CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Prescription Drug Event Slide Presentations

2011 Regional IT Technical Assistance

A Reddix & Associates

Introduction

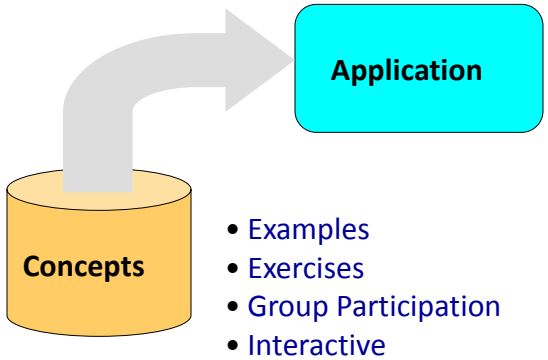
2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

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

TECHNICAL ASSISTANCE FORMAT



- Examples
- Exercises
- Group Participation
- Interactive

PARTICIPATION MAKES THE DIFFERENCE

TECHNICAL ASSISTANCE TOOLS

- Flash Drive
  - Participant Guide
  - Job Aids
- www.csscoperations.com
- MAPD Help Desk
- Panel of Experts

AUDIENCE

- 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

AGENDA TOPICS – DAY ONE

Welcome
Introduction
Part D Payment Methodology
PDE Process Overview
Break
Data Format
Lunch
The Basic Benefit
Break
Total Gross Covered Drug Costs (TGCDC) and True Out-of-Pocket Costs (TrOOP)
Question & Answer Session
Adjourn

AGENDA TOPICS – DAY TWO

Welcome
Review of Day One
Low Income Cost-Sharing Subsidy
Enhanced Alternative Benefit
Break
Edits
Reports – Part 1
Lunch
Reports – Part 2
Coverage Gap Discount Program Invoice & Payment Process
Break
Reconciliation
Question & Answer Session
Adjourn

OBJECTIVES

- 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

OBJECTIVES (CONTINUED)

- 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.

OBJECTIVES (CONTINUED)

- 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

INTRODUCING THE TEAM

CMS

Palmetto (CSSC)

A. Reddix & Associates (ARDX)

Part D Payment Methodology

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

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

OBJECTIVES

- Identify and define the four legislative payment mechanisms for Part D
- 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 generic drugs

PART D PAYMENT METHODOLOGIES

- Direct Subsidy
- Low Income Subsidy
- Reinsurance Subsidy
- Risk Sharing (Risk Corridors)

WHAT IS COVERED?

- Part D drugs covered under a plan's basic benefit
- Applicable Drugs
- Non-Applicable Drugs

COVERED DRUG COST

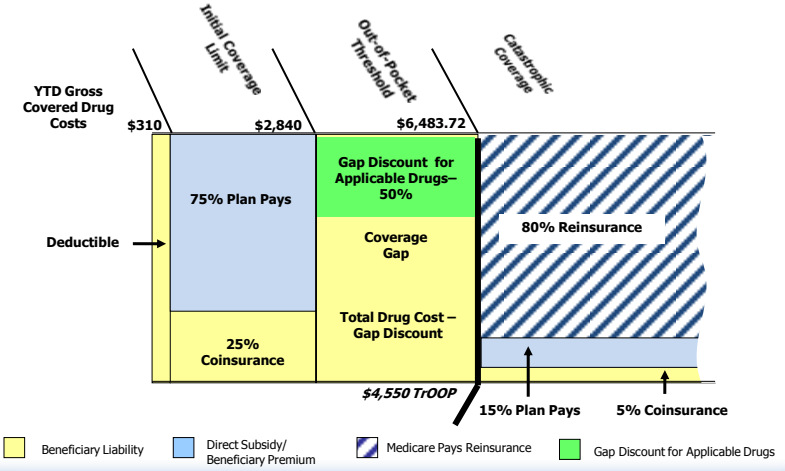
- Drug cost reported on a PDE record must be net of plan administrative costs and net of any point of sale (POS) price concessions

DRUG COST SUBJECT TO PART D PAYMENT

- Payment is based on the gross covered drug cost for dispensing event
- PDE fields:
  - Ingredient Cost Paid
  - Dispensing Fee Paid
  - Amount Attributed to Sales Tax
  - Vaccine Administration Fee

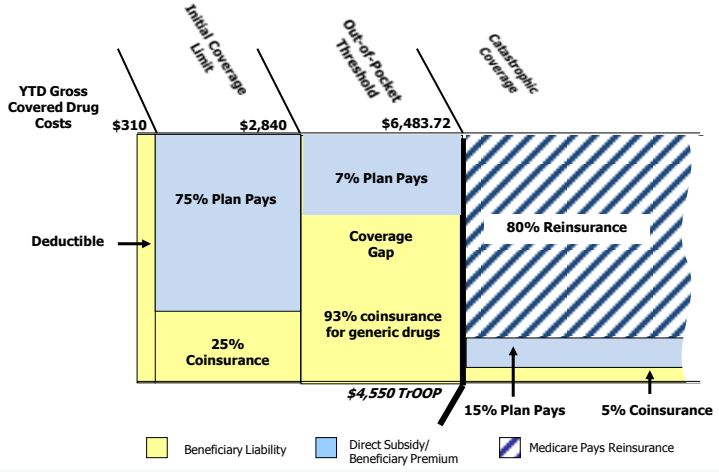
DEFINED STANDARD BENEFIT 2011

APPLICABLE BENEFICIARIES AND APPLICABLE DRUGS



DEFINED STANDARD BENEFIT 2011

APPLICABLE BENEFICIARIES AND COVERAGE FOR GENERIC DRUGS



DEFINED STANDARD BENEFIT 2011

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 ≤$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 5% coinsurance or $2.50/$6.30 generic/brand co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)

DEFINED STANDARD BENEFIT 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 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)

DIRECT SUBSIDY

- Applies in the Initial Coverage Phase, Coverage Gap for non low-income beneficiaries, and Catastrophic Coverage Phase
- Risk component of payment
- The direct subsidy (plus basic premiums) covers:
  - 75% of covered drug cost
  - 14% of costs for generics
  - Approximately 15% of plan costs in the catastrophic phase
  - Administrative costs and profit approved in bid

LOW INCOME COST SUBSIDY

- Applies throughout all phases of the benefit for low income eligible beneficiaries

REINSURANCE SUBSIDY

- Applies in the Catastrophic Coverage Phase

RISK SHARING

- Applies to allowable plan-paid amounts
- Calculated at the plan level for the basic benefit and compares risk payments with aggregate allowed plan paid drug costs

PART D PAYMENT RECONCILIATION

- CMS makes prospective payments to plans that cover three subsidies based on information in the approved basic bid and on updated payments throughout the year
- During reconciliation
  - CMS compares the finalized prospective payments and the corresponding actual costs reported on PDEs
  - Makes payment adjustment according to the rules for each payment methodology

PAYMENT TIMETABLE AND RECONCILIATION

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.

PRESCRIPTION DRUG EVENT (PDE)

- CMS collects a limited subset of data elements on 100% of PDEs
- CMS uses four criteria to determine data submission requirements:
  - Ability to make timely, accurate payment via the four legislated mechanisms
  - Minimal administrative burden
  - Legislative authority
  - Data validity and reliability
- Plans must maintain audit trails to PDE source data

DIRECT & INDIRECT REMUNERATION (DIR)

- Discounts, chargebacks or rebates, cash discounts, free goods, up-front payments, coupons, goods in kind, free or reduced-price services, grants to serve to decrease the costs incurred by Part D sponsor
- Any payments or re-payments that plans make as part of risk arrangements with providers

DIRECT & INDIRECT REMUNERATION (DIR)

- Reflected in the price at POS that is reported on PDE record
- Price must be net of POS price concessions
- Other types of DIR are not reflected in POS price and must be reported to CMS in a data stream
- DIR not reflected in the cost of the drug on PDE record must be reported separately to CMS

PART D RECONCILIATION: DIRECT SUBSIDY

- A capitated payment that is an estimate of the revenue requirements needed
- Adjusted for the individual risk characteristics of each beneficiary enrolled in the plan
- Direct subsidies cover costs, which would match actual costs (if all bid assumptions realized)
- CMS compares actual covered drug costs to direct subsidy payments
  - If differ by legislatively specified percentages, CMS calculates a risk sharing payment adjustment
- Used in two parts of payment
  - Actual prospective payment
  - To determine any risk sharing

PART D RECONCILIATION: LICS

- Cost-sharing reductions are applied and paid for by the plan at POS
- CMS reconciles to the actual amounts paid after the payment year ends

PART D RECONCILIATION: REINSURANCE SUBSIDY

- Reduces the risk of participating in Part D
- Government subsidizes 80% of covered Part D costs paid by the plan in the Catastrophic Coverage Phase (net of administrative costs and DIR)

PART D RECONCILIATION: RISK SHARING

- Single, annual payment adjustment computed after year-end
- Unadjusted Risk Corridor Costs (URCC) are plan paid costs for covered Part D drugs in all phases of the benefit
- Adjusted Allowable Risk Corridor Costs (AARCC) are the URCC reduced for Net DIR

RECONCILIATION: RISK SHARING (CONTINUED)

- Calculate the plan's "goal" (target amount) payments
  - Includes direct subsidy
- Determine actual costs from PDEs
- Compare actual to target within specified risk limits ≥ Payment adjustment if applicable

CALCULATE TARGET AMOUNT

- The target amount is the total projected revenue necessary for the risk portion of the basic benefit excluding administrative costs.

In formula:

(Total direct subsidy+Total Part D basic premiums related to standardized bid) *
(1-Administrative Cost Ratio)

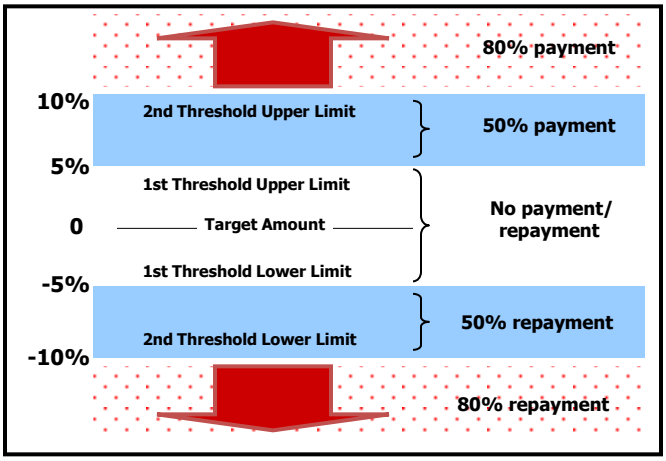
CALCULATE ADJUSTED ALLOWABLE RISK CORRIDOR COSTS (AARCC)

- 4 Steps to determine AARCC
  - Determine URCC
  - Subtract Plan-level reinsurance subsidy
  - Subtract Net Covered Part D DIR
  - Reduce by the induced utilization ratio plans reported in their bids (for enhanced alternative plans only)

THRESHOLDS & CALCULATE PAYMENT ADJUSTMENT

- Risk sharing reduces the impacts of unexpected gains or losses
- Plans may receive payments from CMS to cover a portion of unexpected losses
- Plan may share a portion of unexpected gains with CMS

RISK CORRIDORS 2010 - 2012



AFFORDABLE CARE ACT

- By 2020, the Affordable Care Act requires that CMS close the coverage gap
- The ACA establishes:
  - The Coverage Gap Discount Program
  - Coverage for Applicable Drugs in the Coverage Gap
  - Coverage for Generic Drugs in the Coverage Gap

COVERAGE GAP DISCOUNT PROGRAM (CGDP) OVERVIEW

- Established by Affordable Care Act
- Makes manufacturer discounts available to applicable Medicare beneficiaries receiving applicable drugs in the Coverage Gap
- Generally, discount on each applicable drug is 50% of amount equal to negotiated price

COVERAGE GAP DISCOUNT PROGRAM (CGDP) OVERVIEW
(CONTINUED)

- Part D Sponsors provide discount at point-of-sale (POS) on behalf of manufacturers so the beneficiary can immediately receive out-of-pocket cost reduction
- Discounts can be provided at POS if the following is determined at POS:
  - Drug is an applicable drug
  - Beneficiary is eligible for the discount
  - Claim is wholly/partially in the Coverage Gap
  - Amount of discount, taking into consideration plan supplemental benefits pay first

COVERAGE GAP DISCOUNT PROGRAM (CGDP) OVERVIEW
(CONTINUED)

- Reported Gap Discount submitted on PDE
- Monthly prospective payment made to Part D Sponsors for manufacturer discounts under CGDP
- Gap discount amounts are aggregated quarterly and invoices/reports distributed to manufacturers and Part D Sponsors

CGDP RECONCILIATION

- Cost-based reconciliation
- Separate from Part D payment reconciliation
- Takes place after the sixth invoicing and payment processing cycle for the benefit year
- CGDP reconciliation is based on:
  - Submitting Contract – includes PDE data submitted by plan for Part D eligible beneficiaries even if not enrolled in plan
- Conducted at the contract/PBP level

CALCULATING THE CGDP RECONCILIATION

- Compares actual CGDP costs incurred to total CGDP prospective payments received:

  Actual CGDP Costs – CGDP Prospective Payments

- The reconciliation adjustment can be positive or negative
- After the CGDP reconciliation for the benefit year:
  - CMS will discontinue additional CGDP offsets
  - Part D Sponsors will receive payment for invoiced CGDP costs from the manufacturer

RECONCILIATION OF DISCOUNT PROGRAM PAYMENTS

	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

SUMMARY

- Identified and defined the four legislative payment mechanisms for Part D
- Described payments subject to reconciliation and risk sharing
- Established 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 generic drugs

Evaluation

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

Your Feedback is Important! Thank you!

Process Overview

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

To present participants with the important terms, key resources, and schedule information that provide the foundation for the Prescription Drug Event (PDE) Data technical assistance program.

OBJECTIVES

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

COMMON PDE SYSTEM TERMS

PDFS	Prescription Drug Front-End System
DDPS	Drug Data Processing System
IDR	Integrated Data Repository
PRS	Payment Reconciliation System
MBD	Medicare Beneficiary Database
HPMS	Health Plan Management System
MARx	Medicare Advantage Prescription Drug System

PART D BENEFIT OPTIONS

Plans may offer the following benefits:

- Defined Standard (DS)
- Actuarially Equivalent (AE)
- Basic Alternative (BA)
- Enhanced Alternative (EA)

PDE RECORD OVERVIEW

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

PDE RECORD OVERVIEW (CONTINUED)

Includes CMS and NCPDP-defined data elements that track:

- Covered drug costs above and below the OOP threshold
- Payments made by Part D plan sponsors, other payers, and by or on behalf of beneficiaries
- Amounts for supplemental costs separately from the Basic benefit costs
- Costs that contribute towards TrOOP
- Coverage Gap Discount amounts

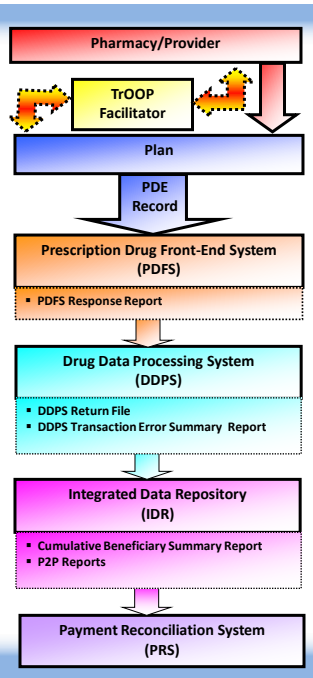
2011 PDE DATA SUBMISSION TIMELINE

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 31, 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 & 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.

