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Regional Training

PACE Prescription Drug Event Data Training



August 17, 2005
Baltimore, MD

2005

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Training

Introduction

Presented by:
Aspen Systems Corporation

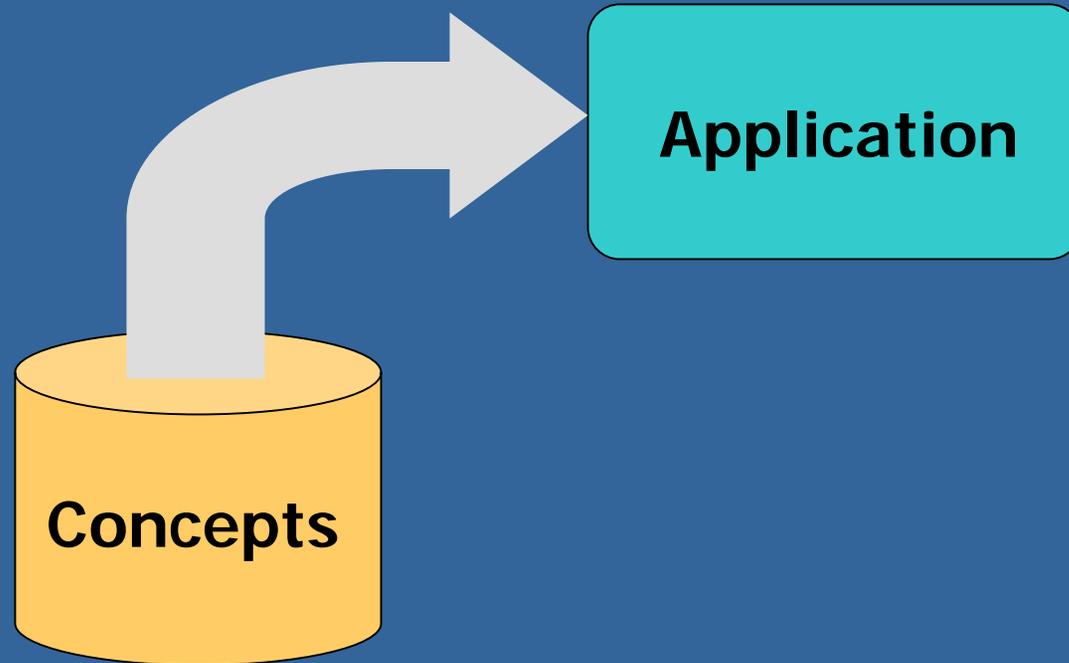
Purpose

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- To provide participants with the support needed to understand Part D payment and data submission.

Training Format

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- Examples
- Exercises
- Group Participation
- Interactive

Participation Makes the Difference

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Training Tools

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- Participant Guide
- Job Aids
- www.csssoperations.com
- Panel of Experts



Audience

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- Staff of PACE organizations
- PBMs
- Third Party submitters

Agenda – Day One

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7:30 – 8:30	Registration
8:30 – 9:00	Introduction
9:00 – 10:00	Part D Payment Methodology
10:00 – 10:15	Break
10:15 – 11:00	PACE Payment Calculations
11:00 – 11:30	PDE Process Overview
11:30 – 12:30	Data Format
12:30 – 1:30	Lunch
1:30 – 2:15	Defined Standard
2:15 – 3:00	Tiered Cost-Sharing
3:00 – 3:15	Break
3:15 – 4:15	Reconciliation
4:15 – 4:45	Question & Answer Session
4:45	Adjourn

Objectives

- Identify the prescription drug payment calculation methodology.
- Describe the flow of the data from the PDFS to the DDPS.
- Identify the fields required for completion of the PACE PDE record.
- Interpret the edit logic and error reports for PPDFS and DDPS as applied to PACE.

Objectives (continued)

- Describe how reports can ensure accurate quality and quantity of data stored in the system.
- Understand how the process of submission, processing, and editing leads to reconciliation of payment.

Introducing the Team

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CMS



Palmetto
(CSSC)

Aspen

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Part D Payment Methodology

Presented by:
Centers for Medicare & Medicaid Services

Purpose

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- Introduce Part D payment methodology so PACE organizations understand the legislated methodology and how PDE data collection supports it.

Objectives

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- Identify the four legislated payment mechanisms for Part D as they apply to dual eligible and Medicare only PACE organizations.
- Understand payment methodologies specific to PACE organizations.
- Establish context for understanding PACE PDE data reporting and reconciliation processes.

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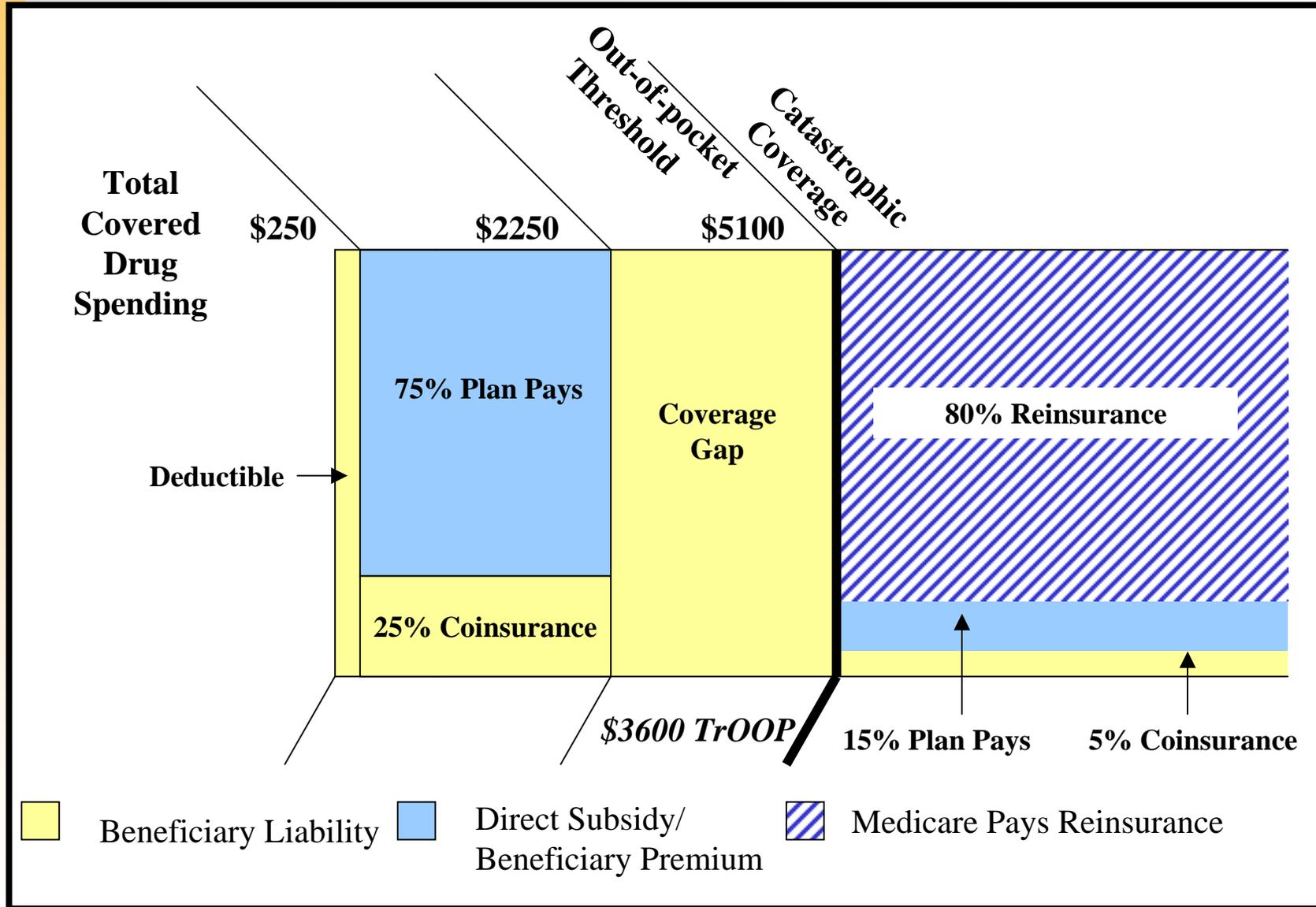
Four MMA Payment Mechanisms

- Direct subsidy
- Low income subsidy
- Federal reinsurance subsidy
- Risk sharing

Defined Standard Benefit 2006

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What is Covered?

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- Statutorily-specified Part D drugs also covered under a specific plan benefit package (PBP).

Direct Subsidy

- Monthly risk payments.
- Standardized bid, risk adjusted for health status and net of beneficiary premiums.
- Estimate of plan costs (drug product, dispensing fee, and administrative cost).
- The direct subsidy (plus basic premiums) covers:
 - 75% of plan costs in the initial coverage period.
 - Approximately 15% of plan costs in the catastrophic phase.
 - Administrative costs and profit approved in bid.

Low Income Subsidy

- Two types: cost-sharing assistance and premium assistance.
- PDE data: cost-sharing assistance, referred to as the low-income cost-sharing subsidy (LICS)
 - Applies throughout all phases of the benefit for qualifying beneficiaries
 - A cost-based component of payment

Reinsurance Subsidy

- The federal government acts as a re-insurer for Part D
- Covers 80% of allowable drug costs above the out-of-pocket threshold.
 - Applies in the catastrophic coverage phase of the benefit.
- A cost-based component of payment.

