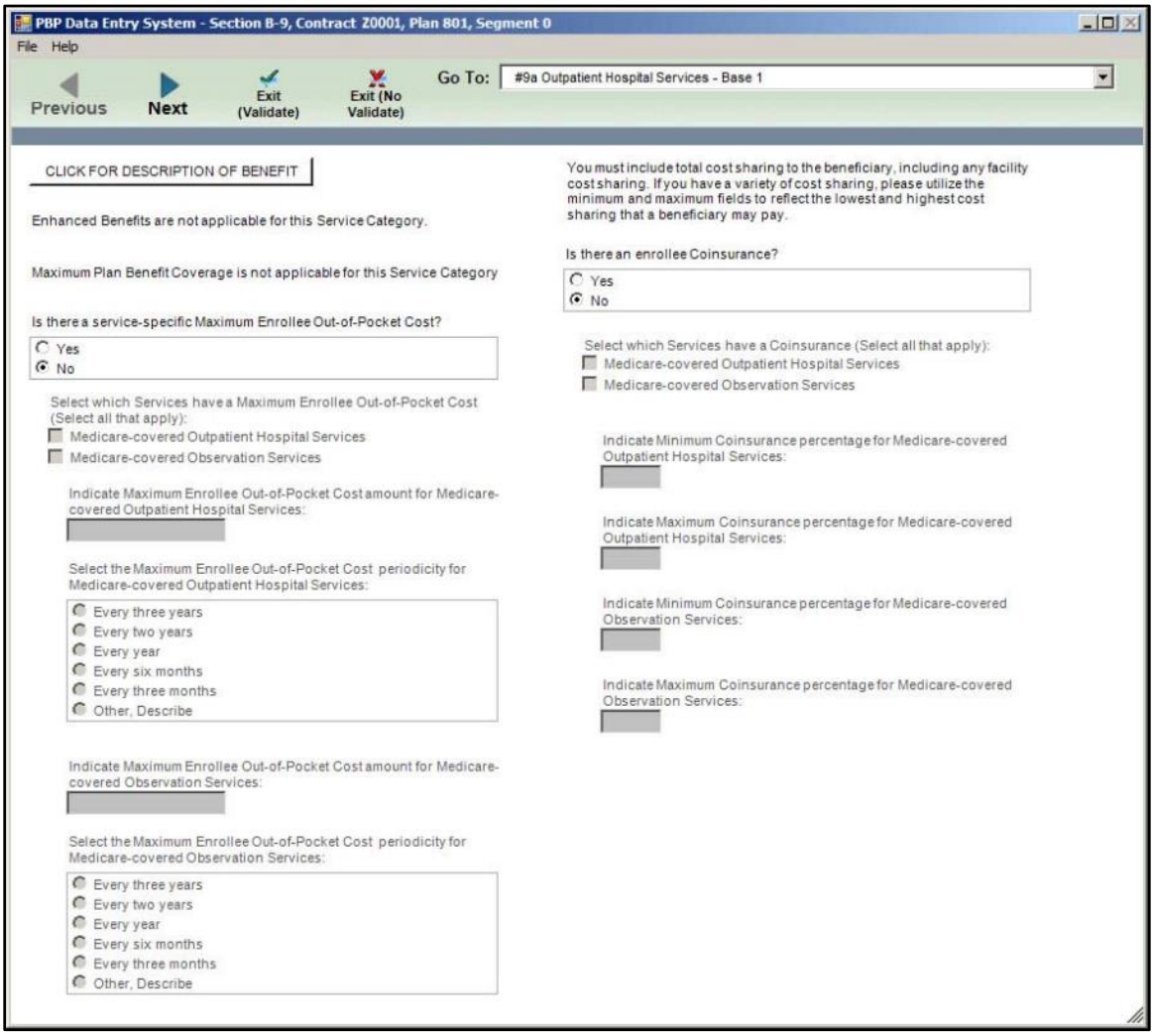
- B9b: Ambulatory Surgical Center (ASC) Services
- B9c: Outpatient Substance Abuse
- B9d: Outpatient Blood Services

Depending on the subcategory, there are two to three data entry screens associated with the subcategory. **Note**: If coinsurance is entered for Outpatient Blood Services, the coinsurance may not be greater than 50%.

BASE 1 SCREEN

Depending on the subcategory, the plan will indicate whether it provides services as a supplemental benefit under Part C and cost sharing on the Base 1 screen. See Table 4-24 (while this is a table for Outpatient Hospital Services, the screen is similar for other subsections in this Service Category). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-24



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #10: AMBULANCE / TRANSPORTATION SERVICES

Includes the following subcategories:

- B10a: Ambulance Services
- B10b: Transportation Services

Depending on the subcategory, there are two to three data entry screens associated with the subcategory.

BASE 1 SCREEN

Depending on the subcategory, the user must indicate whether the plan provides any services as a supplemental benefit under Part C and cost sharing on the Base 1 screen (Table 4-25 and 4-26). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-25

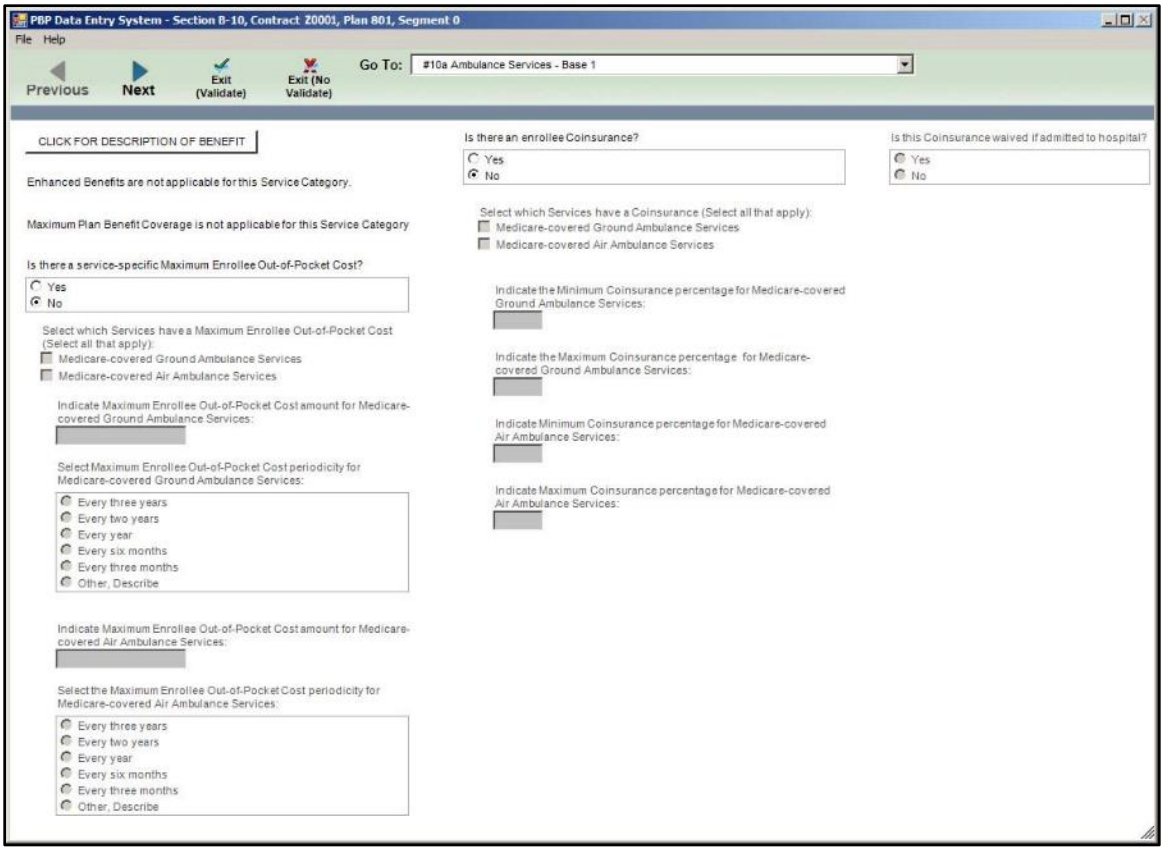
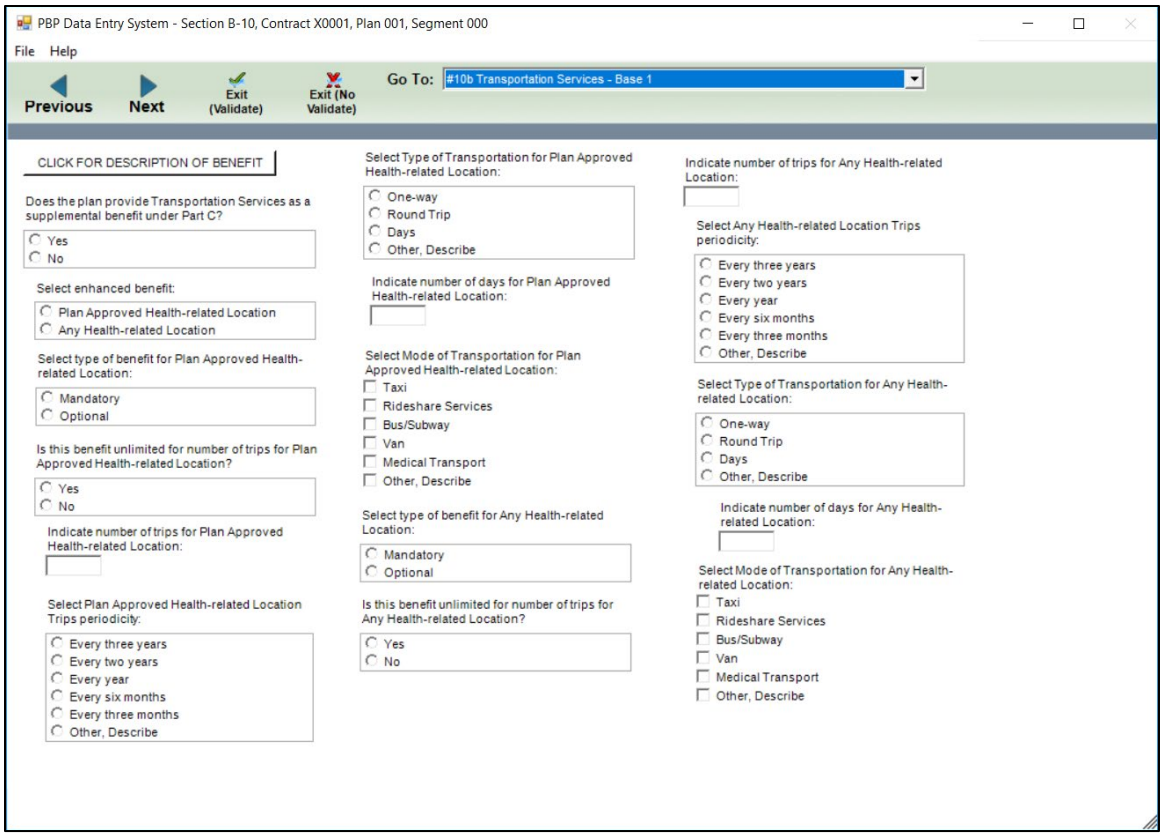

PBP Data Entry System - Section B-10, Contract Z0001, Plan 801, Segment 0
File Help
Previous
Next
Exit (Validate)
Exit (No Validate)
Go To:
#10a Ambulance Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT
Enhanced Benefits are not applicable for this Service Category.
Maximum Plan Benefit Coverage is not applicable for this Service Category
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):
Medicare-covered Ground Ambulance Services
Medicare-covered Air Ambulance Services
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Ground Ambulance Services:
Select Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Ground Ambulance Services:
Every three years
Every two years
Every year
Every six months
Every three months
Other, Describe
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Air Ambulance Services:
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Air Ambulance Services:
Every three years
Every two years
Every year
Every six months
Every three months
Other, Describe
Is there an enrollee Coinsurance?
Yes
No
Select which Services have a Coinsurance (Select all that apply):
Medicare-covered Ground Ambulance Services
Medicare-covered Air Ambulance Services
Indicate the Minimum Coinsurance percentage for Medicare-covered Ground Ambulance Services:
Indicate the Maximum Coinsurance percentage for Medicare-covered Ground Ambulance Services:
Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:
Indicate Maximum Coinsurance percentage for Medicare-covered Air Ambulance Services:
Is this Coinsurance waived if admitted to hospital?
Yes
No

Table 4-26



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #11: DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, AND MEDICAL & DIABETIC SUPPLIES

Includes the following subcategories:

- B11a: Durable Medical Equipment (DME)
- B11b: Prosthetics/Medical Supplies
- B11c: Diabetic Supplies and Services

Depending on the subcategory, there are two to three data entry screens associated with the subcategory.

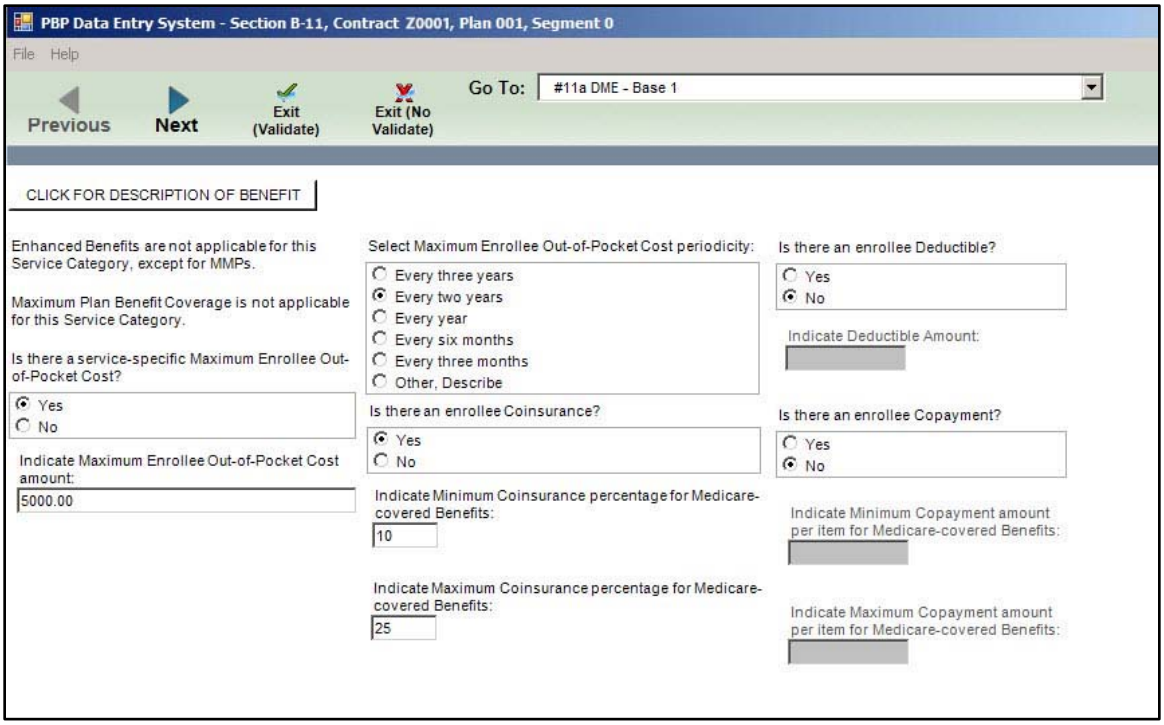
Notes:

- B11a: DME collects information on Medicare-covered Durable Medical Equipment not related to Diabetes Monitoring Supplies.
- MMPs have two extra data entry screens associated with B11a: DME. These screens allow the plan to enter information for up to two supplemental services (offered as either a Medicaid or plan benefit). MMPs have an extra data entry screen associated with B11b: Prosthetics/Medical Supplies. This screen has data entry for the plan to enter a supplemental service (offered as either a Medicaid or plan benefit). B11c: The Diabetic Supplies and Services category distinguishes between Diabetic Monitoring Supplies and other DME, since cost sharing may differ between these two categories. Benefit information for Diabetes Self-Management Training should continue to be entered in subcategory B14e: Other Medicare-covered Preventive Services.

BASE 1 SCREEN

On the Base 1 screen, the plan will indicate whether it has a service-specific MOOP cost and cost sharing. See Table 4-27 (while this is a table for DME, the screen is similar for other subsections in this Service Category). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-27



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #12: DIALYSIS SERVICES

Includes the following category:

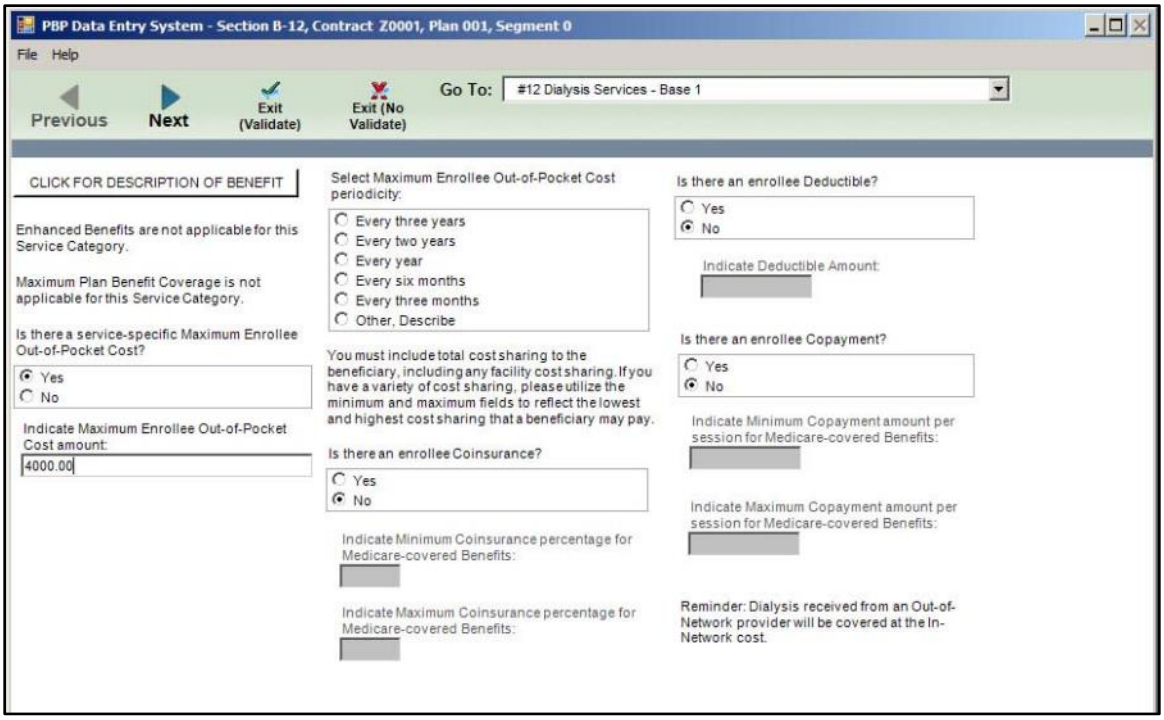
- B12: Dialysis Services

This Service Category collects information on Medicare-covered Dialysis Services for patients with end-stage renal disease (ESRD) who receive maintenance dialysis services from approved ESRD dialysis facilities or kidney transplant services. There are two data entry screens associated with this category.

