2008 Regional Technical Assistance

PRESCRIPTION DRUG EVENT DATA

Centers for Medicare & Medicaid Services

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INTRODUCTION

Purpose (Slide 3)

The purpose of this technical assistance session is to provide participants with the support needed to understand Part D payment and data submission. This information will enable participants to collect and submit Part D data in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

About This Technical Assistance Session

This session is organized into 12 modules:

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1. **Part D Payment Methodology**
   Defines the Part D Prescription Drug payment calculation methodology based on the four legislated mechanisms.
2. **PDE Process Overview**
   Introduces key concepts associated with Prescription Drug Event (PDE) data, including collection, submission, formatting, editing, and processing.
3. **Data Format**
   Identifies the file layout for the PDE record and the formatting requirements for PDE fields.
4. **Calculating and Reporting the Basic Benefits**
   Provides an overview of PDE data submission for administration of the Part D Basic Benefit and Tiered Cost-Sharing.
5. **Calculating and Reporting True Out-of-Pocket (TrOOP) Costs**
   Explains the process and requirements related to administering the TrOOP component of the Part D benefit.
6. **TrOOP Facilitation**
   Describes the TrOOP facilitation process through the use of the Coordination of Benefits (COB) system to ensure appropriate payment at the point of sale (POS) by Part D participants.
7. **Calculating and Reporting Low Income Cost-Sharing Subsidy (LICS)**
   Describes the LICS and the process for calculating and reporting LICS amounts via PDE record submissions.
8. **Calculating and Reporting Enhanced Alternative (EA) Benefit**
   Provides the description of the EA benefit and essential reporting rules related to submitting data, including beneficiaries eligible for LICS.
9. **Calculating and Reporting Payment Demonstrations**
   Identifies PDE record rules and how to calculate payment for beneficiaries with Payment Demonstration options.
10. **Edits**
    Interprets the edit logic for the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS).
11. **Reports**
    Provides an understanding of the way management reports can ensure both quality and quantity of data stored in the system.
12. **Reconciliation**
    Explains the systems and steps for calculating components used in the reconciliation process.

Participant Guide (Slide 6)

This Participant Guide is designed as the foundation of the technical assistance program. The presentation slides complement the Participant Guide, and both are used extensively throughout this program. The participant binder includes the Participant Guide, Presentation Slides, a Resource Guide, and Job Aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

TABLE A – TECHNICAL ASSISTANCE TOOLS

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant Part D information • Examples
Slides	• Organized by module • Printed two slides per page
Resource Guide	• Official CMS Instructions • List of Acronyms • Website Links

Future Use of This Participant Guide

The Participant Guide, Slides, and Resource Guide are designed for use when participants return to their organizations. Additional copies of the materials are available at www.cssoperations.com. CMS revises the materials when required. An appropriate label will appear in the footer of the replacement pages affected by the revisions. Organizations are encouraged to register at www.csscoperations.com to receive notification for these revisions.

Audience (Slide 7)

This program is designed for plans new to the Part D drug benefit submission process, as well as new staff at existing plans and staff unable to attend previous sessions. The primary audiences for this session include:

- Staff of Prescription Drug Plans (PDPs).
- Staff of Medicare Advantage-Prescription Drug (MA-PD) plans, including demonstration projects and specialty plans.
- Pharmacy Benefit Managers (PBMs) staff.
- Third party submitters, contracted to submit data on behalf of plans.

Learning Objectives (Slides 10-12)

At the completion of this technical assistance session, participants will be able to:

- Identify the prescription drug payment calculation methodology.
- Describe the flow of the data from PDFS to DDPS.
- Identify the fields required for completion of the PDE record.
- Explain claims processing for the Basic benefit structure.
- Distinguish between what does and does not count toward TrOOP.
- Describe the TrOOP facilitation process.
- Identify the fields on the PDE associated with LICS.
- Interpret the layout rules for the EA benefit.
- Define the Payment Demonstration options.
- Interpret the edit logic and error reports for PDFS and DDPS.
- Describe how management reports can ensure accurate quality and quantity of data stored in the system.
- Identify the systems and steps for calculating components used in the reconciliation process.

Roles and Contact Information (Slide 13)

Table B provides the roles and contact information for important resources.

TABLE B – PART D PAYMENT PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
CMS Center for Beneficiary Choices (CBC)	Develops and implements the Part D payment methodology. Monitors plans to improve the quality of data.	Jeff Grant jeffrey.grant@cms.hhs.gov Henri Thomas henry.thomas@cms.hhs.gov Sandra Anderson sandra.anderson@cms.hhs.gov Janice Keys janice.keys@cms.hhs.gov Amanda Ryan amanda.ryan@cms.hhs.gov Tara Waters tara.waters@cms.hhs.gov
MMA Help Desk ViPS	Customer Support for Medicare Modernization technical help desk (CSMM). Provides technical assistance to plans using Gentran for connectivity.	www.cms.hhs.gov/mmahelp mmahelp@cms.hhs.gov
Palmetto Government Benefits Administration (Palmetto GBA)	Manages the PDFS and the Customer Service and Support Center (CSSC).	www.csscoperations.com csscoperations@palmettogba.com
Leading Through Change, Inc. (LTC)	Technical Assistance Contractor responsible for Prescription Drug Event Data technical assistance initiatives.	www.tarsc.info TARegistrations@ltcinc.net

MODULE 1 – PART D PAYMENT METHODOLOGY

Purpose (Slide 2)

Introduce Part D payment mechanisms so plans understand the statutorily established payment methodologies and the financial data needed to support Part D payment.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify and define the four legislative payment mechanisms.
- Describe payments subject to reconciliation and risk sharing.
- Establish other context for understanding PDE data reporting and reconciliation processes.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 Overview

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement, and Modernization Act (MMA), amending the Social Security Act (the Act) by adding Part D under Title 18. The new benefit allows Medicare payment to plans that contract with CMS to provide qualified Part D prescription drug coverage. The law provides four payment mechanisms and, as a condition of payment, requires that plans submit data and information necessary for CMS to carry out those payment provisions.

1.2 Payment Methodologies (Slide 4)

All Part D plans are required to provide a minimum set of prescription drug benefits, typically referred to as the "basic" benefit (see Module entitled The Basic Benefit). The MMA mandated either a specific benefit design called the Defined Standard benefit or an alternative that is considered to be actuarially equivalent. For an extra premium, plans can offer benefits that exceed the basic amount (see Modules entitled Enhanced Alternative Benefit and Payment Demonstrations), but the government only pays for the basic benefit.

Part D provides four mechanisms to pay plans for Part D basic benefits. The Prescription Drug Event (PDE) record is structured to report data to make these four payments. The four payment mechanisms are the direct subsidy, low income subsidy, reinsurance subsidy, and risk sharing. Part D payment is risk-based, but also has some cost components.

- Direct Subsidy – The direct subsidy is designed, together with beneficiary premiums, to cover the plan's cost for the risk portion of the basic benefit. The direct subsidy is a capitated per member per month risk payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment score, minus the monthly beneficiary premium related to the standardized bid amount.

  The plan's standardized bid is designed to cover a certain percentage of drug costs (see 1.3.3) as well as administrative costs that include the plan's estimate of gain or loss.

  The beneficiary premium related to the standardized bid amount includes premium amounts paid by enrollees or paid on their behalf, including A/B rebates applied to the basic benefit and low income premium subsidies. Unless specifically noted, reference to the basic beneficiary premium in this module means the "premium related to the standardized bid amount" without specifying who pays the premium. Excluded are any premiums for supplemental benefits or A/B benefits. Detailed discussion of the premiums is in the Target Amount section of this module.

- Low Income Subsidy (LIS) – The MMA provides two types of subsidies for qualifying low-income beneficiaries: premium assistance and cost-sharing assistance. Low income premium subsidies are part of the risk payment that results from the standardized bid. The government also issues cost-sharing subsidies that are not included in the standardized bid amount and are separate government payments on behalf of certain beneficiaries based on their income and asset levels. When applicable, this low income cost-sharing subsidy (LICS) applies to each prescription drug event and is subject to year-end cost-based reconciliation.

- Reinsurance subsidy – Reinsurance reduces the risk of participating in Part D by guaranteeing plans a certain amount of payment for beneficiaries with high drug costs. The reinsurance subsidy is a federal subsidy for 80 percent of allowable drug costs above the out-of-pocket (OOP) threshold, net of any other remuneration (e.g., rebates, coupons, discounts collectively referred to as direct and indirect remuneration or DIR; see 1.4.2.2). The reinsurance subsidy is subject to cost-based reconciliation.

- Risk Sharing (Risk Corridors) – The purpose of risk sharing is to limit a plan's exposure to unexpected expenses not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits or losses resulting from expenses for the basic benefit within defined symmetrical risk corridors around a target amount. Risk sharing payment is also referred to as risk corridor payment and can be positive, negative, or zero.

1.2.1 Covered Drugs (Slide 5)

The four payment methodologies only apply to covered drugs. The term covered drugs refers to Part D drugs that a plan covers under its basic benefit. Covered drugs are Part D drugs approved for coverage under a specific Plan Benefit Package (PBP) or under exceptions, transitions, grievances, appeals, or other coverage determination processes. A Part D drug is defined as:

> Any prescription drug described in §1927(k)(2)(A) of the Act, a vaccine licensed under section 351 of the Public Health Service Act, a biological product described in §1927(k)(2)(B) of the Act, or insulin described in §1927(k)(2)(C) and medical supplies associated with the injection of

insulin as allowed under §1860D-2(e)(1)(B). Except for smoking cessation drugs, Part D drugs must be prescribed for the purposes allowed under §1862(a) and §1927(d)(2) (e.g., reasonable and necessary guidelines, exclusion of drug classes used for weight loss or cosmetic surgery). Drugs cannot be billed as Part D drugs if they are already covered under Medicare Parts A or B as prescribed, dispensed, or administered (§1860D-2(e)(2)(B)).

1.2.2 Gross Covered Drug Cost (Slide 6)

This and subsequent modules delineate specific rules plans must follow to report the prescription drug cost and payment amounts for covered drugs on the PDE record under all types of PBPs. This training also describes how CMS then uses those amounts to determine allowable costs for reinsurance and risk corridor payment and to pay the low income cost-sharing subsidy.

For two reasons, the drug cost reported on a PDE record must be net of plan administrative costs and net of any point of sale (POS) price concessions:

1. Part D payment is based on a subset of the reported cost that must be net of these amounts; and
2. Beneficiary cost-sharing is determined as a portion of the cost net of these two amounts.

1.2.2.1 Drug Cost Subject to Part D Payment (Slide 7)

Part D payment is made based on the gross covered prescription drug cost for a dispensing event. The term "gross covered drug cost" is the cost incurred by the plan for covered Part D drugs including amounts paid by or on behalf of an enrollee and including certain dispensing fees, but not including administrative costs.

§1860D-15(b) and 42 CFR 423.308

On the PDE record, the plan reports gross covered drug cost using several fields:

1. As the sum of the detail fields Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee; and
2. In the summary fields Gross Drug Cost Above the OOP Threshold (GDCA) or Gross Drug Cost Below the OOP Threshold (GDCB).

The statute and regulation define the sub-categories of gross covered prescription drug costs that are subject to reinsurance and risk corridor payment, namely "allowable reinsurance costs" and "allowable risk corridor costs". These allowable costs are subsets of gross covered prescription drug costs that are "actually paid," which means net of administrative costs and net of POS discounts and all other direct and indirect remuneration. CMS determines allowable costs based on values reported on PDE records.

§1860D-15(b) and 42 CFR 423.308

Reinsurance and risk corridor payment must be net of administrative costs, POS price concessions and all other direct and indirect remuneration (DIR) (see 1.4.2.1).

Plans that use a PBM to negotiate prices and/or provide administrative services on its behalf must follow CMS guidance for reporting gross covered drug cost on the PDE record (see “Modified Q&A Addressing Drug Costs Reported on Prescription Drug Events (PDEs)” issued July 20, 2006). For coverage years 2006 to 2009, these plans may use either the lock-in amount or the pass-through amount as the basis for calculating beneficiary cost sharing and gross covered drug costs throughout the benefit, as well as reporting drug costs on the PDE. The plan must choose only one pricing approach and cannot switch between them for purposes of calculating cost sharing and reporting drug costs. The plan must use this pricing approach as a consistent basis for (i) calculating beneficiary cost sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the PDE; and (v) developing bids submitted to CMS. This ensures that the beneficiary cost sharing and reinsurance payments received by the plan are consistent with its bidding assumptions.

CMS issued a Notice of Proposed Rulemaking, which proposes that only one price, the price paid to the pharmacy or pass-through amount, be used to calculate beneficiary cost sharing and report gross covered drug cost on the PDE record beginning in 2010. CMS is currently reviewing the comments received on this Notice of Proposed Rulemaking.

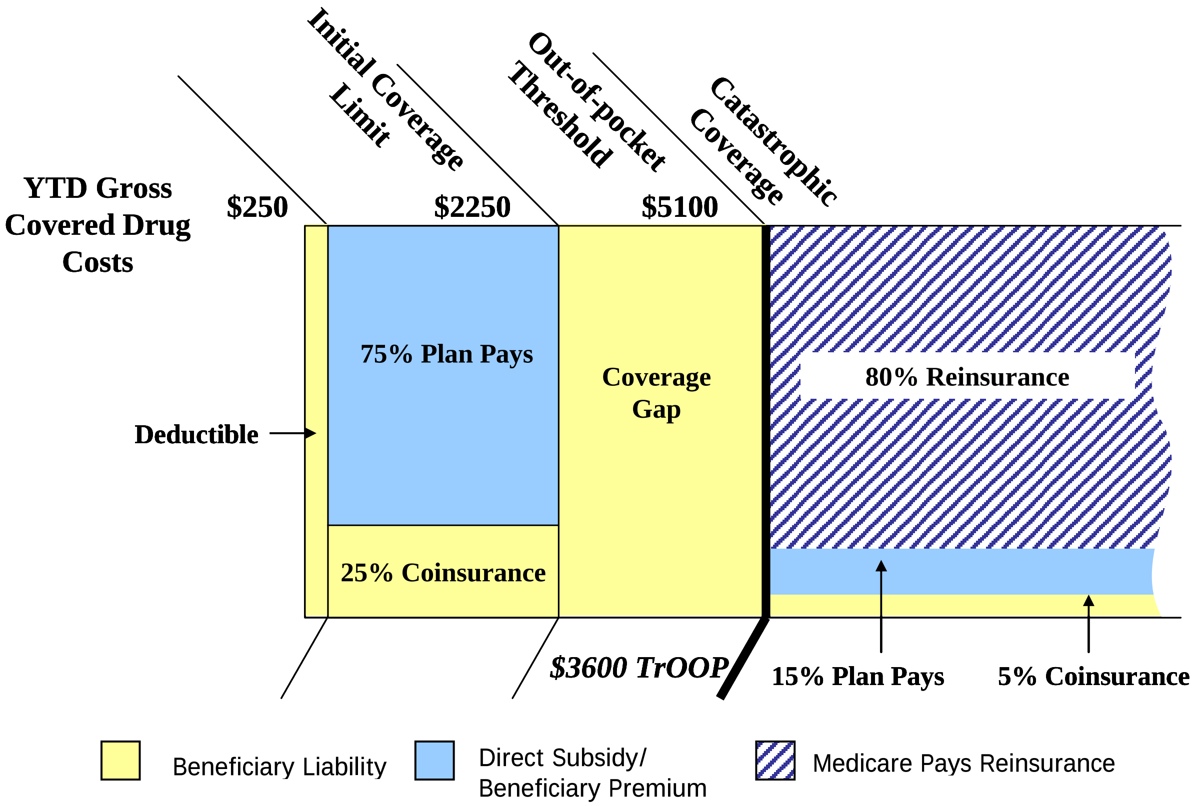
1.3 The Four Payment Mechanisms Related to the Defined Standard Benefit

The four payment mechanisms can be illustrated by showing how they apply in the Defined Standard benefit.

1.3.1 The Defined Standard Benefit (Slides 8-9)

Figure 1A illustrates the phases of the Defined Standard benefit plan for 2006.

Figure 1A - Defined Standard Benefit 2006



The Defined Standard benefit (Figure 1A) has four benefit phases: the Deductible phase, the Initial Coverage period, the Coverage Gap, and the Catastrophic Coverage phase. Year-to-Date (YTD) gross covered drug costs determine when the beneficiary is in the Deductible phase and the Initial Coverage period, and when the beneficiary enters the Coverage Gap. However, entry into the Catastrophic Coverage phase is determined by beneficiary accumulation of True Out-of-Pocket (TrOOP) costs greater than the OOP threshold amount.

In accordance with law, the parameters (dollar values) of the Defined Standard benefit are indexed annually to account for factors such as inflation and average annual Part D per capita drug expenditure. All examples included in the training materials reflect the 2006 parameters in Table 1A. Table 1B provides benefit parameters associated with the Defined Standard benefit in 2008. To assist plans with future systems configuration, calculation, and reporting, Table 1C provides the benefit parameters associated with the Defined Standard benefit in 2009.

Note: All examples in this Prescription Drug Event Data Training Participant Guide reflect the 2006 Defined Standard benefit parameters listed in Table 1A.

- TrOOP is only used to determine the threshold for Catastrophic Coverage. The Deductible, Initial Coverage period and Coverage Gap are not dependent on achieving any specific TrOOP level. The beneficiary or any party on behalf of the beneficiary may pay the beneficiary liabilities in these phases of the benefit.

- YTD gross covered drug costs determine if the beneficiary is in the Deductible phase, the Initial Coverage period or the Coverage Gap. YTD accumulated TrOOP costs greater than the OOP Threshold determine if the beneficiary is in Catastrophic Coverage. The Fixed Capitated demonstration plan discussed in Module 9 is the single exception.

TABLE 1A - THE DEFINED STANDARD BENEFIT 2006

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	**YTD TrOOP Costs**		
Deductible	≤ $250	N/A*	100% coinsurance (= $250)	0%
Initial Coverage Period	> $250 and ≤ $2,250	N/A*	25% coinsurance (= $500)	75% (= $1,500)
Coverage Gap	> $2,250 and ≤ $5,100	≤ $3,600	100% coinsurance (= $2,850)	0%
Catastrophic Coverage Phase	> $5,100	> $3,600 (OOP threshold)	Greater of 5% coinsurance or $2/$5 (generic/ brand) co-payment	Lesser of 95%** or (Gross Covered Drug Cost – $2/$5)

TABLE 1B - THE DEFINED STANDARD BENEFIT 2008

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	**YTD TrOOP Costs**		
Deductible	≥ $275	N/A*	100% coinsurance (= $275)	0%
Initial Coverage Period	> $275 and ≤ $2,510	N/A*	25% coinsurance (= $558.75)	75% (= $1,676.25)
Coverage Gap	>$2,510 ≤$5,726.25	≤ $4,050	100% coinsurance (= $3,216.25)	0%
Catastrophic Coverage Phase	> $5,726.25	> $4,050 (OOP threshold)	Greater 5% coinsurance or $2.25/$5.60 generic/brand co-payment	Lesser of 95%** or (Gross Covered Drug Cost - $2.25/$5.60)

TABLE 1C - THE DEFINED STANDARD BENEFIT 2009

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	**YTD TrOOP Costs**		
Deductible	≥ $295	N/A*	100% coinsurance (= $295)	0%
Initial Coverage Period	> $295 and ≤ $2,700	N/A*	25% coinsurance (= $601.25)	75% (= $1,803.75)
Coverage Gap	>$2,700 ≤$6,153.75	≤ $4,350	100% coinsurance (= $3,453.75)	0%
Catastrophic Coverage Phase	> $6,153.75	> $4,350 (OOP threshold)	Greater 5% coinsurance or $2.40/$6.00 generic/brand co-payment	Lesser of 95%** or (Gross Covered Drug Cost - $2.40/$6.00)

Notes to Tables 1A, 1B, 1C:
* It is not necessary to achieve a minimum TrOOP balance for transitioning from the Deductible to the Initial Coverage period or from the Initial Coverage period to the Coverage Gap. These phases are dependent upon YTD gross covered drug costs, regardless of who pays for the drug. However, any beneficiary paid amounts will count as TrOOP during these phases of the benefit.
** 80 percent reinsurance subsidy and 15 percent government/plan shared risk.
"Generic" also includes a preferred multiple source drug as defined in §1860D-2(b)(2)(D)(ii) of the Act.

- Deductible Phase – In 2006, the Part D Defined Standard benefit begins with a $250 deductible for covered drug costs for which the beneficiary (or another party on the beneficiary's behalf) is responsible.

Beneficiary liability	100%
Plan liability	0%

- Initial Coverage Period – The next $2,000 of covered drug costs (above $250 and up to and including $2,250) falls in the Initial Coverage Period in which the beneficiary pays 25 percent coinsurance and the plan is responsible for 75 percent of the costs.

Beneficiary liability	25%
Plan liability	75%

- Coverage Gap – The next $2,850 of covered drug costs (above the Initial Coverage limit of $2,250 and up to and including the OOP threshold) falls in the Coverage Gap in which the beneficiary pays 100 percent coinsurance.

Beneficiary liability	100%
Plan liability	0%

The Coverage Gap is unique to the Part D benefit.

Because plans offering the Defined Standard benefit cannot alter beneficiary cost-sharing in any phase of the benefit, the point at which the beneficiary reaches the OOP threshold almost always corresponds to $5,100 in YTD gross covered drug costs. (The only case in which this would vary is when a beneficiary has other health insurance (OHI) from a non-TrOOP eligible payer.)

- Catastrophic Coverage - Catastrophic Coverage begins after the beneficiary reaches the OOP threshold. Costs in Catastrophic Coverage are split three ways, with the government providing reinsurance equal to 80 percent, the Part D plan covering approximately 15 percent, and the beneficiary paying the greater of a 5 percent coinsurance, or co-payments of $2 for generic drugs and $5 for brand drugs.

Beneficiary liability	Greater of 5% or $2/$5 (in 2006)
Plan liability	Approximately 15%
Government liability	80% reinsurance subsidy

1.3.2 Other Benefit Types: Year-to-Date Gross Covered Drug Cost and the Out-of-Pocket (OOP) Threshold

Note the relationship between YTD gross covered drug costs and the point at which the beneficiary reaches the OOP threshold. When all beneficiaries pay exactly the same cost-sharing as in the Defined Standard benefit, and assuming no non-TrOOP OHI, $5,100 of YTD covered drug cost coincides with the point at which the beneficiary reaches the OOP threshold by accumulating $3,600 in TrOOP (2006 values). Part D allows three other plan types, which have variable cost-sharing. Modules 4 and 8 cover these other plan types in detail. Because of cost-sharing differences in these other plan types, the YTD gross covered drug cost that coincides with the OOP threshold varies.

- Actuarially Equivalent (AE) and Basic Alternative (BA) plans are considered to be actuarially equivalent in value to the Defined Standard benefit. On average, the relationship between YTD gross covered drug costs and the OOP threshold will be the same as under the Defined Standard benefit in these plans. However, the 2006 YTD drug cost coinciding with the OOP threshold is higher or lower than $5,100 for some beneficiaries. For example, YTD covered drug cost will be higher for a beneficiary who consistently purchases drugs with low cost-sharing.

- Enhanced Alternative (EA) plans may offer lower cost-sharing in exchange for higher premiums. Lower cost-sharing extends the point at which the beneficiary reaches the OOP threshold (normally $5,100 in the Defined Standard benefit). The 2006 YTD drug cost coinciding with the OOP threshold is higher than $5,100.

- The Module entitled Payment Demonstrations discusses two payment demonstration plans that are variations of EA plans and have some unique rules related to TrOOP.

1.3.3 Payment Methodologies in Relation to the Defined Standard Benefit (Slides 10-14)

The four payment mechanisms apply to the Defined Standard benefit as follows:

- The direct subsidy applies in the Initial Coverage period and in the Catastrophic Coverage phase of the benefit. The direct subsidy is one of the two risk components of payment. The other is the basic beneficiary premium. The direct subsidy and basic beneficiary premium are designed to cover 75 percent of covered drug cost in the Initial Coverage period and approximately 15 percent of covered drug costs in the Catastrophic Coverage phase, as well as administrative costs approved in the bid.

- LICS applies throughout all phases of the benefit for low income eligible beneficiaries.

- Reinsurance Subsidy applies in the Catastrophic Coverage phase of the benefit.

- Like the direct subsidy, risk sharing applies to allowable plan-paid amounts in the Initial Coverage period and in the Catastrophic Coverage phase of the benefit. Risk sharing is calculated at the plan level for the basic benefit and compares risk payments (direct subsidy and basic beneficiary premium) with aggregate allowed plan paid drug costs.

1.4 General Summary of Part D Payment Reconciliation (Slide 15)

Throughout the benefit year, the government makes prospective payments to plans that cover three subsidies: the direct subsidy, LICS, and the reinsurance subsidy. The payment amounts are based on information in the approved basic bid and on data provided by CMS that update payments throughout the year. These data include enrollment dates, low income subsidy eligibility, long-term institutional status, and risk adjustment scores. Enrollment dates and low income subsidy status may change throughout the year, and retroactive changes may even occur after the payment year. Those updates will result in monthly adjustments to prior payments. There is a final update of long-term institutional status and risk adjustment scores before reconciliation begins. During reconciliation, CMS compares the finalized prospective payments and the corresponding actual costs reported on PDEs and makes payment adjustment according to the rules for each payment methodology. Payment adjustment can be positive or negative.

1.4.1 Payment Timetable and Part D Payment Reconciliation Status (Slide 16)

Table 1D displays the four payment types and shows if the payment is prospective and subject to reconciliation.

TABLE 1D – FOUR PAYMENT MECHANISMS

PAYMENT MECHANISM	PAYMENT SCHEDULE	RECONCILIATION
Direct Subsidy	Monthly Prospective Payments	Yes-recalculate Risk Adjustment Scores
LICS*	Monthly Prospective Payments	Yes
Reinsurance Subsidy	Monthly Prospective Payments	Yes
Risk sharing	Reconciliation Payment	Yes

*Low income subsidy beneficiaries also receive premium assistance, which is paid and reported separately.

1.4.2 Data Collection for Part D

1.4.2.1 Prescription Drug Event (PDE) (Slide 17)

Criteria to determine data requirements - In order to implement the four payment mechanisms, CMS collects a limited subset of data elements on 100 percent of PDEs. CMS uses the following four criteria to determine data submission requirements:

- Ability to make timely, accurate payment using the four legislated mechanisms (direct subsidy, low income subsidy, reinsurance, and risk corridors).
- Minimal administrative burden on CMS, plans and other entities including PBMs, pharmacies, and others.
- Legislative authority.
- Data validity and reliability.

As a condition of payment, Part D plans must submit PDE and other data necessary for CMS to carry out these four payment provisions. CMS uses the PDE data to reconcile LICS and reinsurance payments and to implement risk sharing.

PDE data also reflect how a plan has administered its Part D benefit package. Most plans use a PBM or other third party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates a claim for payment. The PDE is a summary record that documents the final adjudication of a dispensing event. Since the PDE record summarizes multiple transactions, the plan must maintain audit trails to PDE source data. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted and replicate the summarization.

1.4.2.2 Direct and Indirect Remuneration (DIR) (Slides 18-19)

Direct and indirect remuneration (DIR) includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants of other price concessions or similar benefits offered to some or all purchasers from any source, including manufacturers, pharmacies, enrollees, or any other person, that would serve to decrease the costs incurred by the Part D sponsor for the drug.

42 CFR 423.308

DIR also includes any payments or re-payments that plans make as part of risk arrangements with providers in accordance with CMS guidance. By law, all DIR must be excluded from reinsurance and risk corridor payment. Allowable costs for reinsurance and risk corridor payment are a portion of gross covered prescription drug costs, net of all DIR and net of administrative costs.

As described in Section 1.2.2, some DIR is reflected in the price at POS that is reported on the PDE record. This price must in fact be net of POS price concessions for purposes of determining beneficiary cost-sharing. However, other types of direct and indirect remuneration are not reflected in the POS price and therefore must be reported to CMS in a data stream that is separate from PDE data for exclusion from payment.

Any DIR that is not reflected in the cost of the drug on the PDE record must be reported separately to CMS for exclusion from allowable costs for payment. Within six months of year-end, plans must submit all applicable DIR to CMS.

This annual DIR report is commonly referred to as the DIR report for reconciliation.

Plan sponsors must also submit a second DIR report to CMS with different categorical break-downs (see “Medicare Part D Reporting Requirements for Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions” at http://www.cms.hhs.gov/PrescriptionDrugCovContra/08_RxContracting_ReportingOversight.asp#TopOfPage).

1.5. Part D Payment Reconciliation

1.5.1 Direct Subsidy (Slide 20)

The direct subsidy is a capitated payment that, along with the basic beneficiary premium, is an estimate of the revenue requirements needed to provide the risk portion of basic benefits as approved in the bid, including plan payments for covered drugs and plan administrative expenses on the basic benefit. The estimate is adjusted for the individual risk characteristics of each beneficiary enrolled in the plan. Every plan receives a monthly prospective payment from CMS for every enrollee, called direct subsidies, to cover these costs.

If all bid assumptions are realized, the direct subsidy would match actual costs. Neither CMS nor the plan would need risk sharing to mitigate the impact of over-estimates or under-estimates. But after year-end, CMS compares actual covered drug costs to direct subsidy payments and if they differ by legislatively specified percentages, CMS calculates a risk sharing payment adjustment.

The direct subsidy is used in two parts of payment:

1. As actual prospective payment; and
2. To determine if any risk sharing is necessary.

1.5.1.1 Timing of Payment – Monthly

Plans receive prospective payments each month. After year-end, prospective payments are used in risk sharing calculations. In risk sharing, the prospective payments are compared to actual plan payments for the basic benefit that are reported on PDE records.

1.5.1.2 Risk Adjustment Model (Slide 21)

1.5.1.2.1 Overview

Risk adjustment is a statistical method that predicts an individual's health care cost based on the individual's health status; the model uses diagnoses and demographic characteristics such as age and gender to predict costs the following year. The MMA requires adjustment to the direct subsidy to account for the health status of the beneficiary. Under risk adjustment, a plan receives a relatively higher payment for a beneficiary with a higher risk score than for a beneficiary with a lower risk score.

CMS uses a model called the Rx-HCC model to calculate the beneficiary-level Part D risk scores used to adjust the direct subsidy payment. It is a linear regression model that produces coefficients that are used to calculate relative weights, or factors, for each disease condition and demographic characteristic in the model. Each beneficiary's factors are added together to calculate their risk score. The model is structured such that the average total risk score across the population of beneficiaries is 1.0. An individual with a total risk score >1.0 is expected to have higher annual drug expenditure relative to the average beneficiary, so the direct subsidy payment for this individual is incremented accordingly. Similarly, a beneficiary with a total risk score <1.0 is expected to have lower annual drug expenditure relative to the average beneficiary, so the direct subsidy payment for the individual is adjusted downwards.

Because Part D is a relatively new program, CMS does not yet have sufficient Part D data to update the relative factors in the Rx-HCC model. Researchers used alternate data sources to simulate Part D utilization as discussed in the 45 Day Advance Notice of Methodological Change and Final Payment Notice. See http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf

The Rx-HCC model is similar to other models CMS uses for risk adjustment payments to Medical Advantage plans. The underlying principles of these medical cost risk adjustment models are found in the research paper *Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report); December 2000*. See http://www.cms.hhs.gov/reports/downloads/pope_2000_2.pdf

The Rx-HCC model has good predictive power, which is comparable to other models for drugs that are reported.

1.5.1.2.2 Rx-HCC Model

The Rx-HCC model uses an individual's demographic and disease information collected in a base year to predict the Part D drug costs for that individual in the next year. The drug risk adjustment model explains approximately 23 percent of the variation in drug costs. That is, the R^2 of the Rx-HHC is 0.23. The R^2 measures "goodness of fit" and explains how well a model uses data to make predictions.

Demographic data includes age, gender, and originally disabled status.

Individuals 65 and older who originally qualified for Medicare when they were under age 65 because they were disabled are defined as being "originally disabled." Upon reaching age 65, the reason for entitlement becomes "aged" instead of "disabled." However, this population still has greater health risks, so the Rx-HCC model assigns an across-the-board risk score increase to these beneficiaries.

Disease data consists of *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) codes submitted either through Fee-for-Service claims for inpatient and outpatient hospitals settings and physician settings or through the Risk Adjustment Processing System (RAPS). [Medicare Advantage (MA) plans submit diagnosis encounter records via RAPS.]

Even if a beneficiary has no diagnoses reported, the Rx-HCC model increments payment by factors associated with demographic characteristics.

The Rx-HCC model is additive, that is, if a beneficiary has more than one demographic or diagnostic factor, the relative weights are summed to produce a total risk score. The demographic and diagnostic components of the Rx-HCC model are referred to as the "base model."

1.5.1.2.3 Hierarchical Condition Categories (HCCs)

The Rx-HCC model categorizes diagnosis codes into separate groups of clinically related codes with similar cost implications, (e.g., diabetes, cancer, ischemic heart disease, infections, etc.) The model groups 3,562 diagnosis codes into 84 categories called hierarchical condition categories or hierarchies (HCCs).

The term “hierarchical” refers to the fact that certain disease groups (HCCs) in the model are clinically related to other diseases but are more severe manifestations of the disease and typically have higher associated costs, for example diabetes with or without complications. When a beneficiary is assigned to two or more disease groups within a hierarchy, the model assigns the risk factor associated with the most clinically severe or “highest” manifestation of the disease. The associated relative weight assigns a payment increment that is greater than or equal to the payment that would be associated with any less severe or "lower" manifestation.

Example: 1

Table 1E illustrates two diabetes codes that are on file for a sample beneficiary, Mrs. Washington, this year.

TABLE 1E – EXAMPLE OF MANIFESTATIONS OF TWO OR MORE RISK FACTORS

Dx Code	Definition	RxHCC Group	Relative Weight
250.00	Diabetes without mention of complication, unspecified	RxHCC18	0.190
250.70	Diabetes with peripheral circulatory disorders, unspecified	RxHCC17	0.258

The higher weight of 0.258 is added to Mrs. Washington’s risk calculation.

1.5.1.2.4 Base Year Diseases Predict Payment Year Costs

The Rx-HCC model uses demographic and condition categories for an individual in a base year to predict the individual’s expected drug costs to the plan for the drug benefit in the next year. The Rx-HCC model assigns a factor (also called a relative weight) to each demographic and condition category that represents the marginal expected cost of that beneficiary characteristic or condition. Table 1F provides examples of condition categories and their relative weights.

TABLE 1F- EXAMPLES OF CONDITION CATEGORIES AND RELATIVE WEIGHTS

RxHCC GROUPS	RxHCC LABELS	RELATIVE WEIGHT
RxHCC17	Diabetes with Complications	0.258
RxHCC18	Diabetes without Complications	0.190
RxHCC91	Congestive Heart Failure	0.257
RxHCC102	Cerebral Hemorrhage and Effects of Stroke	0.063
RxHCC106	Vascular Disease	0.035

1.5.1.2.5 Interactions

The Rx-HCC model also includes interactions, which are combinations of conditions or characteristics that, in combination, predict additional cost. In the Rx-HCC model, there are three interactions. Those interactions occur between disabled status and certain conditions, including:

- Schizophrenia (RxHCC65)
- Other Major Psychiatric Disorders (RxHCC66)
- Cystic Fibrosis (RxHCC108)

Table 1G provides the relative weights for the Rx-HCC interactions.

TABLE 1G - RX-HCC INTERACTIONS

RxHCC Groups	RxHCC Labels	Relative Weight
RxHCC65	Disabled and Schizophrenia	0.375
RxHCC66	Disabled and Other Major Psychiatric Disorders	0.165
RxHCC108	Disabled and Cystic Fibrosis	0.897

1.5.1.2.6 Low Income Subsidy and Institutionalized Beneficiaries

The Rx-HCC model also provides higher payments for low income subsidy eligible (LIS) and long-term institutionalized (LTI) beneficiaries.

The model projects higher overall spending for long-term institutionalized (LTI) beneficiaries, primarily because it is expected that the prices for the specific packages of drugs that beneficiaries receive are somewhat higher in the institution than the same drugs in the community.

Long-term institutionalized status is defined as a beneficiary who resides in an institution for more than 90 days as reported by the Minimum Data Set (MDS).

For any qualifying beneficiary, either an LIS or LTI factor is applied. That is, a beneficiary can be either LTI or LIS but the beneficiary cannot be both for purposes of risk adjustment. When a beneficiary is eligible for both factors, the LTI factor is assigned. There is an important distinction between how the demographic and disease factors are used to calculate a beneficiary's Part D risk score, and how the LIS and LTI factors are applied to the risk score. The demographic and disease factors are additive; the LTI and LIS factors are multipliers. After the demographic and disease factors are summed for a total score yielded by the base model, the score is multiplied by the LTI or LIS factor, if applicable. The final value is referred to as the beneficiary's risk score. Table 1H provides the LTI and LIS factors.

TABLE 1H – LTI AND LIS FACTORS

Long-Term Institutional		Low Income	
Aged ≥ 65	Disabled < 65	Group 1 – Full subsidy eligible	Group 2 – Partial subsidy eligible (15%)
1.08	1.21	1.08	1.05

When a beneficiary is eligible for both LIS and LTI factors, the LTI factor is assigned**.**

1.5.1.2.6.1 Systems Reporting LIS and LTI Status

LIS is a concurrent adjustment reported monthly in the payment system. When retroactive changes in LIS status occur, risk adjusted payments for the affected months are adjusted to reflect the new information.

LTI status is determined on a month-by-month basis. It is designated based on the beneficiary's long-term institutionalized status on the first day of each month. However, for purposes of making payment during the year, CMS uses a status that is assigned prior to each payment year. CMS may elect to update this initial status during the year based on new information, in which case the new status would be applied as a payment adjustment for every month of the year.

Whether or not there was a mid-year update, during reconciliation after year-end, CMS implements the status that is determined to be applicable for each month of the year and issues any concomitant payment adjustment. Thus, month-by-month variation in LTI status is available only upon final reconciliation.

1.5.1.2.7 Plan Liability Model

Finally, the Rx-HCC is a Plan Liability model that takes into account the plan liability for spending after deductibles and other cost-sharing in the Defined Standard Part D benefit.

- Researchers also developed a risk model for total drug spending that does not account for cost-sharing. The spending model is predictive of total expenditures on prescription drugs covered by Part D.

For additional information about both the Plan Liability model and the spending model see the 2006 Final Payment Notice at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage or the Final Part D Risk Adjustment Model spreadsheet at http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp.

1.5.1.2.8 Implementation of the Rx-HCC Model

CMS uses the Rx-HCC model to calculate risk scores for all Medicare-eligible beneficiaries. CMS uses demographic and diagnosis data from the base year for beneficiaries with 12 months of either Part A or Part B during the data collection period. For beneficiaries with less than 12 months of either Part A or Part B, CMS calculates the risk score using demographic data only.

1.5.1.2.8.1 Risk Score Calculation – Data Collection Periods

CMS calculates risk scores three times throughout each payment year: at the beginning of the year, at mid-year, and at final reconciliation. For the first score, there is a built-in 6-month lag between the end of the data collection period and the start of the payment year. This lag needs to occur to allow collection, submission, and processing of the data. At mid-year, the data collection period is shifted forward by 6 months to include the most recent diagnosis data available. This is the final data collection period for the payment year and the one that is used for final reconciliation. The main difference between the mid-year scores and those used for final reconciliation is that CMS has additional data. In the final reconciliation, CMS also has more complete information regarding LIS and LTI.

1.5.1.2.8.1.1 Risk Score Examples

Example: 2

New Enrollee

Mrs. Polk enrolled in a Part D plan on March 6, 2006 when Mrs. Polk became 65. Mrs. Polk is a new enrollee. Mrs. Polk's risk score is 0.459.

New enrollees do not have 12 months of diagnosis data on file with Medicare, so the Rx-HCC model only assigns new enrollees a risk score using demographic factors.

Example: 3

Continuing Enrollee

Mrs. Adams is a 76-year old female with diabetes, high cholesterol, congestive heart failure, and osteoporosis. Mrs. Adams is not originally disabled. Table 1I illustrates how the Rx-HCC will calculate Mrs. Adam's relative weights and base model risk score.

TABLE 1I – RISK SCORE CALCULATION

Rx-HCC FACTOR	RxHCC LABELS	RELATIVE WEIGHT
Female 75-79		0.434
RxHCC17	Diabetes, with complications	0.258
RxHCC19	High cholesterol	0.163
RxHCC91	Congestive Heart Failure	0.251
RxHCC47	Osteoporosis	0.115
Beneficiary Risk Score		1.221

Example: 4

LIS

Mrs. Adams, the beneficiary in Example 3, is deemed partial subsidy eligible for the whole year. The LIS partial subsidy factor is included in the risk score calculation throughout the year. Table 1J illustrates applying the LIS factor to obtain a final beneficiary risk score.

TABLE 1J – FINAL RISK SCORE – LIS BENEFICIARY

FACTORS	RELATIVE WEIGHTS
Beneficiary Risk Score for demographic and disease conditions	1.221
LIS multiplier	1.05
Final Beneficiary Risk Score	1.28205

Example: 5

LTI

As of September 1, 2006 Mrs. Adams, the low income eligible beneficiary in Example 4, had been institutionalized for 100 days. Since Mrs. Adams is now eligible for both LIS and LTI factors, the LTI factor is applied to Mrs. Adam's base model score instead of the LIS factor when calculating her direct subsidy payment for September through her discharge. Table 1K provides the LTI factors for Mrs. Adams.

TABLE 1K – FINAL RISK SCORE – LTI BENEFICIARY

FACTORS	RELATIVE WEIGHTS
Beneficiary Risk Score for demographic and disease conditions	1.221
LTI multiplier	1.08
Final Beneficiary Risk Score, September - Discharge	1.31868

1.5.1.3 Calculate Monthly Direct Subsidy (Slide 22)

In its most basic form, the direct subsidy is the product of the plan's approved Part D standardized bid and the beneficiary's Part D risk adjustment score, minus the monthly beneficiary premium for basic coverage. The plan receives monthly prospective payments per enrollee throughout the year. Figure 1B illustrates the prospective direct subsidy calculation:

Figure 1B – Prospective Direct Subsidy

PDS = (STAND_BID * RS_i) – BENE_PREM

Where
PDS = Prospective direct subsidy payment
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RS_i = Initial beneficiary Part D risk score
BENE_PREM = Premium related to the standardized bid amount

Example: 6

Direct Subsidy for Mrs. Adams

Mrs. Adams enrolls in Happy Health Plan. Happy Health Plan's standardized bid amount is $100.00 and the beneficiary premium is $35.00. CMS uses the risk score of 1.221 from Example 3 to calculate that the direct subsidy that Happy Health Plan will receive for Mrs. Adams is $87.10. The calculation is:

Direct Subsidy = $100.00 * 1.221 - $35
Direct Subsidy = $87.10

The monthly plan-level direct subsidy is the sum of the direct subsidies for each beneficiary enrolled on the first day of the month for a PBP. Also note that direct subsidies can be positive or negative depending on the amount of the standardized bid and the risk adjustment score of any given beneficiary.

CMS will make some adjustments to direct subsidy payments on an ongoing basis (e.g., enrollment changes).

In reconciliation, CMS updates risk adjustment scores based on new diagnostic data received from the plan and final LTI and LIS status. CMS re-calculates what the direct subsidy should be given the final risk adjustment score of each beneficiary, compares prospective direct subsidies paid to the actual final amounts due, and determines the reconciliation payment adjustment. Figure 1C shows the reconciliation calculations:

Figure 1C – Reconciled Direct Subsidy

ADS = (STAND_BID * RS_f) – BENE_PREM

Where
ADS = Actual direct subsidy due
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RS_f = Final beneficiary Part D risk score
BENE_PREM = Premium related to the standardized bid amount

RDS = ADS - PDS

Where
RDS = Reconciliation direct subsidy payment adjustment
PDS = Prospective direct subsidy payment
ADS = Actual direct subsidy payment due

1.5.2 Low Income Cost-Sharing Subsidy (Slide 23)

Medicare subsidizes the cost-sharing liability of qualifying low income beneficiaries for covered Part D drugs. These cost-sharing reductions are applied and paid for by the plan at POS. Each month CMS pays plans prospectively for LICS amounts based on plan projections in the approved bid. CMS reconciles to the actual amounts paid after the payment year ends.

1.5.2.1 Timing of Payment

Plans receive prospective payments each month. After year-end, prospective LICS payments are reconciled to actual LICS amounts reported on PDEs.

1.5.2.2 LICS Reported on Individual PDEs

On each PDE the plan reports the actual amount of LICS paid for the dispensing event in the LICS field.

1.5.2.3 LICS Calculation/Reconciliation

1.5.2.3.1 Monthly Prospective Low Income Cost-Sharing Subsidy (LICS)

The prospective payment for the LICS is based on the low income estimate (p(LI)mpm) calculated from the plan's approved bid and enrollment counts documented in the Medicare Beneficiary Database (MBD).

The plan receives this amount for each low income beneficiary enrolled in the plan as of the first day of the payment month. Figure 1D demonstrates the LICS calculation.

Figure 1D – LICS Calculations

PLICS = BLICS * LI_ENR Where PLICS = Monthly prospective LICS BLICS = Low income estimate calculated from the approved bid (See Plan Bid Pricing Tool) LI_ENR = Number of low income beneficiaries enrolled in the month

1.5.2.3.2 LICS Reconciliation Calculation

During reconciliation, CMS subtracts the total prospective LICS payments from the actual LICS dollars reported on PDEs. Figure 1E shows the LICS calculation.

Figure 1E – LICS Reconciliation Calculation

RLICS = ALICS - PLICS Where RLICS = LICS reconciliation amount ALICS = Sum of plan-reported actual LICS dollars in the coverage year PLICS = Sum of all prospective LICS payments (includes any adjusted payments) in the coverage year

Plans are paid dollar for dollar for the LICS. If the LICS reconciliation amount is positive, plans receive payment in full for the LICS reconciliation amount. If the LICS reconciliation amount is negative, plans repay in full the LICS reconciliation amount.

1.5.3 Reinsurance Subsidy (Slide 24)

Reinsurance reduces the risk of participating in Part D. The federal government subsidizes 80 percent of covered Part D costs actually paid by the plan in the Catastrophic Coverage phase of the benefit, net of administrative costs and DIR. CMS pays 80 percent of the gross covered drug costs that are reported by the plan above the OOP threshold and do not include administrative costs, less DIR attributed to those costs via formula. In 2006, the beneficiary enters the Catastrophic Coverage phase of the benefit after accumulating $3,600 in TrOOP. The $3,600 limit applies to 2006 and is subject to annual increases.

1.5.3.1 Plans with Special Reinsurance Provisions

- Plan types exempted from Reinsurance Subsidy reconciliation are:

- Fallback plans – Fallback plans will not receive prospective reinsurance payments.

- Some payment demonstration plans – Flexible and Fixed Payment Demonstration Plans receive prospective reinsurance. There is no reinsurance reconciliation.

- Private Fee-for-Service (PFFS) Plans– PFFS plans will receive reinsurance payments according to separately legislated parameters.

- Employer Group Waiver Plans (EGWPs) – See Section 1.6.

📖 45 Day Advance Notice of Methodological Change and Final Payment Notice at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf.

1.5.3.2 Prospective Reinsurance Subsidy

Plans receive prospective payments each month. After year-end, prospective payments are reconciled to reported reinsurance costs.

Prospective Payment – The prospective payment for the reinsurance subsidy is based on the reinsurance per member per month (pmpm) estimate in the plan's approved bid and on enrollment counts documented in MARx. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month. Figure 1F explains the prospective reinsurance subsidy.

Figure 1F – Prospective Reinsurance Subsidy Calculation

PROSP_REINS = BID_REINS * ENR

Where
PROSP_REINS = Monthly prospective reinsurance subsidy
BID_REINS = Reinsurance pmpm estimate in the approved bid (See Plan Bid Pricing Tool)
ENR = Number of beneficiaries enrolled in the month

1.5.3.3 Unadjusted Reinsurance Costs

Reinsurance costs are those costs for Covered Part D drugs for beneficiaries in the Catastrophic Coverage phase of the benefit. Prior to adjustment for DIR, these costs describe the unadjusted reinsurance costs. For any Part D covered drug, plans report GDCA and GDCB. Unadjusted reinsurance costs are the sum of the reported GDCA, which includes both amounts paid by the plan and amounts paid by the beneficiary.

1.5.3.4 Reinsurance Subsidy Calculation

There is a five-step process to calculate and reconcile the Reinsurance Subsidy. The reinsurance subsidy is a plan-level payment based on aggregated beneficiary-level catastrophic coverage data.

1.5.3.4.1 Calculate DIR Ratio

For any Part D covered drug, plans report gross drug costs above and below the OOP threshold. The DIR ratio is determined by dividing the GDCA by the total gross drug cost above and below the OOP threshold. Figure 1G illustrates the calculation of the DIR Ratio.

Figure 1G – DIR Ratio Calculation

DIR_RATIO = GDCA / (GDCA + GDCB)

Where
GDCA = Gross drug cost above the OOP threshold
GDCB = Gross drug cost below the OOP threshold

1.5.3.4.1.1 Calculate Reinsurance Portion of DIR

To calculate Allowable Reinsurance Costs, CMS must exclude the reinsurance portion of DIR. Figure 1H explains how to determine the reinsurance portion of DIR.

Figure 1H – Reinsurance Portion of DIR Calculation

REINS_DIR = DIR_RATIO * NDDIR

Where
REINS_DIR = Reinsurance portion of DIR
NDDIR = Net DIR for Covered Part D drugs*

*Net DIR is Reported Part D Covered DIR Amount – Total Estimated POS Rebate Amount (see Module entitled Reconciliation)

1.5.3.4.2 Calculate Allowable Reinsurance Costs

To derive Allowable Reinsurance Costs, CMS subtracts the reinsurance portion of DIR. Figure 1I illustrates the Allowable Reinsurance Cost calculation.

Figure 1I – Allowable Reinsurance Cost Calculation

ALLOW_REINS = GDCA – REINS_DIR

Where
ALLOW_REINS = Allowable Reinsurance Costs
GDCA = Gross Drug Costs Above the Out-of-Pocket Threshold
REINS_DIR = Reinsurance Portion of DIR

1.5.3.4.3 Calculate Plan-Level Reinsurance Subsidy

The reinsurance subsidy is 80 percent of Allowable Reinsurance Costs. Figure 1J illustrates the calculation.

Figure 1J – Plan-Level Reinsurance Subsidy Calculation

REINS_SUBS = ALLOW_REINS * 0.8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

1.5.3.4.4 Reconcile Reinsurance Subsidy

The calculation to determine the reconciliation is explained in Figure 1K.

Figure 1K – Reconciliation Reinsurance Subsidy

REINS_RECON = REINS_SUBS – PROSP_REINS

Where
REINS_RECON = Reinsurance Reconciliation Amount
REINS_SUBS = Reinsurance Subsidy
PROSP_REINS = Sum of Prospective Monthly Reinsurance Subsidy

If the Reinsurance Reconciliation Amount is positive, the actual amount incurred exceeded the amount paid prospectively and the plan is entitled to additional payments. The plan receives payment in full for the Reinsurance Reconciliation Amount. If the Reinsurance Reconciliation Amount is negative, the actual amount incurred was less than the amount paid prospectively. The plan refunds the Reinsurance Reconciliation Amount.

1.5.4 Risk Sharing (Slide 25)

Risk corridors minimize unexpected gains or losses to the plan that are not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits and losses resulting from expenses for the standard benefit within defined symmetrical risk corridors around a target amount.

- Risk Sharing is a single, annual payment adjustment computed after year-end. The payment adjustment can be positive, negative, or zero.

- Unadjusted Risk Corridor Costs (URCC) are plan paid costs for covered Part D drugs in all phases of the benefit in which the plan has liability under the basic benefit. The Covered D Plan Paid Amounts (CPP) are summed from PDEs at the plan-level to determine URCC.

- Adjusted Allowable Risk Corridor Costs (AARCC) are the URCC reduced for Net DIR (all plans) and adjusted to account for induced utilization (only enhanced plans). In risk sharing, CMS will compare the AARCC to the Target Amount.

1.5.4.1 Calculate Risk Sharing

There is a four-step process to calculate risk sharing.

1. Calculate the Plan's Target Amount
2. Calculate Risk Corridor Thresholds
3. Calculate Adjusted Allowable Risk Corridor Costs (AARCC)
4. Determine where AARCC fall with respect to the thresholds and calculate any payment adjustment

1.5.4.1.1 Calculate the Plan's Target Amount (Slides 26-27)

In summary, the target amount is the total projected revenue necessary for the basic benefit reduced for administrative costs. Projected revenue has a CMS paid component and a beneficiary paid component.

To fully account for this combined total, CMS sums the following:

- Direct subsidies which constitute the CMS paid component.

- The Part D basic premium amount which is defined for reconciliation purposes as the "premium related to the standardized bid amount." This is the plan premium that results from the bidding process, regardless of the source of payment. In other words, it does not distinguish any low income premium subsidy (LIPS) paid by the government on a beneficiary's behalf or any reduction of the premium by an A/B rebate.

CMS does not share risk on administrative costs. CMS excludes administrative costs by first calculating an administrative cost ratio that includes an estimate of gain or loss. Figure 1L explains how the administrative cost ratio is calculated.

Figure 1L – Administrative Cost Ratio Calculation

AC_RATIO = (NON-PHARMACY EXPENSES + GAIN_LOSS) / BASIC_BID

Where
AC_RATIO = Administrative Cost Ratio
NON_PHARM = Non-Pharmacy Expense*
GAIN_LOSS = Gain/ (Loss)*
BASIC_BID = Total Basic Bid*

*See Plan Bid Pricing Tool

The direct subsidy and the beneficiary premiums are added together. CMS then removes administrative costs to develop a Plan Target Amount. Figure 1M illustrates the calculation.

Figure 1M – Plan Target Amount

TARGET= (DS + PARTD_BASIC_PREM) * (1.00 – AC_RATIO)

Where
TARGET = Target amount
DS = Total direct subsidy
PARTD_BASIC_PREM = Beneficiary premiums related to the standardized bid

AC_RATIO = Administrative cost ratio

Note: CMS calculates beneficiary risk scores three times a year: initial calculation, mid-year correction, and final at year-end. The direct subsidy as used in this calculation reflects all retroactive adjustments made based on changes in enrollment, relevant status (LIS/LTI), and final risk adjustment scores, for any month during the payment year.

1.5.4.1.2 Calculate Risk Corridor Thresholds

CMS uses the threshold risk percentage in combination with the plan's target amount to calculate four symmetrical plan specific risk threshold limits. The four threshold limits are calculated by multiplying the target amount by 1.0 plus or minus the statutory risk percentages, which in 2006 are 2.5 percent and 5.0 percent.

In 2006 and 2007, the threshold risk percentages are:

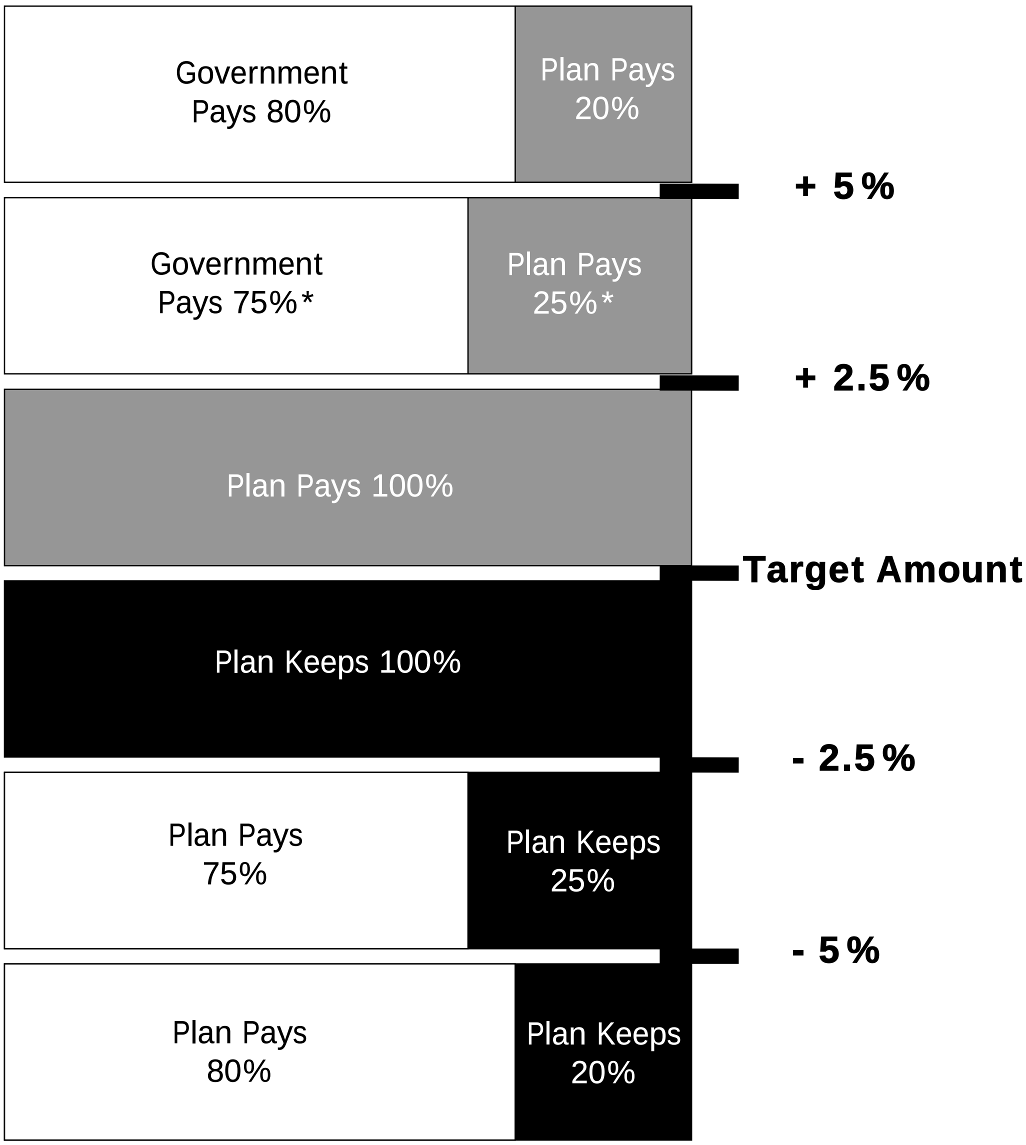
- 2nd threshold upper limit (1.0 + 0.05) 105.0%
- 1st threshold upper limit (1.0 + 0.025) 102.5%
- 1st threshold lower limit (1.0 – 0.025) 97.5%
- 2nd threshold lower limit (1.0 – 0.05) 95.0%

The thresholds used in the 2006 risk sharing calculations for a sample plan with a target amount of $1,000,000 are:

Second threshold upper limit	= $1,000,000 *	1.05	=	$1,050,000
First threshold upper limit	= $1,000,000 *	1.025	=	$1,025,000
First threshold lower limit	= $1,000,000 *	0.975	=	$ 975,000
Second threshold lower limit	= $1,000,000 *	0.95	=	$ 950,000

Different risk sharing percentages are associated with each risk threshold as shown in Figure 1N.

Figure 1N – Risk Sharing Thresholds and Percentages, 2006-2007

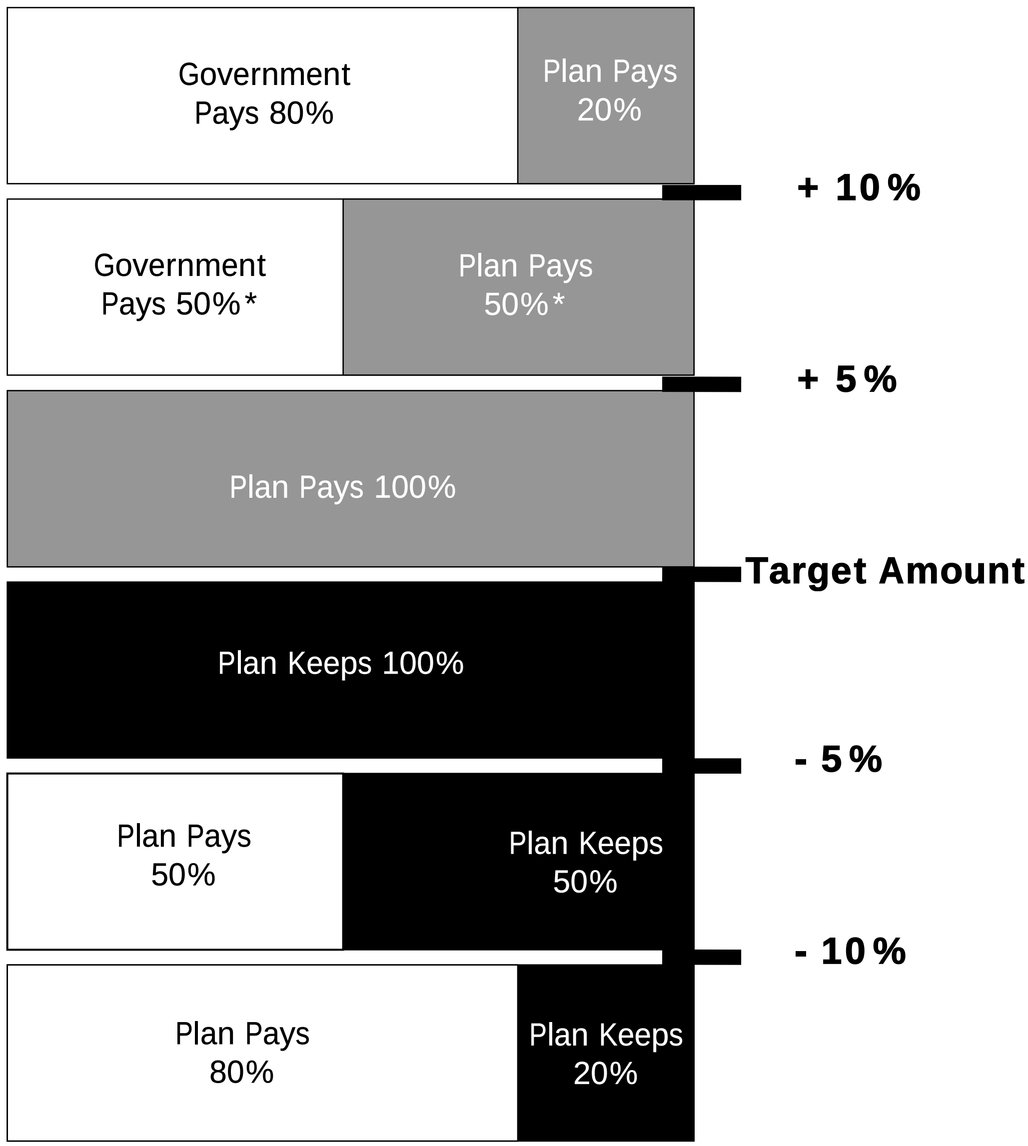


***60/60 Rule** – In 2006 and 2007, the 75 percent risk sharing for adjusted allowable risk corridor costs between the first and second upper threshold limits changes to 90 percent if the following two conditions are met:

1. At least 60 percent of Part D plans that are subject to risk sharing have adjusted allowable risk corridor costs for the Part D plan for the year that is above 102.5 percent of their target amount.
2. Such plans represent at least 60 percent of Part D eligible individuals enrolled in any prescription drug plan or MA-PD plan, i.e. 60% of Part D enrollment except for the retiree drug subsidy program.

§1860D-15(e)(2)(B)(iii) and 42 CFR 423.336((b)(iii)(B).

Figure 1O – Risk Sharing Thresholds and Percentages, 2008-2011



For 2008 to 2011, the first threshold risk percentage changes from 2.5% to 5% of the target amount; the second threshold risk percentage changes from 5% to 10% of the target amount; the payment adjustments for the first corridor change from 75% to 50% and the second corridor remains at 80%; and the conditions for higher percentages (a.k.a. 60/60 rule) under Section 1860D-15(e)(2)(B)(iii) of the Act and the regulations at 42 CFR 423.336(b)(2)(iii) will no longer be applicable.

1.5.4.1.3 Calculate Adjusted Allowable Risk Corridor Costs (AARCC) (Slide 28)

There are 4 steps to determine adjusted allowable risk corridor costs (AARCC).

1. Determine URCC. The plan-level sum of dollars reported in the CPP field represents the URCC.

   The costs for risk sharing differ from the costs for reinsurance. Risk sharing costs are CPP costs, both above and below the OOP threshold. Reinsurance costs are gross covered drug costs, but only those GDCA.

2. Subtract Plan-level reinsurance subsidy.

3. Subtract Net Covered Part D DIR.

4. For enhanced alternative plans only, reduce by the induced utilization ratio plans reported in their bids.

   - Induced Utilization ratio: See Plan Bid Pricing Tool

Figure 1P illustrates the calculation.

Figure 1P – AARCC Calculation

AARCC = (URCC – REINS_SUBS – NDDIR) / IU

Where
AARCC = Adjusted Allowable Risk Corridor Costs
URCC = Unadjusted Risk Corridor Costs
REINS_SUBS = Reinsurance Subsidy
NDDIR = Net Covered Part D DIR
IU = Induced Utilization ratio

1.5.4.1.4 Determine Where Costs Fall With Respect to the Thresholds and Calculate Payment Adjustment (Slide 29)

Risk sharing reduces the impacts of unexpected gains or losses. To the extent that the variation between risk corridor costs and the target amount exceeds certain thresholds, plans receive payments from the government to cover a portion of unexpected losses. To the extent that the variation between risk corridor costs and the target amount falls below certain thresholds, plans share a portion of unexpected gains with the government.

To illustrate, the following five scenarios are provided as examples. Assume a plan with $1 million target amount.

- AARCC > than 5.0 percent of the target amount
- AARCC > 2.5 percent of the target amount and < 5.0 percent of the target amount

- AARCC falls within +/- 2.5 percent of the target amount (i.e., the plan estimate is considered sufficiently accurate)
- AARCC < 97.5 percent of the target amount and ≥ 95 percent of the target amount
- AARCC < 95 percent of the target amount

In the following examples, assume that the plan's target amount is $1,000,000. See 1.5.1.2 for Threshold limit calculations.

Second threshold upper limit	= $1,000,000 * 1.05	=	$1,050,000
First threshold upper limit	= $1,000,000 * 1.025	=	$1,025,000
First threshold lower limit	= $1,000,000 * 0.975	=	$ 975,000
Second threshold lower limit	= $1,000,000 * 0.95	=	$ 950,000

Example: 7

AARCC greater than 5.0 percent of the target amount

AARCC = $1,063,000

Payment adjustment = [0.75*($1,050,000-$1,025,000) + 0.80*($1,063,000-$1,050,000)] = $29,150 (government pays plan)

Example: 8

AARCC greater than 2.5 percent of the target amount and ≤ 5.0% of the target amount

AARCC = $1,035,000

Payment adjustment = 0.75*($1,035,000-$1,025,000) = $7,500 (government pays plan)

Example: 9

AARCC falls within +/- 2.5 percent of the target amount

In the following examples the plan made considerably accurate predictions in the bid pricing tool.

Example: 9a

AARCC = $1,005,000

$1,005,000 falls between the plan's target amount and the first upper limit threshold.
No payment adjustment is made.

Example: 9b

AARCC = $978,000

$978,000 falls between the plan's first lower limit threshold and the target amount.
No payment adjustment is made.

Example: 10

AARCC less than 97.5 percent of the target amount and ≥ 95% of the target amount

AARCC = $973,000

Payment adjustment = 0.75*($975,000-$973,000) = $1,500 (plan pays back to government)

Example: 11

AARCC less than 95 percent of the target amount

AARCC = $945,000

Payment adjustment = [0.75*($975,000-$950,000) + 0.80*($950,000-$945,000)] = $22,750 (plan pays back to government)

1.5.4.2 Risk Sharing for Flexible and Fixed Capitated Demonstration Plans

Flexible and Fixed Capitated demonstration plans receive reinsurance prospectively based on the prospective reinsurance amount on the plan's bid. Flexible and Fixed Capitated demonstration plans forego the reinsurance reconciliation and the 80 percent reinsurance subsidy. These plans risk share on the subset of plan paid costs above the OOP Threshold. The target amount calculation is altered by adding in the prospective capitated reinsurance payments. Figure 1Q explains the calculation.

Figure 1Q – Flexible and Fixed Capitated Demonstration Plan Calculations

TARGET= (DS + PARTD_BASIC_PREM) * (1.00 – AC_RATIO) + PROSP_REINS

Where
TARGET = Target amount
DS = Total direct subsidy
PARTD_BASIC_PREM = Beneficiary premiums related to the standardized bid
AC_RATIO = Administrative cost ratio
PROSP_REINS = Prospective capitated reinsurance payment

Adjusted allowable risk corridor costs (AARCC) are calculated in the same manner as for all other plans. For example, since payment demonstration plans are a variation of enhanced alternative plans, URCC are adjusted for induced utilization in the same manner as are EA plans. However, since there is no reinsurance subsidy to subtract from the allowable risk corridor costs, the actual costs subject to risk sharing increase by the reinsurance subsidy amount that is paid to a non-demonstration plan. Similarly, the target amount also increases because the prospective capitated reinsurance subsidy is added into the target amount.

1.6 Special Rules for Employer Group Waiver Plans (EGWPs)

This section applies to employers/unions that directly contract with Medicare to become Prescription Drug Plans (PDPs), Medicare Advantage Prescription Drug Plans (MA-PDs), and Section 1876 cost-plans that offer employer/union-only group plans. These plans are authorized under §1857(i) and §1860D-22(b) of the Act, which provides that CMS may waive or modify requirements that "hinder the design of, the offering of, or the enrollment in" such employer sponsored plans. CMS refers to employer or union-sponsored plans in these arrangements as employer/union-only group waiver plans (EGWPs).

EGWPs must submit PDE data to CMS like all other plans (specifically, enhanced alternative plans described in Module 9). However, EGWPs are subject to several different payment and reconciliation provisions.