PDE DATAFLOW

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



TECHNICAL ASSISTANCE AND SUPPORT

HPMS:
- Publishes guidance.

Customer Service:
- Customer Service & Support Center (CSSC)
  - 1-877-534-2772
  - www.csscoperations.com
- Customer Support for Medicare Modernization Act (CSSCM)
  - 1-800-927-8069
  - www.cms.hhs.gov/mapdhelpdesk
  - mapdhelp@cms.hhs.gov

MA/PDP Operational User Group Calls

SUMMARY

- Identified common Prescription Drug Event data terminology
- Demonstrated knowledge in interpreting key components of the Prescription Drug Event data process
- Interpreted the Prescription Drug Event data submission timeline
- Identified the CMS outreach efforts available to organizations

Evaluation

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

Your Feedback is Important! Thank you!

Data Format

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

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

OBJECTIVES

- 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

OBJECTIVES (CONTINUED)

- 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

PDE ENROLLMENT PACKAGES

FORM	ENTITY
Electronic Data Interchange (EDI)	All Contracts All Third Party Submitters
Submitter ID Application	All Contracts Third Party Submitters
Authorization Letter	Contracts who delegate to Third Party Submitters

CONNECTIVITY OPTIONS

Connect:Direct	•Mainframe-to-mainframe connection •Same day receipt of front-end response if file is received before 1:00 p.m. EST. •Next day receipt of front-end response if file is received after 1:00 p.m. 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 1:00 p.m. EST. •Next day receipt of front-end response if file is received after 1:00 p.m. EST. •Only for plans with less than 100,000 enrollees

CERTIFICATION PROCESS

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

≥ 80% acceptance rate

CERTIFICATION PHASES

Phase 1

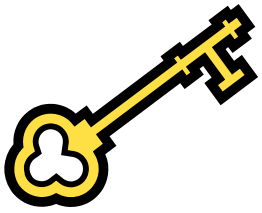
Submitters must establish communication with PDFS, transmit successfully, and clear PDFS edits.

Phase 2

In the DDPS phase, submitters must achieve an 80% acceptance rate (in a file with at least 100 records) and successfully delete at least one saved record.

CERTIFICATION AND SYSTEM CHANGES

KEY POINT



Submitters should test thoroughly following any major changes in processing or submission systems.

2012 DATA SUBMISSION TIMELINE FOR NEW CONTRACTS ONLY

CY	Data Submission Type	Submission Timeline
2012	EDI Agreement and Submitter Application Deadline	October 31, 2011
2012	Certification Complete*	January 31, 2012
2012	First Production File Due	No later than March 30, 2012
2012	Production Submissions	Ongoing Monthly Submissions March 31, 2012 – June 29, 2013
2012	Final Submission Deadline	June 29, 2013 (11:59 p.m. Eastern Time)
2012	Direct & Indirect Remuneration (DIR) Submission Deadline	June 28, 2013

* Only new contracts submitting directly or new third party submitters submitting in CY2012 must complete the testing and certification process.

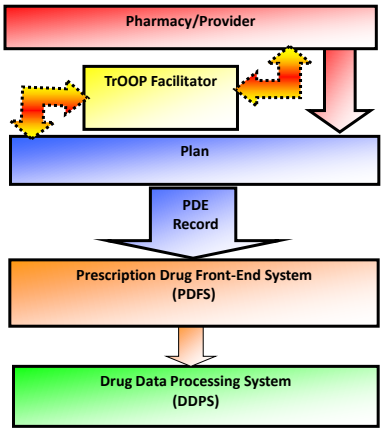
TIMELY SUBMISSION OF PDE RECORDS & RESOLUTION OF PDES

- Submit Original PDEs
  - within 30 days following Date Claim Received / Date of Service (whichever is greater)
- Resolve rejected records and re-submit
  - within 45 days following receipt of rejected record status from CMS
- Submit adjustments and deletions
  - within 45 days following discovery of issue requiring change

PLAN MONITORING

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

PDE PROCESS DATAFLOW FOR PART D PAYMENT RECONCILIATION

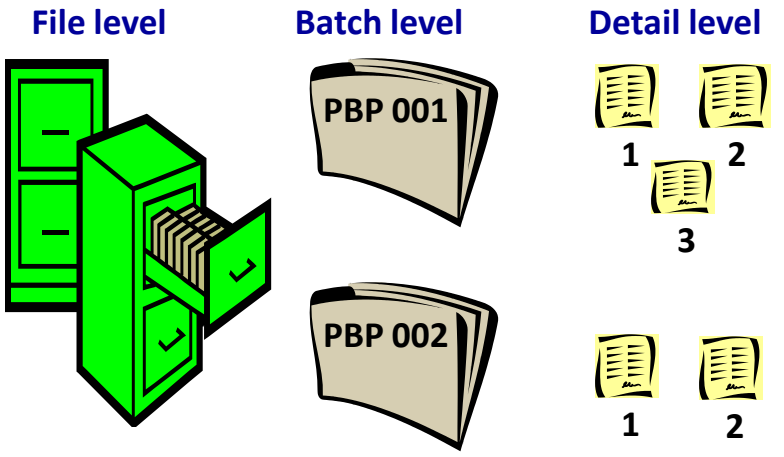


PDE RECORD LAYOUT LOGIC

File level information	Identifies the submitter
Batch level information	Identifies the contract/PBP
Detail level information	Identifies the beneficiary

PDE RECORD LAYOUT LOGIC

(CONTINUED)



CONTRACT IDENTIFICATION

Contract Number Enumeration

Plan Type	First Letter
Local MA-PD Plans	Begins with an “H”
Regional MA-PD Plans	Begins with an “R”
Prescription Drug Plans (PDP)	Begins with an “S”
LI-NET Contract	Begins with an “X”
Employer Group Waiver Plans (EGWP)	Begins with an “E”

PLAN IDENTIFICATION

Plan Benefit Package (PBP) ID

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

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

HICN

CMS Number → 111223334A

SSN **BIC**

RRB Pre 1964 → WA123456

Prefix **Random**

RRB Post 1964 → WA123456789

Prefix **SSN**

Dispensing Status

- DDPS no longer accepts any value for dates of service on or after January 1, 2011
- Plans should combine partial and complete claims and report a single PDE

EFFECTIVE 2012

- Prescriber ID Qualifier
- Prescriber ID

PDE IDENTIFIERS

- Paid Date
- Non-Standard Format Code
- Pricing Exception Code
- Date Original Claim Received
- Claim Adjudication Began Timestamp

BENEFIT DESIGN IDENTIFIERS

- Drug Coverage Status Code
- Catastrophic Coverage Code
- Beginning and Ending Benefit Phase
- Brand/Generic Code
- Tier
- Formulary Code

DRUG COVERAGE STATUS CODE

Drug Coverage Status Code

C = Covered

E = Enhanced

O = Over-the-Counter

DOLLAR FIELDS

COST	=	PAYMENT
Ingredient Cost Paid + Dispensing Fee Paid + Amount Attributed to Sales Tax + Vaccine Administration Fee		Sum of payment fields
GDCB + GDCA		Sum of payment fields for covered drugs

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

COST FIELDS

FIELD NUMBER	FIELD NAME
29	Ingredient Cost Paid
30	Dispensing Fee Paid
31	Amount Attributed to Sales Tax
41	Vaccine Administration Fee
	Populate GDCA and GDCB only for covered drugs
32	Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
33	Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)

PAYMENT FIELDS

FIELD NUMBER	FIELD NAME
34	Patient Pay Amount
35	Other TrOOP Amount
36	Low Income Cost-Sharing Subsidy (LICS) Amount
50	Reported Gap Discount
37	Patient Liability Reduction Due to Other Payer Amount (PLRO)
38	Covered D Plan Paid Amount (CPP)
39	Non-Covered Plan Paid Amount (NPP)

GAP DISCOUNT FIELDS

Effective 2011

FIELD NUMBER	FIELD NAME
50	Reported Gap Discount
53	Gap Discount Override Code

NON-STANDARD FORMAT

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 format	X
Standard Format (NCPDP)	<blank>

NON-STANDARD FORMAT

(CONTINUED)

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

MODIFYING PDE RECORDS

- Reasons for submitting an adjustment or deletion for a stored PDE include:
  - Beneficiary not picking up a prescription (Deletion)
  - Plan receives information about Other Health Insurance (OHI) payment (Adjustment)
  - Beneficiary is declared eligible for low-income assistance and benefits are retroactive (Adjustment)
  - A payment to the pharmacy was adjusted (Adjustment)
- Minimize the need to modify PDE records by initiating a lag between data collection and submission

MODIFYING PDE RECORDS

(CONTINUED)

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

MODIFYING PDE RECORDS

(CONTINUED)

- Adjustments will replace the current (active) record with an adjusted record
- Deletions will inactivate the current (active) record

SUMMARY

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

SUMMARY (CONTINUED)

- Identified the PDE fields added to implement provisions in the Affordable Care Act and to improve CMS' ability to evaluate data quality
- Modified a PDE record

Evaluation

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

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Calculating & Reporting the Basic Benefit

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

Define the basic benefit, the three types of basic plans, and illustrate how plans populate a PDE record for each type.

OBJECTIVES

- 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

OBJECTIVES (CONTINUED)

- 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

BASIC BENEFIT PLAN TYPES

- There are three Basic benefit plan types.
  - Defined Standard (DS)
  - Actuarially Equivalent (AE)
  - Basic Alternative (BA)
- Basic benefit only pays for drugs that:
  - meet a statutorily defined Part D drug
    - and
  - covered under a Part D plan's benefit package (PBP).

COVERED PART D DRUGS

- Eligible for coverage under a specific PBP
- A Part D drug approved under exceptions, transitions, grievances, appeals, and other coverage determination processes
- Applicable drugs covered under a signed Medicare CGDP agreement between CMS and the manufacturer

APPLICABLE DRUGS

- A covered Part D drug product that is approved or licensed by the FDA under a New Drug Application (NDA) or Biologic License Application (BLA).
- Supplemental drugs are not defined as applicable drugs.
- NDCs having labeler codes that are not covered by a signed Medicare CGDP Agreement are not eligible for coverage under Medicare Part D.

THE 2011 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$310	100%
Initial Coverage Phase	>$310 and ≤ $2,840	25%
Coverage Gap	>$2,840 and ≤ $6,483.72	93% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs
Catastrophic Coverage	>$6,483.72	Greater of 5% coinsurance or $2.50/$6.30 (generic/brand) co-payment

THE 2012 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$320	100%
Initial Coverage Phase	>$320 and ≤ $2,930	25%
Coverage Gap	>$2,930 and ≤ $6,730.39	86% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs
Catastrophic Coverage	>$6,730.39	Greater of 5% coinsurance or $2.60/$6.50 (generic/brand) co-payment

BASIC BENEFIT PLAN TYPES

Defined Standard (DS)	• Statutorily mandated cost sharing and benefit parameters that the plan sponsor cannot change (see Tables 4A-B)
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
Basic Alternative (BA) *	• Can reduce the deductible, lower or raise the initial coverage limit, and/or 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.

TIERED COST-SHARING

- Tiered cost-sharing is an alternate way to implement cost-sharing.
- Plans may deviate from the standard cost-sharing rates provided their proposed cost-sharing passes actuarial tests for being actuarially equivalent to the DS benefit.

EXAMPLE OF A TIERED BENEFIT

Tier	Cost-Sharing	Description/Drug Class
1	$5	Generic Drugs
2	$20	Preferred Brand Drugs
3	$40	All Other Brand Name Drugs
4	25%	Specialty Drugs

DATA ELEMENTS KEY TO BASIC BENEFIT

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

"C" = Covered Part D Drug

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

The dollar amount summing beneficiary's covered drug costs for benefit year known immediately before sponsor begins adjudication of individual claim.

<blank> = OTC or Enhanced drugs.

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

The dollar amount summing beneficiary's incurred costs for benefit year known immediately before sponsor begins adjudication of individual claim.

<blank> = OTC or Enhanced drugs.

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase →
Ending Benefit Phase →
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

D=Deductible
N=Initial Coverage Phase
G=Coverage Gap
C=Catastrophic

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB →
GDCA →
Patient Pay Amount
CPP
NPP
Reported Gap Discount

Gross Covered Drug Cost **below** the OOP threshold

Gross Covered Drug Cost **above** the OOP threshold

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

The dollar amount that a beneficiary paid.

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

The dollar amount the plan paid for the Basic benefit

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

The net amount paid by the plan for benefits beyond the Basic benefit

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
GDCB
GDCA
Patient Pay Amount
CPP
NPP
Reported Gap Discount

Reported amount sponsor advanced at POS for Gap Discount

Reported Gap Discount

STEP	DESCRIPTION
1	Determine costs that fall in the Coverage Gap
2	Determine Discount Eligible Cost
3	Calculate Gap Discount
4	Determine Beneficiary Cost-Sharing
5	Calculate Covered and Non-Covered Portion of Plan Paid Cost-Sharing
6	Update TGCDC and TrOOP Accumulators

THE 2012 DEFINED STANDARD BENEFIT

Deductible Phase	Initial Coverage Phase	Coverage Gap Phase	Catastrophic Coverage Phase
100%	25%	86% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs	Greater of 5% or $2.60/$6.50

THE "SIMPLEST" CASE

Understanding the simplest case of coverage will assist with understanding more complex benefit structures.

Characteristics:

- Not eligible for Low Income Cost-Sharing Subsidy
- No other source of coverage
- Enrolled in a Defined Standard plan

DS PLAN: DEDUCTIBLE PHASE

Scenario

In 2012, the beneficiary first purchase of the year is for a $100 covered drug in the Deductible Phase of the Defined Standard benefit.

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

COVERAGE GAP PHASE WITH REPORTED GAP DISCOUNT

Scenario

In 2012, the beneficiary purchased a $100 applicable drug, which includes a $2 dispensing fee. YTD Gross Covered Drug Cost is $3,500. The TrOOP accumulator is at $1,542.50. The Beginning and Ending Benefit phase indicators indicate the claim is in the Coverage Gap Phase of the Defined Standard benefit.

Step 1: Determine if the Costs Fall within the Coverage Gap

Cost falling within Coverage Gap:	$100.00

Step 2: Determine the Discount Eligible Cost

Cost falling within Coverage Gap:	$100.00
Dispensing Fee:	-$ 2.00
Discount Eligible Cost:	$ 98.00

COVERAGE GAP PHASE WITH REPORTED GAP DISCOUNT (CONTINUED)

Step 3: Calculate Gap Discount

	$ 98.00
x	.5
	$ 49.00

Step 4: Determine Beneficiary Cost-Sharing

	$ 100.00
	-$ 49.00
	$ 51.00

Step 5: Calculate Covered and Non-Covered Portion of Plan Paid Cost-Sharing

$ 0.00

Step 6: Update TGCDC and TrOOP Accumulators

TGCDC Accumulator:	$ 3,600.00
TrOOP Accumulator:	$ 1,642.50

COVERAGE GAP PHASE WITH REPORTED GAP DISCOUNT (CONTINUED)

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

COVERAGE FOR GENERIC DRUGS IN THE COVERAGE GAP

Scenario

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. The TrOOP Accumulator is at $1,542.50. The beneficiary purchases a $20 generic drug.