BASE 1 SCREEN

On the Base 1 screen, the plan will indicate whether it has a service-specific MOOP cost and cost sharing (Table 4-28). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-28



BASE SCREEN 2

The Base 2 screen contains questions about plan rules for referrals and authorization, and a "Notes" field. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

Note: Dialysis received from an Out-of-Service area provider will be covered at the In-Network cost.

SERVICE CATEGORY #13: OTHER SUPPLEMENTAL SERVICES

Includes the following subcategories:

- B13a: Acupuncture
- B13b: OTC Items
- B13c: Meal Benefit
- B13d: Other 1
- B13e: Other 2
- B13f: Other 3
- B13g: Dual Eligible SNPs with Highly Integrated Services

Note: Only available for D-SNPs

- B13h: Additional Services

  Note: Only available for MMPs.

- B13i: Non-Primarily Health Related Benefits for the Chronically Ill

  Note: Only available for SSBCI and VBID packages as part of 19b

There are three data entry screens associated with each subcategory, except for Additional Services and Non-Primarily Health Related Benefits for the Chronically Ill, for which there are extra data entry screens.

Notes:

- The B7b: Chiropractic Services, B13a: Acupuncture, and Alternative Therapies (located in 14c: Eligible Supplemental Benefits as Defined in Chapter) benefits may be combined. If they are combined, they must include matching maximum plan-benefit amounts and periodicity, or limits. If enhanced benefits are offered, all benefits must either be Mandatory or Optional. If the enhanced benefits are Optional, all sections included in the combined benefit must be included in the same Optional Supplemental Package.
- MMPs may not use B13b: OTC Items to provide benefit information about OTC drugs or items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should be used only to provide benefit information about OTC drugs and items that are covered as a supplemental benefit.
- The B13d: Other 1, B13e: Other 2, and B13f: Other 3 categories are to collect information that describes supplemental benefits that are not provided in other areas of the PBP. Do not use the categories to provide information on benefits that are listed in other areas, such as the Hepatitis B vaccine. In addition, do not describe optional supplemental benefits and "step-ups" in these categories. Medicare benefits should not be entered in these categories.
- The B13g: Dual Eligible SNPs with Highly Integrated Services category is enabled for D-SNPs only. Users should fill out this section only if the plan has received notification from CMS that it qualifies for the new supplemental benefit flexibility for certain high-quality SNPs.
- B13h: Additional Services is enabled for MMPs only and is used to collect information that describes supplemental benefits that are not provided in other areas of the PBP. Do not use the categories to provide information on benefits that are listed in other areas, such as the Hepatitis B vaccine. Medicare benefits should not be entered in these categories.
- B13i: Non-Primarily Health Related Benefits for the Chronically Ill is for plans offering SSBCI and/or VBID 19b Additional benefits packages. This section will only show up as a part of 19b for packages that are for SSBCI or VBID beneficiaries.

BASE 1 SCREEN

Depending on the subcategory, indicate on the Base 1 screen whether the plan provides any services as a supplemental benefit under Part C, and cost sharing. See Table 4-29 (while this is a table for Acupuncture, the screen is similar for other subsections in this Service Category). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Notes:

- Provide a descriptive title on the Base 1 screen if offering a supplemental benefit in Other 1, Other 2, Other 3, Dual Eligible SNPs with Highly Integrated Services, and/or any "Other" services in the Additional Services Category. See Table 4-30 (while this is a table for Other 1, the screen is similar for other subsections in this Service Category). The title must be longer than two characters. If a title is entered by the user, additional questions will be enabled on the screen. For a few supplemental benefits, plans are required to use specified titles in their PBP data entry. Responses to the questions will dictate which subsequent questions are enabled on this screen.
- Dual Eligible SNPs with Highly Integrated Services must attest that they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain high-quality SNPs. After checking off this attestation, other questions will be enabled on the screen (Table 4-31)
- An MMP plan may use the Additional Services subsection to indicate whether it provides additional services beyond Medicare (Table 4-32). The plan must also provide cost-sharing and referral/authorization information about the Additional Services. If the user selects any of the "Other" services as an Additional Service choice, the name of that additional service must also be entered.

Table 4-29

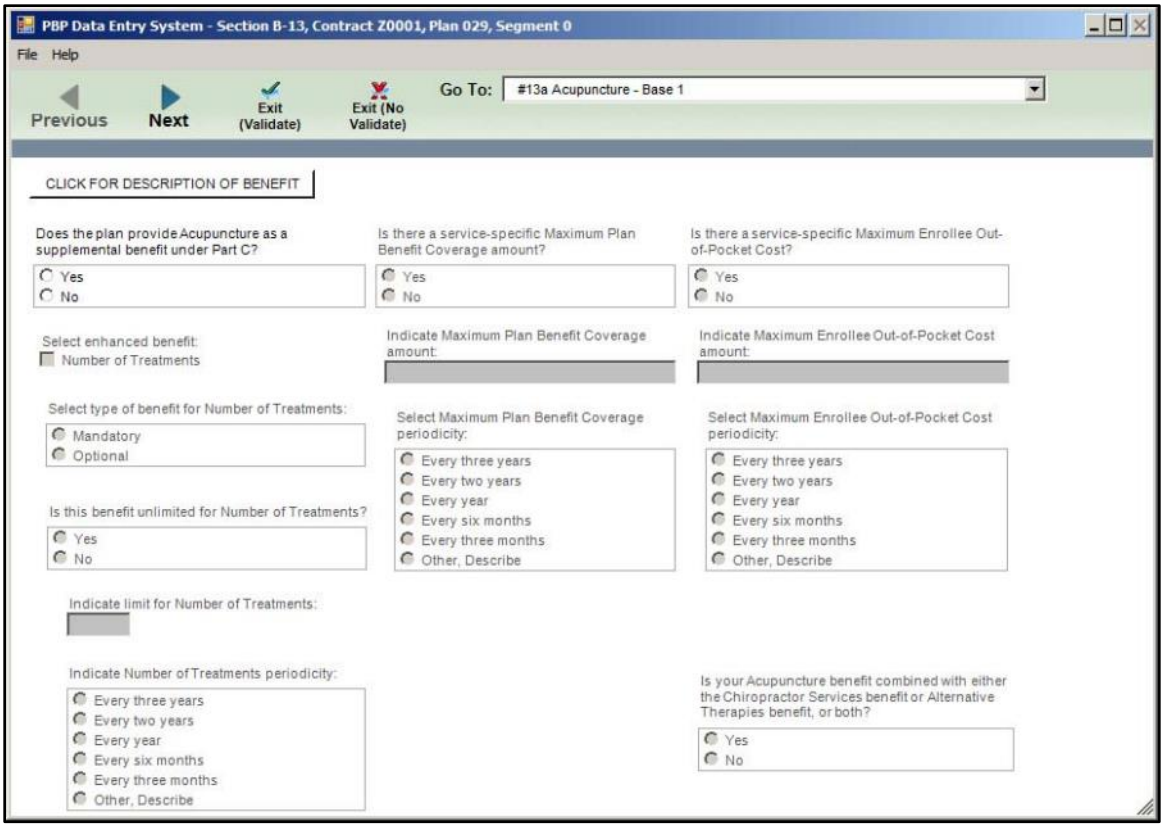


Table 4-30

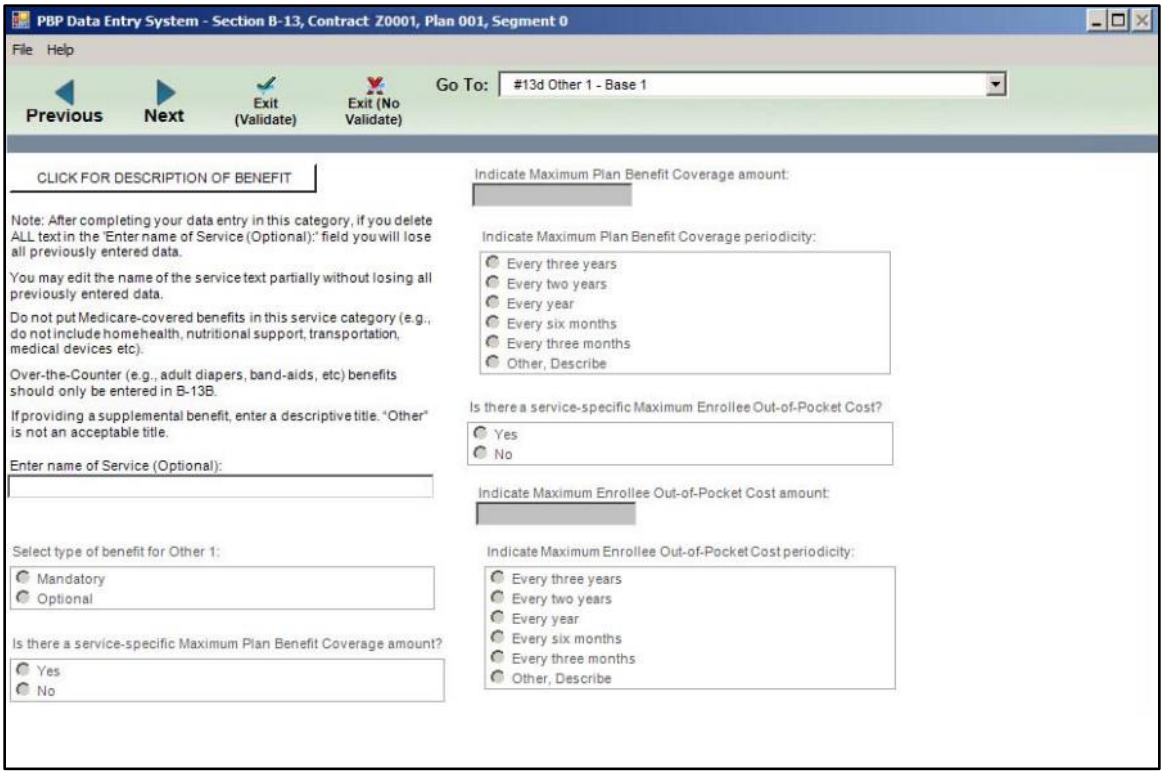


Table 4-31

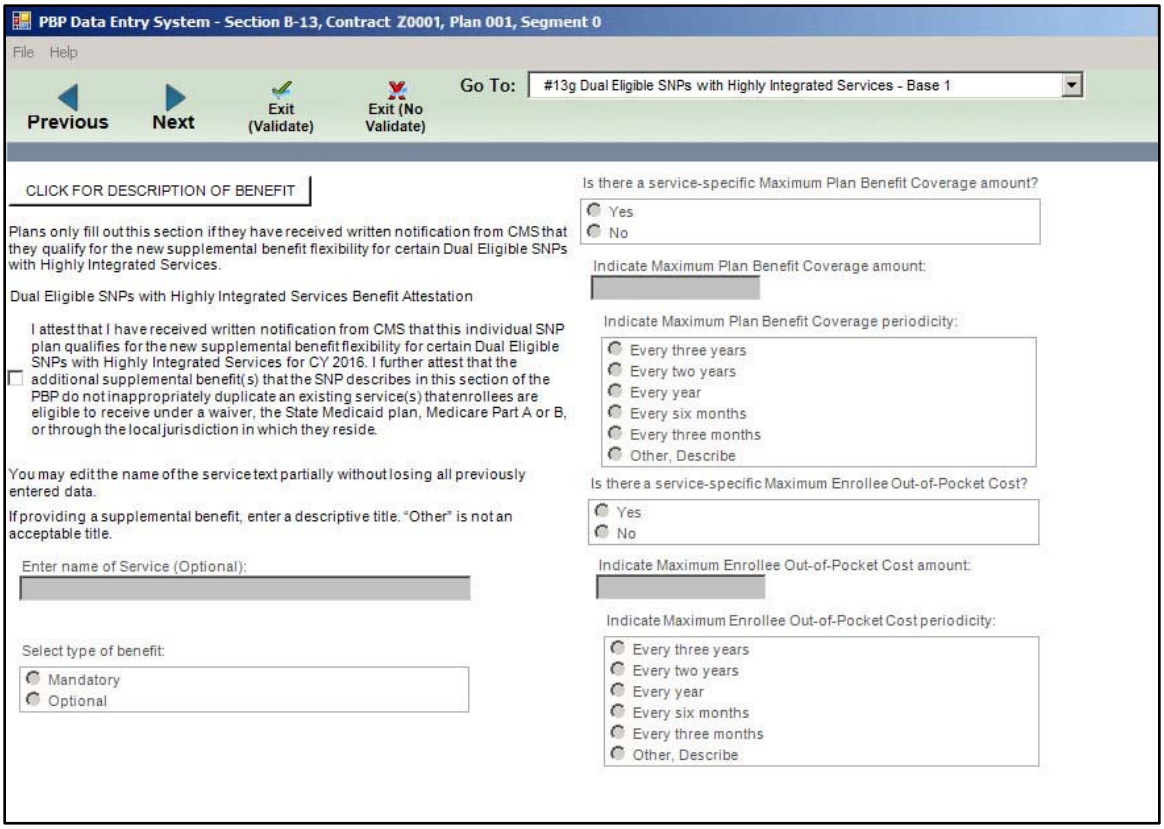
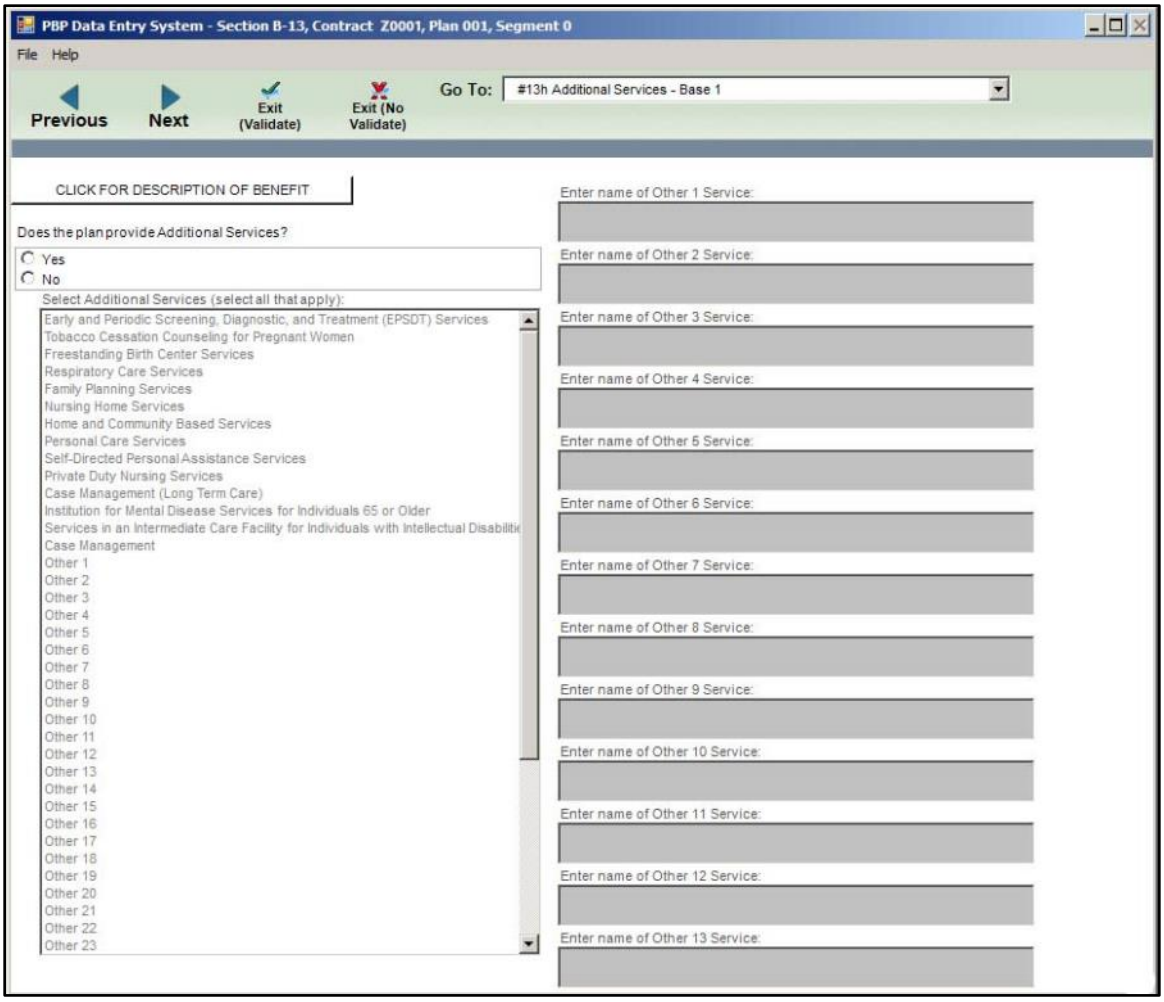

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 0
File Help
Previous
Next
Exit (Validate)
Exit (No Validate)
Go To:
#13g Dual Eligible SNPs with Highly Integrated Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT
Plans only fill out this section if they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services.
Dual Eligible SNPs with Highly Integrated Services Benefit Attestation
I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2016. I further attest that the additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside.
You may edit the name of the service text partially without losing all previously entered data.
If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.
Enter name of Service (Optional):
Select type of benefit:
Mandatory
Optional
Is there a service-specific Maximum Plan Benefit Coverage amount?
Yes
No
Indicate Maximum Plan Benefit Coverage amount:
Indicate Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, Describe

Table 4-32



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, service limits, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

Note: For B13h: Additional Services (which is available only for MMP plans), the remaining base screens will require responses to questions regarding which services are provided, the cost sharing, and other rules related to the services.

SERVICE CATEGORY #14: PREVENTIVE AND OTHER DEFINED SUPPLEMENTAL SERVICES

Includes the following subcategories:

- B14a: Medicare-covered Zero Dollar Preventive Services
- B14b: Annual Physical Exam
- B14c: Other Defined Supplemental Benefits
- B14d: Kidney Disease Education Services
- B14e: Other Medicare-covered Preventive Services

Depending on the subcategory, there are one to fifteen data entry screens associated with the subcategory.

Notes:

- As noted in the on-screen label, a plan should use the Annual Physical Exam category only for supplemental Annual Physical Exams not covered by Original Medicare. Medicare-covered Zero Dollar preventive services are always covered when medically necessary, and consequently are not appropriate as a supplemental benefit.
- SNPs are allowed to offer the Annual Physical Exam as a supplemental benefit in B14b: Annual Physical Exam. C-SNPs are not allowed to choose Enhanced Disease Management in B14c: Other Defined Supplemental Benefits.
- A maximum plan benefit amount now applies to every service category under B14c: Other Defined Supplemental Benefits.
- The B14c: Other Defined Supplemental Benefits subcategory contains separate "Notes" fields for each benefit offered.
- In B14c: Other Defined Supplemental Benefits, if any of the following benefits are offered, a note is required:
  - Fitness Benefit
  - Telemonitoring Services
  - Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)*
  - Home and Bathroom Safety Devices and Modifications
  - Weight Management Programs
  - Alternative Therapies
  - Therapeutic Massage
  - Adult Day Health Services

- Home-Based Palliative Care
- In-Home Support Services
- Support for Caregivers of Enrollees

  *A note is not required if the plan is only offering the Nursing Hotline benefit.