Risk Sharing

- Compares the plan-level risk payments (direct subsidy and premiums) to aggregate allowed plan costs in the initial coverage period and the catastrophic phase.
- Federal government and the plan share unexpected plan loss or gain.

Part D Risk Adjustment: The Basics

- Risk adjustment is used to standardize bids, enabling comparison of Part D bids against a baseline (average) standard.
- Allows direct comparison of bids based on populations with different health status and other characteristics.
- On the payment side, risk adjustment appropriately adjusts payment for the characteristics of the enrolled population.

Part D Risk Adjustment: Overview

- Part D payment is risk-adjusted using the Rx-HCC model which shares most of the characteristics of the CMS-HCC model: demographic, prospective, additive, hierarchical, demographic new enrollee model.
- Key differences:
 - Rx-HCC model designed to predict plan liability for prescription drugs under the Part D benefit rather than Medicare Part A/B costs.
 - Different diseases predict drug costs than Part A/B costs.
 - Incremental costs of Low Income and Long Term Institutional beneficiaries are multipliers to the base Rx-HCC model score.

Demographic Factors

- Age
 - Payment for year based on enrollee age as of February 1st
- Gender
- Disability status
- Originally-disabled and age ≥ 65

Disease Groups in the Rx-HCC Model

- Diseases included in the model cover most body systems and derive from both inpatient and outpatient settings.
- Model development was an iterative process.
 - Diseases grouped into smaller subgroups, then regrouped based on cost and clinical considerations.

Disease Hierarchies

- Payment based on most severe manifestation of disease when less severe manifestation also present.
- Purpose:
 - Diagnoses are clinically related and ranked by cost.
 - Accounts for the costs of lower cost diseases, reducing need for coding proliferation.
- E.g., Beneficiary with Rx-HCC 17 (diabetes w/complications) and Rx-HCC 18 (diabetes w/o complications) gets Rx-HCC 17

Model Coefficients

- Each disease group has an associated coefficient.
- Includes 113 coefficients
 - 84 disease coefficients
 - 24 age-gender adjustments
 - 3 age-disease interactions
 - 2 gender-age-originally disabled status interactions
- Hierarchies cover 11 conditions.

Low Income and Long-Term Institutional Add-ons

- The Part D model includes incremental factors for beneficiaries who are low income subsidy eligible (LIS) or long-term institutionalized (LTI).
- The factors are multipliers that are applied to the basic Part D risk adjustment factor.
- A beneficiary cannot receive both factors (if LIS, cannot receive LTI add-on and vice versa).

Low Income and Long Term Institutional Multipliers

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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

Special Provisions for PACE Payment

- Applicable to Dual Eligible Plans
 - Dual eligible PACE participants are not responsible for Part D premium payments.
 - Dual eligible enrollees in PACE organizations receive 100% premium assistance for the portion of the basic premium below the low income benchmark.
 - Above the low income premium benchmark, CMS will make additional capitated payments to cover any remaining premium amounts

Special Provisions for PACE Payment (continued)

- Applicable to Dual Eligible PACE Enrollees
 - No co-payment responsibility
 - Plans receive monthly capitated payment for nominal low income co-payments the beneficiary would otherwise pay at point of sale
 - 2% of all covered drug costs below the OOP threshold.

Special Provisions for PACE Payment (continued)

- Applicable to Medicare only PACE Enrollees
 - No low income cost-sharing subsidy
 - May receive low income premium subsidy for basic benefit if eligible
 - Prohibited from paying cost-sharing
 - Cost-sharing funded by supplemental premium charged to beneficiary
 - No TrOOP accumulation
 - No Catastrophic Coverage phase

Evaluation

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Please take a moment
to complete the
evaluation form for the
Part D Payment
Methodology Module.



THANK YOU!

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PACE Payment Calculations

Presented by:
Centers for Medicare & Medicaid Services

Purpose

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- Explain PACE calculations and review reconciliation so PACE organizations understand the statutorily established payment methodologies and financial data necessary to support Pat D payments.

Objectives

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- Explain PACE allocation of costs.
- Identify payments subject to reconciliation and risk sharing.
- Establish context for understanding PACE calculated data and reconciliation processes.

Calculations for Dual Eligible Plans

- Map to defined standard benefit
 - \$250 deductible
 - \$2250 initial coverage limit
 - \$5204 catastrophic coverage
- 2% of all payments below \$5100 attributed to additional capitated payment
 - covers normal LI beneficiary liability that PACE beneficiaries do not incur
 - Equals \$104 at catastrophic threshold

Payment Categories

Dual Eligible PACE Plans

- All costs for drugs with coverage status "C" reported as CPP
- Calculated LICS
 - \$0 - \$250, 98% of reported CPP
 - \$250.01 - \$2250, 23% of reported CPP
 - \$2250.01 - \$5100, 98% of reported CPP
 - \$5100.01 - \$5204, 83% of reported CPP
 - \$5204.01 and greater, 5% of reported CPP
- Calculated CPP is equal to reported CPP less calculated LICS

Payment Categories

Dual Eligible PACE Plans

- Unadjusted Reinsurance Amount
 - \$5204.01 and greater, 80% of CPP
- Risk Sharing Amounts
 - \$0 - \$250, 2% of CPP
 - \$250.01 - \$2250, 77% of CPP
 - \$2250.01 - \$5100, 2% of CPP
 - \$5100.01 \$5204, 17% of CPP
 - \$5204.01 and greater, 15% of CPP
- Amounts adjusted for direct and indirect remuneration (DIR) when calculating reinsurance and risk sharing

Payment Categories

Medicare Only PACE Plans

- All costs for drugs with coverage status “C” reported as CPP
- CMS will reassign costs to NPP according to the following formulas:
 - \$0 - \$250, 100% moves to NPP
 - \$250.01 - \$2250, 25% moves to NPP
 - \$2250.01 and \$5100, 100% moves to NPP
 - \$5100.01 and greater, 85% moves to NPP
- No amounts attributed to LICS or reinsurance
- All remaining CPP eligible for risk sharing calculations after accounting for DIR and induced utilization

What is Reconciliation?

- Conducted after the end of the coverage year.
- Compares monthly prospective payments CMS makes throughout the year with actual costs incurred by the plan.
- Different rules for reconciling each payment mechanism.

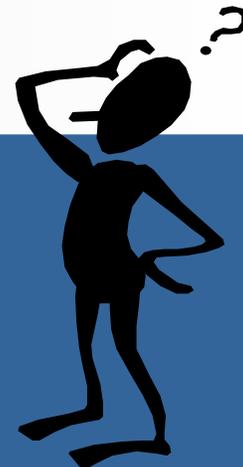
Payment Timetable and Reconciliation

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Payment Mechanism	Payment Schedule	Reconciliation Status
Direct Subsidy	Monthly, prospective	Yes – recalculate risk adjustment factors
Low Income Cost-Sharing Subsidy	Monthly, prospective	Yes
Reinsurance Subsidy	Monthly, prospective	Yes
Risk-sharing	Reconciliation payment	Yes

PDE Data Enable Payment and Reconciliation



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- Plans must submit data to CMS as necessary for payment and reconciliation.
- CMS applied four criteria in determining required data elements:
 - Ability to make timely, accurate payment via the four legislated mechanisms.
 - Minimal administrative burden.
 - Legislative authority.
 - Data validity and reliability.

Direct and Indirect Remuneration (DIR)

- Payment and reconciliation must exclude DIR, defined as:
 - 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.

DIR in Payment/Reconciliation

- Payment and reconciliation must exclude DIR.
- Plans must report DIR to CMS for exclusion from payment.
- DIR also includes any retroactive payments or re-payments that plans make as part of capitated arrangements with providers.

Reconciliation: Direct Subsidy

Calculate the monthly direct subsidy

Direct subsidy =

Plan's approved Part D standardized bid amount

x beneficiary's risk adjustment factor

– monthly beneficiary basic premium

Reconciliation: LICS

LICS applies only to dual eligible PACE plans

Monthly prospective LICS subsidy =
(LICS estimate in approved bid * # LI beneficiaries
enrolled/month)

LICS reconciliation amount =
(Sum of calculated LICS dollars from PDEs – Beneficiary-
plan-level prospective LICS subsidy including
adjustments)

If reconciliation amount is (-), plan re-pays it to
government.

If reconciliation amount is (+), government pays it to
plan.

Reconciliation: Reinsurance

- Reinsurance applies to dual eligible plans
- Plans report drug costs for beneficiaries.
- CMS calculates gross drug costs that are above the out-of-pocket threshold (GDCA).
- CMS sums GDCA by plan.
- Subtract DIR attributed to reinsurance costs (formula)
- Multiply by 0.80.
- Reconciliation payment (+) or (-) after comparing to monthly prospective reinsurance subsidy amounts.

Reconciliation: Risk Sharing



- Calculate target amount.
- Calculate adjusted allowable risk corridor costs (AARCCs).
- Calculate risk corridors (risk threshold limits)
- Determine where costs fall with respect to risk corridor thresholds.
- Calculate reconciliation payment.

Calculate Target Amount



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The target amount is the total projected revenue necessary for the basic benefit reduced for administrative costs.

