CENTERS for MEDICARE & MEDICAID SERVICES

Prescription Drug Event Participant Guide

2011 Regional IT Technical Assistance

A Reddix & Associates

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF FIGURES

INTRODUCTION

Purpose (Slide 2)

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 & Reporting the Benefit Phases**
   Explains the process and requirements related to administering the TrOOP component of the Part D benefit.
6. **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.
7. **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.
8. **Edits**
   Interprets the edit logic for the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS).
9. **Reports**
   Provides an understanding of the way management reports can ensure both quality and quantity of data stored in the system.
10. **Coverage Gap Discount Program (CGDP) Invoice & Payment Process**
    Explains the invoice and payment process and reporting and reconciliation of the CGDP.
11. **Reconciliation**
    Explains the systems and steps for calculating components used in the reconciliation process.

Participant Guide (Slide 5)

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 6)

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:

- Medicare Advantage (MA) Plans
- Medicare Advantage–Prescription Drug (MA-PD) Plans
- Standalone PDPs
- Third Party Submitters submitting on behalf of a Plan
- Industry Association Representatives

Learning Objectives (Slides 9-11)

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.
- Identify the fields on the PDE associated with LICS.
- Interpret the layout rules for the EA benefit.
- 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.
- Discuss the Coverage Gap Discount Program (CGDP) and how to report the gap discount.
- Explain the changes to the program resulting from the Affordable Care Act.
- Identify the systems and steps for calculating components used in the reconciliation process.

Roles and Contact Information (Slide 12)

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.	Sean Creighton sean.creighton@cms.hhs.gov Kim Spurgeon Kim.spurgeon@cms.hhs.gov Sandra Anderson sandra.anderson@cms.hhs.gov Amanda Ryan amanda.ryan@cms.hhs.gov Tara Waters tara.waters@cms.hhs.gov Angela Stanley angela.stanley@cms.hhs.gov Donna Kellett donna.kellett@cms.hhs.gov
MMA Helpdesk ViPS	Customer Support for Medicare Modernization technical helpdesk (CSMM). Provides technical assistance to plans using Gentran for connectivity.	www.cms.gov/mapdhelpdesk/ mapdhelp@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
A. Reddix & Associates (ARDX)	Technical Assistance Contractor responsible for Prescription Drug Event Data technical assistance initiatives.	www.tarsc.info TARegistrations@tarsc.info

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.
- Understand the provisions of the Affordable Care Act, including the Coverage Gap Discount Program and coverage for generics in the Coverage Gap.

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.

The Affordable Care Act, as enacted in section 3301, and amended by section 1101 of the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) (HCERA), phases in a reduction in beneficiary cost-sharing for non-low income beneficiaries when they purchase drugs in the Coverage Gap Phase of the Medicare Part D benefit through the Coverage Gap Discount Program and coverage for generic drugs in the Coverage Gap.

1.2 Part D 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 4 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 Module 7 entitled, Enhanced Alternative Benefit), but the government only pays for the basic benefit.

The Coverage Gap Discount Program has its own payment process wholly separate from the four Part D payment methodologies, which is described in greater detail in Section 1.8 of this module and in Module 10.

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 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 1.5.2.2). 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)).
>
> Applicable drugs may be covered under Part D only if the manufacturer has a signed agreement with CMS to provide the discount on coverage gap claims for all of its applicable drugs and remains compliant with the terms of that agreement.

1.2.1.1 Applicable and Non-Applicable Drugs

The Affordable Care Act identifies covered drugs as applicable drugs and generic drugs. Applicable drugs are drugs that are eligible for discount under the Coverage Gap Discount program. Generic drugs are non-applicable covered drugs that are eligible for generic cost-sharing in the Coverage Gap. Sections 1.4,1 and 1.4.2 provide more information on applicable drugs and generic drugs.

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.

Applicable and Generic Drugs

The Affordable Care Act defines applicable drugs and, as amended by the Health Care and Education Reconciliation Act of 2010, describes the provisions regarding coverage for generic drugs in the coverage gap.

Applicable drugs are Part D covered drugs that are eligible for discount under the Coverage Gap Discount Program. A generic drug is defined at 42 CFR 423.4 as those drug products for which there is an

approved application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)). Generic drugs that are treated as formulary drugs are eligible for the 7% (for benefit year 2011) standard coverage of generic drugs costs in the gap regardless of tier placement (this includes generic drugs obtained through the exceptions process). Furthermore, CMS clarified in the memo, "Additional Guidance concerning Closing the Coverage Gap in 2011," dated September 10, 2010, that all the categories of Part D drugs that are not applicable drugs will be subject to the "generic" coverage gap cost-sharing in 2011 (e.g. medical supplies associated with the delivery of insulin, Part D compounds).

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 Paid + Dispensing Fee Paid + Amount Attributed to 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).

Beginning in 2010, plans that use a PBM to negotiate prices and/or provide administrative services on its behalf must use the price paid to the pharmacy or the pass-through amount to calculate beneficiary cost sharing and to report gross covered drug cost on the PDE records. 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.

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 8-11)

Figures 1A, 1B, 1C, and 1D illustrate the phases of the Defined Standard benefit plan for 2011 and 2012 for applicable beneficiaries and coverage for generic drugs and for applicable beneficiaries and applicable drugs.

Figure 1A - Defined Standard Benefit 2011
Applicable Beneficiaries and Coverage for Generic Drugs

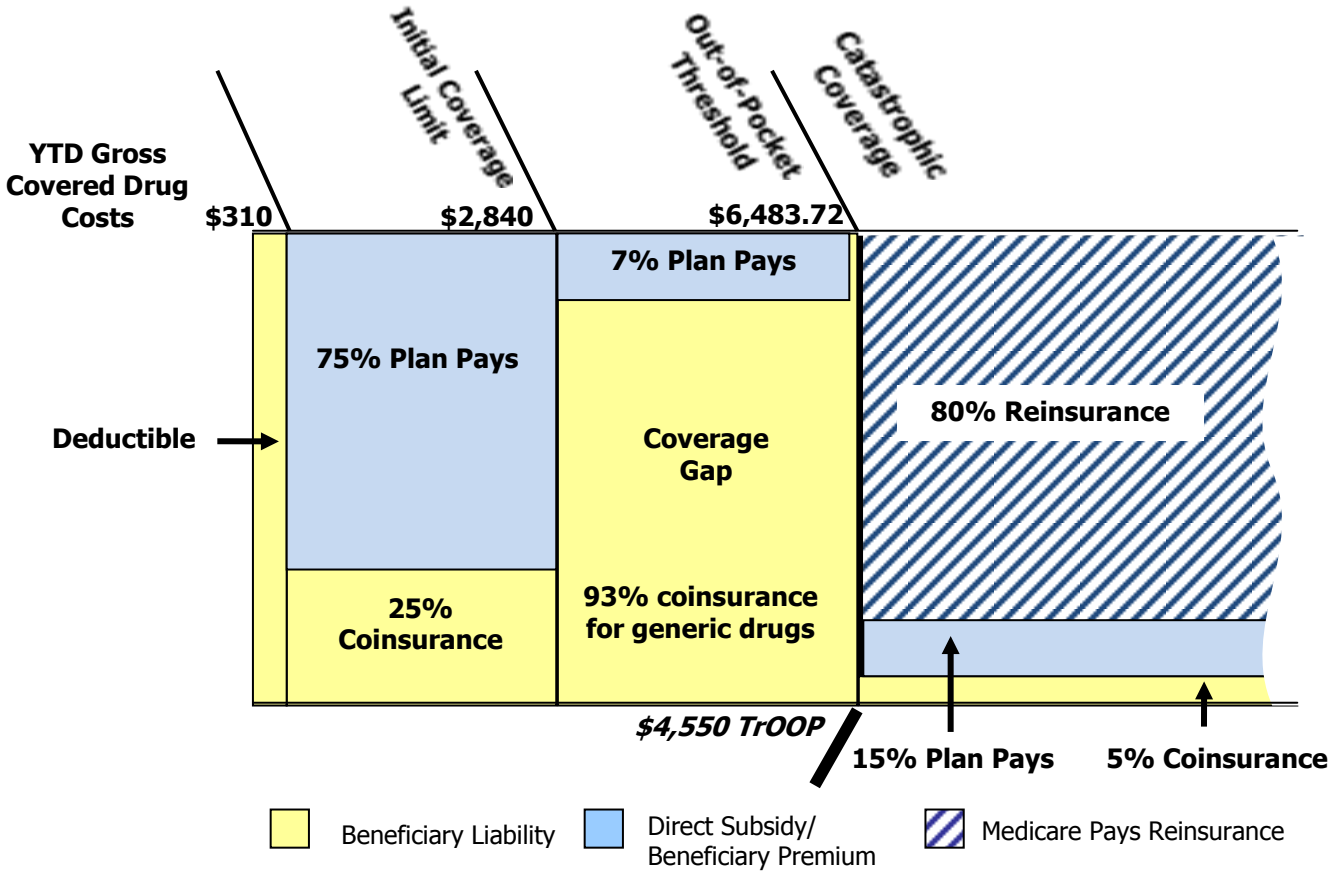


Figure 1B - Defined Standard Benefit 2011
Applicable Beneficiaries and Applicable Drugs

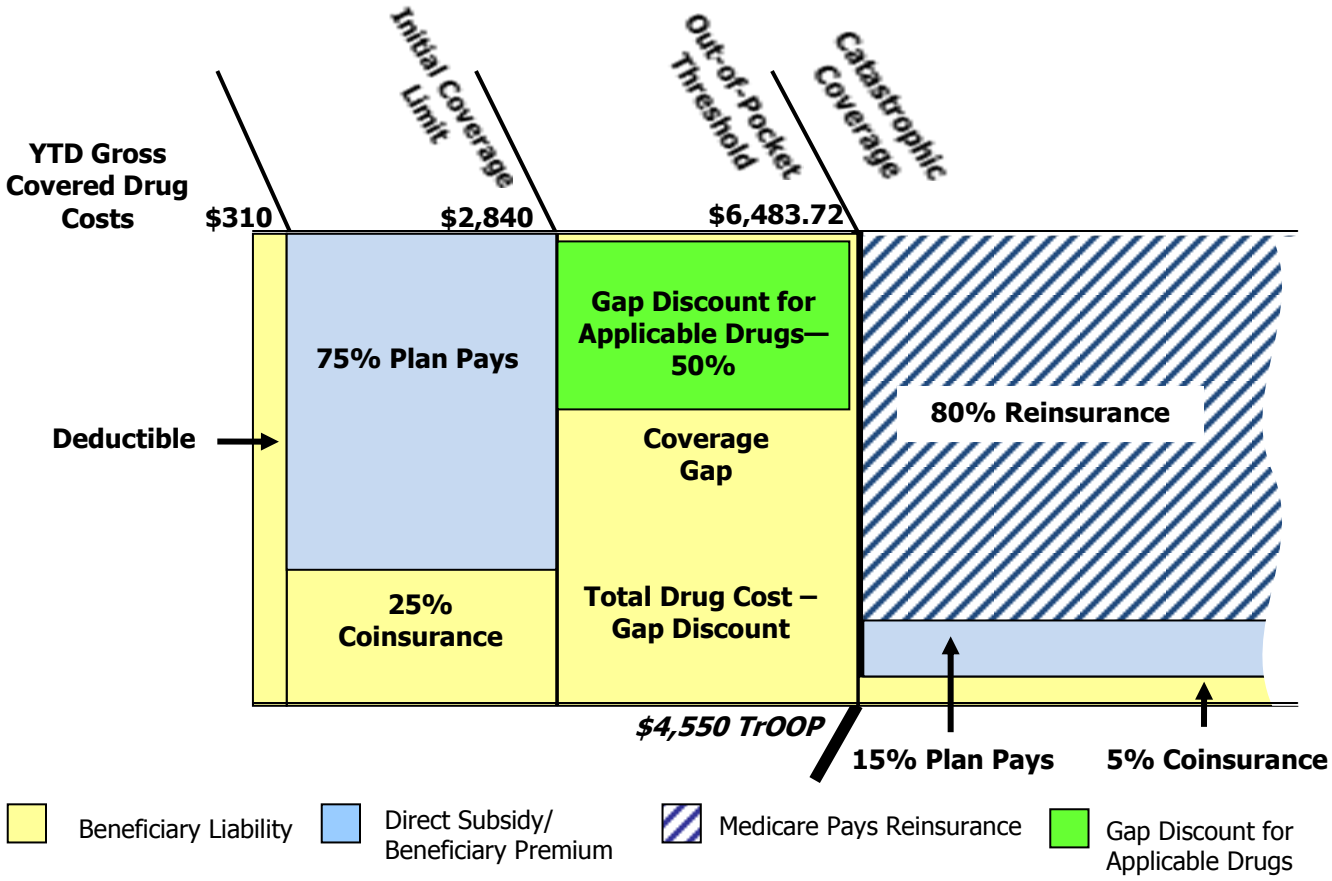


Figure 1C - Defined Standard Benefit 2012
Applicable Beneficiaries and Coverage for Generic Drugs

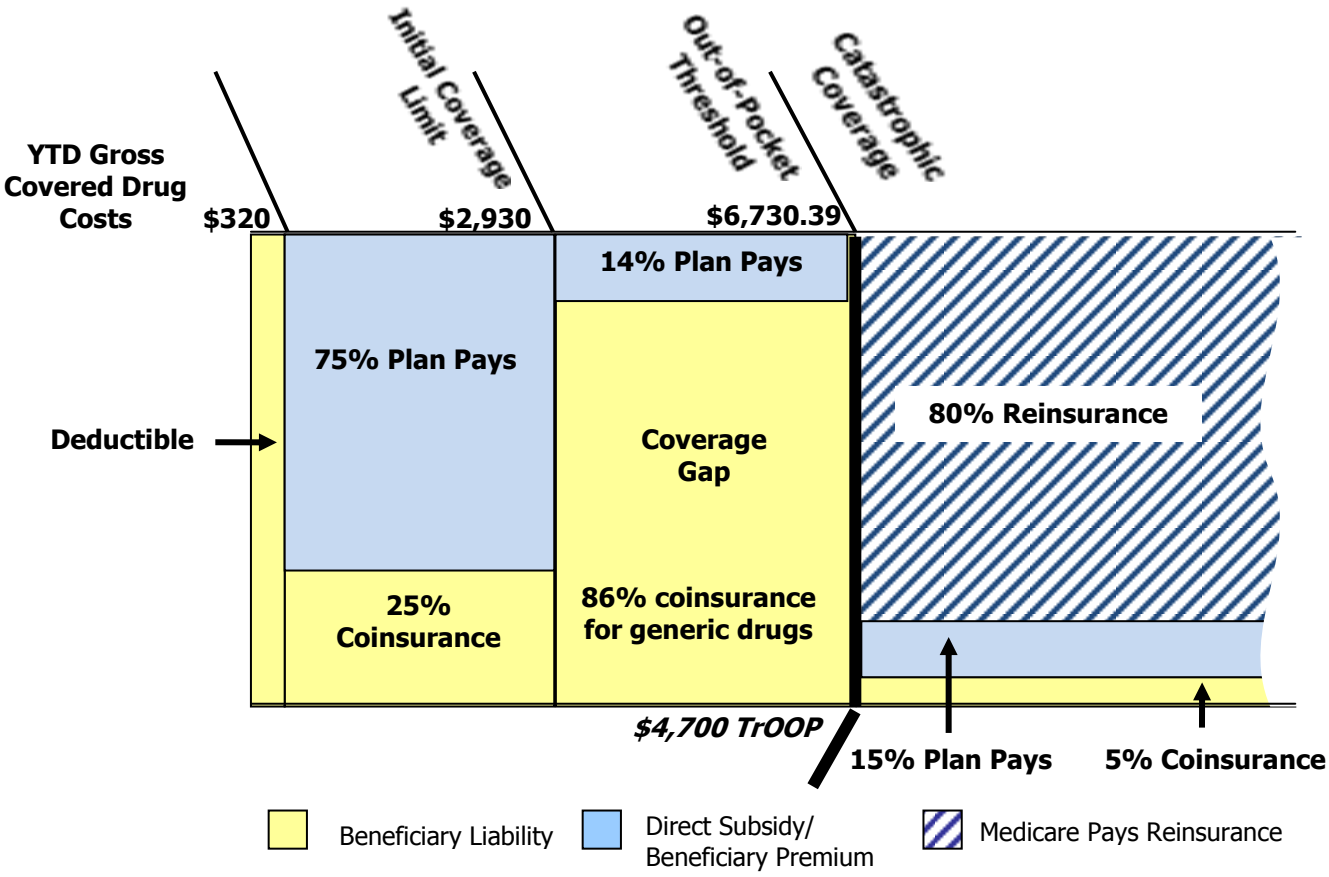
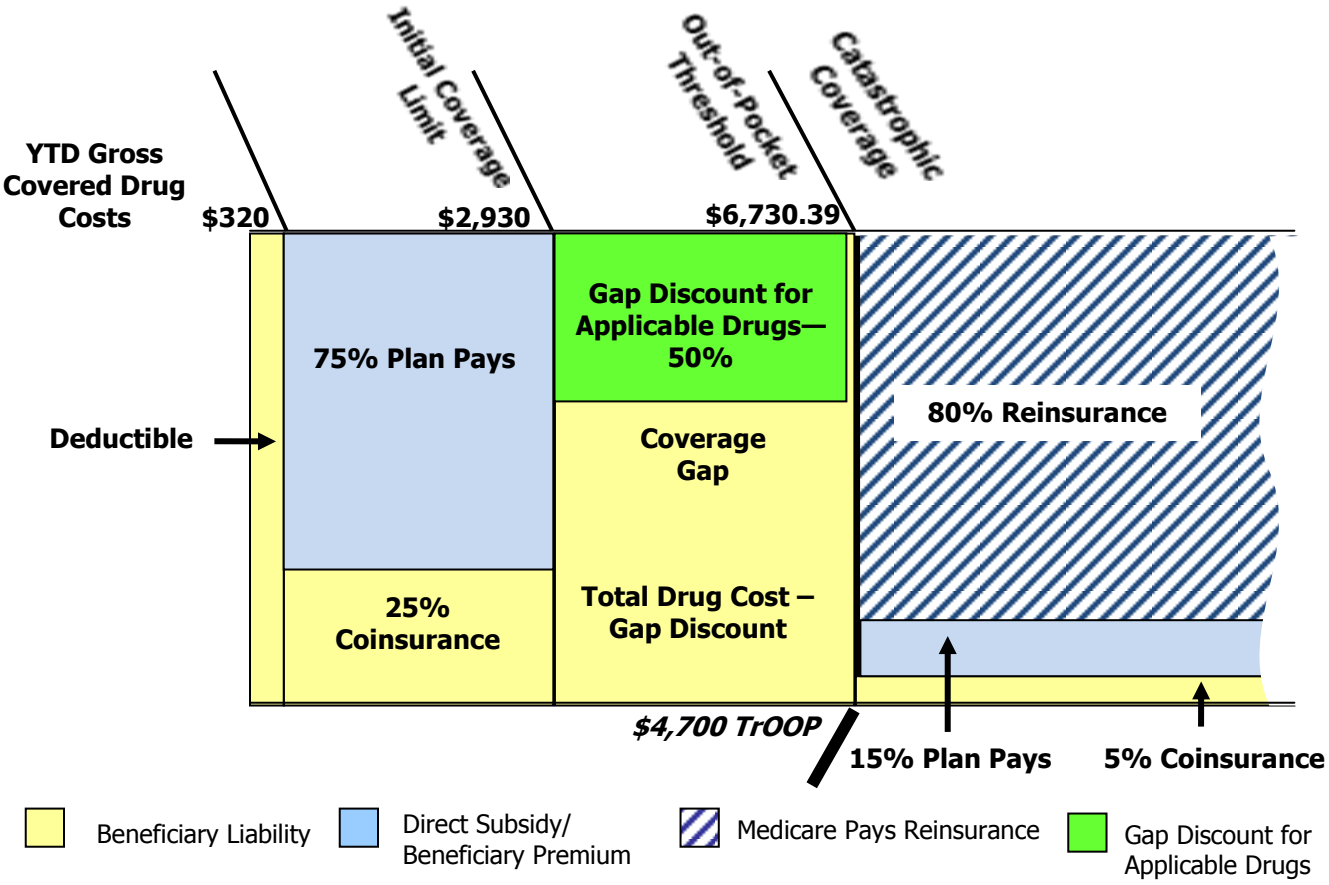


Figure 1D - Defined Standard Benefit 2012
Applicable Beneficiaries and Applicable Drugs



The Defined Standard benefit (Figures 1A, 1B, 1C, and 1D) has four benefit phases: the Deductible Phase, the Initial Coverage Phase, 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 Phase, 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. Table 1A provides benefit parameters associated with the Defined Standard benefit in 2011. All examples (except Module 9 on Reports and Module 11 on Reconciliation) included in the training materials reflect the 2012 parameters in Table 1B.

Note: All examples in this Prescription Drug Event Data Training Participant Guide (except Module 9 on Reports and Module 11 on Reconciliation) reflect the 2012 Defined Standard benefit parameters listed in Table 1B.

- TrOOP is only used to determine the threshold for Catastrophic Coverage. The Deductible, Initial Coverage Phase 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 Phase or the Coverage Gap. YTD accumulated TrOOP costs greater than the OOP Threshold determine if the beneficiary is in Catastrophic Coverage.

TABLE 1A - THE DEFINED STANDARD BENEFIT 2011
EXCLUDING LOW INCOME ELIGIBLE BENEFICIARIES

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	YTD TrOOP Costs		
Deductible	≤ $310	N/A*	100% coinsurance (= $310)	0%
Initial Coverage Phase	> $310 and ≤ $2,840	N/A*	25% coinsurance (= $632.50)	75% (= $1,897.50)
Coverage Gap	>$2,840 and ≤ $6,483.72	≤ $4,550	93% coinsurance for generic drugs; Total Drug Cost – Gap Discount for brand drugs**	7% for generic drugs 0% for applicable drugs
Catastrophic Coverage Phase	> $6,483.72	> $4,550 (OOP threshold)	Greater of 5% coinsurance or $2.50/$6.30 (generic/brand) co-payment	Lesser of 95%*** or (Gross Covered Drug Cost – $2.50/$6.30)

TABLE 1B - THE DEFINED STANDARD BENEFIT 2012
EXCLUDING LOW INCOME ELIGIBLE BENEFICIARIES

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	YTD TrOOP Costs		
Deductible	≥ $320	N/A*	100% coinsurance (= $320)	0%
Initial Coverage Phase	> $320 and ≤ $2,930	N/A*	25% coinsurance (= $652.50)	75% (= $1,957.50)
Coverage Gap	>$2,930 ≤$6,730.39	≤ $4,700	86% coinsurance for generic drugs; Total Drug Cost – Gap Discount for brand drugs**	14% for generic drugs 0% for applicable drugs
Catastrophic Coverage Phase	> $6,730.39	> $4,700 (OOP threshold)	Greater 5% coinsurance or $2.60/$6.50 (generic/brand) co-payment	Lesser of 95%*** or (Gross Covered Drug Cost - $2.60/$6.50)

Notes to Tables 1A and 1B:
* It is not necessary to achieve a minimum TrOOP balance for transitioning from the Deductible to the Initial Coverage Phase or from the Initial Coverage Phase 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.
** Assumes the claim falls squarely in the gap and there are no supplemental benefits.
***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 2012, the Part D Defined Standard benefit begins with a $320 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 Phase – The next $2,610 of covered drug costs (above $320 and up to and including $2,930) falls in the Initial Coverage Phase 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 $3,800.39 of covered drug costs (above the Initial Coverage Limit of $2,930 and up to and including the OOP threshold) falls in the Coverage Gap in which the beneficiary pays 100 percent coinsurance.

	Applicable Drugs*	Generics (in 2012)
Beneficiary liability	50%	86%
Manufacturer	50%*	0%
Plan liability	0%	14%

*Of the negotiated price of the drug.

The Coverage Gap is unique to the Part D benefit. The Affordable Care Act, as enacted in section 3301, and amended by section 1101 of the HCERA, phases in a reduction in beneficiary cost-sharing for drugs in the Coverage Gap Phase through the Coverage Gap Discount Program and generic cost-sharing in the Coverage Gap.

The Coverage Gap Discount Program, which provides manufacturer discounts, is subject to its own payment process outside of the four Part D payment methodologies.

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 should almost always correspond to $6,730.39 in YTD gross covered drug costs for 2012. (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 $2.60 for generic drugs and $6.50 for brand drugs in 2012.

Beneficiary liability	Greater of 5% or $2.60/$6.50 (in 2012)
Plan liability	Approximately 15%
Government liability	80% reinsurance subsidy

1.4 Plan Liability in the Coverage Gap Phase of the Benefit

The Affordable Care Act, as enacted in section 3301, and amended by section 1101 of the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) (HCERA), phases in a reduction in beneficiary cost-sharing for drugs in the Coverage Gap Phase of the Medicare Part D benefit through the Coverage Gap Discount Program and generic cost-sharing in the Coverage Gap.

In 2011, Part D sponsors began to cover a portion of the cost-sharing for generic Part D drugs in the Coverage Gap. Beginning in 2013, the benefit structure for coverage of applicable drugs in the Coverage Gap will also change. Part D sponsors will begin to cover a portion of applicable Part D drugs in the Coverage Gap. These changes affect all Part D plan benefit types.

1.4.1 Applicable Drugs

Applicable drugs are defined at section 1860D-14A(g)((2) of the statute and are generally brand covered Part D drugs that are either approved under a new drug application (NDA) under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (BLA).

All applicable drugs must be covered under a manufacturer discount agreement with CMS for coverage to be available under Part D. A manufacturer must specify all of its labeler codes in an agreement so that all of the manufacturer's applicable drugs will be covered under the agreement. The labeler code is the first five digits of a drug product's 11 digit national drug code (NDC) and identifies the company that assigned the NDC to the drug product.

1.4.2 Generic Drugs

Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug (i.e., generic drugs). The cost sharing reductions, in conjunction with the Coverage Gap Discount Program, will serve to effectively close the Medicare Part D benefit coverage gap for non-LIS beneficiaries by CY 2020.

The categories of Part D drugs that are not applicable drugs will be subject to the "generic" coverage gap cost-sharing in 2011 (e.g. medical supplies associated with the delivery of insulin, Part D compounds). While other drugs, in addition to medical supplies associated with the delivery of insulin and Part D compounds, that meet the definition of Part D drugs also meet the requirements for "generic" coverage gap cost-sharing, CMS does not believe that many of the older prescription drugs currently on the market meet the definition of a Part D drug and, therefore expects Part D sponsors to carefully make determinations to cover any such drugs.

1.4.2.1 Plan Liability for Generic Drugs in Coverage Gap

Starting in 2011, the benefit structure for coverage of generic drugs in the coverage gap was revised to include plan cost sharing for a portion of generic Part D drugs in the Coverage Gap. This change affects all Part D plan benefit types. In 2012, Part D sponsors will cover 14% of the the Gross Covered Drug Cost that falls within the Coverage Gap Phase for generics.

Table 1C provides the beneficiary cost-sharing for generics in the coverage gap and the resultant plan liability.

TABLE 1C – BENEFICIARY AND PLAN COST-SHARING FOR GENERIC PART D COVERED DRUGS

BENEFIT YEAR	BENEFICIARY COST-SHARING	PLAN LIABILITY (CPP)
2011	93%	7%
2012	86%	14%
2013	79%	21%
2014	72%	28%
2015	65%	35%
2016	58%	42%
2017	51%	49%
2018	44%	56%
2019	37%	63%
2020	25%	75%

1.4.3 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, $6,730.39 of YTD covered drug cost coincides with the point at which the beneficiary reaches the OOP threshold by accumulating $4,700 in TrOOP (2012 values). Part D allows three other plan types, which have variable cost-sharing. Modules 4 and 7 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 2012 YTD drug cost coinciding with the OOP threshold is higher or lower than $6,730.39 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 $6,730.39 in the Defined Standard benefit). The 2012 YTD drug cost coinciding with the OOP threshold is higher than $4,700.

1.4.4 Payment Methodologies in Relation to the Defined Standard Benefit (Slides 12-15)

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

- In 2012, the direct subsidy applies in the Initial Coverage Phase, in the Coverage Gap for non low-income beneficiaries, 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 Phase, 14% of costs for generics in the Coverage Gap for 2012 with that percentage increasing annually by 7% until 2020 when it reaches 75% where it will remain in subsequent years, 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 Phase, the Coverage Gap, 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 (the direct subsidy and basic beneficiary premium) with aggregate allowed plan paid drug costs.

1.5 General Summary of Part D Payment Reconciliation (Slide 16)

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.

The Coverage Gap Discount Program has its own payment and reconciliation process wholly separate from the four Part D payment methodologies, which is described in greater detail in Section 1.8 of this module and in Module 10.

1.5.1 Payment Timetable and Part D Payment Reconciliation Status (Slide 17)

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.

1.5.2 Data Collection for Part D

1.5.2.1 Prescription Drug Event (PDE) (Slide 18)

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.

1.5.2.2 Direct and Indirect Remuneration (DIR) (Slides 19-20)

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 1.2.2.1, 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 (The final Medicare DIR Reporting Requirements for Payment Reconciliation are released each year through HPMS.).

1.6. Part D Payment Reconciliation

1.6.1 Direct Subsidy (Slide 21)

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.

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.

1.6.2 Low Income Cost-Sharing Subsidy (Slide 22)

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.

1.6.2.1 Timing of Payment

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

1.6.2.2 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.

1.6.2.3 LICS Calculation/Reconciliation

1.6.2.3.1 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 1E demonstrates the LICS calculation.

Figure 1E – 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

1.6.2.3.2 LICS Reconciliation Calculation

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

Figure 1F – 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.

1.6.3 Reinsurance Subsidy (Slide 23)

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 2012, the beneficiary enters the Catastrophic Coverage Phase of the benefit after accumulating $4,700 in TrOOP. The $4,700 limit applies to 2012 and is subject to annual increases.

1.6.3.1 Plans with Special Reinsurance Provisions

- Plan types exempted from Reinsurance Subsidy reconciliation are:
  - Private Fee-for-Service (PFFS) Plans– PFFS plans will receive reinsurance payments according to separately legislated parameters.
  - Employer Group Waiver Plans (EGWPs) – See Section 1.7.

📖 45 Day Advance Notice of Methodological Change and Final Payment Notice for CY2012 at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2012.pdf

1.6.3.2 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 1G explains the prospective reinsurance subsidy.

Figure 1G – 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

1.6.3.3 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.

1.6.3.4 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.

1.6.3.4.1 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 1H illustrates the calculation of the DIR Ratio.

Figure 1H – 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

1.6.3.4.1.1 Calculate Reinsurance Portion of DIR

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

Figure 1I – 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)

1.6.3.4.2 Calculate Allowable Reinsurance Costs

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

Figure 1J – 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

1.6.3.4.3 Calculate Plan-Level Reinsurance Subsidy

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

Figure 1K – Plan-Level Reinsurance Subsidy Calculation

REINS_SUBS = ALLOW_REINS * 0.8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

1.6.3.4.4 Reconcile Reinsurance Subsidy

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

Figure 1L – 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.

1.6.4 Risk Sharing (Slide 24)

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.

1.6.4.1 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

1.6.4.1.1 Calculate the Plan's Target Amount (Slides 25-26)

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 1M explains how the administrative cost ratio is calculated.

Figure 1M – 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 1N illustrates the calculation.

Figure 1N – 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.

1.6.4.1.2 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.

In 2010 through 2012, the threshold risk percentages (risk corridors) are:

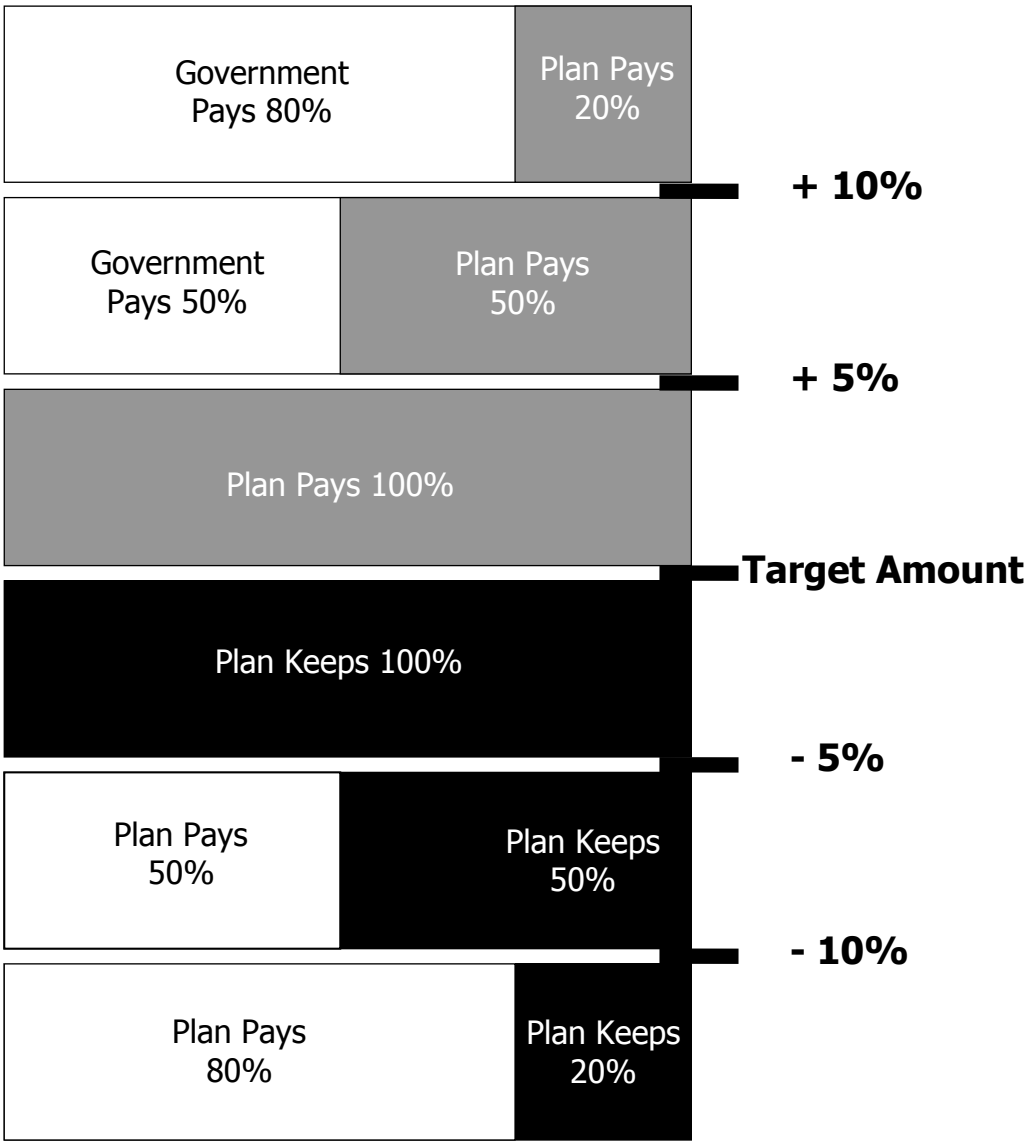
- 2nd threshold upper limit (1.0 + 0.10) 110%
- 1st threshold upper limit (1.0 + 0.5) 105%
- 1st threshold lower limit (1.0 – 0.5) 95%
- 2nd threshold lower limit (1.0 – 0.10) 90%

The thresholds used in the 2010 risk sharing calculations for a sample plan with a target amount of $1,000,000 are:

Second threshold upper limit	= $1,000,000 *	1.10	=	$1,100,000
First threshold upper limit	= $1,000,000 *	1.05	=	$1,050,000
First threshold lower limit	= $1,000,000 *	0.95	=	$ 950,000
Second threshold lower limit	= $1,000,000 *	0.90	=	$ 900,000

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

Figure 1O – Risk Sharing Thresholds and Percentages, 2010 - 2012



1.6.4.1.3 Calculate Adjusted Allowable Risk Corridor Costs (AARCC) (Slide 27)

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

1.6.4.1.4 Determine Where Costs Fall With Respect to the Thresholds and Calculate Payment Adjustment (Slide 28)

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 10.0 percent of the target amount
- AARCC > 5 percent of the target amount and < 10.0 percent of the target amount
- AARCC falls within +/- 5 percent of the target amount (i.e., the plan estimate is considered sufficiently accurate)
- AARCC < 95 percent of the target amount and ≥ 90 percent of the target amount
- AARCC < 90 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 *	1.10	=	$1,100,000
First threshold upper limit	= $1,000,000 *	1.05	=	$1,050,000
First threshold lower limit	= $1,000,000 *	0.95	=	$ 950,000
Second threshold lower limit	= $1,000,000 *	0.90	=	$ 900,000

Example: 7

AARCC greater than 10.0 percent of the target amount

AARCC = $1,123,000

Payment adjustment = [0.50*($1,100,000-$1,050,000) + 0.80*($1,123,000-$1,100,000)] = $43,400 (government pays plan)

Example: 8

AARCC greater than 5 percent of the target amount and ≤ 10.0% of the target amount

AARCC = $1,085,000

Payment adjustment = 0.50*($1,085,000-$1,050,000) = $17,500 (government pays plan)

Example: 9

AARCC falls within +/- 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 95 percent of the target amount and ≥ 90% of the target amount

AARCC = $923,000

Payment adjustment = 0.50*($950,000-$923,000) = $13,500 (plan pays back to government)

Example: 11

AARCC less than 90 percent of the target amount

AARCC = $865,000

Payment adjustment = [0.50*($950,000-$900,000) + 0.80*($900,000-$865,000)] = $53,000 (plan pays back to government)

1.7 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 7). 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.

1.8 Overview of the Coverage Gap Discount Program (Slides 31-33)

The Affordable Care Act, as amended by the HCERA, establishes the Discount Program by adding sections 1860D-43 and 1860D-14A of the Act. Effective January 1, 2011, the Discount Program will make manufacturer discounts available to applicable Medicare beneficiaries receiving applicable drugs while in the Coverage Gap. In general, the discount on each applicable drug is 50 percent of an amount equal to the negotiated price.

1.8.1 Applicable Drugs

Applicable drugs are defined at section 1860D-14A(g)((2) of the statute and are brand covered Part D drugs that are either approved under a new drug application (NDA) under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (BLA).

1.8.2 Manufacturer Agreements

All applicable drugs must be covered under a manufacturer discount agreement with CMS for coverage to be available under Part D. A manufacturer must specify all of its labeler codes in an agreement so that all of the manufacturer's applicable drugs will be covered under the agreement. The labeler code is the first five digits of a drug product's 11 digit national drug code (NDC) and identifies the company that assigned the NDC to the drug product.

CMS maintains an updated list of the labeler codes that are covered by the manufacturer discount agreements and posts the list on the CMS website. CMS updates the list monthly after the January 30th deadline for manufacturers to enter into agreements, terminate agreements for the following plan year or reassign labeler codes.

Part D sponsors must provide prospective notice to affected Part D enrollees (as defined in 42 CFR 423.100) if a covered Part D drug will no longer be covered for failure of a manufacturer to sign a manufacturer discount agreement. In addition, because applicable drugs that are not covered under a manufacturer agreement cannot be covered under Part D, Part D sponsors will not be able to cover any such products under exceptions, emergency first fill, or transition policies, unless CMS has authorized coverage.

Section 1860D-43(c) provides CMS with the authority to allow coverage of Part D drugs that are not covered by manufacturer discount agreements if CMS determines that:
The availability of the drug is essential to the health of Part D enrollees; or
There are extenuating circumstances for 2011.

CMS will inform Part D sponsors if any Part D drug not covered by a manufacturer agreement has been determined to be essential for the health of Part D enrollees and exempt from the manufacturer agreement requirement.

1.8.3 Applicable Beneficiary

An applicable beneficiary is defined as an individual who, on the date of dispensing a covered Part D drug, is:

- Enrolled in a prescription drug plan or an MA-PD plan;
- Not enrolled in a qualified retiree prescription drug plan;
- Not entitled to an income-related subsidy under section 1860D-14(a); and
- Who has reached or exceeded the initial coverage limit under section 1860D-2(b)(3) during the year; and has not incurred costs for covered Part D drug in the year equal to the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B). This does not mean that a beneficiary who has moved through the Coverage Gap is not eligible for cost while in the Coverage Gap.

Enrollees in Employer group health and waiver plans (EGHPs & EGWPs) are eligible for participation in the Discount Program if they otherwise satisfy the definition of an applicable beneficiary.

1.8.4 Part D Sponsors Provide the Discount at Point-of-Sale

Part D sponsors pay the Gap Discount at point-of-sale on behalf of manufacturers so the beneficiary can immediately receive the out-of-pocket cost reduction.

Part D sponsors shall provide the applicable discount on applicable drugs to applicable beneficiaries at point-of-sale, and shall reimburse the pharmacy for the applicable discount within the applicable number of calendar days, which is consistent with current Part D prompt payment requirements under 42 CFR 423.520.

Section 1860D-14A(c)(1)(A)(ii) requires the gap discounts to be provided at POS. Discounts can be provided at POS only if the entity adjudicating the electronic pharmacy claim has the information necessary to determine at that point in time:

- the drug is an applicable drug;
- the beneficiary is eligible for the discount;
- the claim is wholly or partially in the Coverage Gap; and
- the amount of the discount, taking into consideration plan supplemental benefits that pay first.

CMS has determined that the only entity capable of providing the discount at POS is the Part D sponsor because no other entity will have all four pieces of information.

1.8.5 Reported Gap Discount Amount on the PDE

On each PDE, the plan reports the actual amount of gap discount paid for the dispensing event in the Reported Gap Discount field.

1.8.6 Coverage Gap Discount Program Prospective Payment

CMS provides a monthly prospective Coverage Gap Discount payment to Part D sponsors for the manufacturer discounts made available to their enrollees under the Discount Program. The monthly prospective payment is based on the Contract of Record for non-low income subsidy eligible (non-LIS) beneficiaries who are not enrolled in an Employer Group Waiver Plan (EGWP) or a Program of the All Inclusive Care for the Elderly (PACE) organization.

1.8.7 Timing of Payment

Part D sponsors will receive the prospective discount program payments on the first of each month with their other Part D prospective payments. The discount program payments will be reflected as a separate line item on each Part D sponsor's Monthly Membership Detail Reports and included in the Part D payments displayed on the Monthly Membership Summary Reports.

For any benefit year, the prospective payments begin with the January monthly payment for the benefit year and end with the December monthly payment. Adjustments to a benefit year's prospective payments continue to January of the following year. For benefit year 2012, the first prospective payment will be in the January 2012 monthly payment and the last payment containing adjustments to previously paid 2012 prospective payments will be in the January 2013 monthly payment.

1.8.8 Calculation of the Coverage Gap Discount Program Prospective Payment

For 2011, the prospective discount program payments will be calculated based on the projections in each Part D plan's bid and their current enrollment. CMS will estimate the per member per month cost of the manufacturer discounts for each plan based on the Coverage Gap drug costs projected in worksheet 3 of their approved 2011 Part D bids. Specifically, CMS will subtract the projected drug costs for generic drugs provided to applicable beneficiaries in the Coverage Gap from the total projected drug costs in the Coverage Gap and multiply the difference by 50%. Additional adjustments may be made to account for dispensing fees and each plan's LIS enrollment. This plan specific estimate will be made available to Part D sponsors on HPMS on the Part C & D Bid and Premium Information page.

Each month, CMS will determine the prospective discount program payment by multiplying the plan specific CGDP discount estimate by the number of beneficiaries enrolled in the plan who are not eligible for the low-income subsidy.

"Advance Notice of Methodological Changes for Calendar Year (CY) 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter" released in HPMS on February 18, 2011.

HPMS Memo September 24, 2010. Subject: Prescription Drug Event (PDE) Edit Guidance Effective January 1, 2011

1.8.9 Manufacturer/Part D Sponsor Quarterly Invoice Process

CMS aggregates Gap Discount amounts reported on PDE data submitted during the quarter and validated by CMS and sends this information to Palmetto GBA, the Third Party Administrator (TPA) for the CGDP. The TPA is responsible for sending quarterly invoice reports to manufacturers and Part D sponsors simultaneously. Each benefit year will have six quarterly invoices that will be included in the annual CGDP reconciliation.

For 2012, the first quarterly invoice will include PDEs submitted and validated through March 31, 2012 and the last quarterly invoice included in the 2012 benefit year CGDP reconciliation will include PDEs submitted through the reconciliation cutoff date. CMS will continue to accept PDEs with gap discount amounts for 37 months following the end of the benefit year. After reconciliation, Part D sponsors will receive invoiced amounts directly from manufacturers during quarterly invoice processing.