EGWPs that operate on a non-calendar year basis are not eligible for reinsurance. However, they are still required to administer all Catastrophic Coverage provisions prescribed by the MMA, in regulation, and in PDE guidance. EGWPs that operate on a calendar-year basis receive retrospective reinsurance payment based on costs reported on PDEs and in the DIR report for reconciliation; they are not paid prospective reinsurance. EGWPs are not subject to risk sharing.

MODULE 2 – PDE PROCESS OVERVIEW

Purpose (Slide 2)

The success of Prescription Drug Event data submission is dependent on plans understanding the process of collecting and submitting accurate Prescription Drug Event (PDE) data. The purpose of this module is to present participants with the important terms, key resources, and schedule information that provide a foundation for the Prescription Drug Event Data technical assistance program.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify common Prescription Drug Event (PDE) data terminology.
- Demonstrate knowledge in interpreting key components of the PDE data process.
- Interpret the PDE data submission timeline.
- Identify the Centers for Medicare & Medicaid Services (CMS) outreach efforts available to plans.

ICON KEY
Definition
Example
Reminder
Resource

2.1 Common Prescription Drug Event Data System Terms (Slide 4)

Table 2A provides descriptions for common Prescription Drug Event (PDE) system terminology.

TABLE 2A - PRESCRIPTION DRUG EVENT DATA COMMON SYSTEM TERMS

TERMS	DESCRIPTION
PDFS	Prescription Drug Event data submitters send data through the **Prescription Drug Front-End System**.
DDPS	Prescription Drug Event data are processed by the **Drug Data Processing System**.
IDR	The **Integrated Data Repository** calculates beneficiary/plan-level and plan-level LICS, Unadjusted Reinsurance Costs and Unadjusted Risk Corridor Costs.
PRS	The **Payment Reconciliation System** calculates final reconciliation payment.
MBD	The **Medicare Beneficiary Database** maintains Medicare beneficiary eligibility and low income cost-sharing subsidy (LICS) data.
HPMS	The **Health Plan Management System** is a CMS information system that contains health plan-level data.
MARx	**Medicare Advantage Prescription Drug System** supports the enrollment and payment functions for MA, capitated payment, and prescription drug plans.

2.2 Prescription Drug Event Data Benefit Options (Slide 5)

The Medicare Prescription Drug Benefit, Improvement, and Modernization Act of 2003 (MMA) amended the Social Security Act (the Act) by adding Part D to Title 18. Part D requires all plans to provide a minimum set of prescription drug benefits, typically referred to as the Basic benefit or basic prescription drug coverage. The statute designates a specific basic benefit structure called the Defined Standard (DS) and allows two alternate structures that have met certain tests of actuarial equivalence to the DS, the Actuarially Equivalent (AE) plan and the Basic Alternative (BA) plan.

Plans also have the option to provide supplemental benefits that exceed the actuarially equivalent value of the Defined Standard benefit. These plans are referred to as Enhanced Alternative (EA) benefit plans. EA benefits can take two forms:

1. Enhanced alternative cost-sharing (EACS) - additional payments by the plan beyond those provided under the Defined Standard benefit. EACS applies only to covered Part D drugs.

2. Coverage of non-Part D drugs that require a prescription (e.g., benzodiazepines, barbiturates).

Part D plans may also participate in Payment Demonstrations to study the effects of providing supplemental insurance in the coverage gap. There are two Payment Demonstration options:

1. Flexible capitated option
2. Fixed capitated option

Since Payment Demonstration and EA plans have non-standard benefit structures and some variations in payment methodology, Payment Demonstration and EA plans have several different rules for submitting PDE data for payment calculations.

2.3 Prescription Drug Event Data Process Overview (Slide 6)

Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary record called the PDE record to CMS. The PDE record contains prescription drug cost and payment data that enables CMS to make payments to plans and otherwise administer the Part D benefit. PDE data is processed through DDPS.

2.3.1 Prescription Drug Event Data (Slide 7)

Plans must submit a PDE record for each dispensing event. CMS expects that plans will directly link any PDE to the individual claim transaction from which the PDE was extracted and duplicate the summarization.

The 40 data elements required for all PDE records include:

- 16 data elements from the National Council for Prescription Drug Programs (NCPDP) billing transaction.

- 4 data elements from the NCPDP billing response transaction.

- 20 data elements defined by CMS for purposes of administering Part D.

The PDE record includes:

- Covered drug costs above and below the Out-of-Pocket (OOP) threshold.
- Information on payments for supplemental costs from the costs of drugs provided under the Basic benefit.
- Payments made by Part D plan sponsors, other payers, and by or on behalf of beneficiaries.

Plans also identify costs that contribute toward a beneficiary's True Out-of-Pocket (TrOOP) limit, separated into three categories:

- LICS amounts paid by the plan at the point of sale (POS)
- Beneficiary payments
- TrOOP-eligible payments made by qualified entities on behalf of a beneficiary

2.3.2 Prescription Drug Event Data Submission (Slide 8)

The DDPS is the information system that collects, validates, and stores PDE data received from plans or their submitters.

PDE records enter DDPS through the PDFS. The PDFS initially performs format and face validity checks. Once the file has passed the front-end checks, it moves through the DDPS where detail level edits are performed and the data are stored.

Plans or third party submitters must submit PDE records electronically to CMS according to the schedule illustrated in Table 2B.

TABLE 2B - TIMELINE FOR 2008-2009 PDE DATA SUBMISSION

CY	DATA SUBMISSION TYPE	SUBMISSION TIMELINE
2008	Production Submissions	Monthly – March 31, 2008 – May 31, 2009
2008	Final Submission Deadline	May 31, 2009
2008	Direct and Indirect Remuneration (DIR) Submission Deadline	June 30, 2009
2009	EDI Agreement and Submitter Application Deadline	October 31, 2008
2009	Certification Complete*	January 31, 2009
2009	First Production File Due	March 31, 2009
2009	Production Submissions	Monthly March 31, 2009 – May 31, 2010
2009	Final Submission Deadline	May 31, 2010
2009	Direct & Indirect Remuneration (DIR) Submission Deadline	June 30, 2010

* Only new contracts submitting directly or new third party submitters submitting in CY2009 must complete the testing and certification process.

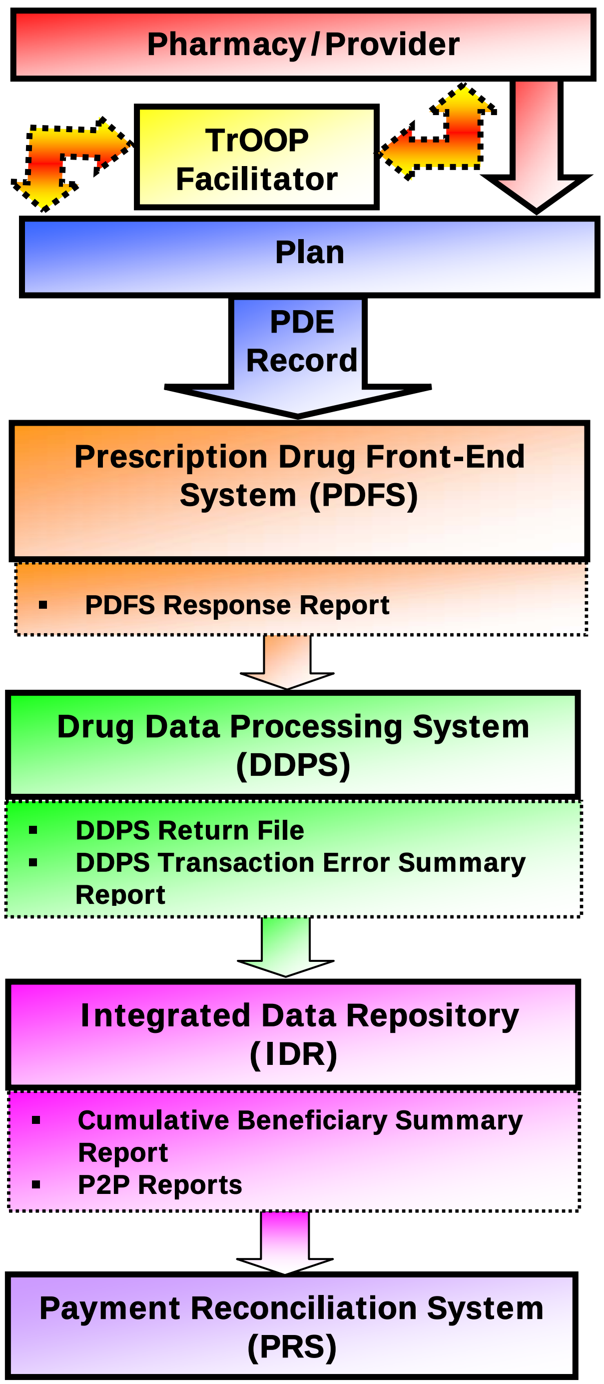
Plans can delay submission until they have finalized the data necessary to populate a PDE, but must submit within the submission deadlines detailed in Table 2B.

2.3.3 Prescription Drug Event Dataflow (Slide 9)

Figure 2A provides an overview of the PDE dataflow.

- The pharmacy, physician, or other provider submits a claim to the Part D Plan.
  - If necessary, the pharmacy generates a secondary claim to any other payers via the TrOOP facilitator.
- The Part D Plan submits data to CMS via the PDE record.
- The Part D Plan successfully submits PDE records at least once a month to PDFS/DDPS.
- The PDE records are sent to PDFS where front-end edits are applied.
- The PDFS response report indicates file acceptance or rejection. If any PDE records fail front-end edits, PDFS reports the failure on the PDFS Response Report.
- After passing the PDFS checks, the file is submitted to DDPS where detail editing is performed.
- The DDPS Return File is returned daily and shows the disposition of all DET records and where errors occurred.
- The DDPS Transaction Error Summary displays the count and rate for each error code found in the submitted data.
- The IDR sums LICS and calculates unadjusted reinsurance and risk corridor costs.
- Management reports are generated in the IDR and provide a summary of net accumulated totals for all dollar fields.
- PRS creates a beneficiary/plan record for each beneficiary enrolled in a plan during the payment year and calculates reconciliation payments at the beneficiary and plan level.

Figure 2A – Prescription Drug Event Dataflow



2.3.4 Important Information About Prescription Drug Event Data

- Part D Plans initially transmit PDE data to PDFS.
- PDFS performs format and face validity checks on the file and batch level as well as sequencing verification on the detail records.
- The PDFS Response Report identifies whether the file is accepted or rejected.
- Once the file has passed front-end checks, it moves to DDPS. All validity edits on detail-level data are performed in this system.
- After the file has processed through DDPS, the plan will receive a daily transaction report identifying any errors.
- CMS expects that plans will directly link any PDE to the individual claim transaction from which the PDE was extracted and duplicate the summarization.
- Plans are responsible for the accuracy of data independent of who submits the data (e.g., third party submitter).
- Plans must keep an accurate report of a beneficiary's TrOOP accumulation.
- Over-the-counter (OTC) and supplemental drugs will be excluded from Part D payment calculations based on PDE records.
- Plans must reconcile financial settlements resulting from Plan-to-Plan (P2P) reconciliation.

2.4 Technical Assistance and Support (Slide 10)

In an effort to ensure that participating plans have the necessary tools and information to be successful with the Prescription Drug Event data process, CMS has planned the following outreach efforts, as described in Table 2C.

TABLE 2C – TECHNICAL ASSISTANCE AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday 9:00 a.m. to 7:00 p.m. ET (with the exception of observed corporate holidays) to provide assistance. The support center provides ongoing assistance. The PDFS system is available for submission of PDE data 24 hours a day, 7 days a week regardless of holidays. The only exception would be from 5:00 p.m. EST to 10:00 p.m. EST on Sunday when the systems and equipment are routinely maintained.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to the PDE Data Processing System. Visitors to the site can access information about DDPS/PDFS, including opportunities to register for service, enroll to submit data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. User Group and other technical assistance information is regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions. To register for email updates, go to www.csscoperations.com and click on Prescription Drug Information Center.
Customer Support for Medicare Modernization (CSMM) **MMA Help**	The MMA Helpdesk provides technical system support to CMS business partners for the implementation and operation of Medicare Parts C and D. This systems information is provided to assist external business partners with connectivity, testing, and data exchange with CMS. Users may contact the MMA Helpdesk by calling 1-800-927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at www.cms.hhs.gov/mmahelp. The MMA Helpdesk is available Monday – Friday 6:00 a.m. to 9:00 p.m. ET.

MODULE 3 – DATA FORMAT

Purpose (Slide 2)

Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary record called the Prescription Drug Event (PDE) record to the Centers for Medicare & Medicaid Services (CMS). This module provides the processes required to collect and submit PDE data to CMS, enabling plans to receive accurate and timely payment.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Explain the processes required for data submission.
- Define standard and non-standard data collection formats.
- Describe the PDE record layout logic.
- Identify the fields and functions in the PDE record format.
- Modify a PDE record.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

3.1 Requirements for Submitting a Prescription Drug Event Record

The Prescription Drug Event (PDE) record contains prescription drug cost and payment data that enable CMS to make payment to plans and otherwise administer the Part D benefit. Specifically, the PDE record includes covered drug costs above and below the Out-of-Pocket (OOP) threshold; distinguishes enhanced alternative costs from the costs of drugs provided under the Basic Benefit; and records payments made by Part D plan sponsors, other payers, beneficiaries, or individuals on behalf of a beneficiary. Plans must also identify costs that contribute toward a beneficiary's True Out-of-Pocket (TrOOP) limit.

Many electronic transactions take place between plans, pharmacies, and intermediaries when an enrollee fills a prescription. This process allows determination of patient cost-sharing at the point of sale (POS) by plan adjudication of the claim, and drives eventual plan payment to the pharmacy. The PDE record contains information that is vital for payment, quality oversight, and program integrity.

Prior to submitting production data, plans must understand the components of the submission enrollment package, connectivity options, testing, and the submission timeline.

3.1.1 Submitter Application Package (Slide 4)

There are three documents in the application package: The Electronic Data Interchange (EDI) Agreement, the Submitter ID Application, and the Authorization Letter. Plans (i.e., contracts) may choose different submission models; plans may submit their own data or they may delegate submission to a third party. There are minor variations in the application documentation required for each model. All parties must complete an EDI Agreement. Everyone must use the Submitter ID Application. Plans that submit for themselves as well as all third party submitters must complete the Submitter ID Application in full. Plans that delegate to third party submitters skip the section in which submitters list the organizations for whom they submit. The Authorization letter applies only to plans that use a third party submitter. Table 3A describes the submission documentation requirements.

TABLE 3A - DATA SUBMISSION DOCUMENTATION REQUIREMENTS

FORM	ENTITY	DESCRIPTION
Electronic Data Interchange (EDI)	• All plans • All third party submitters	• Agreement that specifies the terms under which plans collect and submit PDE data. • Must be signed by an officer of the plan. • Requires an audit trail or maintenance of source documentation related to PDE claims. • Serves as confirmation that data submitted to CMS are accurate and that plans will abide by HIPAA rules. • Required for each contract/plan number submitting data.
Submitter ID Application	• All plans • Third party submitters	• Plans declare report distribution. • Upon processing of the form, submitters are issued a Submitter ID Number.
Authorization Letter	• Plans who delegate to third party submitters	• A letter from the plan authorizing the third party to submit on behalf of the plan.

Use of the submitter and plan identifying information constitutes the organization's legal electronic signature for the data submitted. Plans are responsible for researching and correcting discrepant data. Anyone who submits data (the plan itself or a third party) must complete testing and certification. Every plan must be associated with a certified submitter.

The PDE record summarizes multiple transactions associated with the prescription. The plan must maintain audit trails to PDE source data. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted, and will conduct audits of PDE data to ensure the accuracy of payment.

Plans are responsible for the accuracy of data submitted independent of who submits the data.

3.1.2 Connectivity (Slide 5)

All third party submitters and large plans that submit their own data must establish a connection to the Prescription Drug Front-End System (PDFS) through the Medicare Data Communication Network (MDCN), provided by AT&T Global Network Services (AGNS). The MDCN is the secure network linking the PDE data processing entities. Large plans are defined as contracts with enrollment greater than 100,000. Small plans that submit their own data may submit data to the secure CMS website.

Connectivity refers to the electronic connection used to submit PDE records and receive reports from CMS. Technical specifications are available based on the communication medium that the organization intends to use. Connect:Direct instructions and the PDFS User Guide are available on www.csscoperations.com. The three connectivity options, and the response time associated with each, are described in Table 3B.

TABLE 3B- CONNECTIVITY OPTIONS

Connect:Direct	• Mainframe-to-mainframe connection. • Next day receipt of front-end response. • Formerly known as Network Data Mover (NDM).
File Transfer Protocol (FTP)	• Modem (dial-up) or lease line connection. • Secure FTP. • Same day receipt of front-end response.
CMS Enterprise File Transfer (Gentran)	• Secure FTP. • Next day receipt of front-end response. • Only for plans with less than 100,000 enrollees.

Small plans with less than or equal to 100, 000 members may submit data using the Gentran Mailbox. For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (800) 927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at http://www.cms.hhs.gov/mmahelp.

Note: Datasets must be set up for Connect:Direct users. The Prescription Drug Data specifications should be completed and returned to the Customer Service and Support Center (CSSC) with the Submitter Application and the EDI Agreement. Connect:Direct specifications are available at www.csscoperations.com.

3.1.3 Prescription Drug Event Certification Process (Slides 6-8)

Only new or submitters not previously certified must complete the certification process. Prior to submitting production files to the Drug Data Processing System (DDPS), all submitters must complete testing and certification. CSSC coordinates the certification process; procedures are published at www.csscoperations.com. Certification is not required every year.

Testing and certification includes two levels of editing. The Submitter receives Certification only after successful completion of all requirements.

1. PDFS Phase: Submitters must establish communication with PDFS, transmit successfully, and clear PDFS edits.

2. DDPS Phase: There are two minimal requirements in DDPS. Submitters must achieve an 80 percent acceptance rate in a file of at least 100 records and they must successfully delete at least one saved record.

PDE test data must be submitted from the same automated system that will be used to submit production PDE data. Table 3C illustrates the steps necessary for certification.

TABLE 3C – CERTIFICATION STEPS

STEP	ACTION
1	Complete the EDI Agreement, the Submitter Application, and the Authorization Letter (if applicable) in full. Return to CSSC Operations. A Submitter ID will be assigned to your organization.
2	Submit test and certification files using CMS reserved Contract IDs, Plan Benefit Package (PBP) IDs, and beneficiary IDs. Contact CSSC operations to schedule and coordinate PDE testing and certification.

CSSC will notify submitters when they have met certification requirements. Once certified, submitters may submit production files. **Note:** In order to maintain certification, error rate(s) cannot exceed 20 percent. If any major system changes are made to the system of record after initial certification, the plan must re-test until the 80 percent acceptance rate is met.

3.1.4 Data Submission Timeline (Slide 9)

Only new submitters or new plans are required to test and certify. Plans or a plan's designee must submit PDE records electronically through PDFS to DDPS according to the schedule in Table 3D.

TABLE 3D- TIMELINE FOR 2009 DATA SUBMISSION

DATA TYPE	SUBMISSION TIMELINE
Testing and Certification*	November 15, 2008 – January 31, 2009
Production Submissions	Monthly, March 31, 2009 – May 31, 2010

* Only new plans submitting directly or new third party submitters submitting in CY2009 must complete the testing and certification process.

The plans must submit at least monthly. PDE records, adjustments, or deletions that are received after the end of the fifth month of the subsequent coverage year are not considered in reconciliation. This means that prescription drug claims including adjustments and deletions for all dates of service within calendar year 2009 must be successfully submitted by May 31, 2010 in order to be processed for payment reconciliation. If necessary, CMS may assign submission schedules to high volume submitters in order to balance DDPS workloads.

3.1.5 Plan Monitoring (Slide 10)

Throughout the coverage year, CMS monitors plan data submission levels to detect plans with submission volumes lower than expected. Low submission patterns often indicate technical or system problems. CMS works with plans in an attempt to correct submission problems before the end of the year so they can meet reconciliation submission deadlines. However, it is the responsibility of the plan to submit adequate data for payment.

Late submission or submission of insufficient data to conduct reconciliation may result in payment recovery through a lump-sum recovery; by adjusting or ceasing monthly payments throughout the remainder of a coverage year; or by adjusting monthly payments in a subsequent year.

3.2 Data Collection (Slide 11)

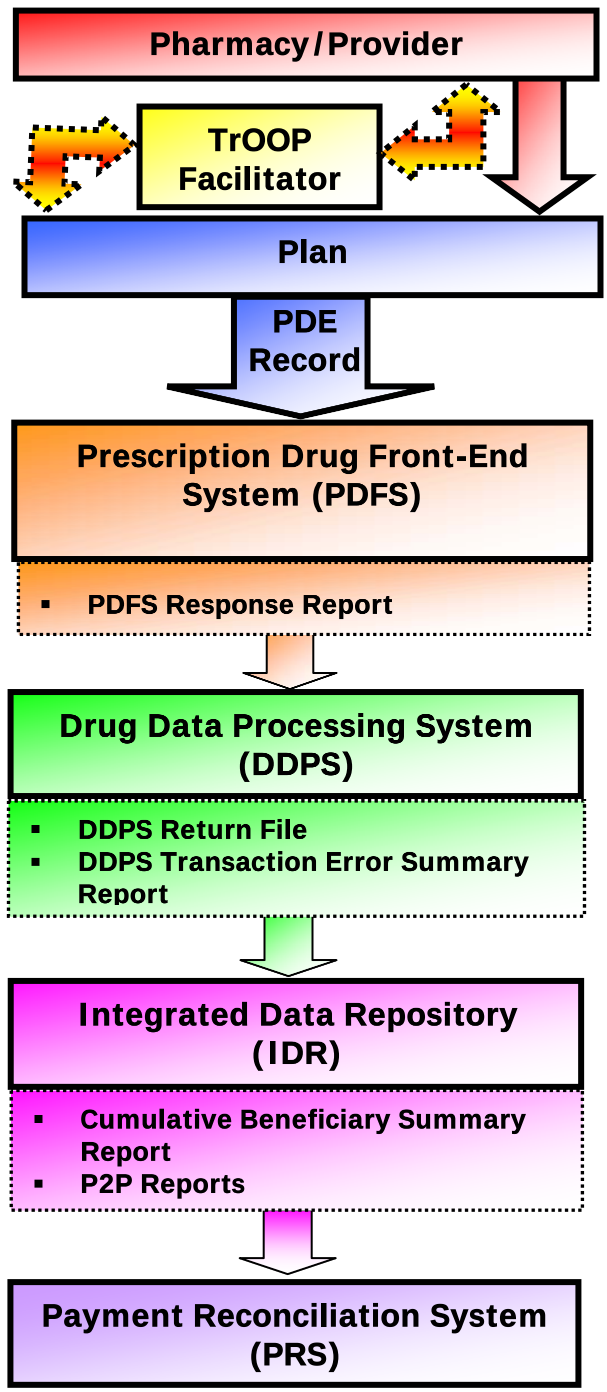
For each dispensing event, the plan must submit a PDE record. Most organizations use a Pharmacy Benefit Manager (PBM) or other third party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates a claim for payment. The PDE is a summary record that documents the final adjudication of a dispensing event.

Plans have an additional reporting requirement to submit Direct and Indirect Remuneration (DIR) data for year-end reconciliation. PDE reporting and DIR reporting are separate information streams.

Figure 3A illustrates the PDE Dataflow.

Figure 3A – Prescription Drug Event Dataflow

- The pharmacy, physician, or other provider submits a claim to the Part D Plan.
    - If necessary, the pharmacy generates a secondary claim to any other payers via the TrOOP facilitator.
- The Part D Plan submits data to CMS via the PDE record.
- The Part D Plan successfully submits PDE records at least once a month to PDFS/DDPS.
- The PDE records are sent to PDFS where front-end edits are applied.
- The PDFS response report indicates file acceptance or rejection. If any PDE records fail front-end edits, PDFS will report the failure on the PDFS Response Report.
- After passing the PDFS checks, the file is submitted to DDPS where detail editing is performed.
- After processing the file, DDPS sends the DDPS Return File. It shows the disposition of all DET records and identifies errors.
- The DDPS Transaction Error Summary displays the count and rate for each error code found in the submitted data.
- The IDR sums LICS and calculates unadjusted reinsurance and risk corridor costs.
- Management reports are generated in the IDR and provide a summary of net accumulated totals for all dollar fields.
- PRS creates a beneficiary/plan record for each beneficiary enrolled in a plan during the payment year and calculates reconciliation payments at the beneficiary and plan level.



3.3 Prescription Drug Event Record Layout Logic (Slides 12-13)

The PDE Record is organized into three levels:

- File level information, which identifies the submitter.
- Batch level information, which identifies the plan.
- Detail level information, which identifies the beneficiary and describes the prescription drug event.

A summary of the PDE record layout is illustrated in Figure 3B. A detailed description of each field, including formatting requirements, is found in Table 3M. The record length of all records (file level, batch level, and detail level) is 512 bytes.

Note: The National Council for Prescription Drug Programs (NCPDP) uses the character coding scheme known as the Extended Binary Coded Decimal Interchange Code (EBCDIC). Because PDEs comply with the NCPDP format, PDEs must be submitted in EBCDIC. If data is compiled in an alternate coding scheme like the American Standard Code for Information Interchange (ASCII), the data must be converted to EBCDIC. Because DDPS uses the EBCDIC coding scheme, the system will not correctly interpret data submitted in the ASCII format. For example, EBCDIC represents signed numeric fields differently from ASCII. The last position of the signed field expresses both the numeric value and its sign. In EBCDIC, an "A" in the last position indicates that the last digit is 1 and field is positive, a "J" in the last position indicates that the last digit is 1 and the field is negative. ASCII, on the other hand, interprets "A" as a character. Programs that convert from ASCII to EBCDIC are available from commercial vendors. The only requirements for these Commercial Off-the-Shelf (COTS) tools are that the input ASCII layout contains all of the necessary data needed to correctly convert the file to the appropriate EBCDIC layout.

Figure 3B – PDE Record File Structure Summary

RT HDR – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BHD.
- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test/Certification Indicator
- Filler

RT BHD – BATCH HEADER (Plan Info)
Must follow RT HDR or RT BTR and must be followed by RT DET.
- Record ID
- Sequence Number
- Contract Number
- PBP ID
- Filler

RT DET – DETAIL RECORD (Drug Event Information)
Must follow RT BHD or RT DET and may be followed by another RT DET or an RT BTR.
- For the detail record, the plan populates 40 fields with data in order to provide DDPS with the information required for identifying each unique PDE and calculating payment.

DETAIL LEVEL

BATCH LEVEL

FILE LEVEL

RT BTR – BATCH TRAILER
Must follow RT DET and may be followed by a RT BHD or RT TLR.
- Record ID
- Sequence Number
- Contract No
- PBP ID
- DET Record Total
- DET Accepted Record Total
- DET Informational Record Total
- DET Rejected Record Total
- Filler

RT TLR – FILE TRAILER
Must follow RT BTR, and must be the last record on the file.
- Record ID
- Submitter ID
- File ID
- TLR BHD Record Total
- TLR DET Record Total
- TLR DET Accepted Record Total
- TLR DET Informational record total
- TLR DET Rejected Record Total
- Filler

3.3.1 File Level Fields

The file level of the PDE record consists of a file header (HDR) and a file trailer (TLR). These are the first and last records in the PDE file. Each record is 512 bytes. The naming conventions HDR and TLR are used to populate the record ID fields at the file level.

The file header contains four fields that are used for processing and tracking submissions. Table 3E provides an overview of those fields.

TABLE 3E – FILE LEVEL INFORMATION

FIELD NAME	CHARACTERISTICS
SUBMITTER ID	• Assigned by CMS (CSSC). • Identifies the entity that is submitting the data. • Must be accurate for appropriate routing of reports and return files.
FILE ID	• Assigned by submitter for file identification purposes. • The same number can only be used once in a 12-month period. • Ten-character alphanumeric field.
TRANS DATE	• The date on which the file is transmitted to PDFS/DDPS. • CCYYMMDD format.
PROD TEST CERT IND	• Indicates if the file is being submitted as a prod, test, or cert file. • Production data are stored separately from test and cert data. - PROD indicates that the file is a production file. - TEST indicates that the file is a test file. - CERT indicates that the file is submitted to earn certification status.

All new submitters must be certified and ready to submit data by January 31, 2009. The first production file must be received by March 31, 2009.

HDR fields 2 and 3, Submitter ID and File ID, are repeated in the TLR fields 2 and 3. The remaining TLR fields confirm input batch, record counts, and document file level processing results.

3.3.2 Batch Level Fields (Slides 14-15)

Like the HDR and TLR, each batch record within the PDE record equals 512 bytes. There can be multiple batches within a file, but each must have a batch header and trailer. The batch header is a BHD record and the trailer is a BTR record; these naming conventions are used to populate the Record ID fields at the batch level.

Batch level information that identifies the plan is reported in two fields: Contract ID and PBP ID. CMS assigns the Contract ID, while the organization proposes PBP IDs when bidding. Each bid must be approved by CMS during the negotiation and contracting process. The Contract ID consists of a letter followed by four numbers. The initial letter will vary by plan type as outlined in Table 3F.

TABLE 3F – CONTRACT NUMBER ENUMERATION BY PLAN TYPE

PLAN TYPE	FIRST LETTER ENUMERATION
Local Medicare Advantage Prescription Drug (MA-PD) Plans	• Begins with an "H" - e.g., H1234
Regional MA-PD Plans	• Begins with an "R"
Prescription Drug Plans (PDP)	• Begins with an "S"
Employer Group Waiver Plans (EGWP)	• Begins with an "E"

The Contract ID is used in conjunction with the PBP ID to describe the organization and the plan for which the data are being submitted. This requires that all DET records included between a set of batch level records (i.e., a BHD and BTR record) are for beneficiaries enrolled in both the contract and the PBP identified at the batch level by the Contract ID and PBP ID fields. Contracts submitting records for multiple PBPs must separate data at the batch level.

Batch level data also provides information necessary for tracking. The Batch Sequence Number is entered by the submitter and identifies the order in which batches were submitted within the file. Instructions for populating this field are outlined in Table 3G.

TABLE 3G – SEQUENCE NUMBER CHARACTERISTICS

FIELD NAME	CHARACTERISTICS
SEQUENCE NO	• Assigned by submitter. • Must begin with 0000001 and incremented by 1.

BHD fields 2 through 4, Sequence No, Contract No, and PBP ID are repeated in the BTR fields 2 through 4. The remaining BTR fields confirm input record counts and document batch level processing results.

3.3.3 Detail Record Fields

The DET record contains 60 fields. Included in these fields are 40 data elements that plans must populate for CMS to reconcile payment and provide program oversight. Plans must sort DET records within each batch by the Health Insurance Claim Number (HICN). This section reviews data elements within the DET record, with emphasis on data used for payment reconciliation.

3.3.3.1 Beneficiary Identifiers (Slide 16)

The following data elements identify the beneficiary:

- HICN
- Cardholder ID
- Patient Date of Birth (DOB)
- Patient Gender

The HICN is the only data element used to identify a beneficiary that is not available in NCPDP standard format. The HICN is a Medicare beneficiary's identification number. Both SSA and the Railroad Retirement Board (RRB) issue Medicare HICNs. The format of a HICN issued by SSA is a Social Security number followed by an alpha or alpha-numeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers preceded with an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 3H illustrates HICN structure.

TABLE 3H – HICN STRUCTURE

HICN TYPE	CHARACTERISTICS
CMS	• 9-digit Social Security number • alpha suffix - "A" beneficiary - "B" spouse - "C" children - "D" divorced spouse, widow, widower • alpha-numeric suffix - indicates type of dependent
RRB pre-1964	• alpha prefix • 6-digit random numbers
RRB post-1964	• alpha prefix • 9-digit Social Security number

The Cardholder ID number is assigned to the beneficiary by the plan. Plans map HICNs to the Cardholder ID so they can link to internal databases.

DOB is an optional field. If reported, DOB must be valid. DDPS routinely uses gender to validate identifying information. When plans submit DOB, DDPS includes the beneficiary's month and year of birth in this validation. DOB match failures alert plans to potential errors in their records.

All data in the DET record must be for beneficiaries enrolled in the contract and PBP indicated at the batch level.

DET records within batches must be sorted by HICN.

3.3.3.2 Prescription Drug Event Identifiers (Slides 17-18)

Thirteen data elements, which are standard throughout the industry, describe both the drug and the method in which the drug was dispensed.

- Date of Service
- Prescription Service Reference Number
- Product Service ID
- Service Provider ID Qualifier
- Service Provider ID
- Fill Number
- Dispensing Status
- Compound Code
- Dispense as Written (DAW) Product Selection Code
- Quantity Dispensed

- Days Supply
- Prescriber ID Qualifier
- Prescriber ID

Product Service ID – Populate this field with the National Drug Code (NDC). NDC is an 11 position identifier. Part D pays for certain diabetic supplies for which no NDC exists. To report Part D covered insulin supplies, use the appropriate Universal Product Number (UPN) or Health Related Item (HRI) code converted to the 11 digit NDC format.

Table 3I describes in detail the data elements used to identify the prescriber who wrote the prescription and the provider who filled the prescription. The qualifier fields associated with these two data elements (i.e., Service Provider ID Qualifier, and Prescriber ID Qualifier) indicate the type of ID being entered into the corresponding fields.

TABLE 3I – SERVICE PROVIDER AND PRESCRIBER IDENTIFIERS

FIELD NAME	DESCRIPTION	NOTES
SERVICE PROVIDER ID	• Identifies the provider (i.e., pharmacy, physician, or home infusion). • May be populated with any of the following: - National Provider Identifier (NPI) - Unique Physician Identification Number (UPIN) - National Council for Prescription Drug Program (NCPDP) number - State License number - Federal tax number - 'Other'	• UPIN, State license number, and 'other' are valid only for PDE records complied from data collected in non-standard format.
PRESCRIBER ID	• Identifies the individual who prescribed the medication. • May be populated with any of the following: - NPI - UPIN - State License Number - Drug Enforcement Agency (DEA) Number	• Plans should report the DEA number whenever available. • Optional for PDE records compiled from data collected in non-standard format.

CMS requires a Prescriber ID for all PDEs and plans must make all reasonable efforts to obtain National Provider Identifiers (NPIs) for the Prescriber ID field. Beginning in May 2008, Plans must submit an attestation that beneficiary access to Part D drugs will not be hindered as the result of a missing Prescriber NPI on a pharmacy claim transaction on or after May 28, 2008. In the event that the prescriber does not have an NPI or the pharmacy cannot obtain a prescriber's NPI, a non-NPI Prescriber ID may be substituted on NCPDP pharmacy claims transactions if allowed by the payer.

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification standards for EDI mandate future use of NPI numbers for health care providers, such as physicians and pharmacists, as well as health care organizations. NPI numbers can be used to populate both the Service Provider ID field and the Prescriber ID field.

Three non-financial data elements are unique to Part D:

- Paid date - the date when payment was made from the plan or pharmacy benefit manager to the pharmacy, not the date the claim was processed and agreed to be paid. It is required only for fallback plans.

- Catastrophic Coverage Code - reports the beneficiary's status in relation to the OOP threshold. The appropriate use of this field is covered in the modules related to calculating and reporting the benefit.

- Drug Coverage Status Code - an essential data element that will impact payment. The code identified in this field will impact how dollar fields are populated. The codes that are applicable to this field are discussed in Table 3J.

TABLE 3J – DRUG COVERAGE STATUS CODE CATEGORIES

FIELD NAME	DESCRIPTION	FIELD VALUES
Drug Coverage Status Code	Indicates the status of a dispensed drug as one of the following: • **Covered** - Part D drug, and - Approved for coverage under a specific PBP • **Enhanced** - Not a Part D drug, and - Approved for coverage under a specific PBP • **Over-the-Counter** - Over the counter drug included in step therapy, and - Approved for coverage under a specific PBP	• C = Covered • E = Enhanced • O = Over-the-Counter

3.3.3.3 Dollar Fields (Slides 19-21)

The PDE Record layout includes 13 fields that must be populated with dollar amounts. These 13 fields can be categorized as detail cost fields, summary cost fields, patient liability payment fields, and plan payment fields. Each of these fields impacts Part D payment. In cost fields, plans must report the dollar amount paid to the pharmacy.

For additional information see the Q&A Addressing Drug Costs Reported on PDEs issued on May 19, 2006.

Specific information on populating these fields, based on the benefit structure, is provided in the Calculating and Reporting modules. Table 3K identifies each of the dollar fields by name and type, and their purpose in the PDE record. The fields shaded gray count toward beneficiaries' TrOOP costs.

TABLE 3K – PURPOSE OF DOLLAR FIELDS

FIELD #	FIELD NAME	FIELD TYPE	PURPOSE
28	Ingredient Cost Paid	Detail Cost	The sum of these four fields equals the Gross Drug Cost.
29	Dispensing Fee Paid	Detail Cost	
30	Amount Attributed to Sales Tax	Detail Cost	
40	Vaccine Administration Fee	Detail Cost	
31	Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB)	Summary Cost/Benefit Phase	Sums the cost per covered drug event, and indicates beneficiary's status in relation to the OOP threshold.
32	Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)	Summary Cost/Benefit Phase	
33	Patient Pay Amount	Payment by/on behalf of patient	Tracks the amount of payments made by the beneficiary (including friends and family), other TrOOP payers, LICS and payments made by other payers. When Medicare as a Secondary Payer (MSP) applies, PLRO sometimes documents the amount paid by the primary payer.
34	Other Troop Amount	Payment by/on behalf of patient	
35	Low Income Cost-Sharing Subsidy (LICS) Amount	Payment by/on behalf of patient	
36	Patient Liability Reduction due to Other Payer Amount (PLRO)	Payment by/on behalf of patient	
37	Covered D Plan Paid Amount (CPP)	Plan Payment	Sums the dollar amount paid by plans, differentiating between covered amounts paid for Part D drugs and non-covered amounts paid for enhanced benefits (non-Part D drugs or supplemental plan cost-sharing) or over-the-counter drugs.
38	Non-Covered Plan Paid Amount (NPP)	Plan Payment	
39	Estimated Rebate at Point of Sale	Detail Cost	The amount of the rebate the plan passed through to the pharmacy.

Note: The field numbers listed correspond to those included in Table 3M, which lists all fields in the PDE record.

3.3.3.4 Additional DET Fields

Table 3L identifies additional DET fields and provides a description of the fields.

TABLE 3L – ADDITIONAL DET FIELDS

FIELD #	FIELD NAME	FIELD TYPE	DESCRIPTION
1	Record ID	Record Type	Identifies record as a detail record
2	Sequence No	Identifier	Identifies the detail record submitted
3	Claim Control Number	Optional	
24	Adjustment Deletion Code	Code	Identifies Adjustment/Deletion
25	Non-Standard Format Code	Code	Identifies type of source date plan used to compile PDE
26	Pricing Exception Code	Code	Identifies PDEs using pricing rules that differ from the plan's negotiated price
41	Prescription Origin Code	Code	Identifies whether prescription provided in a paper or electronic format
43	PBP of Record	Informational	Plans submit with spaces. DDPS will populate as applicable based on editing
44	Alternate Service Provider ID Qualifier	Informational	
45	Alternate Service Provider ID	Informational	
46	Original Submitting Contract	Informational	
47	P2P Contract of Record	Informational	
48	Corrected HICN	Informational	
49-59	Error fields	Error codes/count	
60	Exclusion Reason Code	Subcategory reject code	

3.4 Prescription Drug Event Record Layout

Each field of the PDE Record, including the file, batch, and detail level, is described in Table 3M. The table references the field number and provides the field name, position, submission status, and an explanation of the data element. In addition, the Detail Level Layout includes the NCPDP field names (where applicable) that map to PDE fields.

TABLE 3M – PDE RECORD LAYOUT

PDE RECORD HDR – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory	Record-ID	This field should always be populated with “HDR”.
2	4 – 9	Mandatory	Submitter-ID	Identifies the submitter and should be populated with the six-character alphanumeric SXXXXX assigned by the CSSC.
3	10 – 19	Mandatory	File-ID	Created by submitter using an alphanumeric 10-character ID that identifies the specific file submitted. This file name may not be repeated within a 12-month period.
4	20 – 27	Mandatory	Transaction Date	Specifies the date that the file was submitted to PDFS; formatted as CCYYMMDD.
5	28 – 31	Mandatory	Production/Test/ Certification Indicator	Must be populated with “PROD”, “CERT”, or “TEST”. Submission test data will proceed through the entire process.
6	32 - 512	Mandatory	Filler	Must be populated with 481 spaces. The “Filler” field allows for additional fields in the future.

PDE RECORD BHD – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory	Record-ID	This field should always be populated with “BHD”.
2	4 – 10	Mandatory	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one.
3	11 – 15	Mandatory	Contract Number	Identifies the Plan and should be populated with the five-character alphanumeric H#, R#, S#, E#, or F# assigned by CMS.
4	16 – 18	Mandatory	Plan Benefit Package (PBP) ID	Identifies the specific PBP within a Contract. This field should be populated with a three-character alphanumeric code. All beneficiaries with detail records within this batch must be enrolled in the PBP coded here.
5	19 – 512	Mandatory	Filler	Must be populated with 494 spaces. The “Filler” field allows for additional fields in the future.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory		Record-ID	This field should always be populated with “DET”.
2	4 – 10	Mandatory		Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one.
3	11 – 50	Optional		Claim Control Number	This optional field may be used by the plan to identify the DET record submitted. The field allows up to 40 alphanumeric characters. Left justify and enter spaces, not zeros, in unused spaces.
4	51 – 70	Mandatory		HICN	The Health Insurance Claim Number for the beneficiary. This is a 20-character alphanumeric field.
5	71 – 90	Mandatory	302-C2	Cardholder ID	Plan-assigned beneficiary identification number that maps to the HICN in field 4. This is a 20-position alphanumeric field. Left justify and enter spaces, not zeros, in unused spaces.
6	91 – 98	Optional	304-C4	Patient DOB	This optional field may be populated with the patient’s date of birth and used to verify that the correct beneficiary was submitted. If the field is populated, it must be formatted as CCYYMMDD. If this field is populated, DDPS will edit this field against the information on file at the MBD. If no DOB is submitted, fill with spaces or zeros.
7	99 – 99	Mandatory	305-C5	Patient Gender	This field codes the gender of the beneficiary. It will be used to confirm beneficiary identity. Must be populated with either a “1” or a “2”, no zeros.
8	100 – 107	Mandatory	401-D1	Date of Service	This field identifies the date the prescription was filled and must be submitted in CCYYMMDD format. This field should **not** contain dates associated with plan payment or transaction adjustments.
9	108 – 115	Mandatory for Fallback plans; Optional for all others		Paid Date	This field identifies the date on which the plan originally paid the pharmacy for the prescription drug and must be submitted in CCYYMMDD format. This field will be used to reconcile costs against draw down accounts for Fallback Plans only. Default values for non-Fallback plans are either spaces of zeros.
10	116 – 124	Mandatory	402-D2	Prescription Service Reference NO	A pharmacy-issued 7-character numeric code that identifies a dispensed prescription is used to populate this field. Plans should right justify the number and fill with two leading zeros. Anticipated NCPDP formatting changes will require a 9-character code in the future. In cases where this field is not submitted by the pharmacy the plan must assign a number that is unique for any DOS and Service Provider ID combination.
11	125 – 126	Mandatory		Filler	Must be populated with 2 spaces. The “Filler” field allows for additional fields in the future.
12	127 – 145	Mandatory	407-D7 or 489-TE	Product Service ID	National Drug Code (NDC) 11 format. Identifies the dispensed drug. For compound drugs submit the NDC for the most expensive Part D Covered drug.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
13	146 – 147	Mandatory	202-B2	Service Provider ID Qualifier	Indicates the source of the code used in field 14.
14	148 – 162	Mandatory	201-B1	Service Provider ID	This field identifies the pharmacy or physicians office where the prescription was filled. In standard format PDEs populate the field with the NCPDP number or NPI. In non-standard format PDEs use the UPIN, State License Number, or Federal Tax Identification Number, NCPDP number or NPI.
15	163 – 164	Mandatory	403-D3	Fill Number	Indicates the number of the current fill.
16	165 – 165	Situational	343-HD	Dispensing Status	<blank>=not specified P=Partial fill C=Completion of partial fill
17	166 – 166	Mandatory	406-D6	Compound Code	Indicates if the dispensed drug was compounded or not.
18	167 – 167	Mandatory	408-D8	Dispense as Written (DAW)	This field reports the instructions provided by the Prescriber regarding substitution of generic equivalents.
19	168 – 177	Mandatory	442-E7	Quantity Dispensed	This field lists the number of units (e.g., pills, milliliters) that were dispensed.
20	178 – 180	Mandatory	405-D5	Days Supply	Indicates the number of days of medication provided by the current prescription.
21	181 – 182	Mandatory; Optional for data submitted in Non-standard format.	466-EZ	Prescriber ID Qualifier	Describes the data source of the code used in field 22.
22	183 – 197	Mandatory; Optional for data collected in Non-Standard format; Mandatory for all other data	411-DB	Prescriber ID Number	Populate this field with either the Drug Enforcement Agency (DEA) Number or the NPI, UPIN or State License number that identifies the prescriber in cases where the DEA is not available.
23	198 – 198	Mandatory		Drug Coverage Status Code	Indicates if the dispensed drug is a Part D drug or not.
24	199 – 199	Situational		Adjustment/ Deletion Code	This field is used to identify records for either deletion or adjustment. If neither action is required the field is left blank.
25	200 – 200	Situational		Non-Standard Format Code	This field is coded only when data are collected in non-standard format. Blank indicates standard format.
26	201 – 201	Situational		Pricing Exception Code	Indicates PDEs using pricing rules that differ from the plan's negotiated price.
27	202 – 202	Situational		Catastrophic Coverage Code	This field identifies the beneficiary's status in the benefit. It is populated when the beneficiary either reaches the OOP Threshold (code=A), or is above the OOP Threshold (code=C). This field is left blank for beneficiaries below the OOP Threshold. For any beneficiary with a "C" code in this field, there will usually be one previous record coded "A" to indicate the drug event associated with crossing the OOP threshold.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
28	203 – 210	Mandatory	506-F6	Ingredient Cost Paid	Populate this field with the dollar amount paid to the pharmacy for the drug itself; do not include costs such as dispensing fees or sales tax. When costs are not disaggregated, enter the total cost of the drug in this field.
29	211 – 218	Mandatory	507-F7	Dispensing Fee Paid	Populate this field with the dollar amount paid to the pharmacy for activities related to the transfer of the drug from the pharmacy to the beneficiary. Include charges for mixing drugs, delivery, and overhead. Do not include administrative or other costs in this field.
30	219 – 226	Situational	523-FN	Amount Attributed to sales tax	This field represents the dollar amount of sales tax, if any, associated with the prescription drug event.
31	227 – 234	Mandatory		Gross Drug Costs Below Out-of-Pocket Threshold (GDCB)	Sum fields 28-30 to calculate gross drug costs. This field is populated by an actual dollar amount when the beneficiary is at or **below** the OOP threshold and the drug is a covered Part D Drug. Otherwise enter a zero dollar amount.
32	235 – 242	Mandatory		Gross Drug Costs Above Out-of-Pocket Threshold (GDCA)	Sum fields 28-30 to calculate gross drug costs. This field is populated by an actual dollar amount when the beneficiary is **above** the OOP threshold and the drug is a covered Part D Drug. Otherwise enter a zero dollar amount.
33	243 – 250	Mandatory	505-F5	Patient Pay Amount	Populate this field with the dollar amount paid by the beneficiary.
34	251 – 258	Mandatory		Other TrOOP Amount	This field indicates the dollar amount paid on behalf of the beneficiary by third party TrOOP eligible payers.
35	259 – 266	Mandatory		Low Income Cost-Sharing Subsidy (LICS) Amount	Plans populate this field with the dollar amount attributed to LICS.
36	267 – 274	Mandatory		Patient Liability Reduction Due to Other Payer Amount (PLRO)	This field is populated with the dollar amount paid by entities that reduce patient liability/cost, but do **not** count as TrOOP.
37	275 – 282	Mandatory		Covered D Plan Paid Amount (CPP)	This field reports the net amount the plan paid for a Covered Part D Drug under the Defined Standard benefit. If Drug Coverage Status Code is coded “E” or “O”, then this field must be populated with a zero amount.
38	283 – 290	Mandatory		Non-Covered Plan Paid Amount (NPP)	This field reports the net amount the plan paid for benefits beyond the standard/basic benefit. This dollar amount should include non Part-D drugs, OTC Drugs, EA Drugs and EA cost-sharing.
39	291 – 298	Mandatory		Estimated Rebate at POS	The amount of the rebate the plan passed through to the pharmacy.
40	299 – 306	Mandatory		Vaccination Administration Fee	Amount the plan paid for administering a vaccination.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
41	307	Mandatory for 2010; Optional for 2009	419-DJ	Prescription Origin Code	Indicates the origin of the prescription.
42	308 – 415	Mandatory		FILLER	Must be populated with 108 spaces. The “Filler” field allows for additional fields in the future.
43	416 – 418	Return File		PBP of Record*	This field should be submitted with spaces.
44	419 – 420	Return File		Alternate Service Provider ID Qualifier*	This field should be submitted with spaces.
45	421 – 435	Return File		Alternate Service Provider ID*	This field should be submitted with spaces.
46	436-440	Return File		Original Submitting Contract*	This field should be submitted with spaces.
47	441 – 445	Return File		P2P Contract of Record*	This field should be submitted with spaces.
48	446 – 465	Return File		Corrected HICN*	This field should be submitted with spaces.
49	466 – 467	Return File		Error Count*	This field should be submitted with spaces.
50	468 – 470	Return File		Error 1*	This field should be submitted with spaces.
51	471 – 473	Return File		Error 2*	This field should be submitted with spaces.
52	474 – 476	Return File		Error 3*	This field should be submitted with spaces.
53	477 – 479	Return File		Error 4*	This field should be submitted with spaces.
54	480 – 482	Return File		Error 5*	This field should be submitted with spaces.
55	483 – 485	Return File		Error 6*	This field should be submitted with spaces.
56	486 – 488	Return File		Error 7*	This field should be submitted with spaces.
57	489 – 491	Return File		Error 8*	This field should be submitted with spaces.
58	492 – 494	Return File		Error 9*	This field should be submitted with spaces.
59	495 – 497	Return File		Error 10*	This field should be submitted with spaces.
60	498 – 500	Return File		Exclusion Reason Code	This field should be submitted with spaces.
61	501 – 512	Mandatory		Filler	Must be populated with 12 spaces. The “Filler” field allows for additional fields in the future.

PDE RECORD BTR – BATCH TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory	Record-ID	Batch trailer information should be populated with “BTR”.
2	4 – 10	Mandatory	Sequence NO	7-digit numeric character identifying the batch submitted. Must match the “BHD” record.
3	11 – 15	Mandatory	Contract NO	Contract number assigned by CMS to identify the Plan. Must match the Contract number in the corresponding “BHD” record (i.e., the “BHD” record with the same sequence number).

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD BTR – BATCH TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
4	16 – 18	Mandatory	PBP ID	Three-digit code identifying the PBP in which the beneficiaries in the detail record are enrolled. Must match RT BHD.
5	19 – 25	Mandatory	DET Record Total	This field should total the number of DET records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001).
6	26 – 32	Return File	DET Accepted Record Total*	This field should be submitted with spaces.
7	33 – 39	Return File	DET Informational Record Total*	This field should be submitted with spaces.
8	40 – 46	Return File	DET Rejected Record Total*	This field should be submitted with spaces.
9	47 – 512	Mandatory	FILLER	Must be populated with 466 spaces. The filler field allows for additional fields in the future.

PDE RECORD TLR – FILE TRAILER				
FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
1	1 – 3	Mandatory	Record-ID	This field should always be populated with “TLR”.
2	4 – 9	Mandatory	Submitter-ID	Identifies the submitter and must match the 6-character alphanumeric SH# in the HDR record.
3	10 – 19	Mandatory	File-ID	10-character alphanumeric character identifying the specific file submitted. Must match the File ID in the “HDR” record.
4	20 – 28	Mandatory	TLR BHD Record Total	This field should total the number of batches in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001).
5	29 – 37	Mandatory	TLR DET Record Total	This field should total the number of detail records in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001).
6	38 – 46	Return File	TLR DET Accepted Record Total*	This field should be submitted with spaces.
7	47 – 55	Return File	TLR DET Informational Record Total*	This field should be submitted with spaces.
8	56 – 64	Return File	TLR DET Rejected Record Total*	This field should be submitted with spaces.
9	65 – 512	Mandatory	Filler	Must be populated with 448 spaces. The “Filler” field allows for additional fields in the future.

*These fields will be populated as necessary during data processing.

3.5 Non-Standard Format (Slides 22-23)

It is expected that the majority of data that plans collect from providers will be in standard (i.e., NCPDP) format. However, plans may receive data in other formats. For example, a physician may submit in X12 format or a beneficiary may submit a Pricing Exception claim using a paper form. Independent of the type of source data from which the PDE is compiled, plans must submit PDEs for all events. Specific instructions for submitting data collected in non-standard format follow.

The non-standard format code reports the type of source data from which the PDE was compiled. When PDEs are compiled from standard format, the non-standard format field is left blank. Non-standard format code values of “B”,”X”, “C”, or “P” indicate that the PDE record was derived from a non-standard format. For non-standard formats, DDPS overrides the requirement to populate two DET fields: Prescriber ID Qualifier and Prescriber ID. However, plans should supply this data if it is available. In addition, Claim Control Number, DOB, and Paid Date (for non-Fallback plans), which are optional in standard format, are also optional in non-standard format. Table 3N lists the values for the non-standard format field. Note that these codes are mutually exclusive.

TABLE 3N - NON-STANDARD FORMAT FIELD CODES

DATA SOURCE	CODE
Submitted by beneficiary to plan	B
Submitted by provider in ANSI X12 837 Format	X
Submitted by provider on paper claim	P
Submitted by payer with whom the Part D sponsor must coordinate benefits	C
Standard Format (NCPDP)	<blank>

Only the Prescriber ID, Prescriber ID Qualifier, Claim Control Number, DOB, and Paid Date (for non-Fallback plans) are optional for non-standard format submissions, all other fields in the PDE record must be populated.

Non-standard formats may report default values as specified in the following fields:

- Prescription Service Reference Number
- Service Provider ID
- Fill Number
- Compound Code
- DAW
- Days Supply
- Ingredient Cost Paid
- Dispensing Fee
- Amount Attributed to Sales Tax

For these fields, plans may report default codes when data are unavailable. For example, the prescription service reference number is typically assigned by a pharmacy at the time a prescription is filled. However, if the drug is dispensed in a physician's office, this number may not be included on the claim so the plan will have to assign a number that is unique for the date of service and the service provider. Table 3O provides the field name and the default code or instructions directing plans to populate these fields when source data are not available.

TABLE 3O – INSTRUCTIONS FOR POPULATING THE PDE RECORD WITH DATA COLLECTED IN NON-STANDARD FORMAT

FIELD NUMBER	FIELD NAME	INSTRUCTIONS
10	Prescription Service Reference Number	Assign a number that will be unique for the date of service and the service provided.
14	Service Provider ID	Utilize the UPIN, State License Number, Tax ID# or the TrOOP Facilitator Default value of "PAPERCLAIM" if a NCPDP ID is not available.
15	Fill Number	Populate with: '00'
17	Compound Code	Populate with: '0=not a compound'
18	DAW	Populate with: '0=no product selection indicated'
20	Days Supply	Populate with: '000'
28-30	Ingredient Cost Paid; Dispensing Fee; and Amount Attributed to Sales Tax	In cases where these three fields are not disaggregated, plans should report the total cost in the "Ingredient Cost Paid" field, and report zero dollar amounts for the other two fields.

Note: The field numbers listed correspond to those included in Table 3M, which lists all fields in the PDE record.

Plans are under the same obligation to maintain an audit trail and submit accurate data independent of the data source.

3.6 Modifying Prescription Drug Event Records (Slides 25-27)

To change a PDE after DDPS saves it, plans will submit an adjustment or deletion PDE. Some systems use "void and replace" methodology instead of adjustment logic. These systems do not send adjustment PDEs. They change data by voiding the record in error and replacing it with a new record. DDPS accepts either adjustments or "void and replace" changes. We use the term adjustment to describe both methods to change data. Examples of when an adjustment or deletion might be required include:

- Deletion: A beneficiary does not to pick up a prescription, and the plan is not notified until after the PDE record has been submitted.
- Adjustment: The pharmacy receives an Other Health Insurance (OHI) payment after the PDE has been submitted.
- Adjustment: A beneficiary is declared eligible for low-income assistance and the benefits are retroactive across several PDEs that have been submitted.
- Adjustment: The original payment to the pharmacy is changed after DDPS accepted the PDE.

When the Adjustment/Deletion Code is populated, DDPS recognizes that a record is being either adjusted or deleted. In order for one of these actions to take place, the record submitted with the adjustment/deletion field populated must match the record in the database to be adjusted or deleted in the following nine fields.

- HICN
- Service Provider ID
- Service Provider ID Qualifier
- Prescription Service Reference Number
- DOS
- Fill Number
- Dispensing Status
- Contract Number
- PBP ID

The first seven fields are located in the DET record. These are referred to as “key fields” because they allow DDPS to identify a unique drug event.

The last two fields, located in the BHD, identify the contract number of the plan that originally submitted the PDE Record and the Plan Benefit Package to which the beneficiary belongs. DDPS includes contract and PBP in adjustment match logic to reserve adjustment and deletion authority to the plan that originally submitted the data.

Table 3P provides an overview of the impact of each code.

TABLE 3P – IMPACT OF THE ADJUSTMENT/DELETION CODE ON PDE RECORDS

CODE	CODE DEFINITION	IMPACT
A	Adjustment	If a current (active) record, matching the nine fields is found in the DDPS database the system will inactivate the old record and save the adjusted record.
D	Deletion	If a current (active) record, matching the nine fields, is found in the DDPS database, the system will inactivate the old record without saving the new record.
<blank>	Original PDE	Indicates original PDE

If a current (active) record that satisfies the matching logic is not found, DDPS rejects the record and returns an error message.

There are several things to keep in mind when undertaking this process:

- Internally, DDPS uses the file submission date to identify a PDE, therefore only one original record, adjustment, or deletion for an event can be submitted per day.

- Inactive records (i.e., adjusted or deleted records) are excluded from any payment calculations.

- Inactive records cannot be adjusted. If a plan wants to adjust a record that has previously been deleted, a new record must be submitted. A record that has previously been adjusted but not deleted retains an active record status (the most recent adjustment) and can be adjusted again.

Plans can minimize adjustment/deletion volume by waiting to submit PDEs until data have been finalized, **however** plans must submit data according to the timeline specified by CMS.

MODULE 4 – CALCULATING AND REPORTING THE BASIC BENEFIT

Purpose (Slide 2)

All Part D plans are required to provide a minimum set of prescription drug benefits, typically referred to as the basic benefit. Prescription Drug Event (PDE) data reports how a plan has administered this benefit and provides information to the Centers for Medicare & Medicaid Services (CMS) that is essential to making payment under the four legislated mechanisms. This module defines the basic benefit and the three types of basic plans then illustrates how plans will populate a PDE record for each type.

Learning Objectives (Slides 3-4)

At the completion of this module, participants will be able to:

- Explain the characteristics of the “Basic Benefit” and the three types of Basic benefit plans.
- Illustrate how the Defined Standard benefit is the foundation of all other Basic benefit plans.
- Define covered and non-covered drugs.
- Apply business rules associated with calculating PDE data elements that reflect the administration of the benefit design.
- Describe how plans populate a PDE record with data essential for payment.
- Demonstrate how to modify PDE data and apply Adjustment/Deletion logic.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

4.1 The Basic Benefit (Slide 5)

The Medicare Prescription Drug Benefit, Improvement, and Modernization Act of 2003 (MMA) amended the Social Security Act (the Act) by adding Part D to Title 18. Part D requires all plans to provide a minimum set of prescription drug benefits, typically referred to as the Basic benefit or basic prescription drug coverage.

42 CFR 423.100

The statute designates a specific basic benefit structure called the Defined Standard (DS) and allows two alternate structures that have met certain tests of actuarial equivalence to the DS, the Actuarially Equivalent (AE) plan and the Basic Alternative (BA) plan.

Section 1860D-2 of the Social Security Act; 42 CFR 423.104

- **Actuarial equivalence:** A state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with the MMA and CMS guidelines. Refers to a determination that the overall value of drug coverage for a set of beneficiaries under one plan can be shown to be equal to the overall value for those same beneficiaries under another plan.

Regardless of the plan type, the Basic benefit only pays for drugs that meet the statutory definition of a Part D drug and are covered under a Part D plan's benefit package (see Module 1). These drugs are referred to as covered drugs or covered Part D drugs. CMS classifies drugs for payment using the following terminology:

Part D drug – A Part D Drug includes the following: **(Slide 6)**

- Any prescription drug described in §1927(k)(2)(A) of the Act.
- A vaccine licensed under section 351 of the Public Health Service Act.
- A biological product described in §1927(k)(2)(B) of the Act.
- Insulin described in §1927(k)(2)(C) and medical supplies associated with the injection of insulin as allowed under §1860D-2(e)(1)(B).
- Except for smoking cessation drugs, Part D drugs must be prescribed for the purposes allowed under §1862(a) and §1927(d)(2) (e.g., reasonable and necessary guidelines, exclusion of drug classes used for weight loss or cosmetic surgery).
- Drugs cannot be billed as Part D drugs if they are already covered under Medicare Parts A or B as prescribed, dispensed, or administered (§1860D-2(e)(2)(B)).

- **Covered drug –** a Part D drug that is approved for coverage under a specific Plan Benefit Package (PBP); these include Part D drugs that are approved under exceptions, transitions, grievances, appeals, and other coverage determination processes. Note that supplies used for the injection of insulin are considered covered drugs in accordance with statute.

- **Non-covered drug –** any prescription or over-the-counter (OTC) drug that is not a Part D drug (referred to as a non-Part D drug) or that is already covered under Medicare Part A or Part B as prescribed, dispensed, or administered. Plans must apply multiple rules to determine if a drug should be covered under Parts A or B as prescribed, dispensed, or administered instead of under Part D. For example, the Part that the drug is covered under can depend on the method of administration, patient diagnosis, place of service, or Part A/B carrier/intermediary.

4.1.1 The Defined Standard Benefit (Slides 7-9)

The DS benefit is the foundation for all other plan types. The MMA mandates specific cost-sharing and benefit parameters for the DS benefit. The MMA also mandates that the values associated with the DS benefit be indexed annually to account for inflation and average annual per capita Part D expenditure. Tables 4A, 4B, and 4C illustrate the phases, parameters, cost-sharing, and plan liability in a DS benefit plan for 2006, 2008, and 2009. All examples within the Participant Guide reflect 2006 parameters (Table 4A).

TABLE 4A – THE DEFINED STANDARD BENEFIT, 2006

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Cost	**YTD TrOOP Costs**		
Deductible	≤ $250	N/A	100% coinsurance (=$250)	0%
Initial Coverage Period	> $250 and ≤ $2,250	N/A	25% coinsurance (=$500)	75% (= $1,500)
Coverage Gap	>$2,250 and ≤ $5,100	≤ $3,600	100% coinsurance (= $2,850)	0%
Catastrophic Coverage Phase	> $5,100	> $3,600 (OOP threshold)	Greater of 5% coinsurance or $2/$5 (generic/ brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2/$5)

TABLE 4B - THE DEFINED STANDARD BENEFIT, 2008

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	**YTD TrOOP Costs**		
Deductible	≤ $275	N/A	100% coinsurance (= $275)	0%
Initial Coverage Period	> $275 and ≤ $2,510	N/A	25% coinsurance (= $558.75)	75% (= $1,676.25)
Coverage Gap	>$2,510 ≤$5,726.25	≤ $4,050	100% coinsurance (= $3,216.25)	0%
Catastrophic Coverage Phase	> $5,726.25	> $4,050 (OOP threshold)	Greater 5% coinsurance or $2.25/$5.60 (generic/brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)

TABLE 4C - THE DEFINED STANDARD BENEFIT, 2009

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	**YTD TrOOP Costs**		
Deductible	≤ $295	N/A	100% coinsurance (= $295)	0%
Initial Coverage Period	> $295 and ≤ $2,700	N/A	25% coinsurance (= $601.25)	75% (= $1,803.75)
Coverage Gap	>$2,700 ≤$6,153.75	≤ $4,350	100% coinsurance (= $3,453.75)	0%
Catastrophic Coverage Phase	> $6,153.75	> $4,350 (OOP threshold)	Greater 5% coinsurance or $2.40/$6.00 (generic/brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)

Notes for Tables 4A, 4B, and 4C:

- Year-to-Date (YTD) gross covered drug cost advances the beneficiary through the Deductible, Initial Coverage period and into the Coverage Gap, regardless of the source of payment. Beneficiaries do not need to achieve a minimum True Out-of-Pocket (TrOOP) cost to transition among these phases; however, any beneficiary paid amounts in these phases will count as TrOOP.
- TrOOP advances the beneficiary from the Coverage Gap into Catastrophic Coverage. Entrance into the Catastrophic Coverage phase is dependent on the YTD TrOOP value ($3,600 in 2006) instead of YTD gross covered drug cost.
- The YTD gross covered drug cost associated with the Out-of-Pocket (OOP) threshold assumes no non-TrOOP other health insurance (OHI).
- Plan liability in the Catastrophic Coverage phase is 80 percent reinsurance subsidy and approximately 15 percent shared risk between the government and the plan.

4.1.2 Actuarially Equivalent and Basic Alternative Plans (Slide 10)

The statute allows two options for Basic plans other than the DS: AE and BA plans. These optional plan types share many characteristics with the DS benefit, for example movement among benefit phases is accomplished in the same way. YTD gross covered drug cost determines the beneficiary's placement in pre-catastrophic coverage, and entry into Catastrophic Coverage is determined by YTD TrOOP costs of $3,600 (2006). Most fundamentally, all three plans provide basic prescription drug coverage. In accordance with statute, AE and BA plans differ from the DS benefit and from each other by the structure of their cost-sharing. Table 4D compares the cost-sharing characteristics of the three types of Basic Benefit plans.

TABLE 4D – BASIC BENEFIT PLANS

BENEFIT PLAN	CHARACTERISTIC
Defined Standard (DS)	• Statutorily mandated cost-sharing and benefit parameters that the plan sponsor cannot change (see Tables 4A-C).
Actuarially Equivalent (AE)	• Must use the same deductible and initial coverage limit that apply in the DS benefit. • Can change cost-sharing in the Initial Coverage period and/or Catastrophic Coverage phase from the DS amounts, including use of tiers. • The actuarial value remains equivalent to a DS benefit plan such that no supplemental premium is required.
Basic Alternative (BA)	• Can reduce the deductible, lower or raise the initial coverage limit and change cost-sharing in any phase from the DS provisions, including use of tiers. • The actuarial value remains equivalent to a DS benefit plan such that no supplemental premium is required.

The particular characteristics of any given AE or BA plan will depend on the ability of the benefit design to meet multiple tests of actuarial equivalence to the DS benefit. The plan can choose among the above options as long it can pass the tests.

On average, the relationship between YTD gross covered drug costs and the OOP threshold will be the same under a DS plan as in AE and BA plans. However, because of the different cost-sharing in the AE and BA plans, the YTD gross covered drug cost coinciding with the OOP threshold will be higher or lower than $5,100 (in 2006) for some enrollees in these plans. For example, a beneficiary in an AE or BA plan who consistently purchases drugs with low cost-sharing will reach the OOP threshold at a higher YTD gross covered drug cost.

4.1.2.1 Basic Benefit Plans Tiered Cost-Sharing (Slides 11-12)

Tiering is a common alternate way to implement cost-sharing. The DS benefit has strictly delineated cost-sharing. AE and BA plans may vary the way they implement cost-sharing, including tiering. Tiering is allowable provided that the cost-sharing passes certain actuarial tests for being equivalent to the DS benefit.

When a plan implements tiered cost-sharing, the plan categorizes all drugs on its formulary into tiers and then assigns a flat co-pay amount or coinsurance percentage to each tier. Table 4E is an example of a tiered benefit that employs co-pays and coinsurance. The amounts are only for purposes of illustration and are not necessarily representative of an approved benefit.

TABLE 4E– EXAMPLE OF TIERED COST-SHARING

Tier	Cost-sharing (Co-Pay)	Description/Drug Class
1	$5.00	Generic Drugs
2	$20.00	Preferred Brand Drugs
3	$40.00	All Other Brand Name Drugs
4	25%	Specialty Drugs

4.2 Basic Benefit Data Elements (Slide 13)

While there are 40 fields for plans to populate in the Prescription Drug Event (PDE) record, there are seven that a plan must carefully consider when administering the Part D drug benefit. These seven data elements apply to the Basic benefit plan as well as all other benefit plan types:

1. Drug Coverage Status Code
2. Catastrophic Coverage Code
3. Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
4. Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)
5. Patient Pay Amount
6. Covered D Plan Paid Amount (CPP)
7. Non-covered Plan Paid Amount (NPP)

4.2.1 Coding Fields

The PDE record uses coding fields to record information such as patient gender and whether or not a drug has been compounded. Two fields report codes that are essential to administering the Basic benefit: Drug Coverage Status Code and Catastrophic Coverage Code. Additional coding fields include Dispense as Written Production Selection Code, Adjustment/Deletion Code, Non-Standard Format Code, and Pricing Exception Code. Plans should populate the coding fields with the appropriate values as defined on the PDE Record Layout.

4.2.1.1 Drug Coverage Status Code (Slide 14)

The Drug Coverage Status Code indicates whether a drug is covered and eligible for payment under the Basic benefit. Plans populate the Drug Coverage Status Code with a “C” representing a covered Part D drug, or an “O” representing an OTC drug.