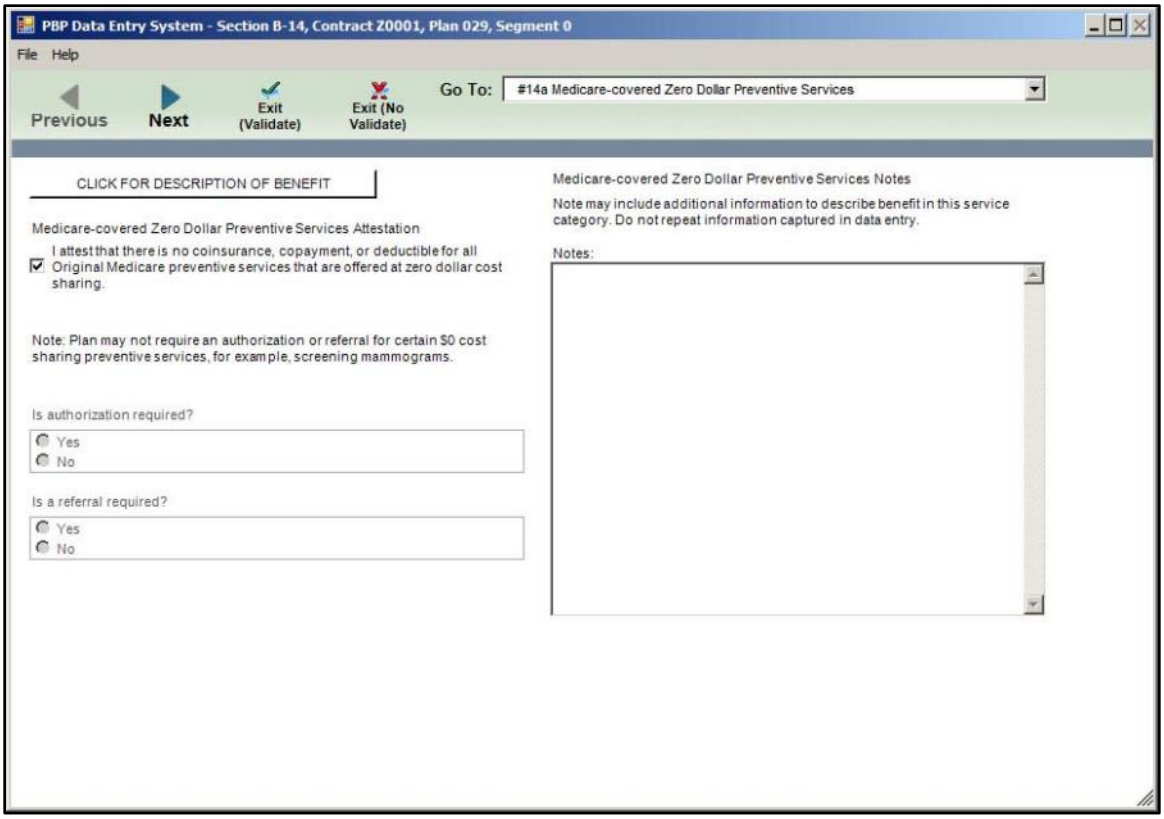
- The B7b: Chiropractic Services, B13a: Acupuncture, and Alternative Therapies (located in 14c: Other Defined Supplemental Benefits) benefits may be combined. If they are combined, they must include matching maximum plan-benefit amounts and periodicity, or limits. If enhanced benefits are offered, all benefits offered must be Mandatory or all benefits must be Optional. If the enhanced benefits offered are Optional, all sections included in the combined benefit must be included in the same Optional Supplemental Package.
- In B14e: Other Medicare-covered Preventive Services, if any additional Medicare-covered Preventive Services are offered that are not part of the Medicare-covered Zero Dollar preventive services, those benefits should be included in this section.
- The B14e: Other Medicare-covered Preventive Services category collects information specifically for Medicare-covered Glaucoma Screening, Diabetes Self-Management Training, Barium Enemas, Digital Rectal Exams, EKG following Welcome Visit, and any other Medicare-covered preventive services that are not part of the zero dollar preventive services. Enter Diabetes supplies in subcategory B11c: Diabetic Supplies and Services.

BASE 1 SCREEN

The Base 1 screen information varies depending on the subcategory.

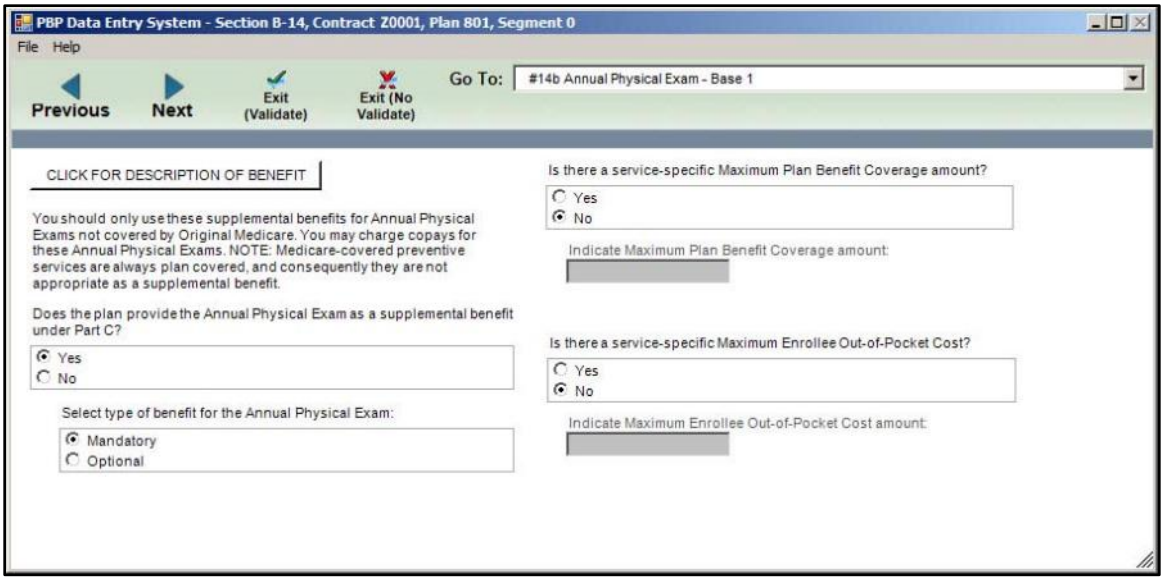
- For B14a: Medicare-covered Zero Dollar Preventive Services, there is one screen (Table 4-33), where the user will check off the attestation statement and respond to the questions related to authorization and referrals.

Table 4-33



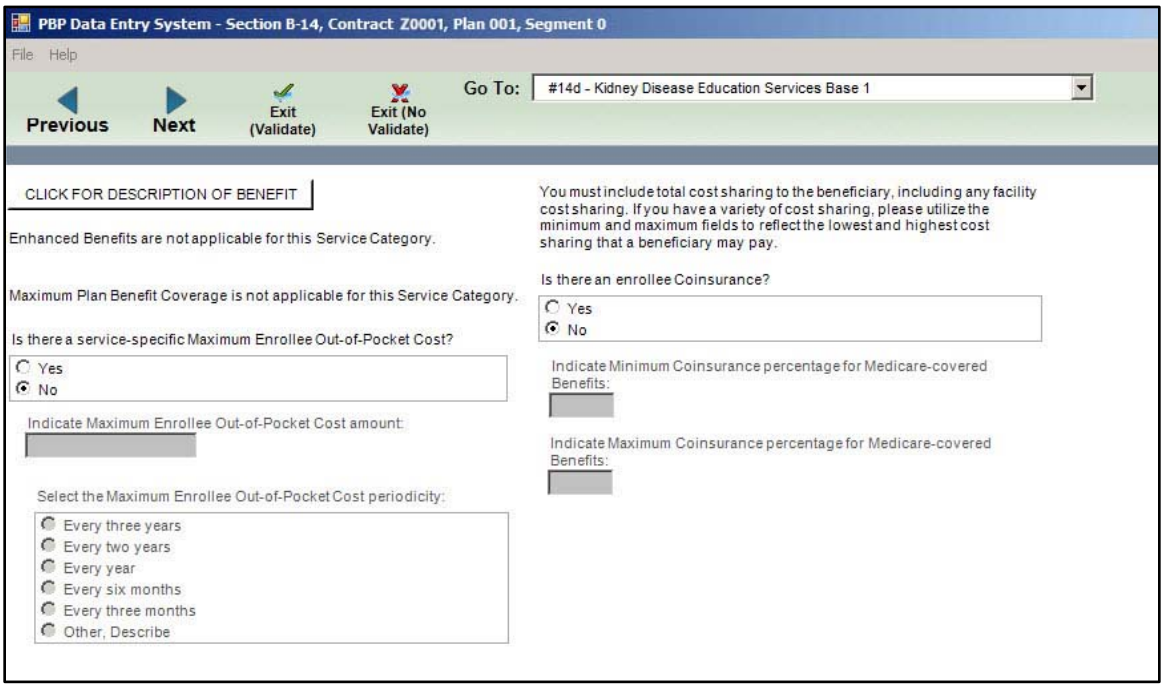
- For the B14b: Annual Physical Exam and B14c: Other Defined Supplemental Benefits, the plan will indicate whether it provides any services as a supplemental benefit under Part C. See Table 4-34 (while this table is for Annual Physical Exam, the screen is similar for Other Defined Supplemental Benefits). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-34



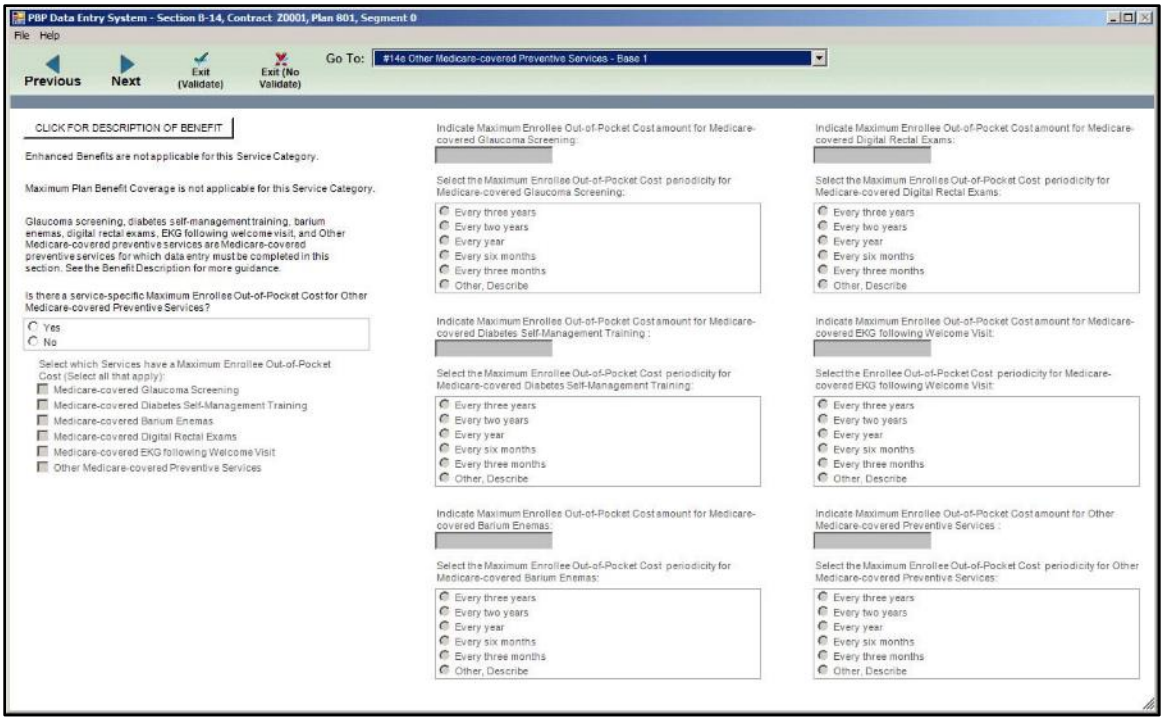
- For B14d: Kidney Disease Education Services and B14e: Other Medicare-covered Preventive Services, the plan will indicate whether there is a service-specific enrollee MOOP (depending on the subcategory), and cost sharing. See Table 4-35 (while this table is for Kidney Disease Education Services, the screen is similar for Other Medicare-covered Preventive Services).

Table 4-35



- For B14e: Other Medicare-covered Preventive Services, the plan will indicate whether there is a service-specific enrollee MOOP, cost sharing, and will select to which of three services the MOOP and cost sharing apply. See Table 4-36.

Table 4-36



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

SERVICE CATEGORY #15: MEDICARE PART B RX DRUGS

Includes the following category:

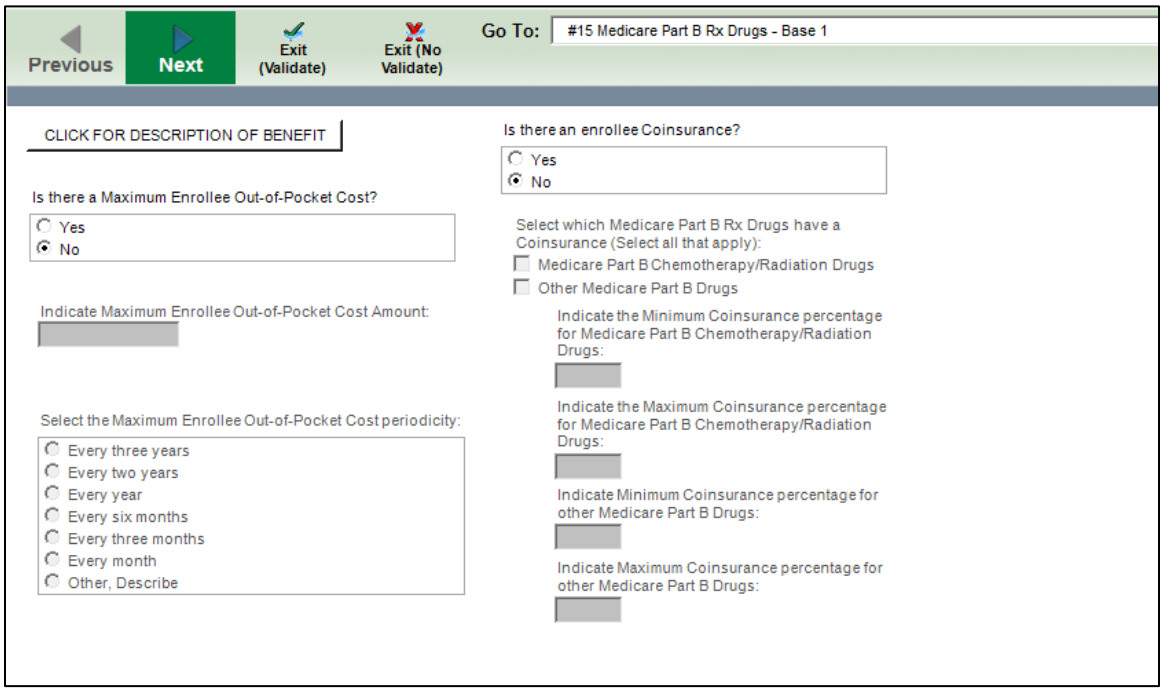
- B15: Medicare Part B Rx Drugs

This Service Category collects information on Medicare Part B Rx Drugs (including Medicare Part B Chemotherapy/Radiation drugs) and Part C Home Infusion Bundled Services that may be offered by the plan as a Mandatory Supplemental Benefit. There are four data entry screens associated with this category.

BASE 1 SCREEN

On the Base 1 screen, the plan will indicate whether it has a service-specific MOOP cost and cost sharing (Table 4-37). Responses to the questions will dictate which subsequent questions are enabled on this screen.

Table 4-37



BASE 2 AND 3 SCREENS

The Base 2 and 3 screens contain questions about cost sharing, plan rules for authorization, step therapy, and a "Notes" field. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

HOME INFUSION BUNDLED SERVICES SCREEN

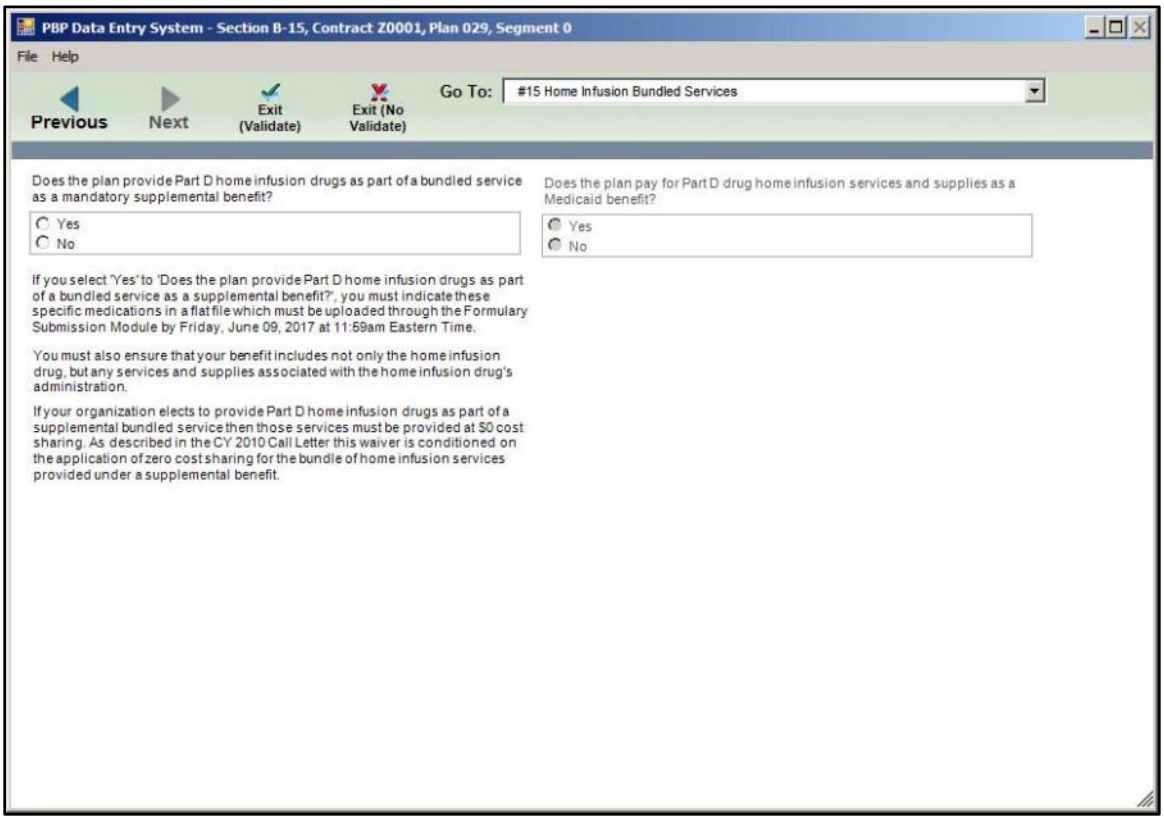
The Home Infusion Bundled Services screen is only enabled for MAPD plans and MMPs.

On this screen, the plan will indicate if it provides Medicare Part D home infusion drugs and drug administration services as a bundled service as a mandatory supplemental benefit under Medicare Part C (Table 4-38). If a plan offers the Part C bundled home infusion drug benefit, the beneficiary cost sharing must be $0, and thus no data entry is required.