Manufacturers are required to pay the invoiced amount in full, subject to the terms in the Manufacturer Agreement, to Part D sponsors within 38 days of report distribution.

1.8.10 CMS Offset Process

On a quarterly basis, following the invoicing cycle, CMS offsets monthly prospective CGDP payments for discount amounts invoiced to manufacturers. The offset amount will appear as a negative adjustment to the next monthly prospective payment processed through APPS. When the APPS offset exceeds the prospective CGDP payments for that month, CMS will apply the offset to the Part D sponsor's total payment.

EGWPs will receive invoiced discount amounts from manufacturers. However, they will not receive prospective CGDP payments because they do not submit Part D bids. As a result, CMS will not apply offsets for invoiced discount amounts to the payments received by EGWPs.

1.8.11 Reconciliation of Discount Program Payments (Slides 34-36)

As noted above, for each benefit year, CMS will conduct a cost-based reconciliation for the CGDP. Prospective payments are an estimate and Part D sponsors may experience actual CGDP costs greater than or less than the prospective payments. If the total CGDP prospective payments received are greater than or less than the actual gap discount amounts documented in PDEs, then CMS will reconcile the differences. Please see the examples below.

	Scenario 1 Prospective Payments are Less Than Actual Gap Discount Costs	**Scenario 2** Prospective Payments are Greater Than Actual Gap Discount Costs
CGDP Prospective Payments Received by Plan	$1,000	$1,000
Actual CGDP amounts Plan pays throughout the year	$1,750	$250
Manufacturer reimbursement to plan	$1,750	$250
CMS Offset	$1,750	$250
CMS Owes Plan at CGDP Recon	$750	$0
Plan Owes CMS at CGDP Recon	$0	$750

The schedule for Coverage Gap Discount Reconciliation will be different from the existing Part D payment reconciliation schedule. It will begin after the sixth invoicing and payment processing cycle has been completed for the benefit year.

Similar to Low Income Cost Sharing Subsidy (LICS) reconciliation, Gap Discount reconciliation is cost-based. The adjustment is dollar for dollar and can be positive or negative. However, unlike LICS reconciliation, the CGDP reconciliation will be based on the submitting contract rather than the contract of record. Said another way, reconciliation of the Coverage Gap Discount amounts will be based on accepted and validated PDEs that the plan submitted regardless of whether the beneficiary was enrolled in the Part D sponsor's plan or not. This is similar to how CMS reconciles the Total Actual Plan-to-Plan (P2P) Non-covered Plan Paid Amount (NPP) Submitted by Enhanced Alternative (EA) Plan Amount portion of the Low Income Subsidy Reconciliation. CMS will calculate the CGDP reconciliation amount by taking the total actual CGDP amounts reported on PDEs minus the Prospective CGDP Payments.

This reconciliation process will ensure that Part D sponsors are fully reimbursed for the manufacturer discount amounts made available to their enrollees as reported on accepted PDE records.

After the CGDP reconciliation, CMS will discontinue additional offsets.

MODULE 2 – PDE PROCESS OVERVIEW

Purpose (Slide 2)

The success of Prescription Drug Event (PDE) data submission is dependent on plans understanding the process of collecting and submitting accurate 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 Medicare Advantage (MA), capitated payments, 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 DS 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).

Since EA plans have non-standard benefit structures and some variations in payment methodology, 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 51 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.

- 31 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.

- Information necessary to implement the provisions in the Affordable Care Act including the Coverage Gap Discount Program and generic drugs in the coverage gap.

- Information to improve the ability to evaluate data quality for the Coverage Gap Discount program and for overall payment accuracy.

Plans also identify costs that contribute toward a beneficiary's True Out-of-Pocket (TrOOP) limit, separated into four 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
- Reported Gap Discount amount advanced by the plan at the POS

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 2011 PDE DATA SUBMISSION

CY	DATA SUBMISSION TYPE	SUBMISSION TIMELINE
2011	EDI Agreement and Submitter Application Deadline	October 31, 2010
2011	Certification Complete*	January 31, 2011
2011	First Production File Due**	March 31, 2011 Comply with routine production timeline thereafter
2011	Production Submissions	Ongoing Monthly Submissions March 30, 2011 – June 29, 2012 • Originals within 30 days following Date of Service or Date Claim Received, whichever is greater. • Adjustments and deletions resubmitted within 45 days following date of discovery. • Rejected records resubmitted within 45 days following receipt of rejected status from CMS.
2011	Final Submission Deadline	June 29, 2012 (11:59 p.m. Eastern Time)
2011	Direct and Indirect Remuneration (DIR) Submission Deadline	June 30, 2012

*Only new contracts submitting directly or new third party submitters submitting in CY2011 must complete the testing and certification process.
** Applies to new contract effective at the beginning of the benefit year.

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.

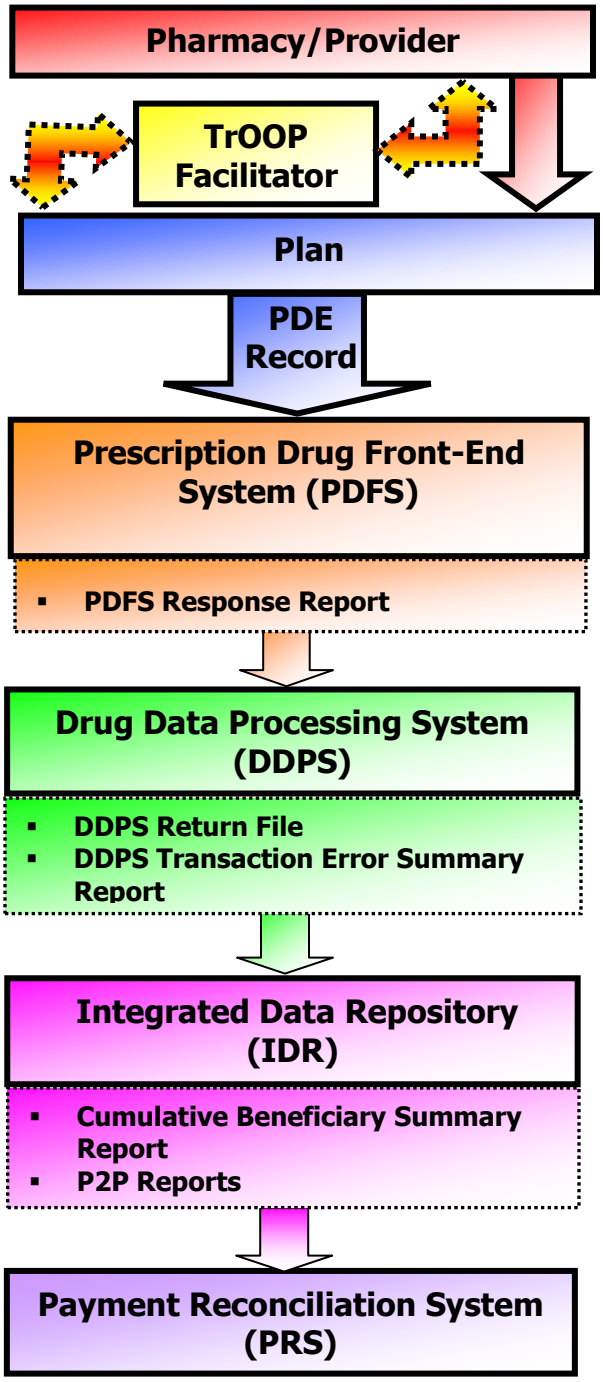
2.3.3 Prescription Drug Event Dataflow (Slide 9)

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.

*Module 10 will discuss the Coverage Gap Discount Dataflow

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.
- The plan must maintain audit trails to PDE source data.
- All PDE data is expected to represent the service components as defined for coverage under a given data field
- 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 and Total Gross Covered Drug Cost (TGCDC) accumulators.
- 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. EST (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 are 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) **MAPD Help**	The MAPD 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 MAPD Helpdesk by calling 1-800-927-8069, emailing mapdhelp@cms.hhs.gov, or viewing the website at http://www.cms.gov/mapdhelpdesk/. The MAPD Helpdesk is available Monday – Friday 6:00 a.m. to 9:00 p.m. EST.

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 (Slides 3-4)

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

- Explain the processes required for data submission.
- Describe the PDE record layout logic.
- Identify the fields and functions in the PDE record format.
- Define standard and non-standard data collection formats.
- Identify the PDE fields added to implement provisions in the Affordable Care Act and to improve CMS' ability to evaluate data quality.
- 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. Several new fields were added to the PDE record to support the provisions in the Affordable Care Act, including the Coverage Gap Discount Program (CGDP) and generic cost sharing in the coverage gap.

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.

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.

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 5)

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. Plans must notify CSSC Operations if they change PDE submitters.

3.1.2 Connectivity (Slide 6)

All submitters that submit PDE data must establish a connection to the Prescription Drug Front-End System (PDFS) through CMSNet provided by Verizon. CMSNet is the secure network linking the PDE data processing entities. Small plans (contracts with enrollment less than 100,000) that submit their own PDE 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. • Same day receipt of front-end response if file is received before 1:00pm EST. • Next day receipt, if file is received after 1:00pm EST. • 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. • Same day receipt of front-end response if file is received before 1:00pm EST. • Next day receipt, if file is received after 1:00pm EST. • 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 7-9)

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

Initial certification is not required every year for existing submitters. On limited occasions where the PDE record format, file format, or submission process undergoes significant changes, such as was the case

implementing the Coverage Gap Discount Program, CMS will require all submitters or plans to re-certify. Plans will be notified in advance if a program-wide re-certification is indicated.

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 and Test Contract 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 (Slides 10-11)

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 2012 DATA SUBMISSION

DATA TYPE	SUBMISSION TIMELINE
Testing and Certification*	November 15, 2011 – January 31, 2012
Production Submissions**	Monthly, March 31, 2012 – May 31, 2013

* Only new plans submitting directly or new third party submitters submitting in CY2012 must complete the testing and certification process.
**Existing plans must submit at least one accepted PDE file per calendar month beginning in January 2012. New plans for 2012 must submit at least one accepted PDE file prior to March 31, 2012, and then at least once per calendar month thereafter.

Plans must submit at least one accepted PDE file per calendar month. Original 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 2012 must be successfully submitted by May 31, 2013 in order to be processed for payment reconciliation.

All new submitters must be certified and ready to submit data by January 31, 2012. The first production file must be received by March 31, 2012.

3.1.5 Plan Monitoring (Slide 12)

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.

Specifically, CMS monitors the following:

- Submission Timeliness: Plans must submit at least one successful PDE file per month. There is an established compliance procedure for plans who do not meet this requirement.
- Submission Completeness: CMS monitors the extent to which PDE volumes follow plan or program wide historical trends.
- Submission Lag: CMS expects PDEs to be submitted within 30 days of the date of service. Rejected records should be corrected and resubmitted within 45 days, unless the plan realizes that the PDE should not have been submitted at all. Adjusted/deleted PDEs should be submitted within 45 days of the event that changed the original PDE.

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 13)

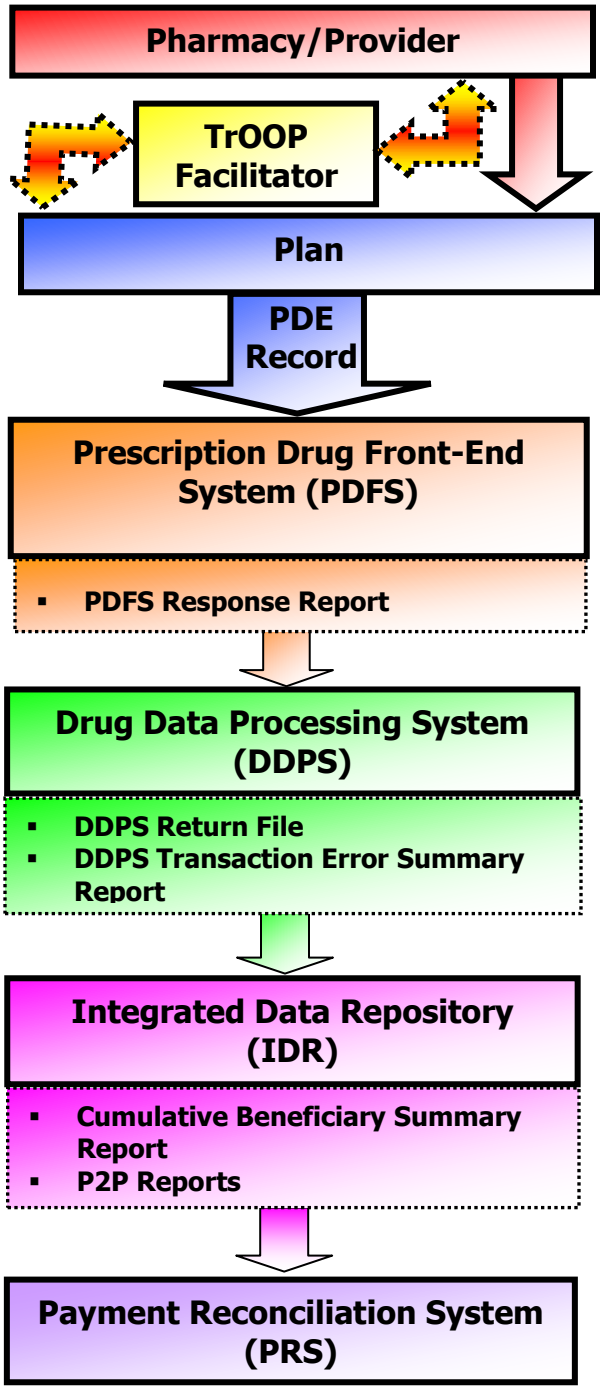
For each dispensing event, the plan must submit a PDE record. Most organizations use a Pharmacy Benefit Manager (PBM) or other third party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates 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 for Part D Payment Reconciliation. Module 10 illustrates the PDE Dataflow for the CGDP.

- 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.

Figure 3A – Prescription Drug Event Dataflow for Part D Payment Reconciliation



3.3 Prescription Drug Event Record Layout Logic (Slides 14-15)

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 51 fields with data in order to provide DDPS with the information required for identifying each unique PDE, calculating payment and generating the CGDP Invoice Reports.

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

*Items with asterisks only appear on the DDPS Return File.

DETAIL LEVEL

BATCH LEVEL

FILE LEVEL

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.

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 and DET record counts.

3.3.2 Batch Level Fields (Slides 16-17)

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 Number and PBP ID. CMS assigns the Contract Number, while the organization proposes PBP IDs when bidding. Each bid must be approved by CMS during the negotiation and contracting process. The Contract Number 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"
LI-NET Contract	• Begins with an "X"
Employer Group Waiver Plans (EGWP)	• Begins with an "E"

The Contract Number 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 Number 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 field confirms input record counts.

3.3.3 Detail Record Fields

The DET record includes 51 data elements that plans must populate for CMS to reconcile payment, provide program oversight, and populates the CGDP Invoice Reports. 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 and for provisions in the Affordable Care Act.

3.3.3.1 Beneficiary Identifiers (Slide 18)

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 Industry Standard Prescription Drug Event Identifiers (Slides 19-20)

Fourteen 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
- Prescription Origin Code

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 - Drug Enforcement Agency (DEA) Number - UPIN - State License Number	• Plans should report the NPI number whenever available. • A valid prescriber ID must be present on all PDEs, regardless of format

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification standards for EDI mandates 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.

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. 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.

For 2012, CMS will continue to permit Part D sponsors to accept on Part D claims and report any one of the four currently acceptable types of prescriber identifiers. Whichever type of identifier is used, however

the identifier must be valid. This is true regardless of the format of claims. CMS will validate the format of all prescriber identifiers of PDEs that are coded as an NPI and will exclude from payment reconciliation PDEs with invalid NPIs.

Also effective in 2012, Part D sponsors are required to confirm the validity of DEA numbers on Schedule II-V drug claims, or map NPIs on these claims to the prescriber's DEA prior to reporting the PDE to CMS.

Beginning in 2013, CMS is considering proposing a regulatory change that will limit acceptable prescriber identifiers on Part D claims and PDE records to only the individual NPI. In other words, a prescription written by an individual prescriber who did not acquire and individual NPI and disclose it to the pharmacy on the prescription or otherwise would not be filled under the Part D program.

Dispensing Status – DDPS no longer accepts any values in the Dispensing Status field for dates of service on or after January 1, 2011. If plans accept partial and complete claims from pharmacies, plans should combine the partial and complete claims and report a single PDE summarizing both billing transactions. If a plan prematurely reports a PDE based on a partial fill only, the plan must adjust the PDE if the completion billing transaction is subsequently received. Dispensing Status should still be reported on outstanding PDE data being submitted with dates of service prior to January 1, 2011.

Prescription Origin Code – identifies the method in which the pharmacy received the prescription. This field was introduced as an optional field in 2009 and became mandatory for PDEs with dates of service on or after January 1, 2010.

3.3.3.3 Part D Specific Prescription Drug Event Identifiers (Slide 21)

Several other data elements included on the PDE Record that describe both the drug and the method in which the drug was dispensed 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 and is optional for all other plan types.
- Non-Standard Format Code – identifies type of source data plan used to compile PDE
- Pricing Exception Code – identifies PDEs using pricing rules that differ from the plan's negotiated price
- Date Original Claim Received – the date when the plan received the original claim
- Claim Adjudication Began Timestamp – the date and time sponsor began adjudicating the claim in Greenwich Mean Time

3.3.3.4 Benefit Design Identifiers (Slides 22-23)

Seven data elements, which are unique to Part D, provide information regarding the benefit design under which the PDE was adjudicated.

- 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 - Approved for coverage under a specific PBP through an exception or appeal • **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

- Catastrophic Coverage Code – reports the beneficiary's status in relation to the OOP threshold. This field is mandatory for PDEs with dates of service on or before December 31, 2010. It is optional for PDEs with dates of service on or after January 1, 2011. The newly added TGCDC Accumulator and TrOOP Accumulator, along with Beginning Benefit Phase and Ending Benefit Phase, will replicate data previously reported in the Catastrophic Coverage Code field.

- Beginning Benefit Phase – the plan-defined phase that is in effect for the beneficiary at the time the plan begins adjudication of the claim being reported. This field is reported for covered drugs only.

- Ending Benefit Phase – the plan-defined phase that is in effect at the time the plan completes adjudication of the claim being reported. This field is reported for covered drugs only.

- Brand/Generic Code – indicates that the plan adjudicated the claim as a brand drug or as a generic drug

If a brand NDC is adjudicated as a generic drug for the purpose of assessing generic cost sharing, the PDE should reflect Generic in the Brand/Generic Code field.

- Tier – the formulary tier (consistent with the plan's benefit as submitted to CMS in the formulary file) in which the sponsor adjudicated the claim. Defined Standard benefit plans and plans with an open formulary and no tiering should report the default value of "1" in the Tier field. When a prescription for a non-formulary drug is approved under an exception process and adjudicated with tier cost-sharing, report the exception tier.

- Formulary Code – indicates if the drug is on a plan's formulary. This field applies to covered drugs only. Defined Standard plans covering all Part D drugs should report "F" in the Formulary Code field. For plans with a closed formulary, if a drug is covered through an exception or appeal, and was not originally on the plan's formulary as submitted to CMS, report "N" in the Formulary Code field.

3.3.3.5 Dollar Fields (Slides 24-27)

The PDE Record layout includes 16 fields that must be populated with dollar amounts. These 16 fields can be categorized as detail cost fields, summary cost fields, patient liability payment fields, plan payment fields, and benefit accumulators. 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
29	Ingredient Cost Paid	Detail Cost	The sum of these four fields equals the Gross Drug Cost.
30	Dispensing Fee Paid	Detail Cost	
31	Amount Attributed to Sales Tax	Detail Cost	
41	Vaccine Administration Fee	Detail Cost	
32	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.
33	Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)	Summary Cost/Benefit Phase	
34	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.
35	Other Troop Amount	Payment by/on behalf of patient	
36	Low Income Cost-Sharing Subsidy (LICS) Amount	Payment by/on behalf of patient	
50	Reported Gap Discount	Payment by/on behalf of patient	
37	Patient Liability Reduction due to Other Payer Amount (PLRO)	Payment by/on behalf of patient	
38	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.
39	Non-Covered Plan Paid Amount (NPP)	Plan Payment	
40	Estimated Rebate at Point of Sale	Detail Cost	The amount of the rebate the plan passed through to the pharmacy.
45	Total Gross Covered Drug Cost Accumulator	Accumulator	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim.
46	True Out-Of-Pocket Accumulator	Accumulator	Sum of beneficiary's incurred costs (Patient Pay Amount, LICS, Other TrOOP Amount, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim.

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

3.3.3.6 Gap Discount Fields

In order to implement the requirements for the Coverage Gap Discount Program (CGDP), the DET record was enhanced to include the following fields:

- Reported Gap Discount (also included in Table 3K above because it is a dollar field)
- Gap Discount Override Code

The Reported Gap Discount is the amount the plan advanced at the point of sale for the Gap Discount for applicable drugs. The Gap Discount Override Code is reserved for future use and must remain blank.

3.3.3.7 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	
25	Adjustment/Deletion Code	Code	Identifies Adjustment/Deletion
55	CMS Calculated Gap	Informational	Plans submit with spaces. DDPS will populate as applicable based on editing
56	PBP of Record	Informational	
57	Alternate Service Provider ID Qualifier	Informational	
58	Alternate Service Provider ID	Informational	
59	Original Submitting Contract	Informational	
60	P2P Contract of Record	Informational	
61	Corrected HICN	Informational	
62-72	Error fields	Error count/codes	
73	Exclusion Reason Code	Informational	

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, 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", "TEST", or "CERT". 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 X# 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.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
10	116 – 127	Mandatory	402-D2	Prescription Service Reference NO	As of January 1, 2011, a pharmacy-issued 12-character numeric code was implemented in preparation for NCPDP D.0 standard in 2012 to identify a dispensed prescription is used to populate this field. Plans should right justify the number and fill with five leading zeros. 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	128 – 129	Mandatory		Filler	Must be populated with 2 spaces. The "Filler" field allows for additional fields in the future.
12	130 – 148	Mandatory	407-D7 or 489-TE	Product Service ID	National Drug Code (NDC) 11 digit format. Identifies the dispensed drug. For compound drugs submit the NDC for the most expensive Part D Covered drug.
13	149 – 150	Mandatory	202-B2	Service Provider ID Qualifier	Indicates the source of the code used in field 14.
14	151 – 165	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 of NPI.
15	166 – 167	Mandatory	403-D3	Fill Number	Indicates the number of the current fill.
16	168 – 168	Mandatory for 2011; Situational prior to 2011	343-HD	Dispensing Status	This field provides the dispensing status of a prescription. Mandatory field is <blank> for PDEs with DOS January 1, 2011 and forward. Situational on PDEs with DOS prior to January 1, 2011 as <blank>, partial fill ('P'), or completion of partial fill ('C').
17	169 – 169	Mandatory	406-D6	Compound Code	Indicates if the dispensed drug was compounded or not.
18	170 – 170	Mandatory	408-D8	Dispense as Written (DAW)	This field reports the instructions provided by the Prescriber regarding substitution of generic equivalents.
19	171 – 180	Mandatory	442-E7	Quantity Dispensed	This field lists the number of units (e.g., pills, milliliters) that were dispensed.
20	181 – 182	Mandatory		Filler	Must be populated with 2 spaces. The "Filler" field allows for additional fields in the future.
21	183 – 185	Mandatory	405-D5	Days Supply	Indicates the number of days of medication provided by the current prescription.
22	186 – 187	Mandatory for 2012	466-EZ	Prescriber ID Qualifier	Describes the data source of the code used in field 23.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
23	188 – 202	Mandatory for 2012	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.
24	203 – 203	Mandatory		Drug Coverage Status Code	Indicates if the dispensed drug is a Part D drug or not.
25	204 – 204	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.
26	205 – 205	Situational		Non-Standard Format Code	This field is coded only when data are collected in non-standard format. Blank indicates standard format.
27	206 – 206	Situational		Pricing Exception Code	Indicates PDEs using pricing rules that differ from the plan's negotiated price.
28	207 – 207	Optional for 2011; Mandatory prior to 2011		Catastrophic Coverage Code	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. 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.
29	208 – 215	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.
30	216 – 223	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.
31	224 – 231	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.
32	232 – 239	Mandatory		Gross Drug Costs Below Out-of-Pocket Threshold (GDCB)	Sum fields 29-31 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.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
33	240 – 247	Mandatory		Gross Drug Costs Above Out-of-Pocket Threshold (GDCA)	Sum fields 29-31 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.
34	248 – 255	Mandatory	505-F5	Patient Pay Amount	Populate this field with the dollar amount paid by the beneficiary.
35	256 – 263	Mandatory		Other TrOOP Amount	This field indicates the dollar amount paid on behalf of the beneficiary by third party TrOOP eligible payers.
36	264 – 271	Mandatory		Low Income Cost-Sharing Subsidy (LICS) Amount	Plans populate this field with the dollar amount attributed to LICS.
37	272 – 279	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.
38	280 – 287	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.
39	288 – 295	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.
40	296 – 303	Mandatory		Estimated Rebate at POS	The amount of the rebate the plan passed through to the pharmacy.
41	304 – 311	Mandatory		Vaccination Administration Fee	Amount the plan paid for administering a vaccination.
42	312 – 312	Mandatory for 2010; Optional prior to 2010	419-DJ	Prescription Origin Code	Required on PDEs with DOS January 1, 2010 and forward. Indicates the origin of the prescription with values: not specified ('0'), written ('1'), telephone ('2'), Electronic ('3'), facsimile ('4'), and <blank>.On PDEs with DOS prior to January 1, 2010, "0" = Not Specified and blank are also allowed.
43	313 – 320	Mandatory for 2011		Date Original Claim Received	Indicates date Part D sponsor received original claim. Required for PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank or zeros. Required for all LI-NET PDEs submitted regardless of DOS.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
44	321 – 346	Mandatory for 2011		Claim Adjudication Began Timestamp	Indicates date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDES with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank or zeros.
45	347 – 355	Mandatory for 2011		Total Gross Covered Drug Cost (TGCDC) Accumulator	This field reports the sum of a beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank or zeros. Must be blank or zeros for non-covered drugs.
46	356 – 363	Mandatory for 2011		True Out-of-Pocket (TrOOP) Accumulator	This field reports the sum of a beneficiary's incurred costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank or zeros. Must be blank or zeros for non-covered drugs.
47	364 – 364	Mandatory for 2011		Brand/Generic Code	Identifies whether the plan adjudicated the claim as a brand or generic drug. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank. Applies to covered drugs only. Valid values: 'B'=brand, 'G'=generic, blank for non-covered drugs.
48	365 – 365	Mandatory for 2011		Beginning Benefit Phase	This field identifies the plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank. Applies to covered drugs only. Valid values: 'D'=Deductible, 'N'=Initial Coverage Phase, 'G'=Coverage Gap, 'C'=Catastrophic, blank for non-covered drugs.
49	366 – 366	Mandatory for 2011		Ending Benefit Phase	This field identifies the plan-defined benefit phase in effect upon completing adjudication of the individual claim being reported. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank. Applies to covered drugs only. Valid values: 'D'=Deductible, 'N'=Initial Coverage Phase, 'G'=Coverage Gap, 'C'=Catastrophic, blank for non-covered drugs.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
50	367 – 374	Mandatory for 2011		Reported Gap Discount	This field identifies the reported amount the Part D sponsor advanced at point-of-sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank or zeros. Counts towards TrOOP. Must be blank or zeros for non-covered drugs.
51	375 – 375	Mandatory for 2011		Tier	Formulary tier in which the Part D sponsor adjudicated the claim. Required on PDEs with DOS January 1, 2011 and forward. PDEs prior to January 1, 2011, must be blank. Applies to covered drugs only. Valid values = 1-6, blank for non-covered drugs.
52	376 – 376	Mandatory for 2011		Formulary Code	Indicates if the drug is on the plan's formulary. PDEs prior to January 1, 2011, must be blank. Applies to covered drugs only. Valid values: 'F'=formulary, 'N'=non-formulary, blank for non-covered drugs.
53	377 – 377	For future use		Gap Discount Plan Override Code	Values TBD. Must be blank.
54	378 – 407	Mandatory		FILLER	Must be populated with 29 spaces. The "Filler" field allows for additional fields in the future.
55	408 – 415	Return File		CMS Calculated Gap*	Amount calculated by CMS during on-line PDE editing based on data reported in the PDE.
56	416 – 418	Return File		PBP of Record*	This field should be submitted with spaces.
57	419 – 420	Return File		Alternate Service Provider ID Qualifier*	This field should be submitted with spaces.
58	421 – 435	Return File		Alternate Service Provider ID*	This field should be submitted with spaces.
59	436-440	Return File		Original Submitting Contract*	This field should be submitted with spaces.
60	441 – 445	Return File		P2P Contract of Record*	This field should be submitted with spaces.
61	446 – 465	Return File		Corrected HICN*	This field should be submitted with spaces.
62	466 – 467	Return File		Error Count*	This field should be submitted with spaces.
63	468 – 470	Return File		Error 1*	This field should be submitted with spaces.
64	471 – 473	Return File		Error 2*	This field should be submitted with spaces.
65	474 – 476	Return File		Error 3*	This field should be submitted with spaces.
66	477 – 479	Return File		Error 4*	This field should be submitted with spaces.
67	480 – 482	Return File		Error 5*	This field should be submitted with spaces.

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

PDE RECORD DET – DETAIL LEVEL					
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
68	483 – 485	Return File		Error 6*	This field should be submitted with spaces.
69	486 – 488	Return File		Error 7*	This field should be submitted with spaces.
70	489 – 491	Return File		Error 8*	This field should be submitted with spaces.
71	492 – 494	Return File		Error 9*	This field should be submitted with spaces.
72	495 – 497	Return File		Error 10*	This field should be submitted with spaces.
73	498 – 500	Return File		Exclusion Reason Code*	This field should be submitted with spaces. This field is the subcategory reject code for an NDC Error Code of 738 identified in Errors 1-10.
74	500 – 512	Mandatory		Filler	Must be populated with 12 spaces. The "Filler" field allows for additional fields in the future.

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

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).
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.

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

TABLE 3M – PDE RECORD LAYOUT (CONTINUED)

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 28-29)

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. Independent of the type of source data from which the PDE is compiled, plans must submit PDEs for all events. The non-standard format code reports the type of source data from which the PDE was compiled. Table 3N lists the values for the non-standard format code field. Note that these codes are mutually exclusive.

TABLE 3N - NON-STANDARD FORMAT FIELD CODES

DATA SOURCE	CODE
Submitted by beneficiary to plan	B
Indicates a COB claim	C
Submitted by provider on paper claim	P
Submitted by provider in ANSI X12 837 Format	X
Standard Format (NCPDP)	<blank>

When PDEs are compiled from standard format, the non-standard format field is left blank. Non-standard format code values of "B", "C", "P", or "X" indicate that the PDE record was derived from a non-standard format. Previously for non-standard formats, DDPS overrode the requirement to populate two DET fields: Prescriber ID Qualifier and Prescriber ID. However, beginning in 2012, plans are required to supply this data. If a plan reports a Prescriber ID on a non-standard format PDE, the Prescriber ID Qualifier must

accompany it. 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.

In 2012, only the 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. Prior to 2012, the Prescriber ID and Prescriber ID Qualifier were also optional for non-standard format submissions.

CMS expects plans and their PBMs to implement standard protocols for non-standard format claims. Documentation to substantiate a non-standard format claim should almost always be equivalent to data required for PDEs derived from standard format claims. Although current CMS guidance allows some flexibility when submitting non-standard format PDEs, plans should use discretion and report default values only when absolutely necessary. In particular plans should report the National Prescriber Identifiers (NPI) for prescribers. Since May 2008 when National Provider Identifier (NPI) reporting was fully implemented, prescriber NPIs should be readily available. Beginning in 2012, CMS will validate NPIs when the Prescriber ID Qualifier Code indicates that the data in the Prescriber ID is an NPI. Currently CMS retains the flexibility to report Prescriber ID Qualifier Code = 99 with a plan defined value is in the Prescriber ID field. Since the option to report default values for prescriber is limited to emergency circumstances, plans who continue to use default prescriber values routinely can expect additional scrutiny both from CMS and their auditors. Non-standard format PDEs 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
- Prescriber ID Qualifier
- Prescriber ID

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 NON-STANDARD FORMAT PDE RECORD (FOR LIMITED USE ONLY.)

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 an NPI 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'
21	Days Supply	Populate with: '000'
22	Prescriber ID Qualifier	Populate with '99'
23	Prescriber ID	Populate with Plan defined value or 'PAPERCLAIM'
29-31	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 30-32)

To change a PDE after DDPS saves it, plans will submit an adjustment or deletion PDE. A small number of 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. 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 adjustment or delete 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.


CMS uses the term "final action" to describe the most recently accepted original, adjustment, or delete PDE record representing a single dispensing event.

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, which is at least one accepted PDE file per calendar month and a PDE submission lag time of original PDEs submitted within 30 days of the date of service.

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 and 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 and provisions in Affordable Care Act, including the Coverage Gap Discount Program.
- 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 Part D drugs. CMS classifies drugs for payment using the following terminology:

Part D drug – A Part D Drug includes the following if used for a medically accepted indication (as defined in section 1927(k)6) of the Social Security Act (the Act)): **(Slides 6-7)**

- Any prescription drug described in §1927(k)(2)(A)(i), A(ii), or (A)(iii) of the Act;
- A biological product described in §1927(k)(2)(B)(i), (B)(ii), or(B)(iii) of the Act;
- A vaccine licensed under section 351 of the Public Health Service Act and for vaccine administration on or after January 1, 2008, its administration; or
- Insulin described in §1927(k)(2)(C) of the Act and medical supplies associated with delivering insulin into the body including syringes, needles, alcohol swabs, and gauze.

Except—A Part D Drug does NOT include:

- Drugs for which payment as so prescribed and dispensed or administered to an individual is available for that individual under Part A or Part B (even though a deductible may apply, or even though the individual is eligible for coverage under Part A or Part B but has declined to enroll in Part A or Part B). 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, Part D versus B coverage determination can depend on the method of administration, patient diagnosis, place of service, or Part A/B carrier/intermediary.; and

- Drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under sections 1927(d)(2) of the Act, except smoking cessation agents.

Covered Part D drug – a Part D drug that is eligible for coverage under a specific Plan Benefit Package (PBP) including Part D drugs that are approved under exceptions, transitions, grievances, appeals, and other coverage determination processes. As of January 1, 2011, applicable drugs may be covered under the Part D program only if they are covered by a signed Medicare Coverage Gap Discount Program Agreement between CMS and the manufacturer or if CMS has used its authority to make an exception under section 1960D-43(c) of the Act.

Applicable drug – a covered Part D drug that is approved or licensed by the Food and Drug Administration (FDA) under a New Drug Application (NDA) or Biologic License Application (BLA). Supplemental drugs are not defined as applicable drugs. As of January 1, 2011, applicable drugs with national drug codes (NDCs) having labeler codes that are not covered by a signed Medicare Coverage Gap Discount Program Agreement are not eligible for coverage under Medicare Part D.

4.1.1 The Defined Standard Benefit (Slides 8-9)

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 and 4B, illustrate the phases, parameters, cost-sharing, and plan liability in a DS benefit plan, excluding Low Income Eligible Beneficiaries 2011 and DS benefit plan, excluding Low Income Eligible Beneficiaries 2012. Module 6 describes the DS benefit for Low Income Eligible Beneficiaries.

The Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter provides sponsors with the benefit parameters for the Part D program.

TABLE 4A – THE DEFINED STANDARD BENEFIT, EXCLUDING LOW INCOME ELIGIBLE BENEFICIARIES, 2011

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Cost	YTD TrOOP Costs		
Deductible	≤ $310	N/A	100% coinsurance (=$310)	0%
Initial Coverage Phase	> $310 and ≤ $2,840	N/A	25% coinsurance (= $632.50)	75% (= $1,897.50)
Coverage Gap	>$2,840 and ≤ $6,483.72*	≤ $4,550	93% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs**	7% for generic drugs 0% for brand drugs
Catastrophic Coverage Phase	> $6,483.72	> $4,550 (OOP threshold)	Greater of 5% coinsurance or $2.50/$6.30 (generic/brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)

* For a beneficiary who is considered an "applicable beneficiary" as defined at section 1860D-14A(g)(1) of the Social Security Act and therefore is eligible for the Coverage Gap Discount Program (i.e. non-LIS beneficiaries), this is the estimated average amount of total drug spending required to attain the out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.

**Assumes the claim falls squarely in the gap and there are no supplemental benefits

TABLE 4B - THE DEFINED STANDARD BENEFIT, EXCLUDING LOW INCOME ELIGIBLE BENEFICIARIES, 2012

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Gross Covered Drug Costs	YTD TrOOP Costs		
Deductible	≤ $320	N/A	100% coinsurance (= $320)	0%
Initial Coverage Phase	> $320 and ≤ $2,930	N/A	25% coinsurance (= $652.50)	75% (= $1,957.50)
Coverage Gap	>$2,930 ≤$6,730.39*	≤ $4,700	86% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs**	14% for generic drugs 0% for brand drugs
Catastrophic Coverage Phase	> $6,730.39	> $4,700 (OOP threshold)	Greater of 5% coinsurance or $2.60/$6.50 (generic/brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.60/$6.50)

* For a beneficiary who is considered an "applicable beneficiary" as defined at section 1860D-14A(g)(1) of the Social Security Act and therefore is eligible for the Coverage Gap Discount Program (i.e., non-LIS beneficiaries), this is the estimated average amount of total drug spending required to attain the out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.

**Assumes the claim falls squarely in the gap and there are no supplemental benefits

Notes for Tables 4A and 4B:

- Year-to-Date (YTD) gross covered drug cost advances the beneficiary through the Deductible, Initial Coverage Phase 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 ($4,700 in 2012) 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 $4,700 (2012). 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 4C compares the cost-sharing characteristics of the three types of Basic Benefit plans.

TABLE 4C – 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-4B).
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 Phase 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 the Initial Coverage Phase, 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 $6,730.39 (in 2012) 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.

Sponsors are expected to validate that their plan benefit design is set up correctly by their Pharmacy Benefit Manager (PBM) at the beginning of each benefit year.

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

Tiering is a common alternative 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 4D 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 4D – 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 51 fields for plans to populate in the Prescription Drug Event (PDE) record, there are eleven that a plan must carefully consider when administering the Part D drug benefit. These eleven data elements apply to the Basic benefit plan as well as all other benefit plan types:

1. Drug Coverage Status Code
2. Total Gross Covered Drug Cost Accumulator
3. True Out-of-Pocket Accumulator
4. Beginning Benefit Phase
5. Ending Benefit Phase
6. Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
7. Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)
8. Patient Pay Amount
9. Covered D Plan Paid Amount (CPP)
10. Non-covered Plan Paid Amount (NPP)
11. Reported Gap Discount

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. The Drug Coverage Status Code field is essential to administering the Basic Benefit. The National Drug Code (NDC) is essential in the Coverage Gap Discount Program and for coverage of generic drugs in the Coverage Gap. Additional coding fields include Dispense as Written Product Selection Code, Adjustment/Deletion Code, Non-Standard Format Code, Pricing Exception Code, Prescription Origin Code, Formulary Code, and Gap Discount Plan Override Code (for future use). 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. 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 Part D drug that is eligible for coverage under a specific Plan Benefit Package (PBP) including Part D drugs that are approved under exceptions, transitions, grievances, appeals, and other coverage determination processes. As of January 1, 2011, applicable drugs may be covered under the Part D program only if they are covered by a signed Medicare Coverage Gap Discount Program Agreement between CMS and the manufacturer or if CMS has used it authority to make an exception under section 1960D-43(c) of the Act.

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), the Coverage Gap Discount Program and TrOOP costs.

(O) Over-the-Counter Drug – OTC drug, paid by a plan under their administrative cost structure either as (1) part of general drug utilization management or (2) as part of an approved step therapy protocol.

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.

4.2.2 Accumulator Fields (Slides 15-16)

Total Gross Covered Drug Cost Accumulator: The Total Gross Covered Drug Cost (TGCDC) Accumulator is one of two values Part D sponsors maintain in real time in order to adjudicate a beneficiary's claim in the correct benefit phase. TGCDC Accumulator is the sum of the beneficiary's covered drug costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. The TGCDC Accumulator value moves the beneficiary through the Deductible Phase, the Initial Coverage Phase, and into the Coverage Gap. We use the TGCDC Accumulator in combination with the True Out-of-Pocket (TrOOP) Accumulator described below to validate benefit phase. The TGCDC Accumulator field should be left blank on PDEs for Over-the-Counter (OTC) or Enhanced drugs.

True Out-of-Pocket (TrOOP) Accumulator: The TrOOP Accumulator is the second value Part D sponsors maintain real time in order to adjudicate a beneficiary's claim in the correct benefit phase. The TrOOP Accumulator is the sum of the beneficiary's incurred costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. Incurred costs are reported in the existing PDE as Patient Pay Amount, Low Income Cost-Sharing Subsidy (LICS) and Other TrOOP Amount and will include the newly Reported Gap Discount. By definition, TrOOP costs apply only to Part D covered drugs. After the TrOOP Accumulator reaches the out-of-pocket threshold, the beneficiary enters the Catastrophic

Phase of the benefit. The TrOOP Accumulator field should be left blank on PDEs for OTC or Enhanced drugs. (Enhanced drugs are discussed in Module 7.) The TrOOP Accumulator does not increase after the beneficiary reaches the out-of-pocket threshold.

The Accumulator fields replace the Catastrophic Coverage Code field, which was a required field prior to 2011. The Accumulator Indicators will be described in greater detail in Module 5.

4.2.3 Benefit Phase Indicators (Slide 17)

Beginning Benefit Phase: The Beginning Benefit Phase is the plan-defined benefit phase that is in effect for the beneficiary at the time the sponsor begins adjudication of the individual claim being reported. For example, the Beginning Benefit Phase for a beneficiary's first claim in the benefit year is the Initial Coverage Phase in a plan with no deductible. In a Defined Standard Plan, the Beginning Benefit Phase for a beneficiary's first claim in the benefit year is the Deductible Phase. The Beginning Benefit Phase applies to covered drugs only.

Ending Benefit Phase: The Ending Benefit Phase is the plan-defined benefit phase that is in effect at the time the sponsor completes adjudication of the individual claim being reported. The Ending Benefit Phase should always be a benefit phase equal to or later than the Beginning Benefit Phase. For example, a beneficiary's claim falls squarely in the Initial Coverage Phase, the Ending Benefit Phase is "N" for Initial Coverage Phase. The Ending Benefit Phase applies to covered drugs only.

The benefit phase indicators will be described in greater detail in Module 5.

4.2.4 Financial Fields

Thirteen financial fields on the PDE report either drug costs or payments. The fields are:

1. Ingredient Cost Paid
2. Dispensing Fee Paid
3. Total Amount Attributed to Sales Tax
4. Gross Drug Cost Below Out-of-Pocket Threshold
5. Gross Drug Cost Above Out-of-Pocket Threshold
6. Patient Pay Amount
7. Other TrOOP Amount
8. Low Income Cost Sharing Subsidy Amount,
9. Patient Liability Reduction Due to Other Payer Amount
10. Covered D Plan Paid Amount
11. Non Covered Plan Paid Amount
12. Vaccine Administration fee
13. Reported Gap Discount

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 nine PDE fields that apply to the simplest case where the beneficiary is in a Basic plan and has no other source of payment.

4.2.4.1 Gross Drug Cost (Slide 18)

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.

4.2.4.1.1 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.

4.2.4.1.2 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.

4.2.4.1.2.1 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 or if the threshold is reached during this event. Once the beneficiary exceeds the OOP threshold plans must populate the GDCB field with a zero dollar value.

4.2.4.1.2.2 Gross Drug Cost Above OOP Threshold (GDCA)

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

Table 4E illustrates the summary cost fields and their relationship to the TrOOP Accumulator field.

TABLE 4E – SUMMARY DRUG COST AND THE TROOP ACCUMULATOR FIELD

TrOOP ACCUMULATOR FIELD	GDCB	GDCA
TrOOP Accumulator < OOP	> $0.00	= $0.00
TrOOP Accumulator < OOP and (TrOOP Accumulator + Patient Pay + Other TrOOP + Reported Gap Discount + LICS) > OOP Threshold	> $0.00	≥ $0.00
TrOOP Accumulator = OOP Threshold	= $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 $4,700 (2012 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, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee) 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.