Step 1: Determine if the Costs Fall within the Coverage Gap

Cost falling within Coverage Gap:	$20.00

Step 2: Determine Beneficiary Cost-Sharing

Cost falling within Coverage Gap:	$20.00
Non-LI Beneficiary Cost-sharing	x .86
Beneficiary Cost-sharing in the Gap	$17.20

COVERAGE GAP PHASE WITH REPORTED GAP DISCOUNT (CONTINUED)

Step 3: Calculate Covered and Non-Covered Portion of Plan Paid Cost-Sharing

$ 20.00
x .14
$ 2.80

Step 4: Update TGCDC and TrOOP Accumulators

TGCDC Accumulator: $ 3,520.00
TrOOP Accumulator: $ 1,559.70

COVERAGE GAP PHASE WITH REPORTED GAP DISCOUNT (CONTINUED)

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

DS PLAN: CATASTROPHIC PHASE

Scenario

2012 YTD TrOOP = $4,700 and YTD gross covered drugs of $7,300.
The beneficiary purchased a $75 brand name covered drug.

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

OVER-THE-COUNTER (OTC) DRUGS

- Basic plans may only cover an OTC drug if it is part of the step therapy on an approved formulary.
- Plans must submit a PDE record.
- OTC drugs are paid for under plan administrative costs.
  - OTC drugs are excluded from all Part D payment calculations.
  - NPP field reports OTC payment.
- Plans may not charge the beneficiary.
- Drug Coverage Status code = “O”

DS PLAN: OTC DRUG

Scenario

2012 YTD gross covered drug cost = $300. The beneficiary purchased a $15.00 OTC drug used in step therapy.

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

EXAMPLE OF A TIERED BENEFIT

Tier	Cost-Sharing	Description/Drug Class
1	$5	Generic Drugs
2	$20	Preferred Brand Drugs
3	$40	All Other Brand Name Drugs
4	25%	Specialty Drugs

AE PLAN: INITIAL COVERAGE PHASE

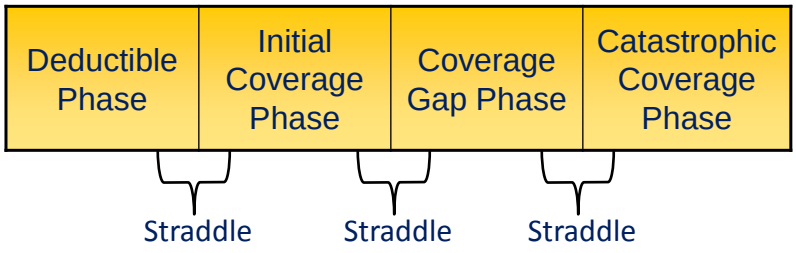
Scenario

YTD gross covered drug cost = $400 in a AE plan. The TrOOP Accumulator is at $340. The beneficiary purchased a $100 covered drug in Tier 2.

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

STRADDLE CLAIMS

Cross one phase of the benefit to another phase of the benefit



DS 2012: COVERAGE GAP (with COVERAGE GAP DISCOUNT) TO CATASTROPHIC COVERAGE PHASE

Scenario

2012 YTD TrOOP is $4,650 and YTD Gross Covered Drug Costs is $6,680.39. The beneficiary purchased a $150 covered brand name drug, which includes a $5 dispensing fee.

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

Step 3: Total the two phases and populate the PDE record

DS 2012: COVERAGE GAP (with COVERAGE GAP DISCOUNT) TO CATASTROPHIC COVERAGE PHASE (CONTINUED)

Results - Calculation

	Coverage Gap	Catastrophic Coverage	PDE
Drug Coverage Status Code			C
TGCDC Accumulator			$ 6,680.39
TrOOP Accumulator			$ 4,650.00
Beginning Benefit Phase			G
Ending Benefit Phase			C
GDCB	$ 50.00	$ 0.00	$ 50.00
GDCA	$ 0.00	$ 100.00	$ 100.00
Patient Pay Amount	$ 25.00	$ 6.50	$ 31.50
CPP	$ 0.00	$ 93.50	$ 93.50
Reported Gap Discount	$ 25.00	$ 0.00	$ 25.00

DS 2012: STRADDLE OF DEDUCTIBLE THROUGH CATASTROPHIC COVERAGE PHASE

Scenario

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 and the TrOOP Accumulator is at $250. The beneficiary purchases a $7,000 applicable drug, which includes a $10 dispensing fee.

Result

Step 1: Calculate the first phase (Deductible)
Step 2: Calculate the second phase (Initial Coverage)
Step 3: Calculate the third phase (Coverage Gap)
Step 4: Calculate the fourth phase (Catastrophic Coverage)
Step 5: Total the four phases and populate the PDE record

DS 2012: STRADDLE OF DEDUCTIBLE THROUGH CATASTROPHIC COVERAGE PHASE (CONTINUED)

Results - Calculation

	Deductible	Initial Coverage	Coverage Gap	Catastrophic Coverage
Drug Coverage Status Code				
TGCDC Accumulator				
TrOOP Accumulator				
Beginning Benefit Phase				
Ending Benefit Phase				
GDCB	$ 70.00	$ 2,610.00	$ 3,800.39	$ 0.00
GDCA	$ 0.00	$ 0.00	$ 0.00	$ 519.61
Patient Pay Amount	$ 70.00	$ 652.50	$ 1,900.19	$ 25.98
CPP	$ 0.00	$ 1,957.50	$ 0.00	$ 493.63
Reported Gap Discount	$ 0.00	$ 0.00	$ 1,900.20	$ 0.00

DS 2012: STRADDLE OF DEDUCTIBLE THROUGH CATASTROPHIC COVERAGE PHASE (CONTINUED)

	PDE
Drug Coverage Status Code	C
TGCDC Accumulator	$ 250.00
TrOOP Accumulator	$ 250.00
Beginning Benefit Phase	D
Ending Benefit Phase	C
GDCB	$ 6,480.39
GDCA	$ 519.61
Patient Pay Amount	$ 2,648.67
CPP	$ 2,451.13
Reported Gap Discount	$ 1,900.20

TIERED COST-SHARING STRADDLE CLAIMS

The beneficiary *cannot pay* more than the negotiated price of the drug.

Patient Pay

≤

Negotiated Drug Cost

BA PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PHASE

Scenario

In 2012, the beneficiary is enrolled in a BA plan with a $200 deductible and tiered cost sharing in the Initial Coverage Phase. The TGCDC Accumulator is $170 and the TrOOP Accumulator is $170. The beneficiary purchases a $100 covered drug that falls under Tier 3 of the co-pay structure.

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

Step 3: Total the two phases and populate the PDE record

BA 2012: PATIENT PAY AMOUNT LESS THAN NEGOTIATED PRICE

Results - Calculation

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

AE PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PHASE

Scenario

YTD gross covered drug cost = $245. The beneficiary purchased a $100 negotiated price covered drug in Tier 3. The TrOOP Accumulator is $245.

Result

Step 1: Calculate the first phase.

Step 2: Calculate the second phase.

Step 3: Total the two phases and populate the PDE record.

AE 2012: TOTAL PATIENT PAY AMOUNT

Results - Calculation

	Deductible Phase	Initial Coverage Phase	PDE
Drug Coverage Status Code			C
TGCDC Accumulator			$ 245.00
TrOOP Accumulator			$ 245.00
Beginning Benefit Phase			D
Ending Benefit Phase			N
GDCB	$ 75.00	$ 25.00	$ 100.00
GDCA	$ 0.00	$ 0.00	$ 0.00
Patient Pay Amount	$ 75.00	$ 25.00	$ 100.00
CPP	$ 0.00	$ 0.00	$ 0.00
Reported Gap Discount	$ 0.00	$ 0.00	$ 0.00

Adjustments/Deletions

KEY FIELDS

The following fields are used to identify the current active record:

- HICN
- Service Provider
- Service Provider ID Qualifier
- Prescription/Service Reference Number
- Date of Service
- Fill Number
- Dispensing Status
- **Contract Number**
- **PBP ID**

ADJUSTMENT/DELETION CODE DEFINITIONS

Code	Description
(blank)	Original PDE record
A	Adjust PDE record
D	Delete PDE record

SITUATIONS THAT MAY CAUSE ADJUSTMENTS AND DELETIONS

- Reversal
  - Deletes the billing transaction it reverses
- Re-adjudication
  - Changes the total amount paid to the pharmacy
- Re-calculation
  - Corrects beneficiary cost-sharing

REVERSALS WITH NO SUBSEQUENT CLAIMS

- Reversals with no benefit phase change impact the following:
  - Benefit Administration
    - TGCDC Accumulator
    - TrOOP Accumulator
  - PDE Reporting

REVERSALS WITH SUBSEQUENT CLAIMS

- Reversals with benefit phase change impact the following:
  - Benefit Administration
    - Update accumulators
    - Pay back benefit
      - Apply cost-sharing difference on future claims
      - Recalculate affected claims/settle with beneficiary
  - PDE Reporting (two options)
    - Report as administered
    - Report as adjusted

PDE REPORTING "AS ADMINISTERED"/"AS ADJUSTED"

Reporting as Administered	Reporting as Adjusted
• Document the actual beneficiary cost-sharing applied at POS • PDEs will "appear" non-sequential throughout the year • No requirement to adjust saved PDEs	• Report recalculated beneficiary cost-sharing • Submit adjustment PDEs reporting the recalculated cost-sharing (only for saved PDEs) • Plans must use this method when: – LICS is involved – Reversal is reported after the end of the benefit year – Following disenrollment

REVERSALS WITH SUBSEQUENT CLAIMS SCENARIO

- Beneficiary:
- Enrolled in BA plan ($175 deductible)
- Purchases three covered drugs
  - January 10 - $100 drug, filled by pharmacy and billed to plan
  - January 15 - $75 drug (deductible satisfied)
  - January 20 - $100 drug, $30 co-pay
    - Adjudicates claim in Initial Coverage Phase
- Reversal – January 21
  - Pharmacy reverses January 10 claim (prescription not picked up) and refunds plan

ADJUSTMENTS IMPACTING STRADDLE CLAIMS

- Pay back amount is portion of the total claim cost
- Straddle claim logic applies

Note: DO NOT simplify calculations for pay back claims by applying cost-sharing from one benefit phase only.

SUMMARY

- Explained the characteristics of the "Basic Benefit" and the three types of Basic Benefit plans
- Illustrated how the Defined Standard benefit is the foundation of all other basic benefit plans
- Defined covered and non-covered drugs

SUMMARY (CONTINUED)

- Applied business rules associated with calculating PDE data elements that reflect the administration of the benefit design
- Described how plans populate a PDE record with data essential for payment
- Demonstrated how to modify PDE data and apply Adjustment/Deletion logic

Evaluation

Please take a moment to complete the evaluation form for the Basic Benefit module.

Your Feedback is Important! Thank you!

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Calculating & Reporting TGCDC and TrOOP

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

To understand the process and requirements related to reporting and administering True Out-of-Pocket (TrOOP), Total Gross Covered Drug Cost (TGCDC), and the benefit phases.

OBJECTIVES

- Define TrOOP costs
- List why TrOOP accounting is important
- Classify payments
- Describe how to administer the Part D benefit with respect to accumulating and reporting TrOOP

OBJECTIVES (CONTINUED)

- Illustrate how to populate a PDE with TrOOP
- Describe how to populate the TGCDC and TrOOP Accumulators and the Beginning and Ending Benefit Phase Indicators on the PDE
- Identify two methods for administering the benefit and reporting retroactive TrOOP changes in PDEs

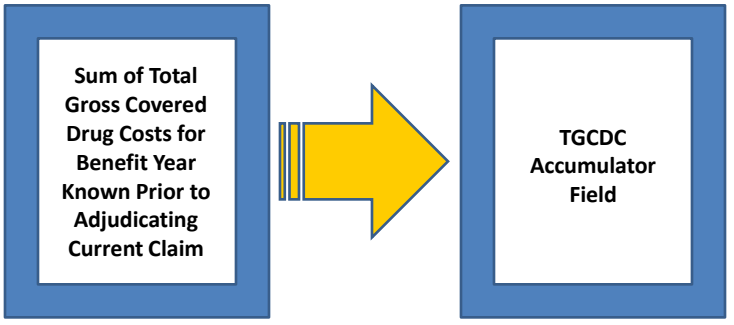
GROSS COVERED DRUG COST

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

REPORTING GROSS COVERED DRUG COST

- Fields for reporting Gross Covered Drug Cost include:
  - Ingredient Cost Paid
  - Dispensing Fee Paid
  - Amount Attributed to Sales Tax
  - Vaccine Administration Fee
  - GDCA and/or GDCB

TOTAL GROSS COVERED DRUG COST (TGCDC) ACCUMULATOR



TGCDC ACCUMULATOR

- Identifies the phase the beneficiary is in:
  - Deductible Phase
  - Initial Coverage Phase
  - Coverage Gap Phase
- Used in conjunction with:
  - TrOOP Accumulator
  - Beginning Benefit Phase Indicator
  - Ending Benefit Phase Indicator
- Field must be left <blank> for OTC or Enhanced Drugs

BEGINNING AND ENDING BENEFIT PHASE INDICATORS

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

THE "SIMPLEST" CASE

Understanding the simplest case of coverage will assist with understanding more complex benefit structures.

Characteristics:

- No Low Income Cost-Sharing Subsidy
  - Income above 150% of the FPL and has met certain asset tests.
- No OHI or other source of coverage
- Enrolled in a Part D plan with a DS benefit design

REPORTING BENEFIT PHASE - DEDUCTIBLE

Scenario

Beneficiary purchases first covered drug of the benefit year for $100.

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

REPORTING BENEFIT PHASE - STRADDLE CLAIM

Scenario

Beneficiary now purchases their second covered drug of the benefit year for $250.

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

THE IMPORTANCE OF TrOOP

Reasons Why TrOOP is Important

1. The beneficiary is subject to lower cost-sharing.

2. The plan is eligible to receive 80% reinsurance subsidy

3. The beneficiary is no longer in the Coverage Gap and no longer eligible to receive the gap discount at POS.

TRACKING TrOOP

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.

TrOOP

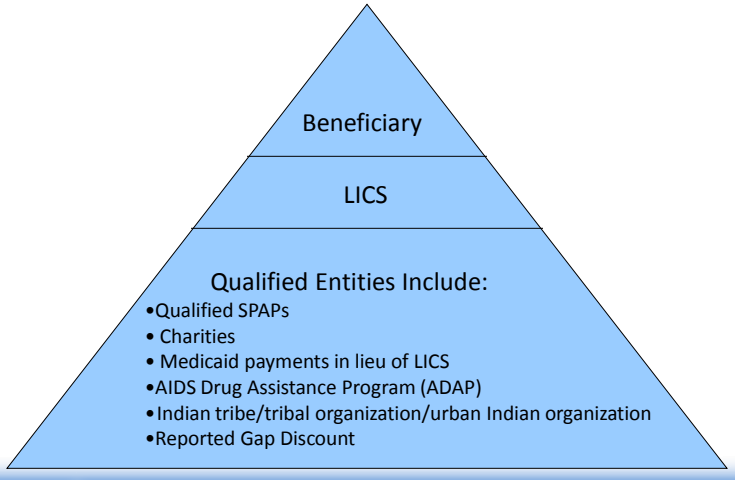
TrOOP is defined as **incurred allowable costs** for **covered Part D drugs** that are paid by the **beneficiary** or by **specified third parties on the beneficiary's behalf** up to a legislatively specified **OOP threshold** per coverage year.

TrOOP is set at $4,550 for 2011.