(C) Covered Part D drug – a drug that meets the definition of a Part D drug and is also covered under a PBP because it is on the plan’s formulary; this also includes Part D drugs approved under exceptions, transitions, grievances, appeals, or other coverage determination processes.

Only PDE records with “C” in the Drug Coverage Status Code field are included under the reinsurance subsidy, risk corridor calculations, low income cost-sharing subsidy (LICS), and TrOOP costs.

(O) Over-the-counter drug – OTC drug, covered by a plan in keeping with approved formulary step therapy.

OTC drugs are the only non-Part D drugs allowable in DS, AE, or BA plans. Plans must submit PDE records to the Drug Data Processing System (DDPS) for OTC drugs, but the drugs are paid for under plan administrative costs as reported in the bid, and are excluded from other Part D payment calculations based on PDE records. Plans may not charge the beneficiary any part of an OTC drug's cost. The OTC Drug Coverage Status Code is "O".

Note: When the plan reports an OTC drug, DDPS validates that the National Drug Code (NDC) is categorized as an OTC drug on the DDPS reference table.

4.2.1.2 Catastrophic Coverage Code (Slide 15)

The Catastrophic Coverage Code field indicates whether a beneficiary has reached the OOP threshold. It is vital for plans to identify this point in the benefit on the PDE because thereafter, catastrophic coverage provisions apply including reinsurance payment for the plan and reduced cost-sharing for the beneficiary.

In 2006, a beneficiary enters the Catastrophic Coverage phase once the beneficiary has accumulated $3,600 in TrOOP costs. Because the DS benefit strictly defines cost-sharing, a beneficiary accumulates $3,600 in TrOOP costs at the same time that the beneficiary reaches $5,100 in gross covered drug costs, assuming there is no non-TrOOP OHI. These two points will not always coincide in other benefit structures because of the different cost-sharing provisions.

Any PDE documenting catastrophic benefits will report Catastrophic Coverage Code = "C". The event during which the OOP threshold is reached or crossed will report Catastrophic Coverage Code = "A". Prior to reaching the threshold, the Catastrophic Coverage Code field is left blank.

Table 4F provides a description for the Catastrophic Coverage Codes.

TABLE 4F – DESCRIPTION OF CATASTROPHIC COVERAGE CODES

CODE	DESCRIPTION OF CODE
<blank>	The OOP threshold has not yet been reached (i.e., the event falls within the Deductible, the Initial Coverage period, or the Coverage Gap phase).
A	The OOP threshold was reached during this event.
C	The event falls within the Catastrophic Coverage phase-- the OOP threshold was reached during an earlier event.

As indicated in Table 4F, on the PDE record where a beneficiary reaches the OOP threshold, moving from the Coverage Gap into Catastrophic Coverage, the plan reports "A" in the Catastrophic Coverage Code field. This typically occurs only once in a coverage year.

Once a beneficiary has entered the Catastrophic Coverage phase, subsequent PDEs during the coverage year are populated with "C" in the Catastrophic Coverage Code field. An exception to this occurs when a beneficiary who previously entered catastrophic coverage has a PDE adjustment or deletion that reduces TrOOP costs below the OOP threshold, moving the beneficiary back into a pre-catastrophic phase of the benefit. This scenario is discussed further in Module 5, Calculating and Reporting TrOOP.

4.2.2 Financial Fields

Eleven financial fields on the PDE report either drug costs or payments. For a given PDE, DDPS edits typically ensure that the sum of the cost fields equals the sum of the payment fields. Several of the payment fields document payment by other sources of coverage or LICS payment on a beneficiary's behalf; this module does not address these fields but rather begins with the eight PDE fields that apply to the simplest case where the beneficiary is in a Basic plan and has no other source of payment.

4.2.2.1 Gross Drug Cost (Slide 16)

Plans must follow regulatory and sub-regulatory guidance issued by CMS when determining the total cost of the drug to report on the PDE record. For a covered drug, this cost is referred to as "gross covered drug cost" (see Module 1). The term "gross drug cost" refers to the total cost of a covered or non-covered drug on the PDE. On the PDE record, there are detail cost fields and summary cost fields that report the gross drug cost. These fields distinguish the cost of the drug itself from any dispensing fee or applicable sales tax and they identify drug costs that are eligible for reinsurance payment.

4.2.2.1.1 Detail Cost Fields

There are three detail cost fields: Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax. For all events, the gross drug cost is a sum total of these three detail fields in the PDE record.

Gross Drug Cost = Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax.

If the PDE includes a Vaccine Administration Fee, this field will be included in the sum of gross drug cost.

4.2.2.1.2 Summary Cost Fields

For covered drugs, the gross drug cost is also represented in two summary cost fields: Gross Covered Drug Cost Below the OOP Threshold (GDCB) and Gross Covered Drug Cost Above the OOP Threshold (GDCA). These two fields distinguish costs for covered drugs that fall above or below the OOP threshold, so that covered drug costs above the OOP threshold are identified for payment under the reinsurance subsidy

For non-covered drugs, both GDCA and GDCB must be populated with a zero dollar amount ($0.00). GDCA and GDCB only track the cost of covered drugs to note their location and indicate the beneficiary's status with respect to the OOP threshold.

4.2.2.1.2.1 Gross Drug Cost Below OOP Threshold (GDCB)

The GDCB field represents the gross covered drug cost that is below or at the OOP threshold. For covered drugs, the GDCB field always has a positive dollar amount if the OOP threshold is not yet reached (Catastrophic Coverage Code=blank) or if the threshold is reached during this event

(Catastrophic Coverage Code=A). Once the beneficiary exceeds the OOP threshold (Catastrophic Coverage Code=C) plans must populate the GDCB field with a zero dollar value.

4.2.2.1.2.2 Gross Drug Cost Above OOP Threshold (GDCA)

The GDCA field represents the gross covered drug cost that is above or exceeds the OOP threshold. For covered drugs, this field is always populated with a positive dollar amount after the OOP threshold is crossed (Catastrophic Coverage Code=C). If the threshold is reached during this event, GDCA will usually have a positive value. If the beneficiary has not reached the OOP threshold (Catastrophic Coverage Code=blank), the GDCA field will have a zero dollar value entered.

Table 4G illustrates the summary cost fields and their relationship to the Catastrophic Coverage code.

TABLE 4G – SUMMARY DRUG COST AND CATASTROPHIC COVERAGE FIELDS

CATASTROPHIC COVERAGE CODE	GDCB	GDCA
<blank>	> $0.00	= $0.00
A	> $0.00	≥ $0.00
C	= $0.00	> $0.00

Note: Typically, a beneficiary reaches the OOP threshold only once in any given coverage year. Since any given dollar amount for a PDE will rarely bring TrOOP costs to exactly $3,600 (2006 value), the event in which the OOP threshold is reached will typically straddle the phases of the benefit on either side of the OOP threshold (the Coverage Gap and the Catastrophic Coverage phase). Therefore, for this event, GDCB will **always** have a positive dollar amount and GDCA will **typically** have a positive dollar amount. It is possible, but not likely, that GDCA will equal $0.00 for the event where the OOP threshold is reached.

When the PDE reports that the OOP threshold has not been reached, DDPS validates that the plan assigned the gross drug cost to the GDCB field. When the PDE reports that the OOP threshold was reached on this event, DDPS validates that the plan assigned a portion of the gross drug cost to the GDCB field. When the PDE reports that the OOP threshold was reached in previous events, DDPS validates that the plan assigned the gross drug cost to the GDCA field.

On every PDE for a covered drug, DDPS totals and compares the dollars in the detail cost fields (Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax) and the dollars in the summary cost fields (GDCB and GDCA). DDPS rejects PDEs for covered drugs when the total detail and total summary costs differ.

4.2.2.2 Payment Fields

4.2.2.2.1 Patient Pay Amount (Slide 17)

The Patient Pay Amount field registers the dollar amount that the beneficiary paid directly. It excludes amounts paid by other parties on behalf of the beneficiary. For covered drugs, this amount contributes to a beneficiary's TrOOP costs.

Plans are responsible for ensuring that beneficiaries are charged amounts consistent with the benefit packages approved in the bidding process.

4.2.2.2.2 Covered D Plan Paid Amount (CPP) (Slide 18)

The Covered D Plan Paid Amount (CPP) field contains the amount the plan paid for a covered Part D drug under the Basic benefit.

DDPS sums dollars reported in CPP. The plan-level sum of CPP equals the plan's unadjusted allowable risk corridor costs.

4.2.2.2.3 Non-Covered Plan Paid Amount (NPP) (Slide 19)

The Non-Covered Plan Paid Amount (NPP) field is designed to report plan-paid amounts that are attributed to benefits beyond the Basic benefit, called supplemental or enhanced benefits (see Module 8). Any amount recorded in NPP is excluded from reinsurance and risk corridor payment and from TrOOP accumulation. Basic benefit plans always populate NPP with $0.00 except for OTC drugs covered under step therapy on an approved formulary. OTC drug costs are reported in full in NPP because they are paid under a plan's administrative costs for the Basic benefit, not under the direct subsidy, reinsurance, or risk sharing. OTC drug costs are primarily reported on the PDE record for purposes of monitoring cost and utilization.

When the PDE reports an OTC drug, DDPS validates that the plan assigned all plan paid costs to the NPP field. DDPS also validates that beneficiary liability is zero. The Patient Pay Amount field is one of four fields that reports beneficiary liability.

Plans must report OTC drug cost in the Ingredient Cost Paid field and, if applicable, in the Dispensing Fee Paid and Total Amount Attributed to Sales Tax fields. If there is no dispensing fee or sales tax, plans will report the gross OTC cost in the Ingredient Cost Paid field.

4.3 Prescription Drug Event Examples – Basic Benefit

DS, AE, and BA plans accumulate year-to-date (YTD) Gross Covered Drug Cost, which determines if the beneficiary is in the Deductible phase, Initial Coverage period, or the Coverage Gap phase of the benefit (see Module 1). Throughout the benefit, the plan tracks accumulated TrOOP costs which determine when the beneficiary enters the Catastrophic Coverage phase.

The following sections demonstrate rules for populating the appropriate fields based on the beneficiary's benefit phase. In particular, amounts reported in CPP and Patient Pay Amount will vary based on the beneficiary's position in the benefit.

4.3.1 Defined Standard Plan – Simplest Case (Slide 21)

Understanding the benefit for a beneficiary with the simplest case of coverage establishes the foundation for understanding how to populate PDE records under more complex benefits. The simplest case of coverage is a beneficiary with the following characteristics:

- No Low Income Cost-Sharing Subsidy
  - The beneficiary has income above 150 percent of the federal poverty level and has met certain asset tests.
- No OHI or source of coverage
- Enrolled in a Part D plan with a DS benefit design

The following examples illustrate how to populate a PDE in each benefit phase of a DS plan, simplest case.

4.3.1.1 Defined Standard Plan - Deductible Phase (Slide 22)

The beneficiary is in the Deductible phase of the benefit (YTD Gross Covered Drug Cost ≤ $250) in 2006. The beneficiary purchases a $100 covered drug.

Table 4H illustrates how the plan populates the following six data elements for this sample PDE in the Deductible phase.

TABLE 4H – 2006 DS DEDUCTIBLE PHASE

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	<blank>	$100.00	$0.00	$100.00	$0.00

Patient Pay Amount + CPP = GDCB

The Drug Coverage Status Code is "C" for a covered drug. The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. The GDCB is therefore $100 and GDCA is $0.00. In the Deductible phase, the beneficiary pays 100 percent coinsurance and the plan pays nothing, so $100 is reported in Patient Pay Amount and CPP is $0.

4.3.1.2 Defined Standard Plan - Initial Coverage Period

The beneficiary is in the Initial Coverage period (YTD Gross Covered Drug Cost > $250 and ≤ $2,250) in 2006. The YTD Gross Covered Drug Cost is $300. The beneficiary purchases a $100 covered drug.

Table 4I illustrates how the plan populates the following six data elements for this sample PDE in the Initial Coverage period.

TABLE 4I – 2006 DS INITIAL COVERAGE PERIOD

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	<blank>	$100.00	$0.00	$25.00	$75.00

The Drug Coverage Status Code is "C" for a covered drug. The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. The GDCB is therefore $100 and GDCA is $0.00. In the Initial Coverage period, the beneficiary pays 25 percent coinsurance ($25) which is reported in Patient Pay Amount. The plan pays 75 percent ($75) which is reported in CPP.

4.3.1.3 Defined Standard Plan - Coverage Gap Phase

The beneficiary is in the Coverage Gap phase (YTD Gross Covered Drug Cost > $2,250 and TrOOP costs ≤ the OOP threshold). The beneficiary purchases a $100 covered drug.

Table 4J illustrates how the plan populates the following six data elements for this sample PDE in the Coverage Gap phase.

TABLE 4J – 2006 DS COVERAGE GAP PHASE

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	<blank>	$100.00	$0.00	$100.00	$0.00

The Drug Coverage Status Code is "C" for a covered drug. The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. The GDCB is therefore $100 and GDCA is $0.00. In the Coverage Gap, the beneficiary pays 100 percent coinsurance ($100) which is reported in Patient Pay Amount, and the plan pays nothing so CPP is $0.

4.3.1.4 Defined Standard Plan - Catastrophic Coverage Phase (Slide 23)

The beneficiary has accumulated more than $3,600 in TrOOP in 2006, and is in the Catastrophic Coverage phase. The beneficiary purchases a $75 brand name covered drug. Table 4K illustrates how the plan populates the following six data elements for this sample PDE in the Catastrophic Coverage phase.

TABLE 4K – 2006 DS CATASTROPHIC COVERAGE PHASE

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	C	$0.00	$75.00	$5.00	$70.00

The Drug Coverage Status Code is “C” for a covered drug. Because the total cost is above the OOP threshold, the plan reports “C” in the Catastrophic Coverage Code and the gross drug cost is reported in GDCA. The beneficiary pays catastrophic cost-sharing, which is the greater of 5 percent coinsurance or $2/$5 co-payment. Patient Pay Amount = $5. At the point-of-sale, the plan pays the remainder of the cost ($70) which is reported in the CPP field. However, in reconciliation 80 percent of the gross drug cost ($75*0.80) or $60 will be subject to reinsurance payment. The government and the plan will share risk for the residual cost ($75-$60-$5) or $10.

4.3.1.5 Defined Standard Plan - Over-the-Counter (OTC) Drug (Slides 24-25)

The beneficiary is in the Initial Coverage period of the benefit in 2006. The beneficiary has YTD gross covered drug costs of $300. The beneficiary purchases a formulary OTC as part of step therapy and the negotiated price is $15.

Table 4L illustrates how the plan populates the following seven data elements for this sample OTC drug PDE.

TABLE 4L – 2006 DS - OVER-THE-COUNTER DRUG

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP	NPP
O	<blank>	$0.00	$0.00	$0.00	$0.00	$15.00

Plans must submit PDE records for formulary OTC drugs. The Drug Coverage Status Code is “O” indicating an OTC drug. The costs of OTC drugs are included in a plan’s administrative costs for the Basic benefit and are excluded from other Part D payment calculations that derive from PDE records. The GDCB and GDCA fields report $0.00 since this drug is a non-covered drug and is excluded from payment. The gross drug cost of $15 is reported in Non-covered Plan Paid Amount (NPP). The Patient Pay Amount is $0 because plans cannot charge beneficiaries for OTC costs.

4.3.2 Tiered Cost-sharing Examples

Plans that implement tiers use plan-specific adjudication logic to determine beneficiary cost-sharing, following Part D guidelines. Whether a plan implements tiered or uniform cost-sharing, the plan populates the PDE fields in the same manner. Since tiering is the more common alternative, the following examples illustrate each type of alternate Basic plan.

4.3.2.1 Actuarial Equivalent Plan – Initial Coverage Period (Slides 27)

The beneficiary is enrolled in an AE benefit that uses the tiered co-pay structure outlined in Table 4E. The YTD gross covered drug cost = $300, which places the beneficiary in the Initial Coverage period. The beneficiary purchases a $100 covered drug in Tier 2 with a $20 co-pay in 2006.

Table 4M illustrates how the plan populates the following six data elements for this sample PDE in the Initial Coverage period of a tiered benefit.

TABLE 4M – 2006 TIERED BASIC PLAN - INITIAL COVERAGE PERIOD

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	<blank>	$100.00	$0.00	$20.00	$80.00

The Drug Coverage Status Code is "C". The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. The GDCB is therefore $100 and GDCA is $0.00. The drug is a Tier 2 drug with a $20 co-pay that is reported in the Patient Pay Amount field. The plan paid amount is $80, reported in the CPP field.

4.3.2.2 Basic Alternative Plan – Deductible

In 2006, a beneficiary is enrolled in a BA plan that uses the tiered co-pay structure outlined in Table 4E and has a $150 deductible. This is the first drug purchase of the year. The beneficiary purchases a $100 covered drug in Tier 3 with a $40 co-pay.

Table 4N illustrates how the plan populates the following six data elements for this sample PDE in the Deductible phase of a tiered benefit.

TABLE 4N – 2006 TIERED BASIC PLAN - DEDUCTIBLE PHASE

Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
C	<blank>	$100.00	$0.00	$100.00	$0.00

The Drug Coverage Status Code is "C". The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. The GDCB is therefore $100 and GDCA is $0.00. Since the beneficiary is in the deductible phase, $100 is reported in the Patient Pay Amount field. The plan paid amount is $0, reported in the CPP field.

4.4 Straddle Claims (Slide 28)

Straddle claims are claims that cross phases of the benefit. This logic is similar to traditional adjudication logic that splits a single claim that crosses a deductible limit. This section introduces how to administer the benefit and report a PDE when a claim crosses different phases of the benefit.

Depending on the plan benefit design, straddle claims usually occur in three instances, when claims cross:

- The Deductible in which coinsurance applies and the Initial Coverage period in which a co-payment structure applies.
- The Initial Coverage period in which a co-payment or coinsurance applies and the Coverage Gap in which coinsurance applies.

- The Coverage Gap in which co-insurance applies and the Catastrophic Coverage phase in which co-payment or coinsurance may apply.

4.4.1 Defined Standard Plan Straddle Claims

The following examples demonstrate how to administer the benefit and calculate and report PDE values for straddle claims in a DS plan.

4.4.1.1 Defined Standard Plan: Straddle of Deductible and Initial Coverage Period

The following PDE moves a beneficiary from the Deductible phase to the Initial Coverage period of the DS benefit plan in 2006. The beneficiary straddles the Deductible phase and the Initial Coverage period. The beneficiary's YTD gross covered drug cost before the PDE was received = $200. The beneficiary purchases a $100 covered drug. In this new PDE, $50 falls at or below the $250 deductible limit and is adjudicated per the rules of the Deductible phase (100 percent cost-sharing). The remaining $50 falls in the Initial Coverage period, in which the beneficiary pays 25 percent coinsurance ($12.50) and the plan pays 75 percent ($37.50).

Table 4O illustrates how the plan populates the following six data elements for this sample PDE that straddles the Deductible and the Initial Coverage period.

TABLE 4O – DS 2006 - DEDUCTIBLE TO INITIAL COVERAGE PERIOD

	Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
Deductible Phase			$50.00	$0.00	$50.00	$0.00
Initial Coverage Period			$50.00	$0.00	$12.50	$37.50
Total	C	<blank>	$100.00	$0.00	$62.50	$37.50

The PDE fields will report the total amounts from the Deductible and the Initial Coverage period. Plans only submit one summary PDE to CMS, and the PDE record should contain the data in the summary "Total" section of Table 4O. The Drug Coverage Status Code is "C" indicating a covered drug. The Catastrophic Coverage Code is blank, indicating that the PDE reports an event below the OOP threshold. Since the gross drug cost in both phases of the benefit falls below the OOP threshold, the GDCB field reports ($50 + $50) = $100. The GDCA field reports $0.00 since there is no drug cost above the OOP threshold. The Patient Pay Amount and the CPP fields report the total for the PDE, where CPP reports the total amount the plan pays ($0 + $37.50 = $37.50) and Patient Pay Amount reports the total amount the beneficiary pays ($50 + $12.50 = $62.50).

4.4.1.2 Defined Standard Plan: Straddle of Coverage Gap Phase and Catastrophic Coverage Phase (Slide 29-30)

In the following PDE, the beneficiary is crossing from the Coverage Gap phase to the Catastrophic Coverage phase in 2006. YTD TrOOP is $3,550 before the PDE is received. The beneficiary purchases a $150 covered generic drug.

Table 4P illustrates how the plan must populate the following six data elements for this sample PDE that straddles the Coverage Gap and the Catastrophic Coverage phase.

TABLE 4P – DS 2006 - COVERAGE GAP TO CATASTROPHIC COVERAGE PHASE

	Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
Coverage Gap Phase			$50.00	$0.00	$50.00	$0.00
Catastrophic Coverage Phase			$0.00	$100.00	$5.00	$95.00
Total	C	A	$50.00	$100.00	$55.00	$95.00

Only one PDE is submitted to CMS, and it should contain the summary data in the “Total” section of Table 4P. The Drug Coverage Status Code is “C” indicating a covered Part D drug. The Catastrophic Coverage code is “A” indicating that the PDE reports an event that crosses the OOP threshold. The $50 amount at or below the OOP threshold falls in the Coverage Gap phase and the $100 amount above the OOP threshold falls in Catastrophic Coverage. The $50 in the Coverage Gap is adjudicated per Coverage Gap rules; the beneficiary pays 100 percent or $50. The $100 portion of the PDE that falls in Catastrophic Coverage is adjudicated per Catastrophic Coverage phase rules; the beneficiary pays the greater of $2/$5 or 5 percent ($5) and at point of sale, the plan pays the balance ($95). Note that even though the drug is generic, the beneficiary pays $5 (5 percent *$100) instead of $2 because it is the greater amount.

The total Patient Pay Amount reported on the PDE is ($50 + $5= $55), and the total CPP reported on the PDE is ($0 + $95 = $95). The GDCB field reports the amount that is below or at the OOP threshold ($50). The GCDA field reports the amount that is above the OOP threshold ($100). Even though the plan has paid $95 at point of sale, in reconciliation 80 percent of the amount of gross drug cost that falls into the Catastrophic phase ($100 * .8 = $80) will be subject to reinsurance subsidy and the plan and the government will share risk on ($100 - $80 - $5) = $15. **Note:** The amounts paid by the beneficiary and the plan sum to the gross drug cost (Patient Pay Amount + CPP = GDCA + GDCB).

4.4.2 Tiered Benefit Straddle Claims (Slide 31)

While the calculations for a coinsurance model (such as a DS plan) are relatively simple, the calculations for a tiered co-pay structure require use of an additional rule. If not calculated correctly, the total beneficiary liability for a straddle claim in a tiered benefit can exceed the gross drug cost. To prevent this error, plans apply “lesser of” logic when adjudicating straddle claims that have co-pay amounts; the beneficiary pays the lesser of 100 percent of the gross drug cost or the sum of the coinsurance and co-pay amounts.

For covered drugs, the co-pay amount is the value by which TrOOP accumulates. See 4.5.2.3, 8.6.7, and 8.6.8 for examples. CMS does not encourage this contracting practice.

4.4.2.1 Basic Alternative Plan: Straddle of Deductible Phase and Initial Coverage Period (Slides 32-33)

The beneficiary enrolled in a BA plan, which has lowered the deductible to $100 in 2006. The beneficiary purchases a Tier 3 covered drug with the negotiated price of $100. The Tier 3 co-pay is $40. The beneficiary’s YTD gross covered drug cost = $70.

Table 4Q illustrates how the plan uses “lesser of” logic to administer this straddle claim and populates the following six PDE data elements.

TABLE 4Q – BA 2006-TOTAL PATIENT PAY AMOUNT IS LESS THAN THE NEGOTIATED PRICE

	Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
Deductible Phase			$30.00	$0.00	$30.00	$0.00
Initial Coverage Period			$70.00	$0.00	$40.00	$30.00
Total	C	<blank>	$100.00	$0.00	$70.00 *	$30.00

Patient Pay Amount: $30 + $40 = $70. Negotiated Price = $100. Using the “lesser of” logic: $70 < $100. Patient Pay Amount = $70.

Only one PDE is submitted to CMS, and it should contain the summary data in the “Total” section of Table 4Q. The Drug Coverage Status Code is “C” indicating a covered drug. The Catastrophic Coverage code is blank indicating that the PDE reports an event below the OOP threshold. Thirty dollars of the gross drug cost of $100 falls in the Deductible phase where the beneficiary is responsible for 100 percent of the cost. For this phase, the patient pay amount is $30 and the CPP is $0. Seventy dollars of the gross drug cost falls into the Initial Coverage period where the beneficiary has a $40 co-pay, so for this phase patient pay amount is $40 and CPP is $30. Using “lesser of” logic, the beneficiary pays the total beneficiary liability for both phases because it is less than the negotiated price of the drug ($30 + $40 = $70, and $70 < $100). The plan pays its liability amount of $30 which is reported in CPP. The gross drug cost that falls into both phases is below the OOP threshold, so the plan reports a total of $100 in GDCB.

4.4.2.2 Actuarially Equivalent Plan: Straddle of Deductible and Initial Coverage Period (Using the "Lesser Of" Logic) (Slides 34-35)

The beneficiary is enrolled in an AE plan and purchases a Tier 3 covered drug with a negotiated price of $100. The Tier 3 co-pay is $40. The beneficiary's YTD gross covered drug cost = $175. If this claim were adjudicated without "lesser of" logic, the total beneficiary cost-sharing of $115 would exceed the negotiated drug price of $100. Using "lesser of" logic, the beneficiary only pays the negotiated price ($100).
Table 4R illustrates how the plan populates the following six PDE data elements for this sample PDE that straddles the Deductible phase and the Initial Coverage period.

TABLE 4R – AE 2006-TOTAL PATIENT PAY AMOUNT IS GREATER THAN THE NEGOTIATED PRICE

	Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP
Deductible Phase			$75.00	$0.00	$75.00	$0.00
Initial Coverage Period			$25.00	$0.00	$25.00	$0.00
Total	C	<blank>	$100.00	$0.00	$100.00	$0.00

Patient Pay Amount: $75 + $40 = $115. Negotiated Price = $100. Using the "lesser of" logic: $115 > $100. Patient Pay Amount = $100.

Only one PDE is submitted to CMS, and it should contain the summary data in the "Total" section of Table 4R. The Drug Coverage Status Code is "C" indicating a covered drug. The Catastrophic Coverage code is blank indicating that the PDE reports an event below the OOP threshold. Because the beneficiary has $175 in YTD gross covered drug cost, the beneficiary pays $75 to meet the deductible. CPP is $0 in this phase and the $75 of drug cost is reported below the OOP Threshold in GDCB. The beneficiary would pay a $40 co-pay according to the plan's Initial Coverage period provisions, however in that event the total patient pay amount would be ($75 + $40) = $115. When the total patient pay amount is compared to the negotiated price in the "lesser of" logic, $115 is greater than the $100 negotiated drug price. So the total Patient Pay Amount is reduced to $100, $25 of which falls into the Initial Coverage period below the OOP threshold. On the PDE record, GDCB totals to $100; CPP totals to $0; and Patient Pay Amount totals to $100.

4.5 Optional Estimated Rebate at Point-of-Sale (POS)

The MMA provides plans with the option of offering the Estimated Rebate at POS. In this option, the negotiated prices made available to Part D beneficiaries at the POS take into account negotiated price concessions for covered Part D drugs such as discounts and rebates, which the Part D sponsor has elected to pass through to beneficiaries at POS, as well as any applicable dispensing fees.

Part D sponsors are **not** required to apply rebates or an estimate of expected rebates to the negotiated price at POS.

Rebates applied at POS reduce both plan liability and beneficiary cost-sharing by reducing the negotiated price used to administer the prescription drug benefit.

The reporting of estimated rebates and drug costs depends on the benefit year. Since the Estimated Rebate at POS field did not exist for the submission of 2006 and 2007 data, plans reported that data in the CPP or NPP fields depending on whether or not the drug was a covered Part D drug. Part D sponsors were required to report the gross drug cost prior to the application of estimated rebate amounts on the PDE record, instead of the gross drug cost, net of the estimated rebates. Specifically, reporting the gross drugs costs in the following fields:

- Ingredient Cost Paid
- Dispensing Fee Paid
- Amount Attributed to Sales Tax
- GDCA
- GDCB

Beginning with the submission of 2008 data, plan sponsors report estimated rebate at POS in the new field. Estimated rebates applied to the POS price must use the negotiated price, net of the estimated rebates to administer the Part D benefit and calculate beneficiary cost-sharing.

To report estimated rebates, plans first use the estimated rebates applied at POS to **reduce** the Ingredient Cost. If the estimated rebates applied to the POS price are greater than the total Ingredient Cost, then the plan must use any remaining estimated rebates to reduce the Dispensing Fee and then finally, the Amount Attributed to Sales Tax.

Plans must base payments made by or on behalf of a beneficiary and Plan Paid Amounts reported to CMS on the PDE record on the reduced negotiated price and reflect the cost-sharing established in the PBP.

The following examples demonstrate how to administer the benefit, and calculate and report PDE values for Estimated Rebate at POS in a DS plan for 2007 and 2008 coverage years.

4.5.1 DS and $50 Estimated Rebate at POS

A Part D beneficiary is enrolled in a DS plan and has YTD gross covered drug costs of $1,000. The beneficiary is not eligible for the low-income subsidy and does not have additional prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $150 ($140 Ingredient Cost Paid and $10 Dispensing Fee Paid). The Part D sponsor chooses to apply an estimated rebate of $50 to the POS price. The actual rebate amount received by the Part D sponsor at the end of the coverage year is $60 for this claim. Table 4S illustrates how to report a $50 estimated rebate on a PDE Record in 2007 and 2008.

TABLE 4S – DS AND $50 ESTIMATED REBATE AT POS

PDE RECORD FIELDS	AMOUNT REPORTED 2007	AMOUNT REPORTED 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$25	$25
CPP	$125	$75
NPP	$0	$0
Estimated Rebate at POS		**$50**

For both coverage years 2007 and 2008, the Part D sponsor uses a reduced negotiated price of $100 ($150 - $50 estimated rebate amount) to determine beneficiary cost-sharing. As indicated above, the Ingredient Cost Paid is $140 and the Dispensing Fee is $10. In coverage year 2008, the plan reduces the Ingredient Cost by the estimated rebate, resulting in $90. The Dispensing Fee Paid remains at $10. The gross drug costs reported for coverage year 2007 are the drug costs prior to the application of the estimated rebates, which is $150. The gross drug costs reported for coverage year 2008 is net of the estimated rebates, which is $100. Based on the YTD gross covered drug costs of $1,000, the beneficiary is in the Initial Coverage period; therefore, the gross drug costs reported in GDCB and GDCA is $0.

Since this beneficiary is in the Initial Coverage period, the beneficiary pays 25 percent of the negotiated price or $25. The plan is responsible for 75 percent of the negotiated price or $75. This is for both coverage years. For coverage year 2007, the CPP field includes both the $75 plan liability and the $50 estimated rebate at the POS. However, for coverage year 2008, only the $75 plan liability is included in the CPP field and the $50 estimated rebate amount is reported in the Estimated Rebate at POS field. This was a covered drug, so NPP equals $0.

For both coverage years, the Part D sponsor reports the actual rebate amount of $60 on the Direct and Indirect Remuneration (DIR) Report for Payment Reconciliation.

Part D sponsors are required to report all applicable rebates for covered Part D drugs on the DIR Report for Payment Reconciliation, including the actual rebate amounts for the rebates, which were estimated and applied at the point of sale.

4.5.2 DS and $25 Estimated Rebate at POS

A Part D beneficiary is enrolled in a DS plan, is not eligible for the low-income subsidy, and has YTD gross covered drug costs of $2,600, placing the beneficiary in the Coverage Gap. The beneficiary does not have prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $35 ($20 Ingredient Cost Paid, $10 Dispensing Fee Paid, and $5 Amount Attributed to Sales Tax). The Part D sponsor chooses to apply an estimated rebate of $25 at POS. The actual rebate amount received by the Part D sponsor at the end of the year is $20 for this claim. Table 4T illustrates how to report a $50 estimated rebate on a PDE Record in 2007 and 2008.

TABLE 4T – DS AND $25 ESTIMATED REBATE AT POS

PDE FIELD	AMOUNT REPORTED 2007	AMOUNT REPORTED 2008
Ingredient Cost Paid	$20	$0
Dispensing Fee Paid	$10	$5
Amount Attributed to Sales Tax	$5	$5
GDCB	$35	$10
GDCA	$0	$0
Patient Pay Amount	$10	$10
CPP	$25	$0
NPP	$0	$0
Estimated Rebate at POS		**$25**

For both coverage years 2007 and 2008, the Part D sponsor uses the reduced negotiated price of $10, which is $35 - $25 for the estimated rebate amount, to determine the beneficiary cost-sharing and administer the prescription drug benefit. The Ingredient Cost Paid, Dispensing Fee Paid, and Amount Attributed to Sales Tax are indicated above. When reporting these fields for 2008, the plan reduces the dollar amounts by the estimated rebate amount of $25. First the Ingredient Cost Paid is reduced to $0. The plan applies the remaining $5 to the Dispensing Fee Paid, which reduces the amount reported in this field to $5. The Amount Attributed to Sales Tax remains $5.

The gross drug costs reported for coverage 2007 are the drug costs prior to the application of the estimated rebates and the gross drug costs reported for coverage year 2008 are net of the estimated rebates. Therefore, GDCB in 2007 is $35 and $10 in 2008. GDCA is $0 for both coverage years. Since this beneficiary is in the Coverage Gap phase, the beneficiary pays 100 percent of the negotiated price of $10 and the plan is responsible for 0 percent ($0) of the negotiated price in both coverage years.

For coverage year 2007, the CPP includes both $0 for plan liability and $25 for the estimated rebate at POS. For 2008, only the $0 plan liability is reported in CPP, while $25 for the estimated rebate is reported in the Estimated Rebate at POS field. There is no NPP to report.

In both coverage years, the Part D sponsor reports the actual rebate amount of $20 on the DIR Report for Payment Reconciliation.

4.6 Adjustment and Deletions (Slides 36-37)

This section briefly reviews the Adjustment/Deletion Code field (which was introduced in the Data Format module), describes situations that frequently cause adjustments and deletions, then discusses how a change affects benefit administration and finally gives examples including adjustment and deletion PDEs. The Adjustment/Deletion Code triggers adjustment/deletion processing in DDPS.

Table 4U provides a description for adjustment/deletion codes.

TABLE 4U – 2006 ADJUSTMENT/DELETION CODE DEFINITIONS

CODE	DESCRIPTION
(blank)	Original PDE record
A	Adjust PDE record
D	Delete PDE record

DDPS uses the seven key fields plus Contract Number and PBP ID to match the adjustment or deletion PDE to the active record on file. If the matching current active record is not found using the seven key fields (Health Insurance Claim Number, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, Date of Service, Fill Number, and Dispensing Status), the Contract Number, and the PBP ID, DDPS returns an error message to the plan. DDPS does not assume that the plan submitted an original PDE incorrectly identified as an adjustment or a deletion.

DDPS edits every adjustment PDE to confirm that the key fields on the adjustment and the record to be adjusted match. DDPS also prevents adjustments to deleted records.

4.6.1 Adjustment/Deletion Code (Slide 38)

The Adjustment/Deletion Code value of "A" identifies adjustment PDEs. When DDPS receives adjustments, DDPS inactivates the current active record and identifies the adjustment PDE as the current active record.

An adjustment completely replaces the original record. The record does not have to be deleted and then resubmitted.

Note: DDPS does not use the debit/credit approach to adjustments that is commonly implemented in claims systems.

The Adjustment/Deletion Code value of "D" identifies a deletion PDE. When DDPS receives deletions, DDPS marks the current record on file as deleted.

DDPS excludes inactive records and deleted records from all Part D Payment Reconciliation calculations.

4.6.2 Situations That May Cause Adjustments and Deletions (Slide 39)

Sometimes claims data changes after the point-of-sale (POS) transaction. When post POS changes occur, the plan must first consider how the change affects benefit administration. The plan then determines if PDEs must be updated. There are several terms to facilitate this discussion.

- **Reversal –** a reversal deletes the billing transaction it reverses. In effect, the pharmacy refunds the plan for the reversal claim. Reversals involve accounting updates at both the pharmacy and the Part D plan. Pharmacies must reverse claims when the billed transaction did not actually happen (e.g., beneficiary did not pick up prescription).

- **Re-adjudication –** a re-adjudication changes the total amount paid to the pharmacy. In order to complete a re-adjudication, both the plan and pharmacy make changes to data on file in their systems.

- **Re-calculation –** a re-calculation corrects beneficiary cost-sharing. It is accomplished within the plan's own system and does not involve the pharmacy. In these situations, the total amount paid to the pharmacy remains the same; however the amounts paid by the plan and by the beneficiary change. (We introduce the generic term "recalculation" to describe processing system updates for changes in Part D cost-sharing reported post point-of-sale. Individual processors may use other vocabulary to describe these same operations.)

Part D beneficiary cost-sharing varies by benefit phase. To maintain the integrity of the benefit, plans must account for these cost-sharing differences when processing reversals. The section entitled "Reversals with no Benefit Phase Change" applies either when the beneficiary has no claims with dates of service after the reversed claim or when the subsequent claim(s) and the reversed claim fall within the same benefit phase. The section entitled "Reversals with Benefit Phase Change" applies when a reversal affects claims in multiple benefit phases.

4.6.2.1 Reversals with No Benefit Phase Change (Slides 40-42)

Benefit Administration: When the plan receives the reversal for a covered drug, the plan immediately adjusts two accumulators the plan uses to administer the Part D benefit, the accumulator for the YTD TrOOP balance and the YTD Gross Covered Drug Cost accumulator. The plan depends on accurate timely values in these accumulators in order to correctly administer the Part D benefit in a real-time environment.

YTD TrOOP Balance: The plan subtracts the Patient Pay amount (and other Troop qualifying amounts to be discussed in other modules) from the YTD TrOOP balance.

YTD Gross Covered Drug Cost Accumulator: The plan subtracts the cost of the covered drug from the YTD Gross Covered Drug Cost accumulator.

When there are no subsequent claims or when the reversed claim and all subsequent claims were adjudicated in the same benefit phase, the plan simply reports the reversal in its internal system. There is no re-calculation.

PDE Reporting: If the plan had successfully reported a PDE for the reversed claim, the plan will also submit a deletion PDE as described above. If the PDE is not on file in DDPS, either because the plan did not submit it or because DDPS rejected the PDE, no PDE reporting requirement applies.

Example: 1 - Reversal with No Benefit Phase Change

The beneficiary is enrolled in an AE plan; all AE plans have a $250 deductible in 2006. In this example the beneficiary purchases three covered drugs. On January 10 the beneficiary's physician calls in a $100 prescription to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. On January 15 the beneficiary purchases a $75 drug and on January 20 the beneficiary purchases a $50 drug. On January 21 the pharmacy reverses the January 10 claim because the beneficiary did not pick up the prescription and refunds the plan. The plan immediately updates its accumulators as shown in Table 4V.

TABLE 4V – PLAN ACCUMULATORS

CLAIM DATE	CURRENT CLAIM		ACCUMULATORS	
	GROSS COVERED DRUG COST	PATIENT PAY AMOUNT	YTD GROSS COVERED DRUG COST	YTD TrOOP BALANCE
Balance effective January 1			$0	$0
January 10	$100	$100	$100	$100
January 15	$75	$75	$175	$175
January 20	$50	$50	$225	$225
January 10 reversal *(effective January 21)*	<$100>	<$100>	$125	$125

The plan also reviews the beneficiary's claims history since January 10. The reversed claim and the two subsequent claims were all adjudicated in the deductible. Since no additional claims were adjudicated in a different benefit phase with different cost-sharing, there is no re-calculation.

This plan submits PDEs once a week and reviews its return files. The PDE for the January 10 claim was accepted in DDPS so the plan submits a deletion PDE in the next cycle. The plan also confirms that the next DDPS return file shows that DDPS accepted the deletion.

4.6.2.2 Reversal with Benefit Phase Change (Slides 43-45)

Benefit Administration: Sometimes a reversed claim advances the beneficiary into the next benefit phase with different beneficiary cost-sharing. Until the reversal is reported, the plan adjudicates claims with the best information available. When a plan receives a reversal, the plan must complete all the processing necessary for the reversal (see 4.6.2.1), and determine if there is a requirement to "pay back the phase of the benefit." Most of the time the plan has two options to pay back the benefit. Typically the plan pays back the benefit (i.e., applies the difference in cost-sharing) on future claims and there is no cash transfer between the plan and the beneficiary. Instead, the plan applies cost-sharing for the reversed claim on future claims. However, when the plan does not expect sufficient claims volume to repay the benefit or when LICS is involved (see Module 7), the plan has only one option; it must recalculate the affected claims and settle with the beneficiary either by establishing a payable/receivable or by directly charging/refunding the beneficiary. For example, if a reversal is reported at the end of the benefit year, the plan must repay (or collect from) the beneficiary directly because plans cannot carry cost-sharing balances across benefit years.

PDE Reporting: The way plans report PDEs depends on the method the plan uses to pay back the benefit. When the plan pays back the benefit on future claims, the plan can report PDEs "as administered". When the plan reports on an "as administered" basis, PDEs document the actual beneficiary cost-sharing applied at POS. By the end of the benefit year, the sum of cost-sharing on all PDEs will be correct. However, during the benefit year PDEs will document beneficiary cost-sharing that "appears" non-sequential. If the PDEs were sorted by date of service (DOS), PDEs would show beneficiary cost-sharing in one benefit phase interrupted by cost-sharing in an earlier phase.

When the plan recalculates and settles directly with the beneficiary, the plan must report the PDE "as adjusted". "As adjusted" PDEs must report the recalculated beneficiary cost-sharing. If the plan has a PDE on file with the original cost-sharing, the plan must submit an adjustment PDE reporting the recalculated cost-sharing. If the PDE was not accepted in DDPS before, the plan must report the recalculated cost-sharing when it submits the original PDE.

Example:2 - Reversal with Benefit Phase Change

The beneficiary enrolled in a BA plan with a $175 deductible. As in the reversal example in 4.6.2.1 the beneficiary purchases three covered drugs. On January 10 the beneficiary's physician calls in a $100 prescription to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. On January 15 the beneficiary purchases a $75 drug. Then on January 20 the beneficiary purchases a third covered drug for $100. Based on the information the plan knows on January 20, the plan adjudicates the claim in the Initial Coverage period because the beneficiary's first two claims satisfied the $175 deductible. A $30 co-pay applies. On January 21 the pharmacy reverses the January 10 claim and refunds the plan. As in the reversal example, the plan immediately updates its accumulators. The reversal affects the January 20 claim. The claim should have been adjudicated as a deductible claim. The beneficiary should have paid $100 instead of $30. To repay the benefit the beneficiary will pay 100 percent cost-sharing on the next $70 of gross covered drug cost.
PDE Reporting (Report as administered): The PDE for the January 20 claim will report $30 in the Patient Pay field. For ease of illustration, assume that the next covered drug purchase costs $70. The PDE for the next claim will report $70 in the Patient Pay field and $0 in the CPP field.

PDE Reporting (Report as adjusted): If this same scenario occurred late in the benefit year and the reversal was reported after December 31 or if the reversal were reported after the beneficiary disenrolled, the plan would recalculate. The plan would collect the $70 directly from the beneficiary and the PDE (either the original or the adjusted PDE) would report $100 in the Patient Pay field.

Note: If a reversal claim advanced the beneficiary from the Initial Coverage period into the Coverage Gap, the plan would owe the beneficiary money. In this case the plan would pay back the beneficiary because the 100 percent coinsurance in the Coverage Gap is higher than cost-sharing in the Initial Coverage period.

This section outlines two ways to address the reversal with benefit change. These examples are for purposes of illustration; they are not prescriptive. Plans may implement an alternate process, provided it maintains the integrity of the benefit. For example, a plan may routinely adjust all affected claims and establish a beneficiary payable/receivable account with which it defrays/repays beneficiary cost-sharing on subsequent claims.

Straddle Claims: Sometimes the calculation to pay back the benefit will be complicated because the pay back amount is a portion of the total claim cost. Straddle claim logic applies in this situation. To show the effect of a straddle claim we modify the example above by making the gross covered drug cost on the pay back claim $100. The plan calculates that $70 falls in the Deductible with 100 percent coinsurance. The remaining $30 of cost falls in the Initial Coverage period, so the $30 co-pay applies. The beneficiary pays $100 (the sum of $70 and $30). Please note that the calculated cost-share does not exceed the negotiated price of $100. CMS includes this example to emphasize that plans cannot bypass straddle calculations; they cannot simplify calculations for pay-back claims by applying cost-sharing from one benefit phase only. For example, the plan cannot simplify the calculation and report only $70 of cost–sharing.

MODULE 5 – CALCULATING AND REPORTING TRUE OUT-OF-POCKET COSTS (TrOOP)

Purpose (Slide 2)

Plans are responsible for maintaining accurate accounting of each beneficiary's True Out-of-Pocket (TrOOP) costs on a day-to-day basis and for coordinating all TrOOP related benefits. The Prescription Drug Event (PDE) record reports how the plan has tracked TrOOP for a beneficiary on a given prescription drug event. It also identifies when a beneficiary has reached the annual limit in TrOOP costs and therefore enters the Catastrophic Coverage phase. The Calculating and Reporting TrOOP module explains the process and requirements related to administering the TrOOP component of the Part D benefit.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Define True Out-of-Pocket (TrOOP) costs.
- List the two key reasons TrOOP accounting is important to the Part D benefit.
- Classify which payments do and do not count toward TrOOP.
- Describe how to administer the Part D benefit with respect to accumulating and reporting TrOOP costs.
- Illustrate how to populate PDE fields associated with TrOOP.
- Identify the two methods plans can use to administer the benefit and report Prescription Drug Events (PDEs) to CMS when requiring retroactive changes in TrOOP.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

5.1 True Out-of-Pocket Costs Overview (Slide 4)

The concept of True Out-of-Pocket (TrOOP) costs is pivotal to the Part D benefit. TrOOP is defined as incurred allowable costs for covered Part D drugs that are paid by the beneficiary or by specified third parties on the beneficiary's behalf up to a legislatively specified Out-of-Pocket (OOP) threshold per coverage year. The TrOOP limit was set at $3,600 for 2006 and increases annually. For purposes of determining catastrophic coverage, TrOOP stops accumulating once the OOP threshold is reached.

Module 1, Part D Payment Methodology includes the 2008 and 2009 TrOOP limits.

5.2 The Importance of True Out-of-Pocket Cost (Slide 6)

Tracking TrOOP accurately is critical to administering the Part D benefit and submitting PDE records to the Centers for Medicare & Medicaid Services (CMS). TrOOP determines when a beneficiary is eligible to receive catastrophic coverage. After a beneficiary has accumulated year-to-date (YTD) TrOOP costs equal to the OOP threshold, Catastrophic Coverage provisions begin for both the beneficiary and the plan. There are two reasons why TrOOP is important:

1. The beneficiary is subject to a lower cost-sharing equal to the greater of 5 percent or $2/$5 once TrOOP costs equal $3,600 for 2006.
2. The plan is eligible to receive an 80 percent reinsurance subsidy once TrOOP costs equal $3,600 for 2006.

Monitoring TrOOP and Coordination of Benefits (COB) enables accurate determination of beneficiary cost-sharing at the point of sale (POS).

5.3 True Out-of-Pocket Cost Contributors (Slides 7-8)

Plans must identify costs that contribute toward a beneficiary's TrOOP to administer Part D benefits. These costs, and the PDE fields in which they are reported, can be separated into three categories:

- Beneficiary payments.
- Low Income Cost-Sharing Subsidy (LICS) Amounts paid by the plan at the POS.
- All TrOOP-eligible payments made by qualified entities or individuals on behalf of a beneficiary.

Payments by some third parties do not count toward TrOOP. Table 5A identifies frequently occurring Other Health Insurance (OHI) payers by TrOOP status, as well as other sources of payment.

TABLE 5A – PAYERS AND THEIR TROOP STATUS

TrOOP ELIGIBLE	NOT TrOOP ELIGIBLE
• Beneficiary • Payments by family, friends, or other qualified entities or individuals on behalf of a beneficiary • Charities and Qualified State Pharmaceutical Assistance Programs (SPAPs) • Low-income cost-sharing subsidy (LICS) • Medicaid payments in lieu of LICS for beneficiaries residing in U.S. territories[1]	• Workers' Compensation • Governmental programs (VA, Black Lung, TRICARE, other) • Automobile/No-fault/Liability Insurances • Group health plans

[1]Medicaid cost-sharing subsidies for residents of the U.S. territories that are funded under §1860D-42(a) of the Act count towards TrOOP. In all other circumstances, Medicaid is not a TrOOP eligible insurance.

Section 1860D-2(b)(4)(C) of the Social Security Act; 42 CFR 423.100

5.3.1 Beneficiary Payments

Beneficiary amounts are reported in the **Patient Pay Amount** field.

5.3.2 Family and Friends

Payments by family, friends, or other individuals can assist a beneficiary in meeting his or her prescription drug costs. These amounts are also reported in the Patient Pay Amount field.

Amounts paid by family and friends are reported in the **Patient Pay Amount** field.

5.3.3 Charities, Pharmaceutical Assistance Programs (PAPs), Qualified State Pharmaceutical Assistance Programs (SPAPs), and Territories' §1860D-42(a) Payments

Any payments for covered drugs made by **charities** on behalf of a beneficiary count towards TrOOP. In accordance with the definition of "charity" in the Part D final regulations, payments by PAPs established as co-pay assistance foundations will count towards TrOOP. Such PAPs will be designated as charities in COB transactions.

SPAPs are state funded programs that provide financial assistance for prescription drugs to low income and medically needy senior citizens and individuals with disabilities. SPAPs that meet certain rules may "wrap around" the Medicare benefit to fill gaps in coverage and are referred to as **"qualified SPAPs"**. Payments made by a qualified SPAP for covered drugs count towards the beneficiary's TrOOP costs.

In accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), beneficiaries residing in the U.S. territories do not receive Medicare LICS payments. Instead, they are eligible for cost sharing assistance under an approved state plan that uses Medicaid funds. Under §1860D-42(a) waiver authority, these payments will count towards the beneficiary's TrOOP costs. In this document, these Medicaid payments are referred to as **"Territories' §1860D-42(a) Payment"** which count towards a beneficiary's TrOOP and should be reported in the Other TrOOP Amount field.

Note: No other Medicaid assistance counts towards TrOOP, only those payments for residents of territories that substitute for LICS in accordance with the statute. Any other Medicaid assistance is reported in the Patient Liability Reduction Due to Other Payer Amount (PLRO) field.

Payments by Charities, Qualified SPAPs, and by Territories under §1860D-42(a) are reported in the **Other TrOOP Amount** field.

Sections 1860D-14(a)(3)(F), 1860D-42(a), and 1935(e) of the Social Security Act; 42 CFR 423.907, 423.859(c)

5.3.4 Low Income Cost-Sharing Subsidy (LICS)

LICS is a Medicare payment to plans to subsidize the cost-sharing liability of qualifying low income beneficiaries; this includes plan deductibles and coinsurances. See Module 7 for further information on LICS. LICS payments count towards a beneficiary's TrOOP costs and are reported in the LICS Amount field.

LICS amounts are reported in the **LICS Amount** field.

5.3.5 Other Health Insurance (OHI)

In the context of PDE data, OHI refers to a source of coverage other than the Part D plan. Some OHI payments count towards TrOOP, however, many OHI payments are excluded from TrOOP. For example, group health plans, employer-sponsored insurance, non-Part D government-funded programs, Workers' Compensation, and similar third party arrangements. Third party payments made by such entities typically do **not** count toward a beneficiary's TrOOP.

Note: Government-funded programs are generally excluded from TrOOP, as are many OHI payers. Please note that Medicaid cost-sharing assistance authorized under §1860D-42(a) to replace LICS in the territories is included in TrOOP, but no other Medicaid payments are TrOOP eligible.

Payments by OHI payers that are not TrOOP eligible are reported in the **PLRO** field.

5.4 Prescription Drug Event Data Elements Relevant to True Out-of-Pocket Costs (TrOOP) (Slide 9)

Interactions between payment fields have a direct impact on TrOOP accounting. PDE fields enable CMS to distinguish costs that must be included or excluded from TrOOP and/or payment. The data elements that are central to TrOOP accounting are:

- Drug Coverage Status Code
- Catastrophic Coverage Code
- Six payment fields
  - Patient Pay Amount
  - Other TrOOP Amount
  - LICS Amount
  - Patient Liability Reduction due to Other Payer (PLRO) Amount
  - Covered D Plan Paid (CPP) Amount
  - Non-covered Plan Paid (NPP) Amount

5.4.1 Drug Coverage Status Code

CMS only pays for drugs that meet both the definition of a covered Part D drug and are approved for coverage under a specific Plan Benefit Package (PBP) where Drug Coverage Status Code = "C". Payment for drugs that do not meet these criteria must be excluded from TrOOP (Drug Coverage Status Code = "E" or "O").

5.4.2 Catastrophic Coverage Code

This field identifies the beneficiary's benefit status, specifically whether or not he/she has crossed the OOP threshold and entered Catastrophic Coverage.

Note: The accumulated value of TrOOP determines when the beneficiary crosses the OOP threshold, entering the Catastrophic Coverage phase.

5.4.3 Six Payment Fields that Affect True Out-of-Pocket Costs (Slides 10-15)

Six payment fields report payments that can affect TrOOP. The payment amounts reported in these fields are mutually exclusive, meaning that a given payment amount cannot be reported in more than one field. Four of the payment fields document payments that report beneficiary liability; three report dollars that are included in TrOOP (Patient Pay Amount, Other TrOOP Amount, and LICS), and the fourth reports dollars (PLRO) that are excluded from TrOOP. The remaining two payment fields (CPP and NPP) document payment by the Part D plan, and neither of these are included in TrOOP.

Table 5B illustrates the impact of each payment field on TrOOP.

TABLE 5B – IMPACT OF PAYMENT FIELDS ON TROOP

FIELD NAME	TrOOP INCLUSION	TrOOP EXCLUSION
Patient Pay Amount	X	
Other TrOOP Amount	X	
LICS	X	
PLRO		X
CPP		X
NPP		X

5.5 Calculating True Out-of-Pocket Costs (Slides 16-21)

When the beneficiary has no other source of payment, only the dollars reported in the Patient Pay Amount field increase TrOOP. When the beneficiary has OHI, the plan will use the following steps to calculate TrOOP. (**Note:** Module 6 describes the TrOOP facilitation process in detail and Module 7 discusses the Low Income Cost-Sharing Subsidy in relation to TrOOP.)

Step 1: Identify the **net** change between the original Patient Pay Amount and the Patient Pay Amount reported by the TrOOP Facilitator.

Step 2: If the OHI payer is TrOOP eligible, report the Patient Pay Amount difference in the Other TrOOP Amount field. If the OHI payer is not TrOOP eligible, report that difference in the PLRO field.

Step 3: Report the amount actually paid by the beneficiary, family, or friends in the Patient Pay Amount field.

Step 4: Change the amounts in the TrOOP accumulator to reflect the changes reported in the Patient Pay Amount field and the Other TrOOP field.

Example: 1

The beneficiary is in the Initial Coverage phase of the Defined Standard benefit. The original Patient Pay Amount was $25. The TrOOP Facilitator reported a Patient Pay Amount of $10 with a secondary insurance paying the difference.

Step 1: $25 - $10 = $15.

Step 2: The OHI payer is not TrOOP eligible and reduced the Patient Pay Amount by $15. The change is reported in the PLRO field. The primary insurer does not know the amounts paid by OHIs; only the updated Patient Pay Amount is available. The reduction in Patient Pay Amount may be due either to re-pricing the claim, “wrap around” payments, or additional payments by the OHI. Regardless of the reason for the reduction, it is the amount of reduction that is reported in the PLRO field.

The PLRO field contains amounts by which patient liability is reduced due to payments by other payers that do not participate in Part D and are not TrOOP eligible. This field documents the benefits that are excluded from TrOOP accumulation.

Step 3: The Patient Pay Amount field reports $10.

Step 4: PLRO field amounts are **not** TrOOP eligible. The TrOOP accumulator for this event increases by $10.

5.6 PDE Examples of Updating the True Out-of-Pocket Accumulator

The following sections demonstrate the interaction among the eight PDE fields that are central to TrOOP and their impact on TrOOP accounting in a Defined Standard plan.

5.6.1 Qualified Third Party Payer – Partial Amounts (Slides 24-29)

The beneficiary is in the Initial Coverage phase of the Defined Standard benefit for calendar year 2006. The beneficiary purchases a covered Part D drug for $100; the beneficiary is responsible for 25 percent coinsurance, or $25. A qualified SPAP reduced the beneficiary’s cost-share to $5.

Table 5C illustrates how a plan populates the following eight data elements for this sample PDE.

TABLE 5C –A QUALIFIED THIRD PARTY PAYER PDE RECORD AND TROOP ACCUMULATOR

Drug Coverage Status Code	Catastrophic Coverage Code	Patient Pay Amount	Other TrOOP Amount	LICS	PLRO	CPP	NPP	TrOOP Accumulator
C	<blank>	$5.00	$20.00	$0.00	$0.00	$75.00	$0.00	+ $25.00

The beneficiary is responsible for 25 percent of the drug cost ($100 x .25 = $25) and the plan is responsible for 75 percent of the cost-share ($100 x .75 = $75). The qualified SPAP reduced the beneficiary's cost-share from $25 to $5, with that $20 reduction reported in the Other TrOOP Amount field. The dollars reported in the Patient Pay Amount field and the Other TrOOP Amount field both count toward TrOOP. Since the OHI in this instance counts toward TrOOP, the total TrOOP amount for this transaction remains $25.

Note: On PDEs reporting payment in the Other TrOOP field, DDPS validates that the PDE reports a covered drug (i.e., Drug Coverage Status Code = C). See error code 757.

5.6.2 Non-Qualified Third Party Payer – Partial Amount

The beneficiary is in the Initial Coverage period of a Basic Alternative (BA) benefit. The beneficiary purchases a $100 brand name covered Part D drug with a $20 co-payment. A secondary insurance reduces the Part D co-payment to $10.

Table 5D illustrates how a plan populates the following eight data elements for this sample PDE.

TABLE 5D – A NON-QUALIFIED THIRD PARTY PAYER PDE RECORD AND TROOP ACCUMULATOR

Drug Coverage Status Code	Catastrophic Coverage Code	Patient Pay Amount	Other TrOOP Amount	LICS	PLRO	CPP	NPP	TrOOP Accumulator
C	<blank>	$10.00	$0.00	$0.00	$10.00	$80.00	$0.00	+ $10.00

The BA plan is responsible for $80 in this example, which is reported in the CPP field. The secondary OHI, which is not TrOOP eligible, reduced the co-payment by $10 that is reported in the PLRO field. The beneficiary pays the remaining $10, which is reported in Patient Pay Amount and is the only TrOOP-eligible payment.

Note: On every PDE, the DDPS totals and compares the dollars in the detail cost fields (Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax) and the dollars in the payment fields (Patient Pay Amount, LICS, Other TrOOP Amount, PLRO, CPP, and NPP). DDPS rejects records when the total costs and the total payments differ by more than the $.05 allowed for rounding error. See error codes 692 and 693.

5.7 Adjustment/Deletion Processing and True Out-of-Pocket Costs (Slide 30)

In order to maintain the integrity of the benefit, plans must understand how claim changes post point-of-sale affect the Catastrophic phase of the benefit and associated PDE reporting. For an introductory discussion about reversals that affect claims in another benefit phase refer to the Adjustment and Deletion section of the module entitled "Calculating and Reporting the Basic Benefit".

Although many of the same general principles apply to any reversal affecting claims in another benefit phase, there are two major differences specific to catastrophic benefit administration. First, only TrOOP of $3,600 (in 2006) moves the beneficiary into the Catastrophic phase of the benefit. Secondly, for purposes of benefit administration, plans do not increment TrOOP balances beyond $3,600. In practical terms, TrOOP accumulation is a pre-catastrophic activity to satisfy the pre-requisite to receive catastrophic benefits. If a pre-catastrophic reversal is reported after the beneficiary enters the Catastrophic phase, catastrophic benefits are suspended until the beneficiary re-establishes eligibility for catastrophic benefits by paying back TrOOP. For example, when plans reverse a pre-catastrophic claim after the beneficiary enters Catastrophic Coverage, plans subtract the TrOOP amount on the reversed claim from $3,600. As the beneficiary "pays back the benefit" on subsequent claims, the TrOOP balance will return to $3,600 and catastrophic benefits will resume.

The examples below illustrate TrOOP accounting for reversals with and without a benefit phase change. Notice the different TrOOP values in the Coverage Gap and Catastrophic benefit phase examples. In each case the beneficiary is not eligible for LICS and has no other health insurance.

NOTE: Negative amounts are shown in the tables below to indicate accounting changes within the plan's internal system. Never adjust a PDE by reporting negative amounts.

5.7.1 Reversal With No Benefit Change – Coverage Gap

The beneficiary who is enrolled in an Actuarially Equivalent (AE) plan has a YTD TrOOP balance of $900 and YTD Gross Covered Drug Cost of $2,500 which places him in the Coverage Gap. In this example the beneficiary purchases three covered drugs. On August 10 the beneficiary's physician calls in a $100 prescription to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. On August 15 the beneficiary purchases a $75 drug and on August 20 the beneficiary purchases a $50 drug. On August 21 the pharmacy reverses the August 10 claim because the beneficiary did not pick up the prescription and refunds the plan. The plan immediately updates its accumulators as shown in Table 5E.

TABLE 5E – PLAN ACCUMULATORS

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance before the August 10 claim				$2,500	$900
August 10	$100	$100	$100	$2,600	$1,000
August 15	$75	$75	$75	$2,675	$1,075
August 20	$50	$50	$50	$2,725	$1,125
August 10 reversal (effective August 21)	<$100>	<$100>	<$100>	$2,625	$1,025

In this example the beneficiary has not accumulated $3,600 in TrOOP. The YTD TrOOP balance changes as each pre-catastrophic claim and the reversal are processed. Finally, there is no recalculation because the reversed claim and the two subsequent claims were all adjudicated in the Coverage Gap.

This plan submits PDEs weekly. The PDE for the August 10 claim was accepted in DDPS by August 21 when the plan learned about the reversal so the plan submits a deletion PDE in the next cycle. Be reminded that in all three PDEs, Catastrophic Coverage Code will be blank, GDCA will be $0.00, and GDCB will equal gross covered drug cost.

5.7.2 Reversal With No Benefit Phase Change – Catastrophic Benefit Phase (Slides 32-33)

The beneficiary who is enrolled in a Defined Standard benefit was in the Catastrophic phase of the benefit on August 10. On August 10 the beneficiary's physician calls in a $100 prescription for a brand drug to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. On August 15 the beneficiary purchases a $75 brand drug and on August 20 the beneficiary purchases a $50 brand drug. On August 21 the pharmacy reverses the August 10 claim because the beneficiary did not pick up the prescription and refunds the plan. The plan immediately updates its accumulators as shown in Table 5F.

TABLE 5F – PLAN ACCUMULATORS

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance before the August 10 claim				$5,500	$3,600
August 10	$100	$5	$0	$5,600	$3,600
August 15	$75	$5	$0	$5,675	$3,600
August 20	$50	$5	$0	$5,725	$3,600
August 10 reversal (effective August 21)	<$100>	<$5>	$0	$5,625	$3,600

The YTD TrOOP balance remains constant at $3,600 as each catastrophic claim and the reversal are processed. The minimal beneficiary catastrophic cost-sharing amounts do not increment TrOOP. Here again, there is no recalculation because the reversed claim and the two subsequent claims were all adjudicated in the Catastrophic phase of the benefit.

This plan submits PDEs monthly. The PDE for the August 10 claim had not been submitted by August 21 when the reversal was processed so there is no PDE reporting requirement. The plan simply notes the deletion in its internal system. The PDEs for the August 15 and August 20 claims report Catastrophic Coverage Code equal to “C”, GDCB equal to $0.00, and GDCA equal to gross covered drug cost.

5.7.3 Reversal With Benefit Phase Change – Catastrophic and the Coverage Gap (Slides 34-41)

The beneficiary in this example is enrolled in a Defined Standard plan. On August 10 his physician calls in a $100 prescription to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. This prescription updates the YTD gross covered drug cost from $5,000 to $5,100 and updates the YTD TrOOP balance from $3,500 to $3,600. The next claim is processed in the Catastrophic phase of the benefit. On August 15 and on August 20 the beneficiary purchases $100 prescriptions. Based on the best information available at point-of-sale, the plan adjudicates the August 15 and August 20 claims in the Catastrophic phase of the benefit. On August 21 the pharmacy reverses the August 10 claim and refunds the plan. The plan updates its system to show the deletion and subtracts $100 from both the YTD gross covered drug cost accumulator and YTD TrOOP balance. The updated TrOOP balance of $3,500 is below the $3,600 threshold (in 2006) so the beneficiary is no longer in the Catastrophic phase. Since the reversal claim fell in the Coverage Gap and the two subsequent claims fell in the Catastrophic phase, there is a requirement to “pay back the benefit”. In effect the beneficiary owes the benefit the $100 for the reversed claim that moved the beneficiary from the Coverage Gap to Catastrophic Coverage.

Generally the plan will choose to recover the $100, either by paying back the benefit on future claims (and reporting PDEs “as administered”) or by recalculating the affected claims (and reporting PDEs “as adjusted”) and settling with the beneficiary either by establishing a payable/receivable or directly charging/refunding the beneficiary. “Report as Administered” PDEs show actual beneficiary cost-sharing at point-of-sale on all PDEs. “Report as Adjusted” PDEs show recalculated beneficiary cost-sharing. In the next examples the beneficiary had two additional $100 prescriptions on August 25 and August 30.

5.7.3.1 Paying Back the Benefit on Future Claims (and Reporting PDEs “as Administered”)

The plan applies 100% coinsurance, the Coverage Gap cost-sharing, to the next $100 in covered drug cost. This will restore the TrOOP balance to $100 and the beneficiary will re-enter the Catastrophic phase of the benefit when the plan processes the August 30 claim. The plan updates accumulators and reports PDEs as shown in Table 5G.

TABLE 5G – PLAN ACCUMULATORS AND PDE DATA ELEMENTS

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS		PDE DATA ELEMENTS		
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance	Cata-strophic Coverage Code	GDCB	GDCA
Balance before the August 10 claim				$5,000	$3,500			
August 10	$100	$100	$100	$5,100	$3,600	A	$100	$0
August 15	$100	$5	$0	$5,200	$3,600	C	$0	$100
August 20	$100	$5	$0	$5,300	$3,600	C	$0	$100
August 10 reversal (effective August 21)	<$100>	<$100>	<$100>	$5,200	$3,500	N/A		
August 25	$100	$100	$100	$5,300	$3,600	A	$100	$0
August 30	$100	$5	$0	$5,400	$3,600	C	$0	$100

PDE Reporting: The plan will submit a deletion PDE for the August 10 claim if that PDE had been submitted and accepted before the reversal was processed on August 21. All PDEs on file document the actual beneficiary cost-sharing paid at point-of-sale.

5.7.3.2 Paying Back the Benefit by Recalculating Claims (and Reporting PDEs "as Adjusted")

The plan recalculates the August 15 claim and recovers the $100 applied to TrOOP directly from the beneficiary. All plans would use this method if the reversal occurred after the end of the benefit year or following disenrollment because there would be outstanding claims to repay the benefit. TrOOP balances, like any other Part D balance, are part of an annual benefit year and cannot be carried forward to the next year.

The plan updates accumulators and reports PDEs as shown in Table 5H and 5I. Table 5H shows activity through August 20. Table 5I shows updated activity through August 30.

TABLE 5H – PLAN ACCUMULATORS AND PDE DATA ELEMENTS, PRE-REVERSAL

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS		PDE DATA ELEMENTS		
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance	Cata-strophic Coverage Code	GDCB	GDCA
Balance before the August 10 claim				$5,000	$3,500			
August 10	$100	$100	$100	$5,100	$3,600	A	$100	$0
August 15	$100	$5	$0	$5,200	$3,600	C	$0	$100
August 20	$100	$5	$0	$5,300	$3,600	C	$0	$100

TABLE 5I – PLAN ACCUMULATORS AND PDE DATA ELEMENTS, POST-REVERSAL

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS		PDE DATA ELEMENTS		
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance	Cata-strophic Coverage Code	GDCB	GDCA
Balance before the August 10 claim				$5,000	$3,500			
August 10	~~$100~~ $0	~~$100~~ $0	~~$100~~ $0	~~$5,100~~ $5,000	~~$3,600~~ $3,500	~~A~~	~~$100~~ $0	~~$0~~ $0
August 15	$100	~~$5~~ $100	~~$0~~ $100	~~$5,200~~ $5,100	$3,600	~~C~~ A	~~$0~~ $100	~~$100~~ $0
August 20	$100	$5	$0	~~$5,300~~ $5,200	$3,600	C	$0	$100
August 25	$100	$5	$0	$5,300	$3,600	C	$0	$100
August 30	$100	$5	$0	$5,400	$3,600	C	$0	$100

PDE Reporting (Report as adjusted): This plan routinely submits PDEs at the end of the month. DDPS will have no information on file about the August 10 claim and the original transaction for the August 15 claim. The PDE for the August 15 claim will document the recalculated cost-sharing.