4.2.4.2 Payment Fields

4.2.4.2.1 Patient Pay Amount (Slide 19)

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.

4.2.4.2.2 Covered D Plan Paid Amount (CPP) (Slide 20)

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.

4.2.4.2.3 Non-Covered Plan Paid Amount (NPP) (Slide 21)

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 7). 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.

4.2.4.2.4 Reported Gap Discount (Slides 22-23)

Effective January 1, 2011, Reported Gap Discount is a new field on the PDE. The new field was added in order to implement the Medicare Coverage Gap Discount Program, as required under Section §1860D-14A and §1860D-43 of the Social Security Act. Reported Gap Discount is the reported amount that the sponsor advanced at point-of-sale for the Gap Discount. Part D sponsors advance the Gap Discount at point-of-sale to applicable beneficiaries (as defined at 1860D-14A(g)(1)) who purchase an applicable drug that falls, in part or in full, in the Coverage Gap. The Gap Discount is based on the plan-defined benefit phase. For employer plans and plans with no Initial Coverage limit, the defined standard Initial Coverage limit is used for purposes of calculating the Gap Discount. The Gap Discount applies to the negotiated price as defined in §1860D-14A(g)(6) which excludes dispensing fee paid and vaccine administration fee. For purposes of calculating the Gap Discount, the negotiated price is the sum of the Ingredient Cost Paid and Total Amount Attributed to Sales Tax.

The steps to populate the PDE fields on a claim for an applicable drug that falls completely or partially in the gap are:

1. **Determine Costs that Fall in the Coverage Gap**: (using existing adjudication logic discussed in Module 3) Claims that begin and end in the Coverage Gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases. In the case of straddle claims apply dispensing fee and vaccine administration fee, to the greatest extent possible, outside the Coverage Gap.

2. **Determine Discount Eligible Cost:** Discount Eligible Cost is cost falling in the Coverage Gap, excluding supplemental benefits, dispensing fee, and vaccine administration fee. The supplemental benefit is calculated first. The dispensing fee and vaccine administration fee are included in the supplemental benefit to the extent that the supplemental benefit equals or exceeds the dispensing fee and the vaccine administration fee.

3. **Calculate Gap Discount:** The Gap Discount is 50% of Discount Eligible Cost**.**

4. **Determine Beneficiary Cost-Sharing:** For claims falling squarely in the Coverage Gap with no other secondary health insurance, beneficiary cost-sharing is Total Drug Cost less Gap Discount. If the beneficiary has other secondary health insurance, the other secondary health insurance reduces beneficiary cost-sharing remaining after the Gap Discount is applied. In Straddle claims beneficiary cost-sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

5. **Calculate Covered and Non-Covered Portion of Plan Paid Cost-Sharing:** (using existing calculations)

6. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

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 Phase, 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 25)

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 26)

The beneficiary is in the Deductible Phase of the benefit (YTD Gross Covered Drug Cost $\leq$ $320) in 2012. The beneficiary purchases a $100 covered drug. The drug is the first prescription purchased in the benefit year.

Table 4F illustrates how the plan populates the following ten data elements for this sample PDE in the Deductible Phase.

TABLE 4F – 2012 DS DEDUCTIBLE PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$0.00	$0.00	D	$100.00	$0.00	$0.00	D

Patient Pay Amount + CPP = GDCB

The Drug Coverage Status Code is "C" for a covered drug. The TGCDC and TrOOP Accumulators are $0.00, indicating that this prescription is the first prescription purchased by the beneficiary during the benefit year. The Beginning and Ending Benefit Phase Indicators show that the beneficiary is in the Deductible Phase. The GDCB is $100 and GDCA is $0.00. The Reported Gap Discount is $0.00 since the PDE falls within the Deductible Phase. 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 Phase

The beneficiary is in the Initial Coverage Phase (YTD Gross Covered Drug Cost > $320 and ≤ $2,930) in 2012. The YTD Gross Covered Drug Cost is $400 and the YTD TrOOP is $340. The beneficiary purchases a $100 covered drug.

Table 4G illustrates how the plan populates the following ten data elements for this sample PDE in the Initial Coverage Phase.

TABLE 4G – 2012 DS INITIAL COVERAGE PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$400	$340	N	$25.00	$75.00	$0.00	N

The Drug Coverage Status Code is "C" for a covered drug. The TGCDC Accumulator is $400 and the TrOOP Accumulator is $340. The beneficiary is in the Initial Coverage Phase, therefore the Beginning and Ending Benefit Phase Indicators are N. The GDCB is $100 and GDCA is $0.00. The Reported Gap Discount is $0.00 since the PDE falls within the Initial Coverage Phase. In the Initial Coverage Phase, 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 (Slides 27-29)

In the following example, the beneficiary is in the Coverage Gap Phase (YTD Gross Covered Drug Cost > $2,930 and TrOOP costs ≤ the OOP threshold). YTD Gross Covered Drug Cost is $3,500 and the YTD

TrOOP is $1,542.50. The beneficiary purchases a $100 applicable drug. The dispensing fee is $2. Vaccine Administration fee and sales tax are $0.

Table 4H illustrates how the plan populates the following ten data elements for this sample PDE in the Coverage Gap Phase.

TABLE 4H – 2012 DS COVERAGE GAP PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$3,500.00	$1,542.50	G	$51.00	$0.00	$49.00	G

Determine the costs falling within the Coverage Gap: The claim falls squarely in the Coverage Gap. When claim adjudication begins, the TGCDC Accumulator is $3,500.00 and the TrOOP Accumulator is $1,542.50. The Beginning and Ending Benefit Phase is the Coverage Gap. The Accumulator and Benefit Phase Indicators validate that the claim falls squarely in the Coverage Gap.

Determine the Discount Eligible Cost: The cost falling within the Coverage Gap is $100 of which $2 is dispensing fee; therefore, $98 is the discount eligible cost

Calculate the Gap Discount: $98 * .5 = $49

Determine beneficiary cost-sharing: $100 - $49 = $51

Calculate Covered and non-covered portion of plan paid cost-sharing: $0 in this example.

Update TGCDC and TrOOP Accumulators: After the claim is processed, the TGCDC Accumulator is $3,600.00 and the TrOOP Accumulator is $1,642.50.

4.3.1.3.1 Coverage for Generic Drugs in the Coverage Gap (Slides 30-32)

Effective January 1, 2011, the benefit structure for the Coverage Gap Phase includes coverage of generic drugs. (see §1860D2-(b)(2)(C) of the Social Security Act)

Table 4I highlights the changes in beneficiary and plan-cost sharing for generic Part D covered drugs through 2020. In 2020 and beyond, beneficiary cost-sharing is 25% and plan-cost sharing is 75%.

TABLE 4I – BENEFICIARY AND PLAN COST-SHARING FOR GENERIC PART D COVERED DRUGS

Year	Beneficiary Cost-Sharing	Plan Cost-Sharing
2011	93%	7%
2012	86%	14%
2013	79%	21%
2014	72%	28%
2015	65%	35%
2016	58%	42%
2017	51%	49%
2018	44%	56%
2019	37%	63%
2020	25%	75%

The steps to populate the PDE fields on a claim for a generic Part D Covered drug that falls completely or partially in the Coverage Gap are:

1. **Determine costs that fall in the Coverage Gap**: (using existing adjudication logic) Claims that begin and end in the Coverage Gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases.

2. **Determine beneficiary cost-sharing:** For claims falling squarely in the Coverage Gap with no other secondary health insurance, the non-LI beneficiary cost-sharing is 86% of the Total Drug Cost in 2012. In straddle claims, beneficiary cost-sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

3. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

4. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

The beneficiary is in the Coverage Gap Phase (YTD Gross Covered Drug Cost > $2,930 and TrOOP costs $\leq$ the OOP threshold). YTD Gross Covered Drug Cost is $3,500. The beneficiary purchases a $20 generic drug.

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

TABLE 4J – 2012 DS COVERAGE GAP PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$20.00	$0.00	$3,500.00	$1,542.50	G	$17.20	$2.80	$0.00	G

Determine the costs falling within the Coverage Gap: The claim falls squarely in the Coverage Gap. When claim adjudication begins the TGCDC Accumulator is $3,500.00 and the TrOOP Accumulator is $1,542.50. The Beginning and Ending Benefit Phase is the Coverage Gap. The Accumulator and Benefit Phase Indicators validate that the claim falls squarely in the Coverage Gap.

Determine beneficiary cost-sharing: $20 * .86 = $17.20

Calculate Covered and non-covered portion of plan paid cost-sharing: $20 * .14 = $2.80

Update TGCDC and TrOOP Accumulators: After the claim is processed, TGCDC Accumulator is $3,520.00 and TrOOP Accumulator is $1,559.70.

4.3.1.4 Defined Standard Plan - Catastrophic Coverage Phase (Slide 33)

The beneficiary has accumulated more than $4,700 in TrOOP in 2012, 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 ten data elements for this sample PDE in the Catastrophic Coverage Phase.

TABLE 4K – 2012 DS CATASTROPHIC COVERAGE PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$0.00	$75.00	$7,300.00	$4,700.00	C	$6.50	$68.50	$0.00	C

The Drug Coverage Status Code is "C" for a covered drug. Because the TrOOP Accumulator is at $4,700.00, the total cost is above the OOP threshold and the plan reports the gross drug cost in GDCA. The beneficiary pays Catastrophic cost-sharing, which is the greater of 5 percent coinsurance ($3.75) or $2.60/$6.50 co-payment. Patient Pay Amount = $6.50. At the point-of-sale, the plan pays the remainder of the cost ($68.50) 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-$6.50) or $8.50.

4.3.1.5 Defined Standard Plan - Over-the-Counter (OTC) Drug (Slides 34-35)

The beneficiary is in the Initial Coverage Phase of the benefit in 2012. The beneficiary has YTD gross covered drug costs of $400. The beneficiary purchases a formulary OTC drug as part of step therapy and the negotiated price is $15.

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

TABLE 4L – 2012 DS - OVER-THE-COUNTER DRUG

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
O	$0.00	$0.00	<Blank>	<Blank>	<Blank>	$0.00	$0.00	$15.00	$0.00	<Blank>

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. The TGCDC and TrOOP Accumulators are blank and the Beginning and Ending Benefit Phases are blank.

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 Phase (Slides 37)

The beneficiary is enrolled in an AE benefit that uses the tiered co-pay structure outlined in Table 4D. The YTD gross covered drug cost is $400, which places the beneficiary in the Initial Coverage Phase. The YTD TrOOP is $340. The beneficiary purchases a $100 covered drug in Tier 2 with a $20 co-pay in 2012.

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

TABLE 4M – 2012 TIERED BASIC PLAN - INITIAL COVERAGE PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$400.00	$340.00	N	$20.00	$80.00	$0.00	N

The Drug Coverage Status Code is "C". The TrOOP Accumulator is < OOP, 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 2012, a beneficiary is enrolled in a BA plan that uses the tiered co-pay structure outlined in Table 4D 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 ten data elements for this sample PDE in the Deductible Phase of a tiered benefit.

TABLE 4N – 2012 TIERED BASIC PLAN - DEDUCTIBLE PHASE

Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$0.00	$0.00	D	$100.00	$0.00	$0.00	D

The Drug Coverage Status Code is "C". The TrOOP Accumulator is $0.00, 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 38)

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 introductory section explains 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 Phase in which a co-payment structure applies.
- The Initial Coverage Phase 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 Phase

The following PDE moves a beneficiary from the Deductible Phase to the Initial Coverage Phase of the DS benefit plan in 2012. The beneficiary straddles the Deductible Phase and the Initial Coverage Phase. The

beneficiary's YTD gross covered drug cost before the claim was received = $270. The beneficiary purchases a $100 covered drug. In this new PDE, $50 falls at or below the $320 Deductible limit and is adjudicated per the rules of the Deductible phase (100 percent cost-sharing). The remaining $50 falls in the Initial Coverage Phase, 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 ten data elements for this sample PDE that straddles the Deductible and the Initial Coverage Phase.

TABLE 4O – DS 2012 - DEDUCTIBLE TO INITIAL COVERAGE PHASE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Deductible Phase		$50.00	$0.00				$50.00	$0.00		
Initial Coverage Phase		$50.00	$0.00				$12.50	$37.50		
Total	C	$100.00	$0.00	$270	$270	D	$62.50	$37.50	$0.00	N

The PDE fields will report the total amounts from the Deductible and the Initial Coverage Phase. 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 TrOOP Accumulator is <OOP, 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). The Beginning Benefit Phase indicator is 'D' since the Deductible Phase is in effect for the beneficiary at the time the sponsor begins adjudication of the claim. The Ending Benefit Phase indicator is 'N' since the claim ends in the Initial Coverage Phase.

4.4.1.2 Defined Standard Plan: Straddle of Initial Coverage Phase and Coverage Gap Phase (with Coverage Gap Discount)

In the following PDE, the beneficiary is crossing from the Initial Coverage Phase to the Coverage Gap Phase in 2012. YTD gross covered drug cost before the PDE received = $2,830. The beneficiary purchases a $150 covered drug, of which the dispensing fee is $5.00 and the vaccine administration fee is zero. In this new PDE, $100 (including the dispensing fee) falls at or below the $2,930 Initial Coverage limit and is adjudicated per the rules of the Initial Coverage Phase (25% cost-sharing). The remaining $50 falls in the Coverage Gap Phase, in which the beneficiary pays 50 percent the discount eligible cost ($25) and the reported gap discount is 50 percent of the discount eligible cost ($25).

Table 4P illustrates how the plan populates the following ten data elements for this sample PDE that straddles the Deductible and the Initial Coverage Phase.

TABLE 4P – DS 2012 - INITIAL COVERAGE PHASE TO COVERAGE GAP PHASE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Initial Coverage Phase		$100.00	$0.00				$25.00	$75.00		
Coverage Gap Phase		$50.00	$0.00				$25.00	$0.00	$25.00	
Total	C	$150.00	$0.00	$2830.00	$947.50	N	$50.00	$75.00	$25.00	G

The claim is calculated as follows:

Determine costs that fall in the Coverage Gap: When claim adjudication begins, the TGCDC Accumulator is $2830.00 and the TrOOP Accumulator is $947.50; the Beginning Benefit Phase is the Initial Coverage Phase. The first $100.00 of the claim falls in the Initial Coverage Phase. The amount is calculated as ICL-beginning value in the TGCDC Accumulator or $2,930.00 - $2830.00. The remaining $50.00 of the claim falls in the Coverage Gap Phase. Because the beneficiary's TrOOP remains below the TrOOP threshold throughout the processing of the claim, the Ending Benefit Phase is the Coverage Gap Phase.

Determine Discount Eligible Cost: The $5.00 dispensing fee was applied outside the Coverage Gap. Therefore, the discount eligible cost is $50.00, the Coverage Gap amount.

Calculate Gap Discount: The gap discount is $25.00; $50.00 * .5 = $25.00

Determine beneficiary cost-sharing: The beneficiary is responsible for cost-sharing in each benefit phase the claim straddles. Initial coverage Phase cost-sharing 25%; Coverage Gap cost-sharing is 100% of the Coverage Gap cost, less gap discount.

Initial Coverage Phase cost-sharing is $25.00 ($100 * .25); Coverage Gap cost-sharing is $25.00 ($50.00-$25.00). The beneficiary's total cost-sharing is $50.00

Calculate Covered and non-covered portion of the plan paid cost-sharing: The plan pays 75% of the cost falling in the ICP and none of the cost in the Coverage Gap. $100.00 * .75 = $75.00. This amount is included as CPP.

4.4.1.3 Defined Standard Plan: Straddle of Coverage Gap Phase (with Coverage Gap Discount) and Catastrophic Coverage Phase (Slide 39-40)

In the following PDE, the beneficiary is crossing from the Coverage Gap Phase to the Catastrophic Coverage Phase in 2012. YTD TrOOP is $4,650 before the PDE is received. The beneficiary purchases a $150 applicable drug. The dispensing fee is $5.00 and falls within the Catastrophic Coverage Phase.

Table 4Q illustrates how the plan must populate the following ten data elements for this sample PDE that straddles the Coverage Gap and the Catastrophic Coverage Phase.

TABLE 4Q – DS 2012 - COVERAGE GAP TO CATASTROPHIC COVERAGE PHASE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Coverage Gap Phase		$50.00	$0.00				$25.00	$0.00	$25.00	
Catastrophic Coverage Phase		$0.00	$100.00				$6.50	$93.50		
Total	C	$50.00	$100.00	$6,680.39	$4,650	G	$31.50	$93.50	$25.00	C

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 Part D drug. The TrOOP Accumulator is below the OOP threshold and the TrOOP Accumulator plus Patient Pay Amount and Reported Gap Discount is greater than the OOP threshold indicating that the PDE straddles the Coverage Gap Phase and the Catastrophic Coverage Phase. 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 50 percent of the discount eligible cost or $25. The $100 portion of the PDE that falls in Catastrophic Coverage is adjudicated per Catastrophic Coverage Phase rules; the beneficiary pays the greater of $2.60/$6.50 or 5 percent ($5) and at point of sale, the plan pays the balance ($93.50).

The total Patient Pay Amount reported on the PDE is ($25 + $6.50 = $31.50), and the total CPP reported on the PDE is ($0 + $93.50 = $93.50). 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 $93.50 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 - $6.50) = $13.50. **Note:** The amounts paid by the beneficiary and the plan sum to the gross drug cost (Patient Pay Amount + CPP + Reported Gap Discount = GDCA + GDCB).

The TGCDC Accumulator on the next PDE will be $6,830.39 and the TrOOP Accumulator will be $4,700.

TGCDC Accumulator continues to increase above the OOP threshold. The TrOOP Accumulator remains at the OOP threshold amount once the beneficiary is in the Catastrophic Coverage Phase.

4.4.1.4 Defined Standard Plan: Straddle of Deductible through Catastrophic Coverage Phase (Slides 41-43)

In the following PDE, the beneficiary purchases a $7,000 drug that straddles four benefit phases, the Deductible, the Initial Coverage Phase, the Coverage Gap, and the Catastrophic Benefit Phase. YTD gross covered drug cost before the claims is received is $250. The beneficiary purchases a $7,000 covered applicable drug. The dispensing fee is $10.

Table 4R illustrates how the plan must populate the following ten data elements for this sample PDE that straddles the Coverage Gap and the Catastrophic Coverage Phase.

TABLE 4R – DS 2012 - DEDUCTIBLE TO CATASTROPHIC COVERAGE PHASE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Deductible Phase		$70.00	$0.00				$70.00	$0.00		
Initial Coverage Phase		$2610.00	$0.00				$652.50	$1957.50		
Coverage Gap Phase		$3800.39	$0.00				$1900.19	$0.00	$1900.20	
Catastrophic Coverage Phase		$0.00	$519.61				$25.98	$493.63		
Total	C	$6480.39	$519.61	$250.00	$250.00	D	$2648.67	$2451.13	$1900.20	C

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 Part D drug. The dispensing fee falls outside of the Coverage Gap Phase. The TGCDC Accumulator is $250; therefore $70 of this claim falls within the Deductible Phase. The beneficiary pays 100% of the drug cost within the Deductible Phase and $2,610 of the claim falls within the Initial Coverage Phase. In the Initial Coverage Phase, the beneficiary pays 25 percent coinsurance ($652.50) and the plan pays 75 percent ($1,957.50). The portion of the claims that falls within the Coverage Gap Phase is $3,800.39, which is the discount eligible cost. The gap discount is 50% of the discount eligible cost ($1,900.20). Note: If the gap discount must be rounded, round up to the nearest penny. The beneficiary pays the total drug cost less the gap discount ($1,900.19). There is no CPP in the Coverage Gap Phase. The remaining $519.61 falls within the Catastrophic Coverage Phase. The beneficiary pays the greater of 5% or $2.60/$6.50. In this example, the beneficiary pays 5% ($25.98). Even though the plan has paid $493.63 at point of sale, in reconciliation 80 percent of the amount of gross drug cost that falls into the Catastrophic Phase ($519.61

* .8 = $415.69) and will be subject to reinsurance subsidy and the plan and the government will share risk on ($519.61 - $415.69 - $25.98) = $77.94.

4.4.2 Tiered Benefit Straddle Claims (Slide 44)

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 additional rules. 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. See 7.6.7 and 7.6.8 for examples.

When a claim crosses multiple phases of the prescription drug benefit that have co-payments, the beneficiary is required to pay one co-payment, the co-payment applicable to the phase of the benefit in which the claim began. See Module 7 (Enhanced Alternative Benefit) for examples.

4.4.2.1 Basic Alternative Plan: Straddle of Deductible Phase and Initial Coverage Phase (Slides 45-46)

The beneficiary enrolled in a BA plan, which has lowered the deductible to $200 in 2012. 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 = $170.

Table 4S illustrates how the plan uses "lesser of" logic to administer this straddle claim and populate the following ten PDE data elements.

TABLE 4S – BA 2012-TOTAL PATIENT PAY AMOUNT IS LESS THAN THE NEGOTIATED PRICE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Deductible Phase		$30.00	$0.00				$30.00	$0.00		
Initial Coverage Phase		$70.00	$0.00				$40.00	$30.00		
Total	C	$100.00	$0.00	$170.00	$170.00	D	$70.00	$30.00	$0.00	N

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 4S. The Drug Coverage Status Code is "C" indicating a covered drug. The TrOOP Accumulator is < OOP 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 Phase 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 Phase (Using the "Lesser Of" Logic) (Slides 47-48)

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 = $245. 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 4T illustrates how the plan populates the following ten PDE data elements for this sample PDE that straddles the Deductible Phase and the Initial Coverage Phase.

TABLE 4T – AE 2012-TOTAL PATIENT PAY AMOUNT IS GREATER THAN THE NEGOTIATED PRICE

	Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	Reported Gap Discount	Ending Benefit Phase
Deductible Phase		$75.00	$0.00				$75.00	$0.00		
Initial Coverage Phase		$25.00	$0.00				$25.00	$0.00		
Total	C	$100.00	$0.00	$245	$245	D	$100.00	$0.00	$0.00	N

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 4T. The Drug Coverage Status Code is "C" indicating a covered drug. The TrOOP Accumulator is < the OOP threshold. Because the beneficiary has $245 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 Phase 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 Phase 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 Adjustment and Deletions (Slides 49-50)

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 – 2012 ADJUSTMENT/DELETION CODE DEFINITIONS

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

DDPS uses seven key fields plus Contract Number and PBP ID to match the adjustment or deletion PDE to the active record on file (see Module 3). 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.

4.5.1 Adjustment/Deletion Code (Slide 51)

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.

4.5.2 Situations That May Cause Adjustments and Deletions (Slide 52)

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 subsequent claims" applies when the beneficiary has no claims with dates of service after the reversed claim. The section entitled "Reversals with subsequent claims" applies when a reversal affects claims submitted after the reversed claim.

4.5.2.1 Reversals with No Subsequent Claims (Slides 53)

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 TGCDC accumulator and the TrOOP 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.

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

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

When there are no subsequent claims, 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.

4.5.2.2 Reversal with Subsequent Claims (Slides 54-56)

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. In option one, 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. In option two, the plan recalculates claims affected by the reversal. When the plan does not expect sufficient claims volume to repay the benefit or when LICS is involved (see Module 7), the plan 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 Claim Adjudication Began Timestamp, PDEs would show beneficiary cost-sharing in one benefit phase interrupted by cost-sharing in an earlier phase. In addition, the relationship between the TGCDC Accumulator and TrOOP Accumulator, the benefit phases, and the cost-sharing terms will appear to be out of order.

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. Plans must submit the adjustment (corrected) PDE within 45 days following the date the reversal is received. If the PDE was not accepted in DDPS before, the plan must report the recalculated cost-sharing when it submits the original PDE.

Example: Reversal with Benefit Phase Change

The beneficiary enrolled in a BA plan with a $175 deductible. 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 Phase 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. 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. Table 4V illustrates Report As Administered".

TABLE 4V – PLAN ACCUMULATORS AND REPORT AS ADMINISTERED

CLAIM DATE	CURRENT CLAIM		ACCUMULATORS		BENEFIT PHASE INDICATORS	
	GROSS COVERED DRUG COST	PATIENT PAY AMOUNT	YTD GROSS COVERED DRUG COST	YTD TrOOP BALANCE	BEGINNING BENEFIT PHASE	ENDING BENEFIT PHASE
January 10	$100	$100	$0	$0	D	D
January 15	$75	$75	$100	$100	D	D
January 20	$100	$30	$175	$175	D	N
January 10 reversal *(effective January 21)*	<$100>	<$100>	$75	$75		
January 25	$70	$70	$75	$75	D	D

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 plan would adjust each PDE after the January 10 reversed PDE (either the original or the adjusted PDE) would report $100 in the Patient Pay field. Table 4W illustrates "Report As Adjusted".

TABLE 4W – PLAN ACCUMULATORS AND REPORT AS ADJUSTED

CLAIM DATE	CURRENT CLAIM		ACCUMULATORS		BENEFIT PHASE INDICATORS	
	GROSS COVERED DRUG COST	PATIENT PAY AMOUNT	YTD GROSS COVERED DRUG COST	YTD TrOOP BALANCE	BEGINNING BENEFIT PHASE	ENDING BENEFIT PHASE
January 10	$100	$100	$0	$0	D	D
January 15	$75	$75	$100	$100	D	D
January 20	$100	$30	$175	$175	D	N
January 10 reversal *(effective January 21)*	<$100>	<$100>	$75	$75		
PDE adjustments after reversal						
January 15	$75	$75	$0	$0	D	D
January 20	$100	$100	$75	$75	D	D
January 25	$70	$30	$175	$175	D	N

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 Phase, 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 TOTAL GROSS COVERED DRUG COSTS (TGCDC) AND TRUE OUT-OF-POCKET COSTS (TrOOP)

Purpose (Slide 2)

Plans are responsible for maintaining accurate accounting of each beneficiary's Total Gross Covered Drug Costs (TGCDC) and True Out-of-Pocket (TrOOP) costs on a real time basis and for coordinating all TrOOP related benefits. Beginning in 2011, the Prescription Drug Event (PDE) record reports how the plan has tracked accumulated TGCDC and TrOOP for a beneficiary on a given prescription drug event.

Accumulated Total Gross Covered Drug Costs identifies when the beneficiary is in the Deductible Phase (if any), the Initial Coverage Phase (ICP), or the Coverage Gap. The accumulated TrOOP identifies when a beneficiary has reached the annual limit in TrOOP costs and therefore enters the Catastrophic Coverage Phase. The Calculating and Reporting TGCDC and TrOOP module explains the process and requirements related to reporting and administering TrOOP, TGCDC, and the benefit phases.

Learning Objectives (Slides 3-4)

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 TGCDC and TrOOP costs.
- Illustrate how to populate PDE fields associated with TrOOP.
- Describe how to populate the TGCDC and TrOOP Accumulators and the Beginning and Ending Benefit Phase Indicators on the PDE
- 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 Total Gross Covered Drug Cost Accumulator Overview (Slides 5-6)

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.

Refer to Modules 1 and 4 for more information regarding calculating Gross Covered Drug 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 Paid + Dispensing Fee Paid + Amount Attributed to Sales Tax + Vaccine Administration Fee; and

2. In the summary fields Gross Drug Cost Above the Out of Pocket (OOP) Threshold (GDCA) or Gross Drug Cost Below the OOP Threshold (GDCB).

5.1.1 The Total Gross Covered Drug Cost (TGCDC) Accumulator (Slides 7-8)

The Total Gross Covered Drug Cost Accumulator field reports the sum of the beneficiary's covered drug costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. In other words, the TGCDC Accumulator is the sum of the beneficiary's total gross covered drug costs for the benefit year as identified on the claims that were adjudicated prior to the current claim. The PDE record should report the TGCDC Accumulator as the total gross covered drug costs of all adjudicated claims for the benefit year up to, but not including, the actual claim that the PDE record is reporting.

On the PDE record, the TGCDC Accumulator value indicates whether the beneficiary is in the Deductible Phase (if any), the Initial Coverage Phase, or the Coverage Gap. The Total Gross Covered Drug Cost Accumulator is used in combination with the True Out-of-Pocket (TrOOP) Accumulator, the Beginning Benefit Phase, and the Ending Benefit Phase described below to validate benefit phase. The Total Gross Covered Drug Cost Accumulator field should be left blank on PDEs for Over the Counter (OTC) or Enhanced drugs.

In Defined Standard (DS) plans, the DS parameters are used in conjunction with the accumulator fields and the benefit phase fields on the PDE record, to validate the phase of the benefit the beneficiary is in at the time of the claim's adjudication. For other benefit designs with plan determined deductible and initial coverage limits, the plan determined parameters are used in conjunction with the accumulator fields and the benefit phase fields to validate which phase of the benefit the beneficiary is in at the time of the adjudication of the claim.

5.2 The Benefit Phase Indicators Fields (Slide 9)

The Beginning Benefit Phase and Ending Benefit Phase indicator fields on the PDE record are used in conjunction with the TGCDC Accumulator and the TrOOP Accumulator to report and validate benefit phase. Like the TGCDC Accumulator and the TrOOP Accumulator, these fields apply to covered drugs only.

Table 5A illustrates the values plans can report in the benefit phase indicator fields.

TABLE 5A – BENEFIT PHASE INDICATOR FIELD CODES

BENEFIT PHASE	CODE
Deductible	D
Initial Coverage Phase	N
Coverage Gap	G
Catastrophic Coverage	C

5.2.1 Beginning Benefit Phase

The Beginning Benefit Phase is the plan-defined benefit phase that is in effect for the beneficiary at the time the sponsor begins adjudication of the individual claim being reported. For example, in a plan without a deductible, a beneficiary's first claim of the benefit year would be in the Initial Coverage Phase. The PDE record for that claim would report 'N' for ICP in the Beginning Benefit Phase field. In a Defined Standard plan, a beneficiary's first claim of the benefit year would be in the Deductible Phase and the Beginning Benefit Phase field on the PDE record would report 'D'. Applies to covered drugs only.

5.2.2 Ending Benefit Phase

The Ending Benefit Phase is the plan-defined benefit phase that is in effect at the time the sponsor completes adjudication of the individual claim being reported. The Ending Benefit Phase should always be a benefit phase equal to or later than the Beginning Benefit Phase. Applies to covered drugs only.

5.2.3 Reporting Benefit Phase – Defined Standard Plan (Slides 10-12)

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 following examples use DS benefit parameters for benefit year 2012. 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 other source of coverage
- Enrolled in a Part D plan with a DS benefit design

The following examples illustrate how to populate the TGCDC Accumulator, Beginning Benefit Phase, and Ending Benefit Phase for a DS plan, simplest case.

Example: 1.1 – Deductible Phase

The beneficiary's first drug purchase of the benefit year is a $100 covered drug. The beneficiary is in a Defined Standard plan.

Table 5B illustrates how the PDE record should be populated for this claim.

TABLE 5B - REPORTING BENEFIT PHASE – DEDUCTIBLE PHASE

Drug Coverage Status Code	Ingredient Cost	Dispensing Fee	Sales Tax	Vaccine Administration Fee	GDCB	GDCA	TGCDC Accumulator	Beginning Benefit Phase	Ending Benefit Phase
C	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	D	D

The Drug Coverage Status Code is populated with a 'C' indicating that this is a covered drug. The TGCDC Accumulator is set to $0.00 because it is the first claim of the benefit year, and there are no accumulated TGCDC costs to report. The Beginning Benefit Phase reports 'D' indicating that the beneficiary is in the deductible prior to the adjudication of the claim. The Ending Benefit Phase also reports 'D' indicating that the beneficiary remains in the Deductible Phase of the benefit after the adjudication of the claim that the PDE is reporting.

Example 1.2 – Straddle from Deductible to Initial Coverage

The same beneficiary makes the second drug purchase of the benefit year. The drug purchase is a $250 covered drug.

Table 5C illustrates how the PDE record should be populated for this claim.

TABLE 5C – REPORTING BENEFIT PHASE – STRADDLE CLAIM

Drug Coverage Status Code	Ingredient Cost	Dispensing Fee	Sales Tax	Vaccine Administration Fee	GDCB	GDCA	TGCDC Accumulator	Beginning Benefit Phase	Ending Benefit Phase
C	$250.00	$0.00	$0.00	$0.00	$250.00	$0.00	$100.00	D	N

Again, the Drug Coverage Status Code is populated with a 'C' indicating that this is a covered drug. The TGCDC Accumulator is set to $100.00 reflecting the previous claim with $100 in gross covered drug costs. The Beginning Benefit Phase reports 'D' indicating that the beneficiary is in the deductible prior to the adjudication of the claim that the PDE record is reporting. The Ending Benefit Phase is populated with 'N' indicating that the beneficiary is in the Initial Coverage Phase after the adjudication of the claim that the PDE is reporting.

5.3 Calculating and Reporting True Out-of-Pocket (TrOOP) Costs (Slides 13-15)

Tracking TrOOP accurately is critical to administering the Part D benefit and the Coverage Gap Discount Program and to submitting PDE records to the Centers for Medicare & Medicaid Services (CMS). TrOOP determines when a beneficiary is eligible to receive catastrophic coverage and when the beneficiary is no longer in the Coverage Gap. 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 three reasons why TrOOP is important:

1. The beneficiary is subject to a lower cost-sharing once TrOOP costs equal the OOP maximum, which is equal to the greater of 5 percent or the generic/brand co-payment of $2.60/$6.50 for 2012.

2. The plan is eligible to receive an 80 percent reinsurance subsidy once TrOOP costs equal the OOP threshold which is $4,700 for 2012.

3. The beneficiary is no longer in the Coverage Gap and is therefore no longer eligible to receive the gap discount at point of sale.

Monitoring TrOOP and Coordination of Benefits (COB) enables accurate determination of beneficiary cost-sharing at the point of sale (POS). In addition, tracking accumulated TrOOP, along with TGCDC, enables accurate determination of Coverage Gap Discounts at POS.

There are two parts to tracking TrOOP:

1. Calculating TrOOP and reporting related TrOOP fields on the PDE accurately

2. Updating and reporting the TrOOP Accumulator field on the PDE.

5.3.1 True Out-of-Pocket Costs Overview

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. The TrOOP limit for benefit year 2012 is $4,700. For purposes of determining catastrophic coverage, TrOOP stops accumulating once the OOP threshold is reached.

Module 1, Part D Payment Methodology includes the 2011 and 2012 TrOOP limits.

5.3.2 True Out-of-Pocket Cost Contributors (Slides 16-17)

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 four 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.
- Reported Gap Discount (RGD) amounts advanced by the plan on behalf of manufacturers at the point of sale.

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

TABLE 5D – 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] • AIDS Drug Assistance Program (ADAP)[2] • Indian tribe or tribal organization, or an urban Indian organization (I/T/U Pharmacy)[2] ▪ Reported Gap Discount	• 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.
[2]Affordable Care Act (ACA) provision effective January 1, 2011

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

5.3.3 Beneficiary Payments

Beneficiary payments are TrOOP eligible.

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

5.3.4 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 and are TrOOP eligible.

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

5.3.5 Coverage Gap Discount

Any Coverage Gap discount amounts advanced at point of sale by the plan on behalf of a manufacturer count towards TrOOP.

📖 Refer to Module 10 for more information regarding Manufacturers.

CMS coordinates through the Third Party Administrator (TPA) the payment of gap discounts by manufacturers to Part D sponsors that advanced the gap discount at the POS to applicable beneficiaries. This coordination involves a quarterly process for invoicing the manufacturers and reimbursing Part D sponsors.

📖 Refer to Module 10 for more information regarding the coverage gap discount and the invoicing process.

Coverage gap discount amounts are reported in the **Reported Gap Discount** field.

Coverage Gap discounts count toward a beneficiary's TrOOP costs and are reported in the Reported Gap Discount field.

5.3.6 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)

5.3.7 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 6 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.

5.3.8 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 18)

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 (on PDEs with DOS of benefit year 2010 and prior)
- Seven 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
  - Reported Gap Discount
- TrOOP Accumulator
- Beginning Benefit Phase
- Ending Benefit Phase

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

For PDES for benefit year 2010 and prior, this field identifies the beneficiary's benefit status, specifically whether or not he/she has crossed the OOP threshold and entered Catastrophic Coverage.

For PDEs with DOS on or after 1/1/2011, the Beginning Benefit Phase, Ending Benefit Phase, TGCDC Accumulator, and TrOOP Accumulator fields on the PDE record represents the same information provided in the Catastrophic Coverage Code field.

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

5.4.3 Seven Payment Fields that Affect True Out-of-Pocket Costs (Slides 19-25)

Seven 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. One payment field (Reported Gap Discount) documents payment advanced by a Part D plan at the POS on behalf of the manufacturer and is also included in TrOOP. The remaining two payment fields (CPP and NPP) document payment by the Part D plan, and neither of these is included in TrOOP.

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

TABLE 5E – IMPACT OF PAYMENT FIELDS ON TrOOP

FIELD NAME	TrOOP INCLUSION	TrOOP EXCLUSION
Patient Pay Amount	**X**	
Other TrOOP Amount	**X**	
LICS	**X**	
Reported Gap Discount	**X**	
PLRO		**X**
CPP		**X**
NPP		**X**

5.5 TrOOP Accumulator (Slide 26)

The TrOOP Accumulator field reports the sum of the beneficiary's incurred costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. The beneficiary's incurred costs are reported on the existing PDE as Patient Pay Amount, Low Income Cost-Sharing Subsidy (LICS), Other TrOOP Amount, and Reported Gap Discount. The TrOOP Accumulator is the sum of the beneficiary's total TrOOP costs for the benefit year as identified on the claims that were adjudicated prior to the current claim. The PDE record should report the TrOOP Accumulator as the true out of pocket costs of all adjudicated claims for the benefit year up to, but not including, the actual claim that the PDE record is reporting. By definition, TrOOP costs apply only to Part D covered drugs.

On the PDE record, the TrOOP Accumulator value indicates whether the beneficiary is in Catastrophic Coverage or is pre-catastrophic. The TrOOP Accumulator field should be left blank on PDEs for OTC or Enhanced drugs. The TrOOP Accumulator does not increase after the beneficiary reaches the out-of-pocket threshold.

5.6 Calculating True Out-of-Pocket Costs – Other Health Insurance (OHI) (Slides 35-40)

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 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 Part D 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 and purchases a $100 covered drug. Prior to the adjudication of the claim for this drug, the beneficiary has $345.00 in accumulated TrOOP and $420.00 in accumulated gross covered drug costs. The original Patient Pay Amount is $25. The TrOOP Facilitator reports a Patient Pay Amount of $10 with a secondary insurance paying the difference.

Step 1: The net change between the original Patient Pay Amount and the Patient Pay Amount reported by the TrOOP facilitator is $15 ($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. Therefore, only the Patient Pay Amount increases the TrOOP accumulator for this event (by $10).

Table 5F illustrates how to populate the PDE record for this claim.

TABLE 5F – CALCULATING TrOOP COSTS - OHI

Drug Coverage Status Code	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	Other TrOOP Amount	LICS	Reported Gap Discount	PLRO	Ending Benefit Phase
C	$420.00	$345.00	N	$10.00	$0.00	$0.00	$0.00	$15.00	N

The Drug Coverage Status Code is populated with a 'C' indicating that this is a covered drug. The TGCDC Accumulator is set to $420.00 because that was the accumulated TGCDC for the benefit year prior to the adjudication of the claim. The TrOOP Accumulator is set to $345.00 because that was the accumulated TrOOP for the benefit year prior to the adjudication of the claim. The Beginning Benefit Phase reports 'N' indicating that the beneficiary is in the Initial Coverage Phase prior to the adjudication of the claim. The Ending Benefit Phase also reports 'N' indicating that the beneficiary remains in the Initial Coverage Phase of the benefit after the adjudication of the claim that the PDE is reporting.

Table 5G illustrates how to populate Drug Coverage Status Code, the accumulators, and Beginning Benefit Phase for the PDE for the next adjudicated claim.

TABLE 5G – UPDATING THE ACCUMULATORS - OHI

Drug Coverage Status Code	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase
C	$520.00	$355.00	N

The TGCDC Accumulator and the TrOOP Accumulator are updated to reflect the previous claim's values and the Beginning Benefit Phase reports 'N' because the last claim ended in the Initial Coverage Phase.

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

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

5.7.1 Qualified Third Party Payer

Example: 2

The beneficiary is in the Initial Coverage Phase of the Defined Standard benefit for calendar year 2012. Prior to the adjudication of the claim for this drug, the beneficiary has $345.00 in accumulated TrOOP and $420.00 in accumulated Gross Covered Drug Costs. 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 5H illustrates how a plan populates the following twelve data elements for this sample PDE.

TABLE 5H – A QUALIFIED THIRD PARTY PAYER PDE RECORD AND TrOOP ACCUMULATOR

Drug Coverage Status Code	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	Other TrOOP Amount	LICS	Reported Gap Discount	PLRO	CPP	NPP	Ending Benefit Phase
C	$420.00	$345.00	N	$5.00	$20.00	$0.00	$0.00	$0.00	$75.00	$0.00	N

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.

The PDE record for the next claim adjudicated would show that the TrOOP Accumulator would increase by $25.00 and that the TGCDC Accumulator would increase by $100.

TABLE 5I – UPDATING THE ACCUMULATORS - QUALIFIED THIRD PARTY PAYER

Drug Coverage Status Code	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase
C	$520.00	$370.00	N

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.

5.7.2 Non-Qualified Third Party Payer

Example: 3

The beneficiary is in the Initial Coverage Phase of a Basic Alternative (BA) benefit plan in 2012. Prior to the adjudication of the claim for this drug, the beneficiary has $365.00 in accumulated TrOOP and $500.00 in accumulated Gross Covered Drug Costs. 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 twelve data elements for this sample PDE.

TABLE 5J – A NON-QUALIFIED THIRD PARTY PAYER PDE RECORD AND TrOOP ACCUMULATOR

Drug Coverage Status Code	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	Other TrOOP Amount	LICS	Reported Gap Discount	PLRO	CPP	NPP	Ending Benefit Phase
C	$500.00	$365.00	N	$10.00	$0.00	$0.00	$0.00	$10.00	$80.00	$0.00	N

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 which 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.

The PDE record for the next adjudicated claim would show that the TrOOP Accumulator would increase by $10.00 and that the TGCDC Accumulator would increase by $100.

Table 5D illustrates how a plan populates the following four data elements for the PDE for the next adjudicated claim.

TABLE 5K – UPDATING THE ACCUMULATORS – NON-QUALIFIED THIRD PARTY PAYER

Drug Coverage Status Code	TGCDC Acc	TrOOP Acc	Beginning Benefit Phase
C	$600.00	$375.00	N

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, NPP, and Reported Gap Discount). DDPS rejects records when the total costs and the total payments differ by more than the $.05 allowed for rounding error. See error codes 690 and 692.

5.8 Adjustment/Deletion Processing and True Out-of-Pocket Costs (Slides 41-42)

In order to maintain the integrity of the benefit, plans must understand how claim changes post point-of-sale affect the Catastrophic Coverage 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 $ 4,700 (in 2012) moves the beneficiary into the Catastrophic Coverage Phase of the benefit. Secondly, for purposes of benefit administration, plans do not increment TrOOP balances beyond $4,700. 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 Coverage 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 $4,700. As the beneficiary "pays back the benefit" on subsequent claims, the TrOOP balance will return to $4,700 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.

5.8.1 Reversal With No Benefit Change – Coverage Gap

The beneficiary who is enrolled in an Actuarially Equivalent (AE) plan has a YTD TrOOP balance of $990 and YTD Gross Covered Drug Cost of $3,000 which places him in the Coverage Gap. In this example the beneficiary purchases three applicable drugs from a pharmacy which, for purposes of this example, does not charge a dispensing fee. 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 5L.

TABLE 5L – PLAN ACCUMULATORS

CLAIM DATE	CURRENT CLAIM				ACCUMULATORS		PDE DATA ELEMENTS	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator	GDCB	GDCA
Balance before the August 10 claim					$3,000	$990		
August 10	$100	$50	$50	$100	$3,000	$990	$100	$0
August 15	$75	$37.50	$37.50	$75	$3,100	$1,090	$75	$0
August 20	$50	$25	$25	$50	$3,175	$1,165	$50	$0
Balance after the August 20 claim					$3,225	$1,215		
August 10 reversal (effective August 21)	<$100>	<$50>	<$50>	<$100>	-	-	N/A	
Balance after reversal on the August 21					$3,125	$1,115		

In this example the beneficiary has not accumulated $4,700 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 GDCA will be $0.00, and GDCB will equal gross covered drug cost.