If the plan provides this benefit, the user must indicate these specific medications in a flat file that will be uploaded via the Formulary Submission Module on June 5, 2020.

MMPs must offer Part D home infusion drugs, thus on this screen, they may indicate whether the plan pays for Part D drug home infusion services and supplies as a Medicaid benefit, or whether it pays for those services and supplies as a Mandatory Supplemental benefit.

Table 4-38



SERVICE CATEGORY #16: DENTAL

Includes the following subcategories:

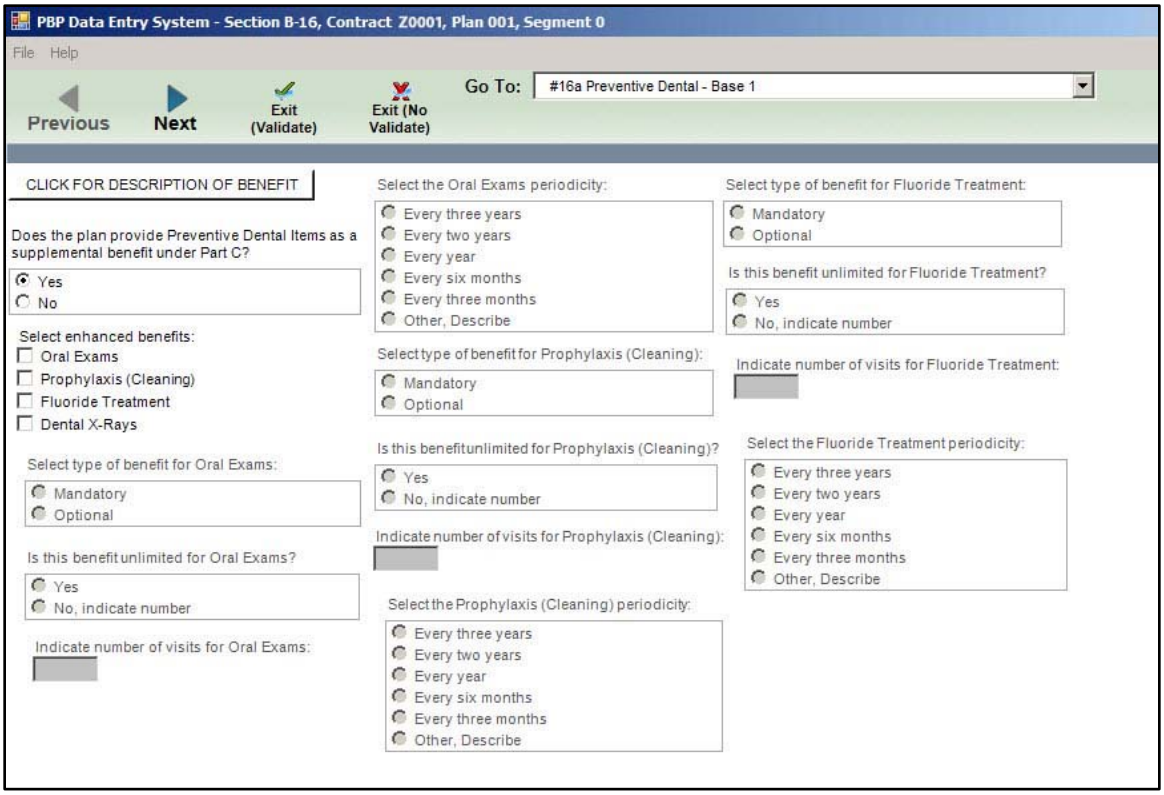
- B16a: Preventive Dental
- B16b: Comprehensive Dental

Depending on the subcategory, there are five to six data entry screens associated with the subcategory.

BASE 1 SCREEN

On the Base 1 screen, the plan will indicate whether it provides Dental Services as a supplemental benefit under Part C (Table 4-39), and if these benefits are offered as Mandatory or Optional supplemental benefits. Responses to the questions will dictate which subsequent questions are enabled on the screen.

Table 4-39



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

HOW TO ENTER A SINGLE COST SHARE FOR AN OFFICE VISIT (PREVENTIVE DENTAL)

Medicare Advantage plans can have a single cost share for an office visit and designate the enhanced benefits that are included in that visit. See the example for how to enter data to describe this benefit.

Example:

The plan offers oral exams, fluoride treatments, cleanings, and X-rays, with one single cost of $30 for a combination of services during an office visit (oral exam, fluoride treatment, and cleaning), and a separate $20 copayment for X-rays.

First, select the services offered as Mandatory supplemental benefits on the **Base 1** and **Base 2** screens (Table 4-40 shows the Base 1 screen). On the **Base 4** screen under the

copayment, select "Yes" for the question, "Is there a combination of services included in a single cost per office visit?" Then select the services covered under the $30 office visit, and separately define the cost of X-rays as $20 per visit (Table 4-41).

Table 4-40

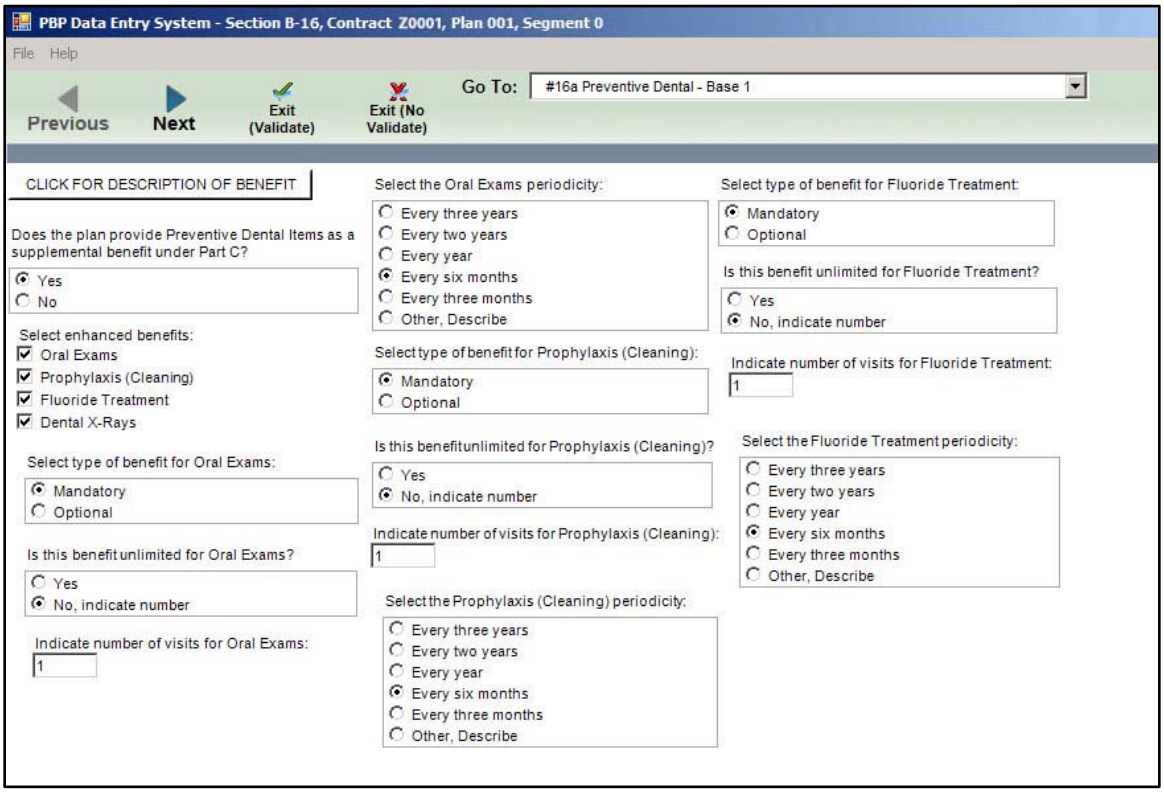
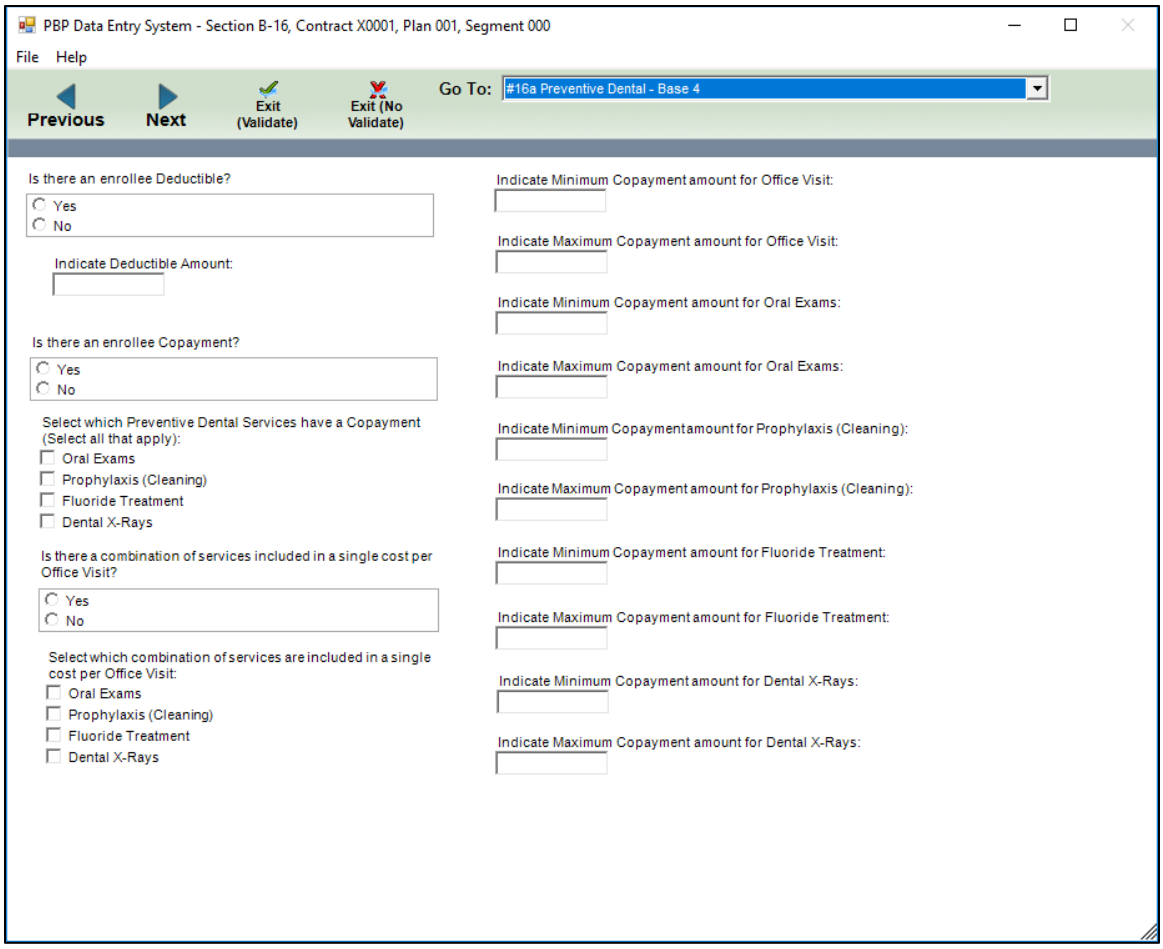


Table 4-41



How to Enter a Combined Maximum Plan Benefit Coverage Amount (Preventive and Comprehensive Dental)

Data elements in the Preventive and Comprehensive Dental categories allow for a maximum plan benefit coverage amount for either a preventive dental and/or comprehensive dental maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

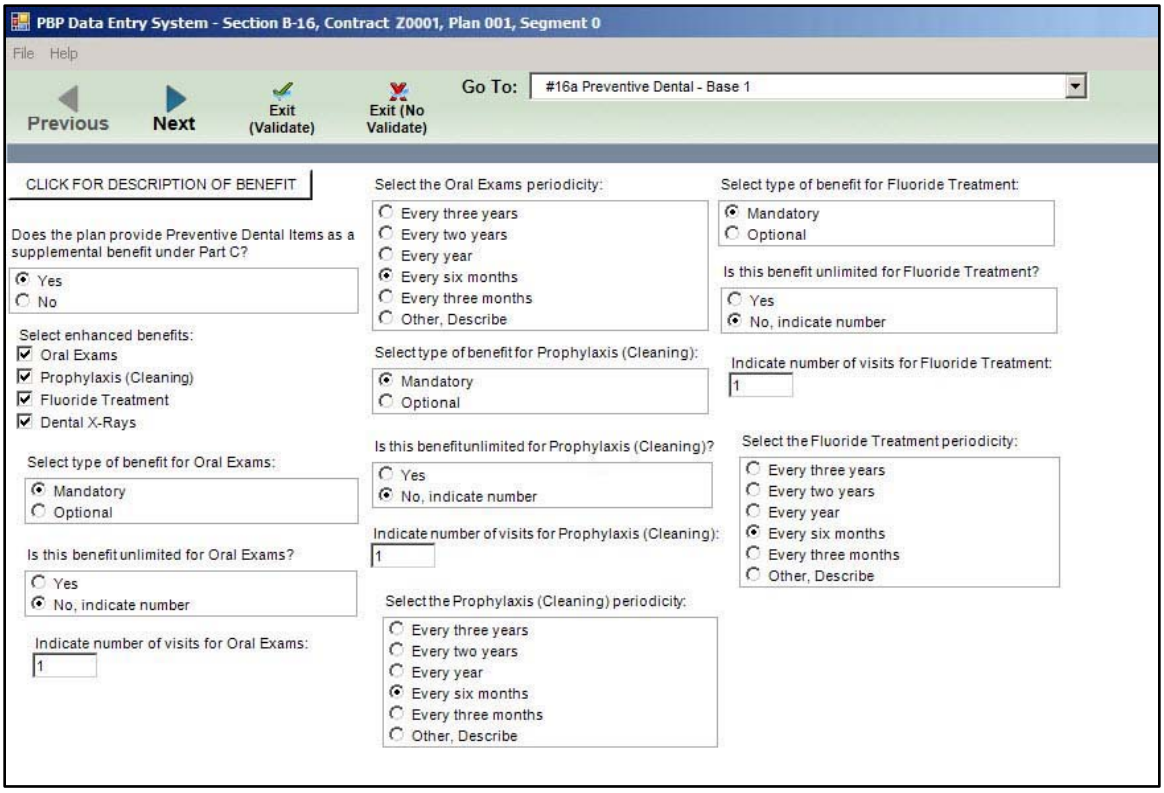
Note: This maximum plan benefit coverage amount applies only to Non-Medicare-covered benefits. See the data-entry example below.

Example:

A plan offers a $150 annual maximum plan benefit coverage amount for dental care. This includes both B16a: Preventive Dental and B16b: Comprehensive Dental.

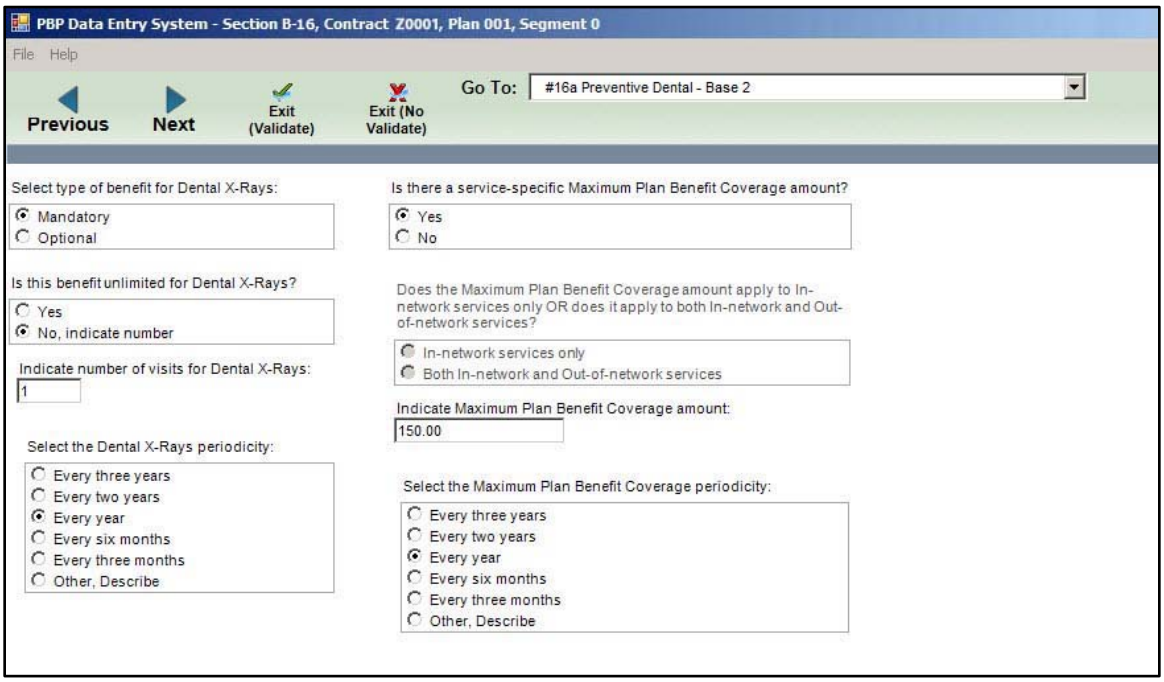
First, select the services offered as Mandatory supplemental benefits on the **B16a: Preventive Dental Base 1** screen (Table 4-42).

Table 4-42



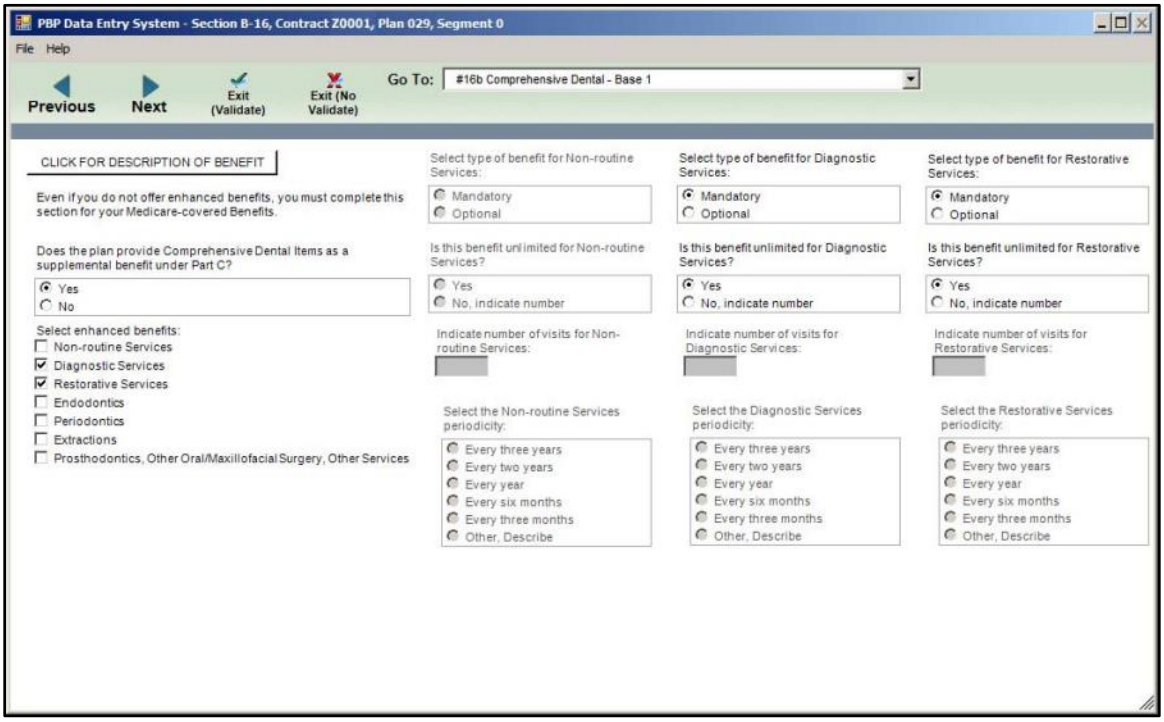
Next, on the **B16a: Preventive Dental Base 2** screen, select "Yes" for "Is there a service-specific Maximum Plan Benefit Coverage amount?" Then enter "$150" and select "Every year" (Table 4-43).