MODULE 6 – TrOOP FACILITATION

Purpose (Slide 2)

Part D plans have various responsibilities to exchange Coordination of Benefit (COB) related information with each other, other providers of prescription drug coverage, and the Centers for Medicare & Medicaid Services (CMS) COB Contractor. CMS established the True Out-of-Pocket cost (TrOOP) Facilitation process to facilitate COB and the exchange of prescription claims data between pharmacies, plans, other providers of prescription drug coverage, and CMS. In this module, participants gain an understanding of the TrOOP Facilitation process through the use of the Coordination of Benefits (COB) process and the TrOOP Facilitator. Participants learn how to submit transactions for prescription drug claims, accurately report TrOOP, and transfer TrOOP information with the use of the facilitation process.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify the requirements and processes for True Out-of-Pocket Cost (TrOOP) Facilitation and Coordination of Benefits (COB) at Point of Sale (POS) and plan.
- Describe the six steps in the TrOOP Facilitation process.
- Explain the role of the COB Contractor and its services.
- Apply the TrOOP Facilitation process.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

6.1 Coordination of Benefits (COB) and TrOOP Facilitator Overview and Requirements (Slides 42-43)

The Part D coordination of benefits (COB) process involves the COB activities of multiple Medicare contractors to a single point of contact through the use of data sharing agreements and the exchange of data through established communication channels. COB includes identifying Medicare Secondary Payer (MSP) situations, instances where Medicare mistakenly paid primary to other health insurance (OHI), and claims involving supplemental payers.

With the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), CMS expanded existing COB information collection and data exchanges to include prescription drug coverage. The regulations require that Part D plan sponsors coordinate Part D benefits with State pharmaceutical assistance programs, insurers, employers and all other providers of prescription drug coverage to ensure that the benefits provided to Part D beneficiaries by all parties are maximized.

The True Out-of-Pocket costs (TrOOP) Facilitation contractor uses the collected COB information to capture paid claims data secondary to Part D and transmit them via transactions to Part D Plans [Medicare Advantage Prescription Drug (MAPD) Plans and Prescription Drug Plans (PDPs)] for TrOOP calculation.

6.1.1 Data Sharing Agreements

One of the components of the streamlined process for COB includes the completion of data sharing agreements. These agreements establish the mechanisms for communication between entities such as CMS, insurers, employers, and vendors. Data sharing agreements include:

- Coordination of Benefits Agreement (COBA)
- Voluntary Data Sharing Agreement (VDSA)
- Eligibility Services

6.1.1.1 Coordination of Benefits Agreement (COBA)

COBA establishes a nationally standard contract between CMS and OHI organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claims data. Through the COBA process, trading partners will no longer need to submit separate eligibility files to CMS' local Medicare contractors to identify covered members, nor will they receive numerous identifiers and crossover claims files or separate invoices from these entities.

6.1.1.2 Voluntary Data Sharing Agreement (VDSA)

VDSA enables Medicare to electronically coordinate payment for beneficiary services with private sector health insurance programs. A VDSA authorizes CMS and an employer, insurer, or agent on behalf of an employer, to electronically exchange health insurance benefit entitlement information. These entities involved in the data exchange now include State Pharmaceutical Assistance Programs (SPAPs), pharmacy benefit managers (PBMs), and plans providing prescription drug coverage (MA-PDs and PDPs).

Quarterly, VDSA partners agree to submit entitlement information about employees and dependents to CMS' Coordination of Benefits (COB) Contractor. In exchange, CMS agrees to provide VDSA partners with Medicare entitlement information for those individuals in the Medicare Advantage Prescription Drug System (MARx) identified as Medicare beneficiaries. This mutual data exchange helps ensure that the appropriate plans pay the claims at first billing.

Using a VDSA to manage data exchange also provides CMS, employers, and insurers with valuable program management information that can smooth benefit program administration and lower administrative costs.

6.1.1.3 Eligibility Services

Vendors for switching services used in TrOOP Facilitation require pharmacies to submit agreements for Eligibility Services. Pharmacies or plans can continue to use their current vendors for Eligibility Services (switching services) or complete and submit an agreement with the CMS TrOOP Facilitation Contractor. The Facilitator has established standard relationships with other switching companies in the industry to enable the pharmacies and plans to utilize their existing switching companies.

6.1.1.4 Part D Sponsor COB/TrOOP Attestation

In addition to data sharing agreements, Part D sponsors are required to sign an attestation document containing statements of compliance with the COB requirements, which includes tracking TrOOP expenditures. All plan sponsors were required to submit the electronically signed attestation in 2006.

Each year new Part D plan sponsors and a subset of the existing sponsors will be required to sign an attestation document. As previously, if a plan is unable to attest to all requirements, then the plan must indicate the areas of non-compliance and submit a corrective action plan for CMS approval.

6.1.2 Connectivity

In order for payers to accurately track beneficiaries' TrOOP expenses, the payers and the TrOOP Facilitator must interact, which involves communication of claims data. The TrOOP Facilitation process provides plans with the ability to exchange real-time claims data.

The TrOOP Facilitator takes the claim information received from pharmacies or other insurers in a transaction, identifies who needs to receive the claim information (e.g., MAPD plans, PDPs, PBMs), creates new transactions based on that information, and transmits the new transactions to the plan that needs to receive the information. The receiving entity then takes the claim information and updates the TrOOP balance for the beneficiary.

Pharmacies submit supplemental claims directly to the TrOOP Facilitator or through a **switch** to the Facilitator. Primary claims are not processed by the TrOOP Facilitator.

Switch – a vendor that handles a pharmacy's or plan's regular billing and forwards the request transactions to the TrOOP Facilitator and the response transaction to the pharmacy or plan.

6.1.2.1 COB User Fees

The MMA provided CMS with the authority to impose user fees on Part D sponsors for transmitting information necessary for benefit coordination between sponsors and other entities providing prescription drug coverage. CMS has the option of updating the user fee annually to reflect costs associated with COB activities. CMS collects the fee as a rate per beneficiary per year. The COB fee collection occurs between January and September each year. Part D sponsors should plan for COB user fees when preparing their bids.

The COB user fee for 2008 is $1.36 per beneficiary per year and will increase to $2.52 in 2009.

6.1.3 BIN/PCN Combinations

Beginning in 2007, to better facilitate access at point-of-sale, CMS revised the enrollment transaction process to require 4Rx data on every enrollment transaction received from plans when submitting to the Medicare Advantage – Prescription Drug (MARx) system. The 4Rx Data are identifying data required for claims routing and are submitted by plans to MARx. If MARx accepts these 4Rx data, the data are then sent to the TrOOP Facilitation Contractor to support eligibility (E1) transactions from pharmacies. These transactions are needed anytime a beneficiary shows up for the first time at a pharmacy and does not have a plan-issued card for drug benefits.

This process change of incorporating 4Rx data into the enrollment transaction results in two important benefits. First, CMS and the TrOOP Facilitation Contractor have a set of 4Rx data for all beneficiaries whose transactions processed successfully in CMS systems. Second, this eliminates most of the time lag between CMS accepting an enrollment and the TrOOP Facilitation Contractor having 4Rx data.

The four prescription identifiers incorporated in the enrollment transaction are:

- Prescription Bank Identification Number (RxBIN)
- Prescription Processor Control Number (RxPCN)
- Prescription Member Identification Number or Cardholder ID (RxID)
- Prescription Group Number (RxGroup)

So that supplemental payers can also communicate information to support POS, CMS recommends the supplemental payers establish unique RxBIN and RxPCN for claims where Part D is the primary payer.

The RxBIN and RxPCN assist in the process of ensuring Part D Plans accurately maintain TrOOP balances. Submitting RxBIN/PCN combinations is a requirement of the VDSA along with sharing Medicare Part D enrollee information for availability at POS for claims processing and TrOOP calculations.

6.2 TrOOP Facilitation Process (Slides 44-45)

The Troop Facilitator system supports the ability to submit real-time and batch transactions from the pharmacy to the Part D plans, which provides Part D plans with the necessary TrOOP information and data necessary to submit PDE records. In conjunction with the TrOOP Facilitator process, the COB Contractor is collecting OHI from various entities and preparing the COB Data File, which is sent to the Medicare Beneficiary Database (MBD) and then to Part D Plans via MARx.

This section describes the steps in the TrOOP Facilitation process and illustrates the transactions for the steps. Table 6A provides a brief overview of the COB and TrOOP process.

TABLE 6A – STEPS IN COB AND TrOOP PROCESS

Step	Description
1	A Part D beneficiary enters a pharmacy to fill a prescription. If the beneficiary does not have a card and does not know which Part D plan they are in, the pharmacy can execute a National Council for Prescription Drug Programs (NCPDP) E1 request transaction to determine plan enrollment. The E1 response will return enrollment information, including payer-specific information about any OHI drug coverage. In the event that the Part D information is not found, the pharmacy can submit a Part A/B E1 request (also known as the Expanded E1) transaction to assess the beneficiary's Part A or Part B eligibility for Part D coverage.
2	The pharmacy submits the claim to the Part D plan.
3	The Part D plan returns a response file to the pharmacy with payment information.
4	If necessary, the pharmacy then generates a secondary claim to any other OHI payers. Pharmacy switches identify the claim as secondary to Part D and routes the claims to the TrOOP Facilitator.
5	The OHI payer(s) send responses back to the pharmacy routed through the TrOOP Facilitator.
6	The TrOOP Facilitator builds an NCPDP N1[3] reporting transaction from the response and sends it to the appropriate Part D Plan.

Within the TrOOP facilitation process, the Part D plan, in combination with knowledge of its own adjudication, will have information necessary to report TrOOP-sensitive dollar fields in the PDE record. In addition, the beneficiary has the benefit of POS coordination of benefits, accurate and perhaps even reduced cash outlay at the POS, and more accurate TrOOP accounting.

The definitions in Table 6B describe each of the transaction types used in the TrOOP Facilitation process.

TABLE 6B – TRANSACTION DEFINITIONS

Term	Definition
E1 Transaction	Pharmacies use this transaction to verify insurance coverage or eligibility for a beneficiary when the coverage is unknown. Basic information is included in this transaction and submitted in real-time by the pharmacy to query the TrOOP Facilitator on eligibility.
Part A/B E1 Transaction (Expanded E1)	In the event that a pharmacy is unable to determine a beneficiary's eligibility for Part D because the TrOOP Facilitator cannot locate the beneficiary's Part D information, the pharmacy can use the Part A/B E1 Transaction to assess the beneficiary's eligibility for Part A or Part B.
B Transactions	Pharmacies use this transaction type to submit supplemental billing claims.
N Transactions (N1, N2, N3)	The TrOOP Facilitator sends an N transaction to the Part D Plan. The type of N transaction depends on the type of B transaction submitted by the pharmacy.

6.2.1 Eligibility Transactions

Figures 6A and 6B illustrate Step 1 described in Table 6A

Figure 6A – Real-Time Transaction from Pharmacy to Facilitator

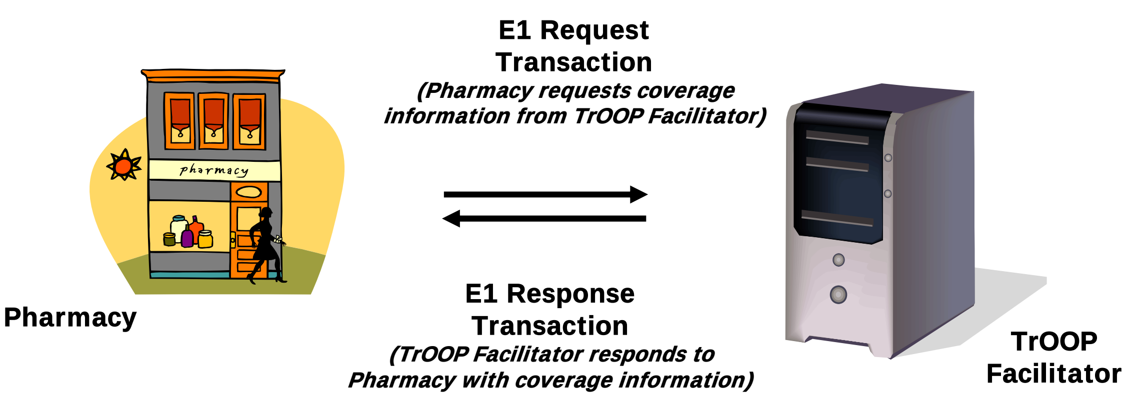
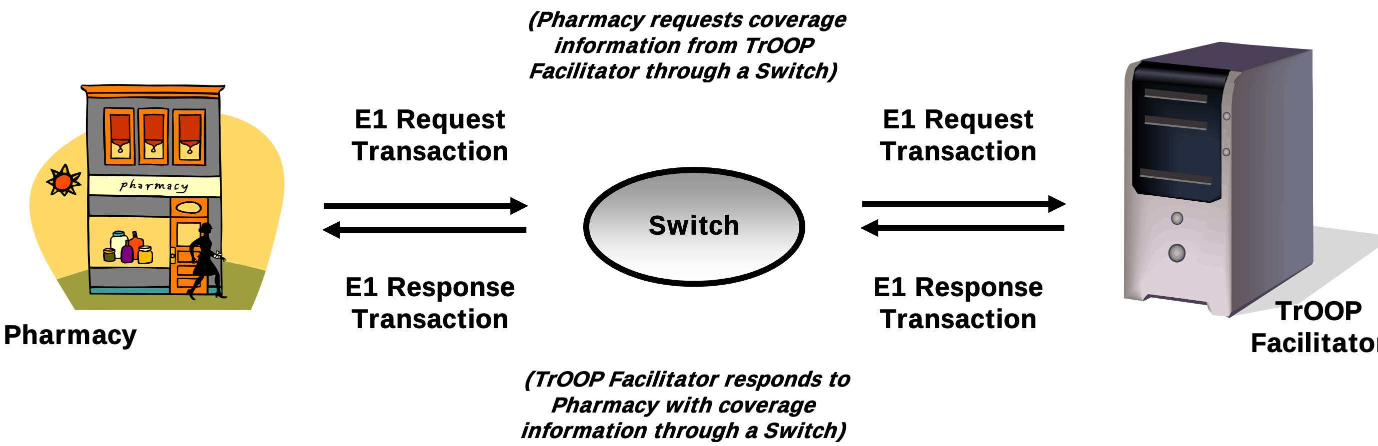


Figure 6B – Real-Time Transaction from Pharmacy to Facilitator Using a Switch



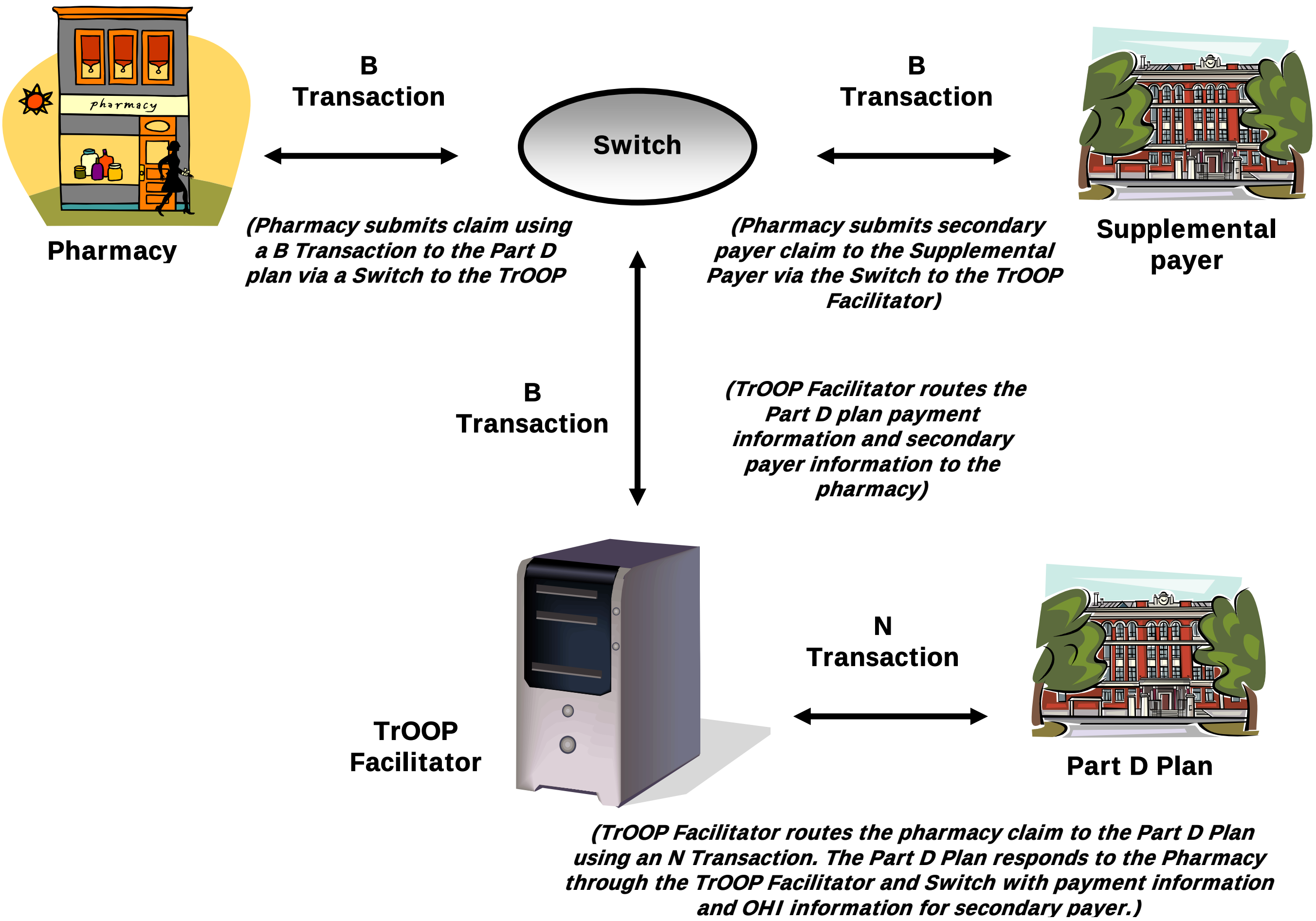
The batch process for E1 Transactions is similar to the transaction process illustrated in Figure 6B, however instead of the switch, transactions are transmitted via Secured File Transfer Protocol (FTP).

Specification for sending Eligibility Transactions is located at http://medifacd.relayhealth.com. Click on the link for Payers Sheets for Part D in the sidebar.

6.2.2 Payer Transactions

Figures 6C illustrates Steps 2 through 6 described in Table 6A.

Figure 6C – Real-Time and Batch Transaction from Facilitator to Part D Plans



📖 Specifications for programming details for Payer Transactions are located at http://medifacd.relayhealth.com. Click on the link for Payers at the top of the page and then click on Programmer Details in the sidebar.

6.2.3 Testing Process

Real-time testing is available for testing the delivery of N transactions from the TrOOP Facilitator to Part D Plans and from supplemental plans to the TrOOP Facilitator. Details of the testing steps for each are available at http://medifacd.relayhealth.com under Payers and Testing Process.

6.3 Establishing the Order of Payment for Part D COB

CMS established standards for Part D plans and all secondary Payers for Part D claims to follow in order to provide consistency in determining the order of payment on Part D claims and a basis for accurate calculation of TrOOP balances.

All payers are legally required to adhere to Medicare Secondary Payer (MSP) laws and any other federal and state laws establishing payers of last resort (e.g., TRICARE). In all other situations, payers should follow the Rules for Coordination of Benefits adopted in the most current National Association of Insurance Commissioners Coordination of Benefits Model Regulation.

The COB Contractor includes payment order indicators on other payer records it sends to MBD. Plans use this data element to sort COB records for display in reply transactions to the pharmacy. The COB Contractor calculates payer order based on MSP rules, relationship to policyholder, and type of supplemental insurance.

📖 Plan Communications User's Guide is located on CMS' MMA Help website at http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage

6.3.1 Coordination of Benefits (COB) Data File Process Flow

The COB File contains the OHI information of enrollees in that Part D Plan. The OHI information contained in the COB File has been collected by the COB Contractor through data exchanges with non-Part D payers (PBMs, insurers, Employer GHP sponsors, State programs); questionnaires filled out by beneficiaries, employers, and providers; and from information submitted from Part D Plans and other Medicare contractors. The information collected by the COB Contractor and provided to the Part D Plan is meant to assist the Part D Plan in fulfilling its requirement to coordinate with OHI.

The COB File consists of a Detail (DTL) record identifying the Part D Plan's Contract Number, the Plan Benefit Package number, and identifying information for the enrollee whose OHI is contained in the records attached to the DTL record. There are two types of records that may be attached to the DTL record of the COB Data File, Primary (PRM) and Supplemental (SUP) Records. Up to 20 PRM records and up to 20 SUP records can be attached to the COB File when it is transmitted to MBD.

Primary records contain OHI that is primary to Part D. "Primary" does not necessarily refer to a single primary insurance, but to all occurrences of insurance they are statutorily required to pay prior to Part D. There may be multiple occurrences of primary insurance. Each occurrence of primary insurance will be contained in PRM records attached to the DTL record. SUP records contain all supplemental insurance that pays after (supplemental to) Part D. Each occurrence of supplemental insurance will be contained in SUP records subordinate to the DTL record.

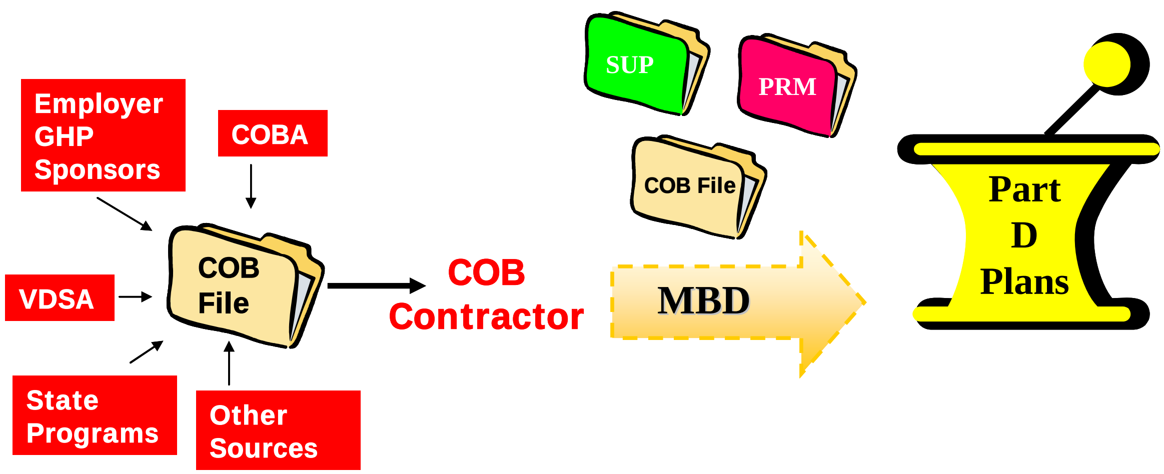
The MBD sends the COB File to Part D Plans via MARx. If MBD already contains OHI information on an enrollee at the time of enrollment, a COB File is automatically sent to Part D Plans. For instance, if an individual has OHI, disenrolls from Part D Plan X, and then enrolls in Part D Plan Y, all of the OHI that the MBD held and had previously sent to Plan X will be automatically sent to Plan Y in the COB File.

The COB File is sent out to Part D Plans as the COB Contractor collects OHI and applies records to the MBD. This can occur as often as daily. The Part D Plan may or may not receive the COB Files daily, and if it does it only receives records for enrollees with changed or newly discovered OHI. Most of the data exchanges that the COB Contractor administers for CMS are on a monthly frequency. However, each data exchange partner has its own submission schedule. The COB Contractor can receive file submissions from data exchange partners on any given day. The COB Contractor conducts development (phone calls, mailed questionnaires) on a continual basis. The COB Contractor may apply records originating from development or data exchanges to the MBD any day. As soon as the records are applied to the MBD, the COB File is sent to the Part D Plan of the enrollee with OHI.

The COB File contains full-record replacements for enrollees with newly discovered or changed OHI. If an enrollee's OHI record has been added, changed, or deleted, full replacement of that enrollee's DTL and subordinate PRM and SUP records are triggered. The Part D Plan replaces its entire existing OHI profile for an enrollee with the most recent DTL and subordinate PRM and SUP records for that enrollee.

The Part D Plan will use the elements contained in the PRM and SUP records to make payment determinations, recover mistaken payments, identify whether or not payments made by OHI count towards TrOOP, and to populate the reply to the pharmacy.

Figure 6D – COB Data File Process Flow



6.4 Facilitator and True Out-of-Pocket Costs (TrOOP) Balances (Slide 46)

The TrOOP Facilitator is not responsible for maintaining TrOOP balances for beneficiaries, nor does it store or have access to TrOOP balances. The responsibility of the TrOOP Facilitator is to deliver prescription drug claim information to the Part D plans so that the plans can calculate TrOOP and maintain TrOOP balances. Maintaining, storing, and calculating TrOOP balances, and transferring if necessary to another insurer is the responsibility of the Part D plans.

6.4.1 Transferring TrOOP Balances When Beneficiaries Change Part D Plans (Slide 47)

Each Part D plan must implement the CMS process for the transfer of TrOOP balance information when a beneficiary disenrolls from its plan and reenrolls in another Part D plan mid-year. To automate this process, CMS has worked with the industry and the National Council for Prescription Drug Programs (NCPDP) to develop an NCPDP Financial Information Reporting (FIR) transaction to support the on-line, real-time transfer of the TrOOP-related data between plan sponsors.

Implementation of the automated process will require that Part D plan sponsors develop the capacity to receive and respond in real-time (or batch) to the FIR transactions that will be used to request TrOOP-related data for disenrolling Part D beneficiaries from the prior plan(s), and to report these data for newly enrolling Part D beneficiaries transferring from another plan mid-year to the subsequent plan(s) of record. Part D plan sponsors will also need to develop the capacity to integrate data received via these electronic transactions into those systems that track and apply beneficiary-level TrOOP and gross covered drug costs. In preparation for automating TrOOP Balance Transfer: CMS, NCPDP, and industry representatives will develop a set of testing scenarios and a FIR testing certification process. As the automated process is developed, CMS will be requesting that plan sponsors participate in its testing and implementation.

To allow adequate time for plan sponsors to program and test the capacity to receive and respond FIR transactions and integrate the reported data into their systems, CMS expects to implement the automated balance transfer process on January 1, 2009. Table 6C provides the timeline for testing, certification, and implementation.

TABLE 6C - TIMELINE FOR 2008 AUTOMATED TROOP BALANCE TRANSFER IMPLEMENTATION

CY	DATA SUBMISSION TYPE	SUBMISSION TIMELINE
2008	Part D Sponsors Prepared to Initiate Systems Testing of New Transactions	September 1, 2008
2008	Part D Sponsors, Pharmacy Benefit Managers, or Other Processors Complete Systems Certification	November 1, 2008
2009	Implementation Date	January 1, 2009

In the meantime, plans should use the CMS developed process to provide other Part D plans with information on TrOOP and gross drug spend balances at the time of a beneficiary's disenrollment, and periodically thereafter as required to provide updates on late claims. Plans may need to send beneficiaries more than one EOB to reflect the retroactive adjustment of TrOOP balances given late claims.

CMS expects the timeline for implementation of the automated TrOOP balance transfer process will allow adequate time for all sponsors to program and test. However, if any Part D sponsors are not prepared to respond to the FIR transaction on January 1, 2009, then CMS will require all Part D sponsors operate dual systems for TrOOP Balance transfer data. The dual system would provide for responding to electronic transactions and transferring manually received data from non-compliant sponsors to systems for electronic retrieval.

6.4.2 Submitting Adjustment Claims

Part D plans are not required to submit adjustment claims to the TrOOP Facilitator, but do need to track adjustments and update TrOOP balances for the beneficiaries. However, supplemental, non-Part D payers must submit adjustment claims to the TrOOP Facilitator for creation of an N2 transaction.

In instances where the plan submitting the claim is supplemental and the PBM adjudicated a claim and an adjustment is required, there are two options. The first option is to establish a process with the PBM to handle adjustments. The second option is for the supplemental payer to submit the adjustment. In either instance, the adjustment should be submitted for creation of an N2 transaction. Also, the transaction for both the original claim and the adjustment should include the unique RxBIN/PCN combination for the beneficiary.

6.5 Scenarios

The scenarios in this section follow the steps illustrated previously in Table 6A and describe situations involving group health plans (GHP), Part D plans, and SPAPs with variations of primary, secondary, and tertiary payers.

6.5.1 Group Health Plan Primary, Part D Plan Secondary, SPAP Tertiary

A beneficiary enters a pharmacy and has primary GHP coverage due to active employment, Part D plan coverage is secondary, and SPAP coverage as a payer of last resort (tertiary).

1. The pharmacist can query the TrOOP Facilitation contractor on all known coverage for the beneficiary using an E1 Request Transaction and receive an E1 Response Transaction from the TrOOP Facilitator.

2. The pharmacy submits the claim to the GHP as the primary payer.

3. The GHP responds with a response file that includes the paid claim amount.

4. Since the GHP is not providing full coverage, the pharmacy then sends a secondary claim transaction to the secondary insurer (Part D plan).

5. The Part D plan returns a response transaction to the pharmacy that indicates the amount paid and lists an SPAP as a tertiary payer. The pharmacy repeats Steps 4 and 5 with the SPAP and flags the transaction for the TrOOP Facilitation contractor.

6. Following completion of the previous steps, the TrOOP Facilitator generates a reporting transaction from the responses sent to the pharmacy and sends the transaction to the Part D plan informing the plan of the amount paid by the SPAP for TrOOP calculation.

6.5.2 Part D Plan Primary and Retiree Group Health Plan Secondary

A beneficiary enters a pharmacy and has primary Part D plan coverage and secondary retiree GHP coverage.

1. The pharmacist can query the TrOOP Facilitation contractor on all known coverage for the beneficiary using an E1 Request Transaction and receive an E1 Response Transaction from the TrOOP Facilitator.

2. The pharmacy submits the claim to the Part D plan as the primary payer.

3. The Part D plan responds with a response file that includes the paid claim amount and displays Retiree GHP coverage as secondary.

4. Since the Part D plan is not providing full coverage, the pharmacy then sends a secondary claim transaction to the secondary insurer (the Retiree GHP) and flags the transaction for the TrOOP Facilitation contractor.

5. The Retiree GHP returns a response transaction to the pharmacy that indicates the amount paid.

6. Following completion of the previous steps, the TrOOP Facilitator generates a reporting transaction from the responses sent to the pharmacy and sends the transaction to the Part D plan informing the plan of the amount paid by the Retiree GHP for TrOOP calculation.

6.5.3 Part D Plan Primary and SPAP Secondary

A beneficiary enters a pharmacy and has primary Part D plan coverage and secondary SPAP coverage.

1. The pharmacist can query the TrOOP Facilitation contractor on all known coverage for the beneficiary using an E1 Request Transaction and receive an E1 Response Transaction from the TrOOP Facilitator.

2. The pharmacy submits the claim to the Part D plan as the primary payer.

3. The Part D plan responds with a response file that includes the paid claim amount and displays SPAP coverage as secondary.

4. Since the Part D plan is not providing full coverage, the pharmacy then sends a secondary claim transaction to the secondary insurer (SPAP) and flags the transaction for the TrOOP Facilitation contractor.

5. The SPAP returns a response transaction to the pharmacy that indicates the amount paid.

6. Following completion of the previous steps, the TrOOP Facilitator generates a reporting transaction from the responses sent to the pharmacy and sends the transaction to the Part D plan informing the plan of the amount paid by the SPAP for TrOOP calculation.

6.6 Resources

Table 6D provides a list of contacts and support available to assist with the TrOOP Facilitation process.

TABLE 6D – CONTACTS AND SUPPORT

Organization	Contact Information
Centers for Medicare & Medicaid Services (CMS)	MMA Help Desk 1-800-927-8069
NDC Health (TrOOP Facilitator Contractor)	http://medifacd.relayhealth.com
CSMM Help Desk	www.cms.hhs.gov/mmahelp mmahelp@cms.hhs.gov

MODULE 7 – CALCULATING AND REPORTING LOW INCOME COST-SHARING SUBSIDY

Purpose (Slide 2)

The Medicare Modernization Act (MMA) amended the Social Security Act (the Act) to provide for Medicare payments to plans to subsidize the cost-sharing liability for covered Part D drugs purchased by qualifying low income (LI) beneficiaries. This module describes the low income cost-sharing subsidy (LICS) and the process for calculating and reporting LICS amounts via the Prescription Drug Event (PDE) record submissions.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Define the Low Income Cost-Sharing Subsidy (LICS).
- Determine how to administer the Part D benefit by determining whether or not any LICS applies to a given prescription event and the appropriate amount of cost-sharing due from a low income beneficiary.
- Calculate LICS amount using the rules that apply to all plan types.
- Identify the data fields required to report LICS amounts.
- Explain how LICS affects True Out-of-Pocket (TrOOP) costs.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

7.1 The Low Income Cost-Sharing Subsidy (Slides 4-7)

The MMA provides for Medicare payment to plans to subsidize cost-sharing for the covered Part D drugs of beneficiaries with limited resources as defined by certain federal poverty level (FPL) standards and asset limits. The federal government pays some or all of the Part D cost-sharing of qualifying beneficiaries. The MMA provides two types of low income (LI) subsidies: premium assistance and cost-sharing assistance. Premium subsidies are taken into account using other data streams and do not impose any Prescription Drug Event (PDE) data reporting requirements on plans. However, cost-sharing assistance is documented and reconciled using PDE data and is referred to as Low Income Cost-sharing Subsidy (LICS).

Accurate PDE reporting begins with accurate benefit administration. Determining accurate cost-sharing is an integral part of Part D benefit administration. First, the plan calculates the amount the low income beneficiary pays at point of sale (POS). Then, the plan calculates LICS which is the amount the plan subsidizes for each low income beneficiary event. So, plans administer the benefit for low income eligible beneficiaries by calculating both the amount the low income beneficiary pays and the LICS amount, and reporting these results in discrete PDE fields.

When the cost-sharing subsidy applies, the plan advances it on behalf of the government. Therefore, the Centers for Medicare & Medicaid Services (CMS) makes prospective payments to plans to cover anticipated LICS that plans will pay. Plans then report the cost-sharing subsidy they pay on behalf of beneficiaries to CMS on PDE records. After the end of the coverage year, CMS reconciles the actual payments from PDE records with the prospective payments made to plans.

Regardless of the plan type, the following rules for calculating and reporting LICS remain constant:

- LICS only applies to covered Part D drugs; the LI-beneficiary pays the same cost-sharing for non-covered drugs as any other beneficiary under their benefit package.
- LICS always counts towards True Out-of-Pocket (TrOOP) costs.
- When the cost-sharing for a non-low income subsidy beneficiary under the plan is less than the statutory maximum low income cost-sharing, the low income beneficiary pays the lesser amount. This policy applies to co-pays, coinsurance, and deductibles.
- Supplemental benefits provided under the plan benefit package (PBP) are always applied before LICS is calculated.
- LICS rules apply to low income subsidy beneficiaries in both basic and enhanced plans.

Plans will adjudicate claims and report PDEs in accordance with the category of assistance for which the beneficiary is eligible. Tables 7A and 7B outline the eligibility requirements and maximum cost-sharing for low income subsidy eligible beneficiaries. Table 7A lists the values that apply for coverage year 2006, Table 7B lists the indexed values that apply to coverage year 2008, and Table 7C provides the values for coverage year 2009.

Note that LI beneficiaries have continuous coverage with one exception: Category 4 beneficiaries are assigned a $50 deductible (2006) that is indexed annually or, if less, the deductible under the PBP. They then have continuous coverage.

Note: All examples in this module use the 2006 coverage year values, identified in Table 7A.

TABLE 7A – 2006 LICS CATEGORIES

		MAXIMUM LI BENEFICIARY COST-SHARING			
Category Code	**Income Category**	**Deductible**	**Initial Coverage Period**	**Coverage Gap**	**Catastrophic**
2	≤100% FPL and fbde	$ 0	$1-generic $3-brand	$1-generic $3-brand	$0
1	<135% or >100% FPL and fbde	$ 0	$2-generic $5-brand	$2-generic $5-brand	$0
4	<150% FPL	$50	15%	15%	$2-generic $5-brand
3	Inst fbde	$ 0	$0	$0	$0

TABLE 7B – 2008 LICS CATEGORIES

		MAXIMUM LI BENEFICIARY COST-SHARING			
Category Code	**Income Category**	**Deductible**	**Initial Coverage Period**	**Coverage Gap**	**Catastrophic**
2	≤100% FPL and fbde	$ 0.00	$1.05-generic $3.10-brand	$1.05-generic $3.10-brand	$0.00
1	<135% or >100% FPL and fbde	$ 0.00	$2.25-generic $5.60-brand	$2.25-generic $5.60- brand	$0.00
4	<150% FPL	$56.00	15%	15%	$2.25-generic $5.60-brand
3	Inst fbde	$ 0.00	$0.00	$0.00	$0.00

TABLE 7C – 2009 LICS CATEGORIES

		MAXIMUM LI BENEFICIARY COST-SHARING			
Category Code	**Income Category**	**Deductible**	**Initial Coverage Period**	**Coverage Gap**	**Catastrophic**
2	≤100% FPL and fbde	$ 0.00	$1.10-generic $3.20-brand	$1.10-generic $3.20-brand	$0.00
1	<135% or >100% FPL and fbde	$ 0.00	$2.40-generic $6.00-brand	$2.40-generic $6.00- brand	$0.00
4	<150% FPL	$60.00	15%	15%	$2.40-generic $6.00-brand
3	Inst fbde	$ 0.00	$0.00	$0.00	$0.00

Notes for Tables 7A, 7B, and 7C: fbde (full benefit dual eligible); Inst (institutionalized).
To be eligible for LICS, beneficiaries must also pass certain asset tests.
A Category Code of 0 (zero) means no LICS eligibility.

For a complete description of eligibility rules, see §1860D-14(a)(3)(D) and (E) of the Act as amended by the MMA.

"Lesser of" test: For all LI categories, if the applicable LI cost-sharing amount is greater than the amount of cost-sharing that would be due under the PBP (standard or enhanced) for a beneficiary who is not LI, the beneficiary is only responsible for the non-LI cost-share (the lesser amount). The "lesser of" test is used to determine all LI co-pays and coinsurances as well as any deductible applicable to a Category 4 beneficiary.

"Generic" also includes a preferred multiple source drug as defined in §1860D-2(b)((2)(D)(ii) of the Act.

A full-benefit dual eligible beneficiary (fbde) is an individual who has prescription drug coverage for the month under a Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MA-PD) plan and is determined eligible by the state for medical assistance under Title XIX of the Act.

An institutionalized (Inst) beneficiary is a full-benefit dual eligible individual who is an inpatient in a medical institution or nursing facility for whom payment is made under Medicaid for a month. When an individual enters such institution, community co-pay levels apply until the beneficiary has spent a continuous, full calendar month in the institution. The zero cost-sharing provision only applies after a continuous stay of one calendar month.

The categories in Table 7A, 7B, and 7C apply to all low income subsidy (LIS) eligible individuals except for beneficiaries residing in the U.S. territories to whom different low income subsidy provisions apply. In addition, calculations of LICS for the PACE program are unique.

See the PACE PDE training materials available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.

Note that in general, there are two phases of low income cost-sharing: the cost-sharing that is assigned before Catastrophic Coverage and the cost-sharing that is assigned during the Catastrophic Coverage phase. Pre-catastrophic low income cost-sharing begins when the beneficiary purchases his/her first Part D covered drug of the benefit year. The only exception is the Category 4 beneficiary in a plan benefit package that has a deductible. The beneficiary must first satisfy the statutory Category 4 deductible or, if less, the plan deductible.

To illustrate the benefits of LICS, consider the following example:

Example: 1

Mr. Smith is eligible for the LI subsidy. He has limited income and assets and falls below 135 percent of the FPL in Category 1. As such, he is eligible for the following benefits:
Note: This example uses 2006 values.

- $0.00 deductible
- No gap in his drug coverage
- A co-pay not to exceed $2 for covered Part D generic drugs and not to exceed $5 for other covered Part D drugs until the Out-of-Pocket (OOP) threshold is reached
- No out-of-pocket costs after the OOP threshold is reached

7.2 Calculating Low Income Cost-Sharing Subsidy (Slides 8-13)

Plans report the amount of LI cost-sharing subsidy in the LICS Amount field. Understanding how to populate this field will ensure accurate reporting and payment of LICS. This section illustrates how to calculate the amount of cost-sharing due from an LI beneficiary and the amount of subsidy to report in the LICS field.

Plans will populate the LICS Amount field with the amount they pay the pharmacy at POS for an eligible beneficiary's cost-sharing.

In formula:

When Non-LI cost sharing > LI cost-sharing, then LICS Amount = Non-LI beneficiary cost-sharing – LI beneficiary cost-sharing When Non-LI cost-sharing ≤ LI cost-sharing, then LICS Amount = Zero*

Notes: Non-LI (non-low income subsidy eligible); LI (low income subsidy eligible).
*When non-LI cost-sharing ≤ LI cost-sharing, then the non-LI cost-sharing is applied to the LI beneficiary and LICS Amount = 0.

This formula is referred to as the **LICS Amount formula**. The non-LI cost-sharing is the amount due from a non-LI beneficiary for a given event under the PBP. The LI cost-sharing is the maximum allowable amount due under the MMA from a low income subsidy beneficiary for that same dispensing event or, if less, the cost-sharing under the PBP. In the LICS Amount field, plans report the difference between the non-LI and LI cost-sharing which is the amount advanced by the plan at point of sale and ultimately subsidized by CMS. The LICS amount thus represents the amount by which cost-sharing was reduced due to the LICS advance payment by the plan.

The "lesser of" test applies equally to LI co-pays or coinsurances and Category 4 deductibles. When the PBP deductible is less than the Category 4 deductible, the Category 4 low income cost-sharing is a 15 percent coinsurance after the annual deductible under the plan. Accordingly, in the LICS Amount formula, the Category 4 cost-sharing shall include whichever is less: the statutory Category 4 deductible or a lower deductible amount if provided under the PBP. In practice, this means that the LICS Amount formula shall not include a Category 4 deductible amount that is greater than that under the PBP.

In summary, the LICS Amount Formula:

- Includes the entire Category 4 deductible when PBP deductible ≥ statutory Category 4 amount ($50 in 2006).
- Includes a partial Category 4 deductible equal to the PBP amount if the PBP deductible is < the statutory Category 4 amount and > $0.
- Excludes the entire Category 4 deductible when the PBP has a deductible = $0.

Like all LICS rules, the Category 4 deductible rules apply to LIS beneficiaries in both basic and enhanced plans.

Also recall that in Part D, YTD gross covered drug costs, not TrOOP costs, satisfy the deductible. Therefore, if the YTD gross drug costs are greater than or equal to the Category 4 deductible amount, even if a third party payment or the "lesser of" test has reduced actual beneficiary liability below the amount, the beneficiary has met their Category 4 deductible.

Note: If a beneficiary has any other health insurance (OHI), whether TrOOP-eligible or not, this formula must use cost-sharing amounts as calculated **BEFORE** any wrap-around coverage is applied (see example 7.3.3). However, this rule does not apply when Medicare is a secondary payer (MSP).

This formula applies for all plan types throughout all phases of the benefit.
To illustrate LICS calculations for the four LI categories, assume a given scenario and calculate LICS for each category under that scenario. For example:

LIS beneficiaries are enrolled in a Defined Standard plan with a 25 percent coinsurance in the Initial Coverage period. Year-to-date (YTD) Gross Covered Drug Costs = $1,500, which places each beneficiary in the Initial Coverage period. Each beneficiary purchases a brand name covered drug for $100.

Table 7D shows the result when the plan follows four steps to accurately calculate LICS and determine the amounts needed to populate the PDE record fields:

Step 1 Calculate the non-LI cost-sharing amount (column C) and the Covered D Plan Paid Amount (CPP) (column G) according to the benefit phase the beneficiary is in. Calculate both amounts as though the beneficiary **were not eligible** for LIS and had no other source of coverage. Cost-sharing and plan payment amounts often vary per benefit phase, so the plan must apply YTD Gross Covered Drug Costs and incurred TrOOP to the plan's benefit structure to determine which benefit phase the beneficiary is in.

Step 2 Using Table 7A, determine the LI beneficiary's maximum cost-sharing amount (column D) that corresponds to the category of assistance for which the beneficiary is eligible (column A).

Step 3 Perform the "lesser of" test by comparing the amount of non-LI cost-sharing (column C) to the amount of LI cost-sharing from Table 7A (column D)**.** The lesser of these two amounts is the beneficiary liability, reported in the Patient Pay Amount field (column E). **Note:** In the "lesser of" test for a Category 4 beneficiary, the LI cost-sharing includes either the statutory Category 4 deductible amount or, if less, the deductible under the PBP.

Step 4 Using the LICS Amount formula, calculate the difference between the non LI-beneficiary cost-sharing (column C) and the LI beneficiary cost-sharing [Patient Pay Amount (column E)]. This amount represents the amount of subsidy advanced by the plan at the POS and is reported as the LICS Amount (column F) on the PDE record. TrOOP (column H) increases by the amounts in the fields Patient Pay Amount and LICS Amount (columns E and F).

TABLE 7D – SAMPLE LICS VALUES

LICS VALUES							
A	B	C	D	E	F	G	H
LI Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C – E*)**	**CPP**	**TrOOP (E + F)**
Category 2	$100.00	$25.00	$ 3.00	$ 3.00	$22.00	$75.00	$25.00
Category 1	$100.00	$25.00	$ 5.00	$ 5.00	$20.00	$75.00	$25.00
Category 4	$100.00	$25.00	$15.00	$15.00	$10.00	$75.00	$25.00
Institutionalized (Category 3)	$100.00	$25.00	$ 0.00	$ 0.00	$25.00	$75.00	$25.00

*The Patient Pay Amount must be the Patient Pay Amount as calculated on the initial claim, without subtracting any PLRO or Other TrOOP amount. In other words, OHI payments, which are reported in Other TrOOP or PLRO, only reduce the beneficiary liability; OHI payments do not reduce LICS. See example 7.3.3.

Except for MSP events, OHI payments only reduce the beneficiary liability; OHI payments do not reduce LICS.

Note: When a plan reports dollars in the LICS field, the Drug Data Processing System (DDPS) validates the beneficiary's low income eligibility status and category against MBD. Then DDPS compares the maximum catastrophic and non-catastrophic cost-sharing allowed for the beneficiary's LI category to the dollars reported in the three beneficiary liability fields (Patient Pay Amount, Other TrOOP, and PLRO). DDPS rejects records when the sum of amounts in these three fields exceeds the maximum allowed LI cost-sharing.

7.3 Populating the PDE Record for LICS Beneficiaries (Slide 14)

This section provides examples of populating a PDE record for LICS-eligible beneficiaries in all benefit phases and at all LI eligibility categories for 2006. There are examples of the "lesser of" test, a straddle claim, Category 4 beneficiaries in plans with varying deductible amounts, and an Over-the-Counter (OTC) drug. The following PDE record fields are highlighted:

- Drug Coverage Status Code
- Catastrophic Coverage Code
- Patient Pay Amount
- Low Income Cost-Sharing Subsidy Amount (LICS Amount)
- Covered D Plan Paid Amount (CPP)
- Non-covered Plan Paid Amount (NPP)
- Other TrOOP Amount

The impact of LICS on TrOOP accumulation is also illustrated.

7.3.1 Defined Standard Deductible Phase

In 2006, NCE Health Plan offers a defined standard benefit package ($250 deductible). Two LICS eligible beneficiaries, one Institutionalized (Category 3) and the other Category 4, with YTD Covered Drug Costs = $0.00, purchase a covered brand name drug for $50. Table 7E indicates how LICS is calculated and how PDE fields are populated, for this event, noting TrOOP accumulation.

TABLE 7E – DEDUCTIBLE PHASE

LICS CALCULATION							
A	B	C	D	E	F	G	H
LI Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C - E)**	**CPP**	**TrOOP (E + F)**
Institutionalized (Category 3)	$50.00	$50.00	$ 0.00	$ 0.00	$50.00	$0.00	$50.00
Category 4	$50.00	$50.00	$50.00	$50.00	$ 0.00	$0.00	$50.00

PDE RECORD FIELDS				
Beneficiary Type	**Drug Coverage Status Code**	**Patient Pay Amount**	**LICS**	**CPP**
Non-LI	C	$50.00	$0.00	$0.00
LI, Institutionalized (Category 3)	C	$ 0.00	$50.00	$0.00
LI, Category 4	C	$50.00	$ 0.00	$0.00

The non-LI beneficiary is in the deductible phase of the Defined Standard benefit requiring 100 percent coinsurance. Even though there is no LICS Amount to report, the PDE field is populated with $0.00. An Institutionalized (Category 3) LI eligible beneficiary is not required to pay a deductible; therefore, LICS pays 100 percent of the cost-sharing. However, in this plan a Category 4 beneficiary has a $50 deductible for 2006 paid by the beneficiary. For the Institutionalized (Category 3) beneficiary the LICS field is populated with $50 because the difference between non-LI ($50) and LI-Institutionalized (Category 3) beneficiary cost-sharing ($0.00) = $50. For the Category 4 beneficiary the LICS field is $0 because the difference between non-LI ($50) and LI-Category 4 beneficiary cost-sharing ($50) = $0.

Patient Pay Amount and the **LICS Amount** count toward TrOOP.

Note: When the plan reports dollars in the LICS field, DDPS validates that the Drug Coverage Status Code reports a value of "C" indicating a covered drug. Similarly, when the plan reports a non-covered drug (i.e., Drug Coverage Status Code = E or O), DDPS validates that LICS is $0.00.

7.3.2 Actuarially Equivalent Initial Coverage Period (Slides 15-17)

In 2006, 3J Prescription Benefit Plan offers an actuarially equivalent standard benefit package with tiered cost-sharing (5%/25%/30%). The beneficiary is eligible for Category 1 of the LICS and has a YTD gross covered drug costs = $500. The beneficiary purchases a Tier 1 generic covered drug that costs $5. Table 7F indicates how LICS is calculated and how PDE fields are populated for this event, noting TrOOP accumulation.

TABLE 7F – ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD

LICS CALCULATION							
A	B	C	D	E	F	G	H
LI Beneficiary Type	Gross Covered Drug Cost	Non-LI Cost Share (Step 1)	LI Cost Share (Step 2)	Patient Pay Amount	LICS (C - E)	CPP	TrOOP (E + F)
Category 1	$5.00	$0.25	$2.00	$0.25	$0.00	$4.75	$0.25

PDE RECORD FIELDS				
Beneficiary Type	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP
Non-LI	C	$0.25	$0.00	$4.75
LI, Category 1	C	$0.25	$0.00	$4.75

In this example, the Non-LI beneficiary is in the Initial Coverage period of the benefit and has only $0.25 of liability. As per the "lesser of" test, this amount is lower than the statutory amount of $2.00 in 2006 for a Category 1 generic drug co-pay, so the beneficiary pays $0.25 and there is no LICS amount. The remaining $4.75 is reported under CPP as the amount the plan paid under its standard benefit.

The LI beneficiary always pays the "lesser of" the two cost-sharing amounts: LI or non-LI.

7.3.3 Defined Standard Coverage Gap With TrOOP Other Payer (Slides 18-21)

Payments by some third parties that reduce or eliminate the LI-beneficiary's cost-sharing may be applied to TrOOP. Qualified State Pharmacy Assistance Programs (SPAPs) are TrOOP-eligible payers (for covered Part D drugs). A LI beneficiary's cost-sharing amount is reduced by the amount of payment made by a qualified SPAP. The amount the beneficiary actually pays is reported in the Patient Pay Amount field and the amount the qualified SPAP pays is reported in the Other TrOOP Amount field.

In 2006, Sunny Valley Health Plan offers a Defined Standard benefit package. The beneficiary is Category 4 eligible and has YTD gross covered drug costs of $2,800. The beneficiary is also eligible for his state's qualified SPAP program, which pays 100 percent of beneficiary cost-sharing. The beneficiary purchases a covered brand drug for $300. Table 7G indicates how LICS is calculated in 2006 and how PDE fields are populated for this event, noting TrOOP accumulation.

TABLE 7G – DEFINED STANDARD COVERAGE GAP WITH QUALIFIED SPAP ASSISTANCE

LICS CALCULATION								
A	B	C	D	E	F	G	H	I
Gross Covered Drug Cost	Non-LI Cost Share (Step 1)	LI Cost Share (Step 2)	Patient Pay Amount (unadj)	LICS (B - D) Or B – (G+H)*	CPP	Patient Pay Amount (adj)	Other TrOOP Amount	TrOOP (E+G+H)
$300.00	$300.00	$45.00	$45.00	$255.00	$0.00	$0.00	$45.00	$300.00

PDE RECORD FIELDS					
Beneficiary Type	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP	Other TrOOP Amount
Non-LI	C	$300.00	$0.00	$0.00	$0.00
LI, Category 4	C	$0.00	$255.00	$0.00	$45.00

*This formula must include PLRO where applicable, just as it includes Other TrOOP in this example. In this example, the change in Patient Pay Amount from unadjusted to adjusted was due to the Other TrOOP payment; the unadjusted Patient Pay Amount is the amount as calculated prior to subtracting the Other TrOOP payment. Note that the LICS amount did not change. OHI payments which are reported in Other TrOOP or PLRO only reduce the beneficiary liability; OHI payments do not reduce LICS.

The Patient Pay Amount for the Category 4 LI beneficiary is zero because the qualified SPAP picked up 100 percent of the beneficiary's liability, and remains $300 for the non-LI beneficiary because the qualified SPAP did not provide any assistance to that individual. LICS is calculated by comparing the Non-LI beneficiary's cost-sharing before applying any qualified SPAP wrap-around ($300) with the Category 4 unadjusted Patient Pay Amount, i.e., the patient pay amount before applying any qualified SPAP wrap-around ($45); the difference, reported in LICS Amount, is $255. Alternatively, the plan can calculate LICS by subtracting the sum of the adjusted Patient Pay Amount (the amount that will come in on the final PDE after adjustment for the qualified SPAP payment) with the Other TrOOP Amount ($45) from the non-LI cost share. The qualified SPAP payment of $45 counts toward TrOOP, which the plan enters in the Other TrOOP Amount field.

7.3.4 Actuarially Equivalent Straddle Claim (Slide 22)

In 2006, Bonneville Benefits offers an actuarially equivalent plan with a tiered co-pay structure ($5 generic; $20 preferred brand drugs; and $50 brand drugs) that applies only during the initial coverage period. The beneficiary's YTD gross covered drug costs are $2,225; she is LI-Category 1 eligible and purchases a covered drug in Tier 2 for $80. Table 7H indicates how LICS is calculated in 2006 and how PDE fields are populated for this event, noting TrOOP accumulation.

TABLE 7H – ACTUARIALLY EQUIVALENT STRADDLE CLAIM

LICS CALCULATION							
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
LI Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C - E)**	**CPP**	**TrOOP Amount (E+F)**
Category 1	$80.00	$75.00	$2.00	$2.00	$73.00	$5.00	$75.00

PDE RECORD FIELDS				
Beneficiary Type	**Drug Coverage Status Code**	**Patient Pay Amount**	**LICS**	**CPP**
Non-LI	C	$75.00	$0.00	$5.00
LI, Category 1	C	$2.00	$73.00	$5.00

In this example, cost-sharing is determined with straddle claim logic. With YTD gross covered drug costs of $2,225 the beneficiary is in the Initial Coverage period, however the $80 purchase moves the beneficiary into the Coverage Gap. The non-LI beneficiary cost share must be calculated as a straddle claim.

The non-LI beneficiary's cost-sharing is calculated by combining the Tier 2 co-pay of $20 in the Initial Coverage period with 100 percent coinsurance for the purchase that falls in the Coverage Gap ($55). Therefore, the non-LI cost share (column C) is $75. A Category 1 beneficiary cannot be charged more than $2 for generic or preferred multiple source drugs that are specified in statute. The beneficiary is charged the cost-sharing only once (despite crossing two phases of the benefit), so the Patient Pay Amount is $2.

7.3.5 Defined Standard Catastrophic Coverage Phase

In 2006, Lara Pharmacy Insurance offers a Defined Standard benefit. Two beneficiaries, Category 2 and Category 4 eligible, each with $5,300 YTD gross covered drug costs, purchase a $200 covered brand drug. Table 7I indicates how LICS is calculated and how PDE fields are populated for this event, noting TrOOP accumulation.

TABLE 7I – DEFINED STANDARD CATASTROPHIC COVERAGE PHASE

LICS CALCULATION						
A	**B**	**C**	**D**	**E**	**F**	**G**
LI Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C-E)**	**CPP**
Category 2	$200.00	$10.00	$ 0.00	$0.00	$10.00	$190.00
Category 4	$200.00	$10.00	$ 5.00	$5.00	$ 5.00	$190.00

PDE RECORD FIELDS						
Beneficiary Type	**Drug Coverage Status Code**	**Patient Pay Amount**	**LICS**	**CPP**	**Catastrophic Coverage Code**	**GDCA**
Non-LI	C	$10.00	$0.00	$190.00	C	$200.00
Category 2	C	$ 0.00	$10.00	$190.00	C	$200.00
Category 4	C	$ 5.00	$ 5.00	$190.00	C	$200.00

This example reinforces that LI beneficiaries in each category are responsible for differing amounts of cost share; however LICS will always be the difference between non-LI beneficiary cost share and the LI beneficiary's cost-sharing.

7.3.6 Additional Examples for Category 4 LICS Beneficiaries

The following examples are devoted to applying the "lesser of" test when calculating and reporting Category 4 beneficiary cost-sharing in plans with zero deductible or a deductible that is less than the statutory Category 4 amount ($50 in 2006). The first example reviews the basic case where the deductible is greater than the statutory amount so that the Category 4 beneficiary pays the full statutory amount (see 7.3.6.1). In contrast, in the ensuing examples the plan deductible is less than the statutory amount but greater than zero or the plan has no deductible at all. The examples illustrate "lesser of" test so that the beneficiary pays whichever is less: the statutory deductible or the plan deductible.

Examples 7.3.6.1 and 7.3.6.2 contain two claims per beneficiary to illustrate calculations before and after the deductible is met. They also illustrate calculations for claims that straddle the deductible and the Initial Coverage period.

7.3.6.1 Category 4 LICS Beneficiary, Plan Deductible Greater Than Statutory Category 4 Amount (Slides 23-26)

A Category 4 beneficiary joined a Defined Standard plan ($250 deductible in 2006). The beneficiary's first two claims of the year have a negotiated price (gross drug cost) of $100 each and both are for covered drugs. In the "lesser of" test, a $50 deductible for the first claim is included in the calculation on the Category 4 side. After the $50 deductible is met, a 15 percent coinsurance provision is applied to the remaining drug cost in Claim 1 and to the gross drug cost in Claim 2.

TABLE 7J – DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT

LICS CALCULATION							
A	B	C	D	E	F	G	H
LI Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C-E)**	**CPP**	**TrOOP Amount (E+F)**
Non-LI, Claim 1	$100.00	$100.00	N/A	$100.00	N/A	$0.00	$100.00
Non-LI, Claim 2	$100.00	$100.00	N/A	$100.00	N/A	$0.00	$100.00
LI Category 4, Claim 1	$100.00	$100.00	$57.50	$57.50	$42.50	$0.00	$100.00
LI Category 4, Claim 2	$100.00	$100.00	$15.00	$15.00	$85.00	$0.00	$100.00

PDE RECORD FIELDS				
Beneficiary Type	**Drug Coverage Status Code**	**Patient Pay Amount**	**LICS**	**CPP**
Non-LI, Claim 1	C	$100.00	$0.00	$0.00
Non-LI, Claim 2	C	$100.00	$0.00	$0.00
LI Category 4, Claim 1	C	$57.50	$42.50	$0.00
LI Category 4, Claim 2	C	$15.00	$85.00	$0.00

The Drug coverage Status code is “C” for a covered drug. On the first claim, the beneficiary pays a reduced deductible of $50 instead of $250, according to the statutory provision. The beneficiary then enters the Initial Coverage period and pays a 15 percent coinsurance on the remaining $50 of the first claim ($7.50) for a total Patient Pay Amount of $57.50 on the PDE record ($50 + $7.50). The difference between the non-LI cost-sharing and the LI cost-sharing is subsidized on the beneficiary’s behalf ($100 - $57.50 = $42.50); this amount is reported in the LICS Amount field. There is no remaining amount for the plan to pay, so CPP is $0.

Since YTD covered drug costs now equal $100, the Category 4 beneficiary has met the deductible. The next plan adjudicates the next claim by continuing to apply a 15 percent coinsurance (15% * $100 = $15).

7.3.6.2 Category 4 LICS Beneficiary, Plan Deductible Less Than Statutory Category 4 Amount and Greater Than Zero (Slide 27)

Assume that in 2006, a Category 4 beneficiary enrolls in a basic alternative PBP with a $30 deductible, followed by 25 percent coinsurance in the Initial Coverage period. The first two claims of the year for the beneficiary are shown, applying the “lesser of” test by including the plan’s $30 deductible (not $50) in the calculation on the Category 4 side. The negotiated prices are $25 for a generic drug in the first claim and $200 for the second claim; both are covered drugs.

TABLE 7K – DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO

LICS CALCULATION							
A	B	C	D	E	F	G	H
LI Beneficiary Type	Gross Covered Drug Cost	Non-LI Cost Share (Step 1)	LI Cost Share (Step 2)	Patient Pay Amount	LICS (C - E)	CPP	TrOOP Amount (E+F)
Non-LI Claim 1	$25.00	$25.00	N/A	$25.00	N/A	$0.00	$25.00
Non-LI Claim 2	$200.00	$53.75	N/A	$53.75	N/A	$146.25	$53.75
LI Category 4, Claim 1	$25.00	$25.00	$25.00	$25.00	$0.00	$0.00	$25.00
LI Category 4, Claim 2	$200.00	$53.75	$34.25	$34.25	$19.50	$146.25	$53.75

PDE RECORD FIELDS				
Beneficiary Type	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP
Non-LI, Claim 1	C	$25.00	$0.00	$0.00
Non-LI, Claim 2	C	$53.75	$0.00	$146.25
LI Category 4, Claim 1	C	$25.00	$0.00	$0.00
LI Category 4, Claim 2	C	$34.25	$19.50	$146.25

The Drug coverage Status code is "C" for covered drugs. For LI Category 4, Claim 1, the beneficiary pays Patient Pay Amount of $25 towards the $30 deductible. The remaining $5 is applied to the next drug purchase. Claim 2 drug cost is $200 less the remaining $5 deductible = $195. The beneficiary is then in the Initial Coverage period and pays (15 percent of $195) + $5 = $29.25 + $5 = Patient Pay Amount of $34.25. LICS is derived by subtracting LI Cost Sharing = $34.25 from Non-LI Cost-Sharing $53.75 = $19.50. The plan pays the remainder ($200 - $34.25 - $19.50) = $146.25 in risk sharing dollars reported in CPP.

When the plan's deductible is less than the Category 4 deductible amount, the Category 4 cost-sharing is a 15 percent coinsurance after the annual deductible under the plan.

7.3.6.3 Category 4 LICS Beneficiary, Zero Deductible Plan

A Category 4 beneficiary joins a basic alternative PBP in 2006 with no deductible and 25 percent cost-sharing in the Initial Coverage period. This is the beneficiary's first claim of the year and the negotiated price (gross drug cost) is $100; it is a covered drug. In the "lesser of" test, the deductible is excluded from the calculation on the Category 4 side and only uses 15 percent coinsurance. The Category 4 beneficiary receives the 15 percent coinsurance provision beginning with the first covered drug of the year.

TABLE 7L- ZERO DEDUCTIBLE

LICS CALCULATION							
A	B	C	D	E	F	G	H
LI Beneficiary Type	Gross Covered Drug Cost	Non-LI Cost Share (Step 1)	LI Cost Share (Step 2)	Patient Pay Amount	LICS (C - E)	CPP	TrOOP Amount (E+F)
Non-LI	$100.00	$25.00	N/A	$25.00	N/A	$75.00	$25.00
LI Category 4	$100.00	$25.00	$15.00	$15.00	$10.00	$75.00	$25.00

PDE RECORD FIELDS				
Beneficiary Type	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP
Non-LI	C	$25.00	$0.00	$75.00
LI Category 4	C	$15.00	$10.00	$75.00

The Drug Coverage Status Code is "C". For LI Category 4, the beneficiary's coinsurance is 15 percent of the Gross Covered Drug Cost of $100, for a Patient Pay Amount of $15. The low income cost-sharing subsidy is the difference between the non-LI cost-sharing of $25 (25% * $100) and $15 (15% * $100) = $10. The plan pays the remaining drug cost ($100 - $15 - $10) of $75 in CPP Amount.

When the deductible is zero, the Category 4 beneficiary also has no deductible and the beneficiary's 15 percent coinsurance provision begins with the first covered drug of the year.

7.3.7 LICS and Over-the-Counter Drugs

As described in Module 4, plans offering any benefit structure may offer OTC drugs as part of their benefit only under certain rules. Plan's administrative costs must always pay for OTC drugs; LICS does not cover the plan's administrative costs. The gross drug cost must be entered into the Non-Covered Plan Paid Amount field, and the Gross Drug Cost Below Out-of-Pocket Threshold (GDCB) or the Gross Drug Cost Above Out-of-Pocket Threshold (GDCA) fields must report $0 because OTC drugs are not covered drugs.

Example: 2

In 2006, World Wide Health offers a Basic Alternative Plan with certain OTC drugs on the formulary as part of approved step therapy. A Category 1 beneficiary with YTD gross covered drug costs = $150 purchases one of these drugs for $5.60. Table 7M indicates how LICS is calculated in 2006 and how PDE fields are populated for this event, noting TrOOP accumulation.

Table 7M – LICS and OTC Drugs

LICS CALCULATION								
A	B	C	D	E	F	G	H	I
LI Beneficiary Type	Gross Covered Drug Cost	Non-LI Cost Share (Step 1)	LI Cost Share (Step 2)	Patient Pay Amount	LICS (C - E)	CPP	NPP	GDCB
Category 1	$0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 5.60	$0.00

PDE RECORD FIELDS						
Beneficiary Type	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP	NPP	GDCB
Non-LI	O	$0.00	$0.00	$0.00	$5.60	$0.00
LI Category 1	O	$0.00	$0.00	$0.00	$5.60	$0.00

The Drug Coverage Status Code is "O" indicating an OTC drug. Plans must submit PDE records for OTC drugs, but the costs of OTC drugs are categorized as administrative costs and therefore excluded from Part D payments that derive from PDE records. Also, plans cannot charge beneficiaries for OTC drug costs and LICS payments cannot be made for OTCs. Therefore, Patient Pay Amount, LICS, and CPP = $0. The GDCB and GDCA fields also report $0 since the drug is not a covered drug. The full amount paid by the plan ($5.60) is reported in NPP amount. The drug cost of $5.60 is also reported as the sum of (Ingredient Cost + Dispensing Fee Paid + Sales Tax).

7.4 Adjustment of PDE Records With LICS Data (Slide 28)

Sometimes plans will submit PDE records for beneficiaries who are later deemed to be LI eligible; LI benefits are retroactive. CMS requires that plans ensure that beneficiaries are not overcharged per the Part D benefit. In other words, plans are required to reimburse the patient fully in cases where prior Patient Pay Amounts are impacted by retroactive LI eligibility. When adjustments result in a plan owing an LI beneficiary refund, plans cannot set up a beneficiary account receivable as described in Module 5. Plans must refund LIS beneficiaries promptly.

In order to reconcile LICS accurately, LICS must be accurate on a claim-by-claim basis. Therefore, plans will also have to submit adjusted PDE records for any submitted PDE record impacted by retroactive eligibility for LICS. Plans cannot use the "Report-As-Administered" Method described in Module 5.

Example: 3

Sunny Valley Health Plan is notified that a beneficiary in their Actuarially Equivalent (AE) plan has been deemed eligible for LICS at Category 4 and the benefits are retroactive. A PDE record for a drug event that occurred during the retroactive period has been submitted to CMS. Sunny Valley Health Plan must adjust that PDE record to account for the beneficiary's LICS. The record was submitted when the beneficiary's YTD gross covered drug costs = $2,800. The beneficiary purchased a covered brand drug for $45. Since the event was in the coverage gap, the beneficiary paid $45 at POS but now only owes LI-Category 4 cost-sharing. Table 7N indicates how LICS is calculated, how PDE fields are populated for this adjustment, how the beneficiary is reimbursed, and notes TrOOP accumulation.

TABLE 7N – ADJUSTMENT OF A PDE RECORD WITH LICS DATA

LICS CALCULATION							
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (C – D)**	**CPP**	**TrOOP Amount (E+F)**
Category 4	$45.00	$45.00	$6.75	$6.75	$38.25	$0.00	$45.00

The adjusted PDE record, matching the original record on the key fields is submitted with the correct information. The Adjustment/Deletion field must be populated with an "A". The plan must promptly issue a refund to the beneficiary in the amount of ($45 - $6.75) = $38.25 and cannot set up an account receivable instead.

	Original PDE Record	**Adjusted PDE Record**
Drug Coverage Status Code	C	C
Patient Pay Amount	$45.00	$ 6.75
LICS	$ 0.00	$38.25
CPP	$ 0.00	$ 0.00
Adjustment/Deletion Field	<blank>	A

Accurate reporting of LICS amounts directly impacts plan payment during reconciliation. In this example, TrOOP accumulation does not change because both Patient Pay and LICS are TrOOP eligible amounts.

MODULE 8 – CALCULATING AND REPORTING ENHANCED ALTERNATIVE BENEFIT

Purpose (Slide 2)

Plans may offer enhanced benefits, also referred to as supplemental benefits, to beneficiaries. The Enhanced Alternative (EA) benefit module describes the benefit and how plans should administer it, including calculating and reporting rules for submitting data.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Define the Enhanced Alternative benefit, including two types of supplemental benefits that may be present in an Enhanced Alternative benefit plan.
- Administer an Enhanced Alternative benefit, using business rules to identify basic versus enhanced components and report these to the Centers for Medicare & Medicaid Services (CMS).
- Utilize the principles for submitting a Prescription Drug Event (PDE) for an enhanced alternative drug.
- Apply the business rules in calculating and reporting plan-paid amounts for enhanced alternative cost-sharing.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

8.1 Enhanced Alternative (EA) Benefit Overview (Slide 4)

All Part D plans are required to provide a minimum prescription drug benefit referred to as the "basic" benefit; the design can either be the Defined Standard benefit or an actuarially equivalent design as discussed in Module 4. However, plans can provide additional or supplemental benefits that exceed the actuarial value of a basic benefit. Such benefits are called Enhanced Alternative (EA) or supplemental benefits, and plans that offer EA benefits are referred to as EA plans. There are two forms of EA benefits, described in Table 8A.