5.8.2 Reversal With No Benefit Phase Change – Catastrophic Benefit Phase (Slides 43-44)

The beneficiary who is enrolled in a Defined Standard benefit was in the Catastrophic Coverage 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 5M.

TABLE 5M – PLAN ACCUMULATORS

CLAIM DATE	CURRENT CLAIM			ACCUMULATORS	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator
Balance before the August 10 claim				$6,800	$4,700
August 10	$100	$6.50	$0	$6,800	$4,700
August 15	$75	$6.50	$0	$6,900	$4,700
August 20	$50	$6.50	$0	$6,975	$4,700
Balance after the August 20 claim				$7,025	$4,700
August 10 reversal (effective August 21)	<$100>	<$6.50>	$0		
Balance after reversal on August 21				$6,925	$4,700

The YTD TrOOP balance remains constant at $4,700 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 TrOOP Accumulator equal to $4700, GDCB equal to $0.00, and GDCA equal to gross covered drug cost.

5.8.3 Reversal With Benefit Phase Change – Catastrophic and the Coverage Gap (Slides 45-51)

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. On August 10 the beneficiary purchases an applicable drug from a pharmacy which, for purposes of this example, does not charge a dispensing fee. The pharmacy fills the prescription immediately and bills the plan. This prescription updates the YTD gross covered drug cost from $6,700 to $6,800 and updates the YTD TrOOP balance from $4,600 to $4,700. 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 $4,600 is below the $4,700 threshold (in 2012) 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.

5.8.3.1 Paying Back the Benefit on Future Claims (and Reporting PDEs "as Administered")

On August 25 the beneficiary purchases an applicable drug from a pharmacy which, for purposes of this example, does not charge a dispensing fee. The plan adjudicates the August 25 claim in the Coverage Gap. This will restore the TrOOP balance to $4,700 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 5N.

TABLE 5N – PLAN ACCUMULATORS AND PDE DATA ELEMENTS

CLAIM DATE	CURRENT CLAIM				ACCUMULATORS		PDE DATA ELEMENTS	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator	GDCB	GDCA
Balance before the August 10 claim					$6,700	$4,600		
August 10	$100	$50	$50	$100	$6,700	$4,600	$100	$0
August 15	$100	$6.50	$0	$0	$6,800	$4,700	$0	$100
August 20	$100	$6.50	$0	$0	$6,900	$4,700	$0	$100
August 10 reversal (effective August 21)	<$100>	<$50>	<$50>	<$100>	-	-	N/A	
Balance after the reversal on August 20					$6,800	$4,600		
August 25	$100	$50	$50	$100	$6,800	$4,600	$100	$0
August 30	$100	$6.50	$0	$0	$6,900	$4,700	$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. The delete record will alert CMS to remove the August 10 Gap Discount from the Manufacturer invoice. All PDEs on file document the actual beneficiary cost-sharing paid at point-of-sale.

5.8.3.2 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 5O and 5P. Table 5O shows activity through August 20. Table 5P shows updated activity through August 30.

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

CLAIM DATE	CURRENT CLAIM				ACCUMULATORS		PDE DATA ELEMENTS	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator	GDCB	GDCA
Balance before the August 10 claim					$6,700	$4,600		
August 10	$100	$50	$50	$100	$6,700	$4,600	$100	$0
August 15	$100	$6.50	$0	$0	$6,800	$4,700	$0	$100
August 20	$100	$6.50	$0	$0	$6,900	$4,700	$0	$100

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

CLAIM DATE	CURRENT CLAIM				ACCUMULATORS		PDE DATA ELEMENTS	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator	GDCB	GDCA
Balance before the August 10 claim					$6,700	$4,600		
August 10	$100 $0	$50 $0	$50 $0	$100 $0	$6,700	$4,600	$100	$0
August 15	$100	~~$6.50~~ $50	~~$0~~ $50	~~$0~~ $100	~~$6,800~~ $6,700	$4,700	~~$0~~ $100	~~$100~~ $0
August 20	$100	$6.50	$0	$0	~~$6,900~~ $6,800	$4,700	$0	$100
August 25	$100	$6.50	$0	$0	$6,900	$4,700	$0	$100
August 30	$100	$6.50	$0	$0	$7,000	$4,700	$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. CMS will invoice the manufacturer for the Reported Gap Discount documented on the August 15 claim.

MODULE 6 – 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	

6.1 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 6A and 6B outline the eligibility requirements and maximum cost-sharing for low income subsidy eligible beneficiaries. Table 6A lists the values that apply for coverage year 2011 and Table 6B lists the indexed values that apply to coverage year 2012.

Note that LI beneficiaries have continuous coverage with one exception: Category 4 beneficiaries are assigned a $63 deductible (2011) and a $65 deductible (2012) 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 2012 coverage year values, identified in Table 6B.

TABLE 6A – 2011 LICS CATEGORIES

		MAXIMUM LI BENEFICIARY COST-SHARING			
Category Code	**Income Category**	**Deductible**	**Initial Coverage Phase**	**Coverage Gap**	**Catastrophic**
2	≤100% FPL and fbde	$ 0	$1.10-generic $3.30-brand	$1.10-generic $3.30-brand	$0
1	<135% or >100% FPL and fbde	$ 0	$2.50-generic $6.30-brand	$2.50-generic $6.30-brand	$0
4	<150% FPL	$63	15%	15%	$2.50-generic $6.30-brand
3	Inst fbde	$ 0	$0	$0	$0

TABLE 6B – 2012 LICS CATEGORIES

		MAXIMUM LI BENEFICIARY COST-SHARING			
Category Code	**Income Category**	**Deductible**	**Initial Coverage Phase**	**Coverage Gap**	**Catastrophic**
2	≤100% FPL and fbde	$ 0.00	$1.10-generic $3.30-brand	$1.10-generic $3.30-brand	$0.00
1	<135% or >100% FPL and fbde	$ 0.00	$2.60-generic $6.50-brand	$2.60-generic $6.50-brand	$0.00
4	<150% FPL	$65.00	15%	15%	$2.60-generic $6.50-brand
3	Inst fbde	$ 0.00	$0.00	$0.00	$0.00

Notes for Tables 6A, and 6B: 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 6A and 6B 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://csscoperations.com/Internet/Cssc.nsf/docsCat/PDE~User%20GroupTraining?OpenDocument&Start=1&Count=45&Expand=1.2.

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:

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 2012 values.

- $0.00 deductible
- No gap in his drug coverage
- A co-pay not to exceed $2.60 for covered Part D generic drugs and not to exceed $6.50 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

6.2 Calculating Low Income Cost-Sharing Subsidy (Slides 8-14)

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).
*Non-LI Cost sharing is defined as the amount the patient pays prior to applying the Coverage Gap Discount Program (CGDP) and generic cost-sharing in the Coverage Gap Phase (i.e., patient pay is 100% of Gross Covered Drug Cost).
**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 ($65 in 2012).
- 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 6.3.3). 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 Phase. Year-to-date (YTD) Gross Covered Drug Costs = $1,500, which places each beneficiary in the Initial Coverage Phase. Each beneficiary purchases a brand name covered drug for $100.

Table 6C 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 6B, 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 6B (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 6C – 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	$ 3.30	$ 3.30	$21.70	$75.00	$25.00
Category 1	$100.00	$25.00	$ 6.50	$ 6.50	$18.50	$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 6.3.3.

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.

6.3 Populating the PDE Record for LICS Beneficiaries (Slide 15)

This section provides examples of populating a PDE record for LICS-eligible beneficiaries in all benefit phases and at all LI eligibility categories for 2012. 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
- 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
- TGCDC Accumulator
- TrOOP Accumulator
- Beginning Benefit Phase
- Ending Benefit Phase

6.3.1 Defined Standard Deductible Phase

In 2012, NCE Health Plan offers a defined standard benefit package ($320 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 6D indicates how LICS is calculated and how PDE fields are populated, for this event, noting TrOOP accumulation.

TABLE 6D – 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**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Ending Benefit Phase**
Non-LI	C	$0.00	$0.00	D	$50.00	$0.00	$0.00	D
LI, Institutionalized (Category 3)	C	$0.00	$0.00	D	$ 0.00	$50.00	$0.00	D
LI, Category 4	C	$0.00	$0.00	D	$50.00	$ 0.00	$0.00	D

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 2012 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.

6.3.2 Actuarially Equivalent Initial Coverage (Slides 16-18)

In 2012, 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. The TGCDC Accumulator is $500 as is the TrOOP Accumulator. Table 6E indicates how LICS is calculated and how PDE fields are populated for this event, noting TrOOP accumulation.

TABLE 6E – ACTUARIALLY EQUIVALENT INITIAL COVERAGE 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)**
Category 1	$5.00	$0.25	$2.60	$0.25	$0.00	$4.75	$0.25

PDE RECORD FIELDS								
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Ending Benefit Phase**
Non-LI	C	$500.00	$365.00	N	$0.25	$0.00	$4.75	N
LI, Category 1	C	$500.00	$365.00	N	$0.25	$0.00	$4.75	N

In this example, the Non-LI beneficiary is in the Initial Coverage Phase 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 $2.60 in 2012 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.

6.3.3 Defined Standard Coverage Gap With TrOOP Other Payer (Slides 19-22)

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 2012, Sunny Valley Health Plan offers a Defined Standard benefit package. The beneficiary is Category 4 eligible and has YTD gross covered drug costs of $3,000. 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. The dispensing fee is $5. The TGCDC Accumulator is $3,000 and the TrOOP

Accumulator is $1,042.50. Table 6F indicates how LICS is calculated in 2012 and how PDE fields are populated for this event.

TABLE 6F – DEFINED STANDARD COVERAGE GAP WITH QUALIFIED SPAP ASSISTANCE

LICS CALCULATION							
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
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**
$300.00	$300.00	$45.00	$45.00	$255.00	$0.00	$0.00	$45.00

PDE RECORD FIELDS										
Beneficiary Type	**Drug Cvg Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Other TrOOP Amount**	**Reported Gap Discount**	**Ending Benefit Phase**
Non-LI	C	$3,000.00	$1,042.50	G	$152.50	$0.00	$0.00	$0.00	$147.50	G
LI, Category 4	C	$3,000.00	$1,042.50	G	$0.00	$255.00	$0.00	$45.00	$0.00	G

*Non-LI Cost share is determined prior to applying the CGDP.
**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 is $152.50 (Total Drug Cost – Gap Discount) for the non-LI beneficiary because the qualified SPAP did not provide any assistance to that individual. The LI beneficiary is not eligible for the CGDP. LICS is calculated by comparing the Non-LI beneficiary's cost-sharing before applying the CGDP and 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. In preparation for the next PDE for the beneficiary, the TGCDC Accumulator will be updated to $3,300 and the TrOOP Accumulator will be updated to $1,342.50.

6.3.4 Defined Standard Coverage Gap – Generic Drug

Effective January 1, 2011, generic coinsurance is reduced for non-low income (LI) eligible beneficiaries with claims that fall, in part or in full, in the coverage gap.

In 2012, Sunny Valley Health Plan offers a Defined Standard benefit package. The beneficiary is Category 2 eligible and has YTD gross covered drug costs of $3,000. The beneficiary purchases a covered generic drug for $5. The TGCDC Accumulator is $3,000 and the TrOOP Accumulator is $1,042.50. Table 6G indicates how LICS is calculated in 2012 and how PDE fields are populated for this event.

TABLE 6G – DEFINED STANDARD COVERAGE GAP WITH QUALIFIED SPAP ASSISTANCE

LICS CALCULATION					
A	**B**	**C**	**D**	**E**	**F**
Gross Covered Drug Cost	**Non-LI Cost Share* (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**LICS (B - D)**	**CPP**
$5.00	$5.00	$1.10	$1.10	$3.90	$0.00

PDE RECORD FIELDS									
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Reported Gap Discount**	**Ending Benefit Phase**
Non-LI	C	$3,000.00	$1,042.50	G	$4.30	$0.00	$0.70	$0.00	G
LI, Category 2	C	$3,000.00	$1,042.50	G	$1.10	$3.90	$0.00	$0.00	G

*Non-LI Cost share is determined prior to applying generic cost-sharing in the Coverage Gap**.**

The non-LI beneficiary is eligible for generic cost-sharing in the coverage gap and therefore pays 86% of the Gross Covered Drug Cost. The LI beneficiary is not eligible for generic cost-sharing in the coverage gap and therefore pays $1.10 as displayed in Table 6B. LICS is calculated by comparing the Non-LI beneficiary's cost-sharing before applying generic cost-sharing in the coverage gap with the co-pay for Category 1 LI beneficiary. Since the non-LI beneficiary cost-sharing is greater than the LI cost-sharing, LICS is $3.90 ($5.00 - $1.10). In preparation for the next PDE for the beneficiary, the TGCDC Accumulator will be updated to $3,005.00 and the TrOOP Accumulator will be updated to $1,047.50.

6.3.5 Actuarially Equivalent Straddle Claim (Slide 23)

In 2012, 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 Phase. The beneficiary's YTD gross covered drug costs are $2,905; she is LI-Category 1 eligible and purchases a covered brand drug in Tier 2 for $80. The dispensing fee is $5. The TGCDC Accumulator is $2,905 and the TrOOP Accumulator is $750. Table 6H indicates how LICS is calculated in 2012 and how PDE fields are populated for this event.

TABLE 6H – 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	$2.60	$2.60	$72.40	$5.00	$75.00

PDE Record Fields									
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Reported Gap Discount**	**Ending Benefit Phase**
Non-LI	C	$2,905.00	$750.00	N	$47.50	$0.00	$5.00	$27.50	G
LI, Category 1	C	$2,905.00	$750.00	N	$2.60	$72.40	$5.00		G

In this example, cost-sharing is determined with straddle claim logic. With YTD gross covered drug costs of $2,905 the beneficiary is in the Initial Coverage Phase, 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 before applying the CGDP is calculated by combining the Tier 2 co-pay of $20 in the Initial Coverage Phase (which includes the dispensing fee) 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 $2.60 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 $2.60. In preparation for the next PDE for the LI beneficiary and the non-LI beneficiary, the TGCDC Accumulator will be updated to $2,985.00 and the TrOOP Accumulator will be updated to $825.00.

6.3.6 Defined Standard Catastrophic Coverage Phase

In 2012, Lara Pharmacy Insurance offers a Defined Standard benefit. Two beneficiaries, Category 2 and Category 4 eligible, each with $6,800 YTD gross covered drug costs, purchase a $200 covered brand drug. The TGCDC Accumulator is $6,800 and the TrOOP Accumulator is $4,700. Table 6I indicates how LICS is calculated and how PDE fields are populated for this event.

TABLE 6I – 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	$ 6.50	$6.50	$3.50	$190.00

PDE RECORD FIELDS									
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**GDCA**	**Ending Benefit Phase**
Non-LI	C	$6,800.00	$4,700.00	C	$10.00	$0.00	$190.00	$200.00	C
Category 2	C	$6,800.00	$4,700.00	C	$ 0.00	$10.00	$190.00	$200.00	C
Category 4	C	$6,800.00	$4,700.00	C	$ 6.50	$ 3.50	$190.00	$200.00	C

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.

6.3.7 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 ($65 in 2012). The first example reviews the basic case where the plan deductible is greater than the statutory amount so that the Category 4 beneficiary pays the full statutory amount (see 6.3.6.1). 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 6.3.6.1 and 6.3.6.2 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 Phase.

6.3.7.1 Category 4 LICS Beneficiary, Plan Deductible Greater Than Statutory Category 4 Amount (Slides 24-27)

A Category 4 beneficiary joined a Defined Standard plan ($320 deductible in 2012). 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 $65 deductible for the first claim is included in the calculation on the Category 4 side. After the $65 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. The TGCDC and TrOOP

Accumulators are $100 for the Category 4 beneficiary. Table 6J illustrates the Deductible greater than the statutory Category 4 amount.

TABLE 6J – DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT

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**
Non-LI, Claim 1	$100.00	$100.00	N/A	$100.00	$0.00	$0.00
Non-LI, Claim 2	$100.00	$100.00	N/A	$100.00	$0.00	$0.00
LI Category 4, Claim 1	$100.00	$100.00	$70.25	$70.25	$29.75	$0.00
LI Category 4, Claim 2	$100.00	$100.00	$15.00	$15.00	$85.00	$0.00

PDE Record Fields								
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Ending Benefit Phase**
Non-LI, Claim 1	C	$0.00	$0.00	D	$100.00	$0.00	$0.00	D
Non-LI, Claim 2	C	$100.00	$100.00	D	$100.00	$0.00	$0.00	D
LI Category 4, Claim 1	C	$0.00	$0.00	D	$70.25	$29.75	$0.00	D
LI Category 4, Claim 2	C	$100.00	$100.00	D	$15.00	$85.00	$0.00	D

The Drug Coverage Status code is "C" for a covered drug. On the first claim, the beneficiary pays a reduced deductible of $65 instead of $320, according to the statutory provision. The beneficiary pays a 15 percent coinsurance on the remaining $35 of the first claim ($5.25) for a total Patient Pay Amount of $70.25 on the PDE record ($65 + $5.25). The difference between the non-LI cost-sharing and the LI cost-sharing is subsidized on the beneficiary's behalf ($100 - $70.25 = $29.75); 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 plan adjudicates the next claim by continuing to apply a LICS Category 4, 15 percent coinsurance (15% * $100 = $15). However, for the purpose of reporting the beginning and ending benefit phase fields, the plan will populate "D" since the beneficiary has not yet met the plan's $320 Defined Standard Deductible for benefit phase purposes.

6.3.7.2 Category 4 LICS Beneficiary, Plan Deductible Less Than Statutory Category 4 Amount and Greater Than Zero (Slide 28)

Assume that in 2012, a Category 4 beneficiary enrolls in a basic alternative PBP with a $30 deductible, followed by 25 percent coinsurance in the Initial Coverage Phase. 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 $65) 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. The TGCDC and TrOOP Accumulators for the Category 4 beneficiary after the second claim is $25. Table 6K illustrates the Deductible less than the statutory Category 4 amount and greater than zero.

TABLE 6K – DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO

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**
Non-LI Claim 1	$25.00	$25.00	N/A	$25.00	$0.00	$0.00
Non-LI Claim 2	$200.00	$53.75	N/A	$53.75	$0.00	$146.25
LI Category 4, Claim 1	$25.00	$25.00	$25.00	$25.00	$0.00	$0.00
LI Category 4, Claim 2	$200.00	$53.75	$34.25	$34.25	$19.50	$146.25

PDE Record Fields								
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Ending Benefit Phase**
Non-LI, Claim 1	C	$0.00	$0.00	D	$25.00	$0.00	$0.00	D
Non-LI, Claim 2	C	$25.00	$25.00	D	$53.75	$0.00	$146.25	N
LI Category 4, Claim 1	C	$0.00	$0.00	D	$25.00	$0.00	$0.00	D
LI Category 4, Claim 2	C	$25.00	$25.00	D	$34.25	$19.50	$146.25	N

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 Phase 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.

6.3.7.3 Category 4 LICS Beneficiary, Zero Deductible Plan

A Category 4 beneficiary joins a basic alternative PBP in 2012 with no deductible and 25 percent cost-sharing in the Initial Coverage Phase. 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. The TGCDC and TrOOP Accumulators are $0. Table 6L illustrates the zero deductible plan.

TABLE 6L- ZERO DEDUCTIBLE

LICS CALCULATION						
A	**B**	**C**	**D**	**E**	**F**	**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**
Non-LI	$100.00	$25.00	N/A	$25.00	$0.00	$75.00
LI Category 4	$100.00	$25.00	$15.00	$15.00	$10.00	$75.00

PDE Record Fields								
Beneficiary Type	**Drug Coverage Status Code**	**TGCDC Accumulator**	**TrOOP Accumulator**	**Beginning Benefit Phase**	**Patient Pay Amount**	**LICS**	**CPP**	**Ending Benefit Phase**
Non-LI	C	$0.00	$0.00	N	$25.00	$0.00	$75.00	N
LI Category 4	C	$0.00	$0.00	N	$15.00	$10.00	$75.00	N

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.

6.3.8 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:

In 2012, 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 6M indicates how LICS is calculated in 2012 and how PDE fields are populated for this event.

Table 6M – 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).

The following fields will be blank on this PDE: TGCDC Accumulator, TrOOP Accumulator, Beginning Benefit Phase, and Ending Benefit Phase.

6.4 Adjustment of PDE Records With LICS Data (Slide 29)

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. Similarly, the plan must reverse any CGDP payments made before the retroactive status was known. 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:

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. The Reported Gap Discount on the PDE was $21.50. Sunny Valley Health Plan must adjust that PDE record to account for the beneficiary's LICS and change the Reported Gap Discount to zero. The record was submitted when the beneficiary's YTD gross covered drug costs = $3,000. The beneficiary purchased a covered brand drug for $45. The dispensing fee is $2. Since the event was in the coverage gap, the beneficiary paid $23.50 (Reported Gap Discount = $21.50) at POS but now only owes LI-Category 4 cost-sharing ($6.75). Table 6N indicates how LICS is calculated, how PDE fields are populated for this adjustment, how the beneficiary is reimbursed.

TABLE 6N – ADJUSTMENT OF A PDE RECORD WITH LICS DATA

LICS CALCULATION								
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
Beneficiary Type	**Gross Covered Drug Cost**	**Non-LI Cost Share* (Step 1)**	**LI Cost Share (Step 2)**	**Patient Pay Amount**	**Reported Gap Discount**	**LICS (C – D)**	**CPP**	**TrOOP Amount (E+F+G)**
Non-LI	$45.00	$45.00	$0.00	$23.50	$21.50	$0.00	$0.00	$45.00
Category 4	$45.00	$45.00	$6.75	$6.75	$0.00	$38.25	$0.00	$45.00

*Non-LI Cost share is determined prior to applying the CGDP.

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 ($23.50 - $6.75) = $16.75 and cannot set up an account receivable instead.

	Original PDE Record	**Adjusted PDE Record**
Drug Coverage Status Code	C	C
Patient Pay Amount	$23.50	$ 6.75
LICS	$ 0.00	$38.25
CPP	$ 0.00	$ 0.00
Reported Gap Discount	$21.50	$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 Patient Pay, Reported Gap Discount and LICS are TrOOP eligible amounts.

MODULE 7 – 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.
- Apply the business rules effective January 1, 2011 related to the Affordable Care Act provisions in the Coverage Gap.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

7.1 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 7A.

TABLE 7A – TWO FORMS OF EA BENEFITS

EA BENEFIT	BENEFIT DESCRIPTION
Coverage of non-Part D drugs	• Allows for the payment of drugs 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 7.4.1).

7.2 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)

7.2.1 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 code 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 and Coverage Gap Discount Program (CGDP) 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).

7.2.2 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).

Note: Part D plans should provide PBM oversight early in the benefit year to confirm that plan type is established correctly.

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 7.4.1 further discusses the rationale for mapping along with its business rules.

7.2.3 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, Patient Liability Reduction due to Other Payer Amount (PLRO), and Reported Gap Discount. These seven payment fields record seven mutually exclusive types of payment. When the PDE reports a covered drug, the sum of these seven 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 dollar amount in the NPP field is EACS.

7.3 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 payment. (See 7.2.1) We emphasize that there is never a CPP amount because all plan payments for EA drugs are excluded from Medicare

payment. No LICS is paid on supplemental drugs and no out-of-pocket or third party payments on these drugs count towards TrOOP. Supplemental benefits are excluded from the CGDP. Therefore, the CPP, LICS Amount, Other TrOOP Amount, and Reported Gap Discount 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 (reported in the Total Gross Covered Drug Cost (TGCDC) Accumulator, nor does it increase the TrOOP costs (reported in the TrOOP Accumulator). For the purpose of reporting plan paid amounts, YTD gross covered drug costs and TrOOP costs determine thebeneficiary's benefit phase. Purchases of non-covered drugs do not change a beneficiary's YTD gross covered drug costs, TrOOP costs, nor benefit phase (see Module 1). On the PDE record for EA drugs, the TGCDC and TrOOP Accumulators are blank and the benefit phase indicators are blank.

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) and that the Reported Gap Discount is zero (see edit 768).

7.4 Business Rules for Calculating and Reporting Enhanced Alternative Cost-Sharing (EACS) (Slides 13-17)

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.

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). To ensure uniform cost sharing across all benefit designs, the following sections delineate 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.

Provisions of the Affordable Care Act effective in 2011 allow for reduced beneficiary cost-sharing for generic drugs for non-Low Income Subsidy (non-LI) beneficiaries in the Coverage Gap. This enhancement to the Defined Standard Part D benefit alters PDE reporting rules for EA plans. Generic Coverage Gap cost-sharing applies to all categories of Part D drugs that are not applicable drugs under the CGDP. The mapping rules must account for the impact of generic utilization in the Coverage Gap.

Impacts to CPP mapping include:

- Creating two separate mapping tables for non-LI beneficiaries [Tables 7C (2011) and 7D (2012)] and for LI beneficiaries [(Tables 7E (2011) and 7F (2012)]
- On the non-LI beneficiary CPP mapping table, delineating CGDP applicable drug CPP (0%) from CGDP non-applicable drug CPP (7% in 2011 and 14% in 2012)

Tables 7B, 7C, and 7D 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").

Note: the following patterns occur when costs are mapped to the Defined Standard benefit (see examples in Sections 7.5 and 7.6):

- 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.

TABLE 7B – 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 Tables 7C and 7D for non-LI beneficiaries).	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, LICS, and Reported Gap Discount. • EACS is reported in NPP.	NPP

7.4.1 Mapping to the Defined Standard Benefit for Non-Low Income Subsidy (Non-LI) Beneficiaries

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.

For 2011, rules affecting CPP calculation in the Gap (Rules 3 and 4) are different for LI and non-LI beneficiaries. This is because for non-LI beneficiaries, TGCDC is slightly higher because of additional plan cost sharing in the Gap for generic drugs. (This TGCDC equivalent value applies only to beneficiaries with no non-TrOOP OHI.)

Also beginning in 2011, for the non-LI beneficiary, we subdivide rule #3 in Table 7C by adding instructions for applicable and non-applicable drugs. In 2011 there is no CPP for applicable drugs. However, for non-applicable drugs CPP is 7% of the Total Gross Covered Drug Cost when a non-Low Income Subsidy (non-LI) beneficiary is in the Coverage Gap. Coverage Gap cost-sharing reduces the non-LI beneficiary's cost-sharing on non-applicable drugs incrementally each year until the Gap is effectively closed in 2020. (Further discussion of non-applicable drugs in the coverage gap phase can be found in Module 5.)

TABLE 7C – MAPPING TO THE 2011 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR NON-LI BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $310	0%
2	> $310 and ≤ $2,840	75%
3	> $2,840 and ≤ $6,483.72	Applicable drugs 0% Non-applicable drugs 7%
4	> $6,483.72 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)

TABLE 7D – MAPPING TO THE 2012 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR NON-LI BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $320	0%
2	> $320 and ≤ $2,930	75%
3	> $2,930 and ≤ $6,730.39	Applicable drugs 0% Non-applicable drugs 14%
4	> $6,730.39 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.60/$6.50)

7.4.2 Mapping to the Defined Standard Benefit for Low Income Subsidy (LI) Beneficiaries

ACA cost sharing provisions in the Coverage Gap do not apply to LI beneficiaries. Therefore, there is no need to make the delineation in Rule #3 when EA plans map CPP to the Defined Standard benefit for an LI beneficiary.

TABLE 7E – MAPPING TO THE 2011 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR LI BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $310	0%
2	> $310 and ≤ $2,840	75%
3	> $2,840 and ≤ $6,447.50	0%
4	> $6,447.50 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)

TABLE 7F – MAPPING TO THE 2012 DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR LI BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $320	0%
2	> $320 and ≤ $2,930	75%
3	> $2,930 and ≤ $6,657.50	0%
4	> $6,657.50 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.60/$6.50)

Note: For covered drug costs that fall above $6,657.50, but below the PBP's Out-of-Pocket (OOP) threshold in 2012, 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).

Plans must use the mapping rules described above. If plans erroneously use other mapping assumptions and mis-report CPP, risk sharing may be paid incorrectly. Plans should conduct diligent oversight of the PDE creation and submission process by monitoring their reports (discussed further in Module 9) to routinely confirm the CPP is being reported correctly.

7.4.2.1 Alternate Method for Determining CPP No Longer Applies (Slide 17)

CMS developed an alternate method for determining CPP that recalculates claims under the Defined Standard Benefit. In this method, CPP is the plan paid amount calculated under the Defined Standard benefit and the NPP is the remaining plan paid balance. Prior to the CGDP, this method produced the same result as the method described in the section above. The alternate method will work in all phases, with the exception of the Coverage Gap Phase when the CGDP applies. Because the alternate method does not work when the CGDP applies, plans are encouraged to no longer use the alternate method for determining CPP.

7.5 Prescription Drug Event Record Examples

This section demonstrates populating the appropriate PDE fields for EA benefits. The first example is an EA drug and second is an OTC. The remaining examples report EACS using the steps and business rules in Tables 7B and 7D. 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).

7.5.1 Enhanced Alternative (EA) Drug (Slides 10-12)

In Sunhealth PBP1, cost-sharing in the Initial Coverage Phase for 2012 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 2012 YTD gross covered drug costs = $1,900. Use the business rules for reporting EA drugs to populate related fields on the PDE record. Table 7G illustrates the calculating and reporting of an EA drug.

TABLE 7G – EA DRUG

2012 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 A – (B+D)	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	Reported Gap Discount
E	$10.00	$0.00	$55.00	$0.00

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). Because the drug is "E", all other dollar fields are blank or zero. Following the adjudication of this claim, the TGCDC Accumulator remains $1,900.00 and the TrOOP Accumulator remains $750.00 because the TGCDC and TrOOP accumulators are not incremented for "E" and "O" drugs.

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".

7.5.2 Enhanced Alternative Cost-Sharing (EACS)

7.5.2.1 Rule #1

In Sunhealth PBP3, the plan has zero deductible for generic drugs. 2012 YTD gross covered drug costs = $25 and no accumulated TrOOP and the beneficiary purchases a covered generic drug that costs $50. Table 7H illustrates the calculating and reporting Rule #1 for EACS.

TABLE 7H – EACS – APPLYING RULE #1

2012 YTD Gross Covered Drug Costs=$25.00							Apply Rule #1
Drug Coverage Status Code	Brand/ Generic Code*	A Gross Covered Drug Cost	B Patient Pay Amount	C Plan POS	D CPP A x 0%	E NPP (EACS) A-(B+D)	F TrOOP
C	**G**	$50.00	$0.00	$50.00	$0.00	$50.00	+ $0.00

*Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$50.00	$0.00	$25.00	$0.00	N	$0.00	$0.00	$50.00	$0.00	N

The Drug Coverage Status Code is "C" for a covered Part D drug. The Beginning and Ending Benefit Phase fields are both "N". Recall that this plan eliminated the Deductible phase for generic drugs and the Benefit Phase Indicators are populated based on the plan defined benefit phase in which the claim was adjudicated. 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. To calculate NPP, subtract the Patient Pay Amount ($0) from the gross drug cost ($50) to derive an NPP amount of $50. Following the adjudication of this claim the TGCDC Accumulator is $75.00 and the TrOOP Accumulator is $0.00.

7.5.2.2 Rule #2 (Slides 18-20)

In 2012, Sunhealth PBP4 requires non-LI beneficiaries to pay a deductible equal to that under the Defined Standard benefit and employs a $5/$15/$30 tiered cost-sharing in the Initial Coverage Phase. In 2012, the beneficiary has met the deductible and has YTD gross covered drug costs of $400 and accumulated TrOOP of $340. The beneficiary is now purchasing a Tier 3 brand name covered drug for $200. Table 7I illustrates the calculating and reporting Rule #2 for EACS.

TABLE 7I – EACS – APPLYING RULE #2

2012 YTD Gross Covered Drug Costs=$400.00							Apply Rule #2
		A	B	C	D	E	F
Drug Coverage Status Code	Brand/ Generic Code*	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 75%	NPP (EACS) A-(B+D)	TrOOP
C	**B**	$200.00	$30.00	$170.00	$150.00	$20.00	+ $30.00

*Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$200.00	$0.00	$400.00	$340.00	N	$30.00	$150.00	$20.00	$0.00	N

The Drug Coverage Status Code is "C" for a covered Part D drug. The Beginning and Ending Benefit Phase fields are both "N", indicating that this claim was adjudicated completely in the plan defined Initial Coverage Phase. Due to the EACS in the Initial Coverage Phase, 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. The plan has reduced the standard beneficiary cost-sharing by $20. The $30 paid by the beneficiary is applied towards TrOOP. Following the adjudication of this claim the TGCDC Accumulator is $600.00 and the TrOOP Accumulator is $370.00.

7.5.2.3 Rule #3 (non-LI beneficiary, non-applicable drug) (Slides 21-23)

In 2012, Sunhealth PBP5 requires beneficiaries to pay the standard $320 deductible and employs tiered cost-sharing in the Initial Coverage Phase of $10/$20/$40. The plan's ICL is $4,000. 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 $6,730.39 as in the Defined Standard benefit with no non-TrOOP OHI). The beneficiary has YTD gross covered drug costs of $3,500 and accumulated TrOOP of $1,900.00. The beneficiary purchased a generic drug (non-applicable) in Tier 1 for $35. Table 7J illustrates the calculating and reporting Rule #3 for EACS.

TABLE 7J – EACS – APPLYING RULE #3

2012 YTD Gross Covered Drug Costs=$3,500.00							Apply Rule #3
		A	B	C	D	E	F
Drug Coverage Status Code	Brand/ Generic Code**	Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP A x 14%*	NPP (EACS) A-(B+D)	TrOOP
C	**G**	$35.00	$10.00	$25.00	$4.90	$20.10	+ $10.00

*The percentage of Gross Covered Drug Cost that maps to CPP for non-LI, non-applicable drugs changes each year. 14% is in effect for 2012.
**Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$35.00	$0.00	$3,500.00	$1,900.00	N	$10.00	$4.90	$20.10	$0.00	N

The Drug Coverage Status Code is "C" for a covered drug. The Beginning and Ending Benefit Phase fields are both "N", indicating that this claim was adjudicated completely in the plan defined Initial Coverage Phase. 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 86% of gross drug cost ($30.10) because this drug is a generic (non-applicable) drug. However, due to EACS provided under the PBP, the beneficiary is in this EA plan's Initial Coverage Phase and is instead responsible for only a $10 co-payment. The plan is responsible for the remaining $25, but CPP reports $4.90 because the plan has paid 14% of the Gross Covered Drug Cost amount that is attributable to the Defined Standard benefit. NPP is calculated as $35 (gross covered drug cost) minus $14.90 (sum of patient pay and CPP) resulting in $20.10 NPP. Once again, the Patient Pay Amount of $10 counts toward TrOOP. Following the adjudication of the claim, the TGCDC Accumulator is $3,535 and the TrOOP Accumulator is $1,910.

7.5.2.4 Rule #3 (non-LI beneficiary, applicable drug) (Slides 24-26)

In 2012, Sunhealth PBP6 requires beneficiaries to pay the standard $320 deductible and employs tiered cost-sharing in the Initial Coverage Phase. The standard ICL applies, and the plan offers a 25% coinsurance to beneficiaries on brand drugs in the Gap. The beneficiary has YTD gross covered drug costs of $3,500.00 and accumulated TrOOP of $1,900.00. The beneficiary purchased a brand drug (applicable drug under the CGDP) in Tier 3 for $202, of which $2 is the dispensing fee. Table 7K illustrates calculating and reporting Rule #3 for EACS. For this example, also recall the steps necessary to calculate the Gap Discount Amount found in Module 4.

TABLE 7K – EACS – APPLYING RULE #3

2012 YTD Gross Covered Drug Costs=$3,500.00							Apply Rule #3
Drug Coverage Status Code	Brand/ Generic Code*	A Gross Covered Drug Cost	B Patient Pay Amount	C Plan POS**	D CPP A x 0%	E NPP (EACS) A-(B+D)	F TrOOP (Pt Pay + Gap Disc)
C	**B**	$202.00	$75.75	$75.75	$0.00	$50.50	+ $151.50

*Based on plan's definition.
**This includes the Coverage Gap Discount advanced by the plan at POS.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$202.00	$0.00	$3,500.00	$1,900.00	G	$75.75	$0.00	$50.50	$75.75	G

The Drug Coverage Status Code is "C" for a covered drug. Because this is an applicable drug falling in the Gap, we employ the following steps for determining the values to populate the PDE record:

Step 1: Determine Costs that Fall in the Coverage Gap
The claim falls squarely in the coverage gap. The beneficiary's TrOOP remains below the TrOOP threshold (Accumulated TrOOP < TrOOP threshold) throughout the processing of the claim. When claim adjudication begins, the TGCDC Accumulator is $3,500 and the TrOOP Accumulator is $1,900. The Beginning and Ending Benefit Phase fields are both "G", also indicating that this claim was adjudicated completely in the Gap. The entire Gross Covered Drug Cost of $202 falls in the Gap.

Step 2: Determine Discount Eligible Costs
Discount eligible costs exclude supplemental benefits, dispensing fee, and vaccine administration fee. Since the plan offers a 25% coinsurance to the beneficiary for brand drugs in the Coverage Gap, the value of the supplemental benefit for this claim is 25% of $202.00 or $50.50 because under the Defined Standard benefit the plan would not have paid anything. Since the value of the supplemental benefit exceeds the dispensing fee, we assume that the dispensing fee is covered as part of the supplemental benefit. The discount eligible costs are:

Total Drug Cost in Gap	$202.00
Supplemental Benefit	<$50.50>
Dispensing Fee	Covered by the supp benefit
Vaccine Administration Fee	$0.00
Discount Eligible Cost	**$151.50**

Step 3: Calculate the Gap Discount
The Gap Discount is 50% of the discount eligible costs as calculated in the previous step. The Gap Discount is $75.75.

Step 4: Determine Beneficiary Cost Sharing
Under the Defined Standard benefit, the beneficiary would be in the Coverage Gap and would be responsible for the entire gross drug cost ($202). However, due to EACS provided under the PBP and the

Coverage Gap Discount that applies after the EACS is calculated, the beneficiary is instead responsible for 75% of the Gross Covered Drug Cost minus the Gap Discount Amount, which equals $75.75.

Step 5: Calculate Covered and non-Covered Portion of Plan Paid cost-sharing
As a part of step 2, we determined the value of the supplemental benefit to be $50.50. This amount is included as NPP. There is no CPP since under the Defined Standard benefit the plan pays nothing for brand drugs in the Gap.

Step 6: Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator
In preparation for adjudicating the next claim, the plan updates the accumulators. The Patient Pay Amount and the Reported Gap Discount Amount count towards TrOOP since this was a covered drug. Following the adjudication of this claim, the TGCDC Accumulator is now $3,702.00 and the TrOOP Accumulator is now $2,051.50.

7.5.2.5 Rule #3 (LI beneficiary)

In 2012, Sunhealth PBP7 requires beneficiaries to pay the standard $320 deductible and employs tiered cost-sharing in the Initial Coverage Phase of $10/$20/$40. The plan extends the ICL to $4,000. 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 = $7,000 (not $6,657.50 as in the Defined Standard benefit with no non-TrOOP OHI). The Category 3 (full dual, institutionalized) LI beneficiary has YTD gross covered drug costs of $3,500 and accumulated TrOOP of $1,900. The beneficiary purchased a generic drug (non-applicable) in Tier 1 for $35. (Please note: Mapping Rule #3 makes no distinction for applicable versus non-applicable drugs.) Table 7L illustrates the calculating and reporting Rule #3 for EACS.

TABLE 7L – EACS – APPLYING RULE #3

2012 YTD Gross Covered Drug Costs=$3,500.00							Apply Rule #3
		A	B	C	D	E	F
Drug Coverage Status Code	Brand/ Generic Code*	Gross Covered Drug Cost	Patient Pay Amount*	Plan POS	CPP	NPP (EACS) A-(B+D)	TrOOP
C	**G**	$35.00	$10.00	$25.00	$0.00	$25.00	+ $10.00

*Based on plan's definition.
**Paid by the beneficiary or by someone on the beneficiary's behalf. In this example, all payers are TrOOP eligible.

PDE RECORD FIELDS											
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	LICS	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$35.00	$0.00	$3,500.00	$1,900.00	N	$0.00	$10.00	$4.90	$20.10	$0.00	N

The Drug Coverage Status Code is "C" for a covered drug. The Beginning and Ending Benefit Phase fields are both "N", indicating that this claim was adjudicated completely in the plan defined Initial Coverage Phase. Recall that this plan eliminated the Coverage Gap. Under the Defined Standard benefit, the

beneficiary would be in the Coverage Gap, responsible for the entire gross drug cost ($35). However, due to EACS provided under the PBP, the beneficiary is in this EA plan's Initial Coverage Phase and is instead responsible for only a $10 co-payment. The Patient Pay Amount= $0 since the beneficiary is full subsidy institutionalized LI, and the beneficiary cost sharing is shifted into the LICS field. LICS counts towards TrOOP. The plan is responsible for the remaining $25, and CPP is reported as $0 because LI beneficiaries are not eligible for the CGDP or the cost sharing reduction in the Coverage Gap for generic (non-applicable) drugs. NPP is calculated as $35 (gross covered drug cost) minus $10 (sum of patient pay and CPP) resulting in $25 NPP. Once again, the LICS of $10 counts toward TrOOP. Following the adjudication of this claim, the TGCDC Accumulator = $3,535 and the TrOOP Accumulator = $1,910.

7.5.2.6 Rule #4 (non-LI beneficiary, non-applicable drug)

In 2012, Sunhealth PBP6 requires beneficiaries to pay the standard $320 deductible and employs tiered cost-sharing in the Initial Coverage Phase. The standard ICL applies, and the plan provides no supplemental benefit in the Gap. The beneficiary has YTD gross covered drug costs of $7,000 and accumulated TrOOP of $4,400. The beneficiary purchased a brand drug (applicable drug under the CGDP) in Tier 3 for $202, of which $2 is the dispensing fee. Table 7M illustrates calculating and reporting Rule #4. For this example, also recall the steps necessary to calculate the Gap Discount Amount found in Module 4.

TABLE 7M – EACS – APPLYING RULE #4

2012 YTD Gross Covered Drug Costs=$7,000.00							Apply Rule #4
		A	B	C	D	E	F
Drug Coverage Status Code	Brand/ Generic Code*	Gross Covered Drug Cost	Patient Pay Amount	Plan POS**	CPP A x 15%	NPP (EACS) A-(B+D)	TrOOP (Pt Pay + Gap Disc)
C	**B**	$202.00	$102.00	$100.00	$30.30	-$30.30	+ $202.00

*Based on plan's definition.
**This includes the Coverage Gap Discount advanced by the plan at POS.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$202.00	$0.00	$7,000.00	$4,400.00	G	$102.00	$30.30	-$30.30	$100.00	G

The Drug Coverage Status Code is "C" for a covered drug. Because this is an applicable drug falling in the Gap, we employ the following steps for determining the values to populate the PDE record:

Step 1: Determine Costs that Fall in the Coverage Gap
The claim falls squarely in the coverage gap. The beneficiary's TrOOP remains below the TrOOP threshold (Accumulated TrOOP < TrOOP threshold) throughout the processing of the claim. When claim adjudication begins, the TGCDC Accumulator is $7,000 and the TrOOP Accumulator is $4,400. The Beginning and Ending Benefit Phase fields are both "G", also indicating that this claim was adjudicated completely in the Gap. The entire Gross Covered Drug Cost of $202 falls in the Gap.

Step 2: Determine Discount Eligible Costs
Discount eligible costs exclude supplemental benefits and dispensing fee. The discount eligible costs are:

Total Drug Cost in Gap	$202.00
Supplemental Benefit	$0.00
Dispensing Fee	<$2.00>
Vaccine Administration Fee	$0.00
Discount Eligible Cost	**$200.00**

Step 3: Calculate the Gap Discount
The Gap Discount is 50% of the discount eligible costs as calculated in the previous step. The Gap Discount is $100.00.

Step 4: Determine Beneficiary Cost Sharing
Under the Defined Standard benefit prior to applying the CGDP, the beneficiary would be in the Coverage Gap and would be responsible for the entire gross drug cost ($202). However, the beneficiary is instead responsible for the Gross Covered Drug Cost minus the Gap Discount Amount, which equals $102.00.

Step 5: Calculate Covered and non-Covered Portion of Plan Paid cost-sharing
Using EA Mapping Rule #4, we determined the value of the Covered Plan Paid Amount to be $30.30. This amount is included as CPP. NPP is calculated as $202 (gross covered drug cost) minus $232.30 (sum of patient pay, LICS and CPP) resulting in -$30.30 NPP.