Table 4-43



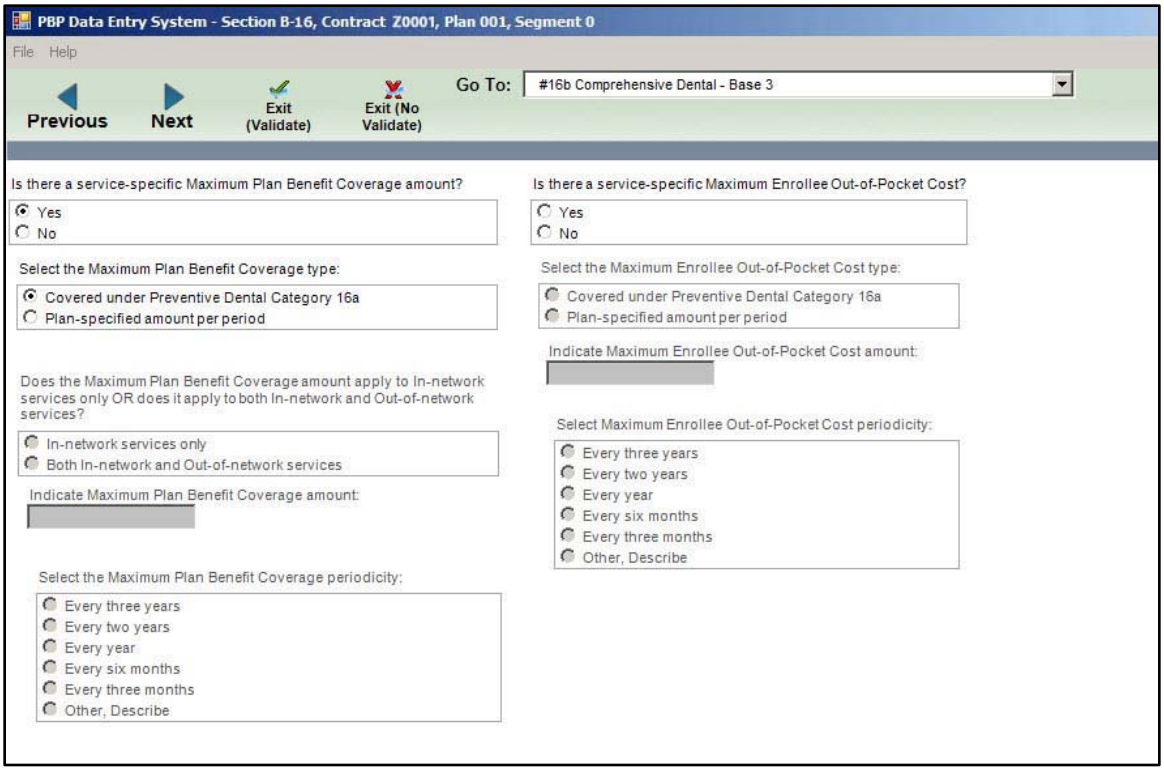
Next, on the **B16b: Comprehensive Dental Base 1** screen, indicate which services are covered (Table 4-44A).

Table 4-44A



On the **B16b: Comprehensive Dental Base 3** screen, select "Yes" for "Is there a service-specific Maximum Plan Benefit Coverage amount?" For the next question, "Select the Maximum Plan Benefit Coverage type," select the option "Covered under Preventive Dental Category 16a" (Table 4-44B).

Table 4-44B



SERVICE CATEGORY #17: EYE EXAMS/EYEWEAR

Includes the following subcategories:

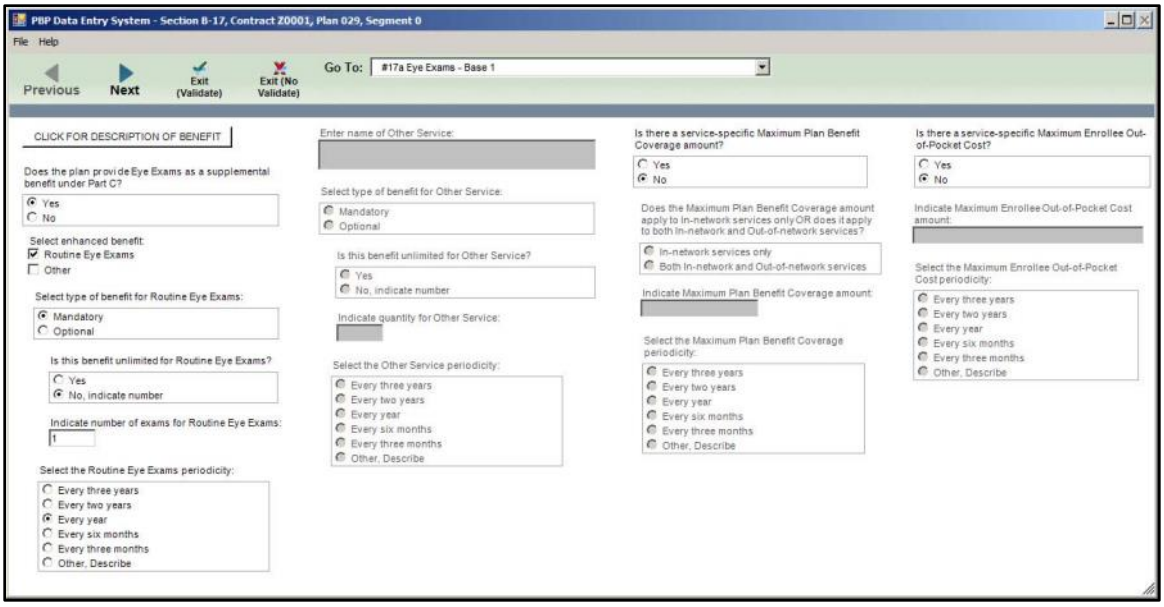
- B17a: Eye Exams
- B17b: Eyewear

Depending on the subcategory, there are three to six data entry screens associated with the subcategory.

BASE 1 SCREEN

On the Base 1 screen, indicate whether the plan provides benefits as a supplemental benefit under Part C (Table 4-45), and whether these benefits are offered as a Mandatory or Optional supplemental benefit. Responses to the questions will dictate which subsequent questions are enabled on the screen.

Table 4-45



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

HOW TO ENTER A COMBINED MAXIMUM PLAN BENEFIT COVERAGE AMOUNT FOR EYE EXAMS AND EYEWEAR

Data elements in the Eye Exam and Eyewear categories allow for a maximum plan benefit coverage amount for eyewear, eye exams, an individual maximum plan benefit coverage amount for each item within the categories, or a combined maximum plan benefit coverage amount for both categories.

Notes:

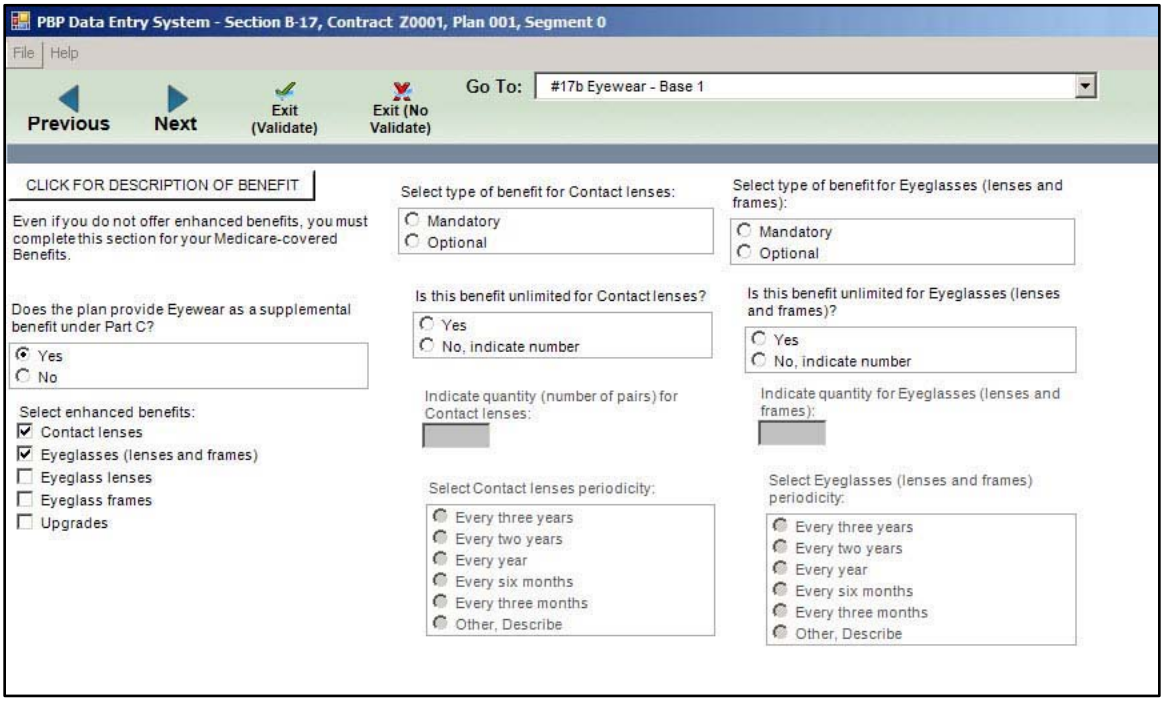
- This maximum plan benefit coverage amount applies only to Non-Medicare-covered benefits. See the data entry example below.
- See Tables 4-43 through 4-44B in #16: Dental for an example of a combined maximum-plan-benefit-coverage amount for both subcategories.

Example:

A plan offers a $150 annual maximum plan benefit coverage amount for contact lenses and a $100 annual maximum plan benefit coverage amount for eyeglasses (lenses and frames). This includes both In-Network and OON services.

First, on the **B17b: Eyewear Base 1** screen, indicate which services are covered (Table 4-46A).

Table 4-46A

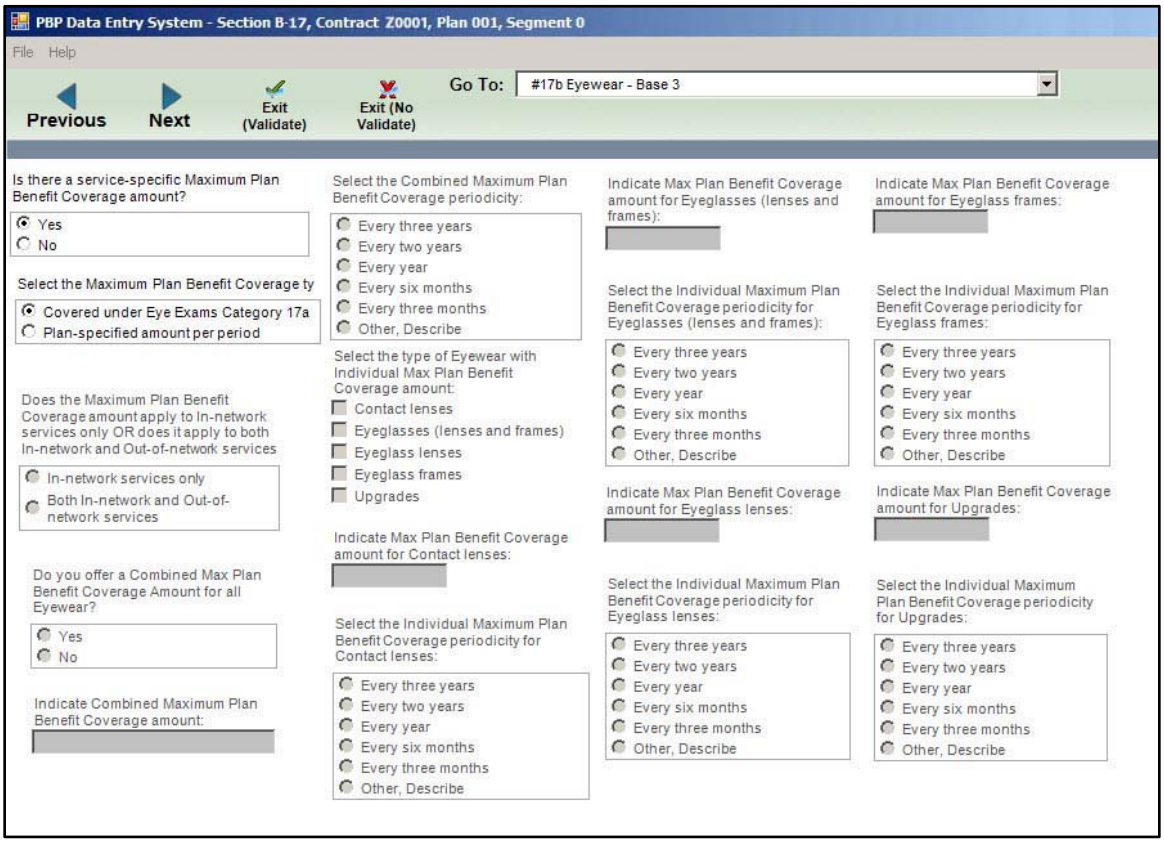


Then, on the **B17b: Eyewear Base 3** screen (Table 4-46B):

1. For "Is there a service-specific Maximum Plan Benefit Coverage amount?" select **Yes**.
2. For "Select the Maximum Plan Benefit Coverage type," select **Plan-specified amount per period**.
3. For "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?" select **Both In-network and Out-of-network services**.
4. For "Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?" select **No**.
5. For "Select the type of Eyewear with Individual Max Plan Benefit Coverage amount," select both **Contact Lenses** and **Eyeglasses (Lenses and Frames)**.
6. For "Indicate Max Plan Benefit Coverage amount for Contact lenses," enter **150.00**.
7. For "Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses," select **Every year**.
8. For "Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames)," enter **100.00**.

9. For "Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames)," select **Every year**.

Table 4-46B



SERVICE CATEGORY #18: HEARING EXAMS/HEARING AIDS

Includes the following subcategories:

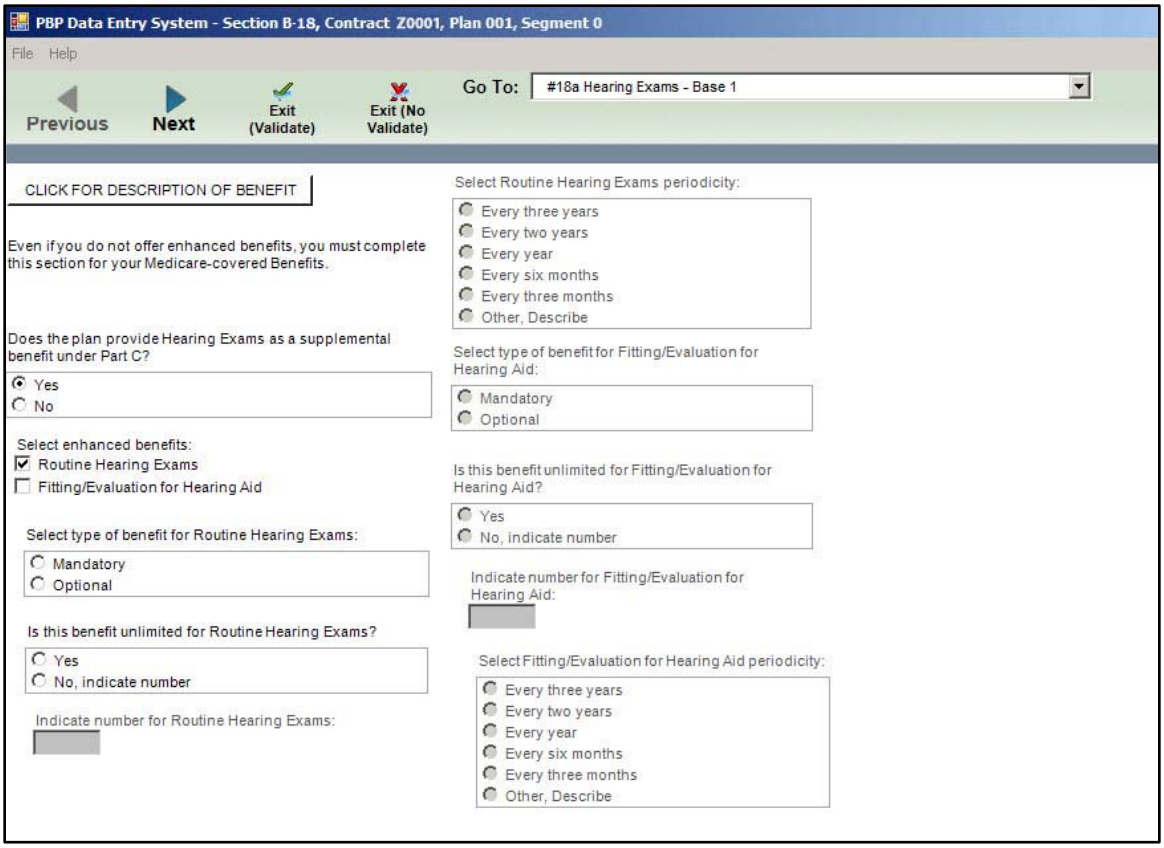
- B18b: Hearing Exams
- B18b: Hearing Aids

Depending on the subcategory, there are four to five associated data entry screens.

BASE 1 SCREEN

On the Base 1 screen, the plan will indicate whether it provides benefits as a supplemental benefit under Part C (Table 4-47), and whether these benefits are offered as Mandatory or Optional supplemental benefit. Responses to the questions will dictate which subsequent questions are enabled on the screen.

Table 4-47



ALL REMAINING BASE SCREENS

Depending on the subcategory, the remaining screens will contain questions about cost sharing, plan rules for referrals and authorization, and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

HOW TO ENTER A COMBINED MAXIMUM PLAN BENEFIT COVERAGE AMOUNT

Data elements in the Hearing Exams and Hearing Aids categories allow for a maximum plan benefit coverage amount for hearing exams, hearing aids, or a combined maximum plan benefit coverage amount for both subcategories.

Notes:

- The plan can also specify whether the Maximum Plan Benefit Coverage amount applies to one single ear, per ear, or for both ears combined on the Base 2 screen within B18b: Hearing Aids.

- See Tables 4-42 through 4-44B in #16: Dental for an example of a combined maximum plan benefit coverage amount for both subcategories.