In formula:

$$\begin{aligned} & \text{Total direct subsidy} \\ & + \text{Total beneficiary premiums for payment} \\ & \quad \text{purposes} \\ & + \text{Additional capitated payments}^* \\ & - \text{Administrative Costs} \\ \hline & \text{Target Amount} \end{aligned}$$

*additional capitated payments apply only to dual eligible PACE plans

Calculate Adjusted Allowable Risk Corridor Costs (AARCCs)

Add

- CMS calculated CPP amounts for covered Part D drugs

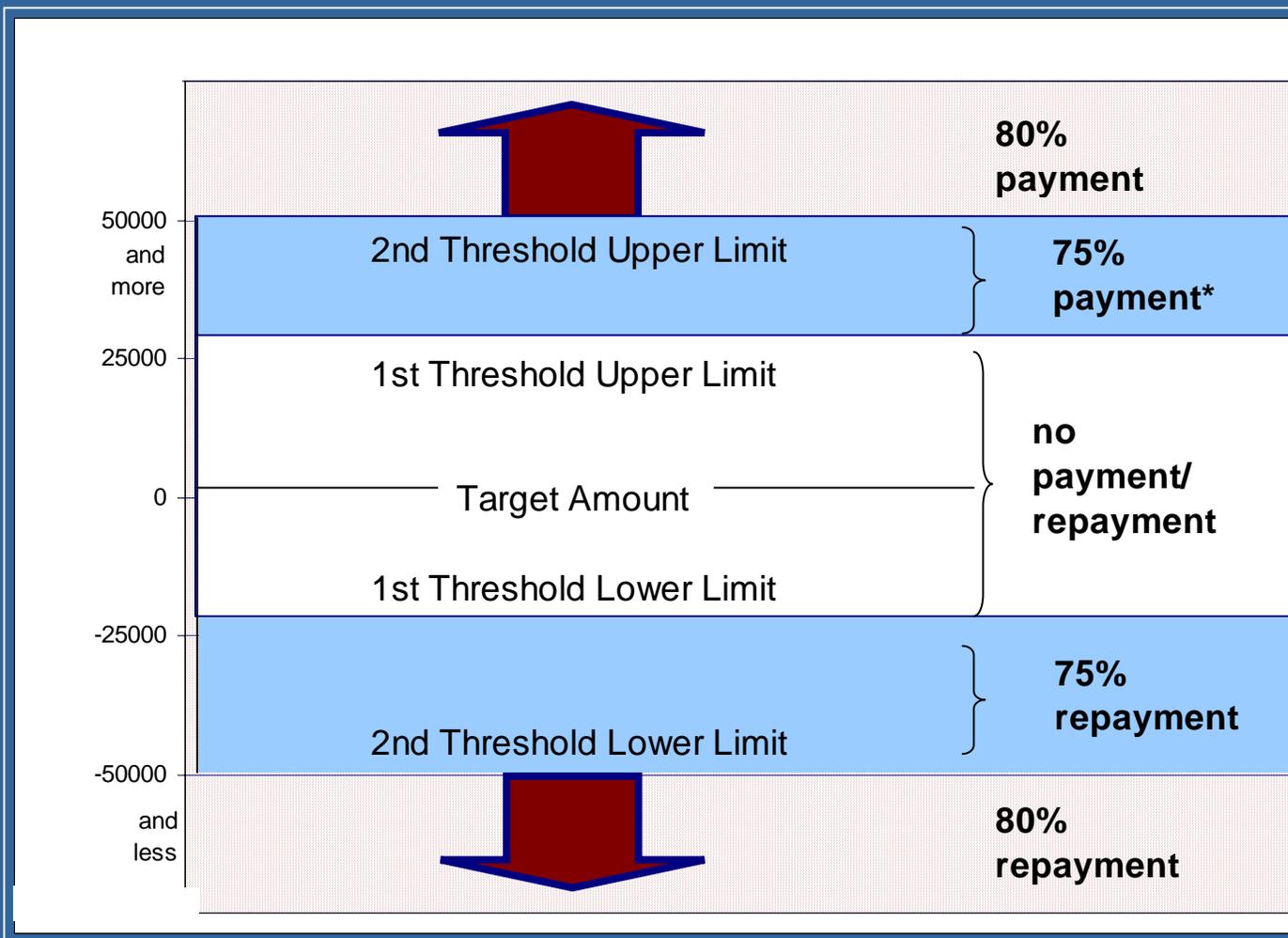
Then subtract

- Induced utilization (Medicare only PACE plans)
- Reinsurance subsidy (dual eligible PACE plans)
- Covered Part D DIR

Risk Corridors 2006

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*75% rate will change to 90% if certain circumstances are met

Summary

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- Explained PACE allocation of costs.
- Identified payments subject to reconciliation and risk sharing.
- Established context for understanding PACE calculated data and reconciliation processes.

Evaluation

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Please take a moment
to complete the
evaluation form for the
PACE Payment
Calculations Module.



THANK YOU!

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PDE Process Overview

Presented by:
Aspen Systems Corporation

Purpose

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- To present participants with the important terms, key resources, and schedule information that provide the foundation for the Prescription Drug Event Data training.

Objectives

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- Identify common Prescription Drug Event processing terminology.
- Demonstrate knowledge in interpreting key components of the Prescription Drug Event data process.
- Review the Prescription Drug Event data schedule.
- Identify the Centers for Medicare & Medicaid Services (CMS) outreach efforts available to organizations.

Common PDE System Terms

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PDFS

Prescription Drug
Front-end System

DDPS

Drug Data Processing
System

HPMS

Health Plan Management System

MARx

Medicare Advantage Prescription
Drug System

MBD

Medicare Beneficiary Database

DBC

Drug Benefit Calculator

PRS

Payment Reconciliation System



PACE Plan Types

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Plans may offer the following benefits:

- Dual eligible
- Medicare only
 - Medicare only plans offer an enhanced alternative benefit

PDE Record Overview

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- Every time a prescription is covered under Part D, plans must submit a PDE record.
- The PDE record contains drug cost and payment data.
- PDE data is processed through DDPS.

PDE Record Overview (continued)

Includes CMS and NCPDP-defined data elements that track:

- Covered drug costs above and below the OOP threshold.
- Payments made by Part D plan sponsors, other payers, the beneficiary, and others on behalf of the beneficiary.
- Amounts for Enhanced Alternative costs separately from Defined Standard benefit costs.
- Costs that contribute toward TrOOP.

2006 Data Submission Timeline

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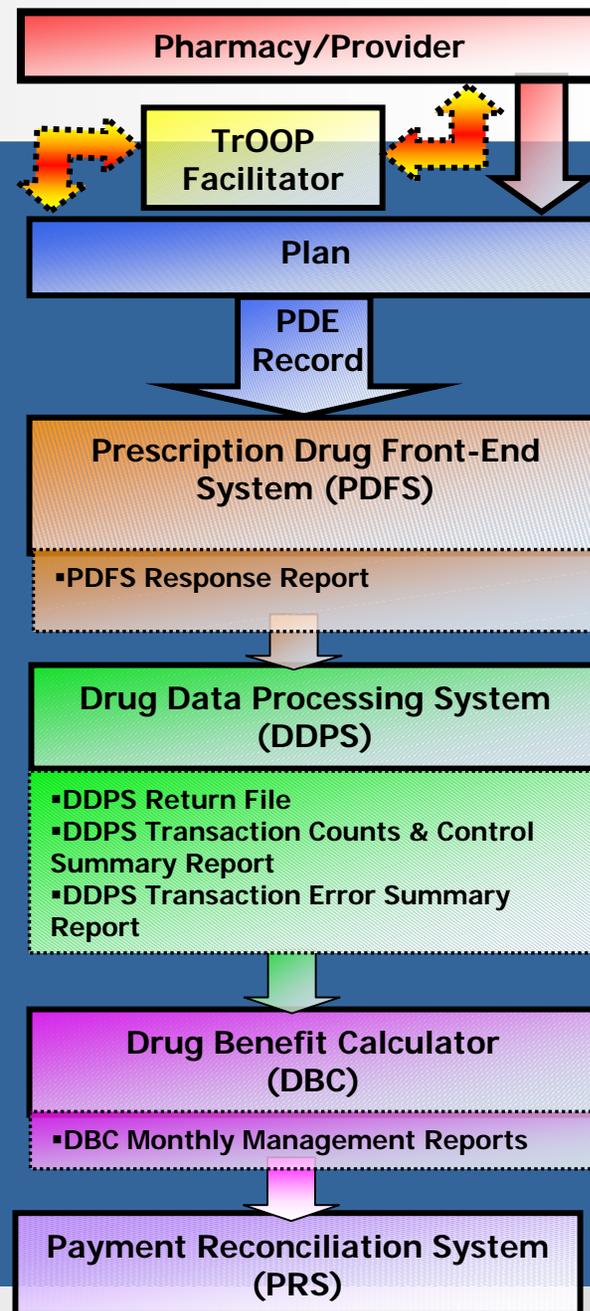
Data Submission Type	Submission Timeline
Testing and Certification	November 15, 2005 – January 31, 2006
DDPS Large Volume Testing	December 1, 2005 – December 23, 2005
PDE Production Submissions	January 1, 2006
Subsequent PDE production files for CY2006	Monthly after March 31, 2006 – May 31, 2007

PDE Dataflow

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- Pharmacy/Provider submits a claim to plan.
- Plan submits PDE data to PDFS.
- PDFS performs front-end checks.
- File is submitted to DDPS.
- DDPS performs detail edits.
- The DBC sums LICS and calculates unadjusted reinsurance and risk corridor payments.
- PRS creates a beneficiary record and calculates payment.