Step 6: Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator
In preparation for adjudicating the next claim, the plan updates the accumulators. The Patient Pay Amount and the Reported Gap Discount Amount count towards TrOOP since this was a covered drug. Following the adjudication of this claim, the TGCDC Accumulator is now $7,202.00 and the TrOOP Accumulator is now $4,602.00.

7.5.2.7 Rule #5

In 2012, Sunhealth PBP10 requires beneficiaries to pay the standard $320 deductible. Cost-sharing in the Initial Coverage Phase is 25 percent and the initial coverage limit has been extended by $1,000 from $2,930 to $3,930 under this plan. Catastrophic cost-sharing is the same as under the Defined Standard benefit. The beneficiary has reached the OOP threshold, having accumulated $4,700 in TrOOP and YTD gross covered drug costs = $7,500. The beneficiary now purchases a covered drug for $150. Use Rule #5 to populate related PDE fields. Table 7N illustrates calculating and reporting Rule #5 for EACS.

TABLE 7N – EACS – APPLYING RULE #5

2012 YTD Gross Covered Drug Costs=$7,500.00							Apply Rule #5
Drug Coverage Status Code	Brand/ Generic 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)	TrOOP
C	**B**	$150.00	$7.50	$142.50	$142.50	$0.00	N/A

* Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$0.00	$150.00	$7,500.00	$4,700.00	C	$7.50	$142.50	$0.00	$0.00	C

Drug Coverage Status is "C" for a covered drug. The Patient Pay Amount is the greater of 5 percent or $2.60/$6.50, which is $7.50. 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 $142.50. There is no EACS or NPP since the plan actually paid the Defined Standard amount ($142.50) at POS. Following the adjudication of this claim, the TGCDC Accumulator = $7,650. TrOOP no longer accumulates since the beneficiary has reached the OOP threshold.

7.6 Additional Examples of Enhanced Alternative Benefits

The following examples demonstrate calculating and reporting for other conditions under an EA benefit.

7.6.1 Enhanced Alternative Benefits and Straddling (Slides 27-29)

In 2012, Sunhealth PBP11 requires beneficiaries to pay the deductible, offers tiered cost-sharing in the Initial Coverage Phase ($10/$15/$20), and extends the initial coverage limit to $4,000. The beneficiary has YTD gross covered drug costs of $2,920 and accumulated TrOOP of $1,500. The beneficiary purchases a covered brand name drug in Tier 3 for $125. The CGDP does not apply because the beneficiary is not in the Coverage Gap as defined by the plan's benefit. However, CPP mapping rules apply based on the defined standard benefit parameters. Even though the claim does not straddle any phase of the EA plan's actual benefit package, it does straddle two phases of the Defined Standard benefit, the Initial Coverage Phase and the Coverage Gap. Therefore, the plan must use Mapping Rules 2 and 3 to calculate the CPP. Table 7O illustrates calculating and reporting this straddle claim with EACS.

TABLE 7O – EACS – STRADDLE CLAIM

2012 YTD Gross Covered Drug Costs=$2,920.00							Apply Rules #2 and #3	
	Drug Coverage Status Code	Brand/ Generic Code*	A	B	C	D	E	G
			Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (EACS) A-(B+D)	TrOOP
Initial Coverage Phase			$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**	B	$125.00	$20.00	$105.00	$7.50	$97.50	+$20.00

*Based on the plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$125.00	$0.00	$2,920.00	$1,500.00	N	$20.00	$7.50	$97.50	$0.00	N

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 Phase and $10 in the Defined Standard Coverage Gap. The Coverage Gap Discount does not apply because the beneficiary does not reach the plan defined Coverage Gap phase.

CPP for this example is only $7.50, 75 percent of the $10 remaining in the Defined Standard Initial Coverage Phase. To calculate NPP, the initial calculations can be done within the benefit phases or at the total level for the PDE. At the summary level, NPP is calculated as $125 (gross covered drug cost) minus $27.50 (sum of patient pay and CPP) resulting in $97.50 NPP. Following the adjudication of this claim, the TGCDC Accumulator = $2,940 and the TrOOP Accumulator = $1,520.

7.6.2 Enhanced Alternative Benefits and Straddling (Co-pay to Co-pay)

In 2012, Sunhealth PBP12 requires beneficiaries to pay the deductible, offers tiered cost-sharing in the Initial Coverage Phase ($10/$20/$30), and maintains the standard initial coverage limit. During the Gap Phase, the plan's supplemental benefit is tiered cost-sharing of $10/$40/$60. The beneficiary has YTD gross covered drug costs of $2,920 and accumulated TrOOP of $1,500. The beneficiary purchases a generic drug in Tier 1 for $35. This event straddles two phases of the EA plan's benefit package, the Initial Coverage Phase and the Coverage Gap. Table 7P illustrates the calculating and reporting of a straddle claim with EACS reflecting co-pays in adjoining benefit phases.

Table 7P – EACS – Straddle Claim (Co-pay to Co-pay)

2012 YTD Gross Covered Drug Costs=$2,920.00								Apply Rules #2 and #3
	Drug Coverage Status Code	Brand / Generic Code*	A Gross Covered Drug Cost	B Patient Pay Amount	C Plan POS	D CPP	E NPP (EACS) A-(B+D)	G TrOOP
Initial Coverage Phase			$10.00	$10.00	$0.00	A x 75% $7.50	- $7.50	+$10.00
Coverage Gap			$25.00	$0.00	$25.00	A x 14% $3.50	$21.50	+$0.00
Total	**C**	G	$35.00	$10.00	$25.00	$11.00	$14.00	+$10.00

*Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$35.00	$0.00	$2,920.00	$1,500.00	N	$10.00	$11.00	$14.00	$0.00	G

Drug Coverage Status is "C" for a covered drug. The Beginning Benefit Phase is "N" and the Ending Benefit Phase is "G" indicating that this claim straddles the ICP and the Gap. The Patient Pay Amount ($10) counts toward TrOOP since this was a covered drug. In this example where adjoining benefit phases both have co-pays, the beneficiary only pays the copay associated with the benefit phase in which the adjudication began, provided that the copay does not exceed drug cost. "Lesser of" logic applies when the copay exceeds total drug cost and the beneficiary pays total drug cost only. (See Module 4 for additional information about "lesser of" logic.)

The drug cost in the ICP is $10, of which $7.50 is CPP. Because the beneficiary's co-pay covered the entire portion of the drug cost falling in the ICP, there is no Plan Paid @ POS amount attributed to the ICP. NPP is equal to the Plan Paid @ POS minus the Patient Pay Amount which equals -$7.50.

Because the drug in this example is a generic, the Coverage Gap Discount does not apply, and the plan must apply the basic benefit generic cost sharing in the gap to determine the amount of the drug cost in the gap to be applied to CPP versus NPP. In 2012, this is 14%, so CPP is $25 * 14% or $3.50. The remaining $21.50 is NPP.

To populate the PDE, the Patient Pay, CPP and NPP amounts calculated for each benefit phase must be summed together. To calculate NPP, the initial calculations can be done within the benefit phases or at the total level for the PDE. At the summary level, NPP is calculated as $35 (gross covered drug cost) minus $21.00 (sum of patient pay and CPP) resulting in $14.00 NPP. Following the adjudication of this claim, the TGCDC Accumulator is $2,955 and the TrOOP Accumulator is $1,510.

7.6.3 Enhanced Alternative Benefits and Straddling (Co-pay to Coinsurance)

In 2012, Sunhealth PBP13 requires beneficiaries to pay the deductible, offers tiered cost-sharing in the Initial Coverage Phase ($10/$20/$30), and maintains the standard initial coverage limit. During the Gap Phase, the plan offers coinsurance of 40% for generic drugs. The beneficiary has YTD gross covered drug costs of $2,900 and accumulated TrOOP of $1,500. The beneficiary purchases a generic drug in Tier 1 for $50. This event straddles two phases of the EA plan's benefit package, the Initial Coverage Phase and the Coverage Gap. Table 7Q illustrates the calculating and reporting of a straddle claim with EACS reflecting a co-pay to coinsurance cost sharing structure in adjoining benefit phases.

Table 7Q – EACS – Straddle Claim (Co-pay to Coinsurance)

2012 YTD Gross Covered Drug Costs=$2,900.00							Apply Rules #2 and #3	
	Drug Coverage Status Code	Brand/ Generic Code*	A	B	C	D	E	G
			Gross Covered Drug Cost	Patient Pay Amount	Plan POS	CPP	NPP (EACS) A-(B+D)	TrOOP
Initial Coverage Phase			$30.00	$10.00	$20.00	A x 75% $22.50	- $2.50	+$10.00
Coverage Gap			$20.00	$12.00	$8.00	A x 14% $2.80	$5.20	+$12.00
Total	C	G	$50.00	$22.00	$28.00	$25.30	$2.70	+$22.00

*Based on plan's definition.

PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$50.00	$0.00	$2,900.00	$1,500.00	N	$22.00	$25.30	$2.70	$0.00	G

Drug Coverage Status is "C" for a covered drug. The Beginning Benefit Phase is "N" and the Ending Benefit Phase is "G" indicating that this claim straddles the ICP and the Gap. In this example where adjoining benefit phases have a co-pay and coinsurance, the beneficiary pays both the copay and the coinsurance associated with each respective benefit phase, subject to the "lesser of" logic.

The drug cost in the ICP is $30, of which $22.50 is CPP. NPP is equal to the Gross Covered Drug Cost ($30) minus the sum of Patient Pay and CPP ($32.50). NPP equals -$2.50 in the ICP.

The drug cost in the Gap is $20. The beneficiary pays 60% of that amount, which equals $12. Because the drug in this example is a generic, the Coverage Gap Discount does not apply, and the plan must apply the basic benefit cost sharing in the gap to determine the amount of the drug cost in the gap to be applied to CPP versus NPP. In 2012, this is 14%, so CPP is $20 * 14% or $2.80. The remaining $5.20 is NPP.

To populate the PDE, the Patient Pay, CPP and NPP amounts calculated for each benefit phase must be summed together. To calculate NPP, the initial calculations can be done within the benefit phases or at the total level for the PDE. At the summary level, NPP is calculated as $50 (gross covered drug cost) minus $47.30 (sum of patient pay and CPP), or $2.70. Following the adjudication of this claim, the TGCDC Accumulator is $2,950 and the TrOOP Accumulator is $1,522.

7.6.4 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Initial Coverage Phase (Slides 31-34)

In 2012, the beneficiary is a Category 1 low income beneficiary who has paid a supplemental premium to enroll in Sunhealth's PBP14. Instead of cost-sharing at 25 percent, the plan has tiered cost-sharing of $10/$15/$30 in the Initial Coverage Phase. The plan's initial coverage limit is shifted up to $4,500. The beneficiary YTD gross covered drug costs = $1,500 and accumulated TrOOP of $790, and she purchases a Tier 1 covered drug for $75. Table 7R illustrates the calculating and reporting of EACS for a low income subsidy beneficiary in the Initial Coverage Phase.

TABLE 7R – EACS AND LICS IN THE INITIAL COVERAGE PHASE

2012 YTD Gross Covered Drug Costs=$1,500.00									Apply Rule #2 with LICS calculations	
Beneficiary Type	Drug Cvg Status Code	A Gross Covered Drug Cost	B Non-LI Cost Share	C LI Cost Share	D Patient Pay Amount	E LICS (B-C)	F Plan POS (Non-LI)	G CPP A x 75%	H NPP (EACS) A-(D+E+G)	I 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	$2.60	$2.60	$7.40	$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**	$2.60	$7.40	$56.25	$8.75

PDE RECORD FIELDS											
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	LICS	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$75.00	$0.00	$1,500.00	$790.00	N	$2.60	$7.40	$56.25	$8.75	$0.00	N

The Drug Coverage Status Code is "C" for a covered drug. Under this EA plan, the beneficiary is in the Initial Coverage Phase. The non-LI plan co-pay would be $10, but the Patient Pay Amount is $2.60, the LI-I co-pay for a generic covered drug. The plan advances the $7.40 difference to the pharmacy at POS and reports this payment in LICS Amount. The $2.60 Patient Pay Amount and $7.40 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 $75 (gross covered drug cost) minus $66.25 (sum of patient pay, LICS, and CPP) resulting in $8.75 NPP. Following the adjudication of this claim, the TGCDC Accumulator =$1,575 and the TrOOP Accumulator is $800.

7.6.5 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Coverage Gap

The same beneficiary now has 2012 YTD gross covered drug costs of $6,700 and $3,800 in accumulated TrOOP. Since the beneficiary has not accumulated $4,700 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 $10. Calculate LICS and use EACS Rule #4 to populate the related PDE fields. Table 7S illustrates the calculating and reporting of EACS for a low income subsidy beneficiary in an EA plan's Coverage Gap.

TABLE 7S – EACS AND LICS IN THE COVERAGE GAP

2012 YTD Gross Covered Drug Costs=$6,700.00								Apply Rule #4 with LICS calculations	
		A	B	C	D	E	G	H	J
Beneficiary Type	Drug Cvg Status Code	Gross Covered Drug Cost	Non-LI Cost Share	LI Cost Share	Patient Pay Amount	LICS (B-C)	CPP A x 15%	NPP (EACS) A-(D+E+G)	TrOOP D+E
Non-LI*	**C**	$10.00	$10.00	N/A	$10.00	$0.00	$1.50	-$1.50	+ $10.00
LI Category 1	**C**	$10.00	N/A	$2.60	$2.60	$7.40	$1.50	-$1.50	+ $10.00

*Prior to applying the generic cost sharing in the Gap

	PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	LICS	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$10.00	$0.00	$6,700.00	$3,800.00	G	$2.60	$7.40	$1.50	-$1.50	$0.00	G

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 LICS Amount is $7.40 (the difference between the non-low income $10 cost (prior to applying the generic cost sharing) - LI Patient Pay Amount of $2.60). The $2.60 Patient Pay Amount and $7.40 LICS count towards TrOOP because the drug is covered, therefore TrOOP accumulates by $10 for this event. The Plan Paid Amount for a non-LI beneficiary at POS prior to applying generic cost sharing in the Gap 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 > $6,657.50. Therefore CPP is 15 percent of gross drug cost or $1.50. NPP is calculated as $10 (gross covered drug cost) minus $11.50 (sum of patient pay, LICS and CPP) resulting in -$1.50 NPP. Following the adjudication of this claim, the TGCDC Accumulator =$6,710 and the TrOOP Accumulator is $3,810.

7.6.6 Enhanced Alternative Cost-Sharing (EACS) and Low Income Cost-Sharing Subsidy (LICS): Category 4 Beneficiary and No Plan Deductible

In 2012, a Category 4 low income beneficiary has paid a supplemental premium to enroll in Sunhealth's PBP15. This EA plan has no deductible and a co-pay of $25 in the EA plan's Initial Coverage Phase. 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 7T 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 6).

TABLE 7T – EACS AND LICS: CATEGORY 4 BENEFICIARY IN ZERO DEDUCTIBLE PLAN

2012 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)	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

PDE RECORD FIELDS											
Drug Cvg Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	LICS	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$100.00	$0.00	$0.00	$0.00	N	$15.00	$10.00	$0.00	$75.00	$0.00	N

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 CPP 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 $100 (gross covered drug cost) minus $25

(sum of patient pay, LICS, and CPP) resulting in $75 NPP. Following the adjudication of this claim, the TGCDC Accumulator =$100 and the TrOOP Accumulator is $25.

7.6.7 Co-pay Greater Than Gross Drug Cost: Enhanced Alternative Cost-Sharing (EACS)

In 2012, Sunhealth PBP16 has a $10/$30/$50 tiered cost-sharing structure in the Initial Coverage Phase and extends the initial coverage limit to $3,500. The beneficiary has YTD gross covered drug costs of $2,000 and accumulated TrOOP of $1,100. The beneficiary purchases a Tier 1 covered drug for $4.80. Table 7U illustrates calculating and reporting EACS when a beneficiary's co-pay is greater than the gross drug cost.

TABLE 7U – CO-PAY GREATER THAN GROSS DRUG COST - EACS

2012 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	$4.80	$0.00	$3.60	-$3.60	$4.80

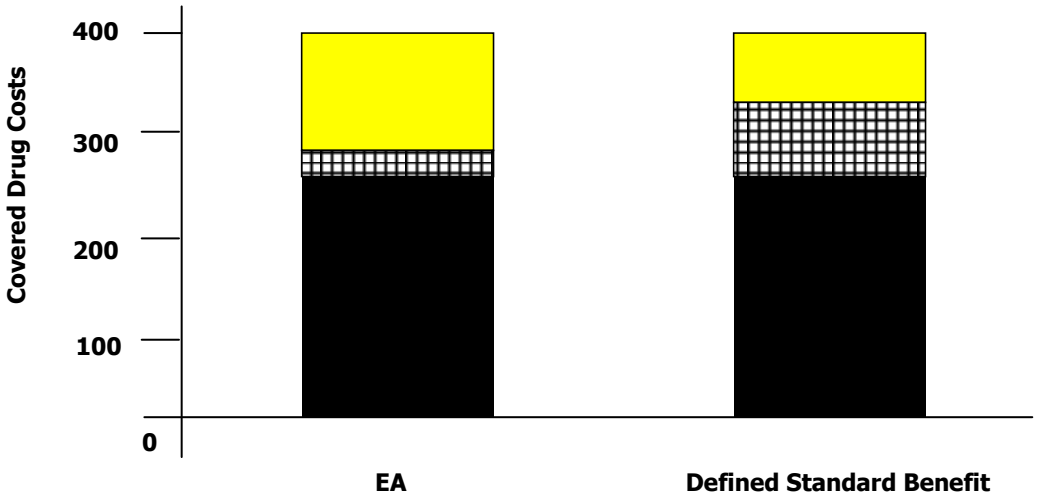
PDE RECORD FIELDS										
Drug Coverage Status Code	GDCB	GDCA	TGCDC Accumulator	TrOOP Accumulator	Beginning Benefit Phase	Patient Pay Amount	CPP	NPP	Reported Gap Discount	Ending Benefit Phase
C	$4.80	$0.00	$2,000.00	$1,100.00	N	$4.80	$3.60	-$3.60	$0.00	N

The Drug Coverage Status Code is "C" for a covered Part D drug. Due to the EACS in the Initial Coverage Phase, the beneficiary is responsible for the lesser of a $10 co-payment or the Gross Covered Drug Cost which is $4.80 instead of the 25 percent associated with the Defined Standard benefit. The plan pays $0 because the patient pay amount completely covers the price. 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 $4.80 paid by the beneficiary is applied towards TrOOP.

7.6.8 Claim that Straddles Both Enhanced Alternative Benefit Phases and Defined Standard Benefit Phases

In 2012, SunHealth's Enhanced Alternative Plan has a $270 deductible, offers tiered cost-sharing in the Initial Coverage Phase ($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 $260. The beneficiary purchases a covered brand name drug in Tier 2 that costs $100. This event straddles the deductible and ICP in both SunHealth's enhanced benefit and the Defined Standard Benefit (Figure 7A).

Figure 7A – Claim Straddles EA and Defined Standard Deductible



1. First, SunHealth calculates Point-of-Sale (POS) cost-sharing under its own benefit design.

Ten dollars of the gross covered drug cost falls in SunHealth's deductible where the beneficiary is responsible for 100% of the cost. In this EA benefit phase the patient pays $10 and the plan pays $0. The remaining $90 falls in SunHealth's Initial Coverage Phase. In this EA benefit phase the patient pays $20 and SunHealth 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 7V(1) illustrates how the plan calculates the POS cost-sharing.

TABLE 7V(1) - POS COST-SHARING UNDER PLAN'S BENEFIT DESIGN

	Patient Pay Amount	Plan Paid Amount
EA Deductible Phase	$10.00	$0.00
EA Initial Coverage Phase	$20.00	$70.00
Total	$30.00	$70.00

2. Secondly, SunHealth determines CPP and NPP.

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 7.2.2) 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." 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. SunHealth 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.

SunHealth calculates the claim under the defined standard benefit as follows. The beneficiary's Year-to-Date Gross Covered Drug Cost is $260. 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 Phase. 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 7V(2).

TABLE 7V(2) – DEFINED STANDARD BENEFIT CLAIM CALCULATION

YTD Gross Covered Drug cost - $260		
Defined Standard Benefit Phase	**Patient Pay Amount**	**Plan Paid Amount (CPP)**
Deductible	$60.00	$ 0.00
Initial Coverage Phase	$10.00	$30.00
Total	$70.00	$30.00

3. Finally, SunHealth populates the PDE. See Table 7V(3).

TABLE 7V(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 7V(1)]	$30.00
CPP	Plan Paid Amount determined under the Defined Standard benefit [see Table 7V(2)]	$30.00
NPP	NPP equals Gross Covered Drug Cost minus the sum of Patient Pay Amount and CPP NPP = Gross Covered Drug Cost – (Patient Pay Amount + CPP) Plan Paid Amount at POS (Table 7V(1)) – CPP (Table 7V(2)) $40 = $100 – ($30 + $30)	$40.00

MODULE 8 – 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). Lastly, participants will learn the new edit codes established to implement provisions of the Affordable Care Act, specifically the Coverage Gap Discount Program (CGDP).

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 11 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.
- Review new CGDP edit codes.
- Discuss IAPs and contract reports.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

8.1 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.

8.2 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.

Edit

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.

Resolution

Sunrise Health Plan resubmits the entire file, now containing the appropriate DET records in the second batch.

8.2.1 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 8A 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 8A – 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.

8.2.2 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 8B.

TABLE 8B – 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 8B – 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. The new PBM currently submits PDE data for other Part D sponsors.

Edit

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

Resolution

Blue Sky Health submits an authorization letter to CSSC. Once the change has been recorded, the PBM resubmits the rejected file.

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.

8.3 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, DDPS 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 five key fields: Service Provider ID, Service Provider ID

Qualifier, Prescription/Service Reference Number, Date of Service (DOS), and Fill Number. 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 drug coverage status equals 'E' or 'O', then the Covered Plan Paid Amount must equal zero.
- The sum of detail cost fields is compared with the sum of the payment fields.

Stage 5 – Gap Discount Calculation Edits

Gap Discount calculation edits are limited to PDEs that have not received rejections in any of the first four stages of PDE editing because the calculations necessary to edit the Reported Gap Discount Amount field are resource intense. The TGCDC and TrOOP Accumulators and the Beginning and Ending Benefit Phases reported on the PDE are used along with information on plan benefit design to allow CMS to calculate the expected Gap Discount amount. (The values in these fields and the relationships between one another are evaluated in previous edit stages. See Stages 1 and 4.) When the Reported Gap Discount Amount varies from the calculated Gap Discount amount, DDPS issues a number of informational and reject edits.

Stage 6 – Adjustment/Deletion Code 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.

8.3.1 DDPS Edit Categories (Slide 13)

Table 8C describes the series of edits and eleven categories by which the DDPS edits are organized.

TABLE 8C – CATEGORIES AND DESCRIPTIONS

RANGES	EDIT CATEGORIES	DESCRIPTION
603-659, 831	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	Edits that test the relationship between the TrOOP Accumulator and the OOP Threshold (2011 and forward or Catastrophic Coverage Code for DOS prior to 2011) 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 Beginning and Ending Benefit Phase and Accumulator fields, and other dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, Reported Gap Discount, and payment calculations.
775-799, 900-999	Miscellaneous	Edits on miscellaneous data elements.
851-855	P2P Phase III Retro Enrollment	Edits describe the Contract and/or PBP of Record changes resulting from the P2P Contract/PBP Update
865-899	Gap Discount	Edits confirm the Reported Gap Discount field with other data reported on the PDE.

8.3.2 DDPS Edit Codes

Tables 8D – 8M provide the DDPS edits by category.

TABLE 8D – 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. FOR DOS PRIOR TO 1/1/2011, DISPENSING STATUS MUST BE EITHER A BLANK OR 'P' OR 'C'. FOR DOS 1/1/2011 AND FORWARD, DISPENSING STATUS MUST BE BLANK.
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', 'S', OR 'C',
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.
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.

TABLE 8D – DDPS DET EDIT CODES – MISSING/INVALID (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
641	FILLER FIELDS MUST BE BLANK.
642	STATE-TO-PLAN PDES ARE NOT ALLOWED WITH DATE OF SERVICE AFTER 3/31/2006.
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 1/1/2008 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 1/1/2008 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'.
649	PRESCRIPTION ORIGIN CODE IS INVALID. VALID VALUES FOR ORIGINAL FILL STANDARD FORMATS ARE '1', '2', '3', AND '4'.
650	DATE ORIGINAL CLAIM RECEIVED IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, MUST BE A VALID DATE IN CCYYMMDD FORMAT. CANNOT BE A FUTURE DATE OR LESS THAN THE DOS. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES.
651	CLAIM ADJUDICATION BEGAN TIMESTAMP IS MISSING OR INVALID FOR DOS 1/1/2011 AND FORWARD, MUST BE A VALID DATE IN CCYY-MM-DD-HH.MM.SS.MMMMMM FORMAT. CANNOT BE A FUTURE DATE OR LESS THAN THE DOS. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES.
652	TOTAL GROSS COVERED DRUG COST ACCUMULATOR IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, MUST BE ≥ ZERO. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES.
653	TRUE OUT-OF-POCKET ACCUMULATOR IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, MUST BE ≥ ZERO. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES. CANNOT EXCEED THE PROGRAM LEVEL OOP THRESHOLD.
654	BRAND/GENERIC CODE IS MISSING OR INVALID. VALID VALUES ARE 'B' FOR BRAND AND 'G' FOR GENERIC.
655	BEGINNING BENEFIT PHASE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'D' FOR DEDUCTIBLE, 'N' FOR INITIAL COVERAGE PHASE, 'G' FOR COVERAGE GAP, AND 'C' FOR CATSTROPHIC. FOR DOS PRIOR TO 1/1/2011, MUST BE BLANK.
656	ENDING BENEFIT PHASE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'D' FOR DEDUCTIBLE, 'N' FOR INITIAL COVERAGE PHASE, 'G' FOR COVERAGE GAP, AND 'C' FOR CATSTROPHIC. FOR DOS PRIOR TO 1/1/2011, MUST BE BLANK.
657	REPORTED GAP DISCOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
658	TIER IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, MUST BE BLANK OR A NUMERIC VALUE FROM 1-6. FOR DOS PRIOR TO 1/1/2011, MUST BE 'BLANK'.
659	GAP DISCOUNT PLAN OVERRIDE CODE IS INVALID. MUST BE BLANK.
831	FORMULARY CODE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'F' FOR FORMULARY AND 'N' FOR NON-FORMULARY. FOR DOS PRIOR TO 1/1/2O11, MUST BE BLANK.

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.

Edit 614 "SERVICE PROVIDER ID IS MISSING OR INVALID": The Service Provider ID must be '01'-NPI or '07'-NCPDP on standard format claims.

Edit 617 "DISPENSING STATUS IS INVALID": Beginning with DOS in 2011, the Dispensing Status must be blank. DOS prior to 2011 must continue to report blank, 'P' or 'C'.

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 for benefit years prior to 2012. 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 two exceptions:

1. Patient Liability Reduction due to Other Payer Amount (PLRO) – Negative values are also valid.

2. Non-covered Plan Paid Amount (NPP) – Negative values are also valid.

Edit 641 "FILLER FIELDS MUST BE BLANK": Effective for all PDEs submitted 1/1/2011 or forward (regardless of the DOS) the positions in the PDE record layout designated as filler must be blank. The PDE record layout in effect beginning 1/1/2011 changed the location and length of the filler positions to accommodate the new gap discount fields.

Prescription Origin Code edits- For standard format PDEs with DOS 1/1/2010 and forward, the valid values for are '1', '2', '3', and '4'. To maintain consistency with the NCPDP format for this field, DDPS will be updated in the near future to recognize '5' as a valid value. Original fills (Fill Number='00') in standard format may not report blank or '0' in the Prescription Origin Code field.

Edit 650 "DATE ORIGINAL CLAIM RECEIVED IS MISSING OR INVALID": This new field is required for LI-NET regardless of DOS, but is only required for all other Part D contracts for PDEs with DOS on or after 1/1/2011. The date reported must be on or after the DOS.

TABLE 8E – 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.
664	ADJUSTMENT OR DELETION LI NET PDES SUBMITTED 1/1/2011 AND FORWARD, THE DATE ORIGNAL CLAIM RECEIVED MUST EQUAL THE DATE ORIGINAL CLAIM RECEIVED SUBMITTED ON THE ORIGINAL.

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 8F – DDPS DET EDIT CODES – CATASTROPHIC COVERAGE

EDIT CODE	EDIT DESCRIPTION
670	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE = 'BLANK', GDCB MUST BE GREATER THAN ZERO. FOR DOS 1/1/2011 AND FORWARD, IF TROOP ACCUMULATOR < OOP THRESHOLD, GDCB MUST BE GREATER THAN ZERO.
671	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE = 'BLANK', GDCA MUST BE ZERO. FOR DOS 1/1/2011 AND FORWARD, IF (TROOP ACCUMULATOR+PATIENT PAY+OTHER TROOP+REPORTED GAP DISCOUNT+LICS) ≤ OOP THRESHOLD, GDCA MUST BE ZERO.
672	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE IS 'A', GDCB MUST BE GREATER THAN ZERO.
673	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE IS 'C', GDCA MUST BE GREATER THAN ZERO. FOR DOS 1/1/2011 AND FORWARD, IF TROOP ACCUMULATOR = OOP THRESHOLD GDCA MUST BE GREATER THAN ZERO.
674	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE IS 'C', GDCB MUST BE ZERO. FOR DOS 1/1/2011 AND FORWARD, IF TROOP ACCUMULATOR = OOP THRESHOLD GDCB MUST BE ZERO.
675	ON PDE THAT STRADDLES THE OUT-OF-POCKET THRESHOLD WHERE LICS IS GREATER THAN ZERO, CPP MUST BE 95% OF GDCA.

Catastrophic Coverage edits test the relationship between the values in the Catastrophic Coverage Code or the TrOOP Accumulator, and the dollar amounts reported in GDCB and GDCA. The edits in this category are conditional upon DOS, where PDEs with DOS prior to 1/1/2011 revert to Catastrophic Coverage Code to validate GDCA, and PDEs with DOS on or after 1/1/2011 use the TrOOP Accumulator. 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'.)

Edit 675 "ON PDE THAT STRADDLES OOP THRESHOLD WHERE LICS IS >0, CPP MUST BE 95% OF GDCA": This edit is effective for PDEs with DOS on or after 1/1/2011 and does not apply to PDEs reporting MSP. The edit only applies for plans that apply the Defined Standard benefit in Catastrophic where co-insurance is reported.

TABLE 8G – DDPS DET EDIT CODES – COST

EDIT CODE	EDIT DESCRIPTION
690	FOR DOS PRIOR TO 1/1/2011, SUM OF COST FIELDS > SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK' OR 'P'. FOR DOS 1/1/2011 AND FORWARD, SUM OF COST FIELDS > SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK'.
691	SUM OF GDCB AND GDCA IS NOT EQUAL TO THE SUM OF INGREDEDIENT COST + DISPENSING FEE + SALES TAX + VACCINE ADMINISTRATION FEE AND MEDICARE IS PRIMARY.
692	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK'.
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.
695	NPP AMOUNT MUST BE ZERO FOR LI NET PDES.
696	TRUE OUT-OF-POCKET ACCUMULATOR CANNOT BE GREATER THAN TOTAL GROSS COVERED DRUG COST ACCUMULATOR.

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') where Medicare is primary.

TABLE 8H – 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 MBD.
702	GENDER DOES NOT MATCH THE VALUE ON MBD.
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. (EDIT DISABLED FOR POS PLANS)
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	EVEN THOUGH SUBMITTING CONTRACT DOES NOT EQUAL CONTRACT OF RECORD, THIS PDE IS NOT SUBJECT TO PLAN TO PLAN RECONCILIATION. PDES WITH DRUG COVERAGE STATUS OF 'E' OR 'O' ARE NOT ELIGIBLE FOR PLAN TO PLAN RECONCILIATION. [INFORMATIONAL]
710	THE BENEFICIARY HICN HAS CHANGED ACCORDING TO CMS RECORDS; USE THE CORRECTED HICN FOR FUTURE SUBMISSIONS. [INFORMATIONAL]
711	PACE PLANS CANNOT SUBMIT PLAN TO PLAN PDES
712	SUBMITTING CONTRACT WAS NOT PRIOR CONTRACT OF RECORD FOR THIS PLAN TO PLAN PERIOD. [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. [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": When the DOS occurs later than the valid P2P period; the beneficiary must be enrolled in the Submitting Contract on the DOS.

TABLE 8I – 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 LOW INCOME BENEFICIARY.
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. PLANS MUST HAVE DOCUMENTED EVIDENCE TO SUBSTANTIATE LICS. [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 8J – 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.
738	NDC IDENTIFIES A PART D NON-COVERABLE DRUG.
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.
743	DRUG COVERAGE STATUS CODE MUST BE 'C' FOR LI NET PDES
744	DOS 1/1/2011 AND FORWARD, THIS DRUG IS NOT COVERED UNDER PART D BECAUSE THE FDA-ASSIGNED MARKETING CATEGORY IS NDA OR BLA, AND NO MEDICARE COVERAGE GAP DISCOUNT PROGRAM AGREEMENT IS ON FILE FOR THE MANUFACTURER RESPONSIBLE FOR THIS LABELER CODE.

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. Subcategory codes further describe inappropriate drug coverage. For example, subcategory code 207 is "Device".

Edit 744 "BRAND DRUG WITH NO MANUFACTURER AGREEMENT": For DOS 1/1/2011 and forward, this drug is not covered under Part D because the FDA-assigned Marketing Category is NDA or BLA, and no CGDP agreement is on file for the manufacturer responsible for this labeler. This edit applies to non-compounded covered drugs only.

TABLE 8K – 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 STATUS CODE IS 'O' AND PRICING EXCEPTION CODE <>'M', THEN PATIENT PAY AMOUNT, LICS, OTHER TrOOP, PLRO, AND CPP MUST EACH 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.
764	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TOTAL GROSS COVERED DRUG COST ACCUMULATOR MUST BE BLANKS OR ZEROS.
765	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TRUE OUT-OF-POCKET ACCUMULATOR MUST BE BLANKS OR ZEROS.
766	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE BEGINNING BENEFIT PHASE MUST BE BLANK.
767	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE ENDING BENEFIT PHASE MUST BE BLANK.
768	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE REPORTED GAP DISCOUNT MUST BE BLANKS OR ZEROS.
769	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE GAP DISCOUNT OVERRIDE CODE MUST BE BLANK.
770	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TIER MUST BE BLANK.
771	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE FORMULARY CODE MUST BE BLANK.
772	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE BRAND/GENERIC CODE MUST BE BLANK.

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 8L – 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. DUPLICATE PDE RECORD EXISTS IN DDPS DATA WAREHOUSE.
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.
786	BEGINNING AND ENDING BENEFIT PHASE COMBINATION IS INVALID.
787	BEGINNING AND ENDING BENEFIT PHASE COMBINATION DOES NOT MATCH THE TRUE OUT-OF-POCKET ACCUMULATOR AND/OR TOTAL GROSS COVERED DRUG COST ACCUMULATOR. [BYPASSED FOR EGWP PLANS] [INFORMATIONAL]
788	DDPS NO LONGER ACCEPTS PDES WITH DOS BEFORE 1/1/2008. [BYPASSED FOR LI NET]
998	INTERNAL CMS ISSUE REGARDING CONTRACT/PBP OF RECORD ENCOUNTERED.
999	INTERNAL CMS SYSTEM ISSUE ENCOUNTERED.

Edits 775 and 776 "INCOMPATIBLE DISPENSING STATUS": These edits apply to PDEs with DOS prior to 1/1/2011. Beginning 1/1/2011, DDPS no longer accepts partial and complete dispensing status codes.

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 781 "SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE": "Service Provider ID is not on master provider file" currently applies to National Provider Identifier (NPI) or National Council for Prescription Drug Programs (NCPDP) numbers.

Edit 783 "SERVICE PROVIDER WAS NOT ACTIVE PHARMACY ON DOS": This edit was re-established on 4/24/2011 for all DOS. This edit triggers when the DOS is less than or equal to the NCPDP defined store close date plus six months.

Edit 786 "BEGINNING AND ENDING BENEFIT PHASE COMBINATION IS INVALID": Applies to Covered Drugs only with DOS on or after 1/1/2011. This edit confirms that the Ending Benefit Phase is equal to or later in the benefit than the Beginning Benefit Phase.

Edit 787 "BENEFIT PHASES DO NOT MATCH THE ACCUMULATORS": This edit applies to non-EGWP PDEs for Covered Drugs with DOS on or after 1/1/2011. A beginning benefit phase that is earlier than the benefit phase associated with the TGCDC Accumulator or the TrOOP Accumulator is consistent with report as administered situations. Gap discount calculation edits depend on accurate benefit phase and accumulator reporting.

Edit 788 "DDPS DOES NOT ACCEPT PDES WITH DOS BEFORE 1/1/2008": This edit is bypassed for LI-NET plans.

TABLE 8M – DDPS DET EDIT CODES – GAP DISCOUNT

EDIT CODE	EDIT DESCRIPTION
865	BENEFICIARIES ELIGIBLE FOR THE LOW INCOME COST SHARING SUBSIDY ON THE DOS ARE NOT ELIGIBLE TO RECEIVE A COVERAGE GAP DISCOUNT.
866	MSP AND COB CLAIMS ARE NOT ELIGIBLE FOR THE COVERAGE GAP DISCOUNT.
867	FDA DOES NOT DESIGNATE THIS DRUG AS NDA OR BLA; THEREFORE IT IS INELIGIBLE FOR THE COVERAGE GAP DISCOUNT.
868	SERVICE PROVIDER ID QUALIFER CANNOT BE '99' WHEN PDE REPORTS THE COVERAGE GAP DISCOUNT.
869	NO PORTION OF THE CLAIM IS IN THE COVERAGE GAP; THEREFORE THE COVAGE GAP DISOUCNT DOES NOT APPLY.
870	REPORTED GAP DISCOUNT <> CMS CALCULATED GAP DISCOUNT +/- 0.05.
871	REPORTED GAP DISCOUNT EXCEEDS AMOUNT ESTIMATED BY CMS +/- 0.05.
872	REPORTED GAP DISCOUNT IS LESS THAN OR EQUAL TO AMOUNT ESTIMATED BY CMS. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. ESIMATION NECESSARY BECAUSE THE ACCUMULATOR AMOUNTS DID NOT AGREE WITH THE BENEFIT PHASE VALUES. [INFORMATIONAL]
873	FOR DOS 1/1/2011 FORWARD, IF DRUG COVERAGE STATUS CODE IS 'C' AND GDCB IS ZERO, REPORTED GAP DISCOUNT MUST BE ZERO.
874	REPORTED GAP DISCOUNT IS > ZERO. THE SPONSOR PROVIDED LICS BASED ON BEST AVAILABLE EVIDENCE. LOW INCOME BENEFICIARIES ARE NOT ELIGIBLE TO RECEIVE A COVERAGE GAP DISCOUNT.
875	CLAIMS SUBMITTED WITH COMPOUND DURGS ARE NOT ELIGIBLE TO RECEIVE THE COVERAGE GAP DISCOUNT.
876	REPORTED GAP DISCOUNT (MINUS ROUNDING ERROR) IS LESS THAN THE DISCOUNT AMOUNT ESTIMATED BY CMS, PROVIDED THAT NPP INCLUDES SUPPLEMENTAL BENEFITS IN THE COVERAGE GAP, THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]

TABLE 8M – DDPS DET EDIT CODES – GAP DISCOUNT (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
877	REPORTED GAP DISCOUNT +/- ROUNDING ERROR EQUALS THE DISCOUNT AMOUNT ESTIMATEDY BY CMS, PROVIDED THAT NPP REPORTS SUPPLEMENTAL BENEFITS IN OTHER BENEFIT PHASES EXCLUDING THE COVERAGE GAP. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]
878	REPORTED GAP DISCOUNT IS ZERO. NO GAP DISCOUNT APPLIES WHEN A PDE STRADDLES TWO ADJOINING CO-PAY BENEFIT PHASES AND THE SECOND BENEFIT PHASE IS THE COVERAGE GAP. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]
879	REPORTED COVERAGE GAP DISCOUNT IS ZERO AND GENERIC COST SHARING IS REPORTED FOR GAP DISCOUNT ELIGIBLE PDE.

Many edits in this series examine whether a PDE is eligible to receive a Gap Discount. Other edits focus on validating the dollars reported in the Reported Gap Discount Amount field.
Examples of edits issued because a PDE is not eligible for the Gap Discount include:

Edit 867 "FDA DOES NOT DESIGNATE THIS DRUG AS NDA OR BLA; THEREFORE IT IS INELIGIBLE FOR THE COVERAGE GAP DISCOUNT"

Edit 869 "NO PORTION OF THE CLAIM IS IN THE COVERAGE GAP, THEREFORE IT IS INELIGIBLE FOR THE COVERAGE GAP DISCOUNT"

After a PDE is confirmed to be eligible for the Gap Discount, DDPS performs a series of calculations to evaluate the Gap Discount Amount. When the Reported Gap Discount Amount varies from the calculated Gap Discount amount, DDPS issues a number of informational and reject edits.

There are two methods CMS uses when evaluating the Reported Gap Discount Amount on a PDE. In the first method, CMS determines the Calculated Gap Discount. In the second method, CMS calculates an expected range for the Gap Discount.

Method 1: Determining Calculated Gap Discount (Slide 14)

Below are four scenarios in which CMS calculates the Gap Discount, along with the formulas used to determine Calculated Gap Discount. If a claim falls within the scenarios below, the Total Drug Cost Accumulator (TGCDC ACC) and True Out-of-Pocket Accumulator (TrOOP ACC) are evaluated to identify costs falling in the Coverage Gap. The Accumulator fields match the Benefit Phase fields. Steps 1 and 2 will vary depending on where the claim falls within the benefit phases. If the claim straddles benefit phases, the claim must not have supplemental benefits (NPP = 0). In all four scenarios, Step 3 remains the same. Drug Cost is defined as the sum of Ingredient Cost Paid, Total Amount Attributed to Sales Tax, Dispensing Fee, and Vaccine Administration Fee.

Scenario 1: Claims falls completely in the Coverage Gap and the plan may or may not offer supplemental benefits within the Coverage Gap

Step 1: Determine costs that fall within the Coverage Gap:

Drug Cost = Ingredient Cost Paid + Total Amount Attributed to Sales Tax + Dispensing Fee Paid + Vaccine Administration Fee

Step 2: Determine Discount Eligible Cost
If NPP ≥ Dispensing Fee Paid and Vaccine Administration Fee then
Discount Eligible Cost = Drug Cost – NPP
Else If (NPP < Dispensing Fee Paid and Vaccine Administration Fee or NPP = 0) then
Discount Eligible Cost = Ingredient Cost Paid + Total Amount Attributed to Sales Tax

Step 3: Calculate Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Scenario 2: Claim straddles either the Deductible or the Initial Coverage Phase and the Coverage Gap and the claim does not contain supplemental benefits

Step 1: Determine costs that fall within the Coverage Gap:

Gap Drug Cost = TGCDC Acc + Drug Cost – Initial Coverage Limit (ICL)

Step 2: Determine Discount Eligible Cost

If (Drug Cost – Gap Drug Cost ≥ Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Gap Drug Cost
Else If (Drug Cost – Gap Drug Cost < Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Ingredient Cost Paid + Total Amount Attributed to Sales Tax

Step 3: Calculate Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Scenario 3: Claim straddles the Coverage Gap and the Catastrophic Coverage Phase and the claim does not contain supplemental benefits

Step 1: Determine costs that fall within the Coverage Gap:

Gap Drug Cost = GDCB

Step 2: Determine Discount Eligible Cost

If (Drug Cost – Gap Drug Cost > = Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Gap Drug Cost
Else If (Drug Cost – Gap Drug Cost < Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Ingredient Cost Paid + Total Amount Attributed to Sales Tax

Step 3: Calculate Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Scenario 4: Claim straddles the Deductible and Catastrophic Coverage Phase or the Initial Coverage Phase and Catastrophic Coverage Phase and the claim does not contain supplemental benefits

Step 1: Determine costs that fall within the Coverage Gap:

Gap Drug Cost = TGCDC Acc + GDCB – ICL

Step 2: Determine Discount Eligible Cost

If (Drug Cost – Gap Drug Cost ≥ Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Gap Drug Cost
Else If (Drug Cost – Gap Drug Cost < Dispensing Fee Paid and Vaccine Administration Fee) then
Discount Eligible Cost = Ingredient Cost Paid + Total Amount Attributed to Sales Tax

Step 3: Calculate Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Method 2: Calculating an Expected Range for Gap Discount

There are instances in which CMS cannot calculate Gap Discount exactly; however, the claim may be eligible for the Gap Discount. In these scenarios, CMS can determine a minimum and maximum Gap Discount. Below are two scenarios to illustrate this concept.