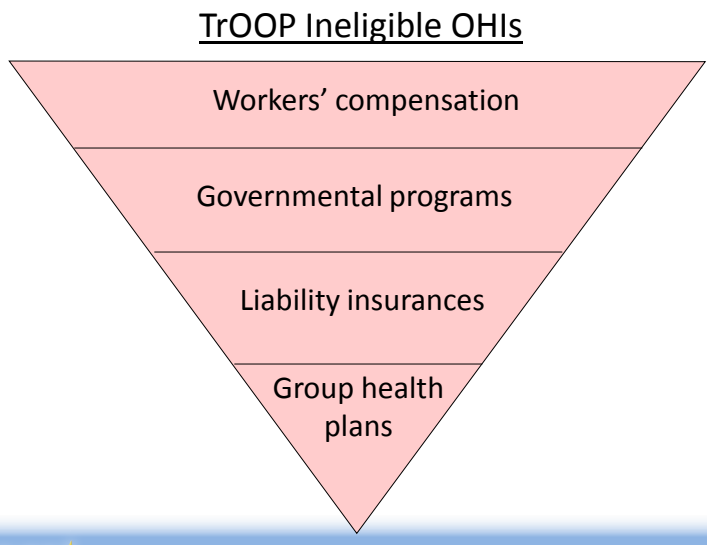
$4,700 for 2012.

CONTRIBUTORS TO TrOOP

TrOOP Eligible



NON-CONTRIBUTORS TO TrOOP



PDE DATA ELEMENTS

- Identify cost included and excluded from TrOOP and/or payment
- Data elements most relevant to TrOOP accounting:
  - Drug Coverage Status Code
  - Catastrophic Coverage Code
    - Prior to and including the 2010 benefit year
  - Seven payment fields
  - TrOOP Accumulator
  - Beginning and Ending Benefit Phase Indicators

PDE RECORD – PAYMENT FIELDS

Patient Pay Amount
Other TrOOP Amount
LICS
Reported Gap Discount
PLRO
CPP
NPP

- Beneficiary
- Family and Friends

Included in TrOOP

PDE RECORD – PAYMENT FIELDS
(CONTINUED)

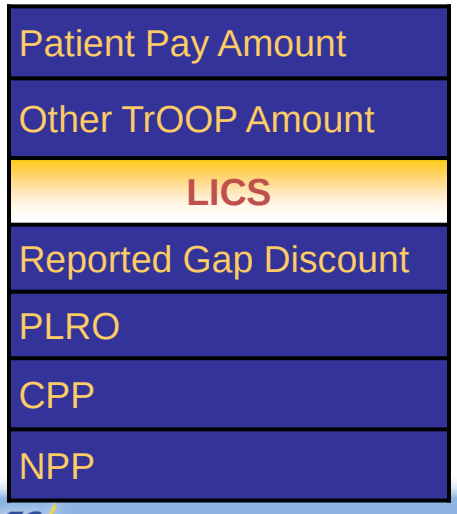
Patient Pay Amount
Other TrOOP Amount
LICS
Reported Gap Discount
PLRO
CPP
NPP

- Qualified SPAPs
- Charities
- Territories' 1860D-42(a) Payments
- ADAP
- Indian Tribe/Tribal Organization

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

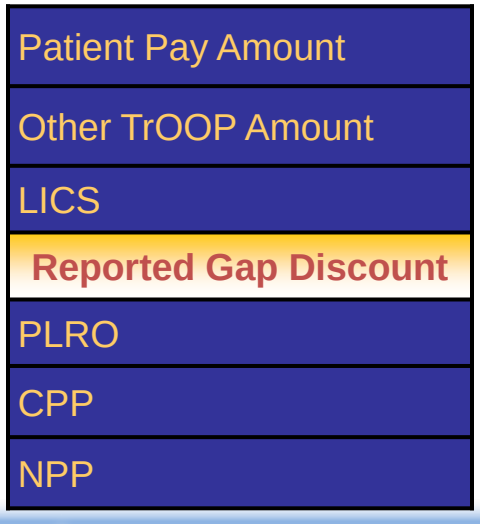


- Low Income Cost-Sharing Subsidy Amounts

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)



- Amounts advanced at POS by plan on behalf of manufacturer

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

- Patient Pay Amount
- Other TrOOP Amount
- LICS
- Reported Gap Discount
- **PLRO**
- CPP
- NPP

Excluded from TrOOP

- Non-TrOOP Third Party Payments

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

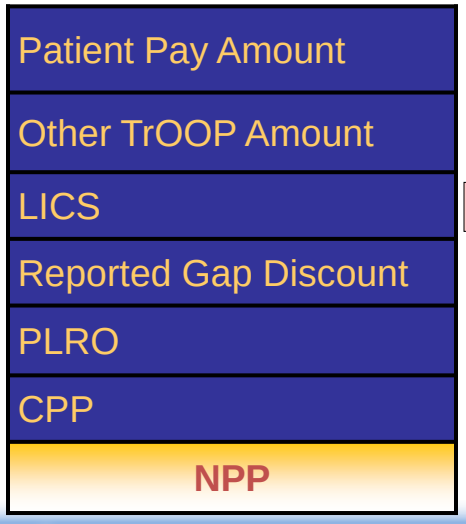
- Patient Pay Amount
- Other TrOOP Amount
- LICS
- Reported Gap Discount
- PLRO
- **CPP**
- NPP

Excluded from TrOOP

- Plan paid amounts attributed to the Basic benefit (covered drugs)

PDE RECORD – PAYMENT FIELDS

(CONTINUED)



Excluded from TrOOP

- Plan paid amounts attributed to supplemental or enhanced benefits (non-covered drugs)

TrOOP Accumulator

- Reports and identifies the sum of the beneficiary's incurred costs for the benefit year known immediately before the sponsor begins adjudication for an individual claim
- Indicates whether the beneficiary is in Catastrophic Coverage or is pre-catastrophic
- Blank for OTC and Enhanced PDEs

CALCULATING TrOOP COSTS

Step 4: Change the amounts in the TrOOP Accumulator

Step 3: Report the amount actually paid by the beneficiary in the Patient Pay Amount field

Step 2: Identify/report if the change is an Other TrOOP or a PLRO amount

Step 1: Identify the net **change** in the Patient Pay Amount between original claim and TrOOP Facilitator amount

STEPS TO CALCULATE TrOOP COSTS

Scenario

Beneficiary is in the Initial Coverage Phase of the Defined Standard benefit and purchases a $100 covered drug. Prior to adjudication of the claim, the beneficiary has $345 in accumulated TrOOP and $420 in accumulated gross covered drug costs. The original Patient Pay Amount is $25. The TrOOP Facilitator reported a Patient Pay Amount of $10 with a secondary insurance paying the difference.

Result

Step 1: Identify the net change in Patient Pay Amount
Step 2: Identify/report if the change is an Other TrOOP or a PLRO amount
Step 3: Report the amount actually paid by the beneficiary in the Patient Pay Amount
Step 4: Update the TrOOP Accumulator

STEPS TO CALCULATE TrOOP COSTS
(CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

$25 (Original Patient Pay Amount)
- $10 (TrOOP Facilitator reported Patient Pay Amount)
$15 (Net Change in Patient Pay Amount)

STEPS TO CALCULATE TrOOP COSTS
(CONTINUED)

Step 2: Identify/report if the change is an Other TrOOP or a PLRO amount

Non-TrOOP OHI = **PLRO field**

PLRO	$15

STEPS TO CALCULATE TROOP COSTS
(CONTINUED)

Step 3: Report the amount actually paid by the beneficiary in the Patient Pay Amount

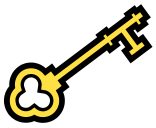
Patient Pay Amount	$10

STEPS TO CALCULATE TROOP COSTS
(CONTINUED)

Step 4: Change amounts in the TrOOP Accumulator

PLRO field amounts are not TrOOP eligible.

$25 (Original TrOOP amount)
-$15 (Changes in TrOOP amount)
+$10 (Amount reported in the TrOOP Accumulator)



KEY POINT

Non-TrOOP OHI payment reported in Patient Pay Amount field would overstate TrOOP.

PDE FIELDS AND TrOOP

Drug Coverage Status Code
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
Patient Pay Amount
Other TrOOP Amount
LICS
Reported Gap Discount
PLRO
CPP
NPP

Scenario-TrOOP ELIGIBLE OHI

The beneficiary is in the Initial Coverage Phase of the Defined Standard benefit for CY2012.

Prior to 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% coinsurance, or $25. A qualified SPAP reduced the beneficiary's cost-share to $5.

TrOOP ELIGIBLE OHI (CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

$25	(Original Patient Pay Amount)
- $ 5	(TrOOP Facilitator reported Patient Pay Amount)
$ 20	**(Net change in Patient Pay Amount)**

TrOOP ELIGIBLE OHI (CONTINUED)

Step 2: Identify/report if the change is an Other TrOOP or a PLRO amount

Other TrOOP Amount	$ 20

Step 3: Report the amount actually paid by the beneficiary in the Patient Pay Amount field

Patient Pay Amount	$ 5

TrOOP ELIGIBLE OHI (CONTINUED)

Step 4: Change the amount in the TrOOP Accumulator

Other TrOOP amount field is TrOOP eligible.

TrOOP Accumulator	+$25

TrOOP ELIGIBLE OHI (CONTINUED)

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

TrOOP ELIGIBLE OHI (CONTINUED)

Updating the Accumulators and Benefit Phases for the next PDE

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

Adjustments/Deletions

ADJUSTMENT/DELETION PROCESSING AND TrOOP

The same general principles apply to reversals affecting claims in another benefit phase with two major differences specific to catastrophic benefit administration.

1. Only TrOOP moves the beneficiary into the Catastrophic phase of the benefit
2. Plans do not increment TrOOP balances beyond $4,700 (in 2012)
   - TrOOP accumulation is a pre-catastrophic activity to satisfy the pre-requisite to receive catastrophic benefits

REVERSAL WITH NO BENEFIT PHASE CHANGE – CATASTROPHIC BENEFIT PHASE

Beneficiary:

- Enrolled in DS plan and was in Catastrophic Phase
- Purchases three covered drugs
  - August 10 - $100 brand name drug, filled by pharmacy and billed to plan
  - August 15 - $75 brand drug
  - August 20 - $50 brand drug
- Reversal – August 21
  - Pharmacy reverses August 10 claim (prescription not picked up) and refunds plan

REVERSAL WITH NO BENEFIT PHASE CHANGE – CATASTROPHIC BENEFIT PHASE (CONTINUED)

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				$6,800.00	$4,700.00
August 10	$100.00	$6.50	$0.00	$6,800.00	$4,700.00
August 15	$ 75.00	$6.50	$0.00	$6,900.00	$4,700.00
August 20	$ 50.00	$6.50	$0.00	$6,975.00	$4,700.00
Balance after the August 20 claim				$7,025.00	$4,700.00
August 10 reversal (effective August 21)	<$100.00>	<$6.50>	$0.00		
Balance after reversal on August 21				$6,925.00	$4,700.00

REVERSALS WITH BENEFIT PHASE CHANGE – CATASTROPHIC AND THE COVERAGE GAP

- Reversals with benefit phase change impact the following:
  - Benefit Administration
    - Update Accumulators
    - Pay back benefit
      - Apply cost-sharing difference on future claims
        or
      - Recalculate affected claims/settle with beneficiary
  - PDE Reporting (two options)
    - Report as administered
    - Report as adjusted

PAYING BACK THE BENEFIT ON FUTURE CLAIMS (AND REPORTING PDEs "AS ADMINISTERED")

Beneficiary:

- Enrolled in DS plan and will be entering the Catastrophic Phase
- Purchases three covered drugs
  - August 10 - $100 name drug, filled by pharmacy and billed to plan
  - August 15 - $100 drug
  - August 20 - $100 drug
- Reversal – August 21
  - Pharmacy reverses August 10 claim (prescription not picked up) and refunds plan
- Purchases
  - August 25 - $100 drug
  - August 30 - $100 drug
- Plan will recover the $100 by paying back the benefit on future claims and reporting PDEs "as administered), which will restore the TrOOP balance to $4,700 and the beneficiary will reenter the Catastrophic phase of the benefit

PAYING BACK THE BENEFIT ON FUTURE CLAIMS (AND REPORTING PDEs "AS ADMINISTERED")
(CONTINUED)

Claim Date	Current Claim				Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator
Balance before the August 10 claim					$6,700.00	$4,600.00
August 10	$100.00	$ 50.00	$50.00	$100.00	$6,700.00	$4,600.00
August 15	$100.00	$ 6.50	$ 0.00	$ 0.00	$6,800.00	$4,700.00
August 20	$100.00	$ 6.50	$ 0.00	$ 0.00	$6,900.00	$4,700.00
August 10 reversal (effective August 21)	<$100.00>	<$50.00>	<$50.00>	<$100.00>		
Balance after the reversal on August 20					$6,800.00	$4,600.00
August 25	$100.00	$50.00	$50.00	$100.00	$6,800.00	$4,600.00
August 30	$100.00	$ 6.50	$ 0.00	$ 0.00	$6,900.00	$4,700.00

PAYING BACK THE BENEFIT ON FUTURE CLAIMS (AND REPORTING PDEs "AS ADMINISTERED")
(CONTINUED)

Claim Date	PDE Data Elements	
	GDCB	GDCA
Balance before the August 10 claim		
August 10	$100.00	$ 0.00
August 15	$ 0.00	$100.00
August 20	$ 0.00	$100.00
August 10 reversal (effective August 21)	N/A	
August 25	$100.00	$ 0.00
August 30	$ 0.00	$100.00

PAYING BACK THE BENEFIT BY RECALCULATING CLAIMS (AND REPORTING PDEs "AS ADJUSTED")

Claim Date	Current Claim				Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	Reported Gap Discount	Change in TrOOP	TGCDC Accumulator	TrOOP Accumulator
Balance before the August 10 claim					$6,700.00	$4,600.00
August 10	~~$100.00~~ $0.00	~~$50.00~~ $0.00	~~$50.00~~ $0.00	~~$100.00~~ $0.00	$6,700.00	$4,600.00
August 15	$100.00	~~$6.50~~ $50.00	~~$0.00~~ $50.00	$0.00 $100.00	~~$6,800.00~~ $6,700.00	$4,700.00
August 20	$100.00	$6.50	$0.00	$0.00	~~$6,900.00~~ $6,800.00	$4,700.00
August 25	$100.00	$6.50	$0.00	$0.00	$6,900.00	$4,700.00
August 30	$100.00	$6.50	$0.00	$0.00	$7,000.00	$4,700.00

PAYING BACK THE BENEFIT BY RECALCULATING CLAIMS (AND REPORTING PDEs "AS ADJUSTED") (CONTINUED)

Claim Date	PDE Data Elements	
	GDCB	GDCA
Balance before the August 10 claim		
August 10	$100.00	$ 0.00
August 15	~~$ 0.00~~ $100.00	~~$100.00~~ $ 0.00
August 20	$ 0.00	$100.00
August 25	$ 0.00	$100.00
August 30	$ 0.00	$100.00

COMPARISON OF BENEFIT ADMINISTRATION: PAY BACK BENEFIT IN FUTURE CLAIM VERSUS RECALCULATED CLAIM

Benefit Administration Approach	Future claim (Table 5N)	Recalculated Claim (Table 5P)
August 15 claim	Catastrophic Phase Plan pays $93.50 Beneficiary pays $ 6.50	Coverage Gap Plan pays $50.00 Beneficiary pays $50.00
August 25 claim	Coverage Gap Plan pays $50.00 Beneficiary pays $50.00	Catastrophic Phase Plan pays $93.50 Beneficiary pays $ 6.50

SUMMARY

- Defined TrOOP costs
- Listed why TrOOP accounting is important
- Classified payments
- Described how to administer the Part D benefit with respect to accumulating and reporting TrOOP

SUMMARY (CONTINUED)

- Illustrated how to populate a PDE with TrOOP
- Described how to populate the TGCDC and TrOOP Accumulators and the Beginning and Ending Benefit Phase Indicators on the PDE
- Identified two methods for administering the benefit and reporting retroactive TrOOP changes in PDEs

Evaluation

Please take a moment to complete the evaluation form for the TGCDC and TrOOP module.