Training and Support

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- Regional Training Program
- 2005 Regional Training Video

Customer Service:

- Customer Service & Support Center
 - 1-877-534-2772
 - www.csssoperations.com

Summary

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- Identified common Prescription Drug Event data terminology.
- Demonstrated knowledge in interpreting key components of the Prescription Drug Event data process.
- Reviewed the Prescription Drug Event data schedule.
- Identified the CMS outreach efforts available to organizations.

Evaluation

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Please take a moment to complete the evaluation form for the Process Overview Module.



THANK YOU!

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Data Format

Presented by:
Aspen Systems Corporation

Purpose

2005

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Training

- To provide the processes required to collect and submit prescription drug event (PDE) data to CMS.

Objectives

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Training

- Identify 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.

Enrollment Packages

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FORM	ENTITY
Electronic Data Interchange (EDI)	Plans
Submitter ID Application	Plans Third Party Submitters
Authorization Letter	Plans

Connectivity Options

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<p>Connect:Direct</p>	<ul style="list-style-type: none"> • Mainframe-to-mainframe connection • Formerly known as Network Data Mover (NDM) • Next day receipt of front-end response
<p>File Transfer Protocol (FTP)</p>	<ul style="list-style-type: none"> • Modem-to-modem connection • Requires password and phone line • Same day receipt of front-end response
<p>Secure Website</p>	<ul style="list-style-type: none"> • Point and click features • Same day receipt of front-end response

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Certification Process

To support an efficient transition from testing to production, submitters must complete a two-phase testing and certification of their PDE transactions.



< 20%
error rate

Certification Phases

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Phase
1

PDFS preliminary test for transmission/communications, format, and content.

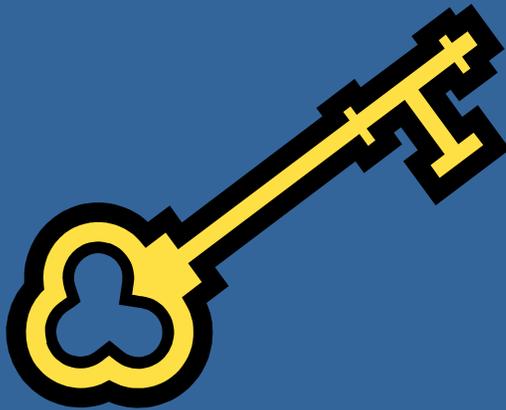
Phase
2

DDPS secondary test fully examines content of PDE records to ensure they pass format and logic edits at the detail level.

Certification and System Changes

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KEY POINT

Any major changes made to the processing or submission systems requires the PDE submission process to be re-certified.

2006 Data Submission Timeline

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Data Submission Type	Submission Timeline
Testing and Certification	November 15, 2005 – January 31, 2006
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PDE Production Submissions begin	January 1, 2006
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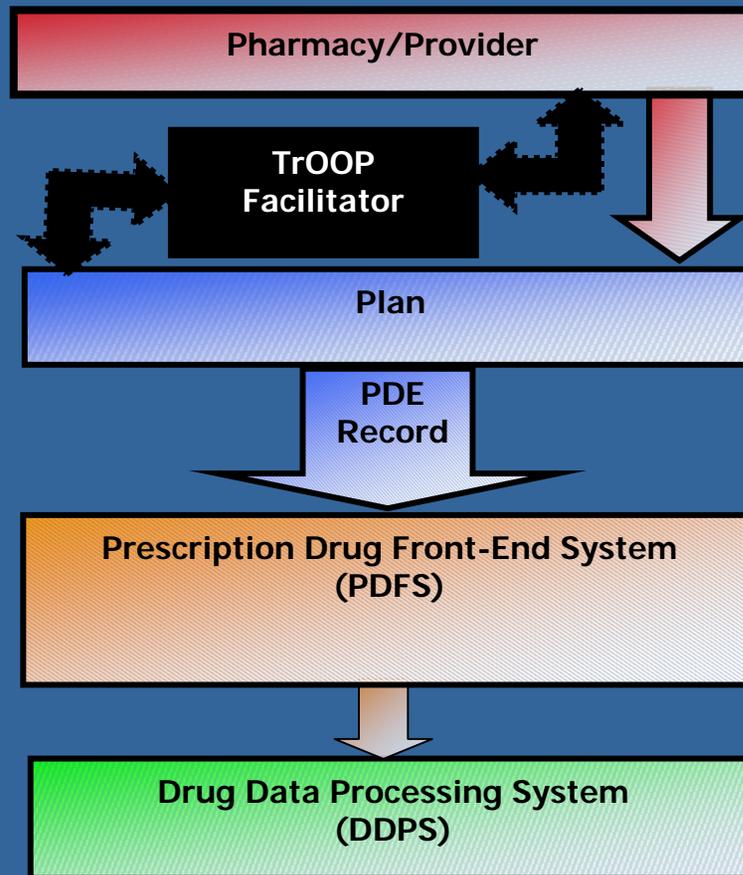
Plan Monitoring

- CMS will monitor plan data submission levels.
- Support is available for plans.
- Ultimate responsibility for accurate and timely data submission belongs to the plan.

PDE Process Dataflow

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PDE Record Layout Logic

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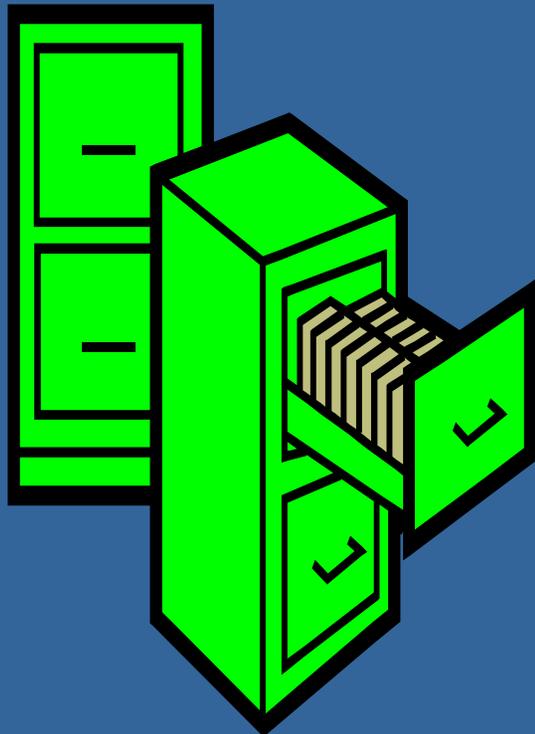
File-level information	Identifies the submitter
Batch-level information	Identifies the contract/plan
Detail-level information	Identifies the beneficiary

PDE Record Layout Logic (continued)

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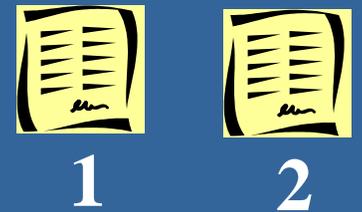
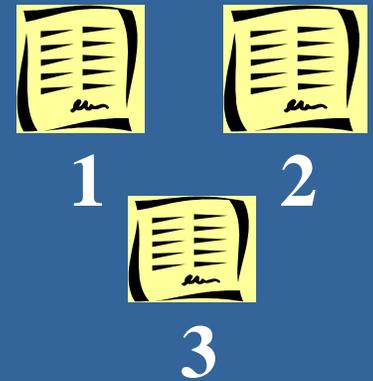
File-level



Batch-level



Detail-level



Plan Identification

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Contract Number Enumeration

Plan Type	First Letter
Local MA-PD Plans	Begins with an "H"
Regional MA-PD Plans	Begins with an "R"
Prescription Drug Plans (PDP)	Begins with an "S"
Fallback Plans	Begins with an "F"

PACE PLANS

Plan Identification (continued)

Plan Benefit Package (PBP) ID

- Three characters
- Identifies a plan benefit package within a contract

Identifying the plan a beneficiary is enrolled in requires both the Contract ID and the PBP ID

PACE PDE Field Exceptions

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Field Name	Field Descriptions
9	Paid Date
27	Catastrophic Coverage Code
31	GDCB
32	GDCA
33	Patient Pay Amount
34	Other TrOOP Amount
35	LICS
36	PLRO

HICN

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CMS
Number



111223334A



SSN

BIC

RRB
Pre
1964



WA123456



Prefix Random

RRB
Post
1964



WA123456789



Prefix

SSN

Drug Coverage Status Code

Drug Coverage Status Code

C = Covered

E = Enhanced

O = Over-the-Counter

Cost & Payment Fields

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FIELD NUMBER	FIELD NAME
28	Ingredient Cost Paid
29	Dispensing Fee Paid
30	Amount Attributed to Sales Tax
37	Covered D Plan Paid Amount
38	Non-Covered Plan Amount (NPP)

Drug Coverage Status Code = C

Drug Coverage Status Code = E/O

Cost

Payment

All dollar fields must be populated with a zero or actual dollar amount.

Non-Standard Format

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DATA SOURCE	CODE
Submitted by beneficiary to plan	B
Submitted by provider in ANSI X12 format	X
Submitted by provider on paper claim	P
Standard Format (NCPDP)	<blank>

Non-Standard Format (continued)

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

Modifying PDE Records

- Reasons for submitting an adjustment or deletion for a stored PDE include:
 - Beneficiary not picking up a prescription.
 - A payment to the pharmacy was adjusted.
- Minimize the need to modify PDE records by initiating a lag between data collection and submission.