TABLE 8A – TWO FORMS OF EA BENEFITS

EA BENEFIT	BENEFIT DESCRIPTION
Coverage of non-Part D drugs	• Allows for the payment of drugs (e.g., benzodiazepines and barbiturates) that are not Part D drugs, but are on the plan's formulary.
Reduced cost-sharing	• Referred to as Enhanced Alternative Cost-Sharing (EACS). • Reduced cost-sharing for covered drugs below the level in the Defined Standard benefit or an actuarially equivalent basic benefit.

The basic benefit is the minimum drug coverage package required in all Part D plans. The design can be either a Defined Standard benefit or one of two benefit designs that are actuarially equivalent to the Defined Standard benefit: an Actuarial Equivalent or Basic Alternative benefit, defined in Module 4.

Enhanced Alternative Cost-Sharing (EACS) is additional plan payments that reduce beneficiary cost-sharing as compared with the basic benefit. On average, EACS reduces cost-sharing across the entire benefit; however, beneficiary cost-sharing for any specific event may be higher or lower in comparison to the Defined Standard benefit (see 8.4.1).

8.2 Data Elements Central to the Enhanced Alternative (EA) Benefit (Slide 5)

As previously described, Medicare does not cover benefits beyond the basic benefit; benefits beyond the basic benefit must be excluded from payment. The Centers for Medicare & Medicaid Services (CMS) uses three data fields in the Prescription Drug Event (PDE) record to identify EA benefits in order to make correct payments:

- Drug Coverage Status Code
- Covered D Plan Paid Amount (CPP)
- Non-covered Plan Paid Amount (NPP)

8.2.1 Drug Coverage Status Code (Slide 6)

The value of "E" in the drug coverage status code indicates when payments are for an EA drug.

(E) Enhanced Alternative Drug – a non-Part D drug that is covered under a Part D plan's benefit package, also referred to as a non-covered or supplemental drug (see Module 1). Only EA plans can report a value of "E" in the drug coverage status field.

When Drug Coverage Status Code = "E", the Drug Data Processing System (DDPS) automatically excludes the gross drug cost from reinsurance subsidies, allowable risk corridor costs, True Out-of-Pocket costs (TrOOP), and low income cost-sharing (LICS) payment calculations. DDPS uses the Drug Coverage Status Code to exclude supplemental drugs from payment.

Note: For purposes of PDE reporting, OTC drugs (Drug Coverage Status Code = "O") are also considered non-covered and DDPS excludes the drug cost from reinsurance, risk corridor, and LICS payment.

However, since OTC drugs are covered under a plan's administrative costs for the basic portion of the benefit, they are not EA drugs and therefore have a different coverage status code (see Module 4).

8.2.2 Covered D Plan Paid Amount (CPP) (Slide 7)

Plans administering a basic plan benefit package cannot offer supplemental benefits, therefore those plans will not have EACS on a PDE for a covered drug. The cost-sharing amount is always the amount in the Defined Standard benefit or an amount that is considered to be actuarially equivalent. Similarly, the plan's share (plan-paid amount) is always the amount in the Defined Standard benefit or an amount that is considered to be actuarially equivalent. Therefore, when basic plans report a covered drug, the plan-paid amount is reported in full in the CPP field, and NPP is zero.

Note: When a plan reports a non-zero amount for a covered drug in NPP, DDPS validates that the plan is not a basic plan (see edit 779).

Only EA plans can offer EACS on covered drugs, which is cost-sharing assistance that exceeds the basic benefit amount. When an EA plan reports a covered drug, the plan-paid amount is partly a basic benefit and partly an enhanced benefit. Therefore, on the PDE the plan-paid amount is split into the amount the plan would have paid under the Defined Standard benefit (which is CPP) and the amount the plan pays in EACS (which is reported in NPP). CMS refers to this process as "mapping to the Defined Standard benefit." Section 8.4.1 further discusses the rationale for mapping along with its business rules.

8.2.3 Non-Covered Plan Paid Amount (NPP) (Slide 8)

The NPP field is used for reporting plan-paid amounts for non-covered drugs [supplemental drugs and formulary over-the-counter (OTC) drugs] and for EACS. Only EA plans populate the NPP field with non-zero amounts, with one exception: When the drug is over-the-counter, both EA and basic plans use the NPP field to report the cost of the drug. In all other cases, basic plans populate NPP with a value of $0.

Note: The dollar amount in NPP is mutually exclusive of the dollar amounts reported in the other payment fields: CPP, Patient Pay Amount, LICS, Other TrOOP Amount, and Patient Liability Reduction due to Other Payer Amount (PLRO). These six payment fields record six mutually exclusive types of payment. When the PDE reports a covered drug, the sum of these six payment fields is the gross covered drug cost.

If a plan reports a value of "C" in the Drug Coverage Status field and a positive dollar amount in the NPP field, DDPS automatically excludes the dollar amount in NPP from risk corridor and TrOOP calculations because the positive dollar amount in the NPP field is EACS.

8.3 Principles for Enhanced Alternative Drugs (Slide 9)

As described above, EA drugs are identified using the drug coverage status code = "E". The plan and the beneficiary pay the pharmacy according to the provisions of the Plan Benefit Package (PBP). The full plan-paid amount is reported in NPP so that it is excluded from allowable reinsurance and risk corridor costs. There is never a CPP amount because all plan payments for EA drugs are excluded from Medicare payment. Finally, recall that no LICS is paid on supplemental drugs and no out-of-pocket or third party payments on these drugs count towards TrOOP. Therefore, the CPP, LICS Amount, and Other TrOOP Amount fields always equal $0.00 on a PDE that reports an EA drug.

For EA drugs (Drug Coverage Status Code = "E") the cost of the drug that is reported on the PDE record does not increase YTD gross covered drug costs. YTD gross covered drug costs determines which non-catastrophic phase of the basic portion of their benefit a beneficiary is in. Purchase of non-covered drugs do not change a beneficiary's YTD gross covered drug costs nor benefit phase (see Module 1).

Note: When an EA plan reports an EA drug, DDPS validates that the covered plan paid amount is zero (see Edit 756). DDPS also validates that the Other TrOOP Amount is zero (see edit 757) and that the LICS amount is zero (see edit 758).

8.4 Business Rules for Calculating and Reporting Enhanced Alternative Cost-Sharing (EACS) (Slides 13-15)

EACS is a key component in administering benefits and reporting PDEs. Reporting EACS is more complicated than reporting EA or OTC drugs. Reporting for EA and OTC drugs is straightforward because CMS uses the Drug Coverage Status Code with a value of "E" or "O" to identify them as non-covered and exclude the entire cost from payment. But because EACS includes an amount the plan would have paid under the basic benefit and an additional amount the plan pays in extra cost-sharing assistance, CMS uses a slightly more complicated process to partition the two amounts and exclude the supplemental cost-sharing from payment.

8.4.1 Mapping to the Defined Standard Benefit

PDE reporting must be consistent with bid information. EA plans' bids have a basic component and a supplemental component. To align PDE reporting with the basic component of the bid, CMS maps payments that include EACS to the Defined Standard benefit using special rules for reporting CPP and NPP amounts.

Note that all EACS amounts are for covered drugs, so both supplemental and basic benefits are being reported in the same PDE (unlike a PDE for an EA drug, which only includes supplemental benefits identified as such). The following section delineates the business rules that allocate covered drug cost reported on a PDE into covered and non-covered amounts paid by the plan. The amount associated with the Defined Standard benefit is reported in CPP. The amount associated with the EA benefit is classified as the supplemental cost-sharing assistance, referred to as EACS, and is reported in NPP.

Tables 8B through 8E delineate how to calculate and report PDEs that have EACS, focusing on the data fields Patient Pay Amount, CPP, and NPP with special rules for calculating CPP.

Plans only map to the Defined Standard benefit for covered drugs (Drug Coverage Status Code = "C"). Plans do not map to the Defined Standard benefit for non-covered drugs, namely EA or OTC drugs (Drug Coverage Status Code = "E" or "O").

TABLE 8B – REPORTING EACS

STEP	DESCRIPTION	PDE FIELD
1	Report the amount paid by the beneficiary at Point of Sale (POS) in the Patient Pay Amount field.	Patient Pay Amount
2	Calculate the amount to report in the CPP field. • CPP is determined by the Defined Standard benefit, and will not necessarily be the same as the amount paid by the plan at POS. • CPP equals Gross Covered Drug Cost multiplied by the applicable percentage for calculating the Defined Standard benefit (see Table 8C).	CPP
3	Determine EACS, which is the amount to report in the NPP field. • NPP equals Gross Covered Drug Cost minus the sum of Patient Pay Amount, CPP, PLRO, Other TrOOP, and LICS.* • Alternatively, NPP also equals plan-paid at POS minus CPP. • EACS is reported in NPP.	NPP

***Note:** This calculation assumes that the sum of costs and payments for the PDE are equal. In several Part D plans, co-pays for inexpensive drugs sometimes exceed cost. In these rare situations when a beneficiary's co-pay is greater than the gross drug cost, plans should not use this calculation to determine NPP because the assumption is violated. Instead, plans should use the alternate equation, NPP equals Plan-Paid at POS minus CPP.

TABLE 8C – MAPPING TO THE 2006 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $250	0%
2	> $250 and ≤ $2,250	75%
3	> $2,250 and ≤ $5,100	0%
4	> $5,100 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2/$5)

Note: All examples within the Participant Guide reflect 2006 benefit parameters.

TABLE 8D – MAPPING TO THE 2008 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $275	0%
2	> $275 and ≤ $2,510	75%
3	> $2,510 and ≤ $5,726.25	0%
4	> $5,726.25 and ≤ OOP threshold	15%
5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)

TABLE 8E – MAPPING TO THE 2009 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $295	0%
2	> $295 and ≤ $2,700	75%
3	> $2,700 and ≤ $6,153.75	0%
4	> $6,153.75 and ≤ OOP threshold	15%
5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)

Note: For covered drug costs that fall above $5,100 but below the PBP's Out-of-Pocket (OOP) threshold in 2006, CMS maps to the 15 percent amount that the plan is at risk for under the basic portion of its bid (Rule #4). CMS only maps to 95 percent (15 percent risk payment plus 80 percent reinsurance payment) once the beneficiary crosses the OOP threshold of the EA plan, because reinsurance does not apply until the beneficiary crosses the OOP threshold (Rule #5).

Also note: the following patterns occur when costs are mapped to the Defined Standard benefit (see examples in Sections 8.5 and 8.6):

- When the plan pays more than what is covered in a given benefit phase under the Defined Standard benefit, the result is a positive EACS/NPP amount.
- When the plan and the Defined Standard benefit payment amounts happen to be the same, the result is a zero EACS/NPP amount.

- When the plan pays less than what is covered in a given phase under the Defined Standard benefit, the result is a negative EACS/NPP amount.

8.4.1.1 Alternate Method for Determining CPP

CMS developed an alternate method for determining CPP that recalculates claims under the Defined Standard Benefit. While this method differs from the methods described above, the results are the same.

In this method, CPP is the plan paid amount calculated under the Defined Standard benefit and NPP is the remaining plan-paid balance. Table 8F illustrates the Alternative Method of reporting EACS.

TABLE 8F – ALTERNATIVE METHOD TO REPORT EACS

STEP	DESCRIPTION	PDE FIELD
1	CPP (per Defined Standard benefit)	CPP
2	Plan Paid Amount at POS (per EA Benefit design) minus CPP (per Defined Standard benefit)	NPP

8.5 Prescription Drug Event Record Examples

This section demonstrates populating the appropriate PDE fields for EA benefits, first an EA drug and second, EACS using the steps and business rules in Tables 8B and 8C. The scenarios follow beneficiaries in Sunhealth PDP. The amounts in the tiers and the drug costs are only for purposes of illustration and the benefit structures are not necessarily representative of actuarially approved benefits. The examples also assume no other health insurance (OHI).

8.5.1 Enhanced Alternative (EA) Drug (Slides 10-12)

In Sunhealth PBP1, cost-sharing in the Initial Coverage period is tiered flat co-pays of $10/$20/$40. The beneficiary fills a prescription for $65 for an EA drug in Tier 1. The beneficiary's 2006 YTD gross covered drug costs = $1,900. Use the business rules for reporting EA drugs to populate related fields on the PDE record. Table 8G illustrates the calculating and reporting of an EA drug.

TABLE 8G – EA DRUG

2006 YTD Gross Covered Drug Costs=$1,900.00						Apply Rules for EA Drugs
Drug Coverage Status Code	A	B	C	D	E	F
	Gross Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP	TrOOP
E	$65.00	$10.00	$55.00	$0.00	$55.00	N/A

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP
E	$10.00	$0.00	$55.00

The Drug Coverage Status Code is "E" for an enhanced alternative drug. The beneficiary pays the $10 co-pay, which does not count towards TrOOP since it is for a supplemental drug. For the same reason, there is no CPP amount; rather the full plan-paid amount ($55) is reported in NPP (EACS).

If the Drug Coverage Status Code is "E" then there is no TrOOP accumulation, even if there is a Patient Pay Amount.

Mapping rules do not apply when Drug Coverage Status = "E" or "O".

8.5.2 Enhanced Alternative Cost-Sharing (EACS)

8.5.2.1 Rule #1

In Sunhealth PBP2, the beneficiary has zero deductible for generic drugs. 2006 YTD gross covered drug costs = $25 and the beneficiary purchases a covered generic drug that costs $50. Table 8H illustrates the calculating and reporting Rule #1 for EACS.

TABLE 8H – EACS – APPLYING RULE #1

2006 YTD Gross Covered Drug Costs=$25.00						Apply Rule #1
Drug Coverage Status Code	A	B	C	D	E	F
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 0%	NPP (EACS) A-(B+D) or C-D	TrOOP
C	$50.00	$0.00	$50.00	$0.00	$50.00	+ $0.00

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
C	$0.00	$0.00	$50.00

The Drug Coverage Status Code is "C" for a covered Part D drug. In this plan, because there is no Deductible phase for generic drugs, the beneficiary cost-sharing is reduced to zero percent in the Deductible phase for generic drugs. The result is a Patient Pay Amount of $0.00. The plan pays $50 at POS, an amount it would not pay under the Defined Standard benefit during the Deductible phase. Since there is no covered plan payment in the Deductible phase of the Defined Standard, CPP equals $0.00. Using the first method of calculating NPP, subtract the Patient Pay Amount ($0) from the gross drug cost ($50) to derive an NPP amount of $50. The same result is obtained with the alternate method, subtracting CPP ($0.00) from the Plan Paid Amount at POS ($50).

8.5.2.2 Rule #2 (Slides 16-18)

In 2006, Sunhealth PBP3 requires beneficiaries to pay a deductible and employs a $5/$15/$30 tiered cost-sharing in the Initial Coverage period. In 2006, the beneficiary has met the deductible and has YTD gross covered drug costs of $400. The beneficiary is now purchasing a Tier 3 brand name covered drug for $200. Table 8I illustrates the calculating and reporting Rule #2 for EACS.

TABLE 8I – EACS – APPLYING RULE #2

2006 YTD Gross Covered Drug Costs=$400.00						Apply Rule #2
	A	B	C	D	E	F
Drug Coverage Status Code	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 75%	NPP (EACS) A-(B+D) or C-D	TrOOP
C	$200.00	$30.00	$170.00	$150.00	$20.00	+ $30.00

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
C	$30.00	$150.00	$20.00

The Drug Coverage Status Code is "C" for a covered Part D drug. Due to the EACS in the Initial Coverage period, the beneficiary is responsible for a $30 co-payment instead of the 25 percent associated with the Defined Standard benefit. The plan pays the remaining $170, but the plan maps 75 percent of the gross cost ($150) to the Defined Standard benefit and reports this amount as CPP. The difference between the gross covered drug cost ($200) and the sum of patient pay amount and CPP ($180) results in an NPP amount of $20. Alternatively, the $20 difference between what the plan actually paid ($170) and what it would have paid under the Defined Standard benefit ($150) is EACS, which is reported in NPP. The plan has reduced the standard beneficiary cost-sharing by $20. The $30 paid by the beneficiary is applied towards TrOOP.

8.5.2.3 Rule #3

In 2006, Sunhealth PBP4 requires beneficiaries to pay the standard $250 deductible and employs tiered cost-sharing in the Initial Coverage period of $10/$20/$40. There is no Coverage Gap. Given the substantial amount of EACS provided by the plan, a beneficiary pays much less cost-sharing in relation to drug cost, and therefore does not reach the OOP threshold until YTD gross covered drug costs = $13,650 (not $5,100 as in the Defined Standard benefit with no non-TrOOP OHI). The beneficiary has YTD gross covered drug costs of $3,500. The beneficiary purchased a Tier 3 brand name covered drug for $100. Table 8J illustrates the calculating and reporting Rule #3 for EACS.

TABLE 8J – EACS – APPLYING RULE #3

2006 YTD Gross Covered Drug Costs=$3,500.00						Apply Rule #3
Drug Coverage Status Code	A	B	C	D	E	F
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 0%	NPP (EACS) A-(B+D) or C-D	TrOOP
C	$100.00	$40.00	$60.00	$0.00	$60.00	+ $40.00

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
C	$40.00	$0.00	$60.00

The Drug Coverage Status Code is "C" for a covered drug. The Patient Pay Amount counts towards TrOOP since this was a covered drug. Under the Defined Standard benefit, the beneficiary would be in the Coverage Gap, responsible for the entire gross drug cost ($100). However, due to EACS provided under the PBP, the beneficiary is in this EA plan's Initial Coverage period and is instead responsible for only a $40 co-payment. The plan is responsible for the remaining $60, but CPP reports $0.00 because the plan has not paid any amount attributable to the Defined Standard benefit. NPP is calculated as either $100 (gross covered drug cost) minus $40 (sum of patient pay and CPP) or as $60 (plan paid at POS) minus $0.00 (CPP), either way resulting in $60 NPP. Once again, the Patient Pay Amount of $40 counts toward TrOOP.

8.5.2.4 Rule #4 (Slides 19-21)

In 2006, Sunhealth PBP5 extends the initial coverage limit to $4,000. The beneficiary pays 100 percent cost-sharing in the EA Coverage Gap. YTD gross covered drug costs = $6,000, which places the beneficiary in the EA Coverage Gap. The beneficiary purchases a covered drug for $100. Table 8K illustrates the calculating and reporting Rule #4 for EACS.

TABLE 8K – EACS – APPLYING RULE #4

2006 YTD Gross Covered Drug Costs=$6,000.00						Apply Rule #4
	A	B	C	D	E	G
Drug Coverage Status Code	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 15%	NPP (EACS) A-(B+D) or C-D	TrOOP
C	$100.00	$100.00	$0.00	$15.00	- $15.00	+ $100.00

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
C	$100.00	$15.00	- $15.00

The Drug Coverage Status Code is “C” because the drug is a covered drug. The Patient Pay Amount of $100 counts towards TrOOP since this was a covered drug. Because the beneficiary remains in the Coverage Gap beyond $5,100 in this PBP, the beneficiary is responsible for 100 percent of the gross drug cost. Under the Defined Standard benefit and in accordance with its bid, the plan is subject to 15 percent risk sharing after $5,100, so it reports $15 in risk payment in CPP. (Since the beneficiary has not yet crossed the OOP threshold under this EA plan, no reinsurance payment applies so the PDE record maps to 15 percent of cost, not 95 percent). NPP is calculated as either $100 (gross covered drug cost) minus $115 (sum of patient pay and CPP) or as $0.00 (plan paid at POS) minus $15 (CPP), either way resulting a negative $15 NPP.

8.5.2.5 Rule #5

In 2006, Sunhealth PBP6 requires beneficiaries to pay the standard $250 deductible. Cost-sharing in the Initial Coverage period is 25 percent and the initial coverage limit has been extended by $1,000 from $2,250 to $3,250 under this plan. Catastrophic cost-sharing is the same as under the Defined Standard benefit. The beneficiary has just reached the OOP threshold, having accumulated $3,600 in TrOOP and YTD gross covered drug costs = $5,850. The beneficiary now purchases a covered drug for $125. Use Rule #5 to populate related PDE fields. Table 8L illustrates the calculating and reporting Rule #5 for EACS.

TABLE 8L – EACS – APPLYING RULE #5

2006 YTD Gross Covered Drug Costs=$5,850.00						Apply Rule #5
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 95%	NPP (EACS) A-(B+D) or C-D	TrOOP
C	$125.00	$6.25	$118.75	$118.75	$0.00	N/A

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
C	$6.25	$118.75	$0.00

Drug Coverage Status is "C" for a covered drug. The Patient Pay Amount is the greater of 5 percent or $2/$5, which is $6.25. Rule #5 applies because the beneficiary has reached the OOP threshold prior to this event. According to Rule #5, 95 percent would be paid under the Defined Standard benefit, so CPP is $118.75. There is no EACS or NPP since the plan actually paid the Defined Standard amount ($118.75) at POS. TrOOP no longer accumulates since the beneficiary has reached the OOP threshold.

8.6 Additional Examples of Enhanced Alternative Benefits

The following examples demonstrate calculating and reporting for other conditions under an EA benefit.

8.6.1 Enhanced Alternative Benefits and Straddling (Slides 22-24)

In 2006, Sunhealth PBP7 requires beneficiaries to pay the deductible, offers tiered cost-sharing in the Initial Coverage period ($10/$15/$20), and extends the initial coverage limit to $4,000. The beneficiary has YTD gross covered drug costs of $2,240. The beneficiary purchases a covered brand name drug in Tier 3 for $125. This event straddles two phases of the Defined Standard benefit, the Initial Coverage period and the Coverage Gap, even though it does not straddle any phase of the EA plan's actual benefit package. Table 8M illustrates the calculating and reporting of a straddle claim with EACS.

TABLE 8M – EACS – STRADDLE CLAIM

2006 YTD Gross Covered Drug Costs=$2,240.00						Apply Rules #2 and #3	
	Drug Coverage Status Code	A	B	C	D	E	G
		Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (EACS) A-(B+D) or C-D	TrOOP
Initial Coverage Period		$10.00	$10.00	$0.00	A x 75% $7.50	- $7.50	+$10.00
Coverage Gap		$115.00	$10.00	$105.00	A x 0% $0.00	$105.00	+$10.00
Total	**C**	$125.00	$20.00	$105.00	$7.50	$97.50	+$20.00

PDE RECORD FIELDS				
	Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)
Total	**C**	$20.00	$7.50	$97.50

Drug Coverage Status is "C" for a covered drug. The Patient Pay Amount ($20) counts toward TrOOP since this was a covered drug. In this example, the plan has chosen to split the $20 patient pay amount between the two benefit phases by allocating $10 in the Defined Standard Initial Coverage period and $10 in the Defined Standard Coverage Gap.

CPP for this example is only $7.50, 75 percent of the $10 remaining in the Defined Standard Initial Coverage period. To calculate NPP, the initial calculations can be done within the benefit phases or at the total level for the PDE. Either way, the results will be the same. At the summary level, NPP is calculated as either $125 (gross covered drug cost) minus $27.50 (sum of patient pay and CPP) or as $105 (plan paid at POS) minus $7.50 (CPP), either way resulting in $97.50 NPP.

8.6.2 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Initial Coverage Period (Slides 30-34)

In 2006, the beneficiary is a Category 1 low income beneficiary who has paid a supplemental premium to enroll in Sunhealth's PBP8. Instead of cost-sharing at 25 percent, the plan has tiered the cost-sharing to $10/$15/$30 in the Initial Coverage period. The plan's initial coverage limit is shifted up to $4,500. The beneficiary YTD gross covered drug costs = $1,500, and she purchases a Tier 1 covered drug for $75. Table 8N illustrates the calculating and reporting of EACS for a low income subsidy beneficiary in the Initial Coverage period.

TABLE 8N – EACS AND LICS IN THE INITIAL COVERAGE PERIOD

2006 YTD Gross Covered Drug Costs=$1,500.00										Apply Rule #2 with LICS calculations
		A	B	C	D	E	F	G	H	I
Beneficiary Type	Drug Cvg Status Code	Gross Covered Drug Cost	Non-LI Cost Share	LI Cost Share	Patient Pay Amount	LICS (B-C)	Plan POS (Non-LI)	CPP A x 75%	NPP (EACS) A-(D+E+G) or F-G	TrOOP D+E
Non-LI	**C**	$75.00	$10.00	N/A	$10.00	$0.00	$65.00	$56.25	$8.75	+ $10.00
LI Category 1	**C**	$75.00	$10.00	$2.00	$2.00	$8.00	$65.00	$56.25	$8.75	+ $10.00

PDE RECORD FIELDS					
	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP	NPP (EACS)
Non-LI	**C**	$10.00	$0.00	$56.25	$8.75
LI Category 1	**C**	$2.00	$8.00	$56.25	$8.75

The Drug Coverage Status Code is "C" for a covered drug. Under this EA plan, the beneficiary is in the Initial Coverage period. The non-LI plan co-pay would be $10, but the Patient Pay Amount is $2, the LI-I co-pay for a generic covered drug. The plan advances the $8 difference to the pharmacy at POS and reports this payment in LICS Amount. The $2 Patient Pay Amount and $8 LICS count towards TrOOP because the drug is covered Part D, so TrOOP accumulates by $10 for this event. Since the plan would have paid 75 percent ($56.25) under the Defined Standard benefit, this amount is reported in CPP. Under the PBP, the plan would pay $65 for a non-LI beneficiary at POS. NPP is calculated as either $75 (gross covered drug cost) minus $66.25 (sum of patient pay, LICS, and CPP) or as $65 (plan paid for non-LI at POS) minus $56.25 (CPP), either way resulting in $8.75 NPP.

8.6.3 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Coverage Gap

The same beneficiary now has 2006 YTD gross covered drug costs of $5,500. Since the beneficiary has not accumulated $3,600 in TrOOP, the beneficiary remains in the EA plan's Coverage Gap. The coverage gap has been moved out due to plan's initial coverage limit of $4,500. The beneficiary again purchases a covered Tier 1 generic drug for $75. Calculate LICS and use EACS Rule #4 to populate the related PDE fields. Table 8O illustrates the calculating and reporting of EACS for a low income subsidy beneficiary in an EA plan's Coverage Gap.

TABLE 8O – EACS AND LICS IN THE COVERAGE GAP

2006 YTD Gross Covered Drug Costs=$5,500.00										Apply Rule #4 with LICS calculations
		A	B	C	D	E	F	G	H	I
Beneficiary Type	Drug Cvg Status Code	Gross Covered Drug Cost	Non-LI Cost Share	LI Cost Share	Patient Pay Amount	LICS (B-C)	Plan POS (Non-LI)	CPP A x 15%	NPP (EACS) A-(D+E+G) Or F-G	TrOOP D+E
Non-LI	**C**	$75.00	$75.00	N/A	$75.00	$0.00	$0.00	$11.25	-$11.25	+ $75.00
LI Category 1	**C**	$75.00	$75.00	$2.00	$2.00	$73.00	$0.00	$11.25	-$11.25	+ $75.00

PDE RECORD FIELDS					
	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP	NPP (EACS)
Non-LI	**C**	$ 75.00	$0.00	$11.25	-$11.25
LI Category 1	**C**	$2.00	$73.00	$11.25	-$11.25

The Drug Coverage Status Code is “C” for a covered drug. Under the Defined Standard benefit, the beneficiary would be in the Catastrophic phase but under this EA plan, the beneficiary is in the Coverage Gap. The non-LI Patient Pay Amount for this plan would be $75, but this beneficiary will pay $2, the LI-I co-pay for a generic covered drug. LICS Amount is $73 (the difference between the non-low income $75 cost-sharing under the PBP and the $2 LI-I co-pay). The $2 Patient Pay Amount and $73 LICS count towards TrOOP because the drug is covered, therefore TrOOP accumulates by $75 for this event. The Plan Paid Amount for a non-LI beneficiary at POS is $0.00, but the plan must map 15 percent of the gross drug cost as risk sharing dollars since the OOP threshold has not been reached but YTD gross covered drug costs > $5,100. Therefore CPP is 15 percent of gross drug cost or $11.25. NPP is calculated as either $75 (gross covered drug cost) minus $86.25 (sum of patient pay, LICS and CPP) or as $0.00 (plan paid for non-LI at POS) minus $11.25 (CPP), either way resulting in a negative $11.25 NPP.

8.6.4 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Category 4 Beneficiary and No Plan Deductible

In 2006, a Category 4 low income beneficiary has paid a supplemental premium to enroll in Sunhealth’s PBP10. This EA plan has no deductible and a co-pay of $25 in the EA plan’s Initial Coverage period. The Category 4 beneficiary purchases a $100 drug, which is the first covered drug of the year. In the lesser of test, the deductible is excluded from the calculation on the Category 4 side and only uses 15 percent coinsurance. In this no-deductible plan, the Category 4 beneficiary receives the 15 percent coinsurance provision beginning with the first covered drug of the year.

Table 8P illustrates calculating and reporting EACS for the first covered drug claim of the year for a Category 4 beneficiary in a plan with no deductible. Note that the calculations for LICS are the same as in examples under basic plans (see Module 7).

TABLE 8P – EACS AND LICS: CATEGORY 4 BENEFICIARY IN ZERO DEDUCTIBLE PLAN

2006 YTD Gross Covered Drug Costs=$0.00										Apply Rule #1 with LICS calculations
		A	B	C	D	E	F	G	H	I
Beneficiary Type	Drug Cvg Status Code	Gross Covered Drug Cost	Non-LI Cost Share	LI Cost Share	Patient Pay Amount	LICS (B-C)	Plan POS (Non-LI)	CPP A x 0%	NPP (EACS) A-(D+E+G) or F-G	TrOOP D+E
Non-LI	**C**	$100.00	$25.00	N/A	$25.00	$0.00	$75.00	$0.00	$75.00	+ $25.00
LI Category 4	**C**	$100.00	$25.00	$15.00	$15.00	$10.00	$75.00	$0.00	$75.00	+ $25.00

PDE RECORD FIELDS					
	Drug Coverage Status Code	Patient Pay Amount	LICS	CPP	NPP (EACS)
Non-LI	**C**	$25.00	$0.00	$0.00	$75.00
LI Category 4	**C**	$15.00	$10.00	$0.00	$75.00

The Drug Coverage Status Code is "C" for a covered drug. The PBP has zero deductible, therefore in the lesser of test the LI-4 cost-sharing does not include any deductible and is 15 percent of $100, or $15. The non-LI plan co-pay would be $25, therefore LICS covers $10. LICS rules do not change; LICS is the difference between the non-low income co-pay under the PBP ($25) and the LI-4 co-pay ($15). The $15 Patient Pay Amount and $10 LICS count towards TrOOP because the drug is covered Part D, so TrOOP accumulates by $25 for this event.

The plan still maps to the Defined Standard benefit. Since the plan would have paid zero percent ($0) under the Defined Standard benefit, this amount is reported in CPP. Under the PBP, the plan would pay $75 for a non-LI beneficiary at POS. NPP is calculated as either $100 (gross covered drug cost) minus $25 (sum of patient pay, LICS, and CPP) or as $75 (plan paid for non-LI at POS) minus $0 (CPP), either way resulting in $75 NPP.

8.6.5 Enhanced Alternative (EA) Plan with Over-the-Counter (OTC) Drug

As described in other modules, any type of plan whether basic or EA can offer OTC drugs as part of step therapy in a formulary approved by CMS. In 2006, Sunhealth PBP11 offers this benefit. The beneficiary's YTD gross covered drug costs = $3,700, and she purchases a formulary OTC with gross drug cost of $12.50. Table 8Q illustrates the calculating and reporting rules for OTC drugs to populate the related PDE fields for an EA plan.

TABLE 8Q – OTC IN AN EA PLAN

2006 YTD Gross Covered Drug Costs=$3,700.00						Apply Rules for OTC Drugs
Drug Coverage Status Code	A	B	C	D	E	G
	Total Non-Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP C-D	TrOOP
O	$12.50	$0.00	$12.50	$0.00	$12.50	N/A

PDE RECORD FIELDS			
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP
O	$0.00	$0.00	$12.50

The EA plan follows the same OTC rules that apply to basic plans. Regardless of where the beneficiary is in the benefit package, this EA plan covers formulary OTCs under administrative costs of the basic benefit. The unique Drug Coverage Status Code of "O" indicates an OTC drug for purposes of monitoring as well as payment exclusion. Just as for an EA non-covered drug, the Plan Paid Amount for an OTC non-covered drug is always reported in full in NPP. There is zero Patient Pay Amount because plans may not charge cost-sharing for OTCs. There is no effect on TrOOP.

Remember, the plan must also report OTC drug cost in the Ingredient Cost Paid field and, if applicable, the Dispensing Fee Paid and Total Amount Attributed to Sales Tax fields.

Formulary OTCs are a basic benefit but are reported like non-covered drugs so that the cost is excluded from reinsurance and risk sharing. There is never EACS for an OTC drug and plans do not map payments to the Defined Standard benefit.

8.6.6 Co-pay Greater Than Gross Drug Cost: Enhanced Alternative Cost-Sharing (EACS)

In 2006, Sunhealth PBP12 has a $10/$30/$50 tiered cost-sharing structure in the Initial Coverage period and extends the initial coverage limit to $3,500. The beneficiary has YTD gross covered drug costs of $2,000. The beneficiary purchases a Tier 1 covered drug for $4.80. The plan's contract with the pharmacy guarantees a minimum payment equal to the co-payment per dispensing event, even when the gross drug cost is less than the co-pay. Table 8R illustrates calculating and reporting EACS when a beneficiary's co-pay is greater than the gross drug cost.

TABLE 8R – CO-PAY GREATER THAN GROSS DRUG COST - EACS

2006 YTD Gross Covered Drug Costs=$2,000						Apply Rule #2 for EACS, Co-pay > gross drug cost
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (EACS) C-D	TrOOP
C	$4.80	$10.00	$0.00	$3.60	-$3.60	$10

PDE RECORD FIELDS					
Drug Coverage Status Code	Patient Pay Amount	CPP	NPP (EACS)	GDCB	Ingredient Cost + Dispensing Fee + Sales Tax
C	$10.00	$3.60	-$3.60	$4.80	$4.80

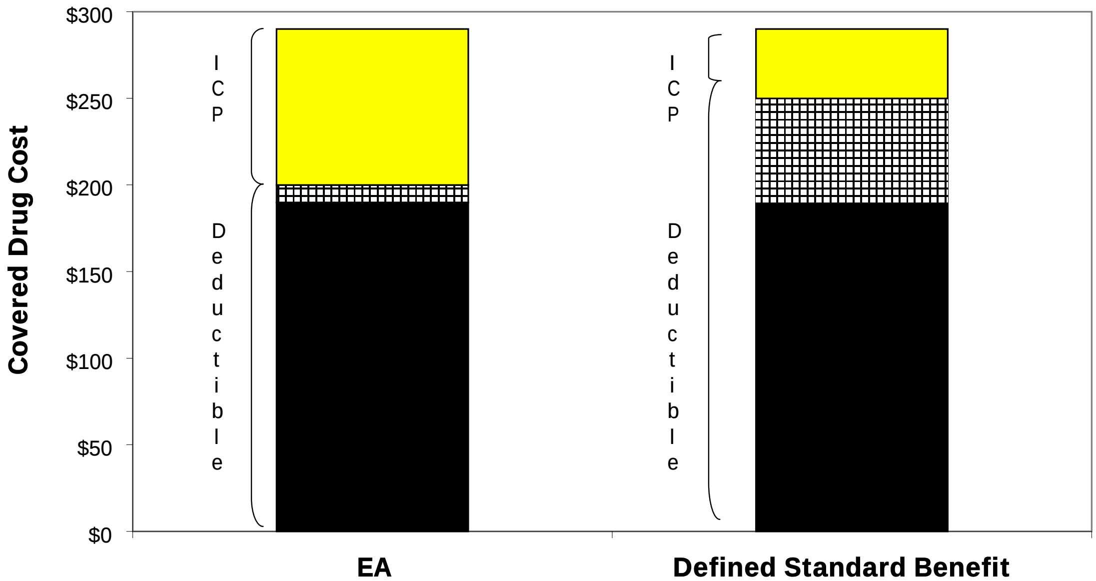
The Drug Coverage Status Code is “C” for a covered Part D drug. Due to the EACS in the Initial Coverage period, the beneficiary is responsible for a $10 co-payment instead of the 25 percent associated with the Defined Standard benefit. The plan pays $0 because the co-pay completely covers the price. The actual drug cost of $4.80 (not the co-pay amount of $10) is considered the gross drug cost for this event. Since this is a covered drug, the plan should map to the Defined Standard benefit using Rule #2, however it should only calculate EACS using the formula NPP=Plan-Paid at POS – CPP. Under these rules, the plan attributes (0.75 x $4.80) = $3.60 to CPP, and EACS/NPP = ($0.00 - $3.60) = -$3.60. In terms of overall benefits, though not in this specific dispensing event, the plan has reduced the standard beneficiary cost-sharing by $3.60. The $10 paid by the beneficiary is applied towards TrOOP.

When the beneficiary’s co-pay is greater than the gross drug cost, the price of the drug (not the co-pay amount) counts as the gross drug cost. However for a covered drug, the co-pay amount counts towards TrOOP in accordance with §1860D-2(b)(4)(C)(i) of the Act.

8.6.7 Claim that Straddles Both Enhanced Alternative Benefit Phases and Defined Standard Benefit Phases

In 2006, Sienna’s Enhanced Alternative Plan has a $200 deductible, offers tiered cost-sharing in the Initial Coverage Period ($10/$20/$30) and extends the Initial Coverage Limit to $4,000. At the time the beneficiary purchases the drug, his YTD gross covered drug cost is $190. The beneficiary purchases a covered brand name drug in Tier 2 that costs $100. This event straddles the deductible and ICP in both Sienna’s enhanced benefit and the Defined Standard Benefit (Figure 8A).

Figure 8A – Claim Straddles EA and Defined Standard Deductible



1. First Sienna calculates Point-of-Sale (POS) cost-sharing under its own benefit design.

   Ten dollars of the gross covered drug cost falls in Sienna's deductible where the beneficiary is responsible for 100 percent of the cost. In this EA benefit phase the patient pays $10 and Sienna pays $0. The remaining $90 falls in Sienna's Initial Coverage Period. In this EA benefit phase the patient pays $20 and Sienna pays $70. The plan applies lesser of logic and determines that the beneficiary pays $30 because it is less than the negotiated price of the drug ($10 + $20 = $30 and $30 < $100). The pharmacy receives $30 from the beneficiary and $70 from the plan. Table 8S(1) illustrates how the plan calculates the POS cost-sharing.

TABLE 8S(1) - POS COST-SHARING

	Patient Pay Amount	Plan Paid Amount
EA Deductible Phase	$10.00	$0.00
EA Initial Coverage Period	$20.00	$70.00
Total	$30.00	$70.00

2. Secondly, Sienna prepares the PDE.

When an EA plan reports a covered drug, the plan-paid amount is partly a basic benefit and partly an enhanced benefit. Therefore, on the PDE the plan–paid amount is split into the amount the plan would have paid under the Defined Standard benefit, which is CPP (refer to Section 8.2.2) and the amount the plan pays in EACS (which is reported in CPP). CMS refers to this process as "mapping to the Defined Standard benefit." CPP is the basis for risk-sharing calculations so it must be reported consistently across all plan types.

There are several ways to determine CPP. Sienna chooses to recalculate its claims under the Defined Standard Benefit. CPP is the plan paid amount calculated under the Defined Standard Benefit. NPP is the remaining plan-paid balance.

Sienna calculates the claim under the defined standard benefit as follows. The beneficiary's Year-to-Date Gross Covered Drug Cost is $190. Sixty dollars of gross covered drug cost falls in the Defined Standard Benefit deductible where the beneficiary is responsible for 100 percent of the cost. For this Defined Standard Benefit phase the patient pays $60 and the plan pays $0. The remaining $40 falls in the Defined Standard Benefit Initial Coverage Period. For this phase the patient pays $10 and the plan paid amount is $30. For covered drugs in the Defined Standard Benefit the plan payments are Covered Part D payments and are reported in CPP. See Table 8S(2).

TABLE 8S(2) – DEFINED STANDARD BENEFIT CLAIM CALCULATION

YTD Gross Covered Drug cost - $190		
Defined Standard Benefit Phase	**Patient Pay Amount**	**Plan Paid Amount (CPP)**
Deductible	$60.00	$ 0.00
Initial Coverage Period	$10.00	$30.00
Total	$70.00	$30.00

3. Finally, Sienna populates the PDE. See Table 8S(3).

TABLE 8S(3) – POPULATING THE PDE

PDE Field	Data Source	Amount
Patient Pay Amount	Amount patient pays at POS; determined under the EA benefit design [see Table 8S(1)]	$30.00
CPP	Plan Paid Amount determined under the Defined Standard benefit [see Table 8S(2)]	$30.00
NPP	Difference between Plan Paid amount at POS (determined under the EA benefit design) and CPP Calculation: NPP = Plan Paid Amount at POS – CPP (Table 8S1) (Table 8S2) $40.00 = $70.00 – $30.00	$40.00

8.6.8 Optional EA Plan and Estimated Rebate at POS

8.6.8.1 EACS and $50 Estimated Rebate at POS

A Part D beneficiary is enrolled in an Enhanced Alternative plan that fills in the coverage gap and has tiered cost-sharing ($10/$20/$30). The beneficiary is not eligible for the low-income subsidy and does not have prescription drug coverage through a third party. In this example, the beneficiary's YTD gross covered drug cost is $3,000. The beneficiary purchases a covered Part D drug in Tier 3 that costs $150 ($140 Ingredient Cost and $10 Dispensing Fee). The Part D sponsor chooses to apply an estimated rebate of $50 at the POS. The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim. Table 8T illustrates how to report a $50 estimated rebate at POS on a PDE Record in 2007 and 2008.

TABLE 8T – EACS AND $50 ESTIMATED REBATE AT POS

PDE RECORD FIELDS	AMOUNT REPORTED 2007	AMOUNT REPORTED 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$30	$30
CPP	$50	$0
NPP	$70	$70
Estimated Rebate at POS		**$50**

The Ingredient Cost and Dispensing Fee for 2007 is $140 and $10, and the reduction of $50 for 2008 makes the amounts $90 and $10. The GDCB is $150 in 2007 for the gross drug cost and $100 for 2008. GDCA is $0 for both years because the beneficiary is in the Coverage Gap and has not yet reached Catastrophic Coverage. The Part D sponsor determines cost-sharing based on its own enhanced benefit design; the beneficiary pays $30 in both coverage years.

For EA plans, the sponsor must map to the Defined Standard benefit in order to determine the CPP and the NPP. For both 2007 and 2008, Part D sponsors must use the gross drug cost net of the estimated rebate amount ($100) when mapping to the Defined Standard benefit to determine the CPP and NPP. This claim falls in the Defined Standard benefit coverage gap, so the mapped amount for CPP is $0 and the NPP is $70. However, for coverage year 2007, plans also need to report Estimated Rebate at POS in the CPP field. In 2007, the mapped amount is $0 and the Estimated Rebate is $50, meaning that the plan reports $50 in CPP. For coverage year 2008, the CPP field reports only the mapped amount, which is $0. The $70 NPP amount is the same in both years. In 2008, plans report the $50 estimated rebate amount in the Estimated Rebate at POS field.

For both coverage years, the Part D sponsor reports the actual rebate amount of $60 on the DIR Report for Payment Reconciliation.

8.6.8.2 EA Supplemental Drug and $50 Estimated Rebate at POS

A beneficiary enrolled in an Enhanced Alternative plan purchases a supplemental drug that costs $150 ($140 Ingredient Cost and $10 Dispensing Fee) and pays a $20 co-payment. The Part D sponsor chooses to apply an estimated rebate of $50 at POS. The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim. Table 8U illustrates how to report a $50 estimated rebate at POS on a PDE Record in 2007 and 2008.

TABLE 8U – EA AND $50 ESTIMATED REBATE AT POS

PDE RECORD FIELDS	AMOUNT REPORTED 2007	AMOUNT REPORTED 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$0	$0
GDCA	$0	$0
Patient Pay Amount	$20	$20
CPP	$0	$0
NPP	$130	$80
Estimated Rebate at POS		**$50**

The Ingredient Cost and Dispensing Fee for 2007 are $140 and $10, and the reduction of $50 for 2008 makes the amounts $90 and $10. The GDCB and GDCA are both $0 because this is a non-covered Part D drug. The Part D sponsor determines cost-sharing based on its own enhanced benefit design. The plan reports the beneficiary co-payment, which is $20 for this drug, in the Patient Pay Amount. This is the same for both coverage years. Since this claim is for a non-covered drug, CPP is $0 for 2007 and $2008.

The plan reports the entire plan paid amount in the NPP field. However, for 2007, the plan also reports the $50 estimated rebate amount in the NPP field because the drug is a non-Part D covered drug. This makes the total reported NPP $130 in 2007. The NPP field only includes the plan paid amount of $80 in 2008. This means that the plan reports the $50 estimated rebate amount in the Estimated Rebate at POS field in 2008.

In both coverage years, the DIR Report for Payment Reconciliation excludes the actual rebate amount of $60. The EA plan includes rebates for non-covered drugs in its accounting for the supplemental premium.

MODULE 9 – CALCULATING AND REPORTING PAYMENT DEMONSTRATIONS

Purpose (Slide 2)

Eligible plans may offer Payment Demonstration Option benefits to their beneficiaries. The Part D Payment Demonstrations module provides descriptions of the benefits and essential reporting rules related to submitting data. This includes how a plan administers the Payment Demonstration option and reports information to CMS essential to making payments.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Define the two payment demonstration options.
- Explain the similarities and differences of the Flexible and Fixed capitated options.
- Understand how to administer benefits under the capitated options using the policy of mapping to the Defined Standard benefit.
- Apply the correct business rules to calculate and report Prescription Drug Events (PDEs) for the Flexible and Fixed Capitated options.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

9.1 Part D Payment Demonstrations Overview (Slide 35)

Payment demonstration options are intended to allow plans maximum flexibility in designing alternative prescription drug coverage. Two payment demonstration options are available: the Flexible Capitated option and the Fixed Capitated option. The Flexible and Fixed Capitated options are variations of the Enhanced Alternative (EA) plans with a supplemental benefit that reduces or eliminates cost-sharing in the Deductible, Initial Coverage period, and/or Coverage Gap, funded by a capitated reinsurance payment. A supplemental premium is charged for supplemental benefits not covered by the capitated payment.

For background on the payment demonstration, see "Instructions for the Part D Payment Demonstration" issued by the Centers for Medicare and Medicaid Services (CMS) on May 10, 2005.

9.1.1 Budget Neutrality Requirement

Restrictions on organization participation eligibility and reducing capitated payments are necessary for the budget neutrality requirement of these demonstrations.

In order to remain budget neutral, in 2006 capitated payments are reduced by at least $3.13 per member per year for Flexible and Fixed Capitated options. For 2008 and 2009 capitated payments are reduced by $10.00 per member per year for Flexible and Fixed Capitated options.

9.1.2 Plan Participant Eligibility

Most Prescription Drug Plans (PDPs) and MA organizations offering Prescription Drug Plans (MA-PDs) are eligible to participate in these demonstration options. The only exceptions are Program of All-Inclusive Care for the Elderly (PACE) organizations, employer group waiver plans (direct contract and employer/union-only plans) and retiree drug subsidy plans. Individual market plans are eligible for the demonstration, however if they are demonstration plans they cannot enroll any beneficiary receiving employer wrap-around benefits. If a beneficiary is receiving any employer support for prescription drug benefits, the beneficiary may not enroll in a demonstration plan.

9.2 Flexible and Fixed Capitated Options (Slides 36-38)

Flexible and Fixed Capitated options reduce or eliminate cost-sharing in the Deductible phase, Initial Coverage period, and/or the Coverage Gap phase by applying a supplemental premium. The Prescription Drug Event (PDE) reporting for these options is similar to the rules for non-demonstration EA plan reporting of enhanced alternative cost-sharing (EACS) (see Module 8). The primary difference between the Capitated payment demonstrations and EA plans is in the Catastrophic Coverage phase risk sharing. Plans offering the Flexible or Fixed Capitated options share risk based on all amounts they would have paid under the Defined Standard (DS) benefit, including the 80 percent reinsurance subsidy. Thus, all Plan Paid Amounts for basic benefits are considered to be risk sharing dollars.

On the PDE record, this policy is accomplished by mapping all costs to the DS benefit to distinguish basic and enhanced dollar amounts. Plan paid dollars allocated to the DS benefit are included in risk corridor calculations. Plan paid dollars that exceed the DS benefit are considered supplemental benefits and are excluded from risk corridor calculations. In addition, for Flexible option plans, 95 percent (not 15 percent) of spending for covered drugs above $5,100 but below the Out-of-Pocket (OOP) threshold is allocated to Covered D Plan Paid Amount (CPP) (see Table 9C). The extra 80 percent allows reinsurance dollars to be counted as risk sharing dollars. In a typical EA plan, only 15 percent would be risk sharing dollars at this point in the benefit design (see Table 8C).

The Capitated options differ from each other with regard to OOP threshold. In the Flexible option just as in non-demonstration EA plans, the OOP threshold is extended by the provision of EACS in the coverage gap. However, in the Fixed option, the OOP threshold remains at $5,100 in Year-to-Date (YTD) gross covered drug costs. Table 9A illustrates this difference.

TABLE 9A – COMPARISON OF THE FLEXIBLE AND FIXED CAPITATED OPTIONS

	FLEXIBLE CAPITATED OPTION	FIXED CAPITATED OPTION
OOP Threshold	The same as a non-demonstration Part D benefit ($3,600 in TrOOP in 2006).	Locked in at the DS OOP threshold [$5,100 in YTD gross covered drug costs in 2006 if no non-TrOOP Other Health Insurance (OHI)].

Once the OOP threshold is reached, all demonstration plans administer and report catastrophic benefits in accordance with their bid.

9.2.1 Business Rules for Calculating and Reporting Flexible and Fixed Capitated Payment Demonstrations (Slide 40)

The three data elements that most significantly impact reporting the Flexible and Fixed Capitated options are Patient Pay Amount, CPP, and Non-covered Plan Paid Amount (NPP). (**Note:** Catastrophic Coverage Code, Gross Drug Cost Above Out-of-Pocket Threshold (GDCA), and Gross Drug Cost Below Out-of-Pocket Threshold (GDCB) are three additional data elements that are central to the capitated options.) These three fields are generally populated the same as for a non-demonstration EA benefit, except that for the fixed capitated option, the TrOOP requirement is waived and the threshold is $5,100 of gross covered drug spending rather than $3,600 of TrOOP for 2006.

CMS uses the following term when describing how plans should calculate and report PDEs for the Capitated demonstration plans:

- **Payment Demonstration coverage period** – the phase of the benefit above the initial coverage limit in the DS benefit (>$2,250 in 2006) up to the point at which the event has reached $3,600 in 2006 in TrOOP spending in the Flexible Capitated option (or $5,100 in 2006 of gross covered drug cost in the Fixed Capitated option). If the Payment Demonstration plan does not completely fill in the Coverage Gap as defined by the DS benefit, the Payment Demonstration Coverage period extends from the DS initial coverage limit up to the initial coverage limit in the Payment Demonstration Plan benefit package.

Capitated demonstration plans administer the provisions of their benefit by mapping costs to the DS benefit in a pattern that is almost identical to the mapping for EA plans. Tables 9B and 9C describe the mapping rules for the Capitated plans and show how to calculate and report PDEs focusing on the data fields Patient Pay Amount, CPP, and NPP. Tables 9D and 9E provide the mapping rules for 2008 and 2009.

TABLE 9B – REPORTING FLEXIBLE AND FIXED CAPITATED OPTIONS

STEP	DESCRIPTION	ASSOCIATED DATA ELEMENTS
1	Report the amount paid by the beneficiary at point of sale (POS) in the Patient Pay Amount field.	Patient Pay Amount
2	Calculate the amount to report in the CPP field. • CPP is determined by the DS benefit, and will not necessarily be the same as the amount paid by the plan at POS. • CPP equals gross covered drug cost multiplied by the applicable percentage for calculating the DS benefit (see Table 9C).	CPP
3	Determine the amount to report in the NPP field. • NPP equals gross covered drug cost minus the sum of Patient Pay Amount (Step 1), CPP (Step 2), Patient Liability Reduction due to Other Payer Amount (PLRO), Other TrOOP, and Low Income Cost-Sharing Subsidy (LICS). • Alternatively, NPP also equals plan-paid at POS minus CPP.	NPP

TABLE 9C – CALCULATING CPP IN FLEXIBLE AND FIXED CAPITATED OPTIONS FOR 2006

<table>
<tr><th rowspan="2">RULE #</th><th rowspan="2">YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS</th><th colspan="2">PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT</th></tr>
<tr><th>FLEXIBLE CAPITATED OPTION</th><th>FIXED CAPITATED OPTION</th></tr>
<tr><td>1</td><td>≤ $250</td><td colspan="2">0%</td></tr>
<tr><td>2</td><td>> $250 and ≤ $2,250</td><td colspan="2">75%</td></tr>
<tr><td>3</td><td>> $2,250 and ≤ $5,100</td><td colspan="2">0%</td></tr>
<tr><td>4</td><td>> $5,100 and ≤ OOP threshold</td><td>Lesser of 95% or (Gross Covered Drug Cost - $2/$5)</td><td>N/A*</td></tr>
<tr><td>5</td><td>> OOP threshold</td><td colspan="2">Lesser of 95% or (Gross Covered Drug Cost - $2/$5)</td></tr>
</table>

Note: This table and all examples within the Participant Guide reflect 2006 benefit parameters.
*By definition, the OOP threshold always coincides with $5,100 in YTD gross covered drug costs in the Fixed Capitated option.

TABLE 9D – CALCULATING CPP IN FLEXIBLE AND FIXED CAPITATED OPTIONS FOR 2008

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT	
		FLEXIBLE CAPITATED OPTION	FIXED CAPITATED OPTION
1	≤ $275	0%	
2	> $275 and ≤ $2,510	75%	
3	> $2,510 and ≤ $5,726.25	0%	
4	> $5,726.25 and ≤ OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)	N/A*
5	> OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)	

TABLE 9E – CALCULATING CPP IN FLEXIBLE AND FIXED CAPITATED OPTIONS FOR 2009

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT	
		FLEXIBLE CAPITATED OPTION	FIXED CAPITATED OPTION
1	≤ $295	0%	
2	> $295 and ≤ $2,700	75%	
3	> $2,700 and ≤ $6,153.75	0%	
4	> $6,153.75 and ≤ OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)	N/A*
5	> OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)	

Note: As with the EA benefit, the following patterns occur when costs are mapped to the DS benefit:

- When the plan pays more than what is covered in a given benefit phase under the DS benefit, the result is a positive NPP amount.
- When the plan and the DS benefit payment amounts happen to be the same, the result is zero NPP.
- When the plan pays less than what is covered in a given phase under the DS benefit, the result is a negative NPP amount.

9.2.2 Flexible and Fixed Capitated Option PDE Record Examples

The following sections demonstrate populating the appropriate PDE fields for the capitated options using the steps and business rules in Tables 9B and 9C. First, submitting a PDE for a Flexible Capitated option is illustrated. Then, submitting a PDE for a Fixed Capitated option is illustrated. The amounts in the tiers and the drug costs are only for purposes of illustration and the benefit structures are not necessarily representative of actuarially approved benefits.

9.2.2.1 Flexible Capitated Option Example

Plan A - Plan A illustrates the Flexible Capitated option. Plan A retains the $250 deductible. After the deductible is satisfied, the plan offers 25 percent cost-sharing throughout the benefit until the beneficiary reaches the Catastrophic Coverage phase. Because Plan A eliminates the Coverage Gap, a beneficiary with no non-TrOOP Other Health Insurance (OHI) reaches the OOP threshold when YTD gross covered drug costs equal $13,650.

9.2.2.1.1 Rule #3

In 2006, the beneficiary's YTD gross covered drug cost = $3,500. The beneficiary purchases a covered Part D drug for $100. Table 9F illustrates the calculating and reporting for the Flexible Capitated option applying Rule #3.

TABLE 9F – FLEXIBLE CAPITATED OPTION – APPLYING RULE #3

2006 YTD Gross Covered Drug Cost= $3,500						Apply Rule #3
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (C-D)	TrOOP
C	$100.00	$25.00	$75.00	$0.00	$75.00	+ $25.00

PDE RECORD FIELDS						
Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP	NPP
C	<blank>	$100.00	$0.00	$25.00	$0.00	$75.00

According to Table 9C, Rule #3 is utilized (YTD gross covered drug costs > $2,250 and ≤ $5,100 = 0 percent cost-sharing).

The DS benefit would place the event in the Coverage Gap where the beneficiary pays 100 percent cost-sharing and the plan pays 0 percent. In Plan A's benefit structure, the event is in the Payment Demonstration Coverage period where the beneficiary pays 25 percent cost share and the plan pays 75 percent. The difference between the plan liability in the plan's benefit structure (75 percent) and the DS benefit plan structure (0 percent) is a supplemental benefit. This amount is reported in the NPP field.

9.2.2.1.2 Rule #4 (Slides 41-42)

In 2006, the beneficiary's YTD gross covered drug costs = $6,000. The beneficiary purchases a covered Part D drug for $100. Table 9G illustrates the calculating and reporting for the Flexible Capitated option applying Rule #4.

TABLE 9G – FLEXIBLE CAPITATED OPTION – APPLYING RULE #4

2006 YTD Gross Covered Drug Costs = $6,000						Apply Rule #4
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (C-D)	TrOOP
C	$100.00	$25.00	$75.00	$95.00	- $20.00	+ $25.00

PDE RECORD FIELDS						
Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP	NPP
C	<blank>	$100.00	$0.00	$25.00	$95.00	- $20.00

According to Table 9C, Rule #4 is utilized [YTD gross covered drug costs > $5,100 and ≤ OOP threshold = lesser of 95 percent coinsurance or (gross covered drug cost - $2/$5 cost-sharing)].

The DS benefit would place the event in the Catastrophic Coverage phase where the beneficiary cost-sharing is the greater of $2/$5 or 5 percent. The CPP field reports the amount the plan would pay under the DS benefit ($15) plus $80 since the reinsurance dollars are transferred to being risk sharing dollars, for a total CPP of $95. Note that under a non-demonstration EA plan, CPP would only be $15 for this event (see Module 8). In Plan A's benefit structure, the beneficiary is in the Payment Demonstration Coverage period where the beneficiary pays 25 percent cost share (Patient Pay Amount) and the plan pays 75 percent (Plan POS). The difference between the plan liability in the Plan's benefit structure (75 percent) and the DS benefit plan structure (95 percent) is a supplemental benefit, which is reported in the NPP field. This resulted in a negative NPP amount to account for the difference between what the plan actually paid at POS and what the plan would have paid under the DS benefit. Plan A would be reporting a blank in the Catastrophic Coverage Code for this event, indicating that the beneficiary has not reached Catastrophic Coverage under Plan A's benefit structure.

9.2.2.2 Fixed Capitated Option Example

Plan B - Plan B illustrates the Fixed Capitated option. It eliminates both the $250 Deductible and cost-sharing in the Coverage Gap. This plan offers tiered cost-sharing of $5/$20/$40 in the Payment Demonstration Coverage period, and it offers DS cost-sharing once the beneficiary crosses the OOP threshold. These amounts are for illustration only and are not necessarily representative of an actuarially equivalent benefit structure. The beneficiary in the Fixed Capitated option reaches Catastrophic Coverage at $5,100 of YTD gross covered drug spending rather than $3,600 of TrOOP.

9.2.2.2.1 Rule #2

In 2006, the beneficiary's YTD gross covered drug costs = $1,400. The beneficiary purchases a covered Part D drug for $100 as a Tier 2 drug ($20 flat co-pay). Table 9H illustrates the calculating and reporting for the Fixed Capitated option applying Rule #2.

TABLE 9H – FIXED CAPITATED OPTION – APPLYING RULE #2

2006 YTD Gross Covered Drug Costs = $1,400						Apply Rule #2
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (C-D)	TrOOP*
C	$100.00	$20.00	$80.00	$75.00	$5.00	+ $20.00

PDE RECORD FIELDS						
Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP	NPP
C	<blank>	$100.00	$0.00	$20.00	$75.00	$5.00

* A TrOOP accumulator is shown here because it is necessary for a Fixed Capitated Option plan to track TrOOP in case the beneficiary transfers to a non-demonstration plan or if the demonstration plan retained any coverage gap. Additionally, all rules associated with Patient Pay Amount, Other TrOOP Amount, and PLRO must be followed when reporting data to CMS.

According to Table 9C, Rule #2 is utilized (YTD gross covered drug cost > $250 and ≤ $2,250= 75 percent cost-sharing).

The DS benefit would place the event in the Initial Coverage period where the beneficiary pays 25 percent cost share and the plan pays 75 percent. In Plan B's benefit structure, the beneficiary has a flat $20 co-pay, which is 20 percent of the gross drug cost. The plan liability is $80 under Plan B's benefit structure as compared with $75 under the DS benefit. The difference between the plan liability in the Plan's benefit structure and the DS benefit plan structure is a supplemental benefit, which is reported in the NPP field.

9.2.2.2.2 Rule #5 (Slides 43-44)

In 2006, the beneficiary's YTD gross covered drug costs = $6,000. In the Fixed Capitated Option, the beneficiary reached Catastrophic Coverage at $5,100 of YTD gross covered drug costs and is eligible for reduced cost-sharing, regardless of TrOOP balance. The beneficiary purchases a covered Part D drug for $100. Table 9I illustrates the calculating and reporting for the Fixed Capitated option applying Rule #5.

TABLE 9I – FIXED CAPITATED OPTION – APPLYING RULE #5

2006 YTD Gross Covered Drug Costs = $6,000						Apply Rule #5
Drug Coverage Status Code	A	B	C	D	E	G
	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (C-D)	TrOOP
C	$100.00	$5.00	$95.00	$95.00	$0.00	+ $5.00

PDE RECORD FIELDS						
Drug Coverage Status Code	Catastrophic Coverage Code	GDCB	GDCA	Patient Pay Amount	CPP	NPP
C	C	$0.00	$100.00	$5.00	$95.00	$0.00

According to Table 9C, Rule #5 is utilized (YTD gross covered drug costs > $5,100 for a Fixed Capitated Option plan).

This plan uses the DS catastrophic cost-sharing once the event crosses the OOP threshold, so the cost-sharing is the greater of $2/$5 or 5 percent. With a $100 drug, the Patient Pay Amount is $5 and the CPP is $95. In contrast to the Flexible Capitated Option (in 9.2.2.1.2), this plan reports a Catastrophic Coverage flag of "C" and all drug costs are listed as GDCA.

MODULE 10 – EDITS

Purpose (Slide 2)

The Centers for Medicare & Medicaid Services (CMS) designed edits to ensure the accuracy of Prescription Drug Event (PDE) data. In this module, participants will learn about the errors generated by the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS) through descriptions of the types of edits and checks performed and how edits and checks are applied to the submitted data. In addition, participants will learn about the resolution process for correcting Immediately Actionable PDE Errors (IAPs) and other PDE errors. Participants will also learn the update codes associated with Plan-to-Plan (P2P).

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Describe the edit logic for the PDFS and DDPS.
- Identify the nine edit categories in DDPS.
- Recognize and apply the resolution process to resolve errors received from PDFS and DDPS.
- Review the P2P process and update codes.
- Discuss IAPs and contract reports.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

10.1 Edit Process (Slide 4)

Plans submit Prescription Drug Event (PDE) data to the Prescription Drug Front-End System (PDFS). PDFS performs format, integrity, and validity checks on the file and batch level records. PDFS performs limited edits on detail level records. Once the file passes the PDFS front-end edits, PDFS forwards the file to the Drug Data Processing System (DDPS) at CMS. DDPS edits the detail level records for format, integrity, and validity before storing the data for future payment calculation.

Understanding the edits and edit logic allows plans to ensure the timely and accurate processing of PDE data. When programming internal systems for submitting PDEs, plans and submitters should incorporate PDFS and DDPS edits. Submitters' error rates must remain below 20 percent to maintain PDE Certification. Refer to the Data Format module, Section 3.1.3 for more information on PDE Certification requirements.

10.2 PDFS Edits (Slide 5)

PDFS performs format, integrity, and validity checks on the data submitted. Examples of edits include checking for:

- Missing data in file and batch level header and trailer records (e.g., Record ID, Submitter ID, Production/Test/Certification Indicator).

- Appropriate sequencing of records:
  - A batch header (BHD) record follows each file header (HDR) record.
  - A detail (DET) record follows each BHD record.
  - A DET record or a batch trailer (BTR) record follows each DET record.
  - A BHD record or a file trailer (TLR) follows each BTR record.

- File IDs that do not duplicate a File ID previously accepted within the last 12 months in test, certification, or production.

- Balance:
  - File ID and Submitter ID are the same in the HDR and TLR.
  - Sequence Number, Contract ID, and Plan Benefit Package (PBP) ID are the same on the BHD and BTR.

- Batch and detail Sequence Numbers always begin with 0000001 and are assigned by incrementing the previous sequence number by one.

- Valid DET and BHD record totals.

If the file passes all the PDFS front-end edits, PDFS will forward the file to DDPS for processing. If any of the data fails the PDFS front-end editing, PDFS will reject the complete file.

Example: 1

Scenario

Sunrise Health Plan submitted a file with two batches and no detail records in the second batch.

Result

PDFS rejects the file with error message 276, “The BTR record is out of sequence. BTR does not follow a DET record.” A DET record must always follow a BHD record; similarly a DET record must always precede a BTR record.

10.2.1 PDFS Edit Logic and Ranges (Slide 6)

When PDFS determines that there is an error, a code and associated message are generated for that error. Table 10A describes the error code logic. The series and ranges indicate whether errors occur on the file, batch, or detail level and more specifically in the header or trailer for the file and batch.

When a file fails any PDFS edit, PDFS rejects the complete file and returns it to the submitter after all possible PDFS checks are completed.

TABLE 10A – PDFS EDIT CODE LOGIC AND RANGES

SERIES	RANGES	EXPLANATION
100	**126-150**	File level errors on the HDR.
	176-199	File level errors on the TLR records.
200	**226-250**	Batch level errors on the BHD.
	276-299	Batch level errors on the BTR records
600	**601-602**	Detail level errors on DET records.

10.2.2 PDFS Edit Codes

PDFS checks the format, integrity, and validity of individual fields before cross-checking field to field. For example, PDFS first checks that there is a Submitter ID in the HDR and one in the TLR before cross-checking the Submitter ID between the HDR and TLR. PDFS performs edits at the file level before preceding to perform edit checks at the batch level. PDFS validates sequence at the detail level as the last edit check performed before the file is passed to DDPS. PDFS file level, batch level, and detail level error codes are described in Table 10B.

TABLE 10B – PDFS EDIT CODES

FILE LEVEL EDIT CODES

EDIT CODE	EDIT DESCRIPTION	
126	RECORD ID IS MISSING OR INVALID.	HDR
127	HDR RECORD IS OUT OF SEQUENCE. HDR RECORD IS NOT FIRST RECORD IN FILE OR DOES NOT FOLLOW A TLR RECORD.	
128	SUBMITTER ID IS MISSING.	
129	SUBMITTER ID IS NOT ON FILE.	
130	SUBMITTER ID IS NOT CERTIFIED TO SEND PRODUCTION DATA.	
131	FILE ID IS MISSING. FILE ID IS BLANK.	
132	FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.	
133	TRANS-DATE IS MISSING OR INVALID. MUST BE A VALID DATE IN CCYYMMDD FORMAT AND CANNOT BE A FUTURE DATE.	
134	PROD-TEST-CERT-IND IS MISSING OR INVALID. PROD-TEST-CERT-IND IS BLANK OR NOT EQUAL TO ‘PROD’, ‘TEST’, OR ‘CERT’.	
176	TLR RECORD IS OUT OF SEQUENCE. TLR RECORD DOES NOT FOLLOW A BTR RECORD.	TLR
177	SUBMITTER ID IS MISSING.	
178	SUBMITTER ID IS NOT EQUAL TO THE SUBMITTER ID IN THE HDR RECORD.	
179	FILE ID IS MISSING.	
180	FILE ID IS NOT EQUAL TO THE FILE ID IN THE HDR RECORD.	
181	TLR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF BATCHES IN THE FILE.	
182	DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.	
183	TEST/CERT FILE CANNOT EXCEED 5,000 RECORDS.	
184	PROD FILE CANNOT EXCEED 3,000,000 RECORDS (effective August 2006).	

TABLE 10B – PDFS EDIT CODES (CONTINUED)

BATCH LEVEL EDIT CODES

EDIT CODE	EDIT DESCRIPTION	
226	BHD RECORD IS OUT OF SEQUENCE. BHD RECORD DOES NOT FOLLOW EITHER A HDR OR BTR RECORD.	BHD
227	SEQUENCE NUMBER IS MISSING OR INVALID. SEQUENCE NUMBER CANNOT BE BLANK OR ZERO. SEQUENCE NUMBER MUST START WITH A 0000001.	
228	SEQUENCE NUMBER IS INVALID. SEQUENCE NUMBER IS OUT OF ORDER.	
229	CONTRACT NUMBER IS MISSING.	
230	CONTRACT NUMBER DOES NOT MATCH NUMBER ASSIGNED BY CMS.	
231	CONTRACT NUMBER IS NOT ACTIVE.	
232	SUBMITTER NOT AUTHORIZED TO SUBMIT FOR THIS CONTRACT.	
233	PBP ID IS MISSING.	
234	PBP IS NOT VALID FOR THE CONTRACT ID.	
235	PBP ID IS NOT ACTIVE. NOT AUTHORIZED TO SUBMIT PRODUCTION DATA.	
236	TEST CONTRACT NUMBER NOT AUTHORIZED FOR PRODUCTION DATA.	
237	TEST/CERT FILES MUST USE TEST CONTRACT NUMBER AND PBP ID.	
276	BTR RECORD IS OUT OF SEQUENCE. BTR RECORD DOES NOT FOLLOW A DET RECORD.	BTR
277	SEQUENCE NUMBER IS MISSING OR INVALID. SEQUENCE NUMBER IS NOT NUMERIC.	
278	SEQUENCE NUMBER IS NOT EQUAL TO THE BHD SEQUENCE NUMBER.	
279	CONTRACT NUMBER IS MISSING OR INVALID.	
280	CONTRACT NUMBER DOES NOT MATCH THE CONTRACT NUMBER IN THE BHD RECORD.	
281	PBP ID IS MISSING.	
282	PBP ID DOES NOT MATCH THE PBP ID IN THE BHD RECORD.	
283	DET RECORD TOTAL ON THE BTR RECORD IS MISSING.	
284	BTR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF DETAIL RECORDS.	