Your Feedback is Important! Thank you!

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Calculating & Reporting Low Income Cost-Sharing Subsidy

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

To describe the Low Income Cost-Sharing Subsidy (LICS) and the process for calculating and reporting LICS payments via PDE record submissions.

OBJECTIVES

- Define 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 PDE data fields required to report LICS payments
- Explain how LICS affects TrOOP

LICS DEFINED

- Federal subsidy that reduces or eliminates Out-of-Pocket costs for beneficiaries
- Administered by plans at POS using prospective LICS payments from CMS
- Reconciled by CMS according to data submitted on PDE records

LICS RULES

- Only applies to covered Part D drugs
- Always counts toward TrOOP
- Beneficiaries have continuous coverage except for the Category 4 deductible

LOW INCOME COST-SHARING SUBSIDY

2011 LICS Categories Maximum LI Beneficiary Cost-Sharing				
Copay Category	**Deductible**	**Initial Coverage**	**Coverage Gap**	**Catastrophic**
2	$ 0	$1.10 generic $3.30 brand	$1.10 generic $3.30 brand	$0
1	$ 0	$2.50 generic $6.30 brand	$2.50 generic $6.30 brand	$0
4	$63	15%	15%	$2.50 generic $6.30 brand
3	$ 0	$0	$0	$0

LI beneficiaries typically have continuous coverage and only two phases of cost-sharing.

LOW INCOME COST-SHARING SUBSIDY (CONTINUED)

2012 LICS Categories Maximum LI Beneficiary Cost-Sharing				
Copay Category	**Deductible**	**Initial Coverage**	**Coverage Gap**	**Catastrophic**
2	$ 0	$1.10 generic $3.30 brand	$1.10 generic $3.30 brand	$0
1	$ 0	$2.60 generic $6.50 brand	$2.60 generic $6.50 brand	$0
4	$65	15%	15%	$2.60 generic $6.50 brand
3	$ 0	$0	$0	$0

LI beneficiaries typically have continuous coverage and only two phases of cost-sharing.

LICS AMOUNT FORMULA

Formula: LICS Amount = Non-LI beneficiary cost-sharing – LI beneficiary cost-sharing

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

- 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).

LICS AMOUNT FORMULA

(CONTINUED)

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

*When Non-LI Cost Sharing ≤ LI cost sharing, then the non-LI Cost Sharing is applied to the LI beneficiary and LICS Amount = 0

LICS CALCULATION STEPS

Scenario

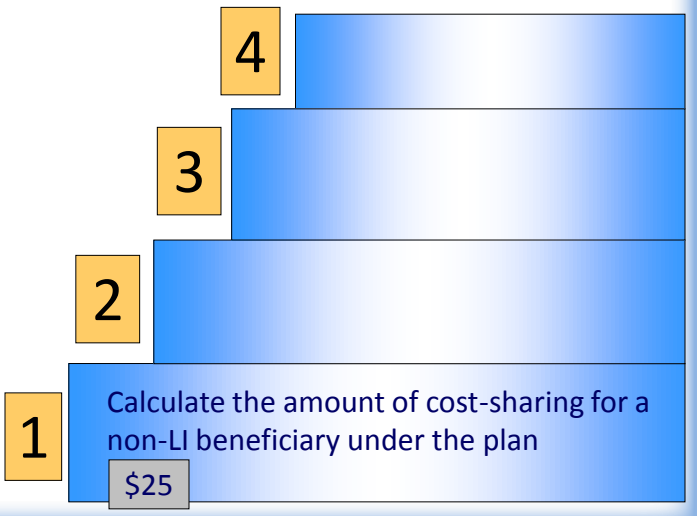
In 2012, NCE Health Plan offers a Defined Standard benefit package to beneficiaries.

A LI-Category 1 beneficiary enrolled in the plan has YTD gross covered drug costs of $1,500.

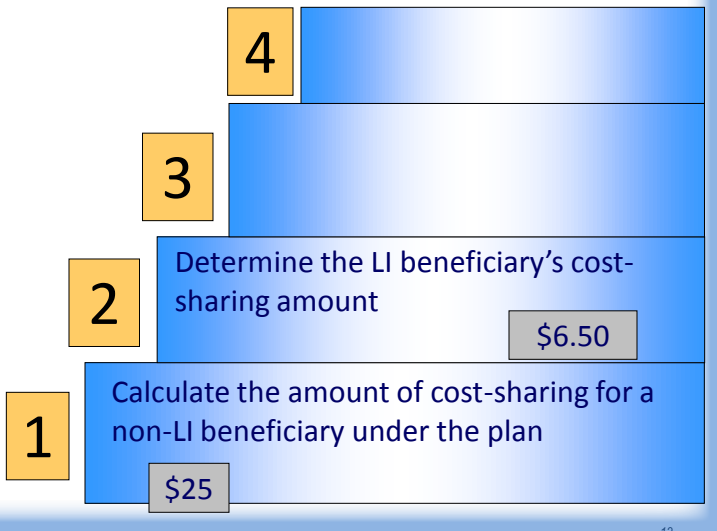
The beneficiary has no other health insurance and is not eligible for charitable or qualified SPAP assistance.

The beneficiary purchases a brand name covered Part D drug for $100.

LICS CALCULATION STEPS
(CONTINUED)



LICS CALCULATION STEPS
(CONTINUED)



LICS CALCULATION STEPS
(CONTINUED)

4

3 Compare non-LI and LI cost-sharing and apply "lesser of" test
$25 > $6.50

2 Determine the LI beneficiary's cost-sharing amount
$6.50

1 Calculate the amount of cost-sharing for a non-LI beneficiary under the plan
$25

LICS CALCULATION STEPS
(CONTINUED)

4 Use the LICS Amount formula
$25- $6.50= $18.50

3 Compare non-LI and LI cost-sharing and apply "lesser of" test
$25 > $6.50

2 Determine the LI beneficiary's cost-sharing amount
$6.50

1 Calculate the amount of cost-sharing for a non-LI beneficiary under the plan
$25

POPULATING THE PDE RECORD

Drug Coverage Status Code
GDCB
GDCA
TGCDC Accumulator
TrOOP Accumulator
Beginning Benefit Phase
Ending Benefit Phase
Patient Pay Amount
LICS Amount
CPP
NPP
Other TrOOP Amount
Adjustment/Deletion

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PHASE

Scenario

In 2012, 3J Prescription Benefit Plan offers an actuarially equivalent standard benefit package with tiered cost-sharing (5%/25%/30%). The beneficiary purchases a Tier 1 generic covered Part D drug for $5.

The beneficiary is eligible for Category 1 of the LICS and has a YTD gross covered drug costs is $500 and the TrOOP Accumulator is $365.

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PHASE (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:

$5 x .05 = $0.25

Step 2: Determine the LI cost share:

$2.60

Step 3: Apply the "Lesser of" Test:

$0.25 < $2.60

Step 4: Use the LICS Amount formula:

$0.25 – $0.25 = $0.00

Drug Coverage Status Code	
TGCDC Accumulator	
TrOOP Accumulator	
Beginning Benefit Phase	
Ending Benefit Phase	
Patient Pay Amount	$ 0.25
LICS Amount	$ 0.00
CPP	
Ending Benefit Phase	

Drug Coverage Status Code	C
GDCB	$5.00
GDCA	$0.00
TGCDC Accumulator	$500.00
TrOOP Accumulator	$365.00
Beginning Benefit Phase	N
Ending Benefit Phase	N
Patient Pay Amount	$0.25
LICS Amount	$0.00
CPP	$4.75

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PHASE (CONTINUED)

Populating the PDE Record

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER

Scenario

In 2012, Sunny Valley Health Plan offers a Defined Standard benefit.

A LI-Category 4 eligible beneficiary with YTD gross covered drug costs of $3,000 purchases a covered brand drug for $300. TrOOP Accumulator is $1,042.

A qualified SPAP pays 100% of the beneficiary cost-sharing.

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

Result

Step1: Calculate the non-LI cost share:
100% coinsurance = $300

Step 2: Determine the LI cost share:
$300 x .15 = $45

Step 3: Apply the "Lesser of " Test:
$45 < $300

Step 4: Use the LICS Amount formula:
$300 - $45 = $255

Drug Coverage Status Code	
GDCB	
GDCA	
TGCDC Accumulator	
TrOOP Accumulator	
Patient Pay Amount	$45.00
CPP	
LICS Amount	$255.00
Other TrOOP Amount	

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

A qualified SPAP pays 100% of the beneficiary cost-sharing

Drug Coverage Status Code	
GDCB	
GDCA	
TGCDC Accumulator	
TrOOP Accumulator	
Patient Pay Amount	$ 0.00
CPP	
LICS Amount	$255.00
Other TrOOP Amount	$ 45.00

Drug Coverage Status Code	C
GDCB	$300.00
GDCA	$ 0.00
TGCDC Accumulator	$3,000.00
TrOOP Accumulator	$1,042.00
Beginning Benefit Phase	G
Ending Benefit Phase	G
Patient Pay Amount	$ 0.00
LICS Amount	$255.00
CPP	$ 0.00
Other TrOOP Amount	$ 45.00
Reported Gap Discount	$ 0.00

DS COVERAGE GAP (TrOOP OTHER PAYER) (CONTINUED)

Populating the PDE Record

LICS AND STRADDLE CLAIMS

- For non-LI beneficiaries – calculate the Patient Pay Amount using rules for straddle claims.
- All low income beneficiaries (except institutional) experience straddle claims when moving from the Coverage Gap phase to the Catastrophic Coverage phase.
- LI-Category 4 beneficiaries may also experience straddle claims when moving from the Deductible phase to the Initial Coverage phase.

CATEGORY 4 LICS BENEFICARY, PLAN DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT

Scenario

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.

CATEGORY 4 LICS BENEFICARY, PLAN DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT (CONTINUED)

Result – Claim 1

Step 1: Calculate the non-LI cost share:
$100.00

Step 2: Determine the LI cost share:
$65.00 + ($35.00 x 0.15) = $70.25

Step 3: Apply the "Lesser of" Test:
$70.25 < $100.00

Step 4: Use the LICS Amount formula:
$100.00 – $70.25 = $29.75

Drug Coverage Status Code	
GDCB	
GDCA	
Patient Pay Amount	$70.25
CPP	
LICS Amount	$29.75

CATEGORY 4 LICS BENEFICARY, PLAN DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT (CONTINUED)

Result – Claim 2

Step 1: Calculate the non-LI cost share:
$100.00

Step 2: Determine the LI cost share:
$100.00 x 0.15 = $15.00

Step 3: Apply the "Lesser of" Test:
$15.00 < $100.00

Step 4: Use the LICS Amount formula:
$100.00 – $15.00 = $85.00

Drug Coverage Status Code	
GDCB	
GDCA	
Patient Pay Amount	$15.00
CPP	
LICS Amount	$85.00

CATEGORY 4 LICS BENEFICARY, PLAN DEDUCTIBLE GREATER THAN STATUTORY CATEGORY 4 AMOUNT (CONTINUED)

	Claim 1	Claim 2
Drug Coverage Status Code	C	C
GDCB	$ 100.00	$ 100.00
GDCA	$ 0.00	$ 0.00
TGCDC Accumulator	$ 0.00	$ 100.00
TrOOP Accumulator	$ 0.00	$ 100.00
Beginning Benefit Phase	D	D
Ending Benefit Phase	D	D
Patient Pay Amount	$ 70.25	$ 15.00
LICS Amount	$ 29.75	$ 85.00
CPP	$ 0.00	$ 0.00

Populating the PDE Record

PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO

When the plan deductible < Statutory Category 4 Amount and > Zero:

- Cost-sharing is 15% coinsurance "after the annual deductible under the plan"
- Cost-sharing is whichever is less:
  - Statutory Category 4 deductible ($65 in 2012)
  - Lower deductible amount under the PBP

MODIFYING THE PDE

- When modifying a PDE for an LI beneficiary, a plan:
  - Must adjust each PDE record for retroactive LI determinations.
  - Must refund beneficiary directly

SUMMARY

- Defined LICS
- Calculated LICS amount using the rules that apply to all plan types
- Determined 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
- Identified the PDE data fields required to report LICS payments
- Explained how LICS affects TrOOP

Evaluation

Please take a moment to complete the evaluation form for the Low Income Cost-Sharing module.

Your Feedback is Important! Thank you!

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Calculating & Reporting Enhanced Alternative Benefit

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

To provide a description of the Enhanced Alternative (EA) benefit option and essential calculating and reporting rules related to submitting data.

OBJECTIVES

- Define the Enhanced Alternative benefit
- Administer an Enhanced Alternative benefit, using business rules
- Utilize the principles for submitting a PDE for an enhanced alternative drug
- Apply the business rules in calculating and reporting plan-paid amounts for EACS
- Apply the business rules related to the Coverage Gap

EA BENEFITS

- Additional or supplemental benefits that exceed the actuarial value of a Basic benefit
- Two forms of EA benefits:
  1. Coverage of certain non-Part D drugs (EA drug)
  2. Reduced cost-sharing (EACS)

DATA FIELDS IN THE PDE RELATED TO EA BENEFITS

Three PDE fields identify EA benefits:

- Drug Coverage Status Code
- Covered D Plan Paid Amount (CPP)
- Non-covered Plan Paid Amount (NPP)

DRUG COVERAGE STATUS CODE AND EA

- Enhanced Alternative Drug = “E” for a supplemental drug
- Only EA plans can report a value of “E”

PDE Record
Drug Coverage Status Code
E

CPP AND EA

- The portion of the Plan Paid Amount placed in the CPP field is based on what a plan pays under the Defined Standard benefit for a covered drug.

PDE Record
CPP
$

NPP AND EA

- The portion of the EA Plan Paid Amount placed in the NPP field is what the plan pays in extra cost-sharing assistance.
- Reports Plan Paid Amounts for both “E” and “O” drugs.
- NPP amounts excluded from risk corridor, reinsurance payment, and TrOOP accumulation.

PDE Record
NPP
$

PRINCIPLES FOR EA DRUGS

- Drug Coverage Status Code = “E”
- Full Plan Paid Amount is reported in NPP
- All payments for EA drugs excluded from Medicare payment
- All payments for EA drugs are excluded from TrOOP
- LICS does not apply to EA drugs
- CGDP does not include supplemental drugs

EA DRUG

Scenario

In 2012, Sunhealth PBP1 provides cost-sharing in the Initial Coverage Phase using tiered flat co-pays of $10/$20/$40. The beneficiary purchased a $65.00 EA drug in Tier 1. The beneficiary is in the Initial Coverage Phase of the benefit.