SERVICE CATEGORY #19: VBID/MA UNIFORMITY FLEXIBILITY/SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

Includes the following subcategories:

- B19a: Reduced Cost Sharing for VBID/UF/SSBCI
- B19b: Additional Benefits for VBID/UF/SSBCI
- B19c: VBID Hospice

Section B19 documents the benefits offered under authority of the Medicare-Advantage VBID Model, MA Uniformity Flexibility (UF)), and/or SSBCI. Users will enter the reduced cost sharing and/or additional benefits offered for VBID, MA Uniformity Flexibility (UF), and/or Special Supplemental Benefits for the Chronically Ill (SSBCI in B-19a and/or B-19b.

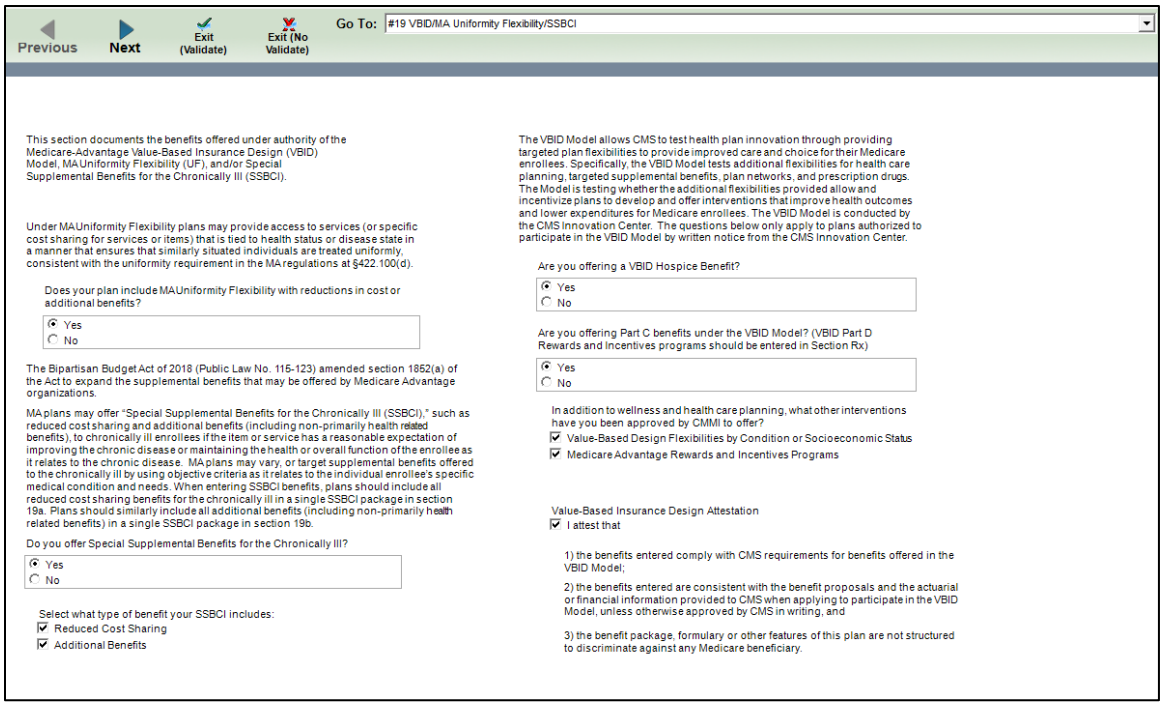
VBID plans are required to offer Wellness and Health Care Planning (WHP) to all enrollees and will outline the components of its WHP program in this section. In addition, VBID plans can offer up to three packages of Part C Rewards and Incentives. VBID plans can offer a VBID Hospice benefit in B19c.

Table 4-48 shows screen B19: VBID/MA Uniformity Flexibility/SSBCI. Indicate whether the plan provides Part C reductions in cost or additional benefits as part of their VBID, UF, and/or SSBCI benefit (Table 4-48).

- MA Uniformity Flexibility – indicate whether, yes or no, the plan includes reductions in cost or additional benefits.
- SSBCI – indicate whether the plan offers Special Supplemental Benefits for the Chronically Ill. If so, indicate the type of benefit (reduced cost sharing or additional benefits).
- VBID Model – indicate whether the plan is offering a VBID Hospice Benefit and whether the plan is offering Part C benefits under the VBID Model. If offering Part C benefits, indicate which interventions the plan has been approved to offer (Value-Based Design Flexibilities or Rewards and Incentives). Complete the VBID attestation.

Responses to these questions will dictate which subsequent screens are enabled.

Table 4-48



Reduced Cost Sharing or Additional Benefits for VBID/MA Uniformity Flexibility (UF)/SSBCI

In Section B19a and/or B19b, users will enter the reduced cost sharing and/or additional benefits offered for VBIDs, MA Uniformity Flexibility (UF), and/or Special Supplemental Benefits for the Chronically Ill (SSBCI). They will define up to 15 packages which will represent the reduced cost sharing (or additional benefits) for certain medical conditions, Low Income Subsidy (LIS) status eligibility status to address social determinants of health, or disease states. These disease states may be listed separately or combined in the various groups. If a disease state(s)/medical condition(s) is entered under "other" a full description of the proposed disease state(s)/medical condition(s) must be included in the notes field for this PBP item for CMS review. SSBCI packages do not select certain medical conditions or disease states.

MA plans may offer "Special Supplemental Benefits for the Chronically Ill (SSBCI)," such as reduced cost sharing and additional benefits (including non-primarily health related benefits), to chronically ill enrollees if the item or service has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease. MA plans may vary, or target, supplemental benefits offered to the chronically ill by using objective criteria as it relates to the individual enrollee's specific medical condition and needs.

Notes:

- If a benefit is offered in B19a: Reduced Cost Sharing for VBID/UF/SSBCI, the Maximum cost sharing amount entered must be equal to or less than the cost

sharing entered for the regular Part C benefit, as identified in the regular PBP Section B screen(s).

- If a benefit included in B1a: Inpatient Hospital-Acute, B1b: Inpatient Hospital Psychiatric, or B2: SNF are offered at a lower cost in a package in B19a: Reduced Cost Sharing for VBID/UF/SSBCI, the respective Section B screen(s) will become enabled within the package.
- If a benefit is offered in B19b: Additional Benefits for VBID/UF/SSBCI, the respective Section B screen(s) will become enabled within the package.
- Use the notes fields provided to enter additional information not captured in the benefit entry, such as the required conditions for obtaining a VBID/UF/SSBCI benefit, or other benefit parameters.
- There can only be one SSBCI package for 19a: Reduced Cost Sharing and one SSBCI package for 19b: Additional Benefits.

BASE 1 SCREEN (FOR PACKAGES)

On the Base 1 screens, the user will indicate which disease states apply, if there is a prerequisite and which benefits apply for the specific package (Table 4-49A, Table 49-B, Table-49C). Table 4-49C shows the screen for B19a: Reduced Cost Sharing for VBID/UF/SSBCI, the B19b: Additional Benefits for VBID/UF/SSBCI screen is similar (only enhanced benefits will be included in B19b: Additional Benefits for VBID/UF/SSBCI).

Notes:

- When entering the VBID/MA Uniformity Flexibility/SSBCI maximum and minimum cost sharing for a service category, list only the cost sharing that would apply to enrollees qualifying for the benefit package. Cost sharing ranges should reflect only the services within the service category or specialty selected that are eligible for reduced cost sharing. If the reduced cost sharing is being offered through reimbursement, the cost sharing range should represent what the enrollee pays after reimbursement, and the note should describe the benefit and any limitations. If there is a maximum aggregate amount of reduced cost sharing, the cost sharing entered should reflect only the costs paid by the enrollee prior to reaching the maximum aggregate amount of reduced cost sharing.

- When entering VBID/MA Uniformity Flexibility benefit packages, create a separate package for each unique benefit offering, or combination of benefit offerings. VBID/MA Uniformity Flexibility packages may be targeted to single or multiple clinical condition groups. When entering an SSBCI benefit package, include all reduced cost sharing SSBCI benefits in a single package in section B19a and all additional SSBCI benefits in a single package in B19b.

- If there is a limit to the number of services units that qualify for VBID/MA Uniformity Flexibility/SSBCI cost sharing, after which the regular cost sharing

amount applies, specify the limit in notes. After an enrollee reaches the limit, CMS will look to the main PBP sections for the applicable cost sharing amount.

Table 4-49A

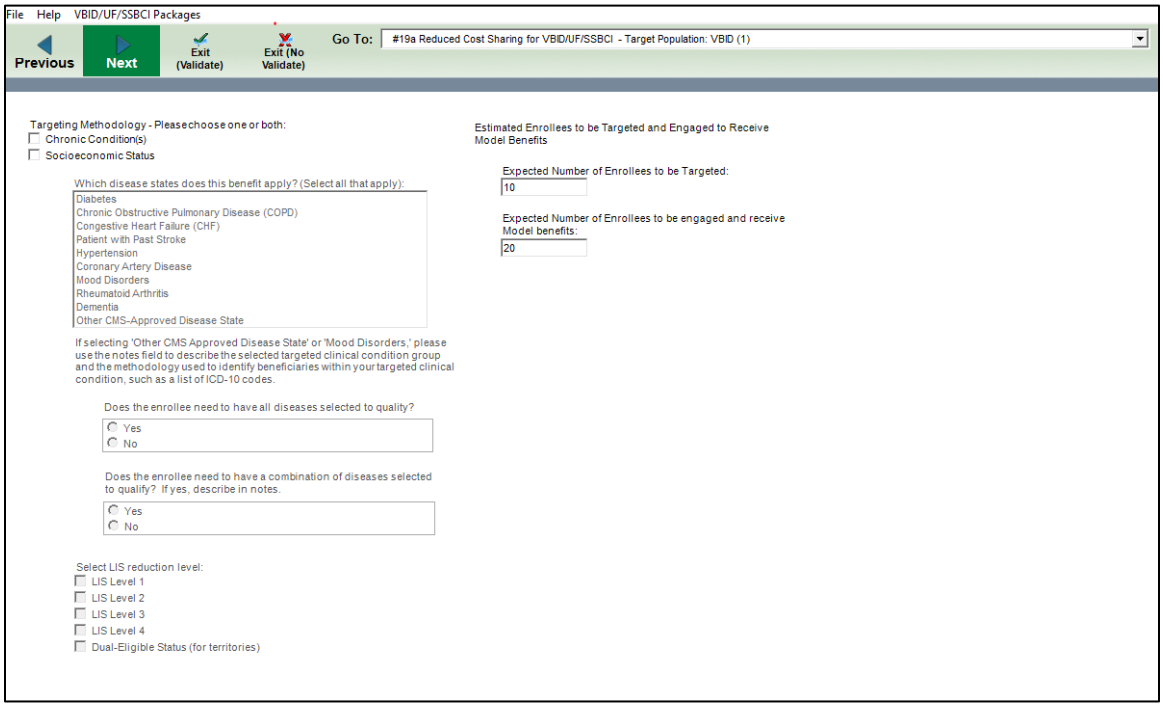


Table 4-49B

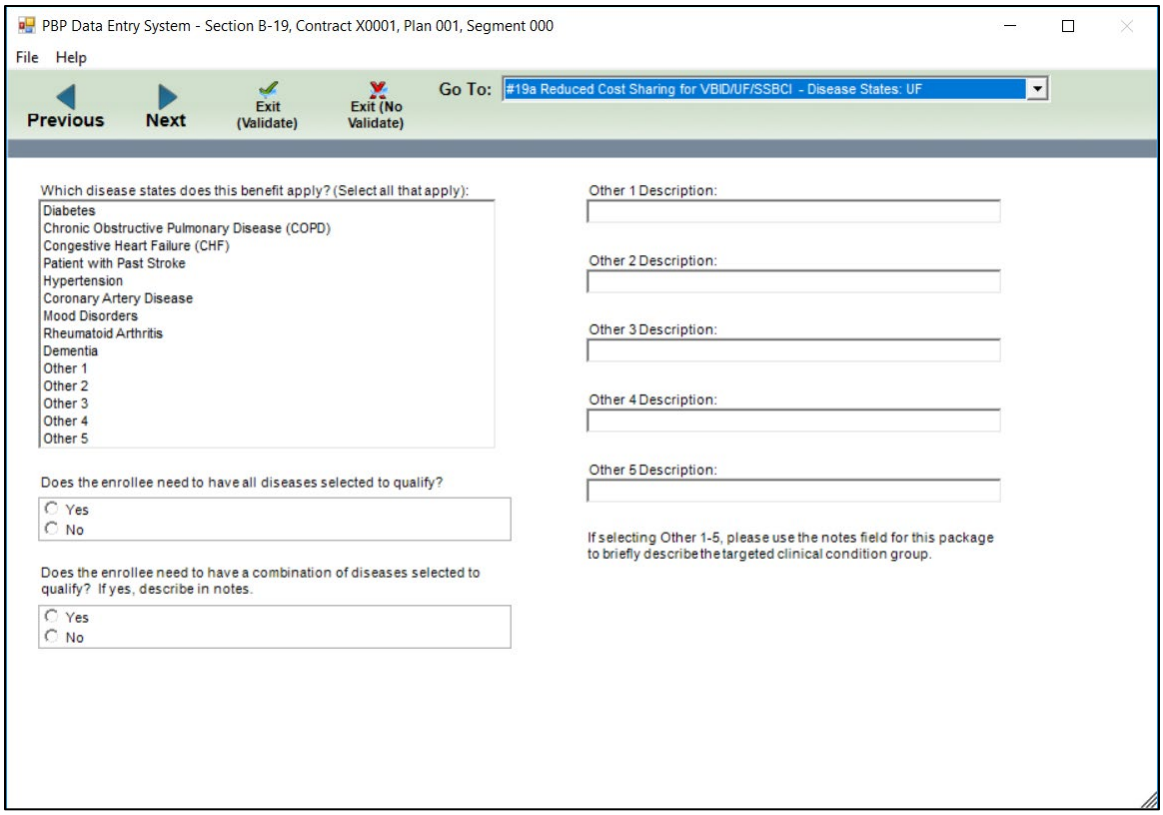
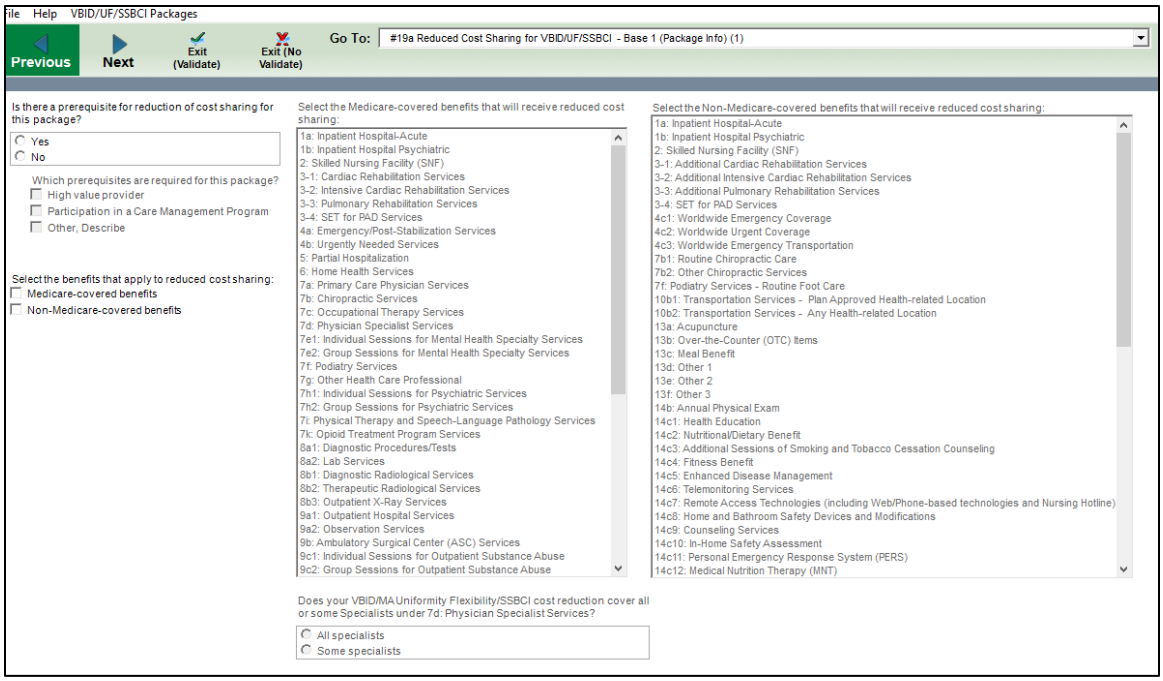


Table 4-49C

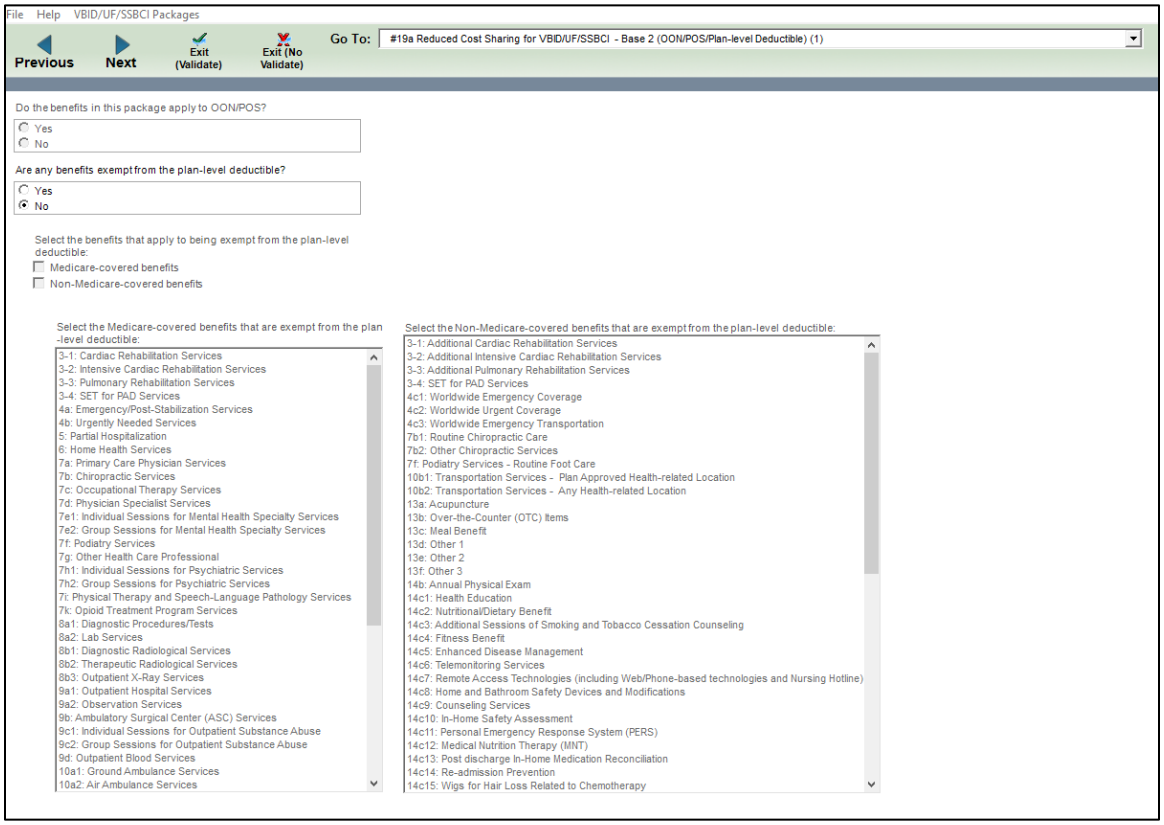


BASE 2 SCREEN (FOR PACKAGES)

On the Base 2 screen, the plan will indicate if the benefits in the package apply to OON/POS and if any of the benefits are exempt from the plan level deductible (Table 4-50). Table 4-50 shows the screen for B19a: Reduced Cost Sharing for VBID/UF/SSBCI, the B19b: Additional Benefits for VBID/UF/SSBCI screen is similar (only enhanced benefits will be included in B19b: Additional Benefits for VBID/UF/SSBCI)

Note: Describe any necessary additional information about the selected targeted clinical condition group, such as the specific code categories selected within Mood Disorders (VBID), in a notes field.