DETAIL LEVEL EDIT CODES

EDIT CODE	EDIT DESCRIPTION	
601	DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT FOLLOW A BHD OR ANOTHER DET RECORD.	DET
602	SEQUENCE NUMBER IS INVALID. DET SEQUENCE NUMBER IS NOT NUMERIC OR NOT EQUAL TO THE COMPUTED SEQUENCE NUMBER.	

Example: 2 (Slides 7-8)

Scenario
Blue Sky Health changes to a new Pharmacy Benefit Manager (PBM) in March 2006 and tells the new PBM to begin submitting data immediately; however, the plan did not provide an authorization letter to CMS.
Result
PDFS rejects the file with error message 232. The submitter is not authorized to submit for Blue Sky Health.

10.3 DDPS System

After the file passes PDFS front end edits, PDFS sends the file via Connect:Direct to the CMS data center for DDPS processing. DDPS performs edits on all the detail level records.

Current DDPS edits are posted on http://www.csscoperations.com.

10.3.1 DDPS Editing Rules (Slide 9)

The DDPS editing process takes place in stages.

Stage 1 – Individual Field Edits

The DDPS performs format, integrity, and validity checks on all DET fields as a first level of editing. Examples include:

- Dates in CCYYMMDD format.
- Health Insurance Claim Number (HICN) field not filled with spaces.
- Fields contain legal values.

Stage 2 - Enrollment/Eligibility Edits

In this stage, eligibility and Low Income Cost-Sharing Subsidy (LICS) data from the PDE are validated against CMS databases. First, DDPS looks up the HICN reported on the PDE and validates that there is a matching HICN on MBD with the same gender and date of birth (DOB) (if present on the PDE). Next, editing cross-checks the appropriate fields against the CMS databases to verify further enrollment and Part D and LICS eligibility information. DDPS then confirms that low income cost-sharing never exceeds the statutorily defined maximum when the beneficiary is low income eligible.

Stage 3 – Duplicate Check Edits

Prior to performing duplicate checking, DDPS looks up the reported HICN to confirm that it exists in the CMS databases. If the HICN is valid, cross-reference information is returned to allow an accurate match on beneficiary (a beneficiary may have more than one HICN). DDPS then searches for an active record on file with matching data in the following six key fields: Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, Date of Service (DOS), Fill Number, and Dispensing Status. DDPS rejects any matches as duplicates.

Stage 4 – Field-to-Field Edits

Following the edits to determine if a record is not a duplicate, DDPS begins logical edits which compare fields against each other. Examples include:

- Edits based on "If Then" statements e.g., if Catastrophic Coverage is blank, then Gross Drug Costs Below the Out-of-Pocket Threshold (GDCB) must be greater than zero.
- The sum of detail cost fields is compared with the sum of the payment fields.

10.3.1.1 Adjustment/Deletion Codes Edits

In the event that the PDE is submitted as an adjustment to or deletion of an original PDE, there is another stage of editing. When the Adjustment/Deletion code reports "A" or "D", DDPS searches for a matching current active record. If the current active record is not found, then an error message is reported on the DDPS Return File. DDPS will not assume that the plan submitted an original PDE with an Adjustment/Deletion field incorrectly populated.

One submitter can submit only one original, adjustment, or deletion PDE for a single dispensing event per day. The submission date and the value of the Adjustment/Deletion Code differentiate the original PDE from subsequent submissions. Multiple versions of the same PDE within one daily submitter file can cause rejections.

10.3.2 DDPS Edit Categories (Slide 11)

Table 10C describes the series of edits and nine categories by which the DDPS edits are organized.

TABLE 10C –CATEGORIES AND DESCRIPTIONS

RANGES	EDIT CATEGORIES	DESCRIPTION
603-659	Missing or Invalid	Straightforward edits identifying invalid or missing values. If blank is a legal value, the missing edit does not apply.
660-669	Adjustment or Deletion	Edits in a hierarchy using nine fields (Contract Number, PBP ID, HICN, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status).
670-689	Catastrophic Coverage Code	Edits that test the relationship between Catastrophic Coverage Code and the summary cost fields for GDCB and Gross Drug Costs Above the Out-of-Pocket Threshold (GDCA), so that allowable reinsurance costs are summed correctly. (Applies only to PDEs for Part D Covered Drugs.)
690-699	Cost	Cost edits perform basic accounting functions to confirm that 1.) the summary cost fields and the detail cost fields balance and that 2.) the detail cost fields and payment fields balance. The summary cost field for GDCA is used to sum allowable reinsurance costs.
700-714	Eligibility	Eligibility edits verify the HICN and the beneficiary's eligibility for Part D and enrollment in a Part D plan. Plan enrollment must be accurate because payment calculations including Plan to Plan reconciliation are summarized at the plan level.
715-734	Low Income Cost-sharing (LICS)	LICS edits confirm that CMS documents the beneficiary's LICS status and validates that beneficiary cost-sharing never exceeds statutorily defined maximum amounts. Dollars reported in LICS are used to reconcile LICS.
735-754	National Drug Code (NDC)	NDC edits confirm that an NDC exists and that the NDC existed on the date of service. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered drugs are excluded from True Out-of-Pocket Costs (TrOOP), LICS, and payment calculations.
755-774	Drug Coverage Status Code	Edits that test the relationship between non-covered drugs, the Catastrophic Coverage Code field, and dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, and payment calculations.
775-799 900-999	Miscellaneous	Edits on miscellaneous data elements.

10.3.3 DDPS Edit Codes

Tables 10D – 10L provide the DDPS edits by category.

TABLE 10D – DDPS DET EDIT CODES – MISSING/INVALID

EDIT CODE	EDIT DESCRIPTION
603	HICN IS MISSING. MUST NOT BE BLANK.
604	CARDHOLDER ID IS MISSING.
605	DOB IS AN INVALID DATE. DATES MUST BE IN CCYYMMDD FORMAT.
606	GENDER IS MISSING OR INVALID. GENDER MUST BE EITHER 1 OR 2.
607	DOS IS MISSING OR INVALID. DOS MUST BE IN CCYYMMDD FORMAT AND BE A VALID DATE.
608	DOS MUST BE ON/AFTER 1/1/2006.
609	DOS MUST BE ON OR BEFORE TODAY'S DATE.
610	PAID DATE IS MISSING. MUST NOT BE BLANK FOR FALLBACK PLANS.
611	PAID DATE IS AN INVALID DATE IN CCYYMMDD FORMAT.
612	PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER IS MISSING OR INVALID. PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER MUST BE NUMERIC.
613	NDC CODE IS MISSING.
614	SERVICE PROVIDER ID QUALIFIER IS MISSING OR INVALID. SERVICE PROVIDER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '07' – NCPDP OR '08' – STATE LICENSE OR '11' – TIN OR '99' – OTHER.
615	SERVICE PROVIDER ID IS MISSING.
616	FILL NUMBER IS MISSING OR INVALID. FILL NUMBER MUST BE EQUAL TO A VALUE BETWEEN 0 AND 99.
617	DISPENSING STATUS IS INVALID. DISPENSING STATUS MUST BE EITHER A BLANK OR 'P' OR 'C'.
618	COMPOUND CODE IS MISSING OR INVALID. COMPOUND CODE MUST BE EQUAL TO 0, 1, OR 2.
619	DAW/PRODUCT SELECTION CODE IS MISSING OR INVALID. DAW/PRODUCT SELECTION CODE MUST BE EQUAL TO VALUE BETWEEN 0 AND 9.
620	QUANTITY DISPENSED IS MISSING OR INVALID. QUANTITY DISPENSED MUST BE ≥ 0.001.
621	DAYS SUPPLY IS MISSING OR INVALID. VALUE MUST BE A VALUE BETWEEN 0 AND 999 DAYS.
622	PRESCRIBER ID QUALIFIER IS MISSING.
623	PRESCRIBER ID QUALIFIER IS INVALID. PRESCRIBER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '08' – STATE LICENSE OR '12' – DEA.
624	PRESCRIBER ID IS MISSING. MUST NOT BE BLANK.
625	DRUG COVERAGE STATUS CODE IS MISSING OR INVALID. VALID VALUES ARE 'C', 'E', AND 'O'.
626	ADJUSTMENT/DELETION CODE IS INVALID. VALID VALUES ARE 'A' FOR ADJUSTMENT AND 'D' FOR DELETION, OR 'BLANK'.
627	NON-STANDARD FORMAT CODE IS INVALID. VALID VALUES ARE 'BLANK', 'B', 'X', 'P', or 'S'.
628	PRICING EXCEPTION CODE IS INVALID. VALID VALUES ARE 'BLANK', 'O', OR 'M'.
629	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE 'BLANK', 'A', OR 'C'.
630	INGREDIENT COST PAID IS MISSING OR INVALID. INGREDIENT COST PAID MUST BE ≥ ZERO.
631	DISPENSING FEE PAID IS MISSING OR INVALID. MUST BE ≥ ZERO.
632	SALES TAX IS MISSING OR INVALID. MUST BE ≥ ZERO.
633	GDCB IS MISSING OR INVALID. MUST BE ≥ ZERO.
634	GDCA IS MISSING OR INVALID. MUST BE ≥ ZERO.

TABLE 10D – DDPS DET EDIT CODES – MISSING/INVALID (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
635	PATIENT PAY AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
636	OTHER TrOOP AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
637	LICS VALUE IS MISSING OR INVALID. MUST BE ≥ ZERO.
638	PLRO IS MISSING OR INVALID. MUST BE NUMERIC.
639	CPP IS MISSING OR INVALID. MUST BE ≥ ZERO.
640	NPP IS MISSING OR INVALID. MUST BE NUMERIC.
641	FILLER FIELDS MUST BE BLANK.
642	STATE-TO-PLAN PDES ARE NOT ALLOWED WITH DATE OF SERVICE AFTER MARCH 31, 2006.
643	STATE-TO-PLAN PDES ARE NOT ALLOWED WITH NON-COVERED DRUGS.
644	SERVICE PROVIDER ID QUALIFIER MUST BE ‘07’ FOR STATE-TO-PLAN PDES.
645	SERVICE PROVIDER ID ‘5300378’ ALLOWED ONLY FOR STATE-TO-PLAN PDES.
646	ESTIMATED REBATE AT POINT OF SALE IS MISSING OR INVALID. FOR SERVICE DATES EFFECTIVE JANUARY 1, 2008 FORWARD, MUST BE ≥ ZERO. FOR SERVICE DATES PRIOR TO 2008, MUST BE ZERO OR SPACES.
647	VACCINE ADMINISTRATION FEE AMOUNT IS MISSING OR INVALID. FOR SERVICE DATES EFFECTIVE JANUARY 1, 2008 FORWARD, MUST BE ≥ ZERO. FOR SERVICE DATES PRIOR TO 2008, MUST BE ZERO OR SPACES.
648	PRESCRIPTION ORIGIN CODE IS INVALID. VALID VALUES ARE ‘BLANK’, ‘0’, ‘1’, ‘2’, ‘3’, AND ‘4’.

Edit 605 “DOB IS AN INVALID DATE”: DOB is optional. When present, DOB must be in CCYYMMDD format. DDPS rejects any record with invalid format in date fields, even though the field is optional. Default values are either blanks or zeros.

Edit 611 “PAID DATE IS AN INVALID DATE IN CCYYMMDD FORMAT”: Fallback plans must report a valid Paid Date. For all other plans, Paid Date is an optional field. When present, Paid Date must be in CCYYMMDD format. DDPS rejects any record with invalid format in date fields, even though the field is optional. Default values for non-Fallback plans are either blanks or zeros.

Prescriber ID edits-The three Prescriber ID edits, 622-PRESCRIBER ID QUALIFIER IS MISSING, 623-PRESCRIBER ID QUALIFIER IS INVALID, and 624-PRESCRIBER ID IS MISSING, always apply to PDEs compiled from standard format. PRESCRIBER ID and PRESCRIBER ID QUALIFIER are optional in PDEs compiled from non-standard format. However, whenever PRESCRIBER ID QUALIFIER is populated, edit 623 applies, and whenever PRESCRIBER ID QUALIFIER is present and valid, edit 624 applies.

Dollar fields – In general, values in dollar fields must be zero or greater. There are three exceptions:

1. Ingredient Cost Paid – Based on the assumption that there is cost for any drug, values must be greater than zero. “Any drug” includes over-the-counter (OTC) drugs, which are funded by administrative costs.

2. Patient Liability Reduction due to Other Payer Amount (PLRO) – Negative values are also valid.

3. Non-covered Plan Paid Amount (NPP) – Negative values are also valid.

TABLE 10E – DDPS DET EDIT CODES – ADJUSTMENT/DELETION

EDIT CODE	EDIT DESCRIPTION
660	ADJUSTMENT/DELETION PDE DOES NOT MATCH THE EXISTING PDE RECORD (9 FIELD MATCH).
661	CANNOT ADJUST RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
662	CANNOT DELETE RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
663	VALUE OF DISPENSING STATUS ON ADJUSTMENT RECORD AND THE RECORD TO BE ADJUSTED MUST BE THE SAME.

PDEs with an Adjustment/Deletion code are always checked against a total of nine fields (HICN, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, DOS, Fill Number, Dispensing Status, Contract Number, and PBP ID). DDPS edits in the following order. First, DDPS looks for an active PDE record with the same values in HICN, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, DOS, Fill Number, Contract Number, and PBP ID. Edit 660 applies when this match fails. Then DDPS compares the value in Dispensing Status. Edit 663 applies when this match fails. Remember that Dispensing Status is part of the key to the PDE record and cannot be adjusted. If the plan must change Dispensing Status or any other key field, the original record must be deleted and a new record with the correct key information must be submitted.

Business Order: If a plan submits multiple adjustments, DDPS will carry the most recent adjustment only. Whenever plans submit multiple adjustments to the same original PDE, plans must ensure that the data in the most recent adjustment record is the data plans intend to save in DDPS.

TABLE 10F – DDPS DET EDIT CODES – CATASTROPHIC COVERAGE CODE

EDIT CODE	EDIT DESCRIPTION
670	IF CATASTROPHIC COVERAGE IS ‘BLANK’, GDCB MUST BE GREATER THAN ZERO.
671	IF CATASTROPHIC COVERAGE IS ‘BLANK’, GDCA MUST BE ZERO.
672	IF CATASTROPHIC COVERAGE IS ‘A’, GDCB MUST BE GREATER THAN ZERO.
673	IF CATASTROPHIC COVERAGE IS ‘C’, GDCA MUST BE GREATER THAN ZERO.
674	IF CATASTROPHIC COVERAGE IS ‘C’, GDCB MUST BE ZERO.

Catastrophic Coverage edits test the relationship between the values in the Catastrophic Coverage Code field and the dollar amounts reported in GDCB and GDCA. DDPS edits these fields to the fullest extent possible because dollars reported in the GDCA field are used to calculate the reinsurance subsidy. Please note that GDCB and GDCA will always equal zero when PDEs report non-covered drugs. (Drug Coverage Status Code = ‘E’ or ‘O’.)

TABLE 10G – DDPS DET EDIT CODES – COST

EDIT CODE	EDIT DESCRIPTION
690	SUM OF COST FIELDS > SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK' OR 'P'.
691	SUM OF GDCB AND GDCA IS NOT EQUAL TO THE SUM OF INGRED COST + DISP FEE + SALES TAX + VACCINE ADMINISTRATION FEE.
692	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK' AND CPP + NPP > 0 AND MEDICARE IS PRIMARY.
693	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'C'.
694	SUM OF INGREDIENT COST, DISPENSING FEE, AND VACCINE ADMINISTRATION FEE MUST BE > ZERO.

Cost edits test the relationship between cost and payment fields. DDPS edits these fields to the fullest extent possible because dollar fields are used in payment calculations. The cost/payment edits account for rounding error of $.05.

Edit 691 "SUM OF GDCB AND GDCA IS NOT EQUAL TO THE SUM OF INGRED COST + DISP FEE + SALES TAX + VACCINE ADMINISTRATION FEE": Only applies to covered drugs (Drug Coverage Code = 'C').

TABLE 10H – DDPS DET EDIT CODES – ELIGIBILITY

EDIT CODE	EDIT DESCRIPTION
700	HICN DOES NOT MATCH AN EXISTING BENEFICIARY.
701	DOB PROVIDED DOES NOT MATCH THE DOB ON CMS FILES.
702	GENDER DOES NOT MATCH THE VALUE ON CMS FILES.
703	DOS CANNOT BE LESS THAN THE DOB.
704	DOS CANNOT BE GREATER THAN THE DATE OF DEATH (DOD) PLUS 32 DAYS.
705	BENEFICIARY MUST BE ENROLLED IN PART D ON THE DOS.
706	THIS DOS DOES NOT FALL WITHIN A VALID P2P PERIOD. BENEFICIARY MUST BE ENROLLED IN THIS CONTRACT ON THE DOS.
707	BENEFICIARY MUST BE ENROLLED IN THIS PART D PLAN BENEFIT PACKAGE ON THE DOS.
708	SUBMITTER CONTRACT DIFFERS FROM CONTRACT OF RECORD; THIS PDE IS SUBJECT TO PLAN TO PLAN RECONCILIATION. [INFORMATIONAL]
709	SUBMITTER CONTRACT DIFFERS FROM CONTRACT OF RECORD; THIS PDE IS NOT SUBJECT TO PLAN TO PLAN RECONCILIATION. [INFORMATIONAL]
710	UPDATED HICN. [INFORMATIONAL]
712	SUBMITTING CONTRACT/PBP DOES NOT OFFER PART D ON DOS. (EFFECTIVE MAY 2007) [INFORMATIONAL]
713	THE SUBMITTING CONTRACT/PBP DOES NOT OFFER PART D ON DATE OF SERVICE.
714	DOS IS GREATER THAN THE DATE OF DEATH (DOD), BUT IS WITHIN THE 32-DAY ALLOWABLE MARGIN. (EFFECTIVE MAY 2007) [INFORMATIONAL]

DDPS applies eligibility edits 705, 706, and 707 hierarchically. DDPS discontinues eligibility edits as soon as a PDE fails an eligibility edit.

Edit 701 "DOB PROVIDED DOES NOT MATCH THE DOB ON CMS FILES": DDPS applies Edit 701 only when DOB is present. Edit 701 compares month and year of birth reported on the PDE to month and year of birth on CMS files and rejects mismatches.

Edit 706 "THIS DOES NOT FALL WITHIN A VALID P2P PERIOD. BENEFICIARY MUST BE ENROLLED IN THIS CONTRACT ON THE DOS": Applies to DOS on and after July 1, 2007. Plan-to-Plan Phase I is effective through June 30, 2007. When the DOS occurs later than the valid P2P period, the beneficiary must be enrolled in the Submitting Contract on the DOS.

TABLE 10I – DDPS DET EDIT CODES – LICS

EDIT CODE	EDIT DESCRIPTION
715	DOLLARS REPORTED IN LICS ARE GREATER THAN ZERO. HOWEVER, BENEFICIARY IS NOT ELIGIBLE FOR LICS.
716	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR INSTITUTIONALIZED LICS BENEFICIARY.
717	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 2 LICS BENEFICIARY.
718	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 1 LICS BENEFICIARY.
719	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 4 LICS BENEFICIARY WHO HAS MET DEDUCTIBLE [INFORMATIONAL]
720	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED CATASTROPHIC MAXIMUM FOR CATEGORY 1 OR CATEGORY 2 LICS BENEFICIARIES WHO HAVE REACHED THE OUT-OF-POCKET THRESHOLD.
721	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED CATASTROPHIC MAXIMUM FOR CATEGORY 4 LICS BENEFICIARY WHO HAS REACHED THE OUT-OF-POCKET THRESHOLD.
722	DOLLARS REPORTED IN LICS ARE GREATER THAN ZERO. HOWEVER, BENEFICIARY IS NOT ELIGIBLE FOR LICS SUBSIDY IN CMS SYSTEMS. [INFORMATIONAL]

Any PDE that reports LICS must also report Drug Coverage Status Code = 'C'. LICS applies only to covered drugs.

DDPS edits the LICS field to the fullest extent possible because it is the basis for reconciling the LICS subsidy. When PDEs report dollars in the LICS field, DDPS first validates that the beneficiary is low income eligible. Then DDPS determines the maximum catastrophic and non-catastrophic low income cost-sharing and, with one exception, rejects PDEs when the beneficiary liability exceeds this maximum. Beneficiary liability equals the sum of Patient Pay Amount, Other TrOOP Amount, and PLRO.

Edit 719 "PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 4 LOW INCOME BENEFICIARY WHO HAS MET DEDUCTIBLE" is informational because DDPS does not delay editing to determine if the beneficiary satisfied an applicable deductible. Typically, Edit 719 will report an error condition so plans should research thoroughly to confirm correct cost-sharing.

TABLE 10J – DDPS DET EDIT CODES – NDC

EDIT CODE	EDIT DESCRIPTION
735	NDC CODE IS INVALID. NDC CODE DOES NOT MATCH A VALID CODE ON THE NDC DATABASE.
737	INAPPROPRIATE DRUG COVERAGE STATUS CODE. DRUG COVERAGE IS NOT 'O' ALTHOUGH THE DRUG IS ON THE OTC LIST.
738	INAPPROPRIATE DRUG COVERAGE. DRUG COVERAGE IS 'C' ALTHOUGH THE DRUG IS ON THE EXCLUSION LIST.
739	THIS NDC IS FOR A DRUG THAT IS USUALLY COVERED UNDER PART B. IF PLAN DETERMINES THAT THIS DRUG IS PART B COVERED, SUBMIT DELETION RECORD. [INFORMATIONAL]
740	NDC IS DESI DRUG.
741	THE DRUG IS ALWAYS EXCLUDED FROM PART D; THE DRUG IS ALWAYS COVERED BY PART B.
742	IF THE AMOUNT IN THE VACCINE ADMINISTRATION FEE FIELD IS > ZERO, THEN THE NDC CODE MUST QUALIFY AS A VALID PART D VACCINE DRUG.

Edit 735 "NDC CODE IS INVALID": Excludes both invalid NDCs as well as inactive NDCs. Inactive NDCs have obsolete dates older than January 1, 2002.

Edit 738 "INAPPROPRIATE DRUG COVERAGE": DDPS validates that NDCs reported as covered drugs are Part D drugs. The definition of Part D drugs excludes, for example, Benzodiazepines and Barbiturates.

Edit 740 "NDC IS DESI DRUG": Part D does not cover drugs determined to be less than effective as determined by the Drug Efficacy Study Implementation (DESI) Program.

For additional information about DESI drugs see http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.

TABLE 10K – DDPS DET EDIT CODES – DRUG COVERAGE STATUS CODE

EDIT CODE	EDIT DESCRIPTION
755	IF DRUG COVERAGE STATUS CODE EQUALS 'E' OR 'O,' CATASTROPHIC COVERAGE CODE MUST NOT EQUAL 'A' OR 'C'.
756	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE COVERED D PLAN PAID AMOUNT MUST BE ZERO.
757	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN OTHER TrOOP AMOUNT MUST BE ZERO.
758	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN LICS MUST BE ZERO.
759	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN GDCB MUST BE ZERO.
760	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN GDCA MUST BE ZERO.
761	IF DRUG COVERAGE IS 'O', THEN PATIENT PAY AMOUNT, LICS, OTHER TrOOP, AND PLRO MUST EQUAL ZERO.
762	IF DRUG COVERAGE STATUS CODE IS 'E', THE CONTRACT TYPE MUST BE ENHANCED ALTERNATIVE.
763	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O' THEN THE VACCINE ADMINISTRATION FEE MUST BE ZERO.

DDPS confirms that PDEs for non-covered drugs do not report data in fields reserved for covered drugs.

Edit 761 "IF DRUG COVERAGE IS 'O', THEN PATIENT PAY AMOUNT, LICS, OTHER TrOOP, AND PLRO MUST EQUAL ZERO": DDPS also confirms that plans do not charge beneficiaries for OTC drugs. Plans must fund OTCs from administrative costs. Each of the following four fields, which report patient liability, must equal zero: Patient Pay Amount, LICS, Other TrOOP, and PLRO.

TABLE 10L – DDPS DET EDIT CODES – MISCELLANEOUS

EDIT CODE	EDIT DESCRIPTION
775	INCOMPATIBLE DISPENSING STATUS ('BLANK' CANNOT FOLLOW 'C' OR 'P'). RECORD FOR A PARTIAL OR COMPLETE FILL IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH DISPENSING STATUS = BLANK FOR THE SAME DISPENSING EVENT.
776	INCOMPATIBLE DISPENSING STATUS ('C' OR 'P' CANNOT FOLLOW 'BLANK'). RECORD WITH UNSPECIFIED FILL STATUS IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'BLANK'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH PARTIAL OR COMPLETE FILL FOR THE SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C').
777	DUPLICATE PDE RECORD.
778	PAID DATE < DOS.
779	SUBMITTING PLAN CANNOT REPORT NPP FOR COVERED PART D DRUG.
780	SERVICE PROVIDER ID QUALIFIER MUST BE '01' – NPI OR '07' – NCPDP ON STANDARD CLAIM.
781	SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE.
783	SERVICE PROVIDER ID WAS NOT AN ACTIVE PHARMACY ON DOS.
784	DUPLICATE PDE RECORD, ORIGINALLY SUBMITTED BY A DIFFERENT CONTRACT.
785	DUPLICATE PDE RECORD EXISTS ON THIS FILE. THIS PDE IS NOT SAVED.
998	INTERNAL CMS ISSUE REGARDING CONTRACT/PBP OF RECORD ENCOUNTERED.
999	INTERNAL CMS SYSTEM ISSUE ENCOUNTERED.

Edit 777 "DUPLICATE PDE RECORD": If a record was previously saved and the Adjustment/Deletion field is 'blank', a duplicate PDE record error message is generated.

Edit 785 "DUPLICATE PDE RECORD EXISTS ON THIS FILE. THIS PDE IS NOT SAVED": This edit distinguishes between a duplicate located within the same file from a duplicate that is already stored in the data warehouse.

Business Order: PDFS and DDPS process PDEs in the order received. The systems assume that PDEs are submitted in the correct business order. If the plan submits multiple original PDEs for the same event, DDPS will save the first PDE that passes edits and reject all subsequent originals for that event. If the first PDE the plan submitted had errors, and the plan submits another original PDE with corrected data within the same batch as the PDE with errors, or later as part of a different batch or file, prior to deleting the original PDE with errors, the PDE with the corrected data would fail edit 785 and be rejected. The incorrect data would be retained.

Edit 778 "PAID DATE < DOS": If the Paid Date field is completed, then the date must be on or after the DOS.

Edit 779 "SUBMITTING PLAN CANNOT REPORT NPP FOR COVERED PART D DRUG": Only Enhanced Alternative (EA) plans, Flexible Capitated Payment Demonstrations, Employer Plans, and Fixed Capitated Payment Demonstrations can report NPP for covered Part D drugs.

Edit 780 "SERVICE PROVIDER ID QUALIFIER MUST BE '01' – NPI OR '07' – NCPDP ON STANDARD CLAIM" further specifies validity edit 614. Only values of '01' and '07' can be reported on standard format PDEs. Service Provider ID Qualifier can be '01'- NPI, '06'- UPIN, '07'- NCPDP, '08' STATE LICENSE. '11' FEDERAL TAX NUMBER, or '99' -OTHER on PDEs compiled from X12, paper, or beneficiary submitted claims. Edit 780 only applies to standard format PDEs.

Edit 781 "SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE": "Service Provider ID is not on master provider file" currently applies only to National Council for Prescription Drug Programs (NCPDP) numbers.

10.3.4 Informational Edits

DDPS has a small number of informational edits. Informational edits either question data reported by the plan or provide additional information from CMS. Either type of informational edit requires plan action. Informational edits such as e.g. 719 and 739 identify conditions that are usually errors. These edits are defined as informational because, infrequently, there are documented circumstances in which the condition is not an error. Plans must ensure that they submit accurate data. If the plan finds that it submitted data inappropriately, the plan must submit adjustments to correct the data whenever necessary.

CMS also uses informational edits to communicate updated information to the plan. For example, edit 710 informs the plan that CMS has updated the HICN. Plans should update their internal records and use the most current number thereafter.

Example: 3 (Slides 12-13)

Scenario

Greenhouse PDP submitted a PDE for a non-covered drug and entered 'O' for an OTC drug. The Plan placed $10 in the CPP field.

Result

DDPS rejected this record and provided error message 756: If the Drug Coverage Status Code is 'E' or 'O', then the CPP must be zero. Greenhouse PDP must enter zero in the CPP field if the Drug Coverage Status Code is 'O'.

10.4 Error Resolution (Slides 15-18)

Error correction/resolution is a central component in ensuring the acceptance, accuracy and completeness of plans' PDE data submissions. As plans correct individual errors, they must assess the factors that caused the error. Plans should also measure and improve their own performance in reducing errors over time.

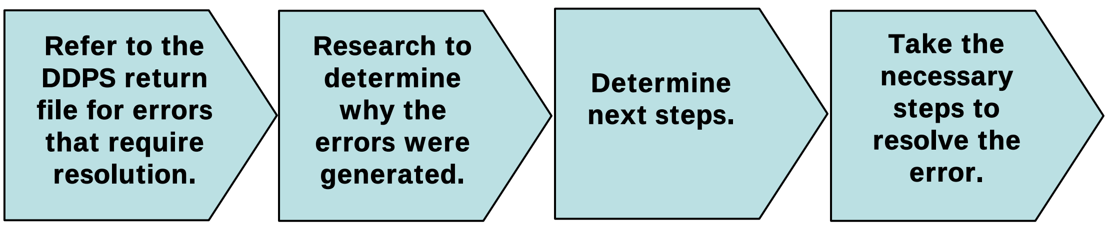
To assist plans with working through the error resolution process, this section provides plans with an explanation of the basic framework of the error resolution process and offers plans different types of error resolution strategies with examples of the types of situations in which these strategies should be used.

10.4.1 The Basic Framework to Error Resolution Process

CMS expects plans to have an active and considered approach to correct errors as a part of their PDE submission strategy. Error resolution has two parallel paths. Plans should have processes in place to respond quickly and effectively to errors that they receive from the DDPS return file. In addition, plans should also have measures in place internally to help identify potential or current errors that require fixes.

Described below are the steps to resolve errors within the DDPS system. These steps remain essentially the same although different types of errors may require additional steps in order to facilitate resolution. Those additional strategies are outlined later in this section.

Figure 10A – Error Resolution Process



- Refer to the DDPS return file for errors that require resolving. Edit resolution is a process that should commence with the receipt of every PDE return file from DDPS. The DDPS return file uniquely identifies and gives details for up to ten errors. This detail information gives the plan sufficient information to correct the majority of errors in a record and submit clean data. Note: The maximum error count is 11. If the error count is 11, plans can conclude that the record contained additional error conditions for which no error detail could be reported.

- Research to determine why the errors were generated. Plans should identify the field or fields that triggered the error, assess the factors that could have caused the error, and determine the root cause of the error.

- Determine next steps. Most errors can be resolved through action on the part of the plan. Other errors require CMS intervention to resolve. Plans should assess the errors received and determine whether the plan is capable of correcting the data or whether CMS needs to be involved in the resolution of the error. Note that not all errors can be corrected; for example, a plan that incorrectly covers a drug, such as a DESI drug, will not be able to correct and re-submit the PDE.

- Take the necessary steps to resolve the error. For errors that are within a plan's control to correct, plans should research the error, and if appropriate, correct the data and resubmit. For errors that require CMS intervention, the plan should bring specific data issues to CMS' attention for assistance with resolution.

Single Field Error Resolution

Error resolution for missing and invalid edits on an individual field is fairly straightforward. Once the plan has received the edit indicating a missing or invalid value, the plan should determine the exact nature of the error, i.e., whether the data is missing or invalid, and then determine how to correct the data.

1. If the data is missing, and it is a required field, the plan should resubmit with the required data.

2. If the data is invalid because it was submitted in an incorrect format, the plan should determine the correct format and resubmit the data.

3. If the data is invalid because an invalid value was submitted, the plan should determine what the appropriate value is, and resubmit the data.

4. If the plan receives a missing/invalid edit for an optional field, such as Date of Birth (DOB), because the data is invalid the plan could also choose to omit the data that caused the reject.

- Determining if the error occurred because the format is invalid.

Example: 4

Scenario

Park PDP submitted a PDE record with the Prescription/Service Reference Number populated using an alphanumeric format instead of numeric.

Result

Park PDP receives edit 612, which indicates that a Prescription/Service Reference Number is missing or invalid. The Prescription/Service Reference Number must be numeric.

Park PDP corrects the invalid format and resubmits with the corrected data.

- Determining if the data value is invalid.

Example: 5

Scenario

Lighthouse Health submitted a PDE record with 'D' in the Drug Coverage Status Code.

Result

Lighthouse Health received edit 625, which indicates the Drug Coverage Status Code is missing or invalid. The only valid values for this field are 'C', 'E', and 'O'.

Lighthouse Health corrects the invalid data and resubmits with a valid value for this field.

Note: Edits 603 through 640 are single field edits and generate single field error codes and messages.

Field-to-Field Edits Resolution

The process for resolving errors associated with field-to-field edits is similar, but involves several additional steps.

1. Identify the relationships between the multiple fields that triggered the error.
2. Determine which fields had incorrect values that caused the error.

Because field-to-field errors could indicate a system issue, plans may need to make internal systems changes prior to resubmitting data.

When resolving errors and implementing prevention mechanisms in internal systems, plans can ask the following questions:

- Are plan system's field definitions and values consistent with PDE definitions and values?
- Are plan system's edits compatible with DDPS edits?
- Did system deficiencies contribute to the error?
- Could system enhancements, such as better user prompts, minimize high volume recurring errors?

Note: Cost Edits, Catastrophic Coverage Code Edits, NDC Edits, and Drug Coverage Status Code Edits are examples of field-to-field edits.

Example: 6

Scenario

Red Farm Health submitted a PDE record in which the detail cost fields do not equal the summary cost fields.

Result

Red Farm Health received edit 691, which indicates that the sum of GDCB and GDCA is not equal to the sum of Ingredient Cost + Dispensing Fee + Sales Tax. Red Farm Health should:

- Determine if the system populated and summed the detail cost fields correctly.
- Determine if the system populated and summed the GDCB and the GDCA correctly.
- If appropriate, make systems changes to correct the error.

Some field-to-field edits require additional problem-solving steps to resolve. For some field to field edits, correcting the data or the source of the data issue and resubmitting may not be appropriate to resolve the error. For these edits, additional problem-solving steps such as contacting CSSC, are required to resolve the error. These steps are described in the section on Error Resolution Process.

Eligibility and LICS edits are examples of field-to-field edits with specific problem-solving steps.

- Eligibility Edits (Edits 700 – 714)

Example: 7

Scenario

Yellow Ridge PBP submitted a PDE record for a beneficiary on 05/13/06.

Result

Yellow Ridge PBP received edit 707 indicating that the beneficiary was not enrolled in the Part D plan benefit package on the DOS. The beneficiary must be enrolled in this Part D plan benefit package on the DOS to receive coverage. Yellow Ridge PBP should:

- Determine if the DOS is accurate.
- Determine if the plan's enrollment file shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS. There may be enrollment date discrepancies when a beneficiary transfers from one plan to another.
- Determine if MARx shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS and if disenrollment date (if applicable) is after DOS.
- If the plan cannot resolve enrollment discrepancies, the last step is to call CSSC.

- LICS Edits (Edits 715-722)

Example: 8

Scenario

Green Fan PDP submitted a PDE record for a non-low income beneficiary and included $10 in the LICS field.

Result

Green Fan PDP received edit 715 indicating that there were dollars reported in LICS that were greater than zero. Since the beneficiary is not eligible for LICS subsidy because the beneficiary is not low income eligible, Green Fan PDP should:

- Determine if the DOS is accurate.
- Determine if the plan's enrollment file shows that the beneficiary was low income eligible on or before the DOS.
- There may be eligibility date discrepancies when a beneficiary first becomes eligible for low income cost-sharing due to retroactive low income eligibility.
- Determine if MARx shows that the beneficiary was low income eligible on or before the DOS. There may be timing lags between MBD and plan data for low income status.
- If the plan cannot resolve low income discrepancies, the last step is to call CSSC.

- Plans have financial incentive to resolve LICS edits because plans will not receive payment for LICS amounts that plans advanced to beneficiaries who are not listed as low income eligible on MARx.
- Plans must also monitor Transaction Reply Reports (TRRs) for retroactive low income status. When a beneficiary receives low income status retroactively, the plan must
  a. Reimburse the beneficiary for cost-sharing greater than the LICS cost-sharing limits for claims occurring during the timeframe covered by the retroactive LICS and;
  b. Submit an adjustment for every saved PDE to report LICS accurately.

- Service Provider ID/NPI

Effective October 23, 2007, CMS added 272 identifiers to the pharmacy master file, which DDPS uses in editing PDE data. CMS made these identifiers available on the CSSC website (www.csscoperations.com). Plans receiving the 781 edit code, should check the current list of identifiers and resubmit the PDE record if possible.

The National Council of Prescription Drug Programs (NCPDP) publishes the Pharmacy Database used in building the master file. CMS rejects standard format PDEs when a submitted National Provider Identifier (NPI) is not present in the database tables. Possible reasons for the NPI unavailability is a time lag between updates or replacement of a previous NPI with a current NPI. This occurred during implementation. If this should occur now, plans should contact pharmacies to confirm the most current NPI crosswalk is on file and resubmit the PDE if the NPI was out of date.

Another source of resolution for PDEs is the Plan-to-Plan (P2P) Update Process related to movement of the beneficiary among contracts and plan benefit packages.

10.5 Plan-to-Plan (P2P) (Slides 21-22)

P2P reconciliation is a financial settlement process between two Part D Sponsors in which the Contract of Record compensates the Submitting Contract for claims paid on a beneficiary that belongs to the Contract of Record. CMS originally implemented P2P in three phases but P2P is an **ongoing process** that will occur throughout each coverage year. This process identifies submitted PDEs for a possible P2P condition and reports the affected PDEs to the Sponsors for financial settlement.

Throughout the year, Sponsors receive P2P reports on a monthly basis. The reports show **payables and receivables**, which Sponsors are responsible for reconciling the full financial amount with one another. Prior to the Annual Part D Payment Reconciliation, CMS updates previously accepted PDEs for any changes in Contract and/or PBP of Record. The monthly reports for the processing month in which CMS performs the Contract/PBP Update will show any new payables and receivables that result from the Contract/PBP Update. The financial amounts must be reconciled in full. CMS conducts this process prior to the Part D Payment Reconciliation to ensure that the Contract of Record has paid all of the claims for each beneficiary enrolled in their Contract.

Figure 10B illustrates the P2P Process Flow.

Figure 10B – P2P Process Overview

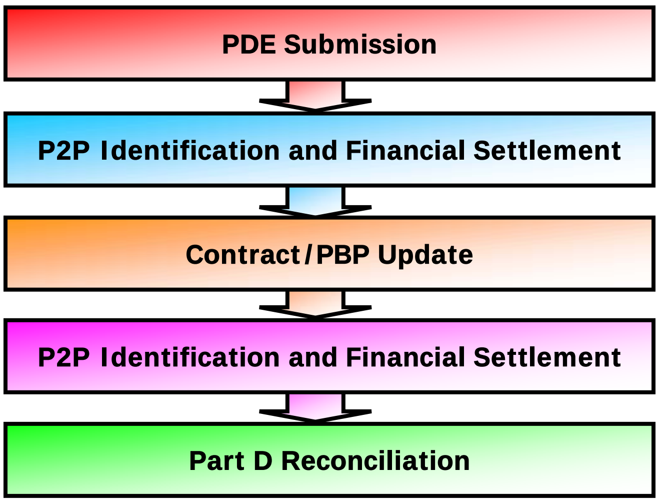


Table 10M provides the definitions of common terms related to the P2P process. Example 9 applies several of these terms in an example.

TABLE 10M – COMMON P2P TERMS

TERMS	DEFINITIONS
Submitting Contract	Contract submitting PDE data.
Submitting PBP	Plan Benefit Package submitting PDE data under the submitting contract.
Original Contract of Record	Beneficiary enrollment as documented in CMS databases when PDE is saved and accepted by CMS.
Original PBP of Record	Plan Benefit Package under the Original Contract of Record as documented in CMS databases.
Updated Contract of Record	New Contract of Record after CMS performs the Contract/PBP Update that affects saved PDE data.
Updated PBP of Record	New Plan Benefit Package of Record after CMS performs the Contract/PBP Update that affects saved PDE data.
P2P PDE	Submitting Contract differs from the Contract of Record within CMS databases on the date of service documented on the PDE.
P2P Reconciliation	Financial Settlement of all Covered Plan Paid amount (CPP) and Low Income Cost Sharing Subsidies (LICS) from a Contract of Record to a Submitting Contract.
P2P Contract/PBP Update	CMS update of Contract and/or PBP of Record on saved PDE data; prerequisite to Part D Payment Reconciliation
Part D Payment Reconciliation	Statutory defined reconciliation conducted after the completion of a coverage year.

Example 9

Scenario

John Brown has been enrolled in Summer Health Plan under Plan Benefit Package 002 since January 1, 2007. Fall Health Plan submitted an enrollment record to CMS on August 15, 2007. The enrollment effective date is August 1, 2007 for Plan Benefit Package 001. Summer Health Plan submitted a PDE for John Brown with a DOS of September 13, 2007.

1. Who is the **Submitting Contract**?
2. What is the **Submitting Plan Benefit Package**?
3. Who is the **Original Contract of Record**?
4. What is the **Original PBP**?
5. Is this a **P2P PDE** situation?

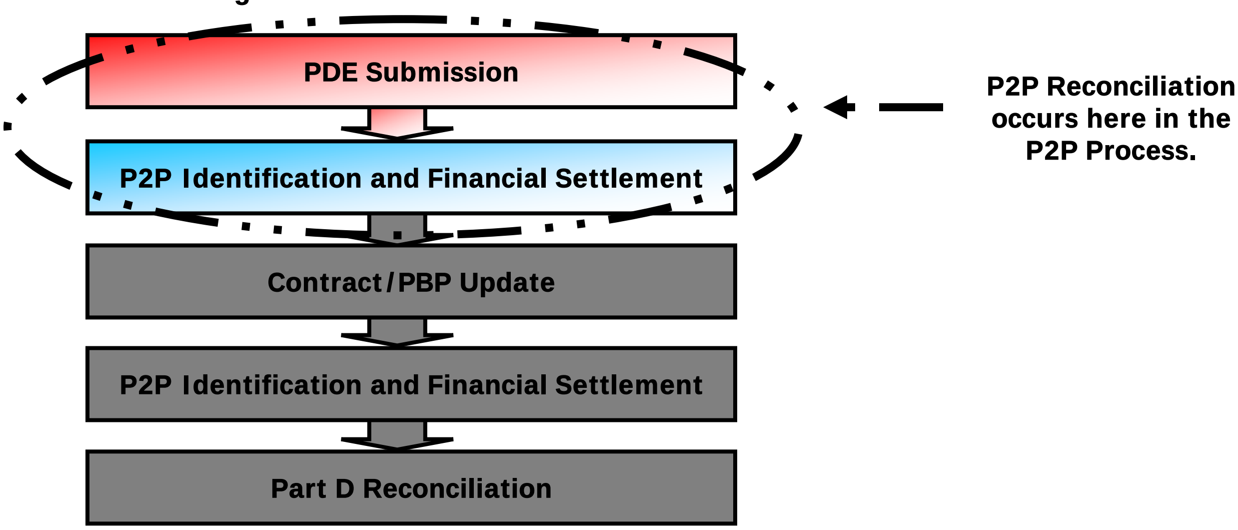
Result

1. Summer Plan since it submitted the PDE data
2. 002, this is the plan benefit package submitted on the PDE
3. Fall Health Plan, which CMS databases determines
4. 001, which is what John Brown selected as the enrollment package under Fall Health Plan
5. Yes, since the definition states a P2P PDE is when the submitting contract differs from the Contract of Record within CMS databases.

10.5.1 P2P Reconciliation (Slide 23)

When there is a P2P PDE, **P2P Reconciliation,** applies. P2P Reconciliation is a financial settlement of all Covered Plan Paid amounts and Low Income Cost-Sharing Subsidy amounts from a Contract of Record to a Submitting Contract. Figure 10C illustrates where P2P Reconciliation occurs in the P2P Process.

Figure 10C – P2P Reconciliation



10.5.2 Statutory Authority (Slide 24)

Under the regulations of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Part D Sponsors have an obligation to coordinate benefits with entities providing other prescription drug coverage to Part D eligible individuals. This obligation includes other Part D Sponsors.

42 CFR 423.464(a)

The P2P process provides a means to coordinate correction of claims payments made by a Part D Sponsor other than the Contract of Record. CMS requires that all Contracts participate in the P2P process.

10.5.3 CMS Transition Period (Slide 25)

Under the same authority, CMS established an initial transition period effective end date policy in order to align the P2P reconciliation process with plan formulary transition periods to ensure that all drug costs included in the Summary Reports are covered Part D drugs with respect to each Part D Sponsor. The start date of this transition period begins with the effective date of enrollment in a specific Contract/PBP. In order to coordinate benefits between the Submitting Contract and the Contract of Record in a fair and equitable manner, CMS established the policy that the end date of the minimum transition period occurs on the later of:

30 days after the effective date of coverage
or
30 days after the date CMS processes the enrollment into the new contract of record

This policy protects the Submitting Contract from exposure to costs that would otherwise be incurred outside the Contract of Record's initial transition period when, without its knowledge and beyond its control, that new Part D Sponsor has delayed submitting the enrollment transaction to CMS.

10.5.4 P2P Roles and Responsibilities (Slides 26-27)

When plans submit the EDI agreement package, the organization assumes certain responsibilities as a Part D sponsor. These responsibilities include:

- Submitting accurate and timely PDEs
- Making appropriate adjustments and reversals
- Accessing and reviewing monthly reports

There are additional responsibilities for Part D sponsors with the P2P process. These additional responsibilities are assigned to the submitting contract, the contract of record, or CMS.

The Contract of Record is required to make timely payments to the Submitting Contract for all CPP and LICS reported on the monthly reports within 30-days of CMS distribution of these reports. The Contract of Record makes payments without intervention from CMS, as CMS does not dictate the manner of payment. The Contract of Record cannot request any additional documentation or attestations regarding the accuracy of the Submitting Contract's financial data on P2P reports. The Contract of Record must pay in full the amount displayed on the monthly payables report.

CMS is providing support through systems and reports, which accept the data and communicate appropriate information to the drug sponsors to facilitate the P2P Reconciliation. This information includes CPP and LICS, which plans receive on the P2P monthly reports. Table 10N summarizes the roles and responsibilities for Part D sponsors and CMS in P2P.

TABLE 10N – P2P ROLES AND RESPONSIBILITIES

Submitting Contract	• Submits PDEs • Attests to accuracy of submitted PDEs • Reports any DIR earned for P2P PDEs
Contract of Record	• Makes timely payments (LICS and CPP) to the submitting contract • Certifies payments
CMS	• Identifies Contract of Record • Provides CPP and LICS amounts

10.5.5 P2P Processing Within PDE Processing

During normal processing of PDE records, DDPS determines whether the PDE is subject to P2P Reconciliation. DDPS conveys this information using Reject edit 706 or Informational edits 708, 709, and 712. Example 9 illustrates P2P processing within PDE processing in DDPS.

Example 10 (Slides 28-31)

Scenario

John Brown joined Winter Health Plan in January 2007 as a dual-eligible and completed an enrollment application on August 27, 2007 for Spring Health Plan's PBP 002. Spring Health Plan submitted the enrollment. CMS processed the enrollment on September 3, 2007. John's effective date is September 1, 2007.

John fills a prescription on September 5, 2007 for a covered drug and on September 7, 2007 for an OTC drug using an ID card from Winter Health Plan. He also fills prescriptions on October 2, 2007 and October 15, 2007 for covered drugs. Winter Health Plan PBP 001 submitted two PDEs on September 29, 2007 for the September 5, 2007 and September 7, 2007 claims. They also submitted a PDE on October 20, 2007 for the October 2, 2007 claim and on October 29, 2007 for the October 15, 2007 claim.

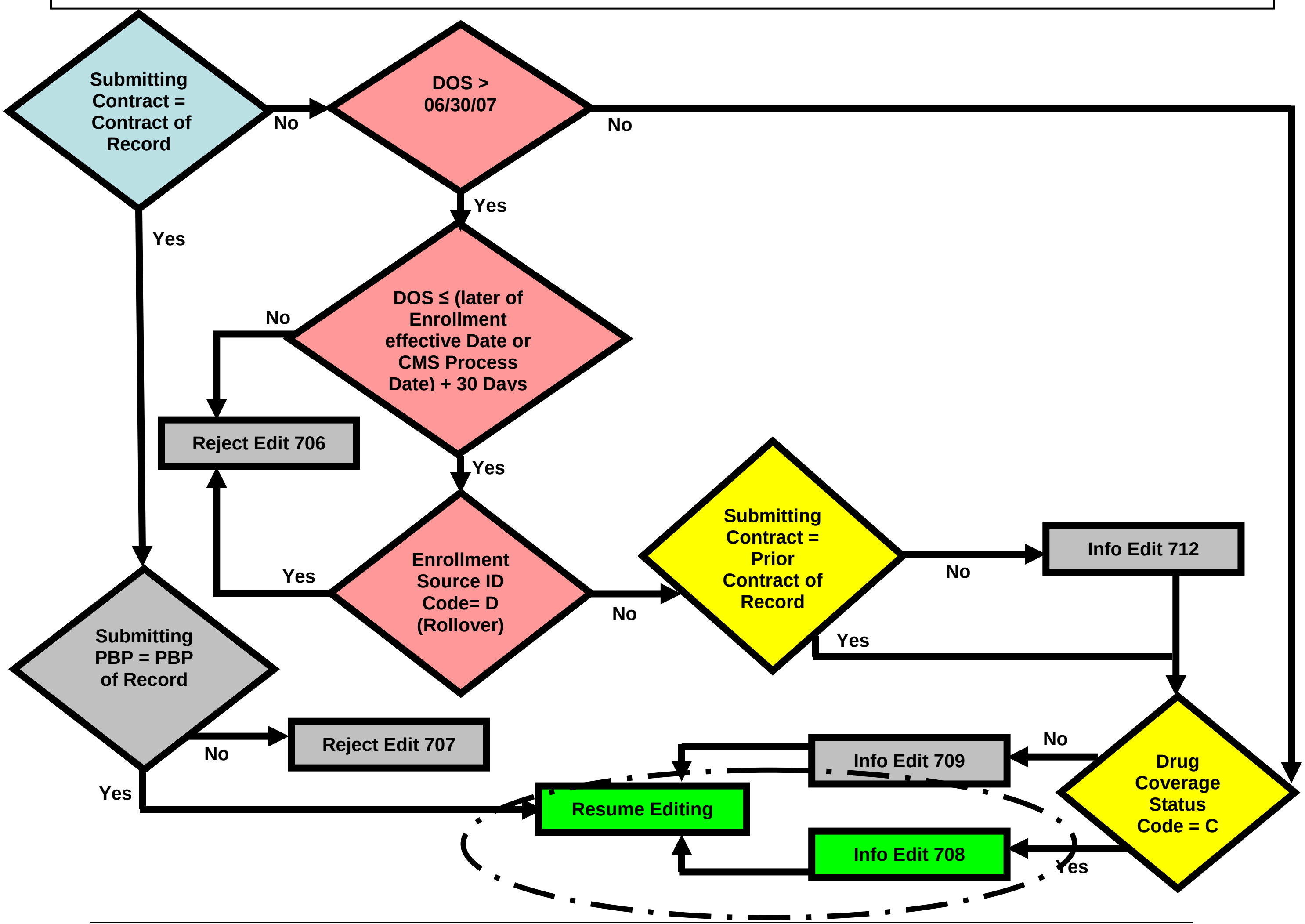
Results

See Results A – D.

Result A

John's effective date is September 1. Winter Health Plan submitted a PDE on September 29 for the September 5 claim.

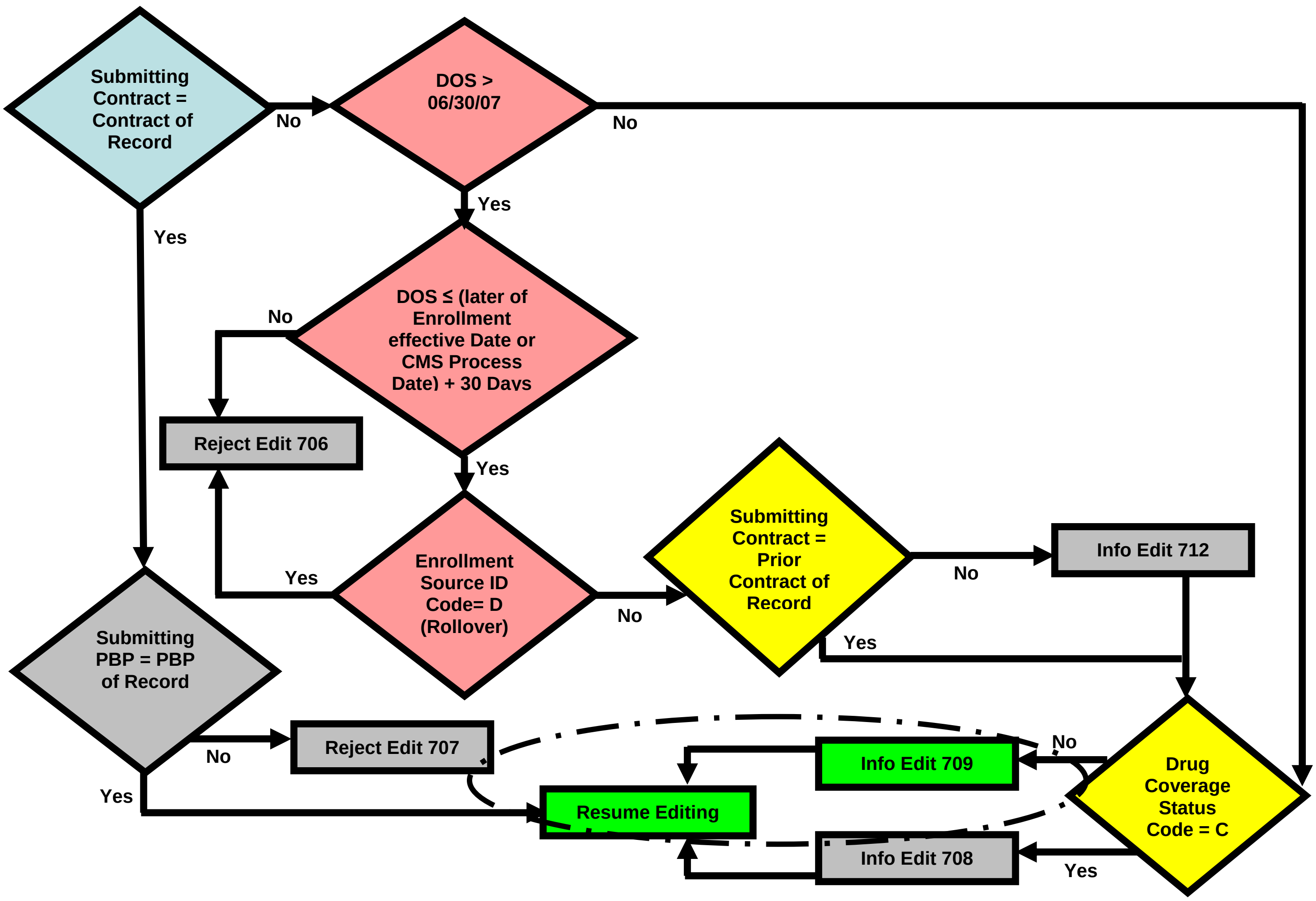
- DDPS compares the Submitting Contract to the Contract of Record.
- If the Submitting Contract is the Contract of Record, DDPS will evaluate whether the Submitting Plan is the Plan of Record. This process is part of the non-P2P processing already in place in DDPS.
- Winter Health Plan is not the Contract of Record for this scenario.
- DDPS examines DOS for Submitting Contracts that are not the Contract of Record.
- The DOS for Winter Health Plan was greater than June 30, 2007.
- DOS is ≤ the CMS process date plus 30-days.
- DDPS evaluates the Enrollment Source ID and determines this is not a rollover by CMS.
- Winter Health is the Prior Contract of Record before Spring Health. Therefore, Informational edit code 712 will not be generated.
- DDPS evaluates if the PDE that Winter Health is submitting is for a covered, enhanced alternative, or an OTC drug. For this claim, the type of drug is Covered. Therefore, Winter Health will receive informational edit 708 identifying this as a covered drug that will be included in Winter Health's P2P reconciliation with Spring Health who is the Contract of Record. Then DDPS will continue editing the PDE record as part of the normal editing process.



Result B

John's effective date is September 1. Winter Health Plan submitted a PDE on September 29 for the September 7 claim.

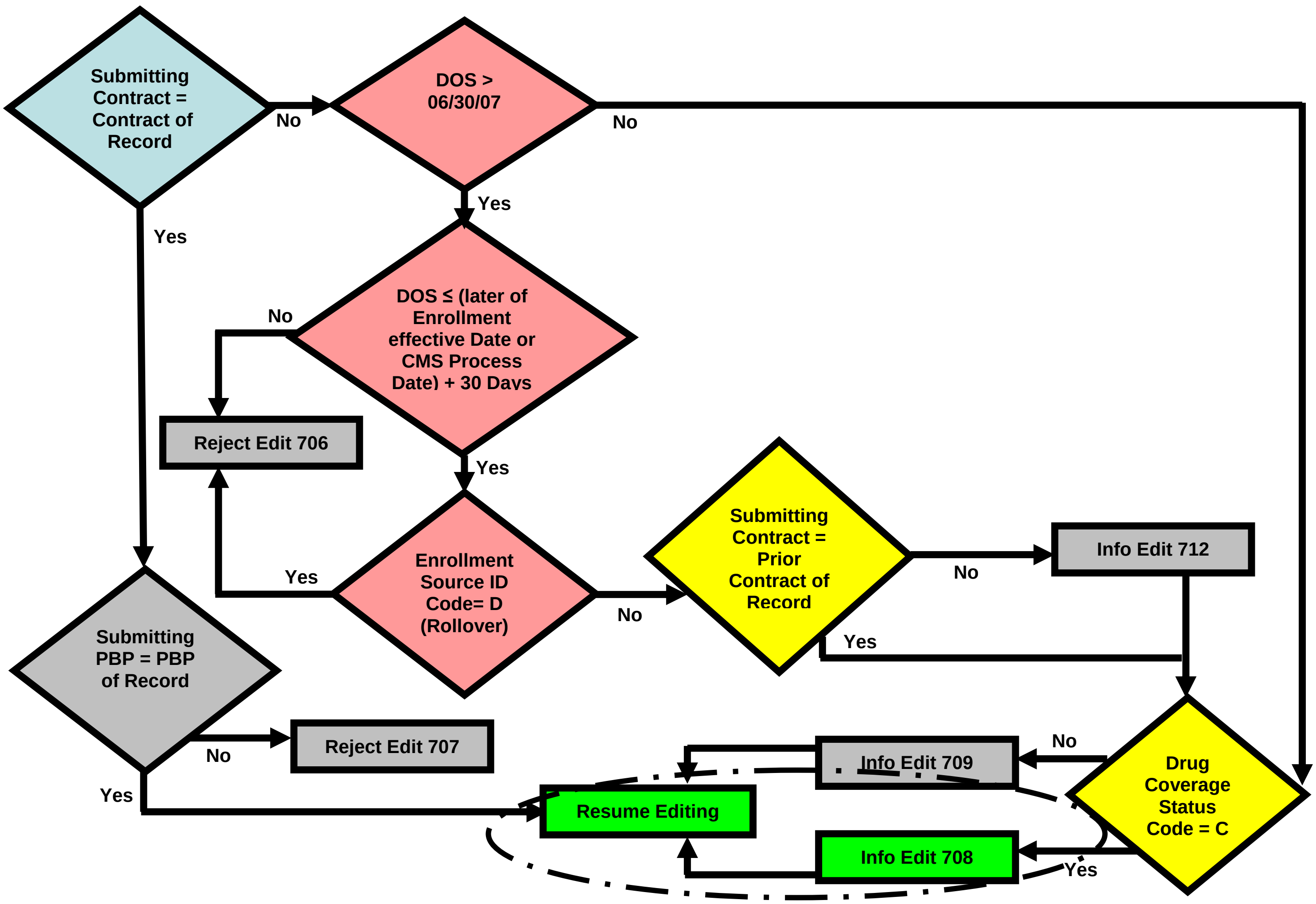
- Winter Health is not the Contract of Record for John.
- DOS for this PDE is greater than June 30, 2007.
- DOS is ≤ the CMS process date plus 30-days.
- This is not a rollover by CMS.
- Winter Health is the Prior Contract of Record before Spring Health. Informational edit code 712 will not be generated.
- DDPS evaluates if the PDE that Winter Health is submitting is for a covered, enhanced alternative, or an OTC drug. For this claim, the type of drug is OTC. Winter Health will receive informational edit 709 identifying this as an OTC drug that will **NOT** be included in Winter Health's P2P reconciliation with Spring Health. Then DDPS will continue editing the PDE record as part of the normal editing process.



Result C

John's effective date is September 1. CMS processed the enrollment on September 3. Winter Health Plan submitted a PDE on October 20 for the October 2 claim.

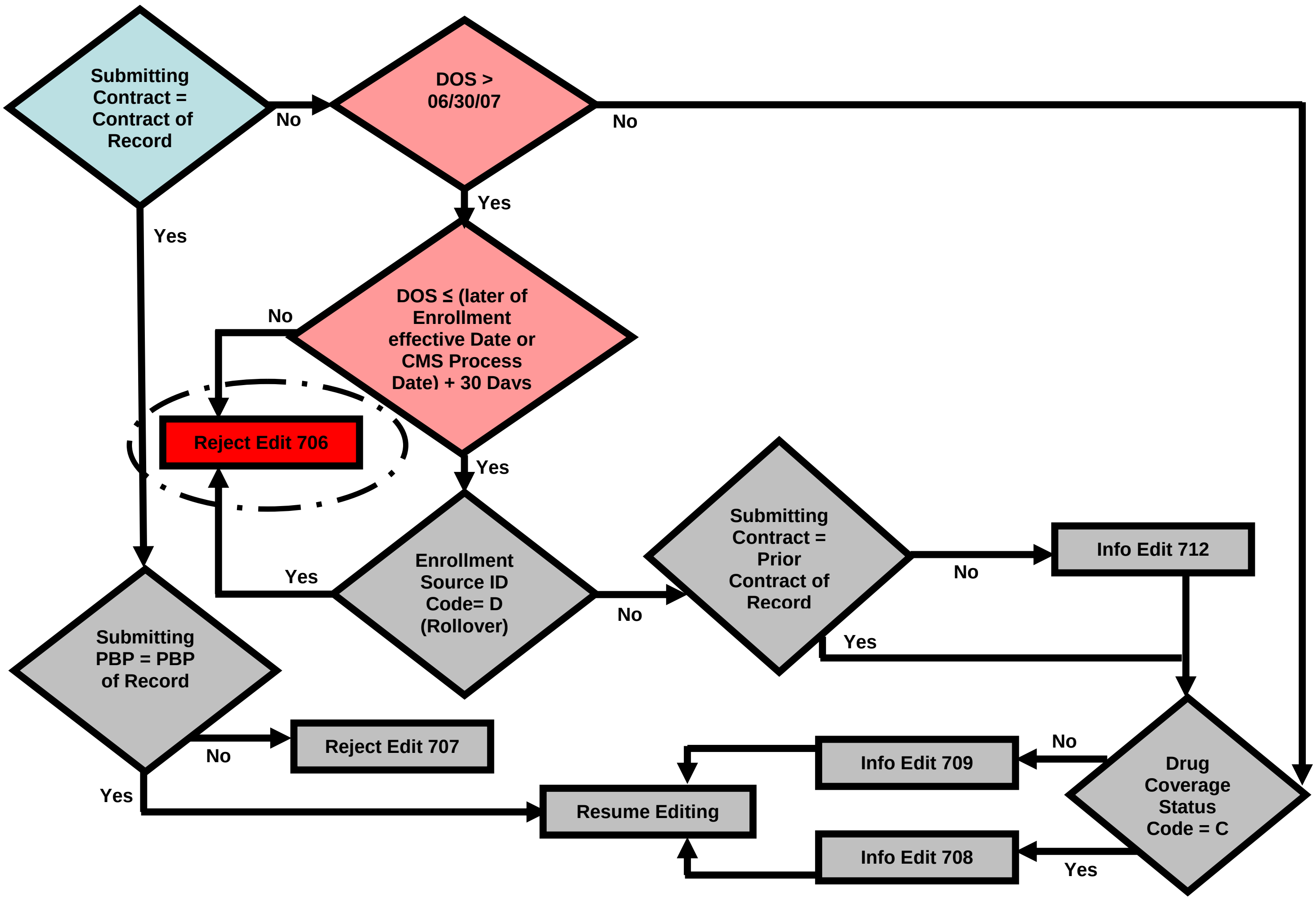
- Winter Health is not the Contract of Record for John.
- DOS for this PDE is greater than June 30, 2007.
- DOS is ≤ the CMS process date plus 30-days.
- This is not a rollover by CMS.
- Winter Health is the Prior Contract of Record before Spring Health. Informational edit code 712 will not be generated.
- DDPS evaluates if the PDE that Winter Health is submitting is for a covered, enhanced alternative, or an OTC drug. For this claim, the type of drug is Covered. Therefore, Winter Health will receive informational edit 708 identifying this as a covered drug that will be included in Winter Health's P2P reconciliation with Spring Health who is the Contract of Record. Then DDPS will continue editing the PDE record as part of the normal editing process.



Result D

John's effective date is September 1. Winter Health Plan submitted a PDE on October 29 for the October 15 claim.

- Winter Health is not the Contract of Record for John throughout this scenario. So, let's move onto evaluating the DOS.
- The DOS for this PDE is greater than June 30, 2007.
- DOS is not ≤ the CMS process date plus 30-days because CMS processed the enrollment on September 3rd and the PDE has a DOS of October 15, 2007. This DOS is beyond the transition period.
- The plan receives rejection edit 706 indicating the DOS does not fall within a valid P2P period. Winter Health Plan should not have John in their enrollment database 30 days after CMS processes the enrollment.



10.5.6 P2P Contract/PBP Update (Slides 32-33)

CMS updates Contract and/or PBP of Record information on saved PDE data. When a change in the CMS enrollment data results in a change to the Contract and/or PBP of Record on saved PDE data, the updates may result in creating a P2P condition or reversing an existing P2P condition on the saved PDE data.

After the completion of the benefit year, CMS conducts a statutory Part D Payment Reconciliation and all PDE-reported costs must be attributed to the appropriate Contract of Record.

P2P Contract/PBP Update allows the DDPS to query MARx for changes to Contract and PBP of Record. If this query results in changes, DDPS will update affected PDE data to reflect the changes. If this query does not result in a change, no update will occur on the saved PDE data.

This process updates all changes to Contract and PBP of Record, but it is not limited to changes that affect P2P. This process also updates enrollment information when the beneficiary moves from one PBP to another PBP within the same Contract.

CMS developed Update Codes that generate as a result of the P2P Contract/PBP Update.

10.5.7 Update Codes (Slide 34)

Submitting Contracts receive the Update Codes on a Special Return File. The Update Codes are only sent to the Submitting Contract and not to the updated or original Contract of Record.

The Contract/PBP update to saved PDEs results in changes that appear on the monthly reports. The monthly reports show any new payables and receivables that result from the P2P contract/PBP update.

Any financial amounts resulting from this process appear the same as any other financial amounts would appear on a monthly report. Since the financial amounts from the P2P contract/PBP Update are not reported differently, the monthly reports should be thoroughly reviewed.

The layout of the monthly reports will not change. The Updated Contract of Record and the Original Contract of Record will only be aware of changes by reviewing the monthly reports.

The Submitting Contract receives Update codes on the Special Return File when enrollment changes result in a change in Part D financial dollar amounts. The change(s) may result in either a payable or receivable.

Each Update Code is meant to provide the Submitting Contract with an explanation of how the enrollment changes affect the saved PDE. The explanation will assist the Submitting Contract when evaluating the monthly reports for changes.

Table 10O describes the P2P Update Codes.

TABLE 10O – P2P UPDATE CODES

UPDATE CODE	DESCRIPTION
851	The Contract of Record has been updated; a P2P condition now exists
852	The Submitting Contract/PBP is now the Contract/PBP of Record; a P2P condition no longer exists.
853	PBP of Record has been updated. This PDE continues to be a non-P2P PDE.
854	The Contract of Record and PBP of Record have been updated. A new P2P condition is established.
855	The Submitting Contract is now the Contract of Record but the Updated PBP of Record is different from the Submitting PBP. A P2P condition no longer exists.

These edits will appear on the Special Return File sent to Submitting Contracts after the Contract/PBP Update.