Drug Coverage Status Code	
Gross Drug Cost	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$
Reported Gap Discount	$

EA DRUG (CONTINUED)

Results - Calculation

Drug Coverage Status Code	E
Gross Drug Cost	$65.00
Patient Pay Amount	$10.00
Plan POS	$55.00
CPP	$ 0.00
NPP	$55.00
Reported Gap Discount	$ 0.00

EA DRUG (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	E
Patient Pay Amount	$ 10.00
CPP	$ 0.00
NPP	$ 55.00
Reported Gap Discount	$ 0.00

AFFORDABLE CARE ACT PROVISIONS EFFECTIVE 2011

- Allows for reduced cost-sharing for generic drugs for non-LIS beneficiaries in the Coverage Gap
- Alters PDE reporting rules for EA plans
- Generic Coverage Gap cost-sharing applies to all categories of Part D drugs that are applicable drugs under the CGDP
- Mapping rules must account for impact of generic utilization in the Coverage Gap

BUSINESS RULES FOR CALCULATING AND REPORTING EACS

Reporting EACS involves three steps.

Step 1	Report beneficiary cost-sharing in **Patient Pay Amount** field
Step 2	Calculate and report **CPP**
Step 3	Calculate and report **NPP**

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2012 – Non-LI

EACS Rule #	YTD Gross Covered Drug Cost	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)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2012–LI

EACS Rule #	YTD Gross Covered Drug Cost	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)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

Calculating and reporting NPP

EACS = Gross Covered Drug Cost − (Patient Pay Amount + CPP + PLRO, Other TrOOP, LICS, and Reported Gap Discount)

Calculating and reporting NPP—Alternative Method

EACS ~~**Method No Longer Applies**~~ **— CPP**

EACS – RULE #2

Scenario

In 2012, Sunhealth PBP4 requires non-LI beneficiaries to pay a deductible equal to the DS benefit and employs a $5/$15/$30 tiered cost-sharing in the Initial Coverage Phase. 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.

Drug Coverage Status Code	
TGCDC Accumulator	$
TrOOP Accumulator	$
Beginning Benefit Phase	
Ending Benefit Phase	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$
Reported Gap Discount	$

EACS – RULE #2 (CONTINUED)

Results - Calculation

Drug Coverage Status Code	C
TGCDC Accumulator	$ 400.00
TrOOP Accumulator	$ 340.00
Beginning Benefit Phase	N
Ending Benefit Phase	N
GDCB	$ 200.00
GDCA	$ 0.00
Patient Pay Amount	$ 30.00
Plan POS	$ 170.00
CPP	$ 150.00
NPP	$ 20.00
Reported Gap Discount	$ 0.00

EACS – RULE #2 (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$ 30.00
CPP	$150.00
NPP	$ 20.00

EACS – RULE #3

(NON-LI BENEFICIARY, NON-APPLICABLE DRUG)

Scenario

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 initial coverage limit is $4,000. 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.

Drug Coverage Status Code	
TGCDC Accumulator	$
TrOOP Accumulator	$
Beginning Benefit Phase	
Ending Benefit Phase	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$
Reported Gap Discount	$

EACS – RULE #3 (CONTINUED)

(NON-LI BENEFICIARY, NON-APPLICABLE DRUG)

Results - Calculation

Drug Coverage Status Code	C
TGCDC Accumulator	$ 3,500.00
TrOOP Accumulator	$ 1,900.00
Beginning Benefit Phase	N
Ending Benefit Phase	N
GDCB	$ 35.00
GDCA	$ 0.00
Patient Pay Amount	$ 10.00
Plan POS	$ 25.00
CPP	$ 4.90
NPP	$ 20.10
Reported Gap Discount	$ 0.00

EACS – RULE #3 (CONTINUED)

(NON-LI BENEFICIARY, NON-APPLICABLE DRUG)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$ 10.00
CPP	$ 4.90
NPP	$ 20.10

EACS – RULE #3

(NON-LI BENEFICIARY, APPLICABLE DRUG)

Scenario

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 Coverage 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.

Drug Coverage Status Code	
TGCDC Accumulator	$
TrOOP Accumulator	$
Beginning Benefit Phase	
Ending Benefit Phase	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$
Reported Gap Discount	$

EACS – RULE #3 (CONTINUED)

(NON-LI BENEFICIARY, APPLICABLE DRUG)

Results - Calculation

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

EACS – RULE #3 (CONTINUED)

(NON-LI BENEFICIARY, APPLICABLE DRUG)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$ 75.75
CPP	$ 0.00
NPP	$ 50.50
Reported Gap Discount	$ 75.75

EACS – STRADDLE CLAIM

Scenario

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.

Drug Coverage Status Code	
TGCDC Accumulator	$
TrOOP Accumulator	$
Beginning Benefit Phase	
Ending Benefit Phase	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$
Reported Gap Discount	$

EACS – STRADDLE CLAIM

(CONTINUED)

Results - Calculation

	Initial Coverage Period	Coverage Gap	PDE
Drug Coverage Status Code			C
TGCDC Accumulator	$	$	$ 2,920.00
TrOOP Accumulator	$	$	$ 1,500.00
Beginning Benefit Phase			N
Ending Benefit Phase			N
GDCB	$ 10.00	$ 115.00	$ 125.00
GDCA	$ 0.00	$ 0.00	$ 0.00
Patient Pay Amount	$ 10.00	$ 10.00	$ 20.00
Plan POS	$ 0.00	$ 105.00	$ 105.00
CPP	$ 7.50	$ 0.00	$ 7.50
NPP	$ -7.50	$ 105.00	$ 97.50
Reported Gap Discount	$ 0.00	$ 0.00	$ 0.00

EACS – STRADDLE CLAIM

(CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$ 20.00
CPP	$ 7.50
NPP	$ 97.50

RULES FOR EACS AND LICS

- EACS is determined before LICS.
- EA plans cannot supplement low income cost-sharing.

EACS - LICS

Scenario

In 2012, the beneficiary is a Category 1 LI 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 ICL is shifted up to $4,500. The beneficiary YTD gross covered drug costs = $1,500 and accumulated TrOOP is $790. She purchases a Tier 1 covered drug for $75.

Drug Coverage Status Code	
Gross Covered Drug Cost	$
Patient Pay Amount	$
LICS	$
Plan POS	$
CPP	$
NPP	$

EACS - LICS (CONTINUED)

Results - Calculation

Drug Coverage Status Code	C
Gross Covered Drug Cost	$ 75.00
Patient Pay Amount	
LICS	
Plan POS	$ 65.00
CPP	$ 56.25
NPP	$ 8.75

Beneficiary Liability	**$10.00**

EACS - LICS (CONTINUED)

Result

Step 1: Determine the non-LI cost share:
$10

Step 2: Identify the LI cost share:
$2.60

Step 3: Apply the "Lesser of" test:
$2.60 < $10

Step 4: Utilize the LICS formula:
$10 – $2.60 = $7.40

Drug Coverage Status Code	C
Gross Covered Drug Cost	$10.00
Patient Pay Amount	$ 2.60
LICS	$ 7.40
Plan POS	$65.00
CPP	$56.25
NPP	$ 8.75

EACS - LICS (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
TGCDC Accumulator	$ 1,500.00
TrOOP Accumulator	$ 790.00
Beginning Benefit Phase	N
Ending Benefit Phase	N
GDCB	$ 75.00
GDCA	$ 0.00
Patient Pay Amount	$ 2.60
LICS	$ 7.40
Plan POS	$ 65.00
CPP	$ 56.25
NPP	$ 8.75
Reported Gap Discount	$ 0.00

SUMMARY

- Defined the Enhanced Alternative benefit
- Administered an Enhanced Alternative benefit, using business rules
- Utilized the principles for submitting a PDE for an enhanced alternative drug
- Applied the business rules in calculating and reporting plan-paid amounts for EACS
- Applied the business rules related to the Coverage Gap

Evaluation

Please take a moment to complete the evaluation form for the Enhanced Alternative Benefit module.

Your Feedback is Important! Thank you!

Edits

2011 Regional IT Technical Assistance

Prescription Drug Event

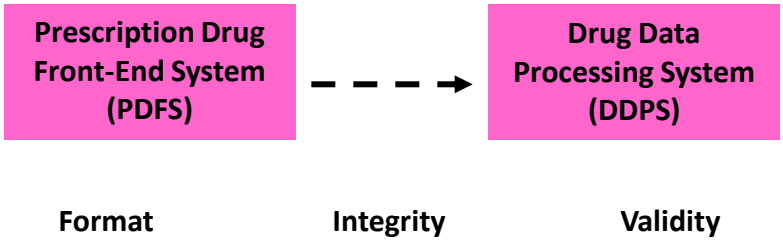
PURPOSE

To provide participants with an understanding of the edits generated by systems that support the processing of PDE data.

OBJECTIVES

- 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

EDIT PROCESS



PDFS EDITS

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

PDFS EDIT LOGIC AND RANGES

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

PDFS EDIT CODES

Scenario

Blue Sky Health changes to a new 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.

PDFS EDIT CODES (CONTINUED)

Edit

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

Result

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

DDPS EDITING RULES

Stage #	Stage Name
1	Individual Field Edits
2	Enrollment/Eligibility Edits
3	Duplicate Check Edits
4	Field-to-Field Edits
5	Gap Discount Calculation Edits
6	Adjustment/Deletion Code Edits

DDPS EDITING RULES (CONTINUED)

Adjustments/Deletions

ELIGIBILITY EDITS

Scenario

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

ELIGIBILITY EDITS (CONTINUED)

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.

Result

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

EDIT RANGES AND CATEGORIES

Series	Edit Category
603-659, 831	Missing/Invalid
660-669	Adjustment or Deletion
670-689	Catastrophic Coverage Code
690-699	Cost
700-714	Eligibility
715-734	LICS
735-754	NDC
755-774	Drug Coverage Status Code
775-799, 900-999	Miscellaneous
851-855	P2P Phase III Retro Enrollment (Update Codes)
865-899	Gap Discount

CMS CALCULATED GAP DISCOUNT

Scenario

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

RESOLUTION PROCESS

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

RESOLUTION PROCESS
(CONTINUED)

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

RESOLUTION PROCESS
(CONTINUED)

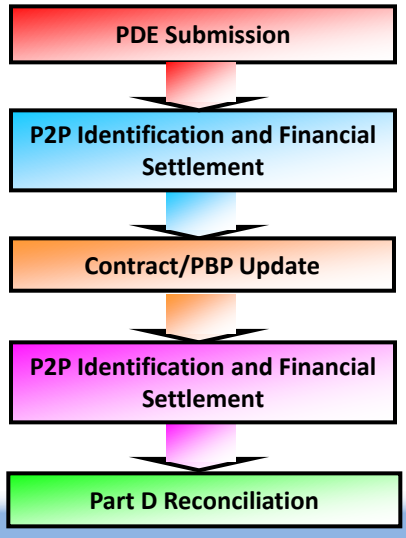
- Edits requiring specific problem-solving steps:
  - Eligibility (Edits 700-714)
  - LICS
    - 715-Use best available data policy
    - 716-722-CMS data is accurate

RESOLUTION PROCESS
(CONTINUED)

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?

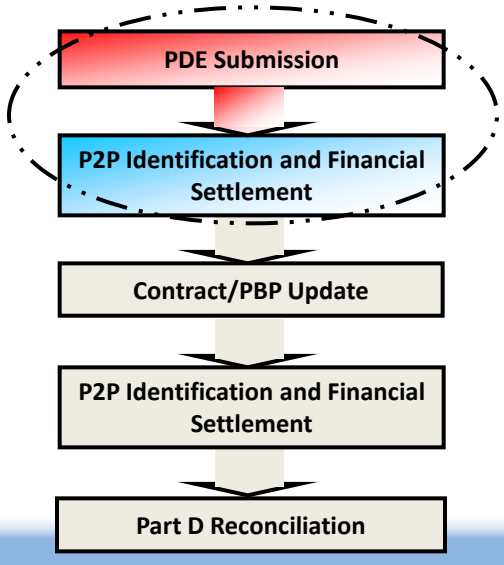
P2P PROCESS OVERVIEW



COMMON TERMS

Term	Definition
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.

P2P PROCESS



STATUTORY AUTHORITY

Under 42 CFR 423.464(a), 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.

CMS TRANSITION PERIOD

- The effective date of enrollment in a specific Contract/PBP

- 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

PART D SPONSOR ASSUMED RESPONSIBILITIES

- Submitting accurate and timely PDEs
- Making appropriate adjustments and reversals
- Accessing and reviewing monthly reports

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

SCENARIO

John Brown joined Winter Health Plan in January 2009 as a dual-eligible and completed an enrollment application on August 27, 2009 for Spring Health Plan's PBP 002. Spring Health Plan submitted the enrollment. CMS processed the enrollment on September 3, 2009. John's effective date is September 1, 2009.

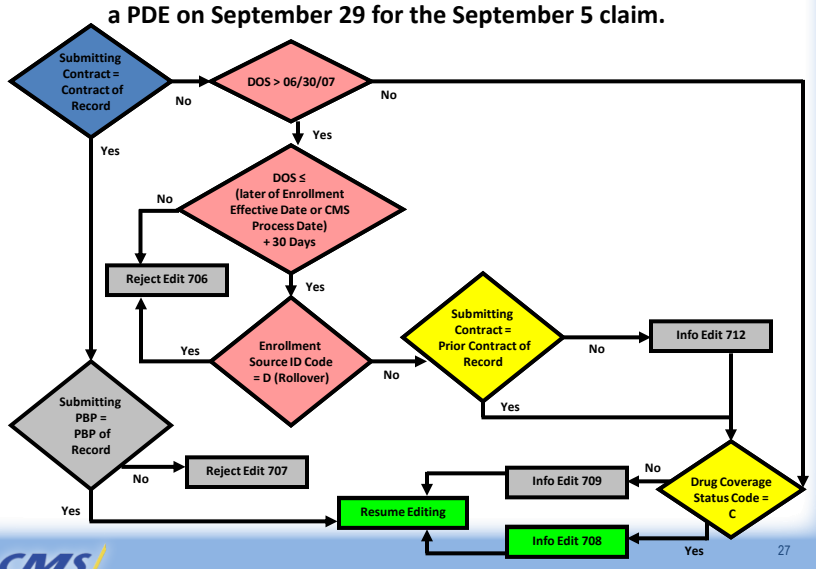
John fills a prescription on September 5, 2009 for a covered drug and on September 7, 2009 for an OTC drug using an ID card from Winter Health Plan.

He also fills prescriptions on October 2, 2009 and October 15, 2009 for covered drugs.

Winter Health Plan PBP 001 submitted two PDEs on September 29, 2009 for the September 5, 2009 and September 7, 2009 claims. They also submitted a PDE on October 20, 2009 for the October 2, 2009 claim and on October 29, 2009 for the October 15, 2009 claim.

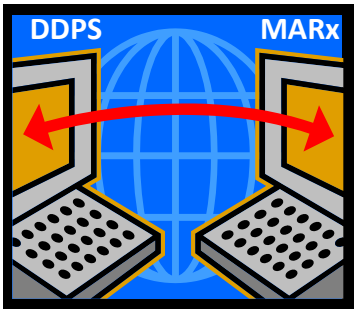
SCENARIO – RESULT

John's effective date is September 1. Winter Health Plan submitted a PDE on September 29 for the September 5 claim.