Table 4-50



ALL REMAINING BASE SCREENS (FOR PACKAGES IN B19A)

The remaining base screens for B19a: Reduced Cost Sharing for VBID/UF/SSBCI will contain questions about cost sharing (reduced coinsurance, copayment, and/or deductible) and "Notes" fields. For the remaining base screens, many questions will be enabled based on how questions were answered on prior base screens. Always carefully review the screen to ensure all enabled questions are answered. If the user fails to respond to an enabled question (unless the enabled question is optional), data entry errors will appear when exiting with validation.

Note: If a benefit is offered in B-19a: Reduced Cost Sharing for VBID/UF/SSBCI, the maximum cost sharing amount entered must be equal to or less than the cost sharing entered in the base bid, as identified in the regular PBP Section B screen(s).

ALL REMAINING DATA ENTRY SCREENS (FOR PACKAGES IN B19B)

The remaining screens for entering data for B19b: Additional Benefits for VBID/UF/SSBCI will populate based on the selections entered on the previous screens. If a user selects a benefit, data entry screens similar to the respective Section B screens will generate and should be completed in the same manner as the Section B screens.

Note: If a plan offers an additional Non-Medicare-covered benefit that shares data entry screens with Medicare-covered benefits, then the plan will not be allowed to select the Medicare-covered benefits on the screens.

VBID HOSPICE

If a VBID plan indicates it is offering a VBID Hospice benefit, four screens in B19c (VBID Hospice) will be enabled.

On the Base 1 screen, the plan will indicate cost sharing for in-network hospice benefits. In the first column, indicate the coinsurance and/or copayment amounts for prescription drugs and biologicals in hospice. In the second column, indicate the coinsurance and/or copayment amounts for a respite care day.

On the Base 2 screen, the plan will indicate cost sharing for out-of-network hospice benefits. In the first column, indicate the coinsurance and/or copayment amounts for prescription drugs and biologicals in hospice. In the second column, indicate the coinsurance and/or copayment amounts for a respite care day.

On the Base 3 screen, the plan will describe hospice supplemental benefits.

The Base 4 screen is for entering notes related to VBID Hospice.

SERVICE CATEGORY #20: PRESCRIPTION DRUGS (COST PLANS ONLY)

Includes the following category:

- B20b: Outpatient Drugs

This Service Category is only enabled for cost plans that do not offer a Medicare Part D benefit. It collects information on Medicare-covered and Non-Medicare-covered prescription drugs offered by cost plans.

Rules for cost plans:

If a cost plan organization states it offers Part D in the Health Plan Management System (HPMS), the cost plan may only create plans that offer prescription drugs using Section Rx in the PBP. That is, cost plans with Part D designation in the HPMS may offer only MAPD or MA-Only plans. The B20: Prescription Drugs Service Category in the PBP should be disabled for all plans in this scenario.

Or

If a cost plan organization states it does not offer Part D in the HPMS, the cost plan may only define drug benefits using the B20: Prescription Drug Service Category in the PBP. Section Rx in the PBP should be disabled for all plans in this case.

Note: Cost plan organizations without Part D are not required to complete B20: Prescription Drugs Service Category in the PBP if they choose to offer Part C benefits only for all plans.

There are five main data entry screens associated with this category, as well as data entry screens for up to five drug groups (which are specified by the plan from a picklist), and one screen on Home Infusion Bundled Services. To provide more flexibility for describing a plan's drug benefit, users may describe the drug benefit in terms of "tiers," rather than having to specifically refer to formulary/non-formulary and Generic/Brand/Preferred Brand drugs. However, these drug types are also available as drug groups.

BASE SCREENS 1 THROUGH 5

On the Base 1 screen, the plan will indicate whether it provides Prescription Drugs as a supplemental benefit under Part C (Table 4-51), and whether these drugs are offered as Mandatory or Optional supplemental benefits. Responses to the questions will dictate which subsequent questions are enabled on the screen. This screen and the remaining base screens will then include questions about maximum plan drug-benefit coverage, enrollee MOOP costs, deductibles, cost shares for Medicare-covered drugs, and authorization.

- Maximum Plan Drug Benefit Coverage: Refer to the section entitled "How to Enter Drug Benefit Coverage Limits" later in this chapter for details about how to enter this information.
- Enrollee MOOP Costs: The plan indicates whether there is an overall drug benefit enrollee MOOP cost on the Base 3 screen. On this screen, also select the drug groups, including Medicare-covered benefits, for which the MOOP applies. There are no other enrollee MOOP cost questions for any of the individual drug groups.
- Deductible: Specify the drug benefit deductible amount on the Base 4 screen. Also select the drug groups, including Medicare-covered benefits, for which the deductible applies. There are no other deductible questions for the individual drug groups.

- Coinsurance (Copayment): The plan indicates the coinsurance and/or copayment amounts for Medicare-covered drugs on the base screens. Indicate the coinsurance and/or copayment amounts for the drug groups in the appropriate groups' set of screens.
- Authorization: There is one authorization question within this Service Category on the Base 4 screen. Written prescriptions from a physician are not considered authorizations within this category.

HOME INFUSION BUNDLED SERVICES SCREEN

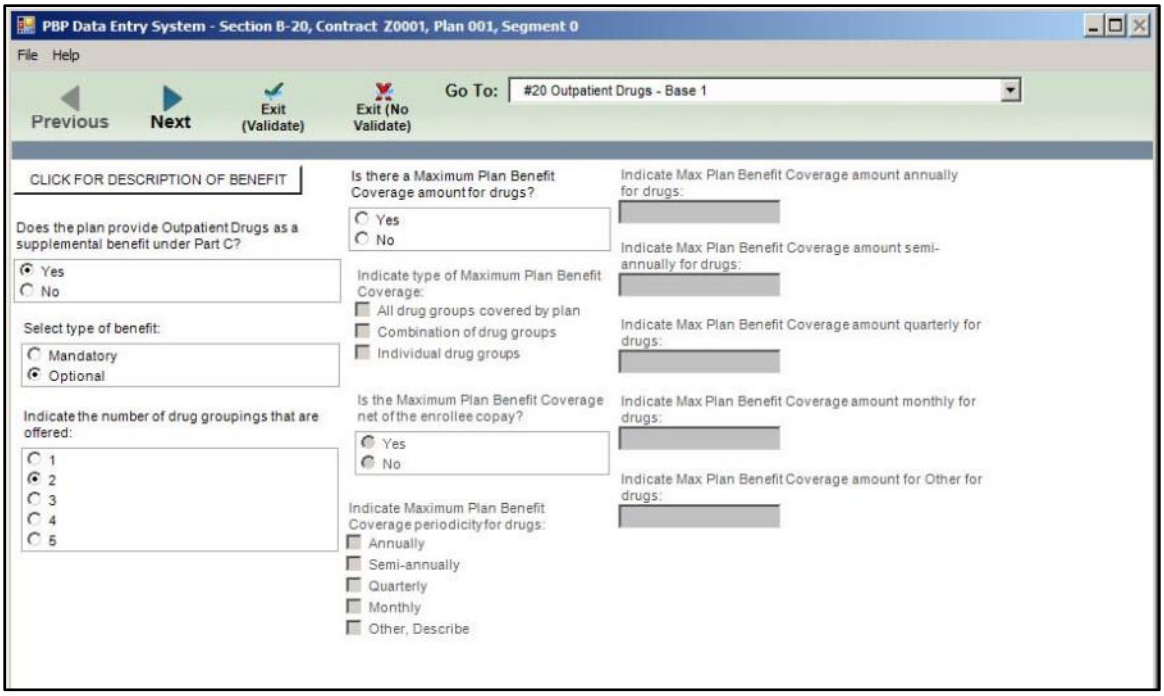
The Home Infusion Bundled Services screen is enabled only for cost plans that do not offer Medicare Part D coverage.

On this screen, the plan will indicate whether it provides Medicare Part D home infusion drugs and drug administration services as part of a bundled service as a Mandatory Supplemental Benefit under Medicare Part C (Table 4-38). If a plan offers the Part C bundled home infusion drug benefit, the beneficiary cost sharing must be $0, thus no data entry is required. If the plan provides this benefit, the user must indicate these specific medications in a flat file that will be uploaded via the Formulary Submission Module on June 5, 2020.

HOW TO ENABLE DRUG GROUPING SCREENS

In order to enable the drug-grouping screens on the Base 1 screen, for the question "Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?" select "Yes." Next, for "Select the type of benefit," select "Mandatory" or "Optional." Finally, for "Indicate the number of drug groupings that are offered," select the number of groups the plan offers (up to five). Depending on the number of groupings chosen, the applicable screens will generate (Table 4-51).

Table 4-51



DRUG-GROUP BASE SCREENS

There are a set of screens for each of five potential drug groups that users may designate to describe the plan's drug benefit. For each drug group, select a label from the picklist that best fits the drug group (Table 4-52A). No selection may be used more than once.

If the group is designated as a tier, indicate what drug types (Generic, Brand, Preferred Brand) are included in that tier (Table 4-52B).

After selecting a label for the group, go through each of the group's base screens to indicate individual coverage limits for that drug group, locations where those drugs can be acquired, cost sharing, and the time limits associated with those costs.

Table 4-52A

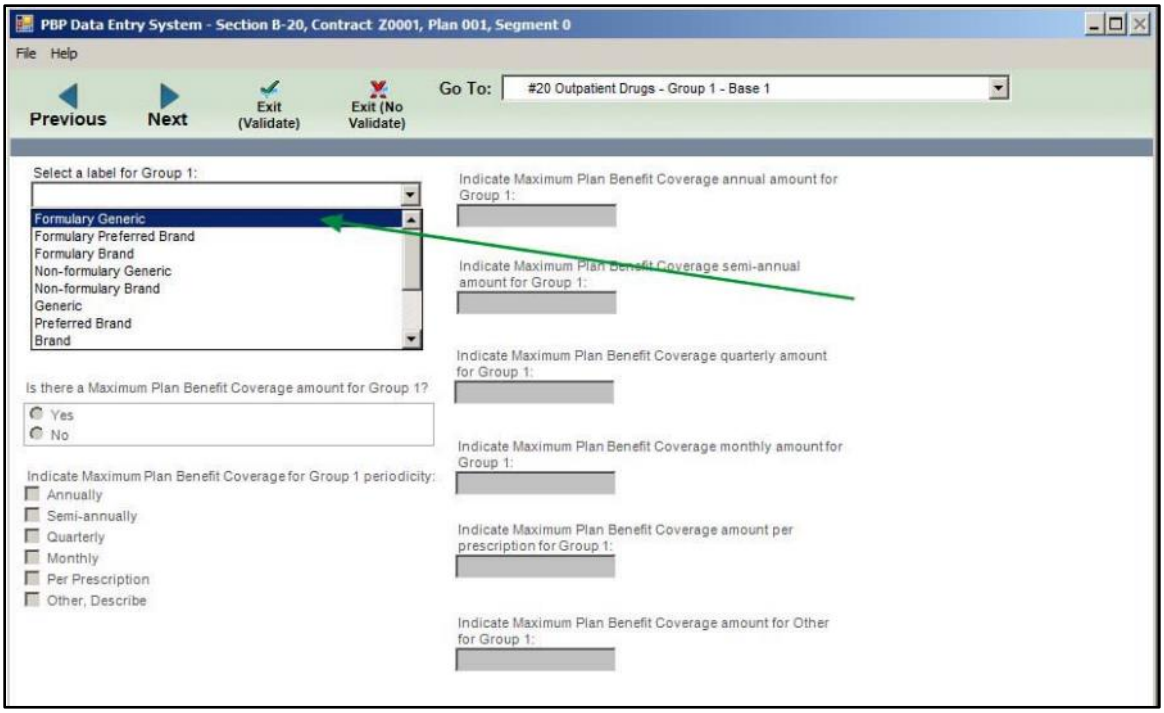
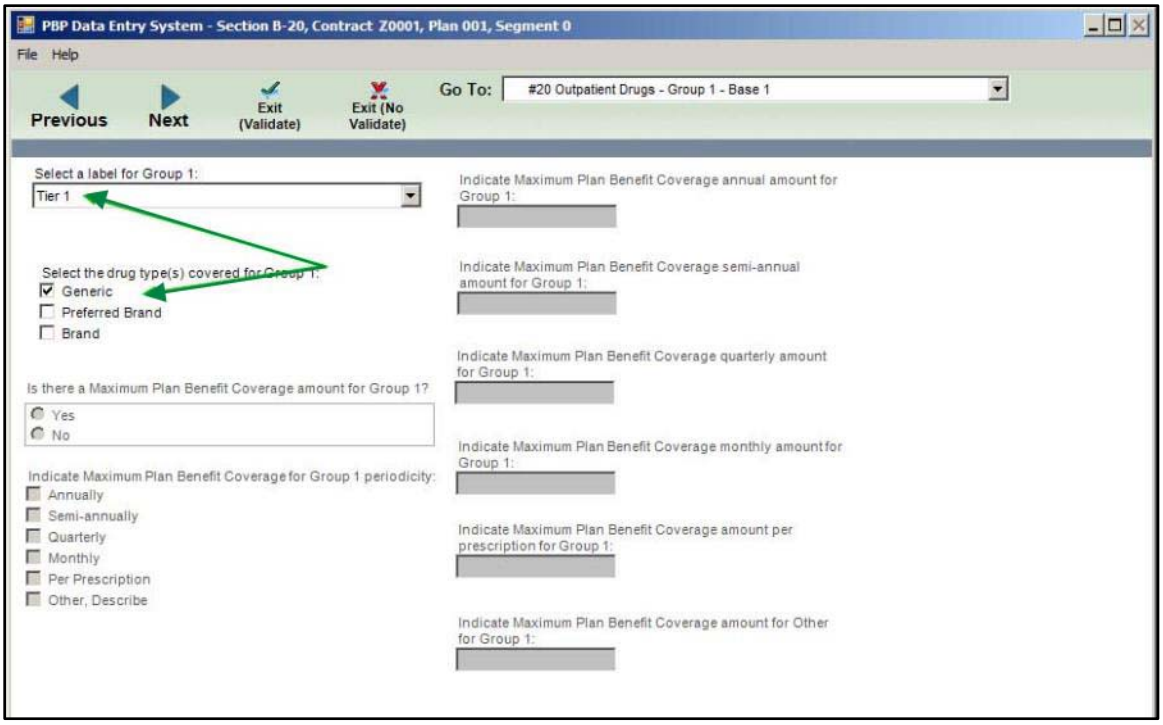


Table 4-52B



HOW TO ENTER DRUG BENEFIT COVERAGE LIMITS

A separate set of questions enables a plan to describe one or more limits on the drug benefit. If the user indicates that the plan has a maximum plan-benefit-coverage amount,

the user must designate if there is an overall limit, a limit on a combination of drug groups, and/or limit(s) on individual drug groups. See the following examples for how to enter this data.

Example 1:

The plan offers generic- and brand-drug groups, and has unlimited generic drugs and a $500 annual limit on brand drugs.

- First, indicate that the plan has a maximum plan-benefit-coverage amount, and that this includes individual (*brand*) drug types.
- For the generic group, indicate that there is no maximum plan-benefit-coverage amount.
- For the brand group, indicate that there is a maximum plan-benefit-coverage amount of $500 annually.

See Tables 4-53A, 4-53B, and 4-53C.