10.6 Responding to Immediately Actionable PDE Errors (IAPs) (Slide 35)

CMS is evaluating PDP and MA-PD contracts on the quality and timeliness of PDE submissions, PDE errors, and error resolution efforts. CMS' contractor Acumen, LLC will provide reports on the quality, timeliness, and accuracy of each contract's PDE data and error resolution efforts. This initiative will be rolled out in phases with the first phase dealing with a subset of PDE errors that CMS considers to be immediately actionable.

These errors include, but are not limited to:

- Formatting mistakes
- Data inconsistencies
- Failure to grant sufficient low income cost-sharing subsidies

CMS expects plans to take immediate, regular, and consistent action to fix and resubmit the Immediately Actionable PDE errors. Plans must continue with error resolution efforts for all errors regardless of whether they are IAPs.

The list of errors considered IAPs will grow over time as CMS adds edits to the DDPS edit code list.

Plans will receive IAP reports on a monthly basis. Plans should use these monthly reports to track the status of the errors as well as the plan's resolution efforts. CMS will also track plans' efforts to resolve IAPs.

Prescription Drug Event (PDE) PDP/MA-PD Contracts Report User Guide (January 2008) provides additional details regarding the calculations of the submission and error rejection rates in the reports.

MODULE 11 – REPORTS

Purpose (Slide 2)

The Centers for Medicare & Medicaid Services (CMS) communicates the status of submitted Prescription Drug Event (PDE) records to submitters and plans on reports. The reports focus on both PDE record processing, including errors generated during processing, and accumulation of dollar amounts. Plan-to-Plan (P2P) processing also leads to determination of P2P conditions and financial settlement between plans, which CMS communicates through P2P Reports. It is essential that plan management staff understand how to read reports and resolve any issues the reports identify. This module provides insights on the appropriate use of reports to manage data collection, data submission, error resolution processes, and help prepare plans for the reconciliation process.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify the purpose of Prescription Drug Front-End System (PDFS), Drug Data Processing System (DDPS), and Integrated Data Repository (IDR) reports.
- Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- Read the DDPS reports to identify and submit corrections accurately.
- Recognize the relationship between values in the financial management reports and reconciliation.
- Determine the existence of P2P conditions and the associated financial settlements.

ICON KEY
Definition
Example
Reminder
Resource

11.1 Accessing Part D Reports (Slide 4)

Plans can access reports designed to support the prescription drug event data process through the following methods:

- Connect:Direct
- File Transfer Protocol (FTP)
- CMS Enterprise File Transfer (Gentran)

FTP users receive reports generated by the Prescription Drug Front-End System (PDFS) typically within 30 minutes of submission. CMS Enterprise File Transfer (Gentran) users and Connect:Direct users should receive PDFS reports the following business day if the file transfer is complete by 5:00 p.m. Eastern Time (ET). If the submission is received after 5:00 p.m. ET, CMS Enterprise File Transfer (Gentran) and Connect:Direct users will usually receive the report two business days after submission.

For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (800) 927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at http://www.cms.hhs.gov/mmahelp.

Submitters typically receive Drug Data Processing System (DDPS) processing reports the next business day. Monthly DDPS reports are expected to be available for download the third business day following month-end. For FTP and CMS Enterprise File Transfer (Gentran) users, reports are sent to the designated mailbox where they remain for 15 days. The system automatically deletes reports from the mailbox after 15 days, but plans and submitters can access reports through the Customer Service and Support Center (CSSC) for up to 7 years.

FTP submitters may request reports in .zip format. To avoid difficulties opening .zip reports, users should:

- Rename the file with the ".zip" extension.
- Change the command to binary when using the FTP command line.

11.2 Report Format

With the exception of the PDFS Response Report, all reports will arrive in flat file format. The flat files may be downloaded into databases and converted to display the necessary fields. Table 11A summarizes the content and general information about each of the reports.

TABLE 11A – REPORTS OVERVIEW

PDFS REPORT	
PDFS RESPONSE REPORT	• Indicates if PDFS accepted or rejected the file • Identifies 100-, 200-, and 600-level error codes • Report layout • FTP users receive reports the same business day; CMS Enterprise File Transfer (Gentran) and Connect:Direct users access reports the next business day
DDPS TRANSACTION REPORTS	
DDPS RETURN FILE	• Contains the entire submitted transaction for all detail record types (rejected, informational, and accepted) • Identifies error codes • Flat file layout • Received the next business day after processing
DDPS TRANSACTION ERROR SUMMARY REPORT	• Provides counts and rates for each error in the batch • Flat file layout • Received the next business day after processing

TABLE 11A – REPORTS OVERVIEW (CONTINUED)

IDR MANAGEMENT REPORTS	
IDR CUMULATIVE BENEFICIARY SUMMARY REPORT	• Three reports, each with same format: - 04COV for covered drugs - 04ENH for enhanced alternative drugs - 04OTC for over-the-counter drugs • Provides summary of accumulated totals per beneficiary for dollar amount fields (when submitting contract is the contract on file at CMS) • Totals apply to one benefit year, with each benefit year having a separate cumulative report • Financial amounts are reported as "net" • Report will break by contract and PBP • Available for download the third business day of the month following month-end
PLAN-TO-PLAN (P2P) REPORTS	
P2P PDE ACCOUNTING REPORT	• This is a YTD report that documents cumulative amounts reported by a contract that is not the Contract of Record. (Effective August 2006)
P2P RECEIVABLE REPORT	• Monthly report that documents the net change in P2P reconciliation receivable amounts. (Effective August 2006)
P2P PART D PAYMENT RECONCILIATION REPORT	• YTD cumulative report of all P2P amounts that will be used in the Contract of Record's Part D Payment Reconciliation. (Effective August 2006)
P2P PAYABLE REPORT	• Monthly report that serves as the "invoice" to the Contract of Record, showing how much is payable to each Submitting Contract. (Effective August 2006)

Table 11B provides the naming conventions for management reports sent to the submitter's mailbox.

TABLE 11B – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
PDFS RESPONSE REPORT	RPT00000.RSP.PDFS_RESP
DDPS RETURN FILE	RPT00000.RPT.DDPS_TRANS_VALIDATION
DDPS TRANSACTION ERROR SUMMARY REPORT	RPT00000.RPT.DDPS_ERROR_SUMMARY
IDR CUMULATIVE BENEFICIARY SUMMARY REPORT	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC
P2P PDE ACCOUNTING REPORT	RPT00000.RPT.DDPS_P2P_PDE_ACCNT
P2P RECEIVABLE REPORT	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P PART D PAYMENT RECONCILIATION REPORT	RPT00000.RPT.DDPS_P2P_PARTD_RCN
P2P PAYABLE REPORT	RPT00000.RPT.DDPS_P2P_PAYABLE

11.3 Prescription Drug Front-End System (PDFS) Report (Slide 9)

The PDFS Response Report identifies errors generated by the PDFS and checks for format, integrity, and validity that occurred in the file and batch level records. PDFS also checks for sequencing errors on all detail level records. The report provides the status of the file and whether it was accepted or rejected by the PDFS. If the file is accepted, the report specifies that the file is completely accepted. If the file is rejected, the report identifies the errors or reasons the file was rejected. Figure 11A illustrates and describes the fields on the PDFS Response Report.

Figure 11A – Rejected PDFS Response Report

```
[1]REPORT: PDFS-RESP              [2]PRESCRIPTION DRUG FRONT END SYSTEM
[3]RUN DATE: 20060513                        PDFS RESPONSE REPORT

[4]SUBMITTER ID: SH1234
[5]FILE ID: 0000000001             [6]REJECTED   PROD

[7]        [8]       [9]
RECORD   SEQ       ERROR       [10]
TYPE       NO        CODE        ERROR DESCRIPTION
HDR                  132          FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE
                                  THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.
END OF REPORT
*****END OF TRANSMISSION*****
```

FIELD NO.	FIELD NAME	FIELD DESCRIPTION
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Report Date	Date the report was generated by PDFS (CCYYMMDD format).
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one contract/plan. A report is generated for each file.
5	File ID	The 10-digit file identification number.
6	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST, CERT, or PRODUCTION.
7	Record Type	Identifies the level of the error (File, Batch, or Detail record level).
8	Sequence Number	Identifies the record where the error occurred.
9	Error Code	Identifies the 3-digit error code that caused the file to reject.
10	Error Code Description	Explains the error code.

NOTE: There are four reasons why users would not receive the PDFS Response Report:

- The HDR record is not included on the file. Submitters receive an "INVALID_FILE_HDR" message.
- No Submitter ID on the HDR record.
- The login ID used to submit data to PDFS does not match the Submitter ID. Submitters receive a "SUBMITTER ID IN FILE DOES NOT MATCH THE LOGIN ID" message (FTP users only).
- Invalid Zip File.

Example: 1

SureHealth submitted a file, but did not change the file ID. The first batch did not include a valid PBP number for the Contract ID. The first detail record of the first batch was out of sequence. The fourth batch trailer's PBP did not match the PBP number in the batch header. The record total in the TLR was missing. Figure 11B illustrates this example.

Figure 11B – PDFS Response Report

REPORT: PDFS-RESP **PRESCRIPTION DRUG FRONT END SYSTEM**
RUN DATE: 20060315 **PDFS RESPONSE REPORT**

SUBMITTER ID: SH9999
FILE-ID: 0000000001 REJECTED PROD

RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
HDR	0000001	132	FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.
BHD	0000002	234	PBP IS NOT VALID FOR THE CONTRACT ID.
DET	0000003	601	DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT FOLLOW A BHD OR ANOTHER DET RECORD.
BTR	0001234	282	PBP ID DOES NOT MATCH THE PBP ID IN THE BHD RECORD.
TLR	0001235	182	DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.

END OF REPORT
*****END OF TRANSMISSION*****

11.4 Drug Data Processing System (DDPS) Transaction Reports (Slide 10)

DDPS produces transaction reports after processing a PDE. These reports give the precise status of each of the submitted PDE records, as well as summary information about the submitted file. Submitters will automatically receive transaction reports. Upon request, plans may receive copies of transaction reports directly from CMS. CMS strongly encourages plans with third party submitters to receive their reports directly from CMS.

Please contact www.csscoperations.com for assistance.

Each of the DDPS reports will be delivered in flat file format. Report files contain up to seven record types, each containing 512 bytes. The record types are presented in the same order for each report file. Table 11C provides the indicator and definition for each record type included in the report flat file.

Transaction reports document the result of DDPS processing. They are specific to each file. Plans, or submitters on behalf of plans, must promptly review transaction reports to identify any problems to be resolved. Plans can track summary data from transaction reports to measure and improve their own performance.

11.4.1 DDPS Return File (Slide 11)

The layout of the DDPS return file closely mirrors that of the submitted PDE file. One key element of the report is a change in the Record ID field. Upon completion of DDPS processing, the Record ID field for each detail record is changed from DET to one of three values: ACC indicates that the record had no errors and was accepted and stored, INF indicates that the record contains an informational error, however, the data were stored. REJ indicates the record was rejected and the data were not stored. Table 11C shows all of the Record ID values for the DDPS Return File.

TABLE 11C - DDPS RETURN FILE - RECORD DEFINITION/DESCRIPTION

RECORD ID	RECORD DEFINITION	NOTES
HDR	File header created by submitter	Occurs once per file. In addition to all fields from the submitted HDR, includes the following: DDPS-SYSTEM-DATE (positions 32-39) DDPS-SYSTEM-TIME (positions 40-45) DDPS-REPORT-ID (positions 46-50)
BHD	Contract/PBP level file header created by submitter	Occurs once per Contract/PBP on file. In addition to all fields from the submitted BHD, includes the following: DDPS-SYSTEM-DATE (positions 19-26) DDPS-SYSTEM-TIME (positions 27-32) DDPS-REPORT-ID (positions 33-37)
ACC*	Accepted PDE records written by DDPS	All fields from ACC records.
INF*	Informational PDE records written by DDPS	All fields from DET records with information data and edit codes appended in fields 49-58 (positions 468-497).
REJ*	Reject PDE records written by DDPS	All fields from DET records with information data (if applicable) and error codes appended in fields 49-58 (positions 468-497).
BTR	Contract/PBP level file trailer created by submitter (modified by DDPS)	Occurs once per each BHD on the file. Contains all fields from submitted BTR (including count of original number of DET records) plus ACC, INF, and REJ record counts.
TLR	File trailer created by submitter (modified by DDPS)	Occurs once per each HDR on the file. Contains all fields from submitted TLR (including counts of original number of DET records) plus ACC, INF, and REJ record counts.

* ACC, INF, and REJ records will be sorted by sequence number and appear in the same sequence as on the submitted file.

The DDPS Return File retains the HDR and BHD data the plan submitted in the original PDE file and adds the following three fields: DDPS-SYSTEM-DATE, DDPS-SYSTEM-TIME, and DDPS-REPORT-ID. DDPS-REPORT-ID '01' identifies the DDPS Return File.

The DDPS return file will return the detail records in the same basic format as the submission file. The records will be in the same sequence as when they were submitted. However, the records will no longer be labeled "DET;" they will be "ACC," "INF," or "REJ."

When the plan submits detail records, the first field on every detail record is "DET". In the DDPS return file, DDPS changes this field to one of the following values:

ACC DDPS accepted the record. DDPS changes the record type from DET to ACC and returns every field the plan submitted.

INF DDPS accepted the record and is reporting informational errors. DDPS changes the record type from DET to INF. DDPS returns every field the plan submitted and populates the error count field and up to ten error codes, including informational errors. Informational edits either alert plans to potential errors or provide additional information from CMS. Either type of informational edit requires plan action.

REJ DDPS rejected the record because it triggered at least one error with a reject outcome. (The rejected record may also have triggered one or more informational edits.) DDPS changes the record type from DET to REJ. DDPS returns every field that was submitted, populates the error count field, and up to ten error codes.

Information about the error codes, including the informational error codes can be found in the Edits Module.

In addition to changing the Record ID field, DDPS provides a count of all errors in the record, error codes associated with those errors, a corrected health insurance claim number (HICN) where applicable, and Plan of Record where applicable. Details about the error count and corrected HICN are included below.

Error count: The error count provides total errors that DDPS encountered. The DDPS return file gives details for up to 10 error codes, which should be sufficient feedback to correct the record. Very few records will contain more than 10 errors. If the error count is 11, plans can conclude that the record contained additional error conditions for which no error detail could be reported. Records will require more research.

Corrected HICN: The Medicare Beneficiary Database (MBD) is the authoritative source for HICNs. If the HICN reported on the PDE does not match the current existing HICN in MBD, DDPS accepts the record and also returns the corrected HICN in field 48. When DDPS reports a corrected HICN, DDPS will also publish edit 710. If the record has informational edits only, DDPS will report back an INF record type. If the record has both informational edits and reject edits, the REJ record type will apply. Anytime a corrected HICN and edit code 710 are reported, plans should update their internal data system with the MBD provided HICN.

Batch Trailer Record: The DDPS return file will provide the same BTR record in the submitted PDE file, including the original count of detail records in the DET field. DDPS also populates batch level record counts in the three fields, reflecting the resolution of the detail records in the batch:

- ACC Total count of DET Accepted records
- INF Total count of DET Informational records
- REJ Total count of DET Rejected records

These data provide a snapshot of the batch level error rate. By calculating the ratio of REJ records to DET records, the plan can determine the percentage of records rejected. Since ACC and INF records are both accepted and stored in DDPS, the percentage of accepted records is calculated by summing those two counts and dividing that sum into the total DET record count. Table 11D provides the BTR record layout.

TABLE 11D – DDPS RETURN FILE BTR RECORD

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION
1	RECORD ID	BTR
2	SEQUENCE NO	Must match BHD
3	CONTRACT NO	Must match BHD
4	PBP ID	Must match BHD
5	DET RECORD TOTAL	Original count of DET records in the submitted batch
6	DET ACCEPTED RECORD TOTAL	Total count of DET Accepted records
7	DET INFORMATIONAL RECORD TOTAL	Total count of DET Informational records
8	DET REJECTED RECORD TOTAL	Total count of DET Rejected records
9	FILLER	

File Trailer Record: As with the BTR record, DDPS updates the TLR record with the ACC, INF, and REJ counts for the entire file. The DDPS return file populates file level record counts in the three fields illustrated in Table 11E.

TABLE 11E – DDPS RETURN FILE TLR RECORD – FIELDS UPDATED BY DDPS

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION
6	TLR DET ACCEPTED RECORD TOTAL	TOTAL COUNT OF DET ACCEPTED RECORDS
7	TLR DET INFORMATIONAL RECORD TOTAL	TOTAL COUNT OF DET INFORMATIONAL RECORDS
8	TLR DET REJECTED RECORD TOTAL	TOTAL COUNT OF DET REJECTED RECORDS

These detail record breakouts can be used to calculate file level error and acceptance rates in the same manner as shown for the BTR record.

11.4.2 DDPS Transaction Error Summary (Slide 12)

The DDPS Transaction Error Summary provides a count of each type of error code generated on a specific transaction. The report provides these data for each submitted batch. This report provides an instant snapshot of the rate at which specific error codes occur. Submitters can use this report to identify the most frequent errors, allowing them to target their resources appropriately to prevent these errors from occurring on future transactions.

The structure of the DDPS Transaction Error Summary is similar to the DDPS Return File. The DDPS Transaction Error Summary file has HDR, BHD, DET, BTR, and TLR records, similar to a PDE file. The DET records on this report display each error code generated in a file and information about that code. Table 11F provides the record definitions and descriptions for the basic record layout for the DDPS Transaction Error Summary.

TABLE 11F - RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
HDR	Submitter file header	Occurs once per file
BHD	Contract/PBP level file header	Occurs once per Contract/PBP on file
DET	Detail records for the report	Occurs 1 to many times per BHD record
BTR	Contract/PBP level file trailer	Occurs once per each BHD on the file
TLR	Submitter file trailer	Occurs once per file

The HDR record is essentially the same as the HDR Record for the DDPS Return File. DDPS-REPORT-ID '03' identifies the DDPS Transaction Error Summary. The HDR also has a date/time stamp from DDPS indicating when it was produced.

The BHD record also resembles that of the DDPS Return File. The Transaction Error Summary also uses the same Sequence Number, Contract Number, and Plan Benefit Package (PBP) ID as provided on the original PDE record.

The DDPS Transaction Error Summary contains one DET record for every error code received in a submitted batch. Each DET record lists the error code, its associated description, frequency of occurrence in the batch, and the rate of occurrence as a percentage of all errors received in that batch. Table 11G provides the flat file layout for the DDPS Transaction Error Summary DET record.

TABLE 11G – DDPS TRANSACTION ERROR SUMMARY DET RECORD

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION
1	RECORD ID	DET
2	SEQUENCE NO	Starts with 0000001
3	ERROR CODE	Identification Number of the Error Code
4	ERROR CODE DESCRIPTION	Description of Error Code
5	FREQUENCY OF OCCURRENCE	Count of each Error Code
6	PERCENTAGE OF ALL EDITS	Percentage of each Error Code's frequency to the frequency of all Error Codes. In formula: Frequency Count of the specific error code divided by Frequency Count of all error codes.
7	FILLER	SPACES

The BTR and TLR records provide balancing totals and information that identifies the batch and file, respectively. These records provide no additional data for purposes of summary reporting.

11.5 Management Reports (Slides 13-14)

Generally, management reports summarize data monthly on a year-to-date basis for any given benefit year. Plans authorize report distribution. When plans use a third party submitter, the submitter as well as the plan may receive management reports. These reports are produced by the IDR, the data warehouse established for the PDE data. In particular, management reports show the way that IDR understands the beneficiary's status at the plan in terms of selected financial data that are relevant to one specific benefit year. For each benefit year, IDR will generate separate management reports. Currently DDPS produces three management reports. Plans also receive monthly management reports for Plan-to-Plan (P2P) PDEs. These reports are explained in the P2P Module in the Prescription Drug Event Data Advanced Training Participant Guide.

Management Report 04COV – Cumulative Beneficiary Summary, Covered Drug
Management Report 04ENH – Cumulative Beneficiary Summary, Enhanced Alternative Drugs
Management Report 04OTC – Cumulative Beneficiary Summary, Over-the-Counter Drugs

Since each report uses the same format, we will explain the file layout of report 04COV, Cumulative Beneficiary Summary Report, Covered Drugs.

11.5.1 Report 04COV – Cumulative Beneficiary Summary Report, Covered Drugs

The Cumulative Beneficiary Summary Report for Covered Drugs provides all of the beneficiary-level PDE financial information necessary to reconcile the cost-based portion of the Part D payment. This report sums a beneficiary's PDE activity at the plan and provides net financial information relevant to a specific Part D plan. Table 11H illustrates the specific types of information in this report.

TABLE 11H - KEY INFORMATION IN THE CUMULATIVE BENEFICIARY SUMMARY REPORT

COST	PAYMENT	PDE SUBMISSIONS	CATASTROPHIC COVERAGE	BENEFICIARY UTILIZATION
• Net Ingredient Cost Paid • Net Dispensing Fee Paid • Net Total Amount Attributed to Sales Tax • Net GDCB • Net GDCA • Vaccine Administration Fee	• Net Patient Pay • Net Other TrOOP • Net LICS • Net PLRO • Net CPP • Net NPP	• Number of Original PDEs • Number of Adjusted PDEs • Number of Deletion PDEs	• Net Number of Catastrophic Coverage Code PDEs • Net Number of Attachment Point PDEs • Net Number of Non-Catastrophic /Non-Attachment Point PDEs	• Net Number of Non-Standard Format PDEs • Net Number of Pricing Exception PDEs. Currently only reports "Net Number of OON PDEs."

11.5.1.1 Basic Record Layout

This file contains a different set of records than the other files. The Beneficiary Summary Report has a contract header record (CHD), followed by a PBP header (PHD). DDPS-REPORT-ID '04COV', '04ENH', and '04OTC' identify the DDPS Cumulative Beneficiary Summary Reports. These records set up cumulative reporting at either the contract or PBP level. The DET records provide the beneficiary level reporting. The PBP trailer (PTR) sums all of the beneficiary level data for each PBP in the file and the contract trailer (CTR) sums all of the PBPs for a contract. Table 11I provides the definitions and descriptions of the records in the Cumulative Beneficiary Summary Report.

TABLE 11I - CUMULATIVE BENEFICIARY SUMMARY REPORT - RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract level file header	Occurs once per Contract
PHD	Contract/PBP level file header	Occurs once per Contract/PBP on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Contract/PBP level file trailer	Occurs once per PHD on the file
CTR	Contract level file trailer	Occurs once per CHD

11.5.1.2 Header Records

The CHD and PHD records identify the contract and PBP, respectively. Each has a file name on the record level, allowing the distribution of reports at the contract level, and a contract to treat plan-level reports as unique reports.

Embedded in the file name is the benefit year on which data are being reported. In addition to the benefit year, the report references an As-of Year and As-of Month. Those dates refer to the latest submission month upon which the data are reported. DDPS produces management reports early in the month for data submitted through the previous month.

Example: 2

On April 6, 2006, IDR produced a report with the following attributes:

- File Name: 04COV2006001
- As-of Year: 2006
- As-of Month: 03
- DDPS Date: 20060406

The identifying information shows that this report has data for the 2006 benefit year, submitted to DDPS by March 31, 2006.

On April 7, 2007, IDR will need to produce two of these reports, one for benefit year 2006 and one for 2007. The attributes for each will be:

April 2007 Cumulative Beneficiary Summary Report (Benefit Year 2006)

- File Name: 04COV2006001
- As-of Year: 2007
- As-of Month: 03
- DDPS Date: 20070407

April 2007 Cumulative Beneficiary Summary Report (Benefit Year 2007)

- File Name: 04COV2007001
- As-of Year: 2007
- As-of Month: 03
- DDPS Date: 20070407

The file name for the first report shows that the report was produced for benefit year 2006. The file name for the second report shows that it was produced for benefit year 2007. Both reports have the same As Of date, indicating that each report represents data submitted through March 31, 2007. (The last three bytes of the File Name indicate that this is the original version of the report. Had a re-run been necessary, this sequence number would have been incremented to indicate a more recent version of the April report.)

11.5.1.3 DET Record

The DET record establishes the basic format for the rest of the file. The layout for the DET record appears in Table 11J.

DET records have important basic characteristics:

- Beneficiaries are identified by their most current HICN on file in MBD, rather than reported HICNs. Plans receive updated HICNs when a beneficiary's HICN changes. Plans are expected to maintain the most current HICN and cross-walk any previous activity under older HICNs to the most current HICN. Medicare Advantage Prescription Drug System (MARx) will report out payment information using the current HICN, and CMS reconciliation reports will have the most recent HICN. Therefore, it is essential that plans track HICN changes and retain the current HICN on file. Plans do not need to resubmit previously accepted or informational PDEs if the HICN subsequently gets updated. Also, when submitting adjustments or deletions for records already existing in DDPS, plans can use either the current HICN or the HICN used on the original PDE.

- Cardholder ID must be the beneficiary's most current cardholder ID for that contract/plan in the benefit year being reported based on PDE data on file. Since CMS will not always know about cardholder ID changes, the plan must maintain a cardholder ID history for each enrolled beneficiary to ensure accurate tracking.
- The Rx Count in field 8 will be net of adjustment and deletion PDEs, as well as partial fill transactions.
- All dollars reported in fields 9-21 and 30-31 will be net of adjustment and deletion PDEs.
- Net TrOOP Amount is estimated based on the sum of Net Patient Pay, Net Other TrOOP, and Net LICS for all PDEs at or below the attachment point. Due to reporting lags and because the attachment point PDE may contain out-of-pocket amounts paid during the Catastrophic phase, this may vary slightly from plan computed TrOOP, which applies only to payments made before catastrophic coverage is reached.
- Fields 22-24 are gross counts of each type of PDE. Net values do not apply to these fields.
- Fields 25-29 represent PDE counts net of adjustments and deletions.

The information on this file should be reconciled with plan records. It is important that plans track PDE submissions and the results of PDE processing. While plans must track the benefit in their claims files, the PDE tracking reflects claims that have been submitted and accepted into DDPS as PDEs (and which have not). The reports generated from IDR will correspond only to data that have been submitted and accepted. If a plan compares the summary report to claims data rather than PDE data, outstanding claims (claims that have not been submitted or that were rejected from DDPS) will cause a discrepancy between the IDR financial summary and the plan financial summary. Once plans have compared the IDR report to PDE data and confirmed the report's accuracy, the same comparison can be performed against claims files to determine the impact of outstanding claims.

CMS holds plans responsible for verifying the Cumulative Beneficiary Summary Report for Covered Drugs every month. This report is the vehicle through which plans receive advance notification of their potential payments or liabilities upon final reconciliation.

Table 11J provides the fields for the DET record to the Cumulative Beneficiary Summary Report.

TABLE 11J - CUMULATIVE BENEFICIARY SUMMARY REPORT - DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	'DET'
2	SEQUENCE NO	4 – 10	9(7)	7	Must start with 0000001
3	DRUG COVERAGE STATUS CODE	11 – 11	X(1)	1	Only 'C' (Covered) is valid for this report
4	CURRENT CMS HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN on file.
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary
6	MOST RECENT PLAN-SUBMITTED CARDHOLDER ID	52 – 71	X(20)	20	Plan identification of the enrollee, as reported on the most recent PDE for the benefit year
7	EARLIEST PDE ATTACHMENT POINT DATE	72 – 79	X(8)	8	Date of service from the earliest attachment point PDE associated with the PBP – 'CCYYMMDD'
8	RX COUNT	80 – 90	9(11)	11	Number of Prescriptions net of deleted and adjusted PDEs, as well as partial fill transactions
9	NET INGREDIENT COST	91 – 104	S9(12)V99	14	Net amount the plan paid the pharmacy for the drug itself.
10	NET DISPENSING FEE	105 – 118	S9(12)V99	14	Net amount the plan paid the pharmacy for dispensing the medication.
11	NET SALES TAX	119 – 132	S9(12)V99	14	Net amount the plan paid the pharmacy to cover sales tax.
12	NET GDCB	133 – 146	S9(12)V99	14	Net amount paid toward allowable point of sale costs below the out-of-pocket threshold. Applies only to covered drugs.
13	NET GDCA	147 – 160	S9(12)V99	14	Net amount paid toward allowable point of sale costs above the out-of-pocket threshold. Applies only to covered drugs.
14	NET TOTAL GROSS DRUG COST	161 – 174	S9(12)V99	14	Net amount paid toward allowable point of sale costs both below and above the out-of-pocket threshold. (Sum of Net Ingredient Cost, Net Dispensing Fee, Net Sales Tax, and Vaccine Administration Fee for covered drugs).
15	NET PATIENT PAY AMOUNT	175 – 188	S9(12)V99	14	Net Payment made by the Beneficiary (including payments made by family or friends on behalf of the beneficiary).
16	NET OTHER TROOP AMOUNT	189 – 202	S9(12)V99	14	Net other health insurance payments by TrOOP-eligible other payers such as SPAPs, charities, friends, family, or other qualified parties.
17	NET LICS AMOUNT	203 – 216	S9(12)V99	14	Net amount that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status

TABLE 11J - CUMULATIVE BENEFICIARY SUMMARY REPORT - DET RECORD (CONTINUED)

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
18	NET TrOOP AMOUNT	217 – 230	S9(12)V99	14	Sum of Net Patient Pay Amount, Net Other Troop Amount and Net LICS Amount (excluding catastrophic PDEs, catastrophic code of 'C')
19	NET PLRO AMOUNT	231 – 244	S9(12)V99	14	Net amount by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Medicare Part D.
20	NET CPP AMOUNT	245 – 258	S9(12)V99	14	Net Medicare covered amount which the plan has paid for a Part D covered drug under the basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
21	NET NPP AMOUNT	259 – 272	S9(12)V99	14	Net amount of plan payment for enhanced alternative benefits (cost-sharing fill-in and/or non-Part D drugs)
22	NUMBER OF ORIGINAL PDES	273 – 284	9(12)	12	The count of original PDEs.
23	NUMBER OF ADJUSTED PDES	285 – 296	9(12)	12	The count of adjusted PDEs.
24	NUMBER OF DELETION PDES	297 – 308	9(12)	12	The count of deleted PDEs.
25	NET NUMBER OF CATASTROPHIC COVERAGE PDES	309 – 320	9(12)	12	Count of PDEs having a 'C' (Above Attachment Point) in the Catastrophic Coverage Code field.
26	NET NUMBER OF ATTACHMENT POINT PDES	321 – 332	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal 'A'
27	NET NUMBER OF NON-CATASTROPHIC PDES	333 – 344	9(12)	12	Count of PDEs with Catastrophic Coverage Code = <blank>
28	NET NUMBER OF NON-STANDARD FORMAT PDES	345 – 356	9(12)	12	Count of PDEs with Non-standard Format Code other then <blank>
29	NET NUMBER OF OON PDES	357 – 368	9(12)	12	Count of PDEs with Pricing Exception code equal 'O'
30	NET ESTIMATED REBATE AT POS AMOUNT	369 - 382	X(14)	14	Net estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
31	NET VACCINE ADMINISTRATION FEE AMOUNT	383 - 396	X(14)	14	Net fee reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
32	FILLER	396 - 512	X(116)	116	SPACES

11.5.1.4 PTR Record

The PTR record has the same basic layout as the DET record. However, in place of the beneficiary ID there is a contract number and PBP ID. This record will sum all of the amounts in each of the DET records for this PBP.

This is the most important record for understanding Part D Payment Reconciliation at a contract/PBP level. The connection between the totals in this report and the final payment reconciliation is explained in detail in the Reconciliation Module. For now, it is sufficient to say that all plan financial totals may impact the plan's reconciliation. It is essential that plans verify these totals monthly to ensure there are no year-end discrepancies when CMS reconciles payment. Failure to review these reports and correct data are not a basis for appealing reconciliation payments.

11.5.1.5 CTR Record

The CTR record has the same layout as the PTR record with one exception; the CTR record has no PBP ID because it represents the activity of all PBPs under one contract number. It is important to note here that the totals in this report are not the totals used for any Part D Payment Reconciliation. All payment reconciliation is at the contract/PBP level which is reported in the batch trailer record. This report may provide a useful contract level summary, but will not directly impact any payment calculation.

11.5.2 Report 04ENH and 04OTC – YTD Beneficiary Summary Reports for Enhanced Alternative and Over-the-Counter Drugs

The EA and OTC drugs summary reports are laid out exactly like the covered drugs report. Less data are on these reports because many of the financial values cannot exist for EA or OTC drugs. Specifically, plans should expect zero dollars reported in the following fields:

- Net GDCA
- Net GDCB
- Net Gross Drug Cost
- Net LICS
- Net Other TrOOP
- Net CPP
- Net Estimated Rebate at POS Amount
- Net Vaccine Administration Fee

In addition, OTC drugs have no Net Patient Pay amount.

11.6 Plan-to-Plan (P2P) (Slides 15-20)

CMS informs plans about Plan-to-Plan (P2P) situations via reports. On the reports, CMS communicates whether there is a P2P situation and identifies who the Submitting Contract and the Contract of Record are for the purpose of financial settlement between the entities. Table 11K identifies the reports CMS uses to communicate with plans and the general purpose of each report.

TABLE 11K – CMS COMMUNICATION WITH PLANS

REPORT	INFORMATION COMMUNICATED
DDPS Return File	Provides the disposition of all DET records and where errors occurred. Distributed following processing of PDEs.
Special Return File	Provides contract/PBP update impact on P2P conditions for PDEs. Will provide 800-level Update Codes. Distributed after contract/PBP update.
Cumulative Beneficiary Summary Report 04COV	Serves as a YTD cumulative report for the Submitting Contract that provides beneficiary-level PDE financial information necessary to perform the YTD Part D Payment reconciliation. Distributed monthly. Displays non-P2P amounts.
P2P Accounting Report 40COV/ENH/OTC	Provides the Submitting Contract with a YTD cumulative report of financial amounts reported by the Submitting Contract for P2P PDEs. This report can be used for accounting purposes but is not used for Part D Payment Reconciliation. Distributed monthly.
P2P Receivable Report 41COV	Provides Submitting Contracts with the net change in P2P reconciliation receivable amounts. Distributed monthly.
P2P Part D Payment Reconciliation Report 42COV	Serves as a YTD cumulative report for the Contract of Record of all financial amounts reported by Submitting Contracts for use in the Contract of Record's Part D Payment Reconciliation. Distributed monthly.
P2P Payable Report 43COV	Serves as the Contract of Record's invoice for P2P reconciliation. Distributed monthly.

The DDPS Return file is the standard Return file that plans receive following the processing the PDEs. The DDPS Return File is different from the Special Return File that is generated after the P2P contract/PBP update, which occurs prior to the Part D Payment Reconciliation.

If edits 708, 709, or 712 apply to the P2P PDEs, DDPS changes the record type to informational (INF). If edit 708 applies, DDPS also annotates the Contract of Record number in positions 441-445. This is located before the corrected HIC Number (HICN) field. DDPS does not report Contract of Record on PDEs receiving 709 because these PDEs are exempt from P2P reconciliation.

P2P Reports provide the documentation for PDE accounting, P2P financial settlement, and Part D Payment Reconciliation. The P2P Reports summarize claims data at the beneficiary level without revealing negotiated prices, which the pharmacy industry considers to be proprietary data.

Whenever a beneficiary transfers to a different contract, the transfer-out plan must promptly forward the Year-to-Date (YTD) TrOOP and gross covered drug cost balances to the transfer-in plan. Enrollment Reconciliation and P2P Reconciliation DO NOT alter this requirement. The P2P Reports are not a proxy for the Transfer EOBs. However, if the EOB Transfer is delayed, the P2P Payable Report (43COV) will sometimes identify the other contract that paid for a beneficiary's claims before the EOB Transfer information is received. In that situation, the contract that received the P2P Payable Report has the option to follow-up with the submitting contract for EOB Transfer information. After the automated EOB transfer process is implemented in January 2009, delays will occur infrequently.

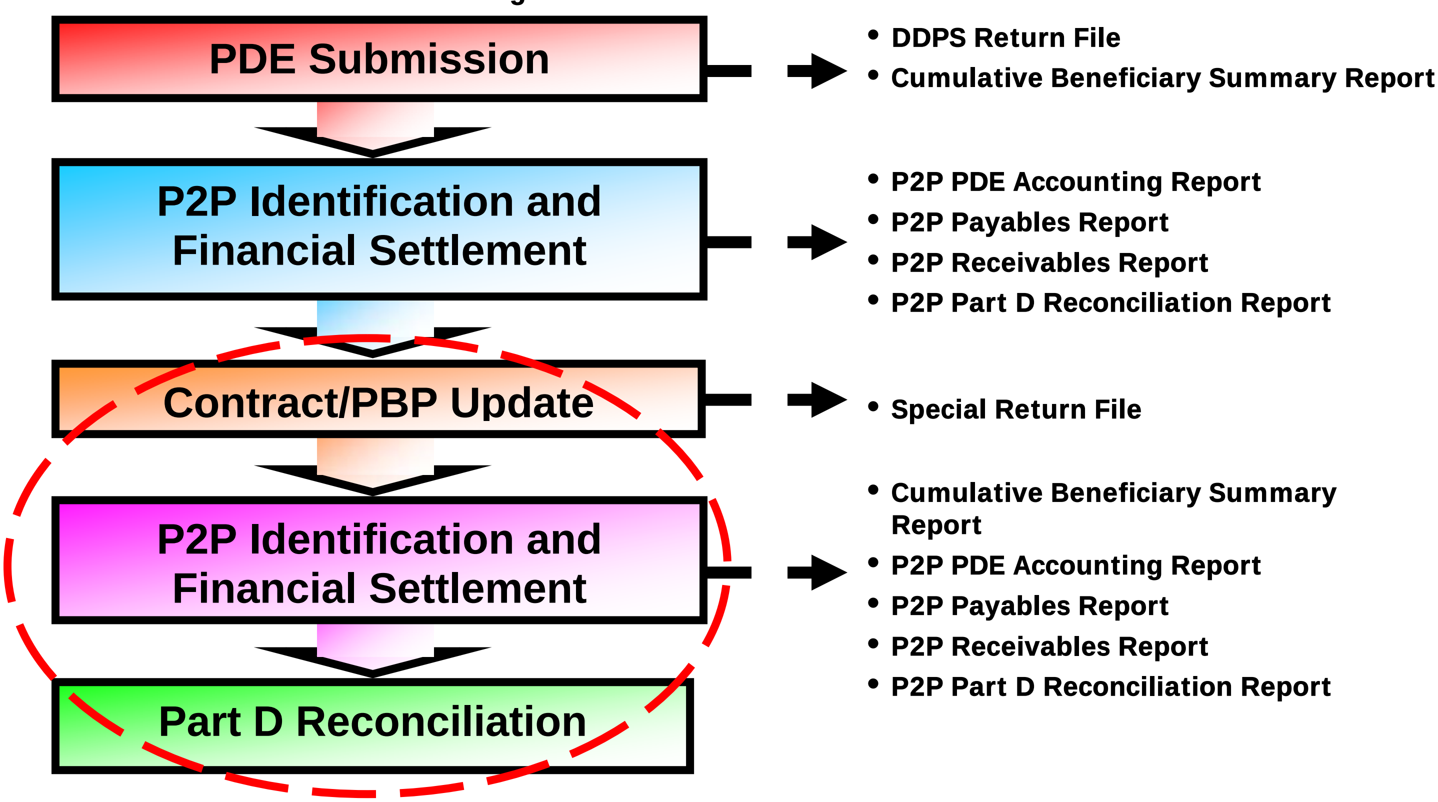
Table 11L provides the naming conventions for each report. When reviewing reports, Plans should pay close attention to the benefit year located in the File ID within the CHD record in order to know which benefit year is affected.

TABLE 11L – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
DDPS Return File	RPT00000.RPT.DDPS_TRANS_VALIDATION
Special Return File	RPT00000.RPT.DDPS_P2P_PHASE3_RTN
Cumulative Beneficiary Summary Report 04COV	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC
P2P Accounting Report 40COV/ENH/OTC	RPT00000.RPT.DDPS_P2P_PDE_ACC_C RPT00000.RPT.DDPS_P2P_PDE_ACC_E RPT00000.RPT.DDPS_P2P_PDE_ACC_O
P2P Receivable Report 41COV	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P Part D Payment Reconciliation Report 42COV	RPT00000.RPT.DDPS_P2P_PARTD_RCON
P2P Payable Report 43COV	RPT00000.RPT.DDPS_P2P_PAYABLE

Figure 11C illustrates the P2P Process and at what stage the different reports are generated. The circled portion of the figure identifies where the focus of the third phase of P2P, the Contract/PBP Update Process, occurs in the overall process.

Figure 11C – P2P Process



11.6.1 P2P and the DDPS Return File

The DDPS Return File indicates with edits if potential P2P PDEs exist before continuing to edit or rejecting the PDE. Example 3 illustrates what occurs in the DDPS Return File when processing PDEs and determining if P2P conditions exist.

Example 3

John Brown joined Winter Health Plan in January 2007 as a dual-eligible and completed an enrollment application on August 27, 2007 for Spring Health Plan's PBP 002. Spring Health Plan submitted the enrollment. CMS processed the enrollment on September 3, 2007. John's effective date is September 1, 2007.

John fills a prescription on September 5, 2007 for a covered drug and on September 7, 2007 for an OTC drug using an ID card from Winter Health Plan. He also fills prescriptions on October 2, 2007 and October 15, 2007 for covered drugs. Winter Health Plan PBP 001 submitted two PDEs on September 29, 2007 for the September 5, 2007 and September 7, 2007 claims. They also submitted a PDE on October 20, 2007 for the October 2, 2007 claim and on October 29, 2007 for the October 15, 2007 claim.

Winter Health Plan Receives the DDPS Return File because they are the Submitting Contract.

DDPS RETURN FILES FOR SUBMISSION OF PDES FOR JOHN BROWN

PDE	DATE OF SERVICE	PDE RECORD SUBMISSION DATE	RECORD TYPE	EDIT CODE	CONTRACT OF RECORD POPULATED (Y OR N)
1	September 5, 2007	September 29, 2007	INF	708	Y
2	September 7, 2007	September 29, 2007	INF	709	N
3	October 2, 2007	October 20, 2007	INF	708	Y
4	October 15, 2007	October 29, 2007	REJ	706	N

The Contract of Record identified in positions 441-445 for PDEs 1 and 3 is Spring Health Plan. For the purposes of P2P financial settlement, both Winter Health Plan (Submitting Contract) and Spring Health Plan (Contract of Record) will receive P2P Reports.

Winter Health Plan will receive two P2P reports as the Submitting Contract. They are Report 40, which is an accounting report and Report 41, which is a receivables report. Report 40 is similar to Report 4, which is the Cumulative Beneficiary Summary Report that you that plans receive monthly. In this case, the report is displaying YTD cumulative P2P financial amounts reported by Winter Health Plan as the Submitting Contract. Report 40, batches the information by PBP. In the case of John Brown, the information would appear under PBP 001.

Report 40 is available with a version for Covered, Enhanced Alternative, and OTC drugs. Only the covered drug version identifies the Contract of Record – Spring Health Plan; the Enhanced Alternative and OTC versions will not because they are not part of financial settlement requirements for P2P.

Report 41 is only available for Covered drugs since Covered Drugs are the only type of drugs involved in P2P Reconciliation. Report 41 batches the information by Contract of Record. Any P2P amounts for beneficiaries under a specific contract of record would be included in one batch. It is possible that there could be a negative P2P amount on this report for a beneficiary because of overpayment. If a negative amount occurs at the contract level, the Submitting Contract would be required to repay the Contract of Record within 30-days of the date CMS distributed the report.

WINTER HEALTH PLAN'S P2P REPORTS (SUBMITTING CONTRACT)

Report 40 – Accounting
Report 41 – Receivables

PDE	DATE OF SERVICE	PDE RECORD SUBMISSION DATE	COV	ENH	OTC	MONTH OF REPORT
1	September 5, 2007	September 29, 2007	X			September
2	September 7, 2007	September 29, 2007			X	September
3	October 2, 2007	October 20, 2007	X			October
4*	October 15, 2007	October 29, 2007				

*PDE 4 rejected, so it will not appear on these reports.

The Contract of Record receives reports for Covered Drugs only since these are the only drugs included in P2P Reconciliation. The Contract of Record, Spring Health Plan, is receiving Reports 42 and 43. Spring Health Plan will see the PDEs for DOS of September 5, 2007 and October 2, 2007 on their P2P Reports.

Report 42 is year-to-date (YTD) cumulative information of what Spring Health has paid to Submitting Contracts like Winter Health Plan for P2P financial settlement. This includes the current month and any previous month's financial settlement. Report 42 batches the information by PBP. Any P2P amounts associated with John Brown will appear under PBP 002, which is the PBP in which John is enrolled.

Report 43 indicates what Spring Health Plan owes in payables to Winter Health and any other Submitting Contracts for that month.

SPRING HEALTH PLAN'S P2P REPORTS (CONTRACT OF RECORD)

Report 42 – Part D Payment Reconciliation
Report 43 – Payables

PDE	DATE OF SERVICE	PDE RECORD SUBMISSION DATE	COV	MONTH OF REPORT
1	September 5, 2007	September 29, 2007	X	September
2	September 7, 2007	September 29, 2007		
3	October 2, 2007	October 20, 2007	X	October
4*	October 15, 2007	October 29, 2007		

*PDE 4 rejected, so it will not appear on these reports.

11.6.2 P2P Contract/PBP Update Prior to Part D Payment Reconciliation

Throughout the benefit year, CMS may receive retroactive enrollments that will not be updated on PDEs for drugs that were already accepted into DDPS by CMS. In order for CMS to perform an accurate Part D Payment Reconciliation, the accepted PDEs have to be attributed to the appropriate Contract and PBP of Record prior to running the Part D Payment Reconciliation.

The last step in the P2P Process performs the final update to Contract and/or PBP of Record on accepted PDEs.

This update only occurs if there are changes to enrollment data. If changes occur and a P2P condition exists, the affected Contract will go through the entire P2P process. The information will appear on the submitting contract and the contract of record reports.

If the update results in a non-P2P condition that was previously a P2P condition, the PDEs will appear on P2P and non-P2P reports. Financial settlement occurs between the Submitting Contract and Contract of Record.

This update to contract/PBP of record will always occur prior to Part D Payment Reconciliation.

P2P Contract/PBP Update will allow the DDPS to query MARx for changes to Contract and PBP of Record. If this query results in changes, DDPS will update affected PDE data to reflect the changes. If this query does not result in a change, no update will occur on the saved PDE data. This process will update all changes to Contract and PBP of Record; it is not limited to changes that affect P2P. This process will also update enrollment information when the beneficiary moves from one PBP to another PBP within the same Contract.

11.6.2.1 Special Return Files and Update Codes

Submitting Contracts receive the update codes on the Special Return File. Only Submitting Contracts receive the update codes. The Contract/PBP update to saved PDEs results in changes that appear on the monthly reports. The monthly reports show any new payables and receivables that result from the P2P contract/PBP update.

Any financial amounts resulting from this process will appear the same as any other financial amounts would appear on a monthly report. Since the financial amounts from the P2P contract/PBP Update is not reported differently, the monthly reports should be thoroughly reviewed.

The layout of the monthly reports will not change. The Updated Contract of Record and the Original Contract of Record will only be aware of changes by reviewing the monthly reports.

The Submitting Contract will receive an update code on the Special Return File when enrollment changes result in a change in Part D financial dollar amounts. The change may result in either a payable or receivable.

UPDATE CODE	DESCRIPTION
851	The Contract of Record has been updated; a P2P condition **now** exists.
852	The Submitting Contract/PBP is now the Contract/PBP of Record; a P2P condition **no longer** exists.
853	PBP of Record has been updated. This PDE **continues** to be a non-P2P PDE.
854	The Contract of Record and PBP of Record have been updated. A **new** P2P condition is established.
855	The Submitting Contract is now the Contract of Record but the Updated PBP of Record is different from the Submitting PBP. A P2P condition **no longer** exists.

Examples 4 through 8 illustrate the update and reporting process of P2P conditions and financial settlements. The examples use CPP to illustrate the changes in financial data between the reports.

Example 4

When Winter Health Plan PBP 001, submitted a PDE for a covered drug on November 10, 2007 for John Brown with DOS October 15, 2007 CMS databases indicated that they were the Contract of Record for John.

When CMS conducted the P2P Contract/PBP Update, the Contract and PBP of Record changed to Spring Health Plan PBP 001 with an effective date of October 1, 2007.

This created a new P2P condition for this PDE record.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	**1**	**A**	**1**	**B**	**1**	**Y**	**N**

A=Winter Health and B=Spring Health

CMS informed Winter Health of this change via the Special Return File with the saved PDE record. The report will indicate Update Code 851 describing the P2P condition. The Special Return File indicates the Contract of Record because the new Contract of Record is Spring Health. The PBP of Record will not appear on the Special Return File since the change occurred at the contract level.

Prior to the P2P Contract/PBP Update, Winter Health was the only Contract that had this PDE on a Monthly Report. Report 4 will document the PDE for the month in which the PDE was submitted and accepted and the month after submission.

After the P2P Contract/PBP Update, the PDE will appear on Monthly Reports for both Winter Health and Spring Health. The updated Report 4 will display $0 since the P2P Reports will document the PDE. The Updated Contract of Record, Spring Health now owes Winter Health $100 as shown in the P2P Reports 40 through 43.

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
4	$100	$100	0
40	$0	$0	$100
41	$0	$0	$100
42	$0	$0	$100
43	$0	$0	$100

CPP = $100

Example 5

Jane Doe was enrolled in Winter Health Plan PBP 001. However, when Winter Health submitted a PDE on November 1, 2007 for an October DOS, CMS had Spring Health plan as the Contract of Record in their databases, so this created a P2P condition.

After the PDE was accepted and saved, a retroactive enrollment processed for Winter Health plan on November 3, 2007. The enrollment effective date of this transaction was October 1, 2007.

When CMS updates the Contract/PBP of Record, Winter Health is now the Updated Contract of Record. The P2P condition no longer exists .Winter Health Plan will receive the Special Return File with 852 for the Update Code, which indicates that the Submitting Contract, Winter Health, is now the Contract and PBP of Record. The Contract of Record and the PBP of Records will not be populated. It is unnecessary to populate these fields since P2P no longer exists.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	**1**	**B**	**1**	**A**	**1**	**N**	**N**

A=Winter Health and B=Spring Health

When the P2P condition existed, Spring Health paid Winter Health $100, as shown in the Original Monthly Reports to complete the required financial settlement.

In the updated monthly reports, the PDE will appear on Report 4 for Winter Health. Winter Health will see ($100) or a negative amount on Report 41. Spring Health will see ($100) as the amount owed to them on Report 43. A negative receivable amount means that Winter Health will owe Spring Health. In other words, Winter Health owes Spring Health $100.

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
4	$0	$0	$100
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

CPP = $100

Example 6

Jane Brown, John's wife, changed from Winter Health's PBP 001 to PBP 002, effective September 1, 2007.

This situation does not qualify as a P2P condition. Even after the Contract/PBP Update, this remains a non-P2P condition. However, CMS will send Winter Health a Special Return File because the Contract/PBP Update is meant to update all enrollment changes including PBP-only updates.

The Return file will include all PDEs with a DOS of September 1, 2007 through December 31, 2007. The return file will not need to populate the Contract of Record. However, the return file will populate the PBP. CMS will inform plans of PBP-only updates. Winter Health will see Update Code 853 for an update in PBP of Record.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	1	A	1	A	2	N	Y

A=Winter Health

Although the financial information will remain on Report 4, the report will display the information under the new PBP of Record.

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
4 (PBP 1)	$100	$100	$0
4 (PBP 2)	$0	$0	$100

CPP = $100

Example 6

Frank Cloud was enrolled in Winter Health Plan effective August 1, 2007. Winter Health submitted a PDE record on September 17, 2007 for DOS September 2, 2007. On August 15, 2007, Spring Health submitted an enrollment transaction for Frank with a September 1, 2007 effective date, which created a P2P condition. Spring Health settled financially with Winter Health.

Summer Health Plan also submitted an enrollment for Frank, but on September 25, 2007, with effective date August 1, 2007. Winter Health was not informed that Summer Health was the Contract of Record until it received the Special Return File following the Contract/PBP Update.

The Update Code reported on the file is 854 and it indicates a new P2P condition. The report identifies the Updated Contract of Record. However, the report will not list the PBP since the P2P condition is established based on the Contract of Record Update.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	**1**	B	**1**	**C**	**1**	**Y**	**N**

A=Winter Health, B=Spring Health, and C=Summer Health

Originally, Spring Health was the Contract of Record and they paid $100 in CPP to Winter Health for the P2P PDE from September for Frank. After the enrollment information updated, Summer Health became the new Contract of Record. As a result, Winter Health must repay Spring Health the $100 for CPP they were originally paid.

Winter Health is returning the money that initially exchanged hands according to the original monthly reports, which displays negative dollar amounts on Report 41 for Winter Health and 43 for Spring Health.

Contract A to Contract B

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

CPP = $100

Because of the new P2P condition between Winter Health and Summer Health, Summer Health is now the Contract of Record. Therefore, Summer Health owes Winter Health $100 in CPP for the PDE.

Summer Health will be aware of the P2P liability through the P2P Monthly Reports generated during the P2P Contract/PBP Update month.

This update will cause two changes on the P2P Reports for Winter Health. Winter Health will see changes in the DET rows for Contract of Record B, which is Spring Health, and Contract of Record C, which is Summer Health, on Reports 40 and 41.

The result is Winter Health owes Spring Health $100 and Winter Health will receive $100 from Summer Health.

Contract A to Contract C

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
40	$0	$0	$100
41	$0	$0	$100
42	$0	$0	$100
43	$0	$0	$100

CPP = $100

Example 7

Sarah Blue was enrolled in Winter Health in August 2007. Spring Health enrolled Sarah in their plan. The enrollment effective date was September 1, 2007. During September, Winter Health submitted a PDE. Spring Health paid Winter Health for the claim because of the P2P condition.

The beneficiary re-enrolled into Winter Health for September 2007 under PBP 002. This enrollment transaction processed after the enrollment into Spring Health. During the Contract/PBP Update process, Winter Health was found to be the Contract of Record, but the PBP had changed according to the Special Return File from PBP 001 to PBP 002.

The plan receives Update Code 855. The report does not populate the Contract of Record, but does report the PBP of Record because the PBP changed.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	1	B	1	A	2	N	Y

A=Winter Health and B=Spring Health

Originally, Spring Health paid Winter Health $100 in CPP for the PDE. Since the P2P condition no longer exists, Winter Health must repay Spring Health the $100 that was initially paid. This is displayed as a negative amount on the Updated P2P Monthly Reports. For Winter Health, Report 4 will now display the CPP amount under the Updated PBP.

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
4	$0	$0	$100
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

CPP = $100

Example 8

Kelly Yellow enrolls in Spring Health in July, which disenrolled her from Winter Health Plan. Spring Health paid Winter Health for Kelly's P2P PDEs for covered drugs that occurred during the transition period. Kelly switched PBPs in July, not long after her enrollment was effective.

Winter Health will not receive a Special Return File about this update because the update occurred at the PBP level within the same Contract of Record. There is no impact to the financial settlement that already occurred between Spring Health and Winter Health.

SUBMITTING CONTRACT	SUBMITTING CONTRACT PBP	ORIGINAL CONTRACT OF RECORD	ORIGINAL PBP OF RECORD	UPDATED CONTRACT OF RECORD	UPDATED PBP OF RECORD	CONTRACT OF RECORD UPDATE REPORTED ON RETURN FILE	PBP OF RECORD UPDATE REPORTED ON RETURN FILE
A	1	B	1	B	2	N	Y

A=Winter Health and B=Spring Health

This update will not result in a change in financial dollar amounts for Winter and Spring Health because they already settled financially on the original P2P condition. However, on the monthly reports, the financial amounts for Spring Health will now be found under the Updated PBP of Record.

REPORT	SUBMISSION MONTH	MONTH AFTER SUBMISSION	UPDATE MONTH
40	$100	$100	$100
41	$100	$0	$0
42	$100	$100	$100
43	$100	$0	$0

CPP = $100

11.6.3 P2P Reconciliation

The goal of the monthly P2P financial settlement process is to ensure that the Contract of Record is financially responsible for PDEs that were submitted to CMS for each beneficiary that is enrolled in the Contract of Record according to CMS databases.

Report 42COV will display the YTD financial totals for P2P conditions between the Contract of Record and Submitting Contracts. This report is a sum of each monthly Report 43 received by the Contract of Record. For Part D Payment Reconciliation, the totals from Report 42COV and Report 4 will be summed for the Contract of Record.

The Submitting Contract will have rebates for some PDEs that were submitted to CMS and resulted in a P2P condition. The Submitting Contract will report the Direct and Indirect Remuneration (DIR) earned for any P2P claims to CMS. DIR is the only P2P financial amount reported by the Submitting Contract that will be included in the annual Part D Payment Reconciliation.

Example 9 illustrates the financial settlement between Submitting Contracts and Contract of Record that result from P2P Reconciliation prior to Part D Payment Reconciliation including the change in enrollment's impacts on PDE Activity and P2P conditions.

Example 9

John Brown disenrolls from Winter Health Plan. Spring Health Plan submits the enrollment to CMS with an enrollment effective date of October 1, 2007 and CMS processed the enrollment on October 13, 2007. This means that the beneficiary disenrolled from Winter Health Plan as of September 30, 2007 and enrolled in Spring Health Plan as of October 1, 2007.

ENROLLMENT INFORMATION		
CONTRACT	**START DATE**	**END DATE**
Winter Health Plan	07/01/07	09/30/07
Spring Health Plan	10/01/07	

The PDE Activity table summarizes the PDE records submitted and processed by Winter Health Plan for John Brown and indicates whether a P2P condition exists for each PDE record based on the enrollment information.

PDE ACTIVITY			
DATE OF SERVICE	**CPP**	**CMS PROCESSED DATE**	**P2P CONDITION?**
09/28/07	$42.50	09/29/07	N
09/28/07	$23.42	09/29/07	N
10/02/07	**$18.36**	**10/03/07**	**Y**
10/02/07	**$12.20**	**10/03/07**	**Y**
10/09/07	$14.72	10/25/07	Y
10/09/07	$23.42	10/25/07	Y
10/15/07	$15.45	10/25/07	Y
11/16/07	$42.50	11/18/07	N

The first two PDE records are for the same date of service and were both processed on September 29th. Based on the enrollment in CMS' databases, Winter Health Plan is the Contract of Record. When these PDEs process they will be viewed as non-P2P. Winter Health Plan will see the information reflected on Report 4 (Cumulative Beneficiary Summary Report).

The third and the fourth PDEs also occurred on the same date of service and were both processed on October 3rd. On this date, Winter Health Plan was known as the Contract of Record. The PDEs will appear on Report 4, but will process through the P2P Contract/PBP Update that occurs annually prior to Part D Payment Reconciliation. The PDEs in the shaded rows are in transition.

The fifth and sixth PDEs were processed on October 25th for date of service October 9th. Winter Health Plan is no longer the Contract of Record. These PDEs will appear on the P2P Reports.

The seventh PDE was processed on October 25th as well, but this was for date of service October 15th. Winter Health Plan is not the Contract of Record for this PDE either and therefore the PDE will appear on the P2P Reports. This PDE is within the 30-day transition period.

CMS processed the enrollment on October 13th. Winter Health Plan has 30-days beyond this process date to submit PDE data to CMS. The last PDE had a date of service of November 16th, which is beyond this 30-day period. Therefore, Winter Health Plan will receive a rejection code of 706 for this PDE, indicating this is a non-P2P PDE.

Below are the Winter Health Plan monthly reports for September and October. Report 4 for September provides the DOS and the CPP for each.

WINTER HEALTH PLAN – SEPTEMBER MONTHLY REPORTS

REPORT 4

DATE OF SERVICE	CPP
09/28/07	$42.50
09/28/07	$23.42

In October Reports 40 and 41 indicate the CPP that Spring Health Plan is responsible for reimbursing Winter Health Plan.

WINTER HEALTH PLAN – OCTOBER MONTHLY REPORTS

REPORT 4

DATE OF SERVICE	CPP
10/02/07	$18.36
10/02/07	$12.20

REPORT 40 AND 41

DATE OF SERVICE	CPP	CONTRACT OF RECORD
10/09/07	$14.72	Spring Health
10/09/07	$23.42	Spring Health
10/15/07	$15.45	Spring Health

Spring Health Plan's Reports 42 and 43 indicate the amounts that they must pay Winter Health Plan. Spring Health Plan has 30-days from the day CMS distributed the P2P reports to pay Winter Health Plan.

SPRING HEALTH PLAN – OCTOBER MONTHLY REPORTS

REPORT 42 and 43

DATE OF SERVICE	CPP
10/09/07	$14.72
10/09/07	$23.42
10/15/07	$15.45

In July 2008, CMS updates the enrollment information on previously accepted PDEs. Winter Health Plan will receive a Special Return File that contains the affected PDEs. Update Code 851 is sent to Winter Health Plan to inform them that the Contract of Record has been updated; a P2P condition now exists.

SPECIAL RETURN FILE

DATE OF SERVICE	CPP	CONTRACT OF RECORD	UPDATE CODE
10/02/07	$18.36	Spring Health	851
10/02/07	$12.20	Spring Health	851

The amounts that Report 4 previously documented will now appear as P2P amounts on Reports 40 and 41 for Winter Health Plan.

WINTER HEALTH PLAN – JULY MONTHLY REPORTS

REPORT 40 AND 41

DATE OF SERVICE	CPP	CONTRACT OF RECORD
10/02/07	$18.36	Spring Health
10/02/07	$12.20	Spring Health

Spring Health Plan now receives Reports 42 and 43 with the CPP amounts owed to Winter Health Plan for the P2P PDEs following the Contract/PBP Update.

SPRING HEALTH PLAN – JULY MONTHLY REPORTS

REPORT 42 and 43

DATE OF SERVICE	CPP
10/02/07	$18.36
10/02/07	$12.20

Reports 4 and 42 will display summed amounts for CPP.

These reports reflect the first seven PDEs of the eight submitted for John Brown. This is because the eighth PDE, which rejected with edit 706, will not be a part of P2P Reconciliation or Part D Payment Reconciliation.

WINTER HEALTH PLAN AND SPRING HEALTH PLAN FOR PART D PAYMENT RECONCILIATION

WINTER HEALTH PLAN

REPORTS	TOTAL CPP
4	$65.92
42	$ 0.00

SPRING HEALTH PLAN

REPORTS	CPP
4	$ 0.00
42	$84.15

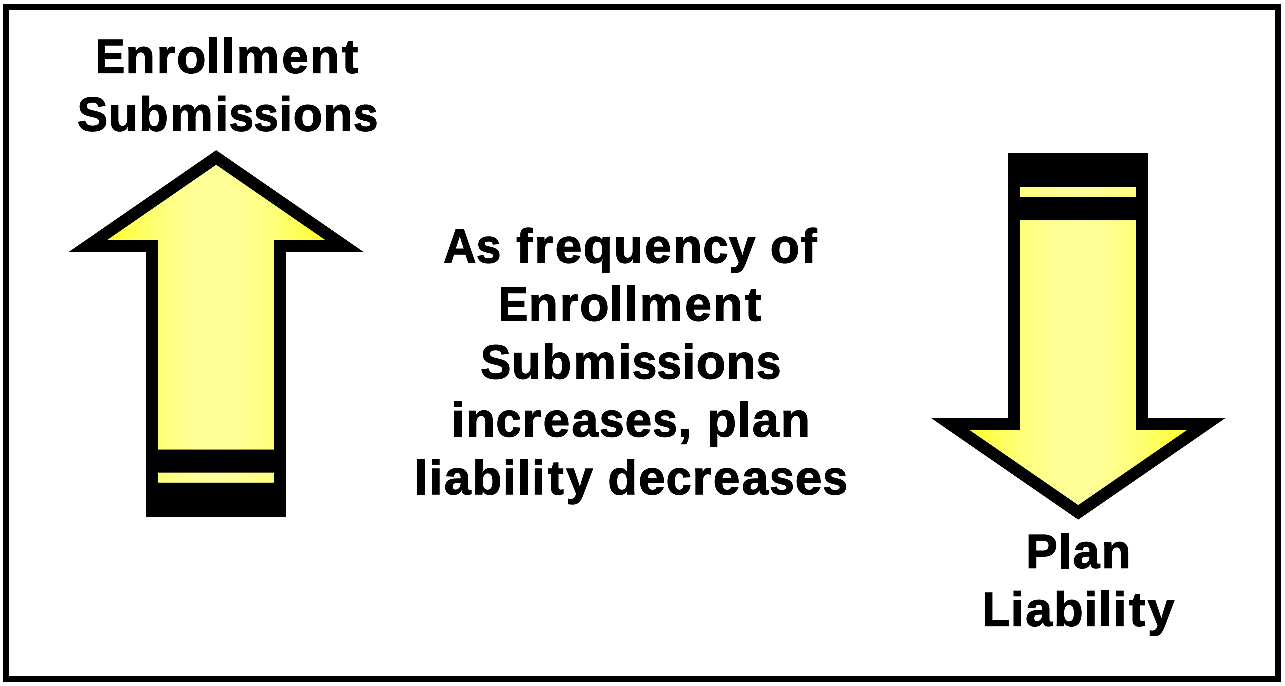
11.6.4 Plan Liability

CMS has an established requirement that plans submit enrollments within at least 14 days of the application date. The P2P transition period provides additional incentive to submit enrollments to CMS as rapidly as possible, and ideally on a daily basis, in order to minimize potential P2P liabilities. Later enrollment submissions expose a new Contract of Record to potentially more P2P PDE activity and greater potential financial liability. Essentially, as the frequency of enrollment submissions increases, the plan's liability decreases.

A Part D Sponsor that submits enrollments to CMS within 24 hours of receipt will incur almost no additional P2P transition period liabilities under this policy. However, a Part D Sponsor that batches enrollments and sends them in to CMS just before payment cut-off in the following month will subject itself to an approximate 45-day potential transition period liability for P2P reimbursements.

Figure 11D illustrates the frequency of enrollment submissions to plan liability.

Figure 11D – Plan Liability



MODULE 12 – RECONCILIATION

Purpose (Slide 2)

Reconciliation of the Direct Subsidy, Low Income Cost-Sharing Subsidy (LICS) and Reinsurance, and calculation of Risk sharing are based on Prescription Drug Event (PDE) data as well as data captured from other Centers for Medicare & Medicaid Services (CMS) systems. In order to ensure that reconciliation is accurate, plans should continually monitor their submitted data throughout the year. This module is designed to explain the steps and systems used in the reconciliation process to calculate final payment amounts.

Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Understand the systems and processes used in payment reconciliation.
- Understand the relationship of reported data to payment.
- Determine how the organization can monitor reports to ensure appropriate reconciliation.
- Determine how the organization can use the PRS reports to understand their Part D reconciliation.

ICON KEY
Definition
Example
Reminder
Resource

12.1 Overview of Part D Reconciliation (Slides 4-5)

Reconciliation compares actual costs to prospective payments, calculates risk sharing, and determines reconciliation amounts for each payment type. Prior to carrying out the cost based portion which consists of reconciling the Low Income Cost-Sharing Subsidy (LICS) and reinsurance, and the calculation of risk sharing, the reconciliation of the direct subsidy will be completed. The final direct subsidy will be used in the cost-based portion of the Part D reconciliation.

12.2 Direct Subsidy (Slide 6)

The direct subsidy is a capitated per member per month (pmpm) payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment score, minus the monthly Part D basic premium related to the standardized bid amount.

The Part D basic premium related to the standardized bid amount includes premium amounts paid by enrollees or paid on their behalf, including A/B rebates applied to the basic benefit and low-income premium subsidies. This section refers to the "premium related to the standardized bid amount" with no further detail about who pays the premium.

All plan types submit a Part D standardized bid. Actuarially Equivalent plans, Basic Alternative plans, and Enhanced Alternative plans report additional bid information to describe their benefit. The direct subsidy is based on the Part D standardized bid.

At reconciliation the direct subsidy is recalculated to update the risk score. If the updated risk score leads to any change in the annual total of month-by-month direct subsidy payments, the plan will be paid (or will repay) the difference. Generally, risk scores increase at reconciliation due to the availability of additional data. As a result, direct subsidy payments also typically increase. Not all beneficiaries will have an increased risk adjustment score, and there may be plan-by-plan variation from this general rule.

12.2.1 Data Oversight

Data oversight requires accurate maintenance of enrollments in plan and CMS systems and the review of CMS responses to enrollment transactions. Monthly membership reports from the Medicare Advantage and Prescription Drug System (MARx) provide information on enrollment and the component parts of the Part D prospective payments, specifically the direct subsidy. These amounts represent the prospective payments against which actual costs will be reconciled.

12.2.2 Direct Subsidy System Overview

MARx reconciles the direct subsidy. The process for the direct subsidy is described in Figure 12A.

Figure 12A – Direct Subsidy System Process

MARx calculates the prospective and final monthly direct subsidy:

- MARx receives the following information for direct subsidy calculations:
  - Reconciled risk score (from RAS).
  - Month-by-month long-term institutional status for risk adjustment (originally from the Minimum Data Set (MDS) data).
  - Month-by-month long-term low-income subsidy status for risk adjustment (originally from the MBD data).
  - MARx reconciles the final direct subsidy and forwards the amount to the APPS for payment.

- MARx also forwards the final direct subsidy to PRS for purposes of calculating the Target Amount in risk sharing.

12.2.3 Direct Subsidy Data Oversight

CMS uses the standardized bid amount, the Part D basic premium, the beneficiary-specific risk score, and enrollment data when calculating the direct subsidy. Throughout the year, plans receive ongoing updates about enrollments. Plans should be aware of the data used in these calculations so they can replicate the direct subsidy calculation.

- Standardized bid amount is the same information received on the plan's approved bid and does not change during the year.
- Part D basic premium is the same information received on the plan's approved bid and does not change during the year.
- Risk Score is reported at the beginning of the year, is updated at mid-year and again at reconciliation as more recent and more complete data become available.