P2P CONTRACT/PBP UPDATE PROCESSING

- DDPS queries MARx for changes to Contract and PBP of Record
  - Changes result in DDPS updating affected PDEs
  - No changes result in no updates to saved PDEs



P2P CONTRACT/PBP UPDATE PROCESSING (CONTINUED)

- Updates are for all changes to enrollment information and are not limited to changes affecting P2P.
- Update Codes regarding P2P changes resulting from Contract/PBP Update will only be sent to the Submitting Contract, not to the Updated or Original Contract of Record.
- Changes to HICN will appear on the Special Return file and will generate an edit code 710.
- Updated Contract of Record and Original Contract of Record are only informed of P2P changes through monthly reports.

P2P CONTRACT/PBP UPDATE INFORMATIONAL EDIT CODES

Update Code	Description	P2P Condition
851	Contract of Record has been updated.	Condition now exists.
852	Submitting Contract/PBP is now the Contract/PBP of Record.	Condition no longer exists.
853	PBP of Record has been updated.	Continues to be non-P2P PDE.
854	Contract of Record and PBP of Record have been updated.	New condition established.
855	Submitting Contract is now the Contract of Record, but Updated PBP of Record is different from Submitting PBP.	Condition no longer exists.

Immediately Actionable PDE Errors (IAPs) Reports

- Provides feedback on errors and quality, timeliness, and accuracy of each plan's PDE data and error resolution efforts.
- Types of IAP errors:
  - Formatting mistakes
  - Data inconsistencies
  - Failure to grant sufficient low income cost-sharing subsidies

IAP Contract Reports

Report Name	Description
PDE Verification Summary Report	• Provides summary information on PDE that includes submission, rejection, and error resolution statistics.
PDE Verification Detail Report	• Provides confidential beneficiary information along with the summary information.

SUMMARY

- Described the edit logic for the PDFS and DDPS
- Identified the 11 edit categories in DDPS
- Recognized and apply the resolution process to resolve errors received from PDFS and DDPS
- Reviewed the P2P process and update codes
- Reviewed the new CGDP edit codes
- Discussed IAPs and contract reports

Evaluation

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

Your Feedback is Important! Thank you!

Reports

2011 Regional IT Technical Assistance

Prescription Drug Event

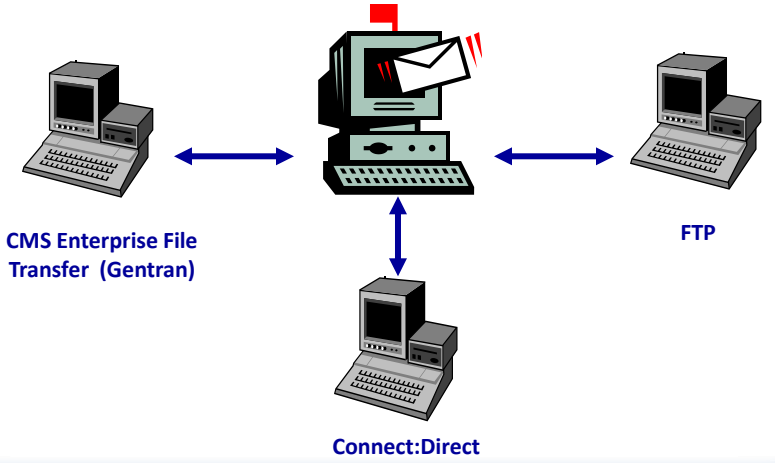
PURPOSE

To provide 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.

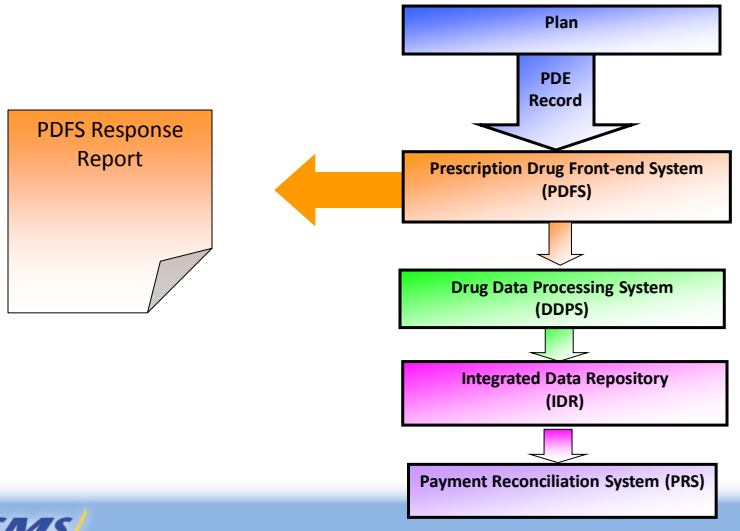
OBJECTIVES

- Identify the purpose of PDFS, DDPS, and IDR reports
- Determine the best uses of the reports to monitor data collection and submission processes; to resolve errors and perform PDE data quality review
- Read DDPS reports to identify and submit corrections accurately
- Recognize the relationship between values in the financial management reports and reconciliation
- Determine existence of P2P conditions and associated financial settlements

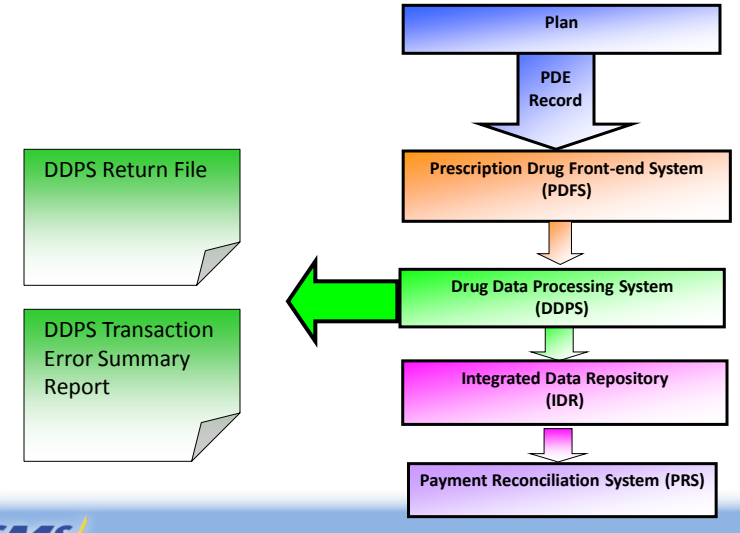
ACCESSING PART D REPORTS



REPORTS OVERVIEW



REPORTS OVERVIEW (CONTINUED)

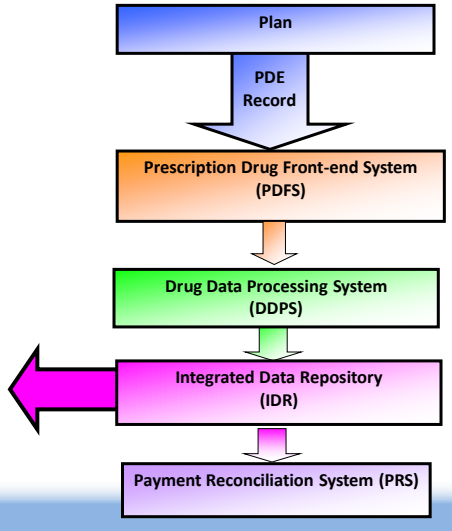


REPORTS OVERVIEW (CONTINUED)

IDR Cumulative Beneficiary Summary Report

Accumulator Comparison Report

IDR Plan-to-Plan (P2P) Reports



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
Cumulative Beneficiary Summary Report (04COV/ENH/ OTC)	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

PDFS RESPONSE REPORT

- Identifies errors generated by PDFS and checks for format, integrity, and validity
- Checks for sequencing errors
- Provides status of the file

DDPS TRANSACTION REPORTS

- Identify processing results including errors
- Contain up to seven record types
- Are available the next business day after processing
- Provided in flat file layout

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

DDPS RETURN FILE

- Identifies error codes
- Communicates the disposition and complete record as submitted for all DET records in the file
- Provides the entire submitted transaction for accepted (ACC), rejected (REJ), or informational (INF) detail records

DDPS TRANSACTION ERROR SUMMARY REPORT

- Provides batch level processing results
- Contains a separate DET record for each error in the file
- Indicates counts and rates for error codes

CUMULATIVE BENEFICIARY SUMMARY REPORTS

- Four management reports
  - 04COV for covered drugs
  - 04ENH for enhanced alternative drugs
  - 04OTC for over the counter drugs
  - 90COV for accumulator comparison
- 04COV provides financial information necessary to reconcile the cost-based portion of the Part D payment
- Key information
  - Net accumulated totals for dollar amount fields
  - Gross counts of originally submitted, adjusted, and deleted PDE records
  - Catastrophic coverage and beneficiary utilization

ACCUMULATOR COMPARISON REPORT

- Identifies Accumulator values reported by the plan
  - Provides the Accumulator values calculated by CMS and from saved PDEs and reports the differences between them
- Evaluates discrepancies between reported and calculated Accumulator values
- Distributed to current contract of record for all beneficiaries enrolled
- Released in phases

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.	

CMS COMMUNICATION TO 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.

P2P REPORT NAMING CONVENTIONS

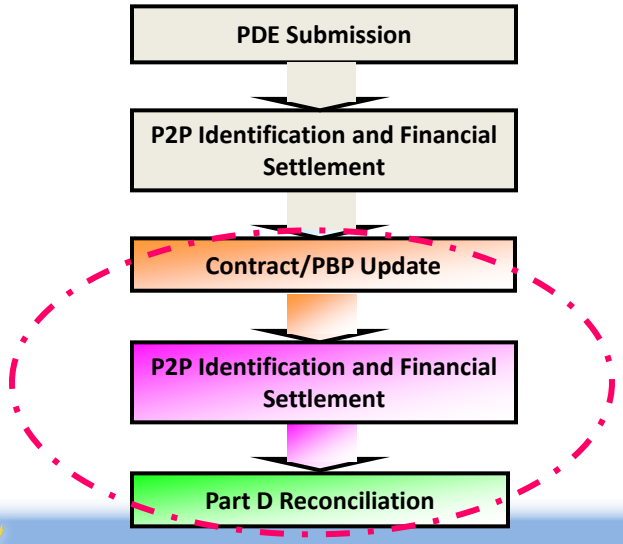
REPORT NAME	MAILBOX IDENTIFICATION
Special Return File	RPT00000.RPT.DDPS_P2P_PHASE3_RTN
P2P Accounting Report (40COV/ENH/OTC)	RPT00000.RPT.DDPS_P2P_PDE_ACC_C RPT00000.RPT.DDPS_P2P_PDE_ACC_E RPT00000.RPT.DDPS_P2P_PDE_ACC_O
P2P Receivable Report (41COV)	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P Part D Payment Reconciliation Report (42COV)	RPT00000.RPT.DDPS_P2P_PARTD_RCON
P2P Payable Report (43COV)	RPT00000.RPT.DDPS_P2P_PAYABLE

P2P CONTRACT/PBP UPDATE PRIOR TO PART D PAYMENT RECONCILIATION

- Prior to running Part D Payment Reconciliation:
  - PDEs must be attributed to the appropriate Contract and PBP of Record

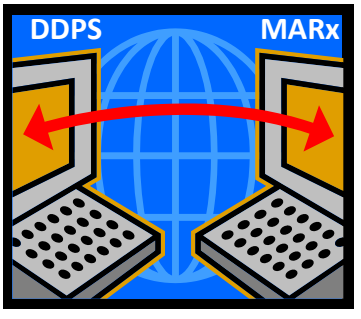
Updates to contract/PBP of record will always occur prior to Part D Payment Reconciliation.

P2P PROCESS



P2P CONTRACT/PBP UPDATE PROCESSING

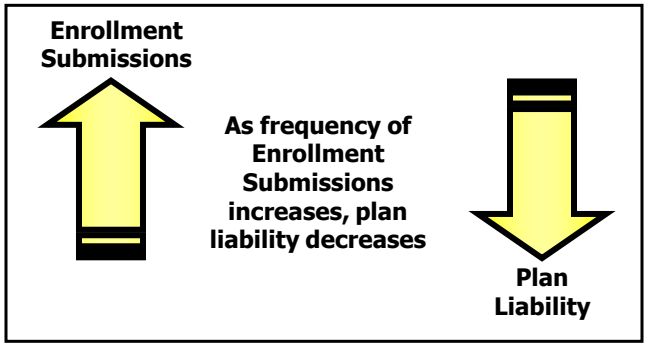
- DDPS queries MARx for changes to Contract and PBP of Record
  - Changes result in DDPS updating affected PDEs
  - No changes result in no updates to saved PDEs



REPORTING P2P IN RETURN FILES

- Fields impacted by P2P Processing
  - Submitting Contract
  - Submitting PBP
  - P2P Contract of Record
  - PBP of Record
  - Contract of Record Update Reported on Return File
  - PBP of Record Update Reported on Return File

PLAN LIABILITY



SUMMARY

- Identified the purpose of PDFS, DDPS, and IDR reports
- Determined the best uses of the reports to monitor data collection and submission processes; to resolve errors and perform PDE data quality review
- Read DDPS reports to identify and submit corrections accurately
- Recognized the relationship between values in the financial management reports and reconciliation
- Determined existence of P2P conditions and associated financial settlements

Evaluation

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

Your Feedback is Important! Thank you!

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Coverage Gap Discount Program Invoice and Payment Process

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

The purpose of this module is to introduce the Coverage Gap Discount Program Invoice and Payment process; and review the reporting, confirmation, offset, and reconciliation processes.

OBJECTIVES

- 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

OBJECTIVES (CONTINUED)

- Review the Payment Confirmation process
- Explain offsets
- Understand the CGDP Reconciliation
- Recognize the importance of timely PDE reporting and corrections

COVERAGE GAP DISCOUNT PROGRAM (CGDP)

- Effective January 1, 2011
- Provides discounts to Medicare beneficiaries receiving applicable Part D drugs
- On average, the discount for each applicable drug is approximately 50% of the negotiated price

COVERAGE GAP DISCOUNT FLOW

- Part D Sponsors advance Gap Discount at the Point of Sale
- Part D Sponsors submit PDEs to CMS recording the Gap Discount amount

- CMS aggregates PDE data and sends to TPA
- TPA sends quarterly invoice reports to manufacturers and Part D sponsors simultaneously

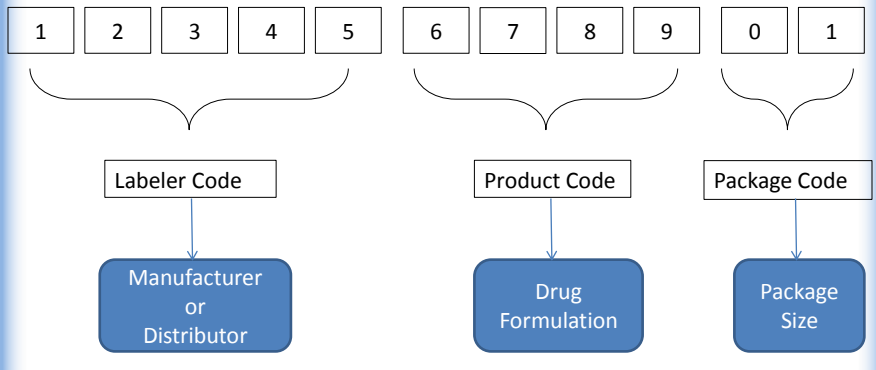
- Manufacturers pay the invoiced amount in full to Part D sponsors within 38 calendar days
- Manufacturers send confirmation of payment to TPA within 5 business days

- Part D Sponsors send confirmation of payment receipt to TPA within 5 business days
- The TPA sends payment confirmation statistics to CMS
- CMS offsets invoiced and now paid amounts from Part D Sponsors through APPS

APPLICABLE DRUGS

- Covered Part D
  - Includes drugs approved under NDA [section 505(b) of the FFDCA]
  - Includes biological products (section 351 of the BLA)
- Covered by a Manufacturer discount agreement

NATIONAL DRUG CODE (NDC)



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.