Modifying PDE Records (continued)

- Adjustment/Deletion PDE records must match the original PDE record.
- DDPS cross-checks for a match on the following eight fields:
 - HICN
 - Service Provider
 - Prescription/Service Reference Number
 - Date of Service (DOS)
 - Fill Number
 - Dispensing Status
 - Contract Number
 - PBP ID



Modifying PDE Records (continued)

- Adjustments will replace the current (active) record with an adjusted record and inactivate the old record.
- Deletions will inactivate the current (active) record without saving a new record.

Summary

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- Identified the processes required for data submission.
- Defined standard and non-standard data collection formats.
- Described the PDE record layout logic.
- Identified the fields and functions in the PDE record format.
- Modified a PDE record.

Evaluation

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Please take a moment to complete the evaluation form for the Data Format Module.



THANK YOU!

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Edits

Presented by:
Aspen Systems Corporation

Purpose

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- To provide participants with an understanding of the Prescription Drug Event data system edits.

Objectives

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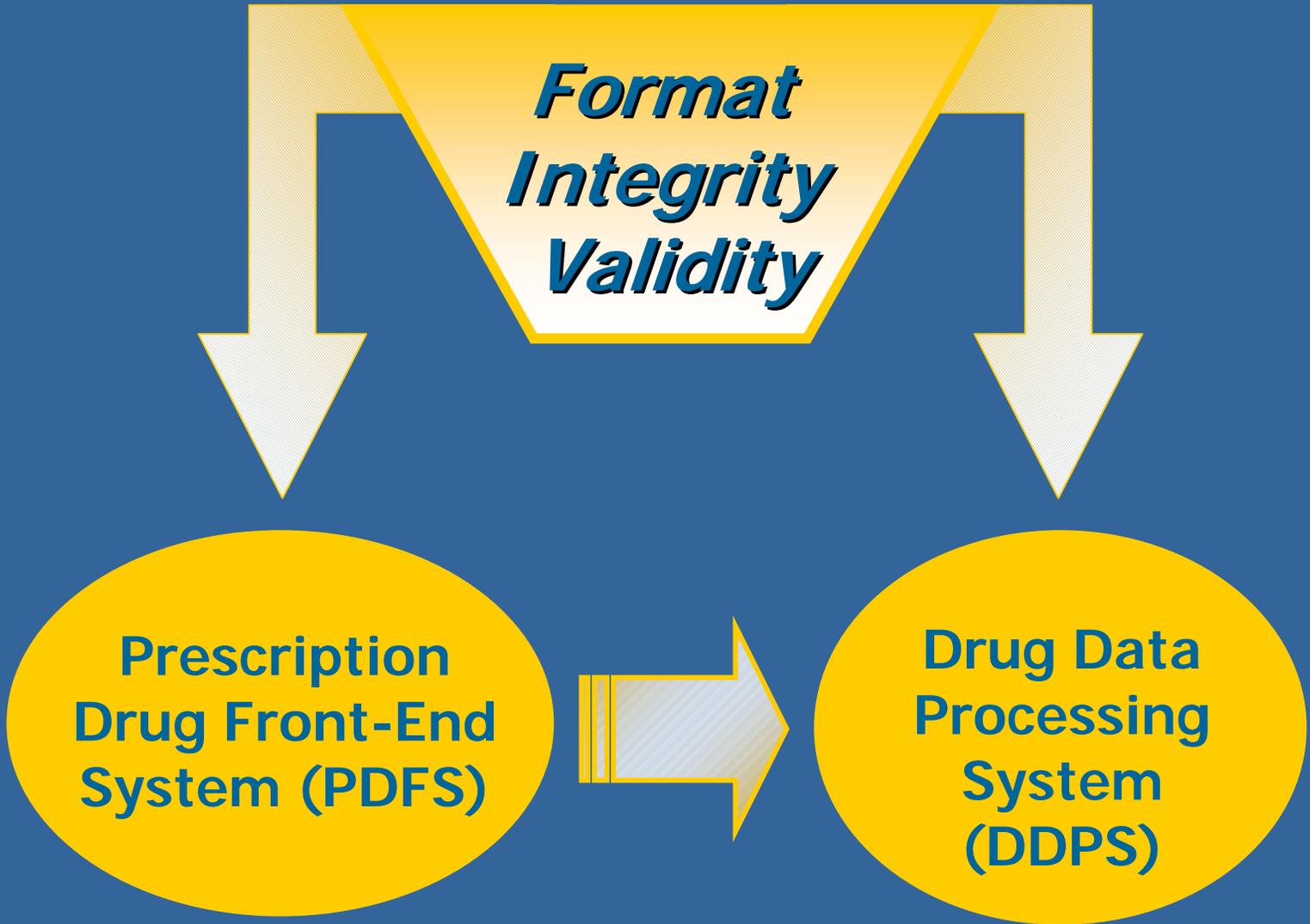
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- Describe the edit logic for the PDFS and DDPS.
- Identify the edits in DDPS that apply to PACE.
- Recognize the resolution process for resolving errors received from the PDFS and DDPS.

Edit Process

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PDFS Edits

- Missing data in header and batch record
- Appropriate sequencing of records
- To ensure a File ID does not duplicate a File ID previously accepted within the last 12 months
- Balanced information in headers and trailers
- Batch and detail Sequence Numbers
- Valid DET and BHD record totals

PDFS Edit Logic and Ranges

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Series	Range	Explanation
100	126-150	File-level errors on HDR
	176-199	File-level errors on TLR
200	226-250	Batch-level errors on BHD
	276-299	Batch-level errors on BTR
600	601-602	Detail-level errors on DET records

Example

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Scenario

Blue Sky Health changes to a new PBM in March 2006 and tells them to begin submitting data immediately, however no authorization letter was provided to CMS.

Example (continued)

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Result

PDFS rejects the file with error message 232 because the submitter was not authorized to submit for Blue Sky Health.

DDPS Editing Rules

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Stage 1

Individual Field Edits

Stage 2

Duplicate Check Edits

Stage 3

Field-to-Field Edits

Stage 4

Medicare Beneficiary Database Edits

DDPS Editing Rules (continued)

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Adjustments/Deletions

Edit Ranges and Categories

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Series	Edit Category
603-659	Missing/Invalid
660-669	Adjustment or Deletion
700-714	Eligibility
735-754	NDC
756	Drug Coverage Status Code
775-799	Miscellaneous
800-809	PACE

Example

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Scenario

Greenhouse Health Plan submitted a PDE for a non-covered drug and entered 'O' for an over-the-counter drug. Greenhouse Health Plan populated \$10 in the Covered D Plan Paid Amount field.

Example (continued)

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Result

DDPS rejected this record and provided error message 756. Greenhouse Health Plan must enter zero in the CPP field if the Drug Coverage Status Code is 'O'.

Resolution Process

- Paths for resolving errors:
 - Correct individual errors.
 - Assess factors causing errors and correct system problems if there are deficiencies.
 - Measure and improve performance in reducing errors over time.
- Tools to manage and reduce errors:
 - DDPS Return File.
 - Management reports.
 - Ongoing test environment.

Resolution Process (continued)

- Identify the field or fields that triggered the error by determining why the error occurred.
 - The format is invalid.
 - The data value is invalid.
 - The relationship between multiple fields triggered the error.
 - Which fields had incorrect values that caused the error.

Resolution Process (continued)

- Edits requiring specific problem-solving steps:
 - Eligibility (Edits 700-707)

Resolution Process (continued)

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Training

Plans can ask the following questions:



- Are plan system field definitions and values consistent with PDE definitions and values?
- Are plan system 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?

Summary

2005

Regional
Training

- Described the edit logic for the PDFS and DDPS.
- Identified the edits in DDPS that apply to PACE.
- Recognized the resolution process for resolving errors received from the PDFS and DDPS.

Evaluation

2005Regional
Training

Please take a moment to complete the evaluation form for the Edits Module.



THANK YOU!

2005

Regional
Training

Reports

Presented by:
Aspen Systems Corporation

Purpose

2005

Regional
Training

- To provide insights on the appropriate use of reports to manage data collection, data submission, error resolution processes, and help prepare plans for the reconciliation process.