12.2.3.1 Beneficiary Level Reconciliation

Example 1 illustrates the data used to calculate the prospective direct subsidy and how that data can change at reconciliation. The example also emphasizes the plan's role in understanding the individual payment calculations and data oversight.

Example: 1

Mrs. Adams was enrolled in Happy Health Plan from January 1, 2006 through December 31, 2006. When Happy Health Plan received Mrs. Adams' enrollment during the last week of December 2005, the plan immediately updated its enrollment file to document Mrs. Adams' enrollment effective January 1. Happy Health Plan's standardized bid amount is $100.00 and the beneficiary premium is $35.00. In January 2006, Mrs. Adams' risk score was 1.106.

Monthly Prospective Direct Subsidy

$75.60 = $100.00 * 1.106 - $35.00

From January through December of 2006 Happy Health Plan received twelve monthly direct subsidy prospective payments of $75.60 each for a total annual prospective direct subsidy of $907.20.

At reconciliation, Mrs. Adams' risk score increased to 1.221 because an additional diagnosis was reported. The additional diagnosis was 733.00 – osteoporosis, which has an associated risk score of .115.

Risk Score

Initial Risk Score	1.106
Reconciled Risk Score	1.221[a]

[a]Risk Score increased .115 because new diagnosis code, 733.00 - Osteoporosis was reported late in the year

Reconciled Monthly Direct Subsidy – Mrs. Adams

Direct Subsidy = $100.00 * 1.221 - $35.00
Direct Subsidy = $87.10

The monthly prospective direct subsidy increased by $11.50 to $87.10 because the final risk score increased from 1.106 to 1.221; the reconciled direct subsidy is $1,045.20.

Prospective Direct Subsidy

Prospective Monthly Direct Subsidy = $100.00 * 1.106 - $35.00
Prospective Monthly Direct Subsidy = $75.60
Month-by-month total of Prospective Direct Subsidy = $75.60 * 12
Total Prospective Direct Subsidy = $907.20

Final Reconciled Direct Subsidy

Reconciled Monthly Direct Subsidy = $100.00 * 1.221 - $35.00
Reconciled Monthly Direct Subsidy = $87.10
Month-by-month total of Reconciled Direct Subsidy = $87.10 * 12
Total Reconciled Direct Subsidy = $1,045.20

Annual Reconciled Direct Subsidy

Annual Reconciled Direct Subsidy = Total Reconciled Direct Subsidy – Total Prospective Direct Subsidy
Annual Reconciled Direct Subsidy = $1,045.20 - $907.20
Annual Reconciled Direct Subsidy = $138.00

The direct subsidy amount for Happy Health Plan increases by $138.00, which is the difference between the total prospective direct subsidy and the total final reconciled direct subsidy.

12.2.3.2 Plan-level Direct Subsidy Reconciliation

The plan-level reconciliation is the sum of the reconciliation amounts for each beneficiary enrolled in the plan for all or part of the year. Because risk scores are based upon more updated information, the risk scores could increase during the year, and the final reconciled direct subsidy will generally be greater than the prospectively paid direct subsidy.

12.3 Reconciliation Overview (Slides 7-9)

One of the primary purposes for collecting and reporting Prescription Drug Event (PDE) data is to support reconciliation of the Low Income Cost-Sharing Subsidy (LICS), Reinsurance, and calculation of any risk sharing. While all PDE data elements are important, four data elements are essential for reconciliation and risk sharing.

- Low Income Cost-Sharing Subsidy (LICS) Amount
- Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
- Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)
- Covered D Plan Paid Amount (CPP)

Other essential PDE fields are used to substantiate these four fields.

The Drug Data Processing System (DDPS) uses Patient Pay Amount, LICS, Other True Out-of-Pocket Costs (TrOOP) Amount, and Patient Liability Reduction due to Other Payers Amount (PLRO), in combination with the Drug Coverage Status Code to first impute TrOOP and then validate GDCB, GDCA, and the Catastrophic Coverage Code. Plans should realize that CMS also uses PDE data for other legislated functions such as quality monitoring, program integrity, and oversight.

Although reconciliation and risk sharing occur after year end, plans must submit PDEs on a timely basis and perform careful data oversight throughout the year. Effective data oversight is continuous, timely and thorough. Data oversight also must be informed by a complete understanding of the individual payment calculations.

PDE data received by May 31 following year-end and saved in DDPS will be included in reconciliation. Payment will not include data submitted after reconciliation begins. Plans cannot appeal reconciliation results based on the failure to submit data in a timely manner.

Reconciliation is conducted at the Plan Benefit Package (PBP) level, referred to as “plan-level” in this module. Within each PBP, individual PDE records roll up to beneficiary summaries and beneficiary summaries roll up to the plan-level summary. Reconciliation uses plan-level summaries.

Data oversight has four aspects:

- Monitor prospective payments.
- Maintain enrollment and LICS eligibility data.
- Ensure that submitted PDE data are accurate and are consistent with plan data at the beneficiary and plan summary level.
- Ensure that CMS summary reports are consistent with the plan’s understanding of the data.

12.4 System Overview (Slide 10)

The Payment Reconciliation System (PRS) uses data from multiple systems for reconciliation and risk sharing. Table 12A provides descriptions of the systems involved in this payment and reconciliation process.

TABLE 12A – SYSTEM OVERVIEW

DDPS PDE Data

Plans submit PDEs to the DDPS through the Prescription Drug Front-End System (PDFS). DDPS receives and edits individual PDEs. DDPS forwards accepted PDE records to the Integrated Data Repository (IDR). IDR is a data warehouse. It stores PDE records and accumulates summary data for reporting. Specifically, IDR accumulates LICS, GDCB, GDCA, CPP, Year-to-Date (YTD) TrOOP, and Estimated POS Rebate (ERPOSA). At reconciliation, IDR sends total plan/beneficiary LICS, GDCB, GDCA, CPP, and ERPOSA to the PRS.

HPMS
Bid Data

Health Plan Management System (HPMS) stores approved bid data and sends it to the Medicare Advantage and Prescription Drug System (MARx) for monthly payment calculation and to PRS for final reconciliation. Both MARx and PRS use bid data for payments. HPMS also sends Direct and Indirect Remuneration (DIR), Induced Utilization, and the Administrative Cost Ratio to PRS for final reconciliation.

MARx
Monthly Prospective Payments

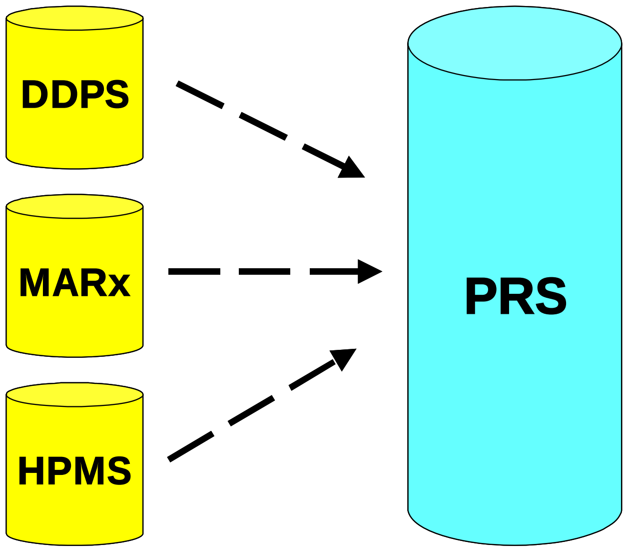
MARx calculates monthly payments using enrollment and LICS eligibility status from Medicare Beneficiary Database (MBD), drug risk adjustment scores from the Risk Adjustment System (RAS), and bid data from HPMS. MARx calculates the final direct subsidy reconciliation. For purposes of LICS reconciliation, reinsurance reconciliation and risk sharing, MARx sends the final direct subsidy, the total Part D basic premium, and the final LICS and reinsurance prospective payment amounts it has calculated to the PRS.

PRS
DDPS Data, MARx Data, HPMS Data

PRS receives the necessary inputs for reconciliation and risk sharing from DDPS, MARx and HPMS. It calculates final reconciliation amounts and forwards them to the Automated Plan Payment System (APPS).

Figure 12B illustrates the system flow.

Figure 12B – System Flow



12.5 Data Oversight

Plans must monitor data on two levels. First, plans must ensure that day-to-day transactions reflect an accurate account of their administration of the Part D benefit. This includes reviewing the PDE return files to understand which records were accepted and which were rejected, and analyzing rejected records to either correct and resubmit or to prevent erroneous data from being submitted in the future. Transactional oversight also requires accurate maintenance of enrollments in plan and CMS systems, as well as reviewing CMS responses to enrollment transactions.

In addition to monitoring the PDE detail record submission for accuracy, plans should also balance summary data in their systems with the CMS monthly management reports. The CMS monthly management reports provide detailed beneficiary summaries as well as plan summaries and will permit plans to ensure that data in their systems agree with CMS. These reports provide all relevant information regarding the cost elements of Part D payment reconciliation. Monthly membership reports from MARx provide information on enrollment and the component parts of the Part D prospective payments, specifically the direct subsidy, prospective LICS, and prospective reinsurance. These amounts represent the prospective payments against which actual costs will be reconciled.

12.5.1 Beneficiary and Payment Data

Plans must monitor enrollment data, LICS status and monthly payment amounts. The purpose of monitoring is to ensure that enrollment and disenrollment dates, as well as LICS status in the plan's internal systems are consistent with MBD information. The purpose of monitoring monthly payments is to ensure that the plan's payment is correct and that the plan understands how the payment was calculated. At reconciliation, total monthly prospective payments will be compared to actual payments. Errors in monthly prospective payments will adversely affect reconciliation.

12.5.2 PDE Data

Plans should incorporate the use of two levels of reports into data oversight. The PDE data are reported on Transaction and Management reports.

12.5.2.1 Transaction Reports

The DDPS Return File documents rejected records. When plans fail to resolve and resubmit rejected records, they introduce payment errors. Rejected records may be original PDEs, adjustments or deletions. The type of payment error depends on the type of record that is rejected.

- Original PDEs – rejected original PDEs cause incomplete DDPS data. Missing data leads to underpayment.
- Deletion PDEs – rejected deletion PDEs cause overstated DDPS data. Overstated data leads to overpayment.
- Adjustment PDEs – rejected adjustment PDEs may change fields essential for payment. Therefore, rejected adjustment PDEs may overstate or understate payment.

12.5.2.2 DDPS Management Reports

DDPS data is the basis for reconciliation. Upon receipt, plans should carefully review DDPS management reports to confirm that there is a common understanding between DDPS data and the plan's data. This common understanding is essential for accurate reconciliation.

Plans should refer to two reports, the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) and the P2P Part D Payment Reconciliation Report (Report 42COV). The P2P Part D Payment Reconciliation Report reflects plan-level amounts on PDEs, which were not originally submitted by the contract but which will be included in the plan-level reconciliation because of the plan-to-plan (P2P) process. The report entitled Cumulative Beneficiary Summary Report, Covered Drugs, reflects records which have been submitted by the plan and that are accepted and stored in DDPS. The net LICS, GDCB, GDCA and CPP, as well as year-to-date TrOOP dollars, at the beneficiary and the plan-level are communicated on the Cumulative Beneficiary Summary Report, Covered Drugs. Any discrepancies in these reported fields may require plans to perform analysis at the detail record level in the DDPS Return File for the beneficiary in question.

Sample questions to resolve differences between the Cumulative Beneficiary Summary Report, Covered Drugs, and the plan's internal data include:

1. Does the number of PDE records agree with the plan's accepted PDE count for each beneficiary? Data in the columns labeled Number of Original PDEs, Number of Adjusted PDEs and Number of Deleted PDEs give a general indication of the PDE volume on which the data is based.

2. Do net dollars on the Cumulative Beneficiary Summary match the plan's view of aggregate financial data? Does the plan's internal data consistently show higher counts and dollars than the Cumulative Beneficiary Summary Report?

First, remember to compare these reports to databases that reflect the accepted PDE data, rather than claims databases. The claims data will reflect more information than has been accepted in DDPS, either because data has not yet been submitted or some of the submitted data has been rejected.

12.6 Certification of Data for Payment

In accordance with the Part D regulation at 42 CFR 423.505(k)(3), the plan sponsor's Chief Executive Officer, Chief Financial Officer, or an individual delegated with the authority to sign on behalf of one of these officers and who reports directly to the officer must certify that the PDE data submitted for payment and reconciliation are accurate, complete, and truthful. The officer or delegate must also certify the same with respect to the underlying claims data. If claims and/or PDE data are generated by a third party on behalf of the plan, the third party must similarly certify.

Certification of PDE and claims data for payment is not the same as the certification required for data submission, which is described in the module Data Format. The two "certification" processes are separate requirements that are both incumbent on the plan sponsor and any third party submitter. CMS expects to conduct certification of PDE and claims data for payment on an annual basis after the end of each coverage year, in preparation for final reconciliation.

42 CFR 423.505(k)(3)

12.7 Appeal

Data submission final deadline is 5 months following year-end. Failure to meet the deadline is not basis for an appeal. Additionally, plans cannot appeal reconciliation decisions because they submitted incomplete or inaccurate data.

Plans should follow up promptly on any discrepancies between their internal data and data in Transaction and Management Reports to ensure that DDPS has complete, correct data before the data submission deadline.

12.8 PRS Part D Payment Reports (Slide 11)

As part of the Part D payment reconciliation, plans active within the coverage year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the reconciliation process for the coverage year.

The PRS Inputs Report to Plans provides plans with the beneficiary-level inputs received from MARx and DDPS. These inputs provide data on the prospective payments and the actual payments made on behalf of a beneficiary. The PRS Inputs Report to Plans allows plans to validate the beneficiary-level inputs received from DDPS and MARx that will be used in their Part D payment reconciliation.

The PRS Reconciliation Results Report to Plans provides plan-level inputs received from HPMS, plan-level inputs passed from the PRS Inputs Report to Plans, and the results of the three Part D payment reconciliations: LICS, reinsurance, and risk sharing. The PRS Reconciliation Results Report to Plans is meant to provide plans with all of the inputs plans would need to understand how their Part D payment reconciliation is calculated, in addition to the results of the Part D payment reconciliations and the final reconciliation adjustment amount.

Both the Inputs Report and the Reconciliation Results Report were updated in April 2008 to include fields for a re-opened reconciliation and to account for Prescription Drug Event (PDE) and Part D payment reconciliation operational changes. It is important to note that the updated Inputs Report and Reconciliation Results Report are used for both an initial Part D payment reconciliation and for a re-opened reconciliation. This was done so that plans would have to code to only one set of fields for both an initial Part D payment reconciliation and for a re-opened reconciliation.

12.8.1 PRS Inputs Report to Plans (Slide 12)

The PRS Inputs Report to Plans provides plans with the prospective payment and actual payment inputs at the beneficiary/plan-level from MARx and DDPS. Because a beneficiary could be in more than one contract and/or more than one PBP within a contract within a specific coverage year, beneficiary/plan-level data indicates the beneficiary-level data for a specific plan only. Beneficiary-level and beneficiary/ plan-level are used interchangeably. Plan-level and contract/PBP-level are also used interchangeably.

12.8.1.1 PRS Inputs Report to Plans File Layout (Slide 13)

The layout of the PRS Inputs Report to Plans follows a similar file structure as the DDPS management reports (Report 4, Reports 40-43) that plans are already receiving.

The PRS Inputs Report to Plans file contains a contract header (CHD) record, followed by a plan header (PHD) record which sets up cumulative reporting at both the contract-level and at the plan-level. The CHD and PHD records identify the contract and PBP, respectively. Each has the file name on the record, allowing the distribution of reports at the contract-level, and a contract to treat plan-level reports as unique reports. The CHD record also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first to be run or if the reconciliation has been re-run.

The detail (DET) record provides the beneficiary/plan-level reporting. The DET record establishes the basic format for the rest of the file. It is important to note that on the DET record, beneficiaries are identified by their most current HICN as reported on the DDPS management files.

The plan trailer (PTR) record has the same basic layout as the DET record. However, in place of the beneficiary ID, there is a contract number and a PBP ID. This record will sum all of the amounts in each of the DET records for the contract/PBP. Table 12B provides the record definitions and descriptions for the PRS Inputs Report to Plans.

TABLE 12B – PRS INPUTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

Record Indicator	Record Definition	Notes
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Plan-level file trailer	Occurs once per PHD on the file
CTR	Contract-level file trailer	Occurs once per CHD

12.8.1.2 Data Elements and Report Fields

Beneficiary/plan-level information is present only on the Inputs Report and is rolled up to the plan and contract-level.

12.8.1.2.1 P2P and Non-P2P Fields (Slides 14-15, 17)

The Inputs Report to Plans contains both Plan-to-Plan (P2P) amounts and non-P2P amounts for the following fields: Actual Low Income Cost-Sharing Subsidy Amount (ALICSA), Gross Drug Cost Below the Out of Pocket Threshold Amount (GDCBA), Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA), Covered Part D Plan Paid Amount (CPPA), and Estimated Point-of-Sale (POS) Rebate Amount. These five fields represent data received from the Drug Data Processing System (DDPS). Table 12C provides the names and field locations on the DET record of the data elements which have both P2P and non-P2P amounts.

TABLE 12C – P2P AND NON-P2P FIELDS ON PRS INPUTS REPORT DET RECORD

Data Element	Short Name	Field Number		
		Non-P2P	P2P	Total
ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	4	5	6
GROSS DRUG COST BELOW THE OUT OF POCKET THRESHOLD	GDCBA	8	9	10
GROSS DRUG COST ABOVE THE OUT OF POCKET THRESHOLD	GDCAA	11	12	13
COVERED PART D PLAN PAID AMOUNT	CPPA	14	15	16
ESTIMATED POS REBATE AMOUNT	ERPOSA	22	23	24

The P2P amounts represent plan-level amounts paid when the contract was not the Submitting Contract. Since the Contract of Record (COR) has repaid the Submitting Contract during the P2P process, the P2P amounts incurred will be on the COR's reconciliation. Contracts will only be reconciled for plan-level amounts incurred when they are the COR.

Note that the P2P Estimated POS Rebate amount is the only P2P amount found on the PRS Inputs Report that represents plan-level amounts from the Submitting Contract. The Submitting Contract must retain (and report as DIR) any rebates earned for P2P claims.

PRS sums the P2P and non-P2P amounts for these fields at the beneficiary-level. The beneficiary/plan-level sums of these four fields are on the DET record and are aggregated to the plan and contract levels in the Inputs Report. Plans should also refer to the DDPS Management Report 4 COV and Report 42 for the non-P2P and P2P amounts for these fields. For P2P Estimated POS Rebate amounts, refer to Report 40. Prior to reconciliation, CMS will release Report 4 COV, Report 42, and Report 40 with the coverage year's cumulative results as they will be used in the Part D reconciliation. These reports are critical for the plan to review and refer to in understanding their Part D payment reconciliation.

12.8.1.2.2 Data Elements and Field Numbers

The beneficiary/plan-level information received from DDPS and MARx present on the Inputs Report is rolled up to the plan-level and the contract-level on the PTR and CTR records. The plan-level summaries of the data elements present on the PTR record are used for the Part D payment reconciliation. Table 12D provides the data elements and field numbers for the Inputs Report.

TABLE 12D – INPUTS REPORT – DATA ELEMENTS AND FIELD NUMBERS

Field No.			Data Elements
DET Record	PTR Record	CTR Record	
4	5	4	NON P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
5	6	5	P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
6	7	6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
7	8	7	ACTUAL P2P NPP SUBMITTED BY EA PLAN AMOUNT
8	9	8	NON P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
9	10	9	P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
10	11	10	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
11	12	11	NON P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
12	13	12	P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
13	14	13	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
14	15	14	NON P2P COVERED PART D PLAN PAID AMOUNT
15	16	15	P2P COVERED PART D PLAN PAID AMOUNT
16	17	16	TOTAL COVERED PART D PLAN PAID AMOUNT
17	18	17	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT
18	19	18	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT
19	20	19	PART D BASIC PREMIUM AMOUNT
20	21	20	DIRECT SUBSIDY AMOUNT
21	22	21	PACE COST-SHARING ADD-ON AMOUNT
22	24	23	NON P2P ESTIMATED POS REBATE AMOUNT
23	25	24	P2P ESTIMATED POS REBATE AMOUNT
24	26	25	TOTAL ESTIMATED POS REBATE AMOUNT

12.8.1.2.3 Plan-to-Plan (P2P) Actual Non-Covered Plan Paid (NPP) Amount Submitted by an Enhanced Alternative (EA) Plan

Actual P2P NPP Submitted by EA Plan Amount is a new data element on the Inputs Report. This data element was added to credit Enhanced Alternative (EA) plans for NPP amounts paid on behalf of a low income (LI) status beneficiary when reported on a PDE that was subsequently included in a P2P transaction. This value will be included in the Low Income Cost-Sharing Subsidy reconciliation for EA plans effective immediately.

As the P2P NPP Amount represents an actual LICS cost paid on behalf of a low income status beneficiary, it will be included in the calculation for Total Actual Low Income Cost-Sharing Subsidy Amount (ALICSA). The previous calculation for ALICSA summed the P2P LICS amounts received from Report 42 and the non-P2P LICS amounts received from Report 4. The revised calculation will now include the P2P NPP amounts which are found on Report 40. The revised calculation is as follows:

Total Actual Low Income Cost-Sharing Subsidy Amount =
Non-P2P Actual Low Income Cost-Sharing Subsidy Amount + P2P Actual Low Income Cost-Sharing Subsidy Amount + Actual P2P NPP Submitted by EA Plan Amount

As with the other values that comprise the Total Actual Low Income Cost-Sharing Subsidy Amount, it is passed indirectly to the Reconciliation Results Report because it has been included in the Total Actual Low Income Cost-Sharing Subsidy Amount which gets passed to the Reconciliation Results Report at the contract/PBP-level.

12.8.1.2.4 Estimated Rebate at Point-of-Sale (POS) Amount (Slide 16)

Beginning with benefit year 2008, contracts were given the ability to report the estimated rebate applied at the point-of-sale (POS) on the PDE. Beginning with the 2008 Part D payment reconciliation, the Estimated POS Rebate Amount will be used to calculate the Direct and Indirect Remuneration (DIR) used in the reinsurance reconciliation and in risk sharing. More information regarding this change to DIR can be found in a later section of this module.

PRS will receive Estimated Point-of-Sale (POS) Rebate amounts at the beneficiary/PBP-level from DDPS. As with the other data elements received from DDPS, the P2P and non-P2P amounts are summed to get the total amount at the beneficiary/plan-level.

Total Estimated POS Rebate Amount =
Non-P2P Estimated POS Rebate Amount + P2P Estimated POS Rebate Amount

As explained in the previous section, the P2P amounts represent amounts paid when the Submitting Contract for the plan was not the Contract of Record. Contracts should note that the P2P estimated POS rebate amounts are included in the Submitting Contract’s reconciliation because the Submitting Contract must retain (and report as DIR) any rebates earned for P2P PDEs. Contracts should refer to the DDPS Management Report 4 COV and Report 40 for the non-P2P and P2P values for the Estimated Rebate at POS amounts.

The beneficiary-level Total Estimated POS Rebate Amounts are summed up to the contract/PBP-level and passed to the Reconciliation Results Report where, beginning with the 2008 Part D payment reconciliation, they will be used to determine the DIR amount used in the reinsurance reconciliation and in risk sharing.

The Estimated POS Rebate fields will be populated with zero for the 2006 and 2007 reconciliation reports.

12.8.2 PRS Reconciliation Results Report to Plans (Slide 18)

The PRS Reconciliation Results Report to Plans provides plans with the results of the three Part D payment reconciliations and the final reconciliation payment adjustment amount. The Results Report also provides the contract/PBP-level inputs received from HPMS and the totaled plan-level inputs from DDPS and MARx that are necessary for plans to understand how their Part D payment reconciliation is calculated.

12.8.2.1 PRS Reconciliation Results Report to Plans File Layout (Slide 19)

As with the PRS Inputs Report to Plans, the PRS Reconciliation Results Report to Plans has been updated. The PRS Reconciliation Results Report to Plans file layout is similar to that of the PRS Inputs Report, but there are key differences. The Results Report file begins with the CHD record. In the Results Report, there are no beneficiary-level records; the DET record in the Results Report provides the reconciliation results at the contract/PBP-level. As with the Inputs Report, each report also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first run for the coverage year or if the reconciliation has been re-run. Table 12E provides the definitions and descriptions of the records in the PRS Reconciliation Results Report to Plans.

TABLE 12E – PRS RECONCILIATION RESULTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

Record Indicator	Record Definition	Notes
CHD	Contract-level file header	Occurs once per Contract
DET	Detail records for the report	Occurs 1 to many times per CHD record
CTR	Contract-level file trailer	Occurs once per CHD

The CTR record provides reconciliation results summarized to the contract level and represents the activity of all PBPs under one contract number. It is important to note here that the totals in this CTR record are not the totals used for any Part D payment reconciliation. All payment reconciliation is at the contract/PBP-level which is reported in the DET record. The CTR record may provide a useful contract-level summary, but will not directly impact any payment calculation.

12.8.2.1.1 Reconciliation Number (Slide 20)

On the DET record of the Reconciliation Results Report, the Reconciliation Number field is now called Current Reconciliation Number and a new field, Previous Reconciliation Number, has been added. The Previous Reconciliation Number field is used during a re-opened reconciliation and reports the number of the last reconciliation or re-opening in which there was a payment adjustment for the coverage year and the specific contract.

Contracts should note that the PRS Report ID for the Reconciliation Results Report to Plans, RECRSCTR, will be the same whether the report is being used for an initial Part D payment reconciliation or a re-opened reconciliation. The PRS Report ID can be found on the CHD record. Contracts will be able to identify whether the reports are for an initial reconciliation or a re-opened reconciliation by using the Current Reconciliation Number and Previous Reconciliation Number fields. The Current Reconciliation

Number will always be populated with 001 on an initial reconciliation. In a re-opened reconciliation, the Previous Reconciliation Number will be populated.

12.8.2.2 Inputs Report Fields Passed to the Results Report (Slide 21-22)

Certain fields from the Inputs Report are carried through to the Reconciliation Results Report. The elements passed are summed to the contract/PBP-level on the PRS Inputs Report PTR record. The data elements that are passed from the Inputs Report to the Results Report are values that are necessary inputs into the payment reconciliation calculations PRS performs. For example, the plan-level Total Actual Low Income Cost-Sharing Subsidy Amount (ALICSA) and the plan-level Prospective Low Income Cost-Sharing Subsidy Amount (PLICSA) are the only data elements used to calculate the LICS Reconciliation Adjustment Amount (LICSAA) and therefore, are passed to the Results Report from the Inputs Report. Other data elements passed from the Inputs Report to the Results Report also comprise values in the Part D payment reconciliation calculations. These data elements are shown in Table 12F.

TABLE 12F – DATA ELEMENTS PASSED FROM THE PRS INPUTS REPORT TO THE PRS RESULTS REPORT

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
DDPS	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	7	8
	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	11	18
	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	14	17
	TOTAL COVERED PART D PLAN PAID AMOUNT	17	34
	TOTAL ESTIMATED POS REBATE AMOUNT	26	21
MARx	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	18	11
	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	19	28
	PART D BASIC PREMIUM AMOUNT	20	38
	DIRECT SUBSIDY AMOUNT	21	37
	PACE COST-SHARING ADD-ON AMOUNT	22	40

12.8.2.3 Plan-Level HPMS Inputs (Slide 23)

Plan-level inputs needed to calculate reconciliation amounts are only found on the PRS Reconciliation Results Report to Plans. These plan-level inputs are HPMS inputs and include: the Reported Part D Covered DIR Amount, the Administrative Cost Ratio, and the Induced Utilization Ratio (for Enhanced Alternative plans only). Table 12G provides the HPMS plan-level inputs found on the PRS Reconciliation Results Report to Plans.

TABLE 12G – HPMS PLAN-LEVEL INPUTS FOUND ON THE PRS RECONCILIATION RESULTS REPORT TO PLANS

Data Element	Short Name
REPORTED PART D COVERED DIR AMOUNT	DDIRA
ADMINISTRATIVE COST RATIO	ACR
INDUCED UTILIZATION RATIO	IUR

12.8.2.4 Program-Level CMS Inputs (Slide 24)

The last set of reconciliation inputs that are found in the Results Report are CMS provided, program-wide data elements. These fields are necessary to perform the risk sharing portion of reconciliation. The values for these data elements will be the same for all plans that participate in risk sharing. Table 12H provides the CMS program level inputs on the PRS Results Report to Plans.

TABLE 12H – CMS PROVIDED PROGRAM LEVEL INPUTS ON THE PRS RESULTS REPORT TO PLANS

Data Element	Short Name
FIRST UPPER THRESHOLD PERCENT	FUTP
SECOND UPPER THRESHOLD PERCENT	SUTP
FIRST LOWER THRESHOLD PERCENT	FLTP
SECOND LOWER THRESHOLD PERCENT	SLTP
FIRST UPPER RISK SHARING RATE	FURSR
SECOND UPPER RISK SHARING RATE	SURSR
FIRST LOWER RISK SHARING RATE	FLRSR
SECOND LOWER RISK SHARING RATE	SLRSR

12.8.2.5 Payment Reconciliation Plan Type Code (Slide 25)

The Payment Reconciliation Plan Type Code (PRPTC) indicates which of the three reconciliations (LICS, reinsurance, and risk sharing) a plan may participate in and how those reconciliations will be calculated. The PRS contains a decision process to determine Payment Reconciliation Plan Type Code which considers the HPMS Plan Benefit Package Type Code (PBPTC), among other plan type flags and indicators to arrive at one of 14 distinct PRS reconciliation plan types. Table 12I provides a list of the PRS plan types and their allowed reconciliations.

TABLE 12I – PART D PLANS AND ALLOWED RECONCILIATION CALCULATIONS

Payment Reconciliation Plan Types	Unique PRS Plan Type Code	LICS Reconciliation	Reinsurance Reconciliation	Risk Corridor Analysis
Defined Standard Benefit Plan*	1	Yes	Yes	Yes
Actuarially Equivalent Plan*	2	Yes	Yes	Yes
Basic Alternative Plan*	3	Yes	Yes	Yes
Enhanced Alternative Plan*	4	Yes	Yes	Yes
Employer Group Waiver Plan (EGWP) Calendar Year	5	Yes	Yes	No
Employer Group Waiver Plan (EGWP) Non-Calendar Year	6	Yes	No	No
Dual-eligible PACE Plan	7	Yes	Yes	Yes
Medicare-only PACE Plan	8	Yes	Yes	Yes
Flexible Capitated Payment Demonstration Option	9	Yes	No	Yes
Fixed Capitated Payment Demonstration Option	10	Yes	No	Yes
MA Rebate Payment Demonstration Option**	11	Yes	Yes	Yes
Non-Payment Demonstration Private Fee-for-Service (Non-Demo PFFS)	12	Yes	Yes	No
Limited Risk	13	Yes	Yes	Yes
Fallback	99	TBD	TBD	TBD

* Mutually exclusive of all other plan types.
** No longer a valid plan type beginning in 2008. This plan type is included for training purposes only.

Note: All plans are required to bid as one of the four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative), but if the plan also falls into another category in addition to the HPMS PBP Type Code, such as a payment demonstration or an employer group, for PRS and reconciliation purposes, that is the designation to which the plan is assigned.

All PRS plan types participate in LICS reconciliation. Non-Calendar Year Employer Group Waiver Plans and Fixed and Flexible Capitated Payment Demonstration Plans do not receive reinsurance reconciliation. Calendar Year and Non-Calendar Year Employer Group Waiver Plans and Non-Payment Demonstration Private Fee-For-Service Plans do not participate in risk sharing.

12.8.2.6 Data Elements with Current, Previous, and Delta Values (Slides 26-30)

Certain key data elements on the Reconciliation Results Report will have fields for the Previous values (the values from the previous reconciliation or re-opening in which there was a payment adjustment), the Current values which are used to calculate the reconciliation in progress, and the difference between them, the Delta values. The Previous values for the data elements will be from the last reconciliation or prior re-opening as identified by the Previous Reconciliation Number. For these data elements the Delta values are calculated as:

Delta Data Element = Current Data Element – Previous Data Element

In a re-opened reconciliation, the delta values are critical for Contracts because they represent the values by which their final payment determination would be adjusted. The Delta values can be negative as well as positive. Table 12J provides the data elements that now have Previous, Current, and Delta fields.

TABLE 12J – DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES

Category	Data Element				
	Current		Previous		Delta
DDPS INPUTS	CURRENT TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	-	PREVIOUS TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	=	DELTA TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
MARx INPUTS	CURRENT PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	-	PREVIOUS PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	=	DELTA PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT
	CURRENT PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	-	PREVIOUS PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	=	DELTA PROSPECTIVE REINSURANCE SUBSIDY AMOUNT
MARx/HPMS DERIVED INPUTS	CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT	-	PREVIOUS ACTUAL REINSURANCE SUBSIDY AMOUNT	=	DELTA ACTUAL REINSURANCE SUBSIDY AMOUNT
PRS CALCULATED RECONCILIATION RESULTS	CURRENT LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	-	PREVIOUS LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	=	DELTA LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT
	CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-	PREVIOUS REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	=	DELTA REINSURANCE SUBSIDY ADJUSTMENT AMOUNT
	CURRENT RISK-SHARING AMOUNT	-	PREVIOUS RISK-SHARING AMOUNT	=	DELTA RISK-SHARING AMOUNT
	CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	-	PREVIOUS BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	=	DELTA BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)
	CURRENT ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	-	PREVIOUS ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	=	DELTA ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT

12.9 Reconciling Low Income Cost-Sharing Subsidy (Slide 31)

LICS reconciliation compares actual LICS to prospective LICS. Each month CMS pays plans prospectively for LICS amounts based on plan projections in the approved bid. The prospective payment for the LICS is based on the low income estimate (p(LI)mpm) calculated from the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each low-income subsidy beneficiary enrolled in the plan as of the first day of the payment month. PDE data reports actual LICS.

12.9.1 Low Income Cost-Sharing Subsidy System Overview

MARx calculates prospective LICS payments month-by-month and again after year-end. DDPS provides the actual LICS payments made. The information process for LICS is described in Figure 12C.

Figure 12C – LICS System Process

PRS calculates the LICS reconciliation amount:

- Receives final prospective LICS payments from MARx. MARx uses the following information to calculate the prospective LICS subsidy:
  - Low income estimate calculated from the approved bid (from HPMS).
  - Number of low income beneficiaries enrolled in the month (from MBD).
- Receives actual LICS reported on PDEs from DDPS.
- Calculates the difference between actual and prospective LICS.

Note: LICS reconciliation is performed at the plan-level based on the sum of all beneficiary LICS amounts for that plan.

12.9.2 Low Income Cost-Sharing Subsidy Data Oversight

The following information is used to calculate prospective LICS.

- Plans should review prospective payments for accuracy.
- Plans should understand the low-income estimate calculated from the approved bid in order to replicate the prospective LICS calculation.
- Plans should closely monitor and update LICS status for their enrolled beneficiaries to determine the number of low income subsidy beneficiaries enrolled in the month.

LICS data reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV), the P2P Part D Payment Reconciliation Report (Report 42COV), and the P2P PDE Accounting Report (Report 40) will be used for LICS reconciliation. The NPP amount from Report 40 is considered LICS in situations in which the Submitting Contract offers an Enhanced Alternative benefit. The plan's understanding of LICS in internal files and LICS reported on the Cumulative Beneficiary Summary Report, Covered Drugs should be the same. Plans should be able to explain any interim differences between the two. At reconciliation, the plan's internal records and LICS reported on PDEs should agree.

Each PDE must reflect accurate data. Retroactive LICS status changes warrant careful follow-up. When LICS status is established retroactively, plans must repay the beneficiary for any overpayments in cost-sharing. To ensure accurate reconciliation amounts, plans must also submit PDE adjustments for every PDE affected by the retroactive status.

12.9.3 Low Income Cost-Sharing Subsidy Reconciliation Calculation (Slide 32)

Plans are paid dollar for dollar for the LICS. If the LICS reconciliation amount is positive, plans will receive payment in full for the LICS reconciliation amount. If the LICS reconciliation amount is negative, plans will repay in full the LICS reconciliation amount.

Example: 2

Bayside Health Plan (refer to Table 12K on page 32) received $120 per low-income member per month of prospective LICS based on their Part D bid. The plan had 24,000 LI member months, meaning that the plan received a total of $2,880,000 of prospective LICS. Based on PDE data, the plan had $3,000,000 of actual LICS.

LICS Reconciliation Amount

LICS Reconciliation Amount = $3,000,000 - $2,880,000

LICS Reconciliation Amount = $120,000

Bayside's LICS Reconciliation – Results Report, DET Record

Field No.	Field Name	
8	CURRENT TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$3,000,000
11	CURRENT PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$2,880,000
14	**CURRENT LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT**	**$120,000**

12.10 Reconciling the Reinsurance Subsidy

As with the LICS reconciliation, the Reinsurance Subsidy reconciliation compares actual reinsurance to prospective reinsurance. Each month, CMS pays plans prospectively for the Reinsurance Subsidy based on plan projections in the approved bid. The prospective payment for the Reinsurance Subsidy is based on the estimate (per member per month) in the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month.

PDE data reports GDCA, which is the basis for determining allowable reinsurance costs. The Reinsurance Subsidy is 80 percent of GDCA, after Direct and Indirect Remuneration (DIR) has been subtracted.

12.10.1 Reinsurance System Overview

PRS reconciles the Reinsurance Subsidy. The Reinsurance Subsidy process is described in Figure 12D.

Figure 12D – Reinsurance Subsidy System Process

PRS calculates the Reinsurance Subsidy reconciliation:

- Receives final prospective Reinsurance Subsidy payments from MARx. MARx uses the following information to calculate the prospective Reinsurance subsidy.
  - Reinsurance pmpm estimate in the plan's approved bid (from HPMS).
  - Monthly enrollment.
- Receives DIR from HPMS.
- Receives GDCA, GDCB, and Estimated POS Rebate data reported on PDEs from DDPS.
- PRS calculates the Reinsurance Subsidy.
- PRS calculates the difference between the actual Reinsurance Subsidy and the prospective Reinsurance Subsidy.

Remember that Flexible and Fixed Payment Capitated Demonstration plans, and Employer Group Waiver Plans (EGWPs) that operate on a non-calendar year basis are excluded from reinsurance reconciliation. EGWPs that operate on a calendar-year basis are subject to reinsurance reconciliation (they are not paid prospective reinsurance, but they do receive retrospective reinsurance payment based on costs reported on PDEs and in the DIR report for reconciliation). EGWPs that operate on a non-calendar year basis receive no federal reinsurance subsidy.

12.10.2 Reinsurance Data Oversight

The following information is used to calculate prospective Reinsurance payments.

- Plans should understand the prospective reinsurance estimate in the approved bid in order to replicate the reinsurance calculation.
- Plans should closely monitor and update enrollment dates for their enrollees in order to determine the number of beneficiaries enrolled in the month.

- GDCA, GDCB and Estimated POS Rebate data reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV), the P2P Part D Payment Reconciliation Report (Report 42COV), and the P2P PDE Accounting Report (Report 40) will be used for reinsurance reconciliation. As stated previously, Report 40 displays the P2P Estimated POS Rebate data. The plan's understanding of GDCA, GDCB, and Estimated POS Rebate in internal files and the GDCA, GDCB, and Estimated POS Rebate reported on the CMS Reports should agree. Plans should be able to explain any interim differences between their internal files and the CMS generated reports. At reconciliation, the plan's internal records and GDCA, GDCB, and Estimated POS Rebate reported on PDEs should agree.
- Before plans are able to report data correctly on PDEs, they must first calculate TrOOP costs correctly in order to appropriately administer catastrophic benefits when the Out of Pocket (OOP) limit is reached. Final PDE data must accurately report GDCA totals at the plan/beneficiary level.

- If the plan incorrectly reported dollars in GDCB instead of GDCA, reinsurance costs will be understated. Similarly, if the plan incorrectly reported dollars in GDCA instead of GDCB, unadjusted reinsurance costs would be overstated.

Report as Administered - When reversal of a prior claim causes one or more subsequent claims to move from catastrophic coverage to non-catastrophic coverage, plans must be careful to report GDCA and GDCB accurately on PDEs affected by the reversal. For additional information, see the Module entitled Calculating and Reporting True Out-of-Pocket Costs (TrOOP).

CMS will evaluate the accuracy of GDCA data. CMS will estimate net TrOOP Amount based on the sum of the Net Patient Pay, Net Other TrOOP, Net LICS, and Net Patient Liability due to Other Payers Amount (PLRO) for all PDEs at or below the attachment point. Because the attachment point PDE may contain Out-of-Pocket (OOP) amounts paid during Catastrophic, this may vary slightly from plan computed TrOOP, which applies only to payments made before Catastrophic Coverage is reached.

12.10.3 Reinsurance Subsidy Calculations (Slide 36)

There is a five-step process to calculate and reconcile the Reinsurance Subsidy.

- Calculate DIR Ratio
- Calculate Reinsurance Portion of DIR
- Calculate Allowable Reinsurance Cost
- Calculate Plan-Level Reinsurance Subsidy
- Reconcile Reinsurance Subsidy

The DIR ratio is the unadjusted reinsurance cost divided by the total drug cost. Unadjusted reinsurance cost is the plan-level GDCA amount reported on PDEs. Total drug cost is the sum of GDCA and GDCB. The DIR ratio is applied to DIR to allocate the reinsurance portion of DIR. To derive allowable reinsurance cost, the reinsurance portion of DIR is subtracted from unadjusted reinsurance cost. The plan-level reinsurance subsidy is eighty percent (80%) of the plan's allowable reinsurance cost. The reconciliation calculation determines the difference between the actual reinsurance subsidy and the plan's prospective reinsurance payments.

12.10.3.1 Calculate Net Part D Covered DIR (Slide 33)

As mentioned in a prior section of this module, the Estimated POS Rebate Amount will be used to calculate the net Direct and Indirect Remuneration (DIR) amount used in the reinsurance reconciliation and in risk sharing. Prior to running the reinsurance portion of reconciliation, the Net Part D Covered DIR amount must be determined.

Changes regarding the Net Part D Covered DIR Amount are effective immediately. For Coverage Years 2006 and 2007, Net Part D Covered DIR Amount will be equal to Reported Part D Covered DIR Amount, and Total Estimated POS Rebate Amount will be equal to 0. Beginning with the Coverage Year 2008 Part D payment reconciliation, Net Part D Covered DIR Amount will begin to reflect the estimated POS rebate amounts for contracts that chose to report rebates at the point of sale.

12.10.3.1.1 Reported Part D Covered DIR

CMS requires plans to report their Direct and Indirect Remuneration (DIR) data using the DIR Report for Payment Reconciliation. Therefore, the Part D Covered DIR Amount, as it was reported in the 2006 PRS Reconciliation Results Report to Plans, is now called Reported Part D Covered DIR Amount.

12.10.3.1.2 Net Part D Covered DIR (Slides 34-35)

In addition, a new DIR field has been added to the Reconciliation Results Report, Net Part D Covered DIR Amount. Net Part D Covered DIR Amount is a PRS calculated field in which the Contract/PBP-level Total Estimated POS Rebate Amount passed from the Inputs Report to the Results Report is subtracted from the Reported Part D Covered DIR Amount. Table 12K provides the names and field locations on the Reconciliation Results Report detail (DET) record for these fields.

TABLE 12K – DIR FIELDS ON THE RECONCILIATION RESULTS REPORT DETAIL RECORD

Data Element	Field Number	Field Position
REPORTED PART D COVERED DIR AMOUNT	20	188-201
TOTAL ESTIMATED POS REBATE AMOUNT	21	202-215
NET PART D COVERED DIR AMOUNT	22	216-229

Bayside's Reported Part D Covered DIR Amount is $2,000,000. Bayside reported Total Estimated POS Rebate Amount equal to $350,000. To determine Bayside's Net Part D Covered DIR Amount, subtract Total Estimated POS Rebate Amount from the Reported Part D Covered DIR Amount. Bayside's Net Part D Covered DIR Amount is $1,650,000.

Net Part D Covered DIR

Net Part D Covered DIR = $2,000,000 - $350,000

Net Part D Covered DIR = $1,650,000

Bayside's Reinsurance Portion of DIR – Results Report, DET Record

Field No.	Field Name	
20	REPORTED PART D COVERED DIR AMOUNT	$2,000,000
21	TOTAL ESTIMATED POS REBATE AMOUNT	$350,000
23	**NET PART D COVERED DIR AMOUNT**	**$1,650,000**

12.10.3.2 Calculate DIR Ratio (Slides 37-38)

Bayside reported GDCA equal to $2,750,000 and GDCB equal to $13,750,000. The sum of GDCA and GDCB, which equals $16,500,000, is Bayside's total gross drug cost. To determine Bayside's DIR ratio, divide GDCA by total gross drug cost. Bayside's DIR ratio is .1667.

DIR_Ratio

DIR_Ratio = $2,750,000/($2,750,000 + $13,750,000)

DIR_Ratio = $2,750,000/$16,500,000

DIR_Ratio = .1667

Bayside's Reinsurance DIR Ratio – Results Report, DET Record

Field No.	Field Name	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$2,750,000
18	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	$13,750,000
19	**REINSURANCE DIR RATIO**	**0.1667**

12.10.3.3 Calculate Reinsurance Portion of DIR (Slides 39-40)

Bayside's net DIR for total covered drugs is equal to $1,650,000. To calculate the reinsurance portion of Bayside's DIR, multiply the net DIR for total covered drugs by the DIR Ratio. Bayside's reinsurance portion of DIR is $275,055.

Reinsurance Portion of DIR

Reinsurance Portion of DIR = $1,650,000 * .1667

Reinsurance Portion of DIR = $275,055

Bayside's Reinsurance Portion of DIR – Results Report, DET Record

Field No.	Field Name	
19	REINSURANCE DIR RATIO	0.1667
22	NET PART D COVERED DIR AMOUNT	$1,650,000
23	**REINSURANCE PORTION OF DIR AMOUNT**	**$275,055**

12.10.3.4 Calculate Allowable Reinsurance Cost (Slides 41-42)

Bayside reported GDCA equal to $2,750,000. To calculate Bayside's allowable reinsurance cost, subtract the reinsurance portion of DIR from GDCA. Bayside's allowable reinsurance cost is $2,474,945.

Allowable Reinsurance Cost

Allowable Reinsurance Cost = $2,750,000 - $275,055

Allowable Reinsurance Cost = $2,474,945

Bayside's Allowable Reinsurance Cost Amount – Results Report, DET Record

Field No.	Field Name	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$2,750,000
23	REINSURANCE PORTION OF DIR AMOUNT	$275,055
24	**ALLOWABLE REINSURANCE COST AMOUNT**	**$2,474,945**

12.10.3.5 Calculate Plan-Level Reinsurance Subsidy (Slides 43-44)

The reinsurance subsidy is 80 percent of allowable reinsurance cost. To calculate Bayside's reinsurance subsidy, multiply allowable reinsurance cost by .8. Bayside's reinsurance subsidy is $1,979,956.

Reinsurance Subsidy

Reinsurance Subsidy = $2,474,945 * 0.8

Reinsurance Subsidy = $1,979,956

Bayside's Actual Reinsurance Subsidy – Results Report, DET Record

Field No.	Field Name	
24	ALLOWABLE REINSURANCE COST AMOUNT	$2,474,945
25	**CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,979,956**

12.10.3.6 Reconcile Reinsurance Subsidy (Slides 45-46)

The reinsurance reconciliation amount is the difference between the actual and prospective reinsurance subsidy. Bayside's total prospective reinsurance was $2,100,000. Since Bayside bid a prospective reinsurance amount of $35 pmpm and had 60,000 member months, Bayside's total prospective reinsurance was $2,100,000 ($35*60,000 = $2,100,000). The difference between $1,979,956 and $2,100,000 is -$120,044. The reinsurance reconciliation amount is negative. Bayside over-estimated its reinsurance subsidy. In other words, Bayside's prospective reinsurance, based on its own bid estimates, was greater than the actual reinsurance subsidy, which was based on the plan's own PDE data. Bayside will pay back $120,044.

Reinsurance Reconciliation Amount

Reinsurance Reconciliation Amount = $1,979,956 – $2,100,000

Reinsurance Reconciliation Amount = -$120,044

Bayside's Reinsurance Reconciliation – Results Report, DET Record

Field No.	Field Name	
25	CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
28	CURRENT PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
31	**CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**-$120,044**

12.10.3.7 Reinsurance Subsidy Reconciliation

If the reinsurance reconciliation amount is positive, the actual amount incurred exceeded the amount paid prospectively, and the plan is entitled to additional payments. The plan will receive payment in full for the reinsurance reconciliation amount. If the reinsurance reconciliation amount is negative, the actual amount incurred was less than the amount paid prospectively. The plan will repay in full the reinsurance reconciliation amount.

12.11 Risk Sharing

Risk sharing includes both actual costs and prospective payments. Costs subject to risk sharing are plan paid costs attributed to the standard benefit. The government and the plan share risk when actual costs and prospective payments differ in excess of certain thresholds.

Each month, CMS prospectively pays plans the direct subsidy based on plan projections in the approved bid. The direct subsidy is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment score, minus the Part D basic premium related to the standardized bid amount. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month.

PDE data reports actual CPP, which is the basis for determining adjusted allowable risk corridor costs (AARCC) used in calculating risk sharing.

12.11.1 Risk Sharing System Overview

PRS calculates risk sharing. The risk sharing process is described in Figure 12E.

Figure 12E - Risk Sharing System Process

PRS calculates risk sharing:

- PRS receives the final direct subsidy amount, final Part D basic premium related to the standardized bid and prospective reinsurance payments of the flexible and fixed capitated demonstration plans from MARx.
- PRS receives the administrative cost ratio, reported DIR for covered drugs, and induced utilization from HPMS.
- PRS receives CPP and Estimated POS Rebate amounts from DDPS.
- PRS calculates AARCC.
- PRS calculates risk sharing.

12.11.2 Risk Sharing Data Oversight

The following information is used for risk sharing.

- Plans should review month-by-month direct subsidy payments and the reconciled direct subsidy for accuracy. The following information is used to calculate the direct subsidy:
  - Standardized bid amount is the same information received on the plan's approved bid.
  - Part D basic premium is the same information received on the plan's approved bid.
  - The risk score reported at the beginning of the year is updated at mid-year and again at the direct subsidy reconciliation as more recent data and more complete data become available.
  - Plans should update enrollment and disenrollment dates throughout the year.
- Administrative cost data includes non-pharmacy expense and gain/loss in the approved bid.
- Induced Utilization: Enhanced Alternative plans should also understand the induced utilization ratio reported on the bid.
- CPP: CPP reported on the Cumulative Beneficiary Summary Report, Covered Drugs will be used for risk sharing calculations. The plan's understanding of CPP in internal files and of the CPP reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) should agree. Plans should be able to explain any interim differences between the two. At reconciliation, the plan's internal records and CPP reported on PDEs should agree. CPP as reported on the P2P Part D Payment Reconciliation Report (Report 42COV) will also be used for risk sharing calculations.

- Drug Coverage Status Code: All plans must report covered drugs accurately. Errors in the Drug Coverage Status Code field directly affect risk sharing. Risk sharing calculations include covered drugs only (i.e., Drug Coverage Status Code = "C"). CPP will be understated when covered drugs are reported as either enhanced alternative drugs or OTC drugs. CPP will be overstated when either enhanced alternative drugs or OTC drugs are reported in error as covered drugs. Any other reasons for over-reporting covered drugs, like including Part A/B drugs, will overstate CPP. Finally, Enhanced Alternative Plans and Payment Demonstration Plans must map costs to CPP correctly for accurate risk sharing.

12.11.3 Risk Sharing Calculations (Slide 47)

There is a four-step process to calculate risk sharing:

- Calculate the plan's target amount
- Calculate risk corridor thresholds
- Calculate AARCC
- Determine where costs fall with respect to the thresholds and calculate payment adjustment

12.11.3.1 Calculate the Plan's Target Amount (Slides 48-49)

Bayside received $2,868,000 in total direct subsidy payments and $2,100,00 in Part D basic premiums related to the standardized bid. Bayside's administrative cost ratio is 15 percent. To calculate Bayside's target amount, sum the total direct subsidy payments and the Part D basic premiums related to the standardized bid which add up to $4,968,000.

Next, eliminate administrative costs. Bayside's administrative cost ratio is 15 percent; the remaining cost, which should be included in the target amount, is non-administrative cost. Find Bayside's non-administrative cost by first subtracting .15 from 1.00, which is .85. To calculate Bayside's target amount, multiply the sum of the total direct subsidy payments and the Part D basic premium amount by .85.

Target Amount

Target Amount = ($2,868,000 + $2,100,000) * (1.00 - 0.15)

Target Amount = $4,968,000*.85

Target Amount = $4,222,800

Bayside's Target Amount – Results Report, DET Record

Field No.	Field Name	
37	DIRECT SUBSIDY AMOUNT	$2,868,000
38	PART D BASIC PREMIUM AMOUNT	$2,100,000
39	ADMINISTRATIVE COST RATIO	0.15
41	**TARGET AMOUNT**	**$4,222,800**

12.11.3.2 Calculate Risk Corridor Thresholds (Slides 50-53)

Bayside uses its target amount and Part D threshold risk percentages to calculate the risk corridor thresholds. Bayside's target amount is $4,222,800. Part D threshold risk percentages for 2006, in descending order are 105 percent, 102.5 percent, 97.5 percent, and 95.0 percent. To calculate the four threshold limits, multiply Bayside's target amount by each of these percentages. Later, these threshold limits are part of the final risk sharing amount calculation.

Risk Corridor Thresholds

Second threshold upper limit (STUL)	= $4,222,800 * 1.05	=	$4,433,940
First threshold upper limit (FTUL)	= $4,222,800 * 1.025	=	$4,328,370
First threshold lower limit (FTLL)	= $4,222,800 * 0.975	=	$4,117,230
Second threshold lower limit (STLL)	= $4,222,800 * 0.95	=	$4,011,660

Bayside's Risk Corridors – Results Report, DET Record

Field No.	Field Name	
41	TARGET AMOUNT	$4,222,800
43	FIRST UPPER THRESHOLD PERCENT	1.025
44	SECOND UPPER THRESHOLD PERCENT	1.05
45	FIRST LOWER THRESHOLD PERCENT	0.975
46	SECOND LOWER THRESHOLD PERCENT	0.95
47	**FIRST UPPER THRESHOLD AMOUNT**	**$4,328,370**
48	**SECOND UPPER THRESHOLD AMOUNT**	**$4,433,940**
49	**FIRST LOWER THRESHOLD AMOUNT**	**$4,117, 230**
50	**SECOND LOWER THRESHOLD AMOUNT**	**$4,011,660**

12.11.3.3 Calculate Adjusted Allowable Risk Corridor Costs (AARCC) (Slides 54-55)

There are 4 steps to determine adjusted allowable risk corridor costs.

1. Determine unadjusted allowable risk corridor costs. The plan-level sum of dollars reported in the CPP field represents the unadjusted allowable risk corridor costs.

2. Subtract plan-level reinsurance subsidy.

3. Subtract Net Part D Covered DIR.

4. For Enhanced Alternative (EA) plans only, reduce by the induced utilization factor plans reported in their bids.

To summarize, the calculation for Adjusted Allowable Risk Corridor Cost (AARCC) includes four numbers: unadjusted allowable risk corridor costs, the reinsurance subsidy (calculated above), net DIR for total covered drug costs, and the induced utilization factor (EA plans only).

The AARCC for all plans excludes the reinsurance subsidy and net DIR. In addition, EA plans (including payment demonstration plans) must account for induced utilization. Beneficiaries in EA plans pay a higher premium in exchange for reduced cost-sharing. These beneficiaries are expected to have higher drug costs than equivalent beneficiaries in other plans. Bayside is a payment demonstration plan. Bayside uses the induced utilization factor submitted in its bid to exclude the effect of this potentially higher utilization.

First, subtract the reinsurance subsidy and net DIR from the unadjusted allowable risk corridor cost. Bayside's unadjusted allowable risk corridor cost is $8,250,000. The reinsurance subsidy for Bayside is $1,979,956 and their Net Part D Covered DIR is $1,650,000. The result is $4,620,044. Then divide that amount by the induced utilization ratio. Bayside's induced utilization ratio is 1.018. Bayside's AARCC is $4,538,353.

Adjusted Allowable Risk Corridor Cost (AARCC)

AARCC = ($8,250,000 - $1,979,956 - $1,650,000) / 1.018
AARCC = $4,620,044 / 1.018
AARCC = $4,538,353

Bayside's Adjusted Allowable Risk Corridor Cost – Results Report, DET Record

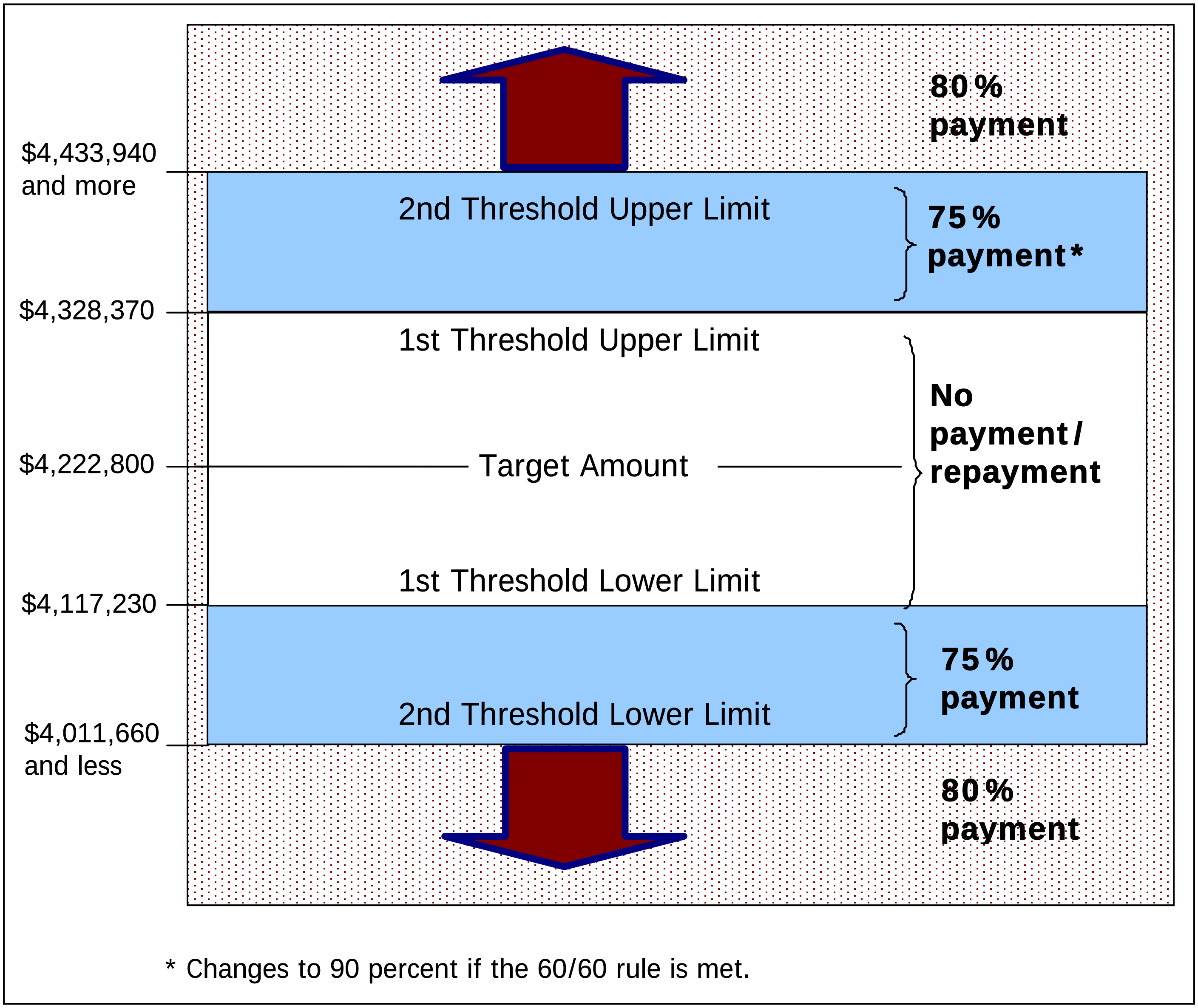
Field No.	Field Name	
22	NET PART D COVERED DIR AMOUNT	$1,650,000
25	CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
34	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,250,000
35	INDUCED UTILIZATION RATIO	1.018
36	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,538,353**

12.11.3.4 Determine Where Costs Fall With Respect To The Thresholds And Calculate Payment Adjustment (Slides 56-59)

The last step in risk sharing is to determine where AARCC falls with respect to the thresholds and calculate the payment adjustment. To review, Bayside's AARCC is $4,538,353. Figure 12F displays Bayside's risk sharing thresholds and percentages. In this example, assume that the 60/60 rule is met.

The 60/60 rule - In 2006 and 2007, the government has the authority to increase the risk sharing percentage between the FTUL and STUL from 75 percent to 90 percent if at least 60 percent of Part D plans subject to risk sharing have AARCC above the FTUL, provided that those plans represent at least 60 percent of Part D enrollees.

Figure 12F – Bayside's Risk Sharing Thresholds and Percentages



Since Bayside's AARCC is above the $4,433,930 that marks the Second Threshold Upper Limit (STUL), there are two portions of Bayside's risk sharing.

The first portion lies between $4,328,370 and $4,433,940 (between the First Threshold Upper Limit (FTUL) and the STUL) and has 90 percent risk sharing. The second portion falls above the $4,433,940 that marks the STUL and has 80 percent risk sharing.

Cost Subject to Risk Sharing
Total Cost Subject to Risk Sharing = $4,538,353 - $4,328,370
Total Cost Subject to Risk Sharing = $209,983
Cost Subject to Risk Sharing > FTUL and ≤ STUL = $4,433,940 - $4,328,370
Cost Subject to Risk Sharing > FTUL and ≤ STUL = $105,570
Cost Subject to Risk Sharing > STUL = $4,538,353 - $4,433,940
Cost Subject to Risk Sharing > STUL = $104,413

Finally, calculate the risk sharing percentage for each portion of AARCC. First apply 90 percent risk sharing to the $105,570 between the FTUL and STUL, which is $95,013.

Then, apply 80 percent risk sharing to the $104,413 above the STUL, which is $83,530. Sum these two amounts to calculate Bayside's total risk sharing payment of $178,543.

Risk Sharing Payment
Risk Sharing Payment = (.90 * $105,570) + (.80 * $104,413)
Risk Sharing Payment = $95,013 + $83,530
Risk Sharing Payment = $178,543
The risk sharing payment between the FTUL and STUL assumes that the 60/60 rule was met.

Bayside's Risk Sharing – Results Report, DET Record

Field No.	Field Name	
36	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,538,353
47	FIRST UPPER THRESHOLD AMOUNT	$4,328,370
48	SECOND UPPER THRESHOLD AMOUNT	$4,433,940
52	FIRST UPPER RISK SHARING RATE	0.9
53	SECOND UPPER RISK-SHARING RATE	0.8
56	**CURRENT RISK-SHARING AMOUNT**	**$178,543**
59	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$83,530
60	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$95,013

12.12 Final Reconciliation Payment Adjustment

After PRS has completed calculating the LICS, reinsurance, and risk sharing reconciliation values, these values are used to calculate the Adjustment Due to Payment Reconciliation Amount (ARA). The ARA is the total of the three reconciliations (LICS, reinsurance, and risk sharing) minus the Budget Neutrality Adjustment Amount (BNAA).

12.12.1 Determine Budget Neutrality Adjustment Amount (Slides 60-61)

The BNAA applies to demonstration plans only and is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA). Bayside is a MA Rebate Payment Demonstration Plan and is therefore subject to the budget neutrality adjustment.

Budget Neutrality Adjustment

Budget Neutrality Adjustment = $7.57 * 5000

Budget Neutrality Adjustment Amount = $37,850

Bayside's Budget Neutrality Adjustment – Results Report, DET Record

Field No.	Field Name	
61	COUNT OF UNIQUE MEMBERS PER YEAR	5000
62	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	$7.57
63	**CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)**	**$37,850**

12.12.2 Determine Adjustment Due to Payment Reconciliation Amount (Slides 62-64)

The Adjustment Due to Payment Reconciliation Amount (ARA) is the plan level final net reconciliation value. Table 12L illustrates how ARA is calculated.

TABLE 12L – PART D RECONCILIATION ADJUSTMENT AMOUNTS AND FIELD LOCATIONS

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost Sharing Subsidy Adjustment Amount	Field 14
+	Reinsurance Subsidy Adjustment Amount	Field 31
+	Risk Sharing Amount	Field 56
–	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 63
=	**Adjustment Due to Payment Reconciliation Amount**	**Field 66**

At this point, every step in the reconciliation process has been completed. In addition, to the reconciled direct subsidy that Bayside received from MARx, Bayside receives the net reconciliation amount of $140,649 from PRS.

Total Reconciliation Payment from PRS

LICS Reconciliation	$120,000
Reinsurance Subsidy Reconciliation	+($120,044)
Risk Sharing	+ $178,543
Budget Neutrality Adjustment Amount	- $37,850
Adjustment Due to Payment Reconciliation Amount	**$140,649**

Bayside's Adjustment Due to Payment Reconciliation – Results Report, DET Record

Field No.	Field Name	
14	CURRENT LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
31	CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$120,044
56	CURRENT RISK-SHARING AMOUNT	$178,543
63	CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	$37,850
66	**CURRENT ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**$140,649**

12.12.3 Interpreting the PRS Reconciliation Results Report

12.12.3.1 Interpreting the Revised Results Report in an Initial Reconciliation (Slide 65)

On the Reconciliation Results Report, in an initial Part D payment reconciliation, Previous values are not populated. However the formula for calculating Delta values still applies. Therefore, Delta values will be populated and will be to equal to Current values. This was done so that Contracts would have to code to only one set of fields for both an initial Part D payment reconciliation and for a re-opened reconciliation. Contracts may choose to ignore Delta fields on an initial reconciliation since the amounts will be equal to Current value fields.

12.12.3.2 Interpreting the Revised Results Report in a Re-Opening (Slide 66)

It is important to note that the Previous data elements are not used by PRS to calculate the re-opened reconciliation. The previous amounts are used to determine adjustment amounts to the reconciliation. PRS determines the re-opened reconciliation as it would calculate an initial Part D payment reconciliation using the same calculations as are used in the Part D payment reconciliation. The PRS inputs with Previous values such as the Total Actual Low Income Cost-Sharing Subsidy Amount are included to show the net change between the inputs of the initial reconciliation or prior re-opening and the current re-opening. The PRS reconciliation results previous values are included in the Reconciliation Results Report to help contracts understand how CMS arrives at the adjustment to the final payment determination.

For example, a re-opened LICS reconciliation would be calculated by PRS by using the LICS reconciliation calculation:

Current Low Income Cost-Sharing Subsidy Adjustment Amount = Current Total Actual Low Income Cost-Sharing Subsidy Amount – Current Prospective Low Income Cost-Sharing Subsidy Amount

The next step would be to compare the calculated Current Low Income Cost-Sharing Subsidy Adjustment Amount (LICSAA) and compare it to the Previous LICSAA to arrive at the Delta LICSAA.

Delta Low Income Cost-Sharing Subsidy Adjustment Amount = Current Low Income Cost-Sharing Subsidy Adjustment Amount - Previous Low Income Cost-Sharing Subsidy Adjustment Amount

The Delta LICSAA will be used with the Delta Reinsurance Subsidy Adjustment Amount (RSAA), the Delta Risk Sharing Amount (RA), and the Delta Budget Neutrality Adjustment Amount (BNAA) to determine the Delta Adjustment Due to Payment Reconciliation Amount (ARA). The Delta ARA is the value on which any payment adjustment to the final payment determination would be based. The fields identified in Table 12M are used to calculate the Delta ARA:

TABLE 12M – RE-OPENED PART D PAYMENT RECONCILIATION ADJUSTMENT AMOUNTS FIELD NUMBER AND LOCATIONS ON THE RECONCILIATION RESULTS REPORT DET RECORD

	Re-Opened Reconciliation Amounts	Field Number
	Delta Low Income Cost-Sharing Subsidy Adjustment Amount	Field 16
+	**Delta Reinsurance Subsidy Adjustment Amount**	Field 33
+	**Delta Risk Sharing Amount**	Field 58
–	**Delta Budget Neutrality Adjustment Amount (Demonstration Plans Only)**	Field 65
=	**Delta Adjustment Due To Payment Reconciliation Amount**	Field 68

Table 12N illustrates the data used to calculate Bayside's Health Plan's total reconciliation payment.

TABLE 12N – BAYSIDE HEALTH PLAN

HPMS Information

Plan Bid Information	
1. Standard Bid	$92
2. Part D Basic Premium Related to the Standardized Bid	$35
3. Prospective Low Income Cost-Sharing	$120
4. Prospective Reinsurance	$35
5. Admin Cost Ratio	0.15
6. Induced Utilization	1.018

DIR Information

7. Reported Covered Part D DIR	$2,000,000

MARx Information

8. Average Monthly Enrollment	5,000
9. Total Member Months	60,000
10. Average Risk Score	0.900
11. Risk Adjusted Bid	$4,968,000
12. Total Direct Subsidy	$2,868,000
13. Total Low Income Member Months	24,000
14. Total Prospective Low Income Cost-Sharing	$2,880,000
15. Total Prospective Reinsurance	$2,100,000
16. Total Part D Basic Premium Related to the Standardized Bid	$2,100,000
17. Unique Member Per Year Count	5,000

DDPS Data

18. Low Income Cost-Sharing	$3,000,000
19. Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)	$2,750,000
20. Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)	$13,750,000
21. Covered D Plan Paid Amount	$8,250,000
22. Total GDCA+GDCB	$16,500,000
23. Estimated POS Rebates	$350,000

CMS Provided Data

24. Annual Budget Neutrality Dollar Amount (MA Rebate Payment Demonstrations)	$7.57