Scenario 5: The Accumulator Fields match the Benefit Phase Indicators, the claim straddles two or more benefit phases and one of those phases is the Coverage Gap and the claim may have supplemental benefits within the Coverage Gap (NPP <> 0) or the claim is submitted by an EGWP and NPP<>0.

There are four steps in calculating the expected range for Gap Discount in scenario 5. The steps are outlined below. Step 2, Determining Gap Drug Cost, varies depending on where the claim falls within the benefit phase. Drug Cost is defined as the sum of Ingredient Cost Paid, Total Amount Attributed to Sales Tax, Dispensing Fee, and Vaccine Administration Fee.

Step 1: Determine minimum gap discount

Minimum gap discount = 0

Step 2: Determine Gap Drug Cost

If claim begins in the Deductible and ends in the Coverage Gap or if the claim begins in the Initial Coverage Phase and ends in the Coverage Gap:
Gap Drug Cost = TGCDC ACC + Drug Cost – ICL

If claim begins in the Coverage Gap and ends in the Catastrophic Coverage phase:
Gap Drug Cost = GDCB

If Claim begins in the Deductible and ends in the Catastrophic Coverage Phase or if the claim begins in the Initial Coverage Phase and ends in the Catastrophic Coverage Phase:

Gap Drug Cost =TGCDC ACC + GDCB - ICL

Step 3: Determine maximum discount eligible cost

If (Drug Cost-Gap Drug Cost ≥ Dispensing Fee Paid) then
Max discount Eligible Cost = Gap Drug Cost

If (Drug Cost – Gap Drug Cost < Dispensing Fee Paid) then
Max discount Eligible cost = Ingredient cost Paid + Total Amount Attributed to Sales Tax +Vaccine Administration Fee

Step 4: Determine Maximum Gap Discount

Maximum Gap Discount = Maximum Discount Eligible cost * 0.5

Scenario 6: The PDE has one or more illogical values within the following fields: TGCDC ACC, TrOOP ACC, Beginning Benefit Phase, and Ending Benefit Phase

Step 1: Determine minimum gap discount

Minimum gap discount = 0

Step 2: Determine maximum gap discount

If (Ingredient cost Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee) < GDCB then
Maximum Gap Discount = (Ingredient cost Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee) * 0.5

If (Ingredient cost Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee) > GDCB then
Maximum Gap Discount = GDCB * 0.5

8.3.3 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

Scenario

Greenhouse PDP submitted a PDE for a beneficiary with HICN 000-00-0000A.

Edit

While DDPS accepted this record, the system issued a 710 informational edit and provided error message: The beneficiary HICN has changed according to CMS records; use the corrected HICN for future submissions.

Resolution

Greenhouse PDP does not resubmit the PDE that received the 710 edit. The plan updates its system to reflect the new HICN to avoid receiving additional 710 edits on future PDEs for this beneficiary.

8.4 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.

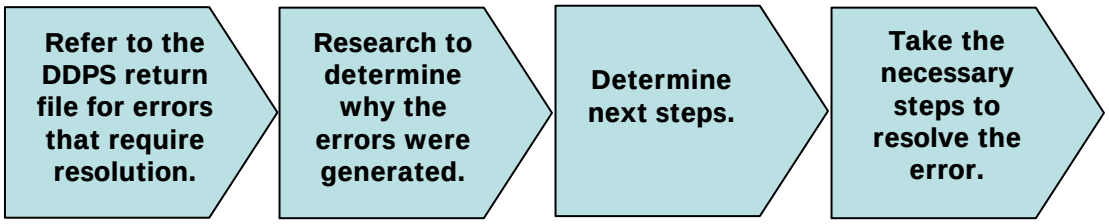
To assist plans with working through the error resolution process, this section provides plans with an explanation of the basic framework of the error resolution process and offers plans different types of error resolution strategies with examples of the types of situations in which these strategies should be used.

8.4.1 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.

Figure 8A describes 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 8A – 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.

Edit

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.

Resolution

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.

Edit

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'.

Resolution

Lighthouse Health corrects the invalid data and resubmits with a valid value for this field.

Note: Edits 603 through 640 and edits 646 through 659 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 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.

Edit

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 + Vaccine Administration Fee.

Resolution

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 the error. 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 05/13/11.

Edit

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.

Resolution

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.

Edit

Green Fan PDP received edit 715 indicating that there were dollars reported in LICS that were greater than zero.

Resolution

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

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. If this should occur, plans should contact pharmacies to confirm the most current NPI is on file and resubmit the PDE if the NPI was out of date.

8.5 Plan-to-Plan (P2P) (Slides 19-20)

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 8B illustrates the P2P Process Flow.

Figure 8B – P2P Process Overview

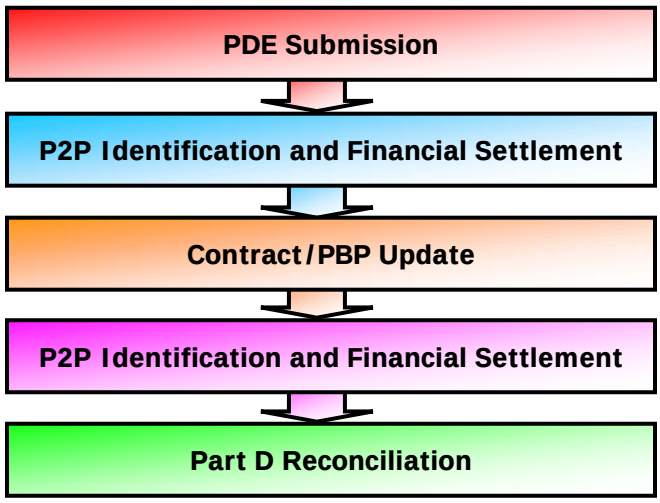


Table 8N provides the definitions of common terms related to the P2P process.

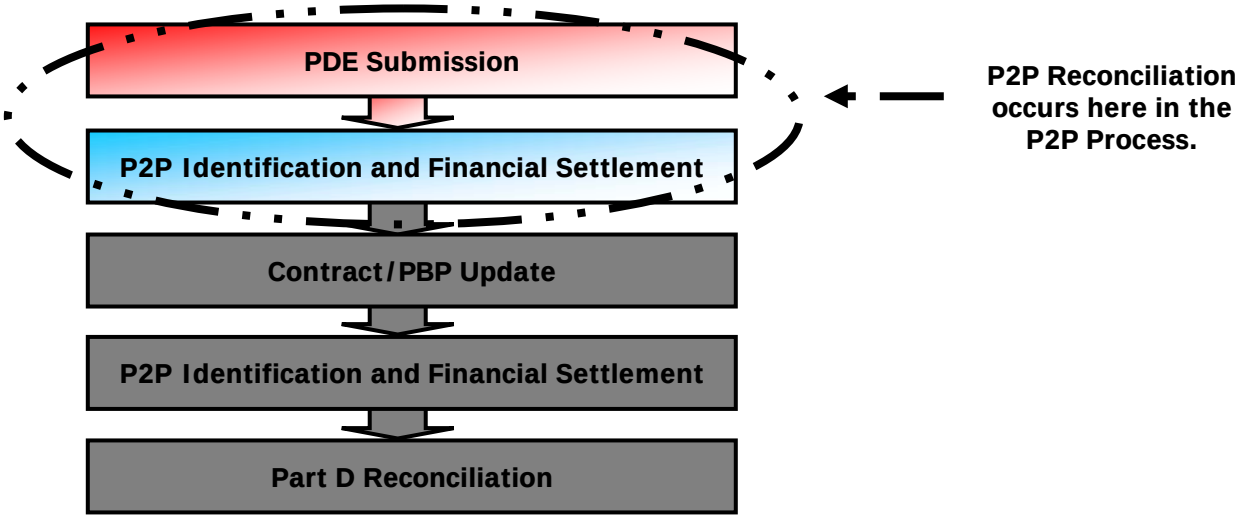
TABLE 8N – COMMON P2P TERMS

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.

8.5.1 P2P Reconciliation (Slide 21)

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 8C illustrates where P2P Reconciliation occurs in the P2P Process.

Figure 8C – P2P Reconciliation



8.5.2 Statutory Authority (Slide 22)

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.

8.5.3 CMS Transition Period (Slide 23)

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.

8.5.4 P2P Roles and Responsibilities (Slides 24-25)

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 8O summarizes the roles and responsibilities for Part D sponsors and CMS in P2P.

TABLE 8O – 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 through the Attestation of P2P Reconciliation Payment Data
CMS	• Identifies Contract of Record • Provides CPP and LICS amounts

8.5.5 P2P Processing Within PDE Processing (Slides 26-27)

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. Figure 8D illustrates P2P processing within PDE processing in DDPS.

Figure 8D – Diagram Illustrating P2P Processing Within PDE Processing in DDPS for Informational Edit and Resume Editing

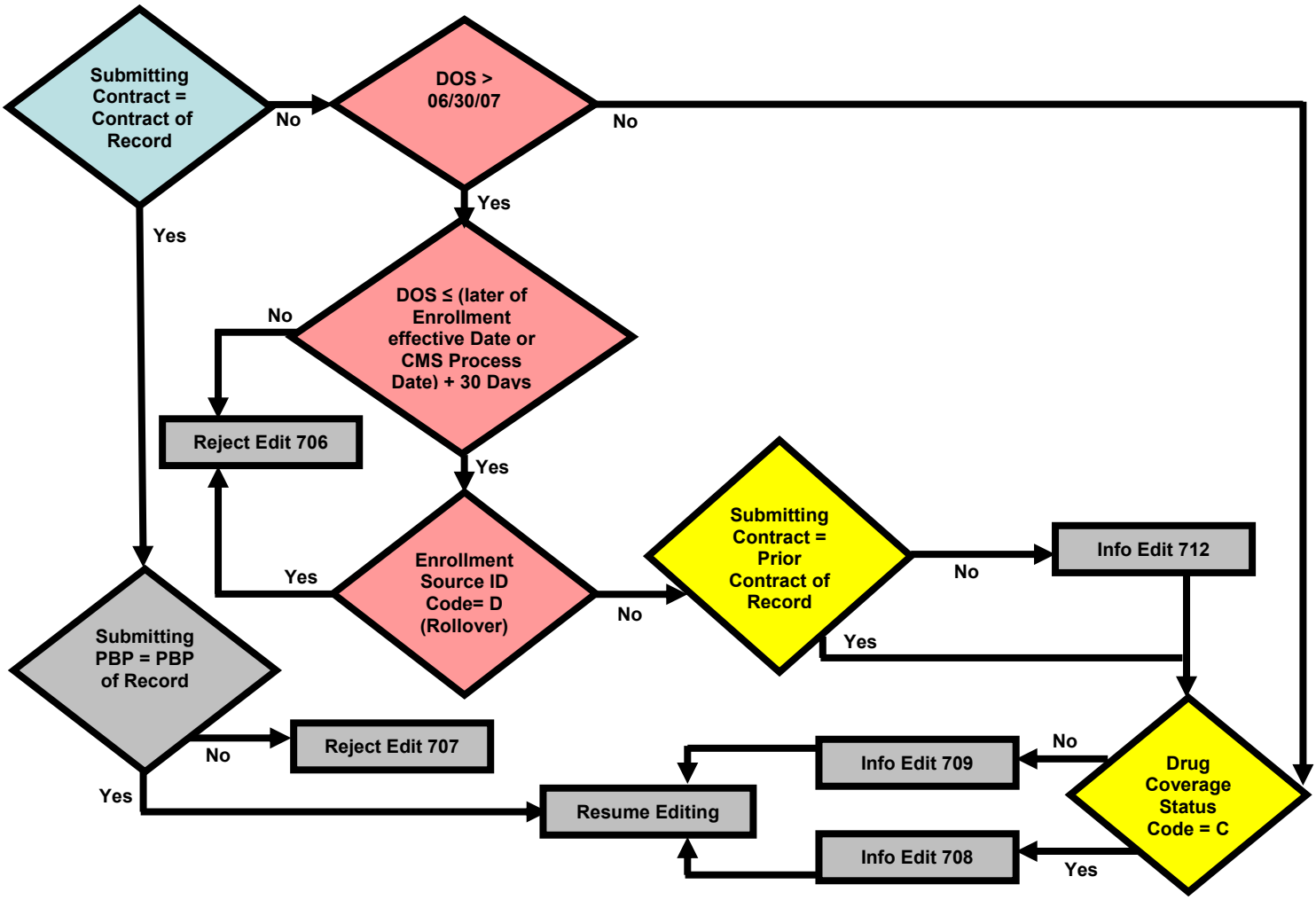
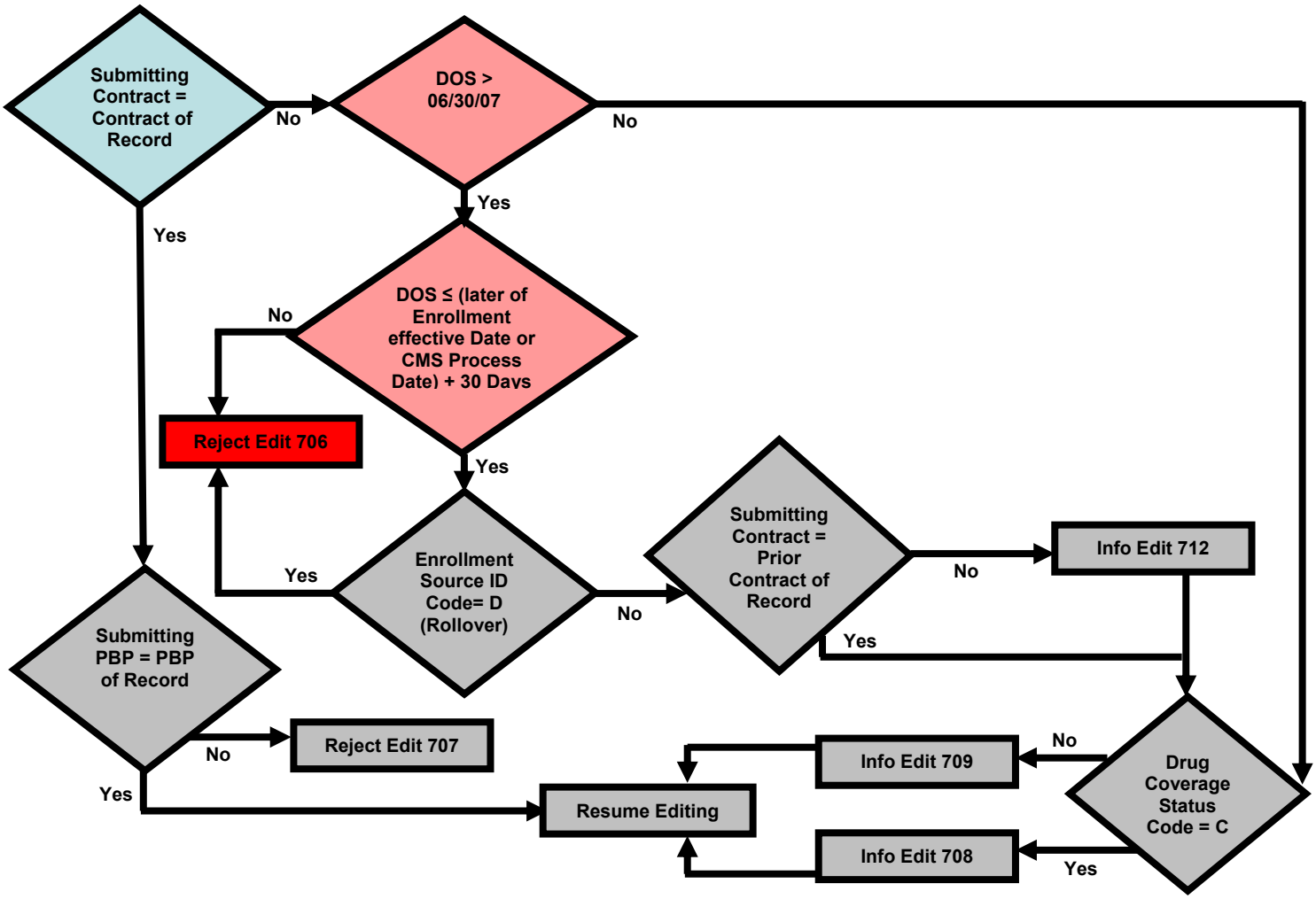


Figure 8E – Diagram Illustrating P2P Processing Within PDE Processing in DDPS for Reject Edit



8.5.6 P2P Contract/PBP Update (Slides 28-29)

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.

8.5.7 Update Codes (Slide 30)

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 8P describes the P2P Update Codes.

TABLE 8P – 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.

8.6 Responding to the Immediately Actionable PDE (IAP) Errors and Eligibility Error Reports (Slides 31-32)

CMS evaluates PDP and MA-PD contracts on the quality and timeliness of PDE submissions, PDE errors, and error resolution efforts. CMS, through its contractor Acumen LLC, will provide reports on the quality, timeliness, and accuracy of each contract's PDE data submission and error resolution efforts. This initiative will be rolled out in phases. The first phase of this initiative deals 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 has grown 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.

In 2010, CMS began a second initiative on PDE edit reporting, called the Eligibility Errors Report. The Eligibility Errors Report includes edits 705, 706, and 707. As with the IAP reports, CMS expects plans to demonstrate action toward the resolution of both the error, and the underlying enrollment or eligibility issue that caused the error.

MODULE 9 – 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, PDE data quality review, 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 and perform PDE data quality review.
- 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	

9.1 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 same day if file is received before 1:00 p.m. Eastern Time (ET). If the submission is received after 1:00 p.m. ET users should received PDFS reports the following day .

For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (800) 927-8069, emailing mapdhelp@cms.hhs.gov, or viewing the website at http://www.cms.gov/mapdhelpdesk.

Submitters typically receive Drug Data Processing System (DDPS) processing reports the next business day. Sponsors and submitters should subscribe to email notifications from the Customer Service and Support Center (CSSC) to ensure timely notification of the availability of monthly DDPS reports. 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 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.

9.2 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 9A summarizes the content and general information about each of the reports.

TABLE 9A – 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 same or 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 9A – 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
ACCUMULATOR COMPARISON REPORT	• For each beneficiary compares most recent Accumulator value reported by the plan to value CMS calculates from PDEs • Includes covered drugs only • Distributed to the current Contract of Record • Excludes beneficiaries in PACE Organizations or non-Calendar Year Employer Group Waiver Plans (EGWPs)
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.
P2P RECEIVABLE REPORT	• Monthly report that documents the net change in P2P reconciliation receivable amounts.
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.
P2P PAYABLE REPORT	• Monthly report that serves as the "invoice" to the Contract of Record, showing how much is payable to each Submitting Contract.

Table 9B provides the naming conventions for management reports sent to the submitter's mailbox.

TABLE 9B – 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
ACCUMULATOR COMPARISON REPORT	RPT00000.RPT.DDPS_ACC_COM
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

9.3 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 9A illustrates and describes the fields on the PDFS Response Report.