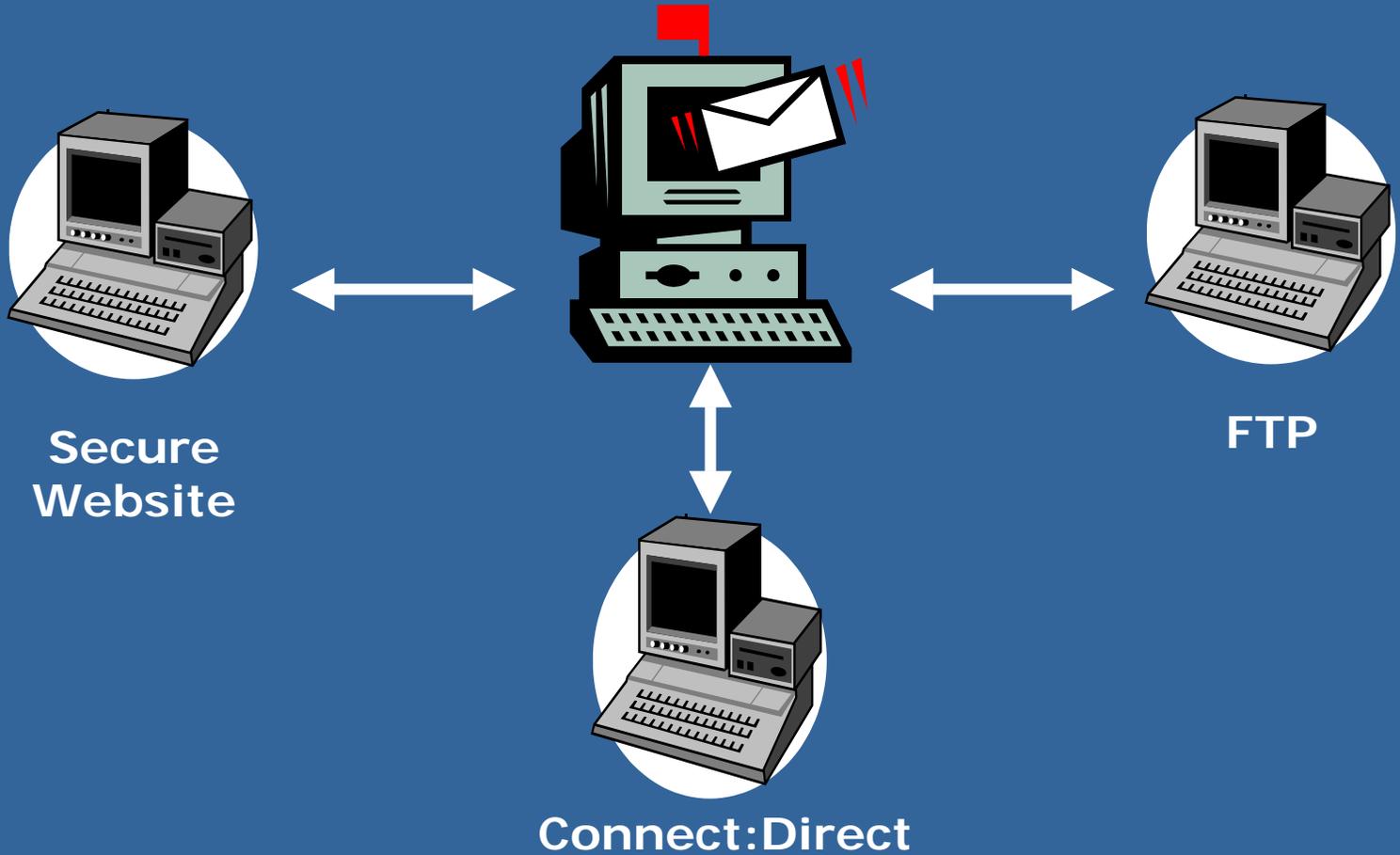
Objectives

- Identify the purpose of PDFS, DDPS and DBC reports.
- Determine the best use of the reports to monitor data processes and resolve errors.
- Accurately read the reports to identify and submit corrections.
- Understand the relationship between values in the management reports and reconciliation.

Accessing Reports

2005

Regional Training

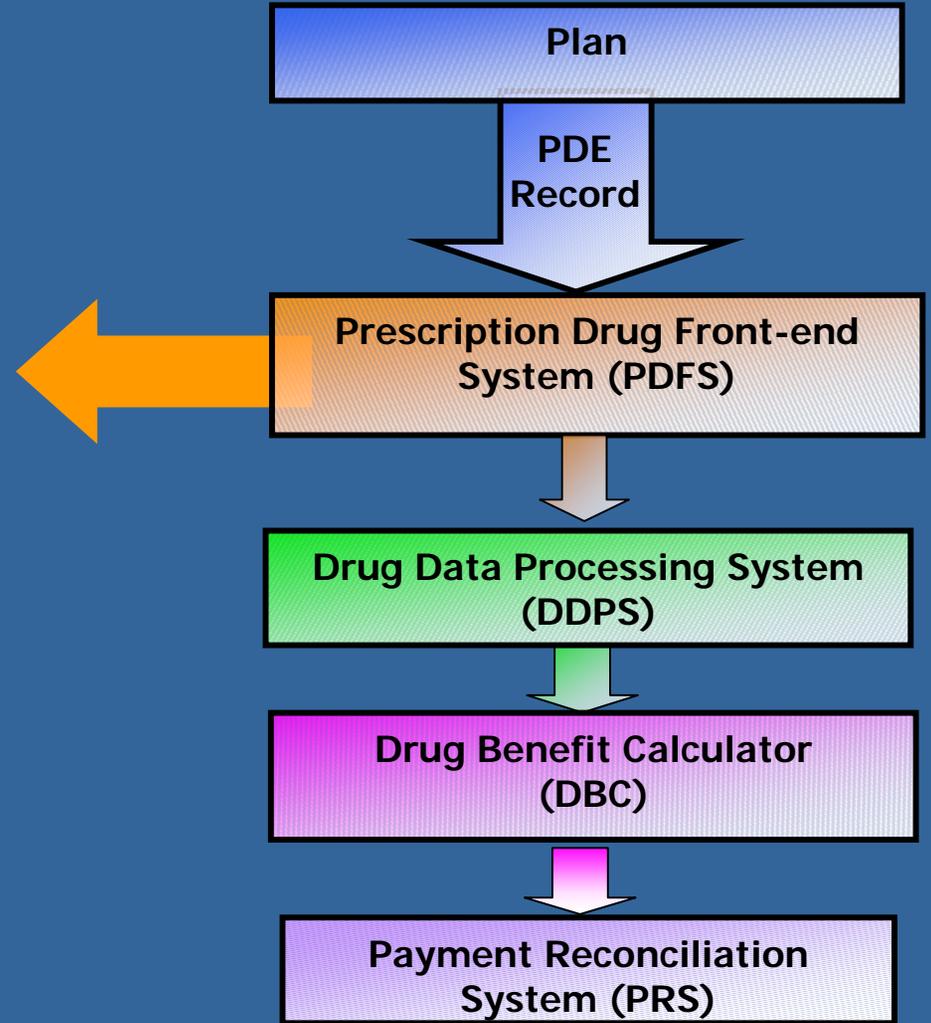


Reports Overview

2005

Regional Training

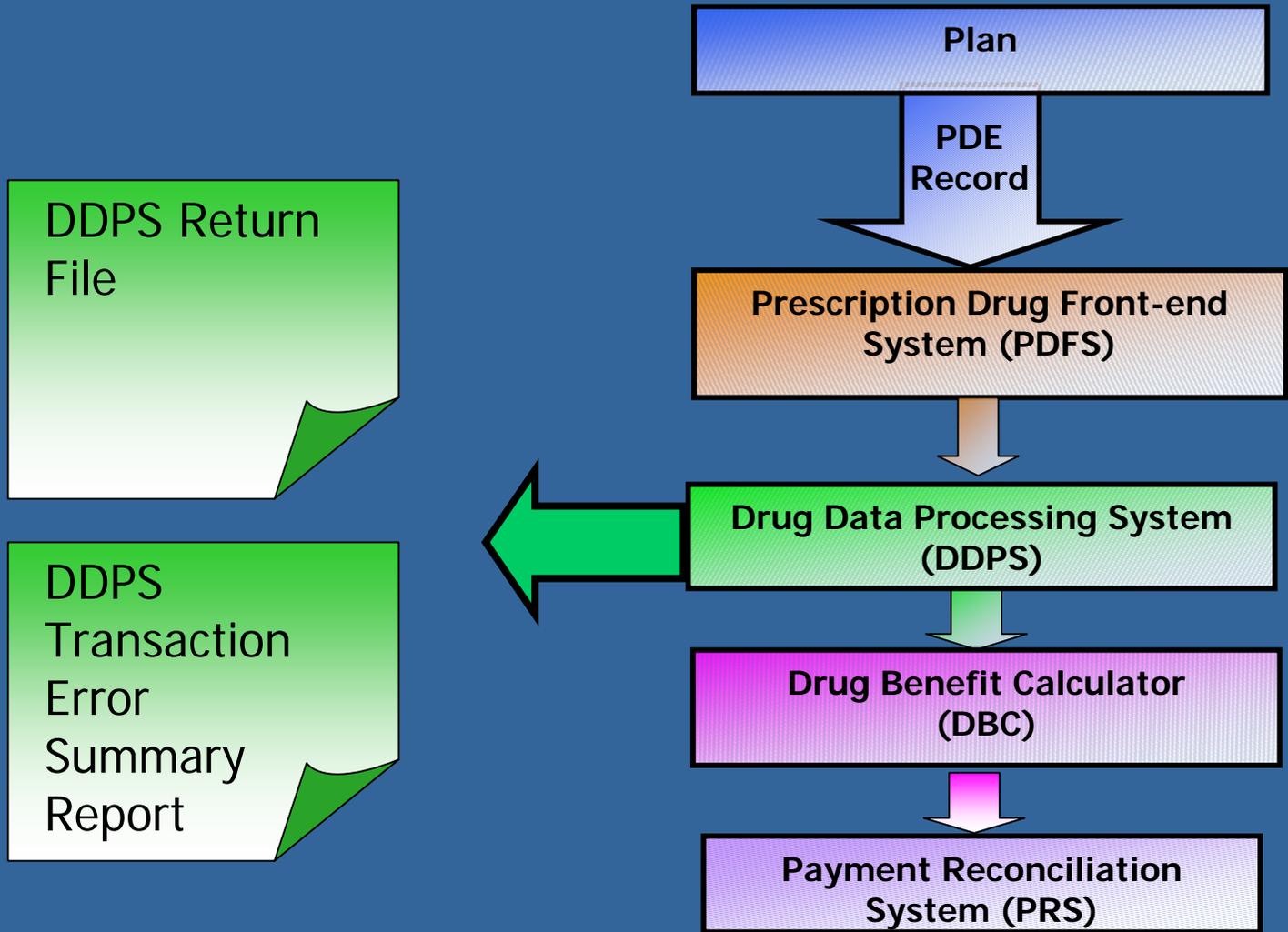
PDFS
Response
Report



Reports Overview (continued)