Table 4-53A

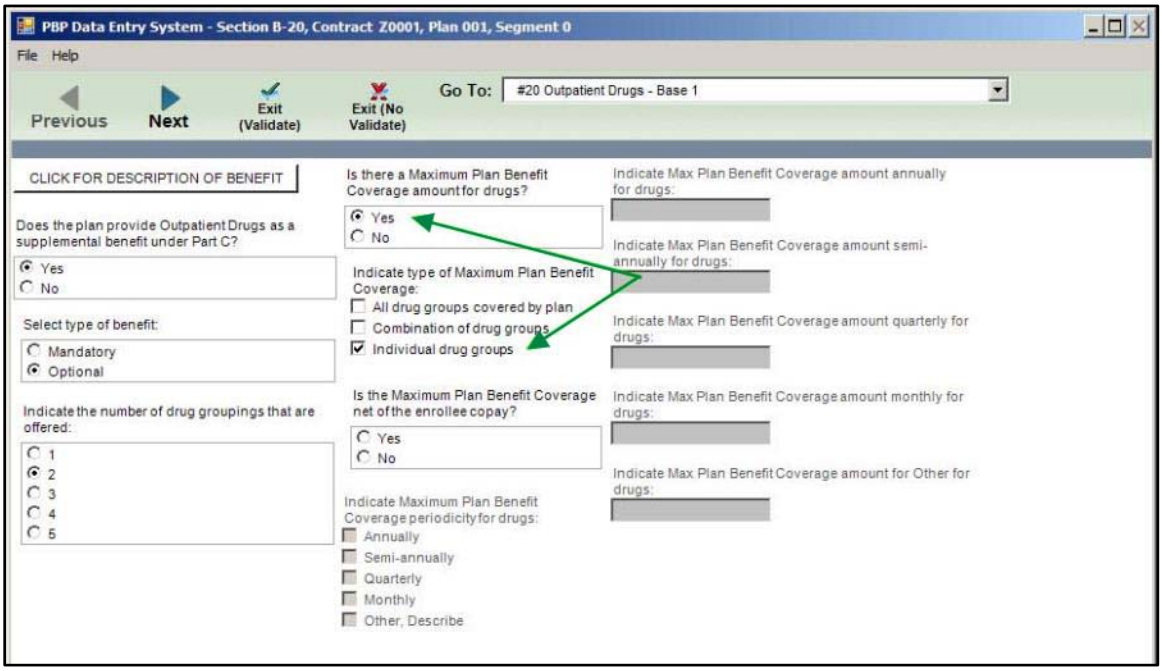


Table 4-53B

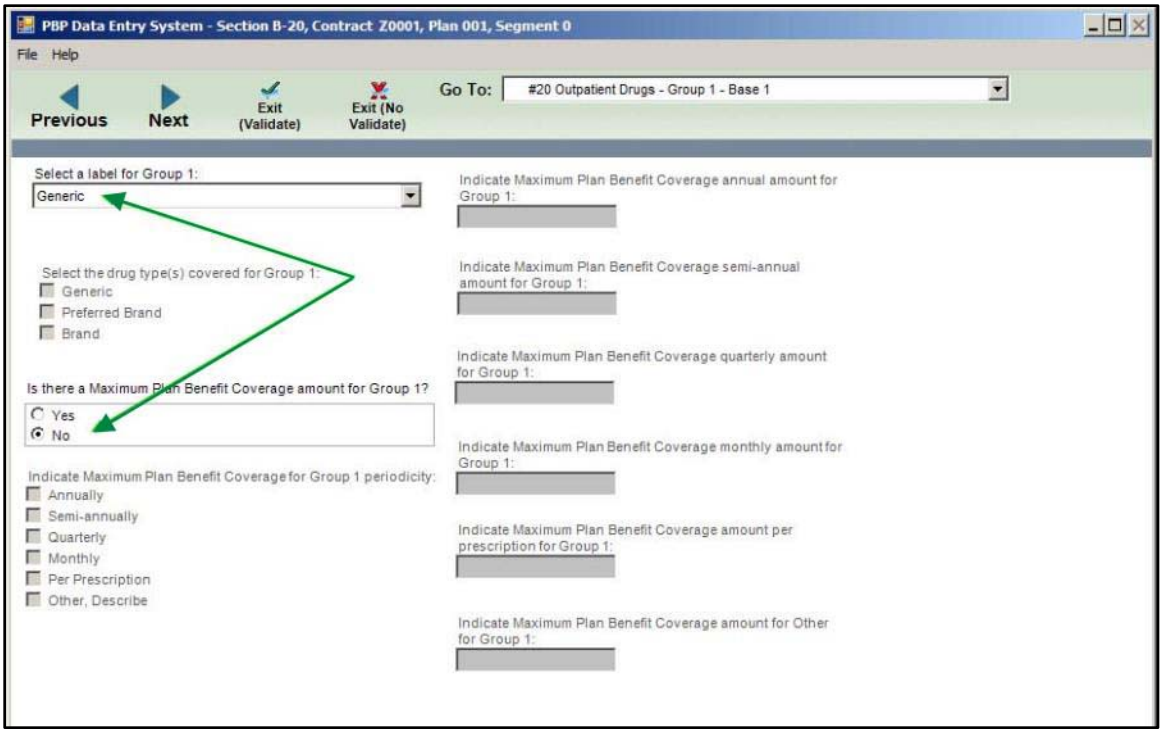
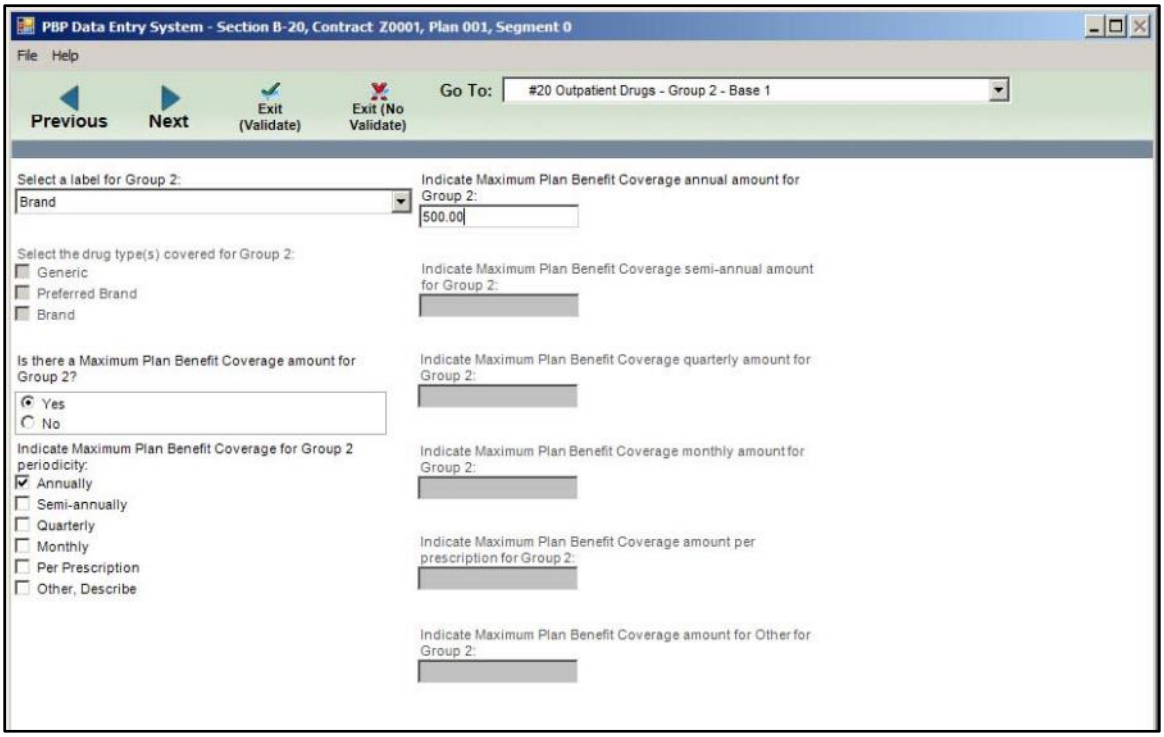


Table 4-53C



Example 2:

The plan offers two drug groups — brand and generic — and has a $750 annual limit on the combination of drugs but offers unlimited generic drugs after the limit is reached.

- First, indicate that the plan has a maximum plan-benefit-coverage amount, and that this includes combination of drug groups.
- Select Group 1 and Group 2 as the combination of drug groups included in the maximum plan-benefit-coverage amount, and enter an overall limit of $750 annually.
- Indicate that there is a selected group that is unlimited after the combination max limit has been reached, and select the group (1 or 2) that will be labeled as generic.

See Tables 4-54A, 4-54B, 4-54C, 4-54D, and 4-54E.

Table 4-54A

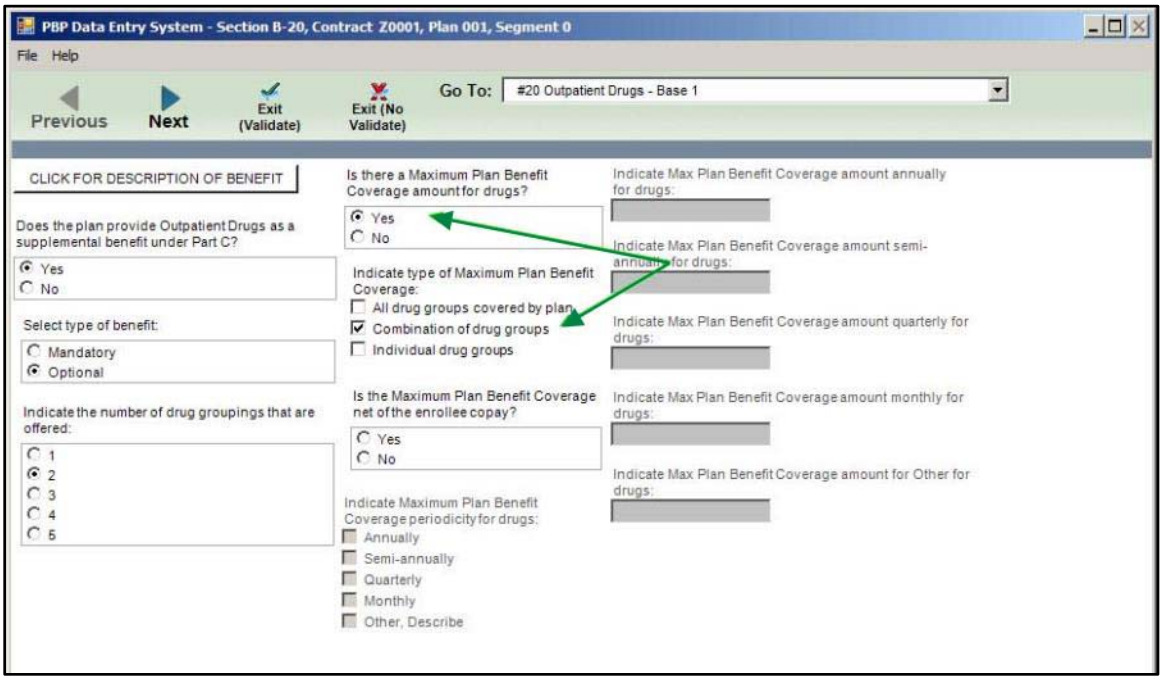


Table 4-54B

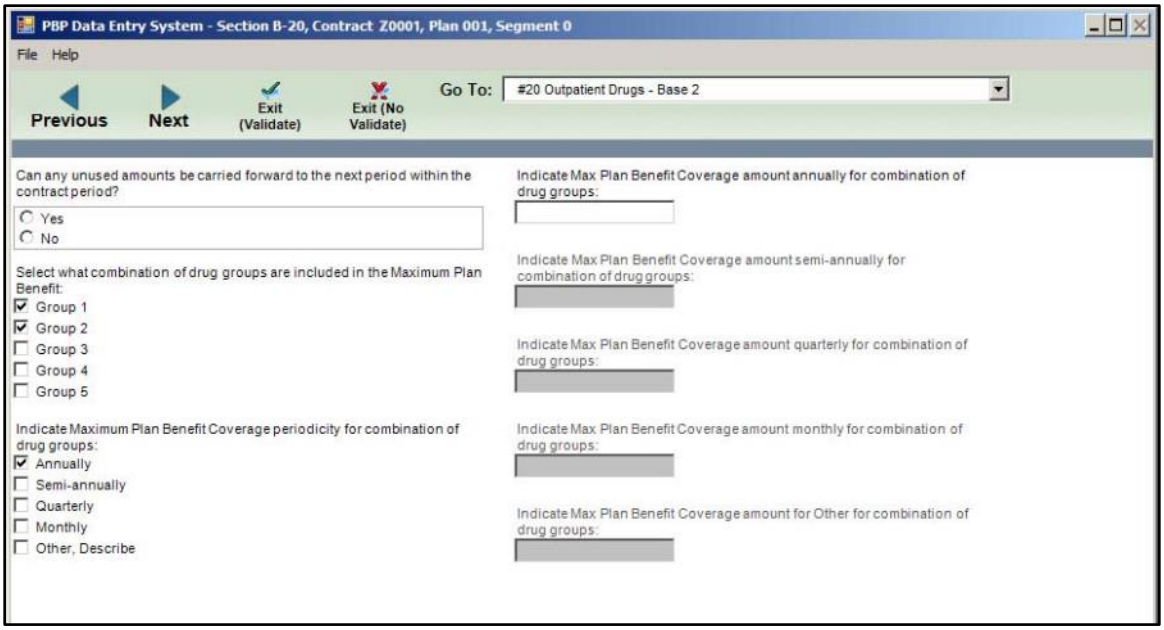


Table 4-54C

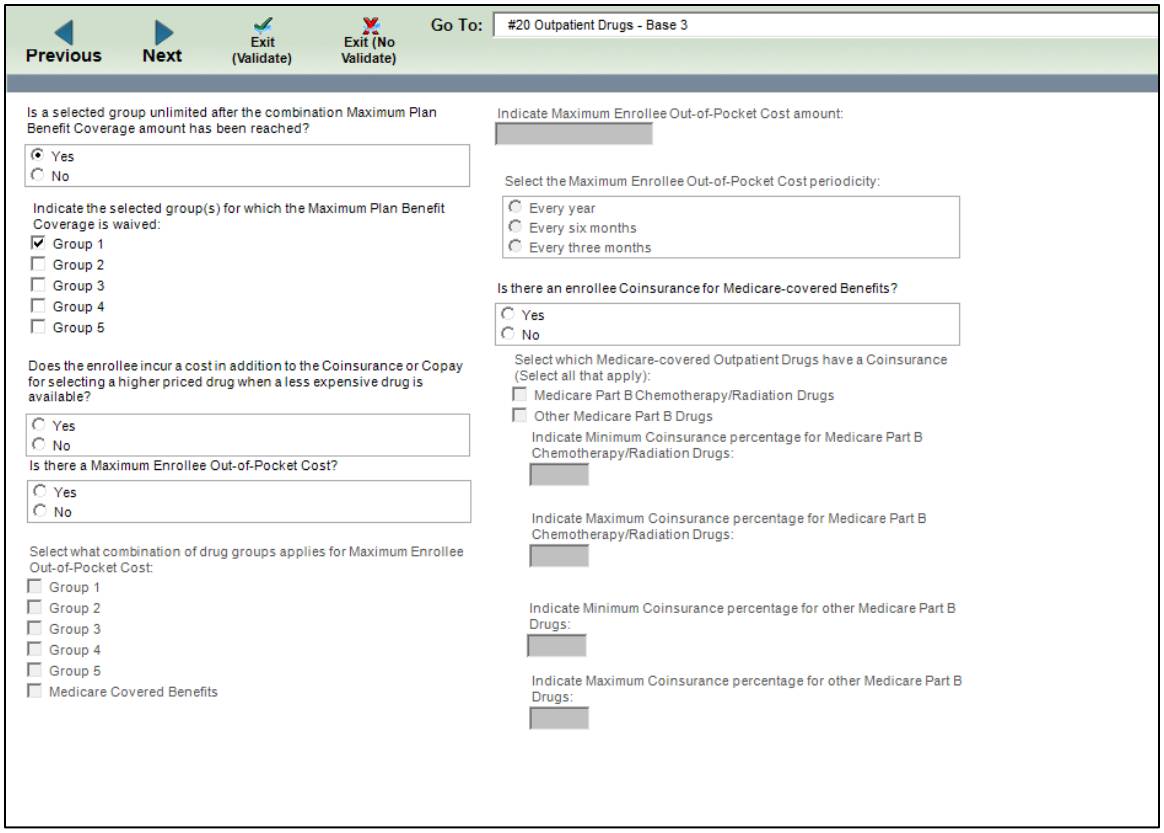


Table 4-54D

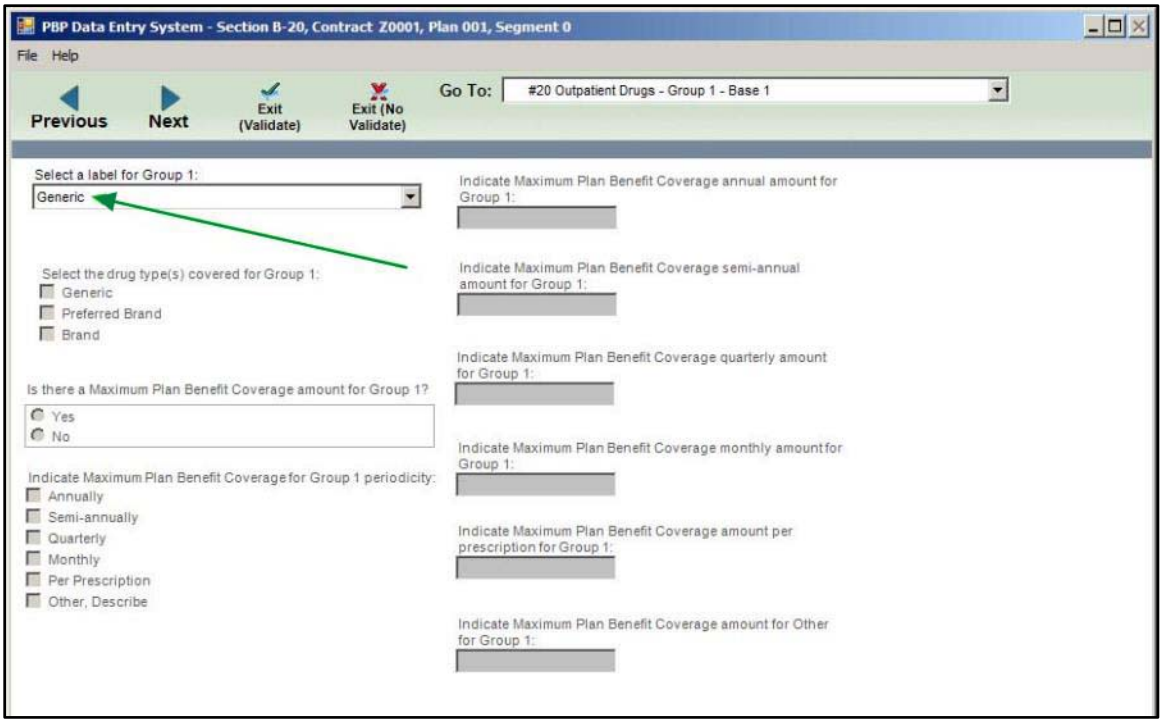
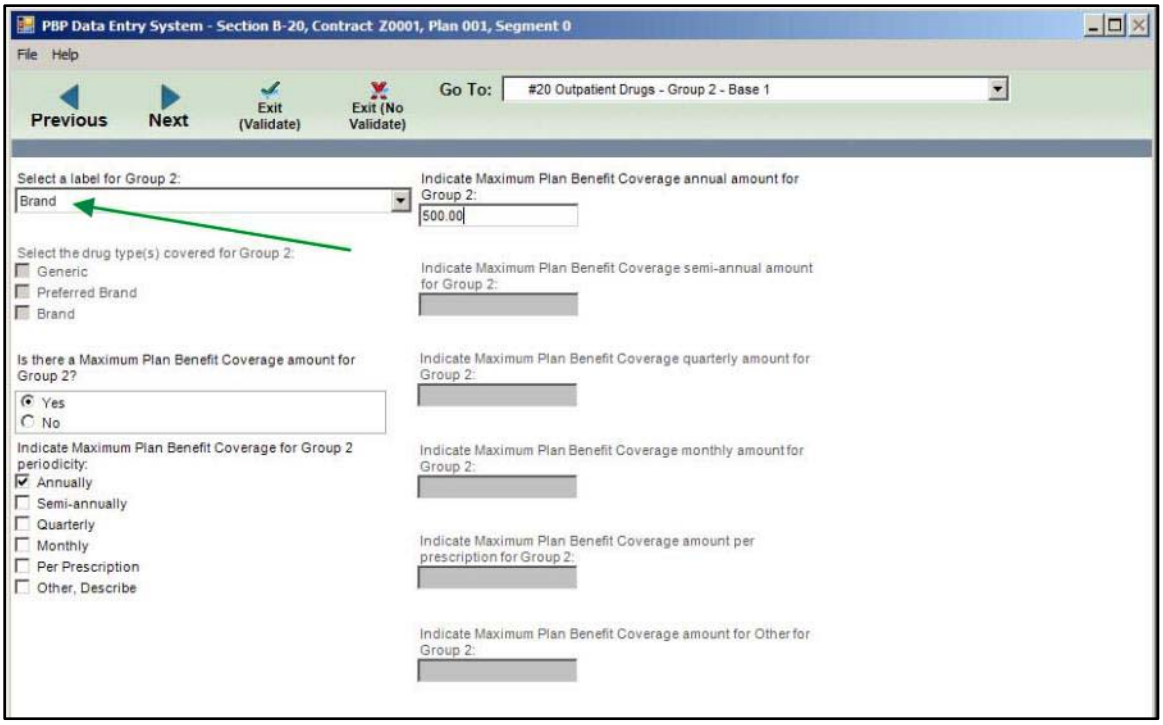


Table 4-54E



EXITING SECTION B

When ready to exit an individual Service Category in Section B, exit with or without validation. Refer to Chapter 2 for information about how to exit with or without validation.

Upon exiting, one of the following status types will show up for each Service Category in Section B on the PBP Management Screen:

- New — Service Category has not been opened for data entry.
- Incomplete — Data entry has begun and has not been completed and/or validated.
- Completed — Data entry has been completed and validated.

Once all data is entered and validated for all the Service Categories in Section B, the status for each will display as Completed.