Figure 9A – Rejected PDFS Response Report

```
[1]REPORT: PDFS-RESP              [2]PRESCRIPTION DRUG FRONT END SYSTEM
[3]RUN DATE: 20110513                      PDFS RESPONSE REPORT
[4] PROCESSED: 20110513 CYCLE 1

[5]SUBMITTER ID: SH1234
[6]FILE ID: 0000000001            [7]REJECTED   PROD

[8]        [9]       [10]
RECORD   SEQ       ERROR      [11]
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 5	Processing Cycle Submitter ID	Indicates the cycle in which the PDE file was submitted to DDPS. Report is grouped by submitter identification number. A submitter may submit for more than one contract/plan. A report is generated for each file.
6	File ID	The 10-digit file identification number.
7	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST, CERT, or PRODUCTION.
8	Record Type	Identifies the level of the error (File, Batch, or Detail record level).
9	Sequence Number	Identifies the record where the error occurred.
10	Error Code	Identifies the 3-digit error code that caused the file to reject.
11	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 9B illustrates this example.

Figure 9B – PDFS Response Report

REPORT: PDFS-RESP **PRESCRIPTION DRUG FRONT END SYSTEM**
RUN DATE: 20110315 **PDFS RESPONSE REPORT**
PROCESSED: 20110315 CYCLE 1

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*****

9.4 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 9C 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 are expected to track summary data from transaction reports to measure and improve their own performance.

9.4.1 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 9C shows all of the Record ID values for the DDPS Return File.

TABLE 9C - 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 63-72 (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 63-72 (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, P2P Contract of Record where applicable, and CMS Calculated Gap Discount where applicable. Details about the error count, corrected HICN, and CMS Calculated Gap Discount 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. Plans and submitters are expected to research PDEs with error codes prior to resubmitting the PDEs to DDPS.

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 61. 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 are expected to update their internal data system with the MBD provided HICN. When submitting future PDEs for the beneficiary, CMS expects the PDEs to contain the corrected 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 9D provides the BTR record layout.

TABLE 9D – 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 9E.

TABLE 9E – 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.

9.4.2 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 are expected to 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 9F provides the record definitions and descriptions for the basic record layout for the DDPS Transaction Error Summary.

TABLE 9F – DDPS 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 9G provides the flat file layout for the DDPS Transaction Error Summary DET record.

TABLE 9G – 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.

9.5 Management Reports (Slides 13-15)

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 four management reports. Plans also receive monthly management reports for Plan-to-Plan (P2P) PDEs. These reports are explained in the P2P section of this module.

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
Management Report 90COV – Accumulator Comparison Report

Since each Management Report 04 uses the same format, we will explain the file layout of report 04COV, Cumulative Beneficiary Summary Report, Covered Drugs.

9.5.1 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 9H illustrates the specific types of information in this report.

TABLE 9H - KEY INFORMATION IN THE CUMULATIVE BENEFICIARY SUMMARY REPORT

COST	PAYMENT	PDE SUBMISSIONS	CATASTROPIC 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 • Net Reported Gap Discount	• 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."

9.5.1.1 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 9I provides the definitions and descriptions of the records in the Cumulative Beneficiary Summary Report.

TABLE 9I - 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

9.5.1.2 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, 2011, IDR produced a report with the following attributes:
- File Name: 04COV2011001
- As-of Year: 2011
- As-of Month: 03
- DDPS Date: 20110406

The identifying information shows that this report has data for the 2011 benefit year, submitted to DDPS by March 31, 2011.

On April 7, 2012, IDR will need to produce two of these reports, one for benefit year 2011 and one for 2012. The attributes for each will be:

April 2011 Cumulative Beneficiary Summary Report (Benefit Year 2011)
- File Name: 04COV2011001
- As-of Year: 2012
- As-of Month: 03
- DDPS Date: 20120407

April 2012 Cumulative Beneficiary Summary Report (Benefit Year 2012)
- File Name: 04COV2012001
- As-of Year: 2012
- As-of Month: 03
- DDPS Date: 20120407

The file name for the first report shows that the report was produced for benefit year 2011. The file name for the second report shows that it was produced for benefit year 2012. Both reports have the same As Of date, indicating that each report represents data submitted through March 31, 2012. (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.)

9.5.1.3 DET Record

The DET record establishes the basic format for the rest of the file. The layout for the DET record appears in Table 9J.

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 30-32 will be net of adjustment and deletion PDEs.

- Net TrOOP Amount is estimated based on the sum of Net Patient Pay Amount, Net Other TrOOP Amount, Net LICS Amount, and Net Reported Gap Discount for all PDEs at or below the Out-of-pocket threshold. Due to reporting lags and because the PDE that straddles the Coverage Gap and Catastrophic Coverage phases 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 and field 33 represent PDE counts net of adjustments and deletions.

The information on this file should be reconciled with plan records and with the DDPS Return files. 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. If plans determine a discrepancy in the Cumulative Beneficiary Summary Reports, the plan should immediately contact a CMS Division of Payment Reconciliation (DPR) representative for further investigation. Plans should not wait until Part D Payment Reconciliation or re-opening to notify CMS of the discrepancy.

Table 9J provides the fields for the DET record to the Cumulative Beneficiary Summary Report.

TABLE 9J - 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	LAST-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	Definition for PDEs with DOS January 1, 2011 and forward: The DOS on the first claim where GDCA>0. Definition for PDEs with DOS prior to January 1, 2011: DOS 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 AMOUNT	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 AMOUNT	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.

TABLE 9J - CUMULATIVE BENEFICIARY SUMMARY REPORT - DET RECORD (CONTINUED)

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
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
18	NET TrOOP AMOUNT	217 – 230	S9(12)V99	14	Sum of Net Patient Pay Amount, Net Other Troop Amount, Net LICS Amount, and Net Reported Gap discount. The amount will be capped at the Out-of-Pocket Threshold limit, for the benefit year being reported, by including only pre-catastrophic PDEs only(i.e., PDEs with GDCA = 0).
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	Definition for PDEs with DOS January 1, 2011 and forward: Count of PDEs with GDCA > zero and GDCB = zero. Definition for PDEs with DOS prior to January 1, 2011: Count of PDEs with Catastrophic Coverage Code equal "C".
26	NET NUMBER OF ATTACHMENT POINT PDES	321 – 332	9(12)	12	Definition for PDEs with DOS January 1, 2011 and forward: Count of PDEs with GDCA > zero and GDCB > zero. Definition for PDEs with DOS prior to January 1, 2011: Count of PDEs with Catastrophic Coverage Code equal "A"
27	NET NUMBER OF NON-CATASTROPHIC PDES	333 – 344	9(12)	12	Definition for PDEs with DOS January 1, 2011 and forward: Count of PDEs with GDCA = zero and GDCB > zero. Definition for PDEs with DOS prior to January 1, 2011: Count of PDEs with Catastrophic Coverage Code equal "blank"

TABLE 9J - CUMULATIVE BENEFICIARY SUMMARY REPORT - DET RECORD (CONTINUED)

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
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" (out-of-network)
30	NET ESTIMATED REBATE AT POS AMOUNT	369 - 382	S9(12)v99	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	S9(12)V99	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	NET REPORTED GAP DISCOUNT	397-410	S9(12)V99	14	Net reported gap discount amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs.
33	NET NUMBER OF REPORTED GAP DISCOUNT PDES	411-422	9(12)	12	Count of PDEs with Reported Gap Discount >zero
34	FILLER	423 - 512	X(90)	90	SPACES

9.5.1.4 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.

9.5.1.5 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.

9.5.2 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
- Net Reported Gap Discount

In addition, OTC drugs have no Net Patient Pay amount.

9.5.3 Report 90COV – Accumulator Comparison Report (Slides 14-15)

The Accumulator Comparison Report includes the Accumulator values reported by the plan, the Accumulator values calculated by CMS from saved PDEs and differences, if any, between the two. Plans use the Accumulator Comparison Report to evaluate discrepancies between reported and calculated Accumulator values. When discrepancies occur because CMS has incomplete information, plans must submit overdue PDEs. When the plan's accumulator is in error, plans must first adjust any claims adjudicated incorrectly. Plans must also correct errors on all mis-reported PDEs. Since plans have real-time adjudication information, CMS acknowledges that differences between its calculations and plan reported accumulators will occur. However, difference rates should be minimal. Differences should be resolved promptly and both CMS and the plan should see on-going resolution and improvement.

CMS distributes the Accumulator Comparison Report to the current contract of record for all beneficiaries enrolled, excluding beneficiaries in PACE Organizations and non-Calendar year EGWPs. Reporting is based on month-end Date of Service, followed by a two month lag period for plans to complete PDE submissions.

CMS will release the Accumulator Comparison Report in Phases. Initially the report will address the Total Gross Covered Drug Cost (TGCDC) Accumulator for beneficiaries with PDEs in the same contract. Since the TGCDC Accumulator determines if the beneficiary is in the Deductible or the Initial Coverage Phase or has entered the Coverage Gap, Phase One reporting will be limited to pre-catastrophic PDEs. In subsequent phases CMS will add TrOOP Accumulator and benefit phase comparisons and will include beneficiaries with PDEs submitted by multiple contracts. All report changes will be announced to plans in HPMS. Table 9K illustrates the specific types of information in this report.

TABLE 9K - KEY INFORMATION IN THE ACCUMULATOR COMPARISON REPORT – PHASE ONE

BENEFICIARY INFORMATION	ACCUMULATOR INFORMTION	PDE INFORMATION
• Current HICN • Last reported HICN • MULT SUBMITTING CONTRACT IND	• CURRENTLY DISCREPANT TGCDC ACC (Y/N) • CALCULATED TGCDC ACC • LAST REPORTED TGCDC ACC • TGCDC ACC DIFF	• PDE COUNT WITH NO TGCDC ACC DIFF • PDE COUNT WITH TGCDC ACC DIFF • TOTAL PDE COUNT

9.5.3.1 Basic Record Layout

The Accumulator Comparison Report file layout is very similar to the Cumulative Beneficiary Summary Report layout. Header records identify the report. The contract header record (CHD) identifies the contract and is followed by a PBP header (PHD) which identifies the PBP. The DET records provide the beneficiary level reporting. The PBP trailer record (PTR) and the contract trailer record (CTR) provide important summary counts and rates at the PBP and contract level respectively. Table 9L describes the basic record layout for the Accumulator Comparison Report.

TABLE 9L – ACCUMLATOR COMPARISON 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

9.5.3.2 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.

Embedded in the file name is the benefit year of the data being reported. The Accumulator Comparison Report has a built-in two month lag following the date of service cut-off to provide for timely PDE submission. In other words the report data period includes all PDEs saved within two months following the date of service cut-off. To clarify the report data period, the header records include two date parameters for the date of service and the submission through date. The submission through date is the date by which the PDEs were submitted. DDPS produces management reports mid-month for data submitted through the end of the previous month.

Example: 1

On July 15, 2011 CMS produced a report with the following attributes:

- File Name: 90COV2011001
- DOS-AS-OF-YEAR: 2011
- DOS-AS-OF-MONTH: 04
- SBMSN-THROUGH-YEAR: 2011
- SBMSN-THROUGH-MONTH: 06
- DDPS-SYSTEM-DATE: 20110715

Example 1 shows header data for the Accumulator Comparison Report distributed in July 2011. The report is based on PDES saved by June 30, 2011 with 2011 dates of service through April 30. DDPS created the report on July 15, 2011.

Example: 2

One year later on July 15, 2012 CMS produced the final Accumulator Comparison report for the 2011 benefit year. The report has the following attributes:

- File Name: 90COV2011001
- DOS-AS-OF-YEAR: 2011
- DOS-AS-OF-MONTH: 12
- SBMSN-THROUGH-YEAR: 2012
- SBMSN-THROUGH-MONTH: 06
- DDPS-SYSTEM-DATE: 20120715

Example 2 shows header data for the last 2011 Accumulator Comparison Report which was distributed in July 2012 following the reconciliation deadline. The report is based on PDES saved by June 30, 2012 with 2011 dates of service through December 31. DDPS created the report on July 15, 2012.

9.5.3.3 DET Record

The DET record establishes the basic format for the rest of the file. The layout for the DET record appears in Table 9J.

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 use the most current HICN and cross-walk any previous activity under older HICNs to the most current HICN. Accumulator data should be maintained and reported in PDEs under the most current beneficiary identifier.

- A value of 'Y' in CURRENTLY DISCREPANT TGCDC ACC alerts the plan that CMS cannot replicate the most recent TGCDC ACC reported in the report data period. Three fields explain the difference: the CALCULATED TGCDC ACC from CMS, the LAST REPORTED TGCDC ACC from the plan and the TGCDC ACC DIFF. The plan should review beneficiary claims history, be able to explain the difference and update PDEs so that CMS and plan Accumulators agree in the next report.

- When the calculated and reported accumulators agree plans should further review PDE counts and confirm that the PDE COUNT WITH NO TGCDC ACC DIFF (field 11) matches the TOTAL PDE COUNT (field 13).

- Accumulator comparisons are based on the LAST REPORTED TGCDC ACC. The LAST REPORTED TGCDC ACC is the REPORTED TGCDC ACC documented in the most recent PDE in the data period. CMS uses the following logic to identify the most recent PDE.

  - First CMS sorts PDEs by Claim Adjudication Began Timestamp, then Total Gross Covered Drug Cost (TGCDC) Accumulator.
    - If the absolute value of the difference is within rounding error ($.05) CMS sets the value in CURRENTLY DISCREPANT TGCDC ACC to "N".
    - If the absolute value of the difference exceeds rounding error ($.05) and no PDEs were adjusted or resubmitted, CMS sets the value in CURRENTLY DISCREPANT TGCDC ACC to "Y".
    - Otherwise CMS re-sorts the PDEs to correctly identify the accumulator for the adjusted or resubmitted PDE(s). The second sort is by date of Service, Claim Adjudication Began Timestamp, and Total Gross Covered Drug Cost (TGCDC) Accumulator.
    - After identifying the most recent PDE, CMS calculates the Calculated TGCDC Accumulator as the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee reported on all preceding PDEs in the sort order.
      Note: accurate reporting depends on accurate and complete data in sort fields.

- Table 9M lists common discrepancy resolution strategies.

TABLE 9M – COMMON DISCREPANCY RESOLUTION STRATEGIES

DISCREPANCY	COMMON RESOLUTION STRATEGY
CALCULATED TGCDC ACC less than LAST REPORTED TGCDC ACC	• Determine if the plan has outstanding original PDEs, submit (or correct rejected) PDEs • If PDE reporting is current, determine if the plan has included non-Part D claims data in the accumulator. If so, remove the incorrect entries, confirm that the plan adjudicated claims in the correct benefit phase, re-adjudicate any incorrect claims and correct accumulators on all misreported PDES.
CALCULATED TGCDC ACC greater than LAST REPORTED TGCDC ACC	• Determine if the plan has overdue PDEs for deletes or adjustments. Submit overdue PDES. Correct rejected PDEs.
CMS CALCULATED TGCDC ACC equals LAST REPORTED TGCDC ACC and PDE COUNT WITH NO TGCDC ACC DIFF less than TOTAL PDE COUNT	• Determine if the plan has overdue PDEs for deletes or adjustments. Submit overdue PDES. Correct rejected PDEs.
Note: whenever differences occur confirm that the data used to sort PDEs is complete and accurate.	

Table 9N provides the Accumulator Comparison Report DET fields – Phase One.

TABLE 9N - THE ACCUMULATOR COMPARISON REPORT DETAIL RECORD – PHASE ONE

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"DET"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CURRENT CMS HICN	11 - 30	X(20)	20	Most Current HICN per MBD
4	LAST REPORTED HICN	31 - 50	X(20)	20	HICN reported in the latest PDE
5	MULT SUBMITTING CONTRACT IND	51 - 51	X	1	Y - Beneficiary has PDEs from multiple submitting contracts N - All PDEs for this beneficiary are from the same contract
6	FILLER	52 - 61	X(10)	10	SPACES
7	CURRENTLY DISCREPANT TGCDC ACC	62 - 62	X	1	Y or N flag stating whether or not there was a difference between calculated and reported TGCDC ACC for this bene.
8	CALCULATED TGCDC ACC	63 - 76	S9(12)V99	14	Calculated TGCDC ACC
9	LAST REPORTED TGCDC ACC	77 - 90	S9(12)V99	14	TGCDC ACC Reported on the last claim
10	TGCDC ACC DIFF	91 - 104	S9(12)V99	14	Difference of Calculated TGCDC ACC - Reported TGCDC ACC
11	PDE COUNT WITH NO TGCDC DIFF	105 - 115	9(11)	11	Count of PDEs with no difference in TGCDC ACC
12	PDE COUNT WITH TGCDC DIFF	116 - 126	9(11)	11	Count of PDEs with a difference in Calculated and Reported TGCDC ACC
13	TOTAL PDE COUNT	127 - 137	9(11)	11	Count of all PDEs
14	FILLER	138 - 512	X(375)	375	SPACES

9.5.3.4 PTR Record

The PTR record reports the number of beneficiary records with and without discrepancies, the overall discrepancy rate and discrepancies by category. Discrepancies are reported in seven categories by dollar amount: no discrepancy, large positive discrepancy, medium positive discrepancy, small positive discrepancy, large negative discrepancy, medium negative discrepancy, and small negative discrepancy.

Table 9O provides the fields Accumulator Comparison Report PTR fields – Phase One.

TABLE 9O - THE ACCUMULATOR COMPARISON REPORT PTR RECORD – PHASE ONE

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CRNT-CONTRACT-OF-RECORD	11 - 15	X(5)	5	Same as PHD
4	CRNT-PBP-OF-RECORD	16 - 18	X(3)	3	Same as PHD
5	BENEFICIARY COUNT	19 - 29	9(11)	11	Count of beneficiaries through the month reported
6	COUNT OF BENEFICIARY RECORDS WITH TGCDC ACC DISCREPANCIES	30 - 40	9(11)	11	Count of beneficiary records with TGCDC discrepancies
7	COUNT OF BENEFICIARY RECORDS WITH LARGE POSITIVE TGCDC ACC DISCREPANCY	41 - 51	9(11)	11	Count of beneficiary records with a TGCDC ACC variance of $1000.01 or greater
8	COUNT OF BENEFICIARY RECORDS WITH MEDIUM POSITIVE TGCDC ACC DISCREPANCY	52 - 62	9(11)	11	Count of beneficiary records with a TGCDC ACC variance of $100.01 To $1000.00
9	COUNT OF BENEFICIARY RECORDS WITH SMALL POSITIVE TGCDC ACC DISCREPANCY	63 - 73	9(11)	11	Count of beneficiary records with a TGCDC ACC variance of $0.06 to $100
10	COUNT OF BENEFICIARY RECORDS WITH SMALL NEGATIVE TGCDC ACC DISCREPANCY	74 - 84	9(11)	11	Count of beneficiary records with a negative absolute TGCDC ACC variance between $0.06 and $100
11	COUNT OF BENEFICIARY RECORDS WITH MEDIUM NEGATIVE TGCDC ACC DISCREPANCY	85 - 95	9(11)	11	Count of beneficiary records with a negative absolute TGCDC ACC variance between $100.01 and $1000.00
12	COUNT OF BENEFICIARY RECORDS WITH LARGE NEGATIVE TGCDC ACC DISCREPANCY	96 - 106	9(11)	11	Count of beneficiary records with a negative absolute TGCDC ACC variance of $1000.01 or greater
13	COUNT OF BENEFICIARY RECORDS WITH NO TGCDC ACC DISCREPANCIES	107 - 117	9(11)	11	Count of beneficiary records with no TGCDC ACC discrepancies
14	TGCDC ACC DISCREPANCY RATE	118 - 120	9(1)V99	3	Rate of beneficiary records with TGCDC discrepancies. (Field 6 divided by Field 5)
15	FILLER	121 - 512	X(392)	392	SPACES

9.5.3.5 CTR Record

The CTR record has the same layout as the PTR record and reports the same data summarized at the contract level.

9.6 Plan-to-Plan (P2P) (Slides 16-21)

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 9P identifies the reports CMS uses to communicate with plans and the general purpose of each report.

TABLE 9P – 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.

The P2P Accounting Report (Report 40 COV) will display the Reported Gap Discount Amount for accounting purposes. Reports 41-43 will not display the Reported Gap Discount Amount since this field is not part of the P2P reconciliation process.

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. Delays in receiving EOB information should occur infrequently due to the automation of this process in January 2009.

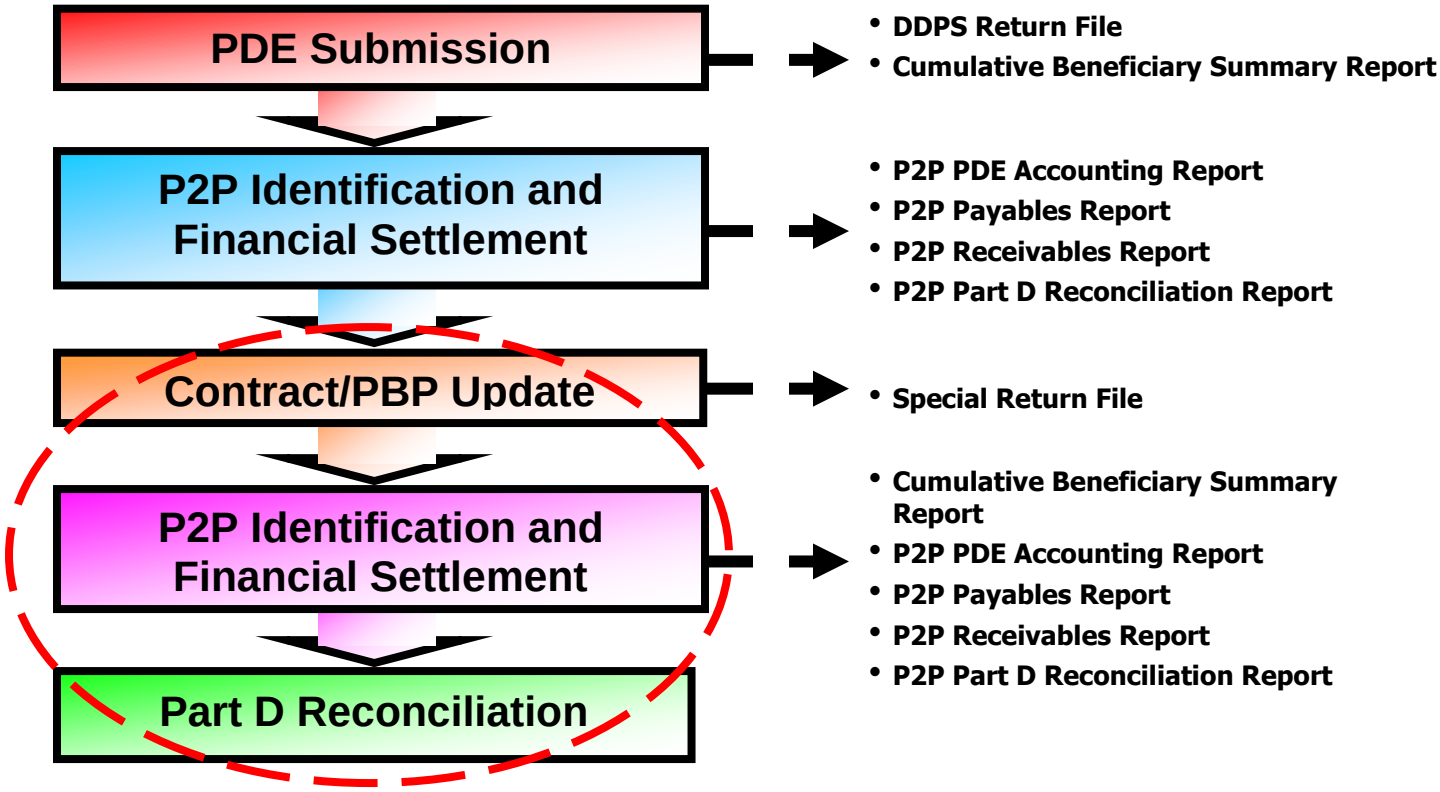
Table 9Q provides the naming conventions for each report. When reviewing reports, Plans should pay close attention to the benefit year located in the File ID within the CHD record in order to know which benefit year is affected.

TABLE 9Q – 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 9C 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 9C – P2P Process



9.6.1 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 2010 as a dual-eligible and completed an enrollment application on August 27, 2010 for Spring Health Plan's PBP 002. Spring Health Plan submitted the enrollment. CMS processed the enrollment on August 31, 2010. John's effective date is September 1, 2010.

John fills a prescription on September 5, 2010 for a covered drug and on September 7, 2010 for an OTC drug using an ID card from Winter Health Plan. He also fills prescriptions on September 20, 2010 and October 15, 2010 for covered drugs. Winter Health Plan PBP 001 submitted two PDEs on September 29, 2010 for the September 5, 2010 and September 7, 2010 claims. They also submitted a PDE on October 20, 2010 for the September 20, 2010 claim and on October 29, 2010 for the October 15, 2010 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, 2010	September 29, 2010	INF	708	Y
2	September 7, 2010	September 29, 2010	INF	709	N
3	September 20, 2010	October 20, 2010	INF	708	Y
4	October 15, 2010	October 29, 2010	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 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 a plan submitted PDEs one month and then deleted the PDEs the subsequent month. 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, 2010	September 29, 2010	X			September
2	September 7, 2010	September 29, 2010			X	September
3	September 20, 2010	October 20, 2010	X			October
4*	October 15, 2010	October 29, 2010				

*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, 2010 and September 20, 2010 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, 2010	September 29, 2010	X	September
2	September 7, 2010	September 29, 2010		
3	September 20, 2010	October 20, 2010	X	October
4*	October 15, 2010	October 29, 2010		

*PDE 4 rejected, so it will not appear on these reports.

9.6.2 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 is 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 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.

9.6.2.1 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 December 10, 2010 for John Brown with DOS November 15, 2010. 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 November 1, 2010.

This enrollment change created a new P2P condition for this PDE record.
A=Winter Health and B=Spring 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	A	1	B	1	Y	N

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, 2010 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, 2010. The enrollment effective date of this transaction was October 1, 2010.

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.
A=Winter Health and B=Spring 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	A	1	N	N

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, 2010.

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, 2010 through December 31, 2010. The return file will not contain 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 7

Frank Cloud was enrolled in Winter Health Plan effective August 1, 2010. Winter Health submitted a PDE record on September 17, 2010 for DOS September 2, 2010. On August 15, 2010, Spring Health submitted an enrollment transaction for Frank with a September 1, 2010 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, 2010, with effective date August 1, 2010. 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 8

Sarah Blue was enrolled in Winter Health in August 2010. Spring Health enrolled Sarah in their plan. The enrollment effective date was September 1, 2010. 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 2010 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 9

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

9.6.3 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.

Reported Gap Discount amounts are excluded from the P2P Reconciliation Process.

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 10

John Brown disenrolls from Winter Health Plan. Spring Health Plan submits the enrollment to CMS with an enrollment effective date of October 1, 2010 and CMS processed the enrollment on October 13, 2010. This means that the beneficiary disenrolled from Winter Health Plan as of September 30, 2010 and enrolled in Spring Health Plan as of October 1, 2010.

ENROLLMENT INFORMATION		
CONTRACT	**START DATE**	**END DATE**
Winter Health Plan	07/01/10	09/30/10
Spring Health Plan	10/01/10	

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?**
09/28/10	$42.50	09/29/10	N
09/28/10	$23.42	09/29/10	N
10/02/10	**$18.36**	**10/03/10**	**Y**
10/02/10	**$12.20**	**10/03/10**	**Y**
10/09/10	$14.72	10/25/10	Y
10/09/10	$23.42	10/25/10	Y
10/15/10	$15.45	10/25/10	Y
11/16/10	$42.50	11/18/10	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 highlighted to show the PDEs that will be a part of the P2P Contract/PBP Update.

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. Winter Health Plan should have updated enrollment records to reflect the disenrollment. Timely updates to enrollment information can reduce the risk of receiving edit 706.

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
09/28/10	$42.50
09/28/10	$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
10/02/10	$18.36
10/02/10	$12.20

REPORT 40 AND 41

DATE OF SERVICE	CPP	CONTRACT OF RECORD
10/09/10	$14.72	Spring Health
10/09/10	$23.42	Spring Health
10/15/10	$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
10/09/10	$14.72
10/09/10	$23.42
10/15/10	$15.45

After the PDE reconciliation cut-off date for the 2010 Part D Payment Reconciliation, 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
10/02/10	$18.36	Spring Health	851
10/02/10	$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 – JUNE MONTHLY REPORTS

REPORT 40 AND 41

DATE OF SERVICE	CPP	CONTRACT OF RECORD
10/02/10	$18.36	Spring Health
10/02/10	$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 – JUNE MONTHLY REPORTS

REPORT 42 and 43

DATE OF SERVICE	CPP
10/02/10	$18.36
10/02/10	$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

	REPORTS	TOTAL CPP
WINTER HEALTH PLAN	4	$65.92
	42	$ 0.00

	REPORTS	CPP
SPRING HEALTH PLAN	4	$ 0.00
	42	$84.15

9.6.4 Plan Liability

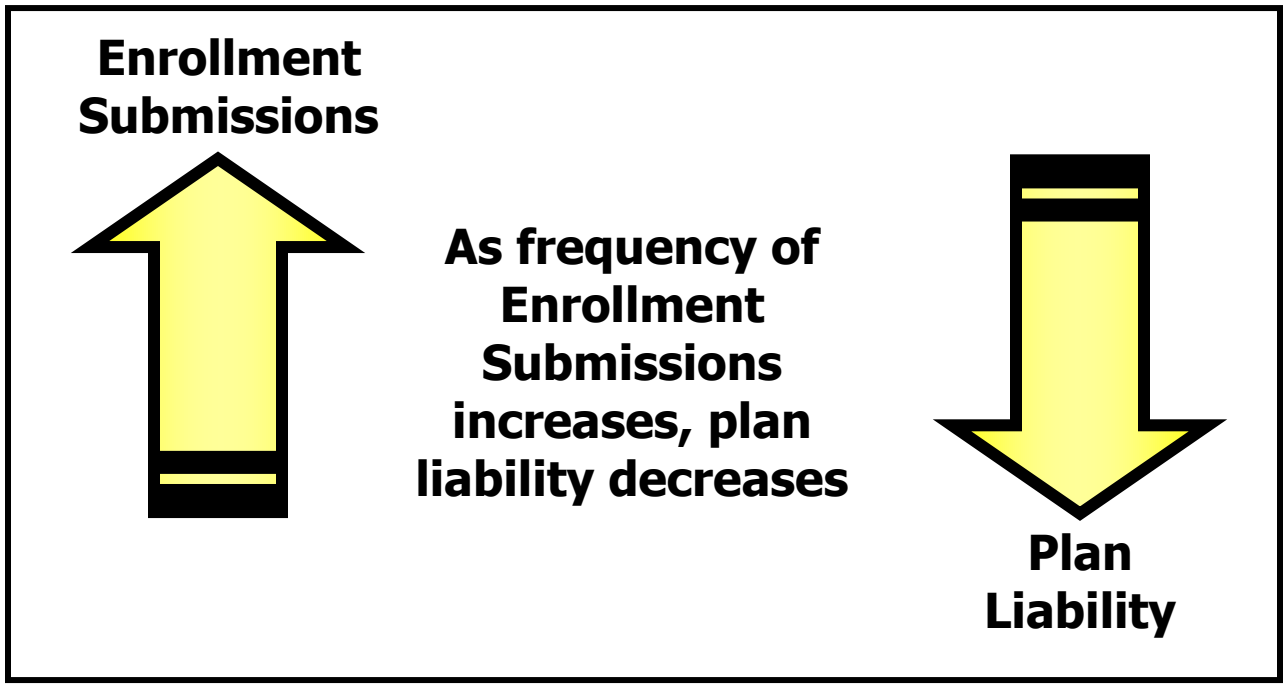
CMS has an established requirement that plans submit enrollments within at least 7 days of the application date (Section 30.3 of Chapter 3 in the Medicare Prescription Drug Benefit Manual and Section 40.3 of Chapter 2 in the Medicare Managed Care Manual). The P2P transition period provides additional 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.

The Submitting Contract can also further reduce P2P activity. When the Submitting Contract begins to receive PDEs with edit code 708, this indicates that CMS records show that the beneficiary is no longer enrolled in the Submitting Contract. The Submitting Contract should compare their enrollment records with CMS records and take necessary action to ensure that the enrollment information for the beneficiary is correct. If the Submitting Contract does not take action to evaluate the enrollment record discrepancy, the Submitting Contract will begin to receive edit 706 on PDEs that fall outside of the P2P transition period.

Figure 9D illustrates the frequency of enrollment submissions to plan liability.

Figure 9D – Plan Liability



MODULE 10 – COVERAGE GAP DISCOUNT PROGRAM INVOICE AND PAYMENT PROCESS

Purpose (Slide 2)

Introduce the Coverage Gap Discount Program Invoice and Payment process; and review the reporting, confirmation, offset, and reconciliation processes.

Learning Objectives (Slides 3-4)

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

- Know the role of the TPA in the CGDP.
- Explain the timeline for Quarterly Invoice generation and payment.
- Describe the Part D sponsor quarterly reports.
- Understand the payment mechanism for quarterly invoices.
- Review the Payment Confirmation process.
- Explain Offsets.
- Understand the CGDP Reconciliation.
- Recognize the importance of timely PDE reporting and corrections.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

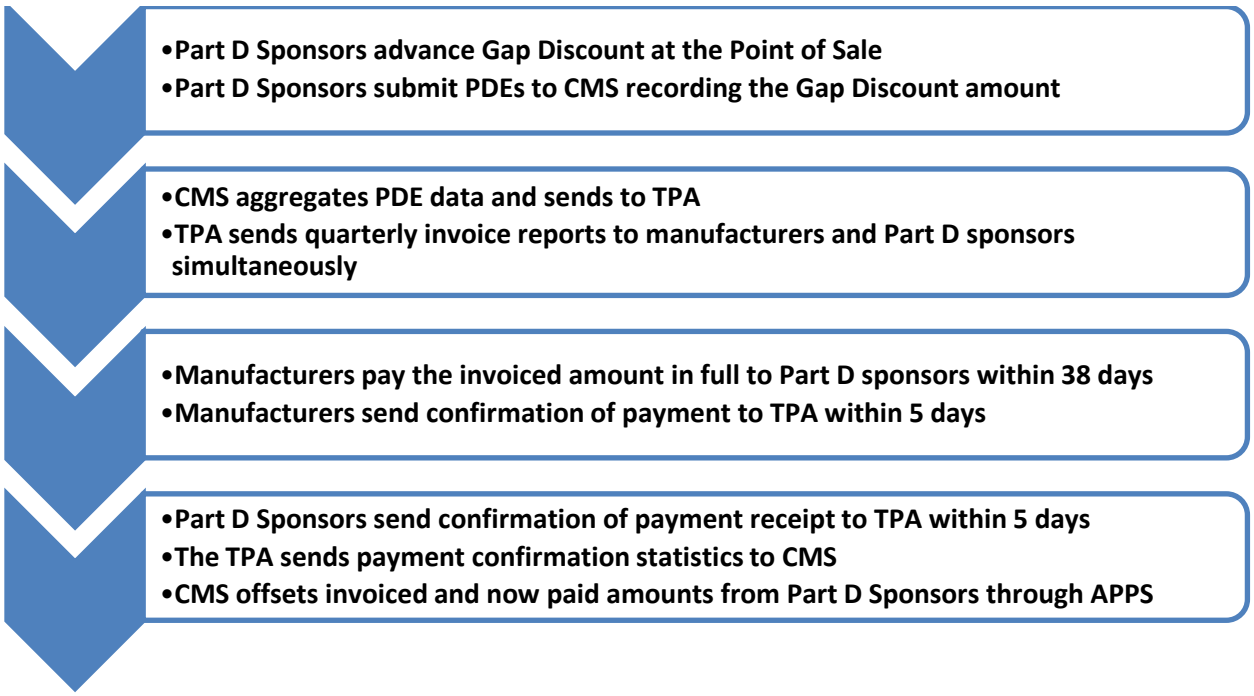
10.1 Overview (Slides 5-6)

Effective January 1, 2011, the Affordable Care Act makes provisions to reduce cost-sharing in the coverage gap for beneficiaries who are not eligible for low-income related subsidy and not enrolled in a qualified retiree prescription drug plan. The objective is to provide a seamless defined standard benefit by 2020 with 25% beneficiary co-insurance after satisfying the deductible until the out-of-pocket threshold is reached. Cost-sharing reductions begin in 2011 for both generic drugs in general and for drugs covered under the Coverage Gap Discount Program (CGDP). The CGDP does not apply to PACE Organizations.

Effective January 1, 2011, the CGDP provides discounts to applicable Medicare beneficiaries receiving applicable Part D drugs while in the coverage gap.

Figure 10A illustrates the overall Coverage Gap Discount flow.

Figure 10A – Coverage Gap Discount Flow



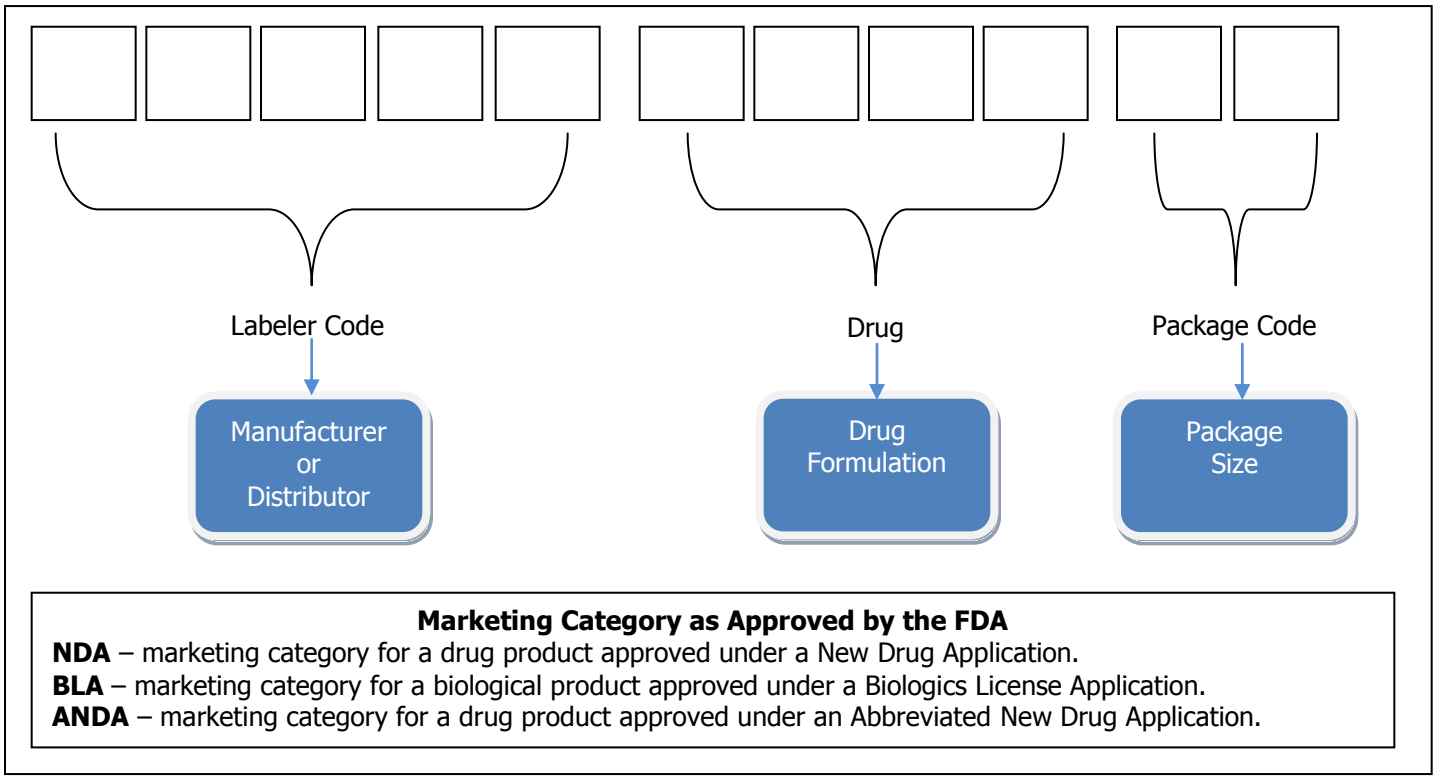
10.1.1 Applicable Drugs (Slides 7-8)

An applicable drug, as defined in §1860D-14A(g)(2) of the Social Security Act is a covered Part D drug, including a drug covered under an exception or appeal, that is either approved under a new drug application (NDA) under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (BLA) (other than a product licensed under subsection (k) of such section 351). In order to identify products approved under an NDA or BLA marketing category, Part D sponsors should look to the FDA NDC Directory and the FDA Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) to assist in making marketing category determinations. If an NDC is not listed on the FDA NDC Directory, as mentioned in the memo entitled CMS/FDA CY 2010 Non-Matched NDC List, dated October 21, 2009, sponsors can take steps to get marketed drug products listed on the FDA NDC Directory by reaching out to Manufacturers or distributors. Also, only those applicable Part D drugs covered by a Manufacturer discount agreement will be covered under the Part D program beginning January 1, 2011.

The Federal Food and Drug Administration assigns National Drug Codes (NDCs). The NDC, as described at 21 CFR 207.35(b), is a unique, three-segment number used to identify biological and drug products. The 11-digit NDC format was adopted as a HIPAA standard and is used for reporting NDCs on PDEs. The first segment is known as the Labeler Code and is made up of five (5) numeric characters. The Labeler Code identifies the manufacturer or distributor of the product. The second segment is known as the Product Code and is made up of 4 numeric characters. The Product Code identifies the drug formulation. The third segment is known as the Package Code and is made up of 2-numeric characters. The Package Code identifies the package size.

Figure 10B illustrates the format for the NDC.

Figure 10B – NDC Format



Marketing Category as Approved by the FDA
NDA – marketing category for a drug product approved under a New Drug Application.
BLA – marketing category for a biological product approved under a Biologics License Application.
ANDA – marketing category for a drug product approved under an Abbreviated New Drug Application.

The CGDP was established to reduce the beneficiary liability in the coverage gap, which was 100% of the drug cost prior to 2011. In general, the discount on each applicable covered Part D drug is approximately 50 percent of the negotiated price in the coverage gap.

Applicable Part D drugs will only be covered under Part D if the Manufacturer has signed Medicare Coverage Gap Discount Program Agreement with CMS to participate in the CGDP and remains compliant with the terms of that agreement.

Medicare Coverage Gap Discount Program Agreements with CMS and with the Third Party Administrator are available at http://www.cms.gov/PrescriptionDrugCovGenIn/05_Pharma.asp#TopOfPage

In order to implement the CGDP, CMS developed additional payment mechanisms and reporting for Manufacturers to reimburse Part D sponsors for CGDP discounts advanced at POS. CMS also advances prospective payments to Part D sponsors to sustain cash flow pending receipt of invoiced CGDP discounts from Manufacturers.

10.1.2 Part D Sponsors Provide the Discount at Point of Sale (Slide 9)

Section 1860D-14A(c)(1)(A)(ii) requires gap discounts to be provided at POS. Part D sponsors pay the CGDP discount at point-of-sale on behalf of Manufacturers so the beneficiary can immediately receive the out-of-pocket cost-sharing reduction. Part D sponsors provide the discount on applicable drugs to applicable beneficiaries at POS and shall reimburse the pharmacy for the CGDP discount consistent with current Part D prompt payment requirements under 42 CFR 423.520.

Discounts can be provided at POS, only if the entity adjudicating the electronic pharmacy claim has the following real time information:

- the drug is a discountable drug;
- the beneficiary is eligible for the discount;
- the claim is wholly or partially in the coverage gap; and
- the amount of the discount, taking into consideration plan supplemental benefits that pay first.

CMS has determined that the only entity capable of providing the discount at POS is the Part D sponsor because in a real-time claims processing environment, no other entity will have all four pieces of information. In particular, only the Part D sponsor knows the beneficiary's position in the benefit phase at any given time and the detailed benefit design for supplemental benefits.

The Gap Discount is based on the plan-defined benefit phase. The Gap Discount applies to the negotiated price as defined in §1860D-14A(g)(6) which excludes dispensing and vaccine administration fees. For purposes of calculating the Gap Discount, the negotiated price is the sum of the Ingredient Cost Paid and the Total Amount Attributed to Sales Tax.

Note: For purposes of calculating the CGDP discount, EGWPs and any other plan benefit with no initial Coverage Limit (ICL) apply the defined standard ICL.

Part D sponsors use the following steps to calculate the CGDP discount.

1. **Determine costs that fall in the Coverage Gap**: (using existing adjudication logic) Claims that begin and end in the coverage gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases. In the case of straddle claims apply dispensing fee and vaccine administration fee, to the greatest extent possible, outside the coverage gap.

2. **Determine Discount Eligible Cost:** Discount Eligible Cost is cost falling in the coverage gap, excluding supplemental benefits, dispensing fee, and vaccine administration fee. The supplemental benefit is calculated first. The dispensing fee and vaccine administration fee are included in the supplemental benefit to the extent that the supplemental benefit equals or exceeds the dispensing fee and the vaccine administration fee.

3. **Calculate Gap Discount:** The Gap Discount is 50% of Discount Eligible Cost**.**

4. **Determine beneficiary cost-sharing:** For claims falling squarely in the coverage gap with no other secondary health insurance, beneficiary cost-sharing is Total Drug Cost less Gap Discount. If the beneficiary has other secondary health insurance, the other secondary health insurance reduces beneficiary cost-sharing remaining after the Gap Discount is applied. In Straddle claims beneficiary

cost-sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

5. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

6. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

10.1.3 Prescription Drug Event (PDE) Records (Slide 10)

PDEs document the way plans administer the Part D benefit. Beginning in January 2011, CMS collected additional PDE information needed for payment and program oversight. New PDE information provides additional data necessary to validate amounts reported in the "Reported Gap Discount" field.

Refer to Module 3 – Data Format for additional information.

On each PDE, the plan reports the actual amount of gap discount advanced at the point of sale for the dispensing event in the Reported Gap Discount field. Reported Gap Discount amounts on accepted and validated PDEs are used to build the invoices sent to manufacturers and are used in the CGDP reconciliation after the close of the benefit year.

During the first year of the CGDP, PDEs give both the sponsor and CMS important, time sensitive feedback about the way the CGDP program is administered. CMS implemented PDE edits to identify applicable beneficiaries, coverage gap costs, applicable drugs and accurate gap discount calculations. Part D sponsors should carefully review rejected records to understand if the CGDP was administered correctly.

Refer to Module 8 – Edits for additional information.

Error Correction Website - CMS also performs PDE Data Quality Review on saved PDEs. CMS posts questions about saved PDEs on the PDE Data Analysis Website. Since CMS needs accurate PDE data for invoicing, Part D sponsors must respond promptly to all CGDP related PDEs posted to the Validation Website.

Access the PDE Data Analysis Website at https://partd.programinfo.us/pdeanalysis

10.1.4 Players and Relationships (Slides 11-13)

There are four organizations that work together in the CGDP:

1. Part D sponsors
2. Manufacturers
3. CMS
4. Third Party Administrator (TPA)

Part D sponsors must calculate the CGDP discount amount at the time of the initial claim adjudication, provide the discount amount in the adjudicated response, make payment to the pharmacy, and include accurate and timely information on PDEs, and specifically Reported Gap Discounts.

Manufacturers reimburse Part D sponsors for the Reported Gap Discounts provided at POS based on data reported on accepted PDEs. CMS, through its Third Party Administrator (TPA), notifies Manufacturers of their liabilities to Part D Sponsors through quarterly invoices. Manufacturers must pay the entire invoiced amount within 38 calendar days following invoice distribution and confirm payment within 5 business days after payment deadline.

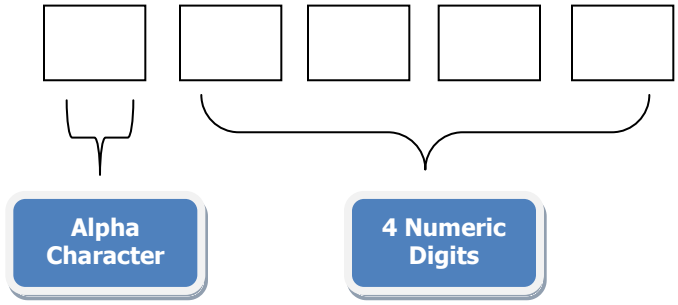
CMS coordinates the collection of discount payments from Manufacturers and payment to Part D sponsors through the TPA.

The TPA acts as a liaison between Part D Sponsors and Manufacturers in all matters related to the Coverage Gap Discount Program. The TPA has multiple functions. It provides customer support to both Part D sponsors and Manufacturers. Contact the TPA for assistance on its website, CSSC Help Line, or by email.

Note: TPA contact information
Website: http://www.csscoperations.com
CSSC Help Line: 1-877-534-CSSC (2772)
Hours of Operation: Monday through Friday, 8:00 a.m. to 7:00 p.m., ET,
Email: csscoperations@palmettogba.com

The TPA works with Manufacturers to establish connectivity and sets up secure mailboxes for both Manufacturers and Part D sponsors. The TPA collects and distributes the Part D sponsor's Electronic Funds Transfer (EFT) information to the Manufacturers while maintaining confidentiality by using secure mailboxes. The TPA distributes quarterly invoices and associated reports to Part D Sponsors and Manufacturers, processes the payment confirmation reports submitted by both parties, and confirms "paid in full" status by comparing payment confirmations totals to invoice totals and reporting any discrepancies to CMS. The TPA maintains a website of information on the CGDP and provide customer service and support through phone and email. Figure 10C illustrates the Manufacturer P-number.

Figure 10C – Manufacturer P-Number



- Unique 5-digit identifier assigned by CMS.
- Each P Number represents a signed Discount Program agreement.
- Leading 'P' followed by 4 digits.
- Found on Contract reports.
- Used by Part D sponsors to identify the manufacturer.
- The numeric portion is found in the 15-character Invoice Id on contract reports and EFT/banking records.
- CGYYQQ**9999**H9999

10.2 Invoice and Payment Process

10.2.1 Invoice Infrastructure

The TPA supports communication and facilitates problem-solving between CMS, Part D sponsors and Manufacturers. CMS encourages Part D sponsors to refer all questions about invoicing directly to the TPA.

10.2.1.1 Electronic Funds Transfer (EFT) (Slides 14-15)

Manufacturers make quarterly invoice payments to Part D sponsors through EFT. The TPA facilitates the invoice process by collecting EFT information from Part D sponsors and reporting that information to the Manufacturer's secure mailbox. Part D sponsors are required to keep banking information up to date so that Manufacturers can pay the sponsor. The TPA maintains EFT information in a file housed on a Secure server. The TPA makes the EFT file available to manufacturers via secure download to their mailboxes. EFT banking information may be updated at the end of the calendar year through the use of an online web form. Because CGDP payment is at contract level, Part D sponsors should maintain a separate EFT entry for each of their distinct contract numbers, even if contracts within the same organization share the same banking information.

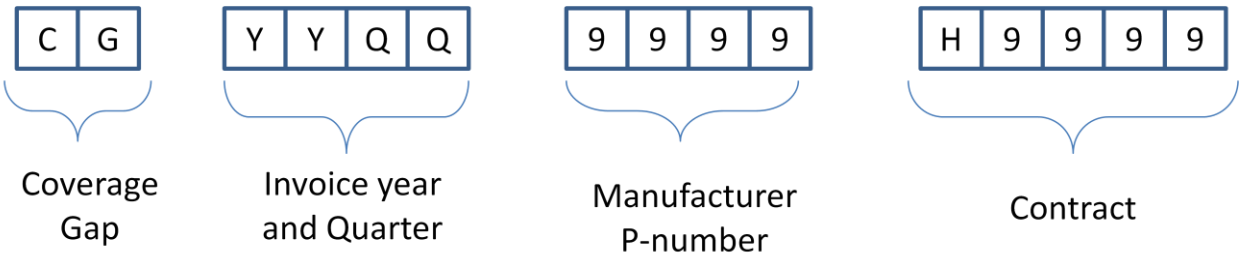
Table 10A displays the EFT Banking Information File layout.

TABLE 10A – EFT BANKING INFORMATION FILE LAYOUT

FIELD NAME	POSITION	PICTURE	FIELD LENGTH	DESCRIPTION/VALUES
MCO	1 – 5	X(5)	5	Contract Number
MCO Name	6 - 40	X(35)	35	Contract Name
EIN	41 - 52	X(12)	12	Federal Tax Identification Number
1099 Name	53 - 87	X(35)	35	1099 Name
1099 Street Address 1	88 - 137	X(50)	50	1099 Street Address Line 1
1099 Street Address 2	138 - 187	X(50)	50	1099 Street Address Line 2
1099 City	188 - 222	X(35)	35	1099 City
1099 State	223 - 224	X(2)	2	1099 State
1099 Zip	225 - 235	X(10)	10	1099 Zip
Bank Name 1	236 - 270	X(35)	35	Sponsor's Bank Name Line 1
Bank Name 2	271 - 305	X(35)	35	Sponsor's Bank Name Line 2
Bank City	306 - 340	X(35)	35	Sponsor's Bank City
Bank State	341 - 342	X(2)	2	Sponsor's Bank State
Bank ABA	343 - 351	X(9)	9	Sponsor's Bank ABA Transit Routing Number
Bank Account Number	352 - 371	X(20)	20	Sponsor's Bank Account Number
EFT Effective Date	372 - 381	X(10)	10	Date this EFT record becomes effective
EFT Obsolete Date	382 - 391	X(10)	10	Date this EFT record becomes obsolete. Default to 12/31/2099
LIflag	392-392	X(1)	1	Indicates minimal CGDP activity

Figure 10D Illustrates the EFT Individual Identification Number.

Figure 10D – EFT Individual Identification Number



10.2.1.2 Quarterly Reporting (Slide 16)

The quarterly reports consist of four contract reports and one response report. The TPA sends three reports to contracts: the Data Report, the Summary Report, and the Tracking Report. The contract creates the Payment Confirmation Report and returns it to the TPA.

The TPA distributes Contract and Manufacturer reports at the same time on the schedule in Table 10B. The TPA publishes all file layouts at www.CSSCOperations.com.

TABLE 10B – REPORT DISTRIBUTION SCHEDULE

Quarter End Date	Report Distribution Date
March 31	April 30
June 30	August 30
September 30	October 31
December 31	January 31

Reports are specific to a benefit year and include PDEs saved during that quarter. Potentially CMS can receive 2011 gap discount PDEs until January 31, 2015. Because CMS continues to accept PDEs for thirteen quarters following the close of the benefit year, the TPA will distribute 2011 reports through April 30, 2015, when it distributes reports for the quarter ending March 31.

10.2.1.2.1 Contract Data Report (Slide 18)

The Sponsor Data Report documents each of the contract's gap discount records invoiced in the quarter, including originals, adjustments, and deletions. Manufacturers also receive a data report itemizing each of the gap discount records they must pay; however, the Manufacturer data report excludes contract and PBP identifiers.

In addition to PDE fields, the Data Report includes Report ID and Sequence Number. It also includes fields that identify updates to previous invoices.

- The **DETAIL REF NUMBER** is a unique number assigned to each individual Gap Discount record invoiced in the quarter. If data changes in subsequent quarters because the record is adjusted or deleted, the Detail Reference Number remains constant from the first time the record was invoiced.

- **PREVIOUS REPORT ID** and **REPORTED GAP DISCOUNT PREVIOUS AMOUNT** indicate adjusted or deleted records that were invoiced previously. Sponsors may initiate adjustments and deletions due to changes in the PDE status and in response to CMS PDE postings on the PDE Date Quality Validation web site.

- **SUBMITTING CONTRACT NUMBER** and **SUBMITTING CONTRACT PBP NUMBER** identify the contract/PBP that advanced the CGDP discount at point-of-sale and will receive payment from the Manufacturer.

10.2.1.2.1.1 Header and Trailer Records

The Header and Trailer records for this report display the File ID "10CSM - Contract Summary", the REPORT ID showing the report year and quarter and the report creation date. The contract header (TPACH) and trailer (TPACT) identify the submitting contract. The manufacturer header (TPAMH) and trailer (TPAMT) identify the Manufactuer. The trailer records also show the number of gap discounts each Manufacturer will pay as well as the total number of gap discounts the contract will receive payment for from all Manufacturers. Both the Manufacturer and Contract trailers show the previous invoice amount (TOTAL REPORTED GAP DISCOUNT PREVIOUS AMOUNT), the discount amount invoiced this quarter (TOTAL REPORTED GAP DISCOUNT CURRENT AMOUNT) and the net payment this quarter (TOTAL GAP DISCOUNT AMOUNT THIS PERIOD calculated as "current amount" minus the "previous amount"). Full file layouts are available at www.csscoperations.com.

The detail record is designated at DETCT. Table 10C displays the Contract Summary Detail Record (DETCT) Layout.

TABLE 10C – CONTRACT DATA REPORT DETAIL RECORD (DETCT) LAYOUT

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD TYPE CODE	1 - 5	X(5)	5	"DETCD"
2	REPORT ID	6 - 11	9(6)	6	Year/Quarter item was placed on the invoice. Format is: "YYYYQQ". QQ represented as "01"-"13".
3	SEQUENCE NO	12 - 18	9(7)	7	An incrementing batch sequence number that starts at 0000001.
4	DETAIL REF NUMBER	19 - 38	X(20)	20	A unique coverage gap reference number for this coverage gap detail. This number can be used between coverage gap discount reports to track adjustments that occur on this coverage gap detail.
5	PREVIOUS REPORT ID	39 - 44	9(6)	6	Preceding Year/Quarter that item was placed on the invoice. Format is: "YYYYQQ" QQ represented as "01"-"12".
6	PRODUCT SERVICE ID	45 - 63	X(19)	19	First 11 positions are NDC, no spaces or hyphens, followed by 8 spaces. Format is: MMMMMDDDDPP.
7	PRESCRIPTION SERVICE REFERENCE NO	64 - 75	9(12)	12	A unique reference number for a prescription assigned by a plan. It must be unique for any DOS and Service Provider ID combination.
8	FILL NUMBER	76 - 77	9(2)	2	Values = 00 - 99.
9	DAYS SUPPLY	78 - 80	9(3)	3	0 – 999
10	QUANTITY DISPENSED	81 - 90	9(7)V999	10	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
11	DATE OF SERVICE (DOS)	91 - 98	9(8)	8	CCYYMMDD
12	SERVICE PROVIDER ID QUALIFIER	99 - 100	X(2)	2	The type of pharmacy provider identifier used in field 12. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number
13	SERVICE PROVIDER ID	101 - 115	X(15)	15	The identifier for the Service Provider.
14	REPORTED GAP DISCOUNT PREVIOUS AMOUNT	116 - 126	S9(9)V99	11	Reported Gap Discount that was reported on preceding Data Report

TABLE 10C – CONTRACT DATA REPORT DETAIL RECORD (DETCT) LAYOUT (CONTINUED)

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
15	REPORTED GAP DISCOUNT CURRENT AMOUNT	127 - 137	S9(9)V99	11	New Gap Discount amounts invoiced this quarter.
16	GAP DISCOUNT AMOUNT THIS PERIOD	138 - 148	S9(9)V99	11	Net payment amount this quarter,calculated as the "current amount" minus the "previous amount"
17	SUBMITTING CONTRACT NUMBER	149 - 153	X(5)	5	The contract that submitted the Gap Discount PDEs
18	SUBMITTING CONTRACT PBP NUMBER	154 - 156	X(3)	3	The PBP that submitted the Gap Discount PDEs
19	PRIOR LOW VOLUME DISCOUNT FLAG	157 - 157	X(1)	1	FOR FUTURE USE- Indicates that this detail was part of a Low Volume Summary on a prior Invoice but its NDC 9 / Pharmacy combination has exceeded a count of 10 distinct beneficiaries and is showing up as a PDE for the first time on this invoice.
20	FILLER	158 - 200	X(43)	43	Spaces

10.2.1.2.2 Contract Tracking Report (Slide 19)

The Tracking Report is a cumulative year report that shows the status of each gap discount PDE saved in the CMS data base. There is one Tracking Report for each benefit year. Status codes report if a PDE was invoiced or pended. Table 10D illustrates the hierarchy for how pended status is assigned.

TABLE 10D – PENDED STATUS ASSIGNMENT HIERARCHY

Pended Status Code	Pended Status Code Description	Explanation	Sponsor Action
blanks	Not Pended	Use the "Invoiced Report ID" to identify the invoice quarter for each PDE then find that specific PDE on the corresponding Contract Data Report.	
01	Retro LI	CMS does not invoice Gap Discount PDEs when a beneficiary receives Low Income Eligibility after the Gap Discount PDE was accepted. The beneficiary's gap discount PDEs are pended.	The sponsor shall re-adjudicate the claim and submit an adjusted PDE. On the adjusted record Reported Gap Discount will be zero. The updated patient liability fields (Patient Pay, LICS, Other TrOOP and PLRO) will include the new low income subsidy and low income co-pay amounts.
02	Low Volume	Since PDEs in low volume groups (defined as groups with ten or fewer beneficiaries in the same pharmacy with the same NDC-9) must be invoiced in aggregate, CMS, at its discretion, temporarily delays invoicing Low Volume PDEs until the count exceeds 10. At that point the records that made up the low volume group are invoiced individually with full report detail.	Sponsors take no action to change Low Volume pend status. The report simply explains why the record(s) was not invoiced.
03	Data Quality Review	The PDE Data Analysis website is the most reliable source to view the current status of records requiring Sponsor validation. When records are pended for retro-LI or low volume that may also require data quality review, the data Quality Review count may be understated.	Sponsor Action: For Gap Discount PDEs, complete Data Quality Review within 15 days.
99	Other	To be defined	

10.2.1.2.2.1 Header and Trailer Records

The Contract and PBP Header and Trailer records for the contract and PBP display the File ID "10CDT – Contract Data", the REPORT ID showing the report year and quarter, the report creation date and the submitting contract and submitting PBP, respectively. In addition, the contract and PBP trailer records show the record count and dollar amount at grand total for all saved gap discount records and by each individual pend category.

The detail record is designated at PTOT. Full file layouts are available at www.csscoperations.com. Table 10E provides the Contract Tracking Report Detail Record Layout.

TABLE 10E – CONTRACT TRACKING REPORT DETAIL RECORD (DETCD) LAYOUT

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD TYPE CODE	1 - 5	X(5)	5	"DETCD"
2	SEQUENCE NUMBER	6 - 12	9(7)	7	An incrementing batch sequence number that starts at 0000001.
3	INVOICED REPORT ID (YEAR/QUARTER)	13 - 18	9(6)	6	Year/Quarter item was placed on the invoice. Format is: "YYYYQQ". QQ represented as "01"-"17".
4	AS OF DATE	19 - 26	9(8)	8	This report contains final action PDEs from January 1 of the benefit year through this date.
5	DETAIL REF NUMBER	27 - 46	X(20)	20	Unique reference number from Contract Data Report. Blank if PDE was never invoiced.
6	PRODUCT SERVICE ID	47 - 65	X(19)	19	First 11 positions are NDC, no spaces or hyphens, followed by 8 spaces. Format is: MMMMMDDDDPP.
7	PRESCRIPTION SERVICE REFERENCE NO	66 - 77	9(12)	12	A unique reference number for a prescription assigned by a plan. It must be unique for any DOS and Service Provider ID combination.
8	FILL NUMBER	78 - 79	9(2)	2	Values = 00 - 99.
9	DAYS SUPPLY	80 - 82	9(3)	3	0 – 999
10	QUANTITY DISPENSED	83 - 92	9(7)V999	10	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
11	DATE OF SERVICE	93 - 100	9(8)	8	CCYYMMDD
12	SERVICE PROVIDER ID QUALIFIER	101 - 102	X(2)	2	The type of pharmacy provider identifier used in field 12. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number
13	SERVICE PROVIDER ID	103 - 117	X(15)	15	The identifier for the Service Provider.
14	ADJUSTMENT DELETION CODE	118 - 118	X(1)	1	Adjustment Deletion Indicator: A - Adjustment D - Delete blank - original
15	CLAIM ADJUDICATION BEGAN TIMESTAMP	119 - 144	X(26)	26	Date and time contract began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011, and forward.

TABLE 10E – CONTRACT TRACKING REPORT DETAIL RECORD (DETCD) LAYOUT (CONTINUED)

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
16	INVOICED FLAG	145 - 145	X(1)	1	Indicates that PDE was invoiced on the Contract Data Report: Y- Yes, PDE was on previous Contract Data Report N - No, PDE was not on previous Contract Data Report
17	REPORTED GAP DISCOUNT AMOUNT	146 - 153	S9(6)V99	8	The reported amount that contract advanced at point of sale for the Gap Discount for applicable drugs. This amount increments the True Out-of-Pocket Accumulator amount.
18	PEND CODE	154 - 155	X(2)	2	Code indicating why a PDE is currently pended from contract data report. blanks - Not Pended 01 - Retro LI 02 - Low Volume 03 - Data Quality Review 99 - Other
19	FILLER	156 - 250	X(95)	95	Spaces

10.2.1.2.3 Contract Summary Report

The detail information in the Contract Data Report is summarized in the Contract Summary Report. The Contract Summary report identifies the payment the contract will receive from each Manufacturer and important information the contract needs to identify the Manufacturer's payment and make confirmation to the TPA. Manufacturers receive similar information in the Invoice Report that they use to create the payment EFT. This report is also used to create the Payment Confirmation report that the Sponsor will send back to the TPA, verifying that payments were received for each contract.

- **MANUFACTURER P NUMBER** is the internal CMS number that uniquely identifies the Manufacturer.
- **EFT INDIVIDUAL IDENTIFICATION NUMBER** is a unique descriptor CMS instructs Manufacturers to report on the EFT transmission so that contract personnel can readily identify CGDP payments. It uniquely identifies the CGDP payment for a specific quarter from a unique manufacturer to the contract. The fifteen position identifier is in the format CGYYQQ8888H1234 where CG is 'Coverage Gap', YYQQ is the 2-character year and the 2 character quarter number of the invoice, 8888 is the numeric portion of the manufacturer's P-number, and H1234 is the contract number of the receiving the payment.
- **GAP DISCOUNT AMOUNT THIS PERIOD** is the amount the Manufacturer owes the Contract.

10.2.1.2.3.1 Header and Trailer Records

The Header and Trailer records for this report display the File ID "10CSM - Contract Summary", the REPORT ID showing the report year and quarter, the report creation date and submitting contract number. In addition the trailer record shows the number of Manufacturers who owe payment to the contract, the previous invoice amount (TOTAL REPORTED GAP DISCOUNT PREVIOUS AMOUNT), the discount amount invoiced this quarter (TOTAL REPORTED GAP DISCOUNT CURRENT AMOUNT) and the net payment this quarter (TOTAL GAP DISCOUNT AMOUNT THIS PERIOD calculated as "current amount" minus the "previous amount"). Full file layouts are available at www.csscoperations.com.

The detail record is designated as PTOT. Table 10F displays the Contract Summary Detail (PTOT) Record Layout.

TABLE 10F – CONTRACT SUMMARY REPORT DETAIL RECORD (PTOT) LAYOUT

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD TYPE CODE	1 - 5	X(5)	5	"PTOT "
2	REPORT ID	6 - 11	9(6)	6	Year/Quarter item was placed on the invoice. Format is: "YYYYQQ". QQ represented as "01"-"13"
3	SEQUENCE NO	12 - 18	9(7)	7	An incrementing batch sequence number that starts at 0000001.
4	MANUFACTURER P NUMBER	19 - 23	X(5)	5	The CMS assigned manufacturer P-Number
5	SUBMITTING CONTRACT NUMBER	24 - 28	X(5)	5	The contract that submitted the Gap Discount PDEs
6	EFT INDIVIDUAL IDENTIFICATION NUMBER	29 - 43	X(15)	15	A descriptive identifier that should be used by the manufacturer as the Individual Identification Number on the EFT Payment that is made to Contracts. Contracts should be able to identify the payment from the manufacturers on their banking records using this number. Format is: "CG" + Year/Quarter (i.e. "YYQQ") + Manufacturer P Number missing the P (i.e."8888") + Contract Number (i.e., "Hxxxx") Example: "CGYYQQ8888Hxxxx"
7	GAP DISCOUNT AMOUNT THIS PERIOD	44 - 57	S9(12)V99	14	The net payment amount this quarter
8	FILLER	58 - 200	X(143)	143	Spaces

10.2.1.2.4 Sponsor Payment Confirmation Report Instructions (Slide 20)

The Contract Payment Confirmation Report is the mechanism by which Part D sponsors inform the TPA that they have received payment from the Manufacturer. Part D sponsors confirm payment at the Contract level. Per terms of the Manufacturer Agreement, Manufacturers agree to pay invoices in full within 38 calendar days following distribution of the quarterly CGDP reports. Both Manufacturers and the

Part D sponsor have roles in payment confirmation. The TPA collects payment confirmation from both parties and reviews the confirmation reports to ensure that the amount paid by Manufacturers equals the amount received by the Part D sponsor.

The EFT INDIVIDUAL IDENTIFICATION NUMBER and the Manufacturer payer name are two important data elements that appear on the Contract's banking statement. Contracts should review this data to quickly confirm payment. The TPA provides the EFT INDIVIDUAL IDENTIFICATION NUMBER in the Quarterly CGDP Summary Report (Field 6 in the Detail Record associated with the Manufacturer's P number.) If banking information does not clearly show the name of the Manufacturer, the amount due, and the 15-character invoice identifier contact the account holder's bank to request this information. The TPA collects payer name from the Manufacturer and distributes it to Part D sponsors. Unless there are unusual circumstances associated with change in ownership, the TPA expects the Manufacturer to use the same payer name quarter by quarter.

Contracts should review banking statements, identify CGDP payments, verify that the amount paid equals the amount invoiced and submit the Contract Payment Confirmation Report to the TPA. If the Manufacturer and the Contract confirmations disagree, the TPA will facilitate problem-solving with the Part D sponsor and the Manufacturer to rule out EFT errors or misinterpretation of banking statement information. Finally, the TPA will report unresolved payment discrepancies to CMS for follow up.

Part D sponsors create the Contract Payment Confirmation Report and send it to the TPA. To create the Contract Summary Report, the Part D sponsor adds DATE OF PAYMENT and PAYMENT AMOUNT, changes the file name from "10CSM" to "10CPC" and renames the report. Full instructions are posted at www.csscoperations.com. See Sponsor Confirmation of Payment Report Instruction.

10.2.1.2.4.1 Header and Trailer Records

The Header and Trailer records for this report display the File ID "10CSM - Contract Summary", the REPORT ID showing the report year and quarter, the report creation date and the submitting contract identifier. In addition the trailer record shows the number of Manufacturers who owe payment to the contract, the previous invoice amount (TOTAL REPORTED GAP DISCOUNT PREVIOUS AMOUNT), the discount amount invoiced this quarter (TOTAL REPORTED GAP DISCOUNT CURRENT AMOUNT) and the net payment this quarter (TOTAL GAP DISCOUNT AMOUNT THIS PERIOD calculated as "current amount" minus the "previous amount"). Full file layouts are available at www.csscoperations.com.

The detail record is designated at PTOT. Table 10G displays the Contract Payment Confirmation Detail (PTOT) Record Layout.

TABLE 10G – CONTRACT PAYMENT CONFIRMATION DETAIL (PTOT) RECORD LAYOUT

FIELD NO	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD TYPE CODE	1 - 5	X(5)	5	"PTOT "
2	REPORT ID	6 - 11	9(6)	6	Year/Quarter item was placed on the invoice. Format is: "YYYYQQ". QQ represented as "01"-"17".
3	SEQUENCE NO	12 - 18	9(7)	7	An incrementing batch sequence number that starts at 0000001.
4	MANUFACTURER P NUMBER	19 - 23	X(5)	5	The CMS assigned manufacturer P-Number
5	SUBMITTING CONTRACT NUMBER	24 - 28	X(5)	5	The contract that submitted the Gap Discount PDEs
6	EFT INDIVIDUAL IDENTIFICATION NUMBER	29 - 43	X(15)	15	A descriptive identifier that should be used by the manufacturer as the Individual Identification Number on the EFT Payment that is made to Contracts. Contracts should be able to identify the payment from the manufacturers on their banking records using this number. Format is: "CG" + Year/Quarter (i.e. "YYQQ") + Manufacturer P Number missing the P (i.e."8888") + Contract Number (i.e. "Hxxxx") Example: "CGYYQQ8888Hxxxx"
7	GAP DISCOUNT AMOUNT THIS PERIOD	44 - 57	S9(12)V99	14	The net payment amount this quarter.
8	FILLER	58 - 200	X(143)	143	Spaces

Confirmation reports are due from both the Manufacturer and the Part D sponsor within 5 business days of the payment deadline following distribution of the quarterly reports. Table 10H shows the Payment schedule for Manufacturers and Part D sponsors.

TABLE 10H – PAYMENT SCHEDULE FOR MANUFACTURERS AND PART D SPONSORS

Quarter End Date	Report Distribution Date	Payment Within 38 Calendar Days Following Quarterly Report Distribution	Payment Confirmation Within 5 Business Days of Payment Deadline
March 31	April 30	June 7	June 14
June 30	August 31	Oct 8	Oct 14
September 30	October 31	Dec 8	Dec 15
December 31	January 31	Mar 7	Mar 14
		Mar 8*	Mar 15*

*leap year only

10.2.1.2.5 Contract Payment Confirmation Response Report

The TPA edits Payment Confirmation reports after they are received from Part D sponsors. There are two levels of edits. The first level performs file level data integrity checks and the second record level editing

verifies the reported payment amounts. A Payment Confirmation Response file is sent to Part D sponsors to communicate the status of the Confirmation report. The Response file will contain one of three statuses.

Accepted response reports indicate that the file has passed the file-level edits and that amounts paid match exactly to the amounts that were due to the sponsors on the Contract Summary report.

Rejected response reports list file level errors due to missing or invalid information on the Confirmation report. The Part D sponsor must make the corrections to the confirmation and resend it to the TPA.

Discrepant response reports indicate when amounts paid do not match amounts invoiced. These amount discrepancies may be due to a data entry error or to incomplete payment from the Manufacturer. The Part D sponsor should review any files they receive with a discrepant status and make any corrections if needed. If the Part D sponsor found errors on the discrepant status report and corrected them, they will resubmit the entire file, not just the records that were updated. If there are no errors and the discrepancy is due to incomplete payment from the manufacturer, the Part D sponsor does not need to submit another file until the manufacturer sends them the remaining balance either before or after the payment deadline.

Figure 10E illustrates the Confirmation Response Report and provides a key to the fields. Table 10I provides a list of the TPA reject codes.

Figure 10E – Confirmation Response Reports