2005

Regional Training

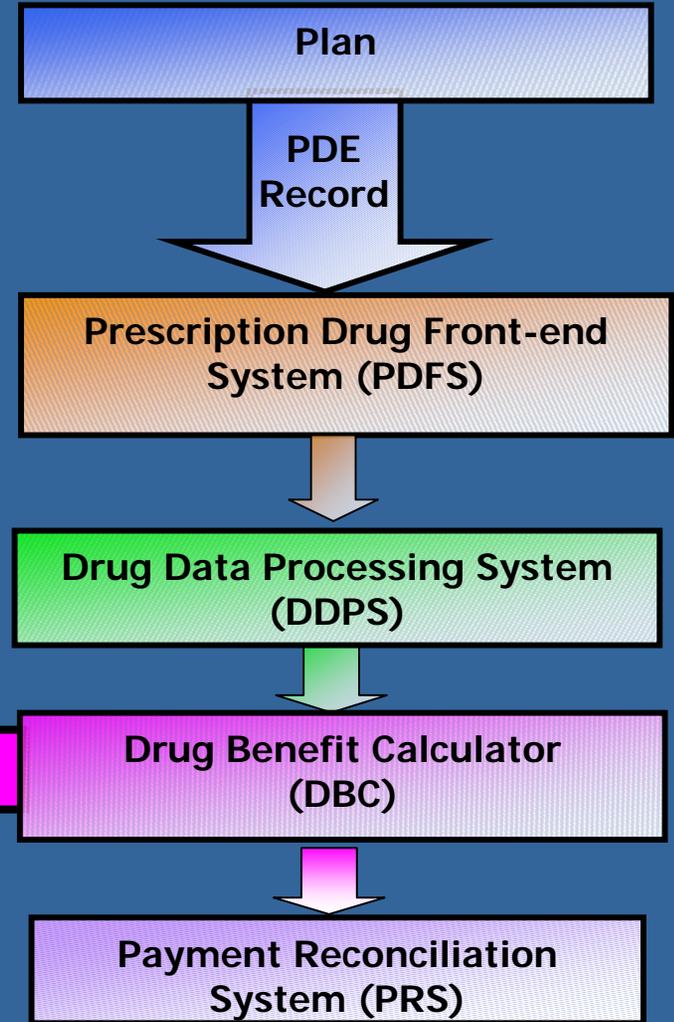


Reports Overview (continued)

2005

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DBC
Cumulative
Beneficiary
Summary
Report



Naming Conventions

2005

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REPORT NAME	MAILBOX IDENTIFICATION
PDFS Response Report	RPT00000.RSP.PDFS_RESP
DDPS Return File	RPT00000.RPT.DDPS_TRANS_VALIDATION
DDPS Transaction Count & Control Summary Report	RPT00000.RPT.DDPS_TRANS_CNT_CNTRL_SUM
DDPS Transaction Error Summary Report	RPT00000.RPT.DDPS_ERROR_SUMMARY
DBC 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

PDFS Response Report

- Indicates if file is accepted or rejected
- Identifies 100-, 200-, and 600-level error codes
- Available in report layout

Transaction Reports

- Identify processing results including errors
- Contain up to seven record types
- Available the next business day after processing
- Flat file layout

Plans should promptly review the DDPS Transaction reports to identify and resolve data issues.

DDPS Return File

- Identifies error codes
- Communicates the disposition of all DET records in the file
- Contains a truncated submitted transaction for accepted (ACC) detail records
- Contains the entire submitted transaction for rejected (REJ) or informational (INF) detail records

Cumulative Beneficiary Summary Reports

2005

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Training

- Three management reports
 - 04PCC for covered drugs
 - 04PEN for enhanced alternative drugs
 - 04POT for over the counter drugs
- Key information:
 - Net accumulated totals for dollar amount fields
 - Count of PDE records by ACC, INF, and REJ
 - Catastrophic coverage and beneficiary utilization

Cumulative Beneficiary Summary Reports (Continued)

2005

Regional
Training

- Totals apply to dates of service for one benefit year
- Each benefit year has separate cumulative reports
- Financial amounts are reported as "net"
- Reports will break by submitter, contract, and PBP
- Available in flat file layout the third business day of the month

Summary

2005

Regional
Training

- Identified the purpose of PDFS, DDPS and DBC reports.
- Determined the best use of the reports to monitor data processes and resolve errors.
- Accurately read the reports to identify and submit corrections.
- Understand the relationship between values in the management reports and reconciliation.

Evaluation

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Training

Please take a moment to complete the evaluation form for the Reports Module.



THANK YOU!

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Reconciliation

Presented by:
Centers for Medicare & Medicaid Services

Purpose

2005

Regional
Training

- Explain systems and steps for calculating payment amounts to be used in the reconciliation process.

Objectives

2005

Regional
Training

- Understand the systems and processes used in PACE payment reconciliation.
- Understand the relationship of reported data to PACE payment.
- Determine how the organization can monitor reports to ensure appropriate reconciliation.

Reconciliation

- Compares prospective and actual payments
- Calculates risk-sharing
- Determines reconciliation amounts for each payment type

Four Payment Methodologies

- Direct Subsidy
- Low Income Cost-Sharing Subsidy
- Reinsurance Subsidy
- Risk Sharing

See Module 1 – Part D Payment Methodology

Prospective Payments

- Medicare Advantage Prescription Drug System (MARx) calculates and reports monthly prospective payments.
- Plans monitor monthly prospective payments for accuracy.



Actual Costs

- PACE PDEs report actual costs for covered drugs as reported CPP.
- DBC calculates the following values which are directly applied to reconciliation:
 - LICS
 - GDCB
 - GDCA
 - Calculated CPP

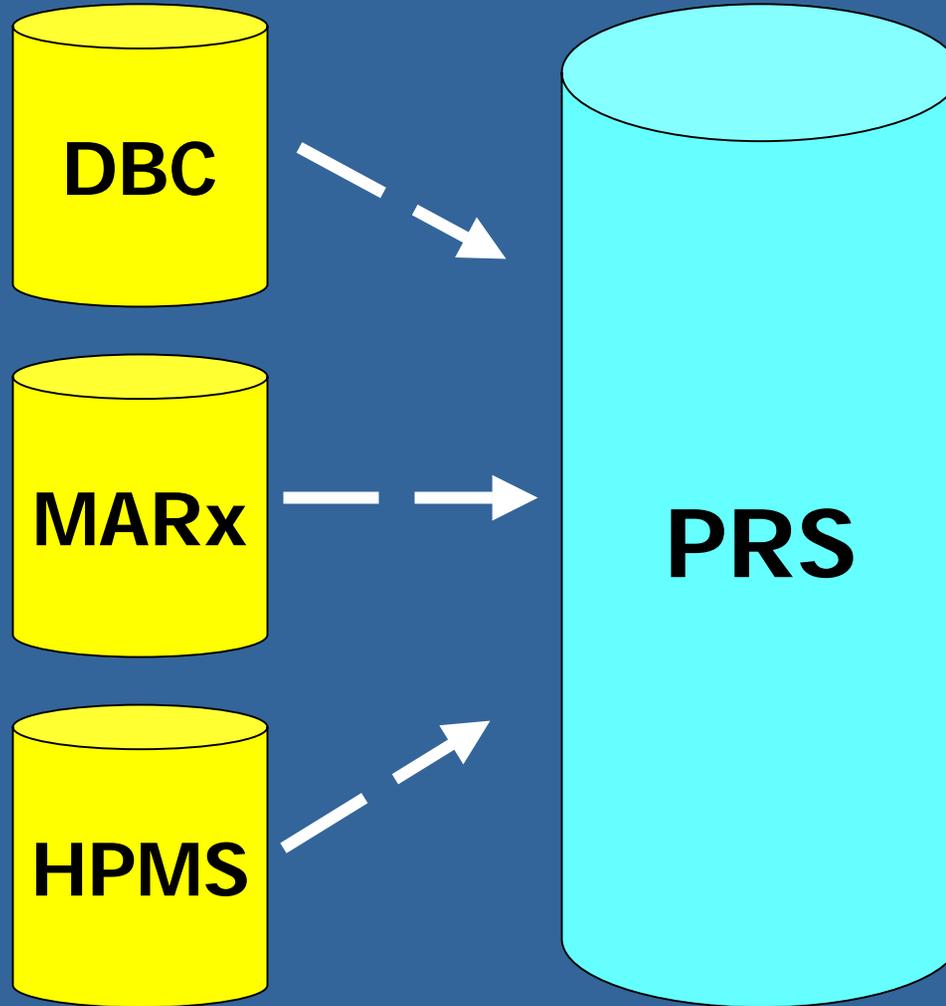
Accurate, Timely PDEs

- PDE data must be accurate and timely.
- For purposes of reconciliation, PDE data must be submitted by May 31 following the end of the benefit year.

Reconciliation Systems Overview

2005

Regional Training



Data Oversight

- Effective data oversight is continuous, timely, and thorough.
- Data oversight has four aspects:
 - Monitor prospective payments.
 - Track enrollment and data.
 - Ensure that submitted PDE data are accurate and consistent with plan data at the beneficiary and plan summary level.
 - Ensure that CMS summary reports are consistent with the plans understanding of the data and CMS calculations of the PACE benefit.