```
REPORT: TPA-RESPS        THIRD PARTY ADMINISTRATOR            Heading Lines
RUN DATE: CCYYMMDD          TPA RESPONSE REPORT                 Every report gets these

SPONSOR: XXXXXX CONTRACT: CCCCC                                                  Accepted
REPORT ID: YYYYQQ FILE ID: AAAAA STATUS: ACCEPTED RECEIPT OF THE REPORT

''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''' OR
SPONSOR: XXXXXX CONTRACT: CCCCC
REPORT ID: YYYYQQ FILE ID: AAAAA STATUS: REJECTED RECEIPT OF THE REPORT   Rejected

RECORD     TPACH        PTOT      ERROR      ERROR DESCRIPTION
  TYPE     SEQ NO       SEQ NO    CODE
TTTTT      9999999                 EEEE        DDDDDD

''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''' OR
SPONSOR: XXXXXX CONTRACT: CCCCC
REPORT ID: YYYYQQ FILE ID: AAAAA STATUS: REJECTED RECEIPT OF THE REPORT

RECORD     TPACH        PTOT      ERROR      ERROR DESCRIPTION
  TYPE     SEQ NO       SEQ NO    CODE
TTTTT      9999999      8888888    RRRR        DDDDDD      Rejected - multiple
TTTTT      9999999      8888888    RRRR        DDDDDD      errors shown
TTTTT      9999999      8888888    RRRR        DDDDDD      here

''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''''' OR
SPONSOR: XXXXXX CONTRACT: CCCCC
REPORT ID: YYYYQQ FILE ID: AAAAA STATUS: DISCREPANT RECEIPT OF THE REPORT

RECORD     TPACH        PTOT      ERROR      ERROR DESCRIPTION
  TYPE     SEQ NO       SEQ NO    CODE
TTTTT      9999999      8888888    OOOO        DDDDDD      Discrepant may contain multiple
TTTTT      9999999      8888888    OOOO        DDDDDD      discrepancies
```

1. Legend for Highlighted Fields Above		
2. RUN DATE:	3. CCYYMMDD	4. The date the report was returned to the TPA.
5. SPONSOR:	6. XXXXXX	7. The Part D sponsor Id that sent the report to the TPA for processing.
8. CONTRACT:	9. CCCCC	10. The Contract number in the Header record of the returned report.
11. REPORT ID:	12. YYYYQQ	13. The Report Id of the report received by the TPA.
14. FILE ID:	15. AAAAA	16. The File Id of the report received by the TPA.
17. RECORD TYPE	18. TTTTT	19. The Record Type that is in Error.
20. TPACH SEQ NO	21. 9999999	22. The TPACH Sequence Number of the Record in Error.
23. PTOT SEQ NO	24. 8888888	25. The PTOT Sequence Number of the Record in Error.
26. ERROR CODE	27. EEEE	28. The Reject Code issued by the TPA.
29. ERROR CODE	30. RRRR	31. The Reject Code issued by the TPA.
32. ERROR CODE	33. OOOO	34. The Reject Code issued by the TPA.
35. ERROR DESCRIPTION	36. DDDDDD	37. The Description of the Reject Code issued by the TPA.

TABLE 10I – TPA REJECT CODES

Reject Code	Error Code Description	Failure Outcome
E001	INVALID REPORT ID	Reject
E003	REPORT ID IN TPACT RECORD DOES NOT MATCH THE TPACH	Reject
E004	INVALID FILE ID	Reject
E006	DATE NOT > DATE REPORT WAS DISTRBUTED BY TPA	Reject
E007	NO DATE ENTERED/INVALID, OR DATE IS > CURRENT DATE	Reject
E008	PAYMENT AMOUNT NOT NUMERIC	Reject
E009	INVALID CONTRACT	Reject
E010	INVALID RECORD TYPES IN FILE.	Reject
E011	MISSING RECORD TYPES IN FILE.	Reject
E012	CONFIRMED PAYMENT AMT ¬= INVOICE PAYMENT AMT	Discrepant
E013	DUPLICATE CONFIRMATION REPORT ALREADY CONFIRMED	Reject

10.3 Payment (Slide 21)

Under the CGDP, Part D sponsors will receive monthly prospective payments from CMS. These prospective payments provide cash flow to Part D sponsors for advancing the gap discounts at the point of sale. On a quarterly basis, CMS will invoice manufacturers for discounts provided by Part D sponsors. Manufacturers will remit payments for invoiced amounts directly to Part D sponsors. The prospective payments made to Part D sponsors will be reduced by the discount amounts invoiced to manufacturers. These offsets will ensure that Part D sponsors do not receive duplicate payments for discounts made available to their enrollees.

After the end of the contract year, during Part D Payment reconciliation for the CGDP, CMS will perform a cost-based reconciliation to ensure the Part D sponsor is paid dollar for dollar for gap discounts advanced at the point of sale, based on accepted Prescription Drug Event (PDE) data. After Part D payment reconciliation for CGDP, Part D sponsors may continue to report discounts to CMS for thirty-seven (37) months following the end of the benefit year.

Note: Refer to the December 17, 2010, HPMS memorandum entitled, "Part D Payment Reconciliation Reopening for 2006 and 2007 and Closing the Drug Data Processing System (DDPS) Database Three Years Following the End of Each Contract Year".

CMS will invoice manufacturers for these discounts and Part D sponsors will be paid through the quarterly manufacturer payments.

10.3.1 Prospective Payments

CMS provides a monthly prospective Coverage Gap Discount payment based on the Contract of Record to Part D sponsors for non-low income subsidy eligible (non-LIS) beneficiaries who are not enrolled in an Employer Group Waiver Plan (EGWP) or a Program of the All Inclusive Care for the Elderly (PACE) organization.

Note: Refer to the August 18, 2010, HPMS memorandum entitled, "Annual Release of the Part D National Average Bid Amount and Other Part C & D Bid Related Information" for the calculation methodology of the 2011 prospective CGDP payments.

For any benefit year, the prospective payments begin with the January monthly payment for the benefit year and end with the December monthly payment. Adjustments to a benefit year's prospective payments continue to January of the following year. For benefit year 2011, the first prospective payment will be in the January 2011 monthly payment and the last payment containing adjustments to previously paid 2011 prospective payments will be in the January 2012 monthly payment. The prospective CGDP payment amounts will be found on the Monthly Membership Report (MMR). The August 30, 2010 HPMS memorandum entitled, "Announcement of November 2010 Software Release", explains the changes to the MMR and other affected reports.

10.3.2 CMS Offset (Slide 22)

Before Payment Reconciliation, CMS offsets monthly prospective CGDP payments for discount amounts invoiced to manufacturers. Offsets are processed through the Automated Plan Payment System (APPS) on a quarterly basis, following the invoicing cycle. The offset amount will appear as a negative adjustment to the next monthly prospective payment processed through APPS. When the APPS offset exceeds the prospective CGDP payments for that month, CMS will apply the offset to the Part D sponsor's total payment.

EGWPs receive invoiced discount amounts from manufacturers. However, they do not receive prospective CGDP payments because EGWPs do not submit Part D bids. As a result, CMS will not apply offsets for invoiced discount amounts to the payments received by EGWPs.

Rationale for Offset: CMS makes prospective payments to support cash flow needed to advance CGDP discounts at POS on the Manufacturer's behalf. When the Manufacturer's pays the invoice the sponsor has duplicate payment from two sources, the Manufacturer and CMS, for the same expense. After receiving the Manufacturer invoice payment, the sponsor no longer needs the cash flow advance from the prospective payment.

10.3.3 Annual Reconciliation (Slide 23)

For each benefit year, CMS will conduct a cost-based reconciliation for the CGDP. Prospective payments are an estimate and Part D sponsors may experience actual CGDP costs greater than or less than the prospective payments. If the total CGDP prospective payments received are greater than or less than the actual gap discount amounts documented in PDEs, then CMS will reconcile the differences. This reconciliation process will ensure that Part D sponsors are fully reimbursed for the manufacturer discount amounts made available to their enrollees as reported on accepted PDE records.

10.3.3.1 Reconciliation by Submitting Contract

The CGDP reconciliation is based on the submitting contract rather than the contract of record. Said another way, reconciliation of the Coverage Gap Discount amounts will be based on accepted and validated PDEs that the plan submits regardless of whether the beneficiary was enrolled in the Part D sponsor's plan or not. This is similar to how CMS reconciles the Total Actual Plan-to-Plan (P2P) Non-

covered Plan Paid Amount (NPP) submitted by Enhanced Alternative (EA) Plan Amount portion of the Low Income Subsidy Reconciliation.

10.3.3.2 Timing of CGDP Reconciliation

The schedule for the Coverage Gap Discount Reconciliation is different from the existing Part D payment reconciliation schedule. It will begin after the sixth invoicing and payment processing cycle has been completed for the benefit year.

After the CGDP reconciliation, CMS will discontinue additional offsets for the benefit year.

After Part D payment reconciliation for CGDP, Part D sponsors may continue to report discounts to CMS for thirty-seven (37) months following the end of the benefit year. The sponsor will receive payment from the Manufacturer invoice process. Table 10J shows the reconciliation and invoicing timeline.

TABLE 10J – QUARTERLY SCHEDULE FOR 2011 BENEFIT YEAR

Quarter Number	PDE Reporting Period End	Quarterly Invoice Distribution	Invoice Paid By 38th Calendar Day After Invoice	Invoice Payment Confirmed By 5th Business Day After Payment	Payment Month of APPS Offset
Q1	3/31/2011	4/30/2011	6/07/2011	6/14/2011	7/2011
Q2	6/30/2011	8/31/2011	10/08/2011	10/14/2011	11/2011
Q3	9/30/2011	10/31/2011	12/08/2011	12/15/2011	1/2012
Q4	12/31/2011	1/31/2012	3/09/2012	3/16/2012	4/2012
Q5	3/31/2012	4/30/2012	6/07/2012	6/14/2012	7/2012
Q6	6/30/2012	8/31/2012	10/08/2012	10/15/2012	11/2012
Q7	9/30/2012	10/31/2012	12/08/2012	12/14/2012	
Q8	12/31/2012	1/31/2013	3/10/2013	3/15/2013	
Q9	3/31/2013	4/30/2013	6/07/2013	6/14/2013	
Q10	6/30/2013	8/31/2013	10/08/2013	10/15/2013	
Q11	9/30/2013	10/31/2013	12/08/2013	12/13/2013	
Q12	12/31/2013	1/31/2014	3/10/2014	3/17/2014	
Q13	3/31/2014	4/30/2014	6/07/2014	6/13/2014	
Q14	6/30/2014	8/31/2014	10/08/2014	10/15/2014	
Q15	9/30/2014	10/31/2014	12/08/2014	12/15/2014	
Q16	12/31/2014	1/31/2015	3/10/2015	3/17/2015	
Q17	3/31/2015	4/30/2015	6/07/2015	6/12/2015	

- First 4 quarters occur within the benefit year.
- Reconciliation occurs after Quarter 6.
- After CGD reconciliation, the benefit year's CGD is not subject to prospective payment or offset.
- PDE cutoff for coverage gap discount eligibility is January 31, 2015, which occurs during Quarter 1 2015, and will appear on Quarter 1 Invoices.

10.3.3.3 Reconciliation Calculations (Slides 24-26)

The CGDP Reconciliation is a cost-based reconciliation that pays Part D sponsors dollar for dollar for gap discount costs documented on invoiced PDEs. During CGDP reconciliation, CMS compares the actual gap discount costs to prospective payments. CMS subtracts the total CGD prospective payments from the actual gap discount dollars reported on invoiced PDEs.

Reconciliation Adjustments can be positive or negative. If gap discount costs exceed prospective payments, the reconciliation adjustment is positive and CMS pays the sponsor the additional costs. Conversely, if the gap discount costs are less than the prospective payments, CMS overpaid the sponsor. The reconciliation adjustment is negative and the sponsor repays CMS for the overpayment.

Figure 10F shows the CGDP reconciliation calculation.

Figure 10F – CGD Reconciliation Calculation

RCGD = ACGD - PCGD

Where
RCGD = Coverage gap discount reconciliation amount
ACGD = Sum of plan-reported actual gap discount dollars as reported on invoiced PDEs in the benefit year
PCGD = Sum of all prospective CGD payments (includes any adjusted payments) in the benefit year

Example 1

The plans in scenarios 1 and 2 had different gap discount costs. The Scenario 1 plan's costs were $1,750; the Scenario 2 plan's costs were only $250. Both plans received $1,000 in prospective payments. Manufacturers paid both plans in full and CMS offsets the invoiced amount. Although there was a time lag between POS and invoice payment, Manufacturer payments equaled the plan costs throughout the year. The Reconciliation corrects the error in the plan's estimated prospective costs. Table 10K shows the two payment scenarios.

TABLE 10K – PAYMENT SCENARIOS

	Scenario 1 Prospective Payments are Less Than Actual Gap Discount Costs	**Scenario 2** Prospective Payments are Greater Than Actual Gap Discount Costs
CGDP Prospective Payments Received by Plan	$1,000	$1,000
Actual CGDP amounts Plan pays throughout the year	$1,750	$250
Manufacturer reimbursement to plan	$1,750	$250
CMS Offset	$1,750	$250
CMS Owes Plan at CGDP Recon	$750	$0
Plan Owes CMS at CGDP Recon	$0	$750

Prospective payments are based on cost estimates. Reconciliation corrects imprecise estimates. In Scenario 1, the plan under-estimated its costs. The prospective payments totaled $1,000. The actual discount counts were $1,750, $750 greater than estimated. The reconciliation adjustment is positive and CMS will pay the plan an additional $750. The calculation is shown below.

Scenario 1

RCGD = ACGD – PCGD
$750 = $1,750 - $1,000

In Scenario 2, the plan over-estimated its costs. Once again, the prospective payments totaled $1,000. However, the actual discount costs were much lower than estimated, only $250. The reconciliation adjustment is negative and the plan will repay CMS $750. The calculation is shown below.

Scenario 2

RCGD = ACGD – PCGD
-$750 = $250 - $1,000

MODULE 11 – 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 Payment Reconciliation System (PRS) reports to understand their Part D reconciliation.

ICON KEY

Definition	
Example	
Reminder	
Resource	

11.1 Overview of Part D Reconciliation (Slide 4-5)

Reconciliation compares actual costs to prospective payments, calculates risk sharing, and determines reconciliation amounts for each payment type. The term Part D payment reconciliation commonly refers to the reconciliation of LICS and reinsurance and the calculation of any risk sharing. Prior to carrying out the LICS and reinsurance reconciliation and risk sharing, the reconciliation of the direct subsidy will be completed as part of the risk adjustment reconciliation. The final direct subsidy will be used in the cost-based portion of the Part D reconciliation.

The Coverage Gap Discount Program has its own payment and reconciliation process wholly separate from the four Part D payment methodologies, which is described in greater detail in Module 1 and in Module 10.

11.2 Reconciliation Overview (Slides 6-7)

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.

PDE data received by 11:59 p.m. Eastern Time, on the Federal business day immediately before June 30 of the following benefit year 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.

42CFR §423.343(c)(1)

HPMS Memo, May 16, 2011, Timely Submission of Prescription Drug Event (PDE) Records and Resolution of Rejected Records.

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.

11.3 Data Oversight (Slide 8)

Although reconciliation and risk sharing occur after year end, plans must monitor and oversee benefit administration by their Plan Benefit Managers (PBM), 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.

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.

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 PDE 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.

11.3.1 Beneficiary and Payment Data (Slide 9)

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.

11.3.2 PDE Data (Slide 10)

Plans should incorporate the use of two levels of reports into data oversight. The PDE data are reported on Transaction and Management reports.

11.3.2.1 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.

11.3.2.2 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 are included in the plan's 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.

11.4 Certification of Data for Payment (Slide 11)

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 is required to receive risk sharing and reinsurance payment adjustments.

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)

11.5 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.

11.6 Reopening

CMS has the authority to reopen and revise initial or reconsidered final payment determinations. The final payment determination must be reopened and revised within the time periods specified below. Therefore, it is crucial that the plan sponsor submit its request for reopening in time for CMS to evaluate the request and if granted, proceed with reopening and revising the final payment determination within the time periods specified below. Final payment determinations include determinations of the final amounts of direct subsidy, reinsurance, low income subsidy, or risk corridor payments.

CMS may reopen a final payment determination within 12 months from the date of the notice of final determination to the Part D sponsor for any reason. After 12 months, but within 4 years, CMS may reopen upon establishment of good cause. "Good cause" is defined in the regulation as:

- New and material evidence that was not readily available at the time the final determination was made;
- A clerical error in the computation of payments; or
- When evidence that was considered in making the determination clearly shows on its face that an error was made.

CMS may reopen final payment determination at any time in instances of fraud or similar fault of the Part D Sponsor or any subcontractor of the Part D Sponsor. Except in instances of fraud or similar fault, the regulation does not allow for reopening beyond the 4-year period.

Subject to 42CFR §423.346 and applicable guidance, CMS may reopen on its own volition or a plan sponsor may request that CMS, at its discretion, reopen and revise a final payment determination.

11.7 System Overview (Slide 12)

The Part D payment reconciliation is calculated by the Payment Reconciliation System (PRS) after the end of the benefit year. PRS uses input data from MARx, HPMS, and DDPS for reconciliation and risk sharing.

11.7.1 Data from DDPS

The Drug Data Processing System passes the following data elements to PRS to calculate Part D payment reconciliation:

- Low Income Cost-Sharing Subsidy (LICS)

- Gross Drug Cost Below the Out of Pocket Amount (GDCB)
- Gross Drug Cost Above the Out of Pocket Amount (GDCA)
- Covered Plan Paid Amount (CPP)
- Estimated Rebate at POS

These data elements are received from DDPS and aggregated at the beneficiary/plan level before being passed to PRS.

PRS uses both P2P and non-P2P amounts for LICS, GDCB, GDCA, and CPP in reconciliation. In other words, these four data elements are comprised of amounts from PDE records submitted by the Contract of Record (non P2P) and by plans not within the Contract of Record which submitted PDEs for beneficiaries enrolled in the Contract of Record's plan (P2P). The P2P amounts represent amounts paid for a particular beneficiary by a Contract/PBP other than the Contract/PBP of Record. The Submitting Contract is not the Contract of Record for the beneficiary, and for this reason, the PDE was subject to the P2P process. In the P2P settlement process, the COR repays any Submitting Contract that paid for Part D drugs in good faith when Part D plan enrollment data were not up-to-date. The P2P amounts are included in the COR's reconciliation because reconciliation compares actual costs to prospective payments. The COR receives the prospective payments for the P2P beneficiaries. In order to align actual costs with prospective payments, the COR receives credit for the actual cost by paying the Submitting Contract in the P2P process.

Note that the P2P Estimated POS Rebate amount is the only Plan-Level P2P amount that is included in the submitting contract's reconciliation rather than the COR's. The Submitting Contract must retain (and report as DIR) any rebates earned for P2P claims.

Plans should 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.

11.7.2 Data from MARx

The Medicare Advantage and Prescription Drug (MARx) system calculates the monthly prospective payments using enrollment and LICS eligibility status. MARx provides the final reconciled direct subsidy and the final LICS and reinsurance prospective payment amounts for use in calculating the Part D payment reconciliation. MARx also passes the total Part D basic premium and the PACE cost-sharing add-on amount.

The following data elements come from MARx at the beneficiary/plan level and are aggregated to the plan level by PRS:

- Prospective Low Income Cost-Sharing Subsidy Amount
- Prospective Reinsurance Subsidy Amount
- Part D Basic Premium Amount
- Direct Subsidy Amount
- PACE Cost-Sharing Add-On Amount

11.7.3 Data from HPMS

The Health Plan Management System (HPMS) provides plan-level inputs needed to calculate reconciliation. These inputs include:

- The Reported Part D Covered DIR Amount
- The Administrative Cost Ratio
- The Induced Utilization Ratio (for Enhanced Alternative plans only)

11.7.4 Program-Level CMS Inputs

The last group of reconciliation inputs include CMS provided, program-wide data elements. These fields are necessary to perform the risk sharing portion of reconciliation. The values for these data elements are the same for all plans that participate in risk sharing. The CMS program level inputs are:

- The First Upper Threshold Percent
- Second Upper Threshold Percent
- First Lower Threshold Percent
- Second Lower Threshold Percent
- First Upper Risk Sharing Rate
- Second Upper Risk Sharing Rate
- First Lower Risk Sharing Rate
- Second Lower Risk Sharing Rate

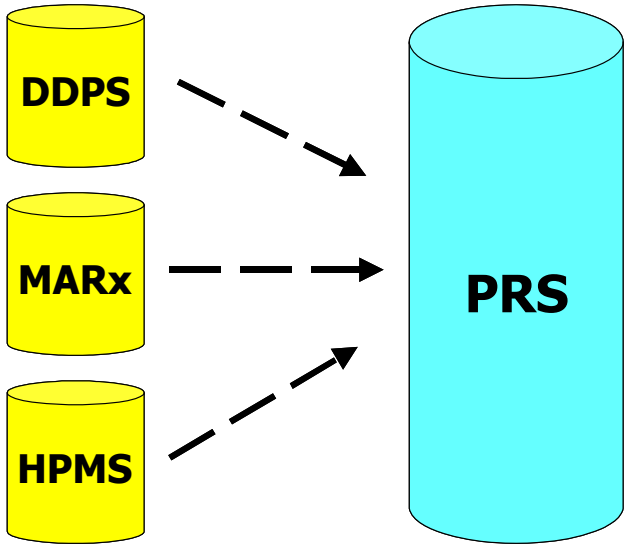
Table 11A provides descriptions of the systems involved in the payment and reconciliation process.

TABLE 11A – 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 11A illustrates the system flow.

Figure 11A – System Flow



11.7.4.1 Payment Reconciliation Plan Type Code (Slide 13)

Prior to running the reconciliation of LICS and reinsurance and calculating risk sharing, PRS assigns a Payment Reconciliation Plan Type Code (PRPTC) to each contract/PBP participating in the Part D payment reconciliation. The 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 11B provides a list of the PRS plan types and their allowed reconciliations.

TABLE 11B – 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.
***No longer a valid plan type beginning in 2011.

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 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.

11.8 Reconciling Low Income Cost-Sharing Subsidy (Slide 14)

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.

11.8.1 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 11B.

Figure 11B – 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.

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.

11.8.2 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 Non Covered Plan Paid (NPP) amount from Report 40 is considered LICS in P2P situations in which the Submitting Contract offers and 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.

11.8.2.1 Plan-to-Plan (P2P) Actual Non-Covered Plan Paid (NPP) Amount Submitted by an Enhanced Alternative (EA) Plan

The PRS systems uses actual LICS amounts reported on PDEs aggregated from Report 4, Report 40, and Report 42. As mentioned in an earlier section, PRS uses both P2P (from Report 42) and non-P2P amounts (from Report 4) to calculate actual LICS amounts. In addition, PRS uses NPP amounts (from Report 40) submitted by Enhanced Alternative plans for LICS beneficiaries as actual LICS when submitted in P2P situations. In other words, the NPP amount from Report 40 is considered LICS in situations in which the Submitting Contract offers an Enhanced Alternative benefit, and the Submitting Contract is not the COR.

Similar to the P2P Estimated Rebate at POS, P2P NPP Submitted by an EA plan is credited to the submitting contract for reconciliation which means that the submitting contract rather than the COR receives credit for the P2P NPP amounts for Part D eligible beneficiaries that may not be enrolled in the contract's plan.

Actual P2P NPP Submitted by EA Plan Amount is included in reconciliation in order 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 is included in the Low Income Cost-Sharing Subsidy reconciliation for EA plans along with the P2P LICS and non-P2P LICS amounts reported on PDEs in the calculation of actual LICS.

11.8.3 Low Income Cost-Sharing Subsidy Reconciliation Calculation (Slide 15)

Example #1

Bayside Health Plan is an enhanced alternative plan (refer to Table 11J on page 30) that 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.

LICS Reconciliation Amount

LICS Reconciliation Amount = $3,000,000 - $2,880,000

LICS Reconciliation Amount = $120,000

Based on PDE data, the plan had $2,500,000 in non-P2P LICS, $400,000 in P2P LICS, and $100,000 in P2P NPP Submitted by an EA Plan amounts, for a total of $3,000,000 in actual LICS.

To determine Bayside's LICS reconciliation amount, the $2,880,000 in prospective payments are subtracted from the $3,000,000 in actual LICS.

Bayside's LICS reconciliation amount is $120,000.

11.8.3.1 Calculate Net Part D Covered DIR (Slide 16)

Prior to performing the reinsurance reconciliation and risk sharing, the Net Part D Covered DIR amount must first be determined. For benefit year 2008 and after, plans have the option to report the estimated rebate applied at the point of sale (POS) on the PDE record in the Estimated Rebate at POS field. During reconciliation, any Estimated Rebate at POS amounts reported by the plan would be factored into the DIR amount the plan reports in their annual DIR report, the DIR Report for Payment Reconciliation, to calculate the 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 as reported on PDEs is subtracted from the Reported Part D Covered DIR Amount as it is reported on the DIR Report for Payment Reconciliation.

11.8.3.2 Estimated Rebate at Point-of-Sale (POS) Amount

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.

As explained in a 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 Estimated POS Rebate fields will be populated with zero for the 2006 and 2007 reconciliation reports.

Example #2

Bayside's Reported Part D Covered DIR Amount is $1,850,000. Bayside submitted $325,000 in non-P2P Estimated Rebate at POS amounts and $25,000 in P2P ERPOSA amounts for beneficiaries that Bayside submitted PDEs for but are not included in their plan for a 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 $1,500,000.

Net Part D Covered DIR

Net Part D Covered DIR = $1,850,000 - $350,000

Net Part D Covered DIR = $1,500,000

11.9 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.

11.9.1 Reinsurance System Overview

PRS reconciles the Reinsurance Subsidy. The Reinsurance Subsidy process is described in Figure 11C.

Figure 11C – 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.

11.9.2 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 Total Gross Covered Drug Costs (TGCDC) and True Out-of-Pocket Costs (TrOOP).

CMS evaluates the accuracy of GDCA data. CMS estimates net TrOOP Amount based on the sum of the Net Patient Pay, Net Other TrOOP, and Net LICS 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.

11.9.3 Reinsurance Subsidy Calculations (Slide 18)

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.

11.9.3.1 Calculate DIR Ratio (Slides 19-20)

Bayside reported GDCA equal to $2,250,000 and GDCB equal to $12,750,000. The sum of GDCA and GDCB, which equals $15,000,000, 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 .15.

DIR_Ratio

DIR_Ratio = $2,250,000/($2,250,000 + $12,750,000)

DIR_Ratio = $2,250,000/$15,000,000

DIR_Ratio = .15

11.9.3.2 Calculate Reinsurance Portion of DIR (Slides 21-22)

Bayside's net DIR for total covered drugs is equal to $1,500,000. 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 $225,000.

Reinsurance Portion of DIR

Reinsurance Portion of DIR = $1,500,000 * .15

Reinsurance Portion of DIR = $225,000

11.9.3.3 Calculate Allowable Reinsurance Cost (Slides 23-24)

Bayside reported GDCA equal to $2,250,000. To calculate Bayside's allowable reinsurance cost, subtract the reinsurance portion of DIR from GDCA. Bayside's allowable reinsurance cost is $2,025,000.

Allowable Reinsurance Cost

Allowable Reinsurance Cost = $2,250,000 - $225,000

Allowable Reinsurance Cost = $2,025,000

11.9.3.4 Calculate Plan-Level Reinsurance Subsidy (Slides 25-26)

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 $1,620,000.

Reinsurance Subsidy

Reinsurance Subsidy = $2,025,000 * 0.8

Reinsurance Subsidy = $1,620,000

11.9.3.5 Reconcile Reinsurance Subsidy (Slides 27-28)

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 $1,620,000 and $2,100,000 is -$480,000. 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 $480,000.

Reinsurance Reconciliation Amount

Reinsurance Reconciliation Amount = $1,620,000 – $2,100,000

Reinsurance Reconciliation Amount = -$480,000

11.9.3.6 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.

11.10 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.

11.10.1 Risk Sharing System Overview

PRS calculates risk sharing. The risk sharing process is described in Figure 11D.

Figure 11D - 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.

11.10.2 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.

11.10.3 Risk Sharing Calculations (Slide 29)

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

11.10.3.1 Calculate the Plan's Target Amount (Slides 30-31)

Bayside received $3,078,000 in total direct subsidy payments and $2,100,000 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 = ($3,078,000 + $2,100,000) * (1.00 - 0.15)

Target Amount = $5,178,000 *.85

Target Amount = $4,401,300

11.10.3.2 Calculate Risk Corridor Thresholds (Slides 32-35)

CMS uses Bayside's target amount and Part D threshold risk percentages to calculate the risk corridor thresholds. Bayside's target amount is $4,401,300. Part D threshold risk percentages for 2010 through 2012, in descending order, are 110 percent, 105 percent, 95 percent, and 90.0 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)	= $4,401,300 *	1.10	= $4,841,430
First threshold upper limit (FTUL)	= $4,401,300 *	1.05	= $4,621,365
First threshold lower limit (FTLL)	= $4,401,300 *	0.95	= $4,181,235
Second threshold lower limit (STLL)	= $4,401,300 *	0.90	= $3,961,170

11.10.3.3 Calculate Adjusted Allowable Risk Corridor Costs (AARCC) (Slides 36-37)

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 $8,120,000. The reinsurance subsidy for Bayside is $1,620,000 and their Net Part D Covered DIR is $1,500,000. The result is $5,000,000. Then divide that amount by the induced utilization ratio. Bayside's induced utilization ratio is 1.018. Bayside's AARCC is $4,911,591.

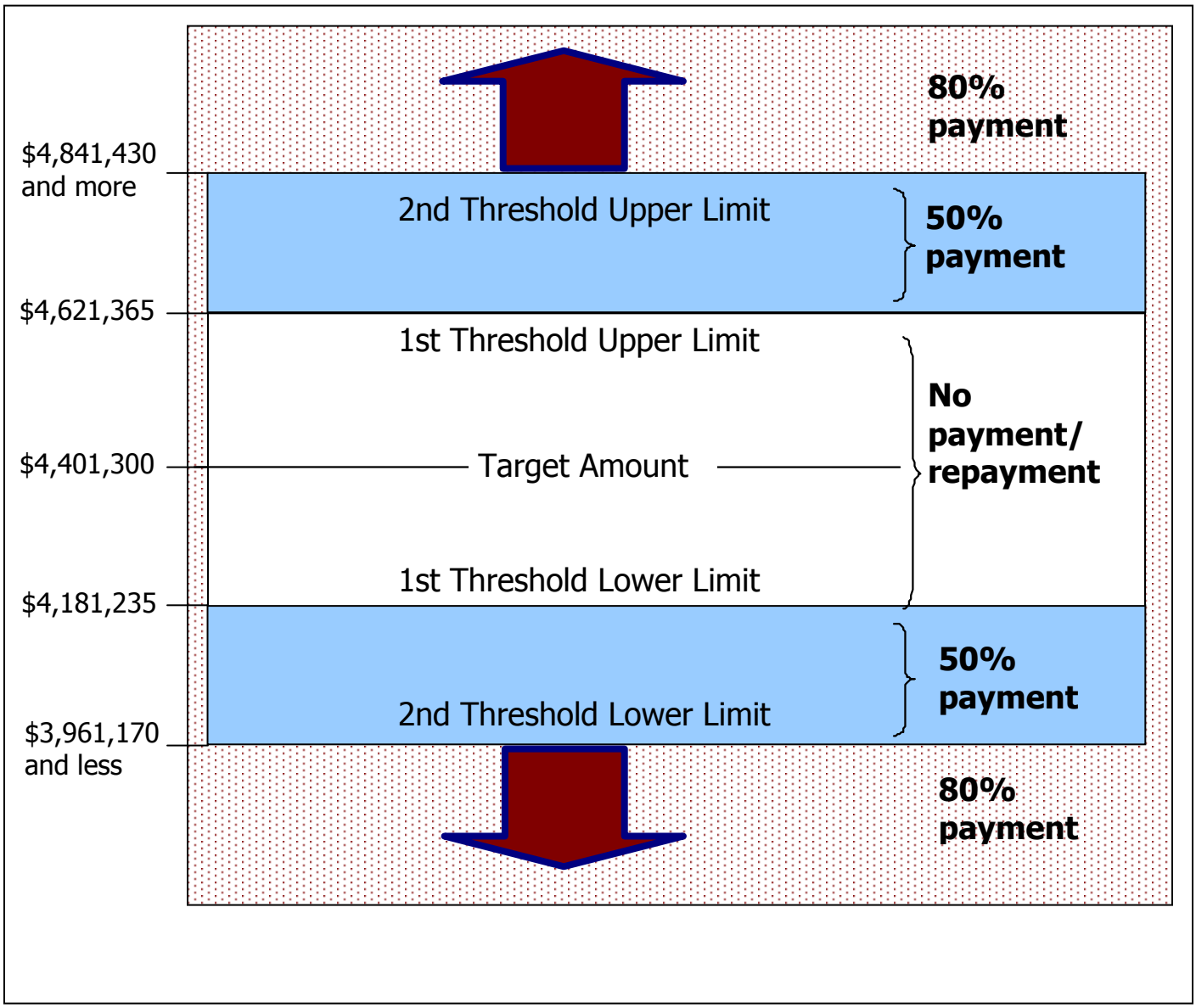
Adjusted Allowable Risk Corridor Cost (AARCC)

AARCC = ($8,120,000 - $1,620,000 - $1,500,000) / 1.018
AARCC = $5,000,000 / 1.018
AARCC = $4,911,591

11.10.3.4 Determine Where Costs Fall With Respect to the Thresholds And Calculate Payment Adjustment (Slides 38-41)

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 $4,911,591. Figure 11E displays Bayside's risk sharing thresholds and percentages.

Figure 11E – Bayside's Risk Sharing Thresholds and Percentages



Since Bayside's AARCC is above the $4,841,430 that marks the Second Threshold Upper Limit (STUL), there are two portions of Bayside's risk sharing.

The first portion lies between $4,621,365 and $4,841,430 (between the First Threshold Upper Limit (FTUL) and the STUL) and has 50 percent risk sharing. The second portion falls above the $4,841,430 that marks the STUL and has 80 percent risk sharing.

Cost Subject to Risk Sharing

Total Cost Subject to Risk Sharing = $4,911,591 - $4,621,365

Total Cost Subject to Risk Sharing = $290,226

Cost Subject to Risk Sharing > FTUL and ≤ STUL = $4,841,430 - $4,621,365

Cost Subject to Risk Sharing > FTUL and ≤ STUL = $220,065

Cost Subject to Risk Sharing > STUL = $4,911,591 - $4,841,430

Cost Subject to Risk Sharing > STUL = $70,161

Finally, calculate the risk sharing percentage for each portion of AARCC. First apply 50 percent risk sharing to the $220,065 between the FTUL and STUL, which is $110,033.

Then, apply 80 percent risk sharing to the $70,161 above the STUL, which is $56,129. Sum these two amounts to calculate Bayside's total risk sharing payment of $166,161.

Risk Sharing Payment

Risk Sharing Payment = (.50 * $220,065) + (.80 * $70,161)

Risk Sharing Payment = $110,032 + $56,129

Risk Sharing Payment = $166,161

11.11 Determine Budget Neutrality Adjustment Amount (BNAA) (Slides 42)

The Budget Neutrality Adjustment Amount (BNAA) applies to demonstration plans only and is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA). The Budget Neutrality adjustment is applied to the final reconciliation payment adjustment. Since Bayside is an enhanced alternative plan, this plan would not receive a budget neutrality adjustment.

11.12 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 BNAA.

11.12.1 Determine Adjustment Due to Payment Reconciliation Amount (Slides 43-45)

The Adjustment Due to Payment Reconciliation Amount (ARA) is the plan-level final net reconciliation value.

At this point, every step in the reconciliation process has been completed. Bayside receives the net reconciliation amount of - $193,839 from PRS.

Total Reconciliation Payment from PRS

LICS Reconciliation	$120,000
Reinsurance Subsidy Reconciliation	+($480,000)
Risk Sharing	+ $166,161
Budget Neutrality Adjustment Amount	- $0
Adjustment Due to Payment Reconciliation Amount	**-$193,839**

11.12.2 PRS Reports to Plans

11.12.2.1 PRS Part D Payment Reports (Slide 46)

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.

11.12.2.1.1 PRS Inputs Report to Plans (Slide 47)

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.

11.12.2.1.1.1 PRS Inputs Report to Plans File Layout (Slide 48)

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 11C provides the record definitions and descriptions for the PRS Inputs Report to Plans.

TABLE 11C – 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

11.12.2.1.1.1.1 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.

11.12.2.1.1.2 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 11D provides the data elements and field numbers for the Inputs Report.

TABLE 11D – 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

11.12.2.1.1.2.1 PRS Reconciliation Results Report to Plans File Layout (Slides 49-50)

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 11E provides the definitions and descriptions of the records in the PRS Reconciliation Results Report to Plans.

TABLE 11E – 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.

11.12.2.1.1.2.2 Reconciliation Number (Slide 51)

On the DET record of the Reconciliation Results Report, there are two fields to indicate whether the reconciliation is an initial reconciliation for the benefit year or a reopened reconciliation. The fields are Current Reconciliation Number and Previous Reconciliation Number. 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. 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.

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.

11.12.2.1.1.2.3 Inputs Report Fields Passed to the Results Report (Slide 52-53)

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 11F.

TABLE 11F – 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

11.12.2.2 Plan-Level HPMS Inputs (Slide 54)

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 11G provides the HPMS plan-level inputs found on the PRS Reconciliation Results Report to Plans.

TABLE 11G – 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

11.12.2.3 Program-Level CMS Inputs (Slide 55)

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 11H provides the CMS program level inputs on the PRS Results Report to Plans.

TABLE 11H – 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

11.12.2.4 Data Elements with Current, Previous, and Delta Values (Slide 56)

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.

11.12.3 Interpreting the PRS Reconciliation Results Report

11.12.3.1 Interpreting the Revised Results Report in an Initial Reconciliation (Slide 57)

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.

11.12.3.2 Interpreting the Revised Results Report in a Re-Opening (Slides 58-59)

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) 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 11I are used to calculate the Delta ARA:

TABLE 11I – 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 11J illustrates the data used to calculate Bayside's Health Plan's total reconciliation payment.

TABLE 11J – 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	$1,850,000

MARx Information

8. Average Monthly Enrollment	5,000
9. Total Member Months	60,000
10. Average Risk Score	0.932
11. Total Direct Subsidy	$3,078,000
12. Total Low Income Member Months	24,000
13. Total Prospective Low Income Cost-Sharing	$2,880,000
14. Total Prospective Reinsurance	$2,100,000
15. Total Part D Basic Premium Related to the Standardized Bid	$2,100,000

DDPS Data

16. Non-P2P Low Income Cost-Sharing	$2,500,000
17. P2P Low Income Cost-Sharing	$400,000
18. P2P NPP Submitted by an Enhanced Alternative Plan	$100,000
19. Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)	$2,250,000
20. Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)	$12,750,000
21. Covered D Plan Paid Amount	$8,120,000
22. Total GDCA+GDCB	$15,000,000
23. Non-P2P Estimated POS Rebates	$325,000
24. P2P Estimated POS Rebates	$25,000

CMS Provided Data

25. 2nd Threshold Upper Limit	110%
26. 1st Threshold Upper Limit	105%
27. 2nd Threshold Lower Limit	95%
28. 1st Threshold Lower Limit	90%