Direct Subsidy

- Calculate final risk adjustment factors.
- Determine month-by-month LTI status.
- Apply risk adjustment factors in the payment system.
- Determine beneficiary-level payment change.
- Determine aggregate plan payment change.

Low Income Cost-Sharing

- Compare prospective LICS amounts from MARx to LICS as calculated in DBC based on PDE data.
 - LICS is calculated and stored in the DBC.
 - LICS reconciliation is performed at the plan level based on the sum of all beneficiary LICS amounts for that plan.

Reinsurance Subsidy

- Sum all calculated GDCA for the plan.
- Calculate the reinsurance portion of DIR and subtract from GDCA.
- Multiply by 0.8 to determine the reinsurance subsidy.
- Subtract the prospective reinsurance amounts paid in MARx from the actual reinsurance subsidy to determine the reinsurance reconciliation amount.

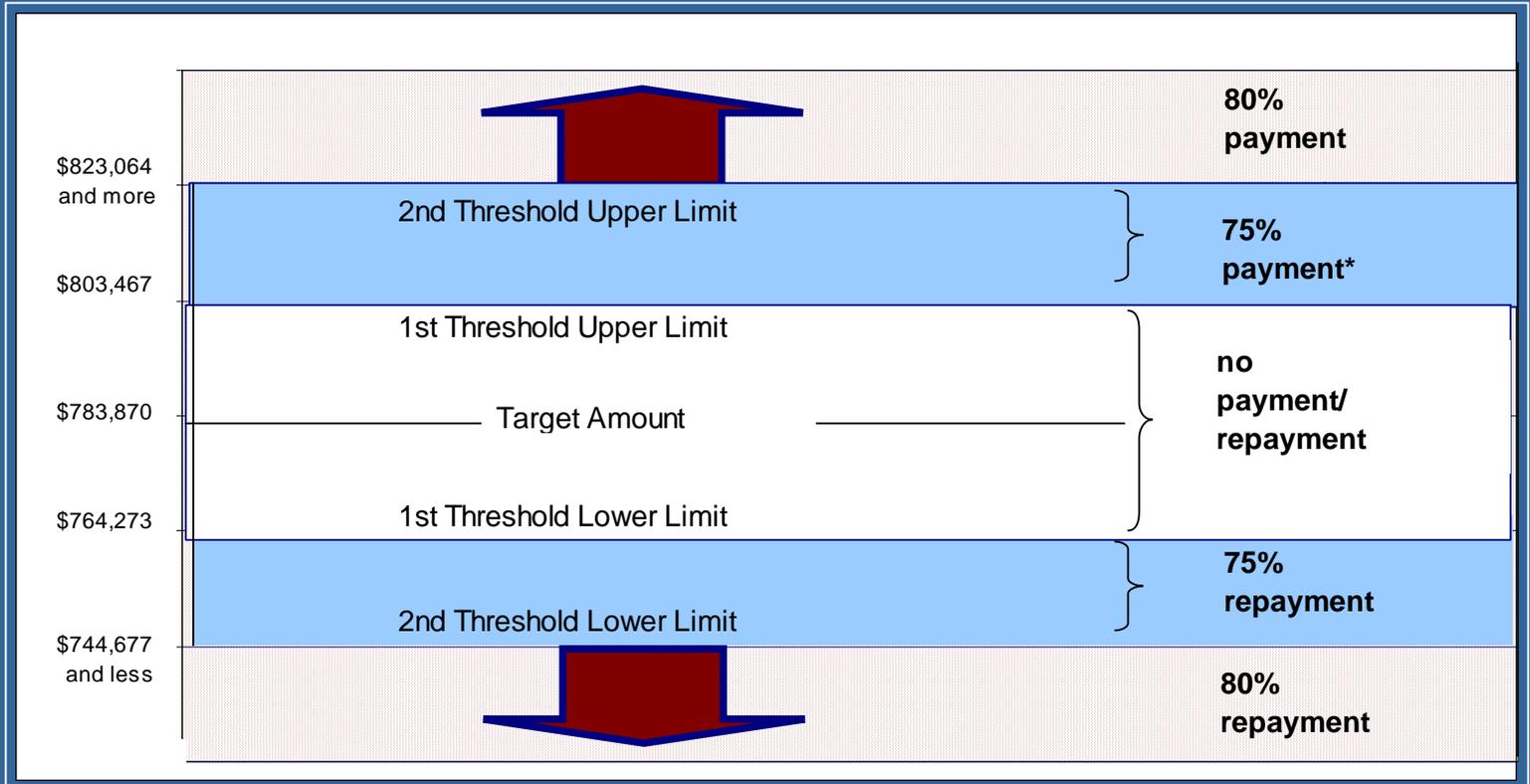
Risk Sharing

- Calculate target amount.
- Calculate risk corridor thresholds.
- Determine adjusted allowable risk corridor costs.
 - Adjust CPP for induced utilization if EA plan.
 - Subtract reinsurance subsidy and covered Part D DIR.
- Compare costs to thresholds and determine risk sharing amount.

Risk Corridors 2006

2005

Regional Training

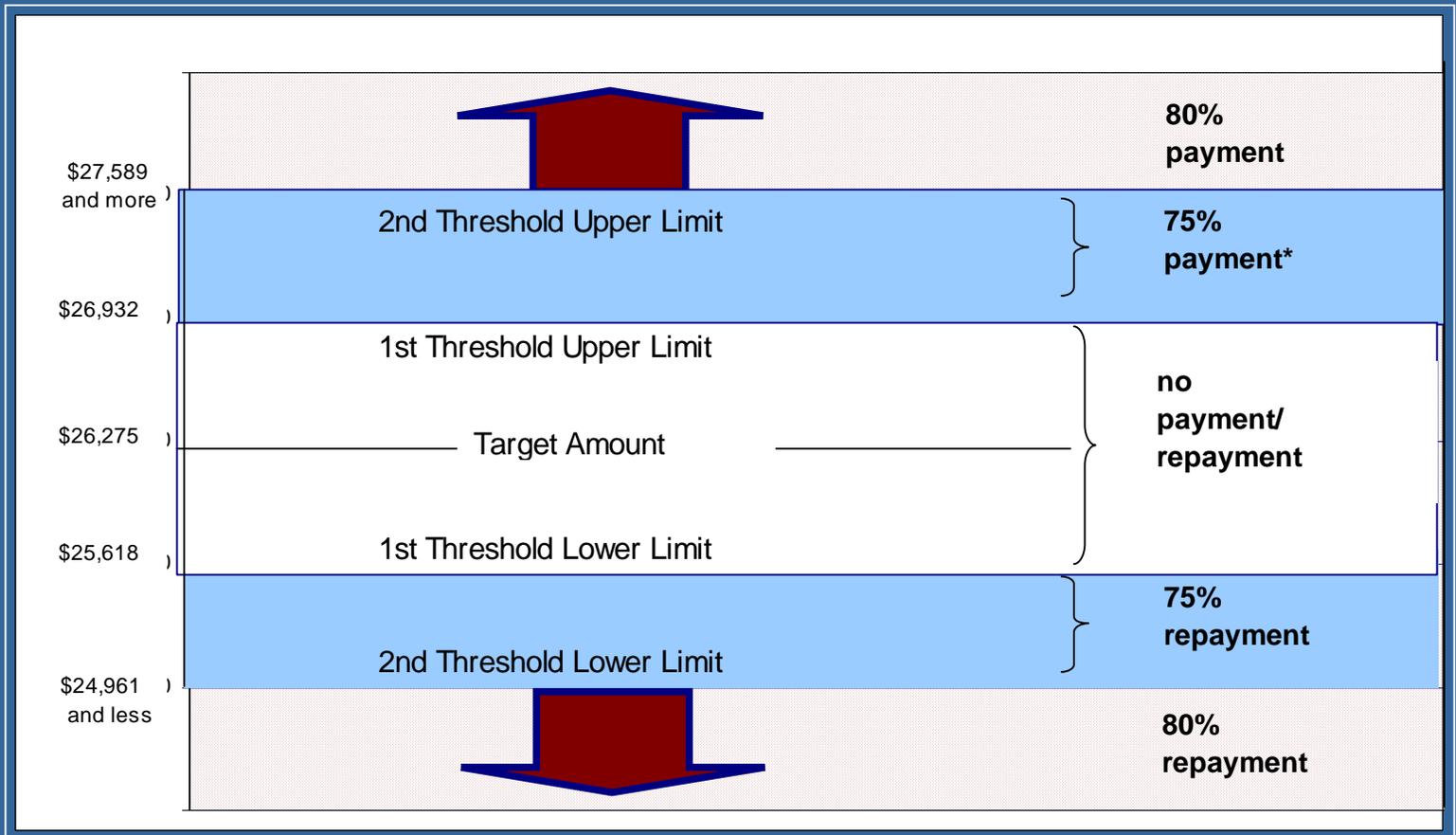


***75% rate will change to 90% if certain circumstances are met**

Risk Corridors 2006 (continued)

2005

Regional Training



***75% rate will change to 90% if certain circumstances are met**

Summary

2005

Regional
Training

- Understand the systems and processes used in PACE payment reconciliation.
- Understand the relationship of reported data to PACE payment.
- Determine how the organization can monitor reports to ensure appropriate reconciliation.

Evaluation

2005

Regional
Training

Please take a moment to complete the evaluation form for the Reconciliation Module.



THANK YOU!