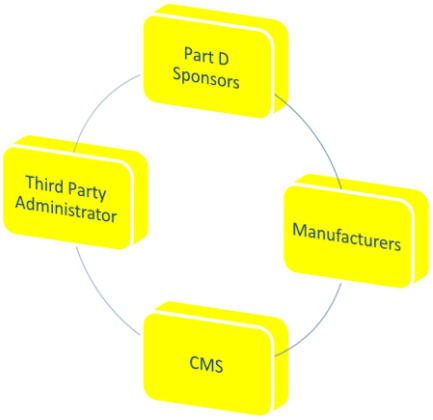
DISCOUNT PROVIDED AT POS

- Must have the following information in real-time:
  - The drug is a discountable drug
  - The beneficiary is eligible for the discount
  - The claim is wholly or partially in the coverage gap
  - The amount of the discount (50% of discount eligible cost)
- The Gap Discount is based on the plan-defined benefit phase

PDE RECORDS

- Plans report actual amount of Gap Discount advanced at POS
- CMS validates amounts reported in the Reported Gap Discount field
- Reported Gap Discount amounts on accepted and validated PDEs are used to build invoices sent to manufacturers and for CGDP reconciliation

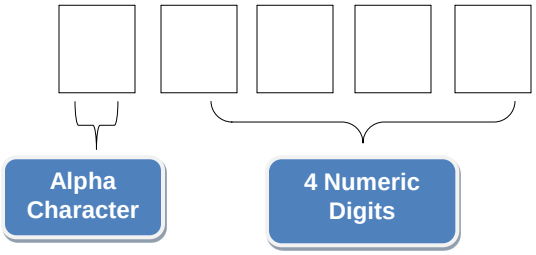
PLAYERS AND RELATIONSHIPS



TPA CONTACT INFORMATION

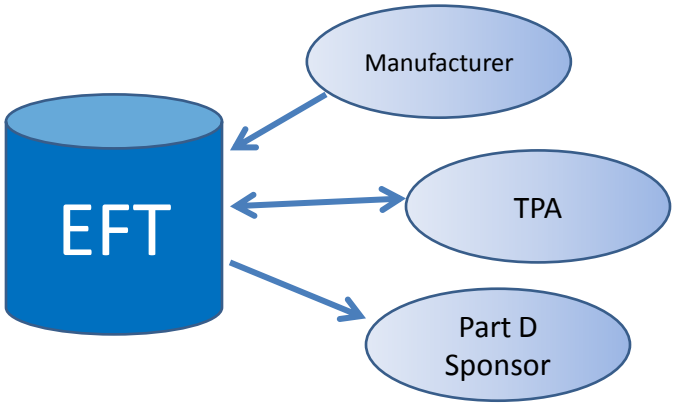
- Website: http://www.csscoperations.com
- Email: csscoperations@palmettogba.com
- CSSC Help Line: 1-877-534-2772
- Hours of Operation: Monday – Friday, 8 a.m. – 7 p.m. ET

MANUFACTURER P-NUMBER

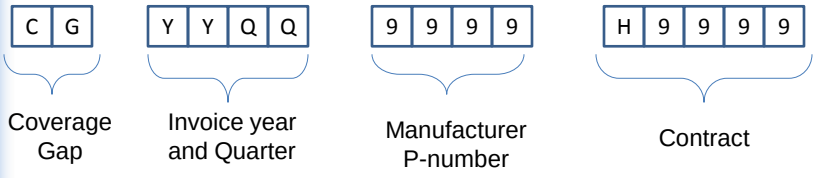


- Unique 5-digit identifier assigned by CMS
- Each P Number represents a signed Discount Program agreement
- Leading 'P' followed by 4 digits
- Found on Contract reports
- Used by Part D sponsors to identify the manufacturer
- The numeric portion is found in the 15-character Invoice Id on contract reports and EFT/banking records
- CGYYQQ9999H9999

ELECTRONIC FUNDS TRANSFER



EFT INDIVIDUAL IDENTIFICATION NUMBER



- Found on Contract report file layouts
- To be used by Part D sponsors to identify:
  - the invoice quarter
  - the manufacturer making payment (last 4 numeric only)
  - contract being paid
- Manufacturer must include on EFT transmission file
- May be visible on the Part D Sponsor banking information
- Part D sponsor should contact their bank if the ID is not visible
- ACH processing network agreement requires all transmission data be made available to banking customers upon request

QUARTERLY REPORTING

- Summary Report
- Data Report
- Tracking Report

(TPA)

- Payment Confirmation Report (Sponsor)
- Payment Confirmation Response Report (TPA)

CONTRACT SUMMARY REPORT

Field	Description
MANUFACTURER P NUMBER	Internal unique identifier
EFT INDIVIDUAL IDENTIFICATION NUMBER	External identifier for CGDP payment, quarter, and manufacturer
GAP DISCOUNT AMOUNT THIS PERIOD	Money Manufacturer owes Sponsor

CONTRACT DATA REPORT

Field	Description
DETAIL REF NUMBER	Unique record number, remains constant
CURRENT REPORT ID and GAP DISCOUNT AMOUNT THIS PERIOD	Net payment amount this quarter
SUBMITTING CONTRACT NUMBER and SUBMITTING CONTRACT PBP NUMBER	Identifies the contract that was discounted and will receive payment

CONTRACT TRACKING REPORT

- A cumulative year report showing the status of each gap discount PDE saved in the CMS data base
- Identifies each gap discount as either invoiced or pended using the following codes:
  - Not pended
  - 01 Retro LI
  - 02 Low volume
  - 03 Data quality review
  - 99 Other

LOW VOLUME

- PDEs withheld from Invoices to preserve beneficiary confidentiality
- Current definition is:
  - 10 beneficiaries or less with
  - Same NDC-9
  - Same pharmacy
- Placed on Pended Status, Written to the Data Quality Review web site
- Can be tracked on the Contract Tracking Report
- Rules found in the Manufacturers Agreement determine what data may be revealed
- CMS is considering options to invoice sooner while preserving confidentiality

CONTRACT PAYMENT CONFIRMATION REPORT

- Payment Confirmation Report is built using information found on the Contract Summary Report
- Sponsor validates payments and creates report to send to the TPA
- Confirmations are made at the contract level

CONFIRMATION RESPONSE REPORT

REPORT: TPA-RESPS THIRD PARTY ADMINISTRATOR
RUN DATE: CCYYMMDD TPA RESPONSE REPORT
SPONSOR: XXXXXX CONTRACT: CCCCC

REPORT ID: YYYYQQ FILE ID: AAAAA STATUS: ***ACCEPTED RECEIPT OF THE REPORT***
STATUS: ***REJECTED RECEIPT OF THE REPORT***
STATUS: ***REJECTED RECEIPT OF THE REPORT***
STATUS: ***DISCREPANT RECEIPT OF THE REPORT***

RECORD TYPE	TPACH SEQ NO	PTOT SEQ NO	ERROR CODE	ERROR DESCRIPTION
TTTTT	9999999		EEEE	DDDDDD **Rejected File level error**
TTTTT	9999999	8888888	EEEE	DDDDDD **Rejected - multiple**
TTTTT	9999999	8888888	EEEE	DDDDDD **errors shown**
TTTTT	9999999	8888888	EEEE	DDDDDD **here**
TTTTT	9999999	8888888	EEEE	DDDDDD **Discrepant may contain multiple**
TTTTT	9999999	8888888	EEEE	DDDDDD **discrepancies**

TPA REJECT CODES

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

INTERIM PAYMENTS

- Monthly interim payments will be sent to Part D Sponsors to provide cash flow for advancing the gap discounts at the POS
- Can be found on the Monthly Membership Report (MMR)
- Are described and explained in the Advanced Call Letter for the Benefit Year, and are based on the Part D sponsor's bid on the contract

CMS OFFSET

- Processed quarterly through APPS
- Negative adjustment to the next month

RECONCILIATION

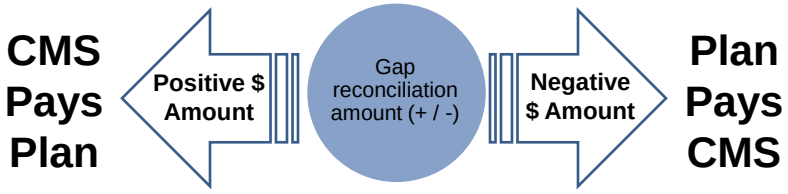
- Annual, cost-based reconciliation
- Based on submitting contract
- Begins after the sixth invoicing and payment processing cycle has been completed
- Amounts reconciled are from Invoiced PDEs

QUARTERLY SCHEDULE 2011

- Benefit Year 2011
- Quarters 1 through 4 are within the benefit year
  - January 1, 2011 through December 31, 2011
- Quarters 5 and 6 Complete the benefit year processing
  - January 1, 2012 through June 30, 2012
- Reconciliation after Quarter 6
- Quarters 7 through 16
  - July 1, 2012 through December 31, 2014
  - No interim payments
  - No offsets
- Quarter 17
  - January 1, 2015 through March 31, 2015
  - Bene Year 2011 PDEs only accepted through January 31, 2015
  - Any PDEs for 2011 will be rejected beginning February 1st

RECONCILIATION CALCULATION

RECONCILIATION CALCULATION (CONTINUED)



EXAMPLE

	Scenario 1 interim Payments are Less Than Actual Gap Discount Costs	Scenario 2 interim Payments are Greater Than Actual Gap Discount Costs
CGDP interim 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

Scenario 1	Scenario 2
$1750 - $1000 = $750	$250 - $1000 = -$750
Actual – Interim = Positive	Actual – Interim = Negative
CMS Pays	Plan Pays

SUMMARY

- Learned the role of the TPA in the CGDP
- Explained the timeline for Quarterly Invoice generation and payment
- Described the Part D sponsor quarterly reports
- Understands the payment mechanism

SUMMARY (CONTINUED)

- Reviewed the Payment Confirmation process
- Explained offsets
- Understands the CGDP Reconciliation
- Recognized the importance of timely PDE reporting and corrections

Evaluation

Please take a moment to complete the evaluation form for the Coverage Gap Discount Program Invoice and Payment Process module.

Your Feedback is Important! Thank you!

Reconciliation

2011 Regional IT Technical Assistance

Prescription Drug Event

PURPOSE

Explain how the Payment Reconciliation System (PRS) performs Part D payment reconciliation.

OBJECTIVES

- Understand the systems and processes used in payment reconciliation
- Understand the relationship of reported data to payment
- Determine how the organization can monitor reports to ensure appropriate reconciliation
- Determine how the organization can use the PRS reports to understand their Part D reconciliation

RECONCILIATION

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

PROSPECTIVE PAYMENTS

- Medicare Advantage Prescription Drug System (MARx) calculates and reports monthly prospective payments
- Plans monitor monthly prospective payments for accuracy
  - Low Income Cost-Sharing Subsidy
  - Reinsurance Subsidy
  - Direct Subsidy

ACTUAL COSTS

- PDEs report actual costs
- PDEs report the following fields, which are directly applied to reconciliation:
  - LICS
  - GDCB
  - GDCA
  - CPP

ACCURATE AND TIMELY PDEs

- PDE data must be accurate and timely
- For purposes of reconciliation, PDE data must be submitted by 11:59 p.m., Eastern Time on the Federal business day immediately before June 30 of the following benefit year

DATA OVERSIGHT

- Monitor prospective payments
- Maintain enrollment and LICS eligibility data
- Ensure submitted PDE data are accurate and consistent with plan data at the beneficiary- and plan-summary levels
- Ensure CMS summary reports are consistent with the plan's understanding of the data

BENEFICIARY AND PAYMENT DATA

- Plans must monitor:
  - Enrollment data
  - LICS status
  - Monthly payment amounts

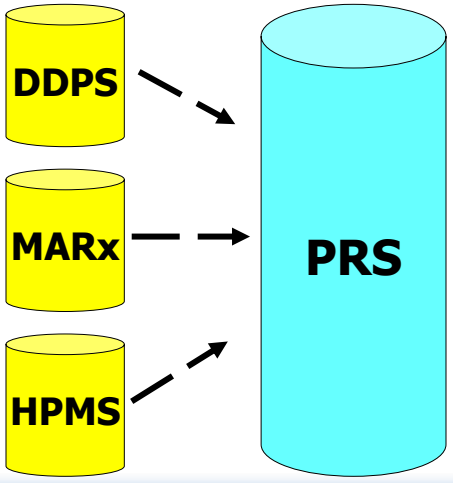
PDE DATA AND REPORTS

- Failure to resolve errors identified in the DPPS Return File and resubmit rejected records can lead to payment errors. Types of payment errors include:
  - 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.
- Plans should carefully review DDPS management reports to confirm that CMS' DDPS data and the plan's data match for accurate reconciliation.

CERTIFICATION OF DATA FOR PAYMENT

- Plan's must certify PDE data submitted for payment and reconciliation are accurate, complete, and truthful.
- Plan must also certify the same with respect to the underlying claims data.
- Certification of PDE and claims data for payment is **not** the same as the certification required for data submission.

RECONCILIATION SYSTEMS OVERVIEW



PAYMENT RECONCILIATION PLAN TYPE CODE

- The PRPTC determines which reconciliations plans participate in and how they are calculated.
- Plans bid one of four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative).
- If plans also fall into another category, for reconciliation purposes, that is the designation to which the plan is assigned.

LOW INCOME COST-SHARING RECONCILIATION

- Compare actual LICS reported on PDEs to prospective LICS amounts from MARx.
  - Actual LICS is retained in the DDPS.
  - LICS reconciliation is performed at the plan level based on the sum of all beneficiary LICS amounts for that plan.

BAYSIDE'S LOW INCOME COST-SHARING RECONCILIATION

LICS Reconciliation Amount

LICS Reconciliation Amount = $3,000,000 - $2,880,000

LICS Reconciliation Amount = $120,000

Results Report, DET Record		
Field No.	**Field Name**	
8	Total Actual Low-Income Cost-Sharing Subsidy Amount	$ 3,000,000
11	Prospective Low-Income Cost-Sharing Subsidy Amount	$ 2,880,000
14	Low-Income Cost-Sharing Subsidy Adjustment Amount	$ 120,000

DIRECT AND INDIRECT REMUNERATION

- Part D Covered DIR Amount is now Reported Part D Covered DIR amount
- Net Part D Covered DIR Amount:
  - Equals the difference between Reported Part D Covered DIR Amount and Total Estimated POS Rebate Amount.
  - Will be used in the reinsurance reconciliation and risk sharing.

DIRECT AND INDIRECT REMUNERATION (CONTINUED)

Net Part D Covered DIR Amount

Net Part D Covered DIR Amount = $1,850,000 - $350,000

Net Part D Covered DIR Amount = $1,500,000

Results Report, DET Record

Field No.	Field Name	
20	REPORTED PART D COVERED DIR AMOUNT	$1,850,000
21	TOTAL ESTIMATED POS REBATE AMOUNT	$350,000
22	**NET PART D COVERED DIR AMOUNT**	**$1,500,000**

REINSURANCE SUBSIDY

- 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

STEP 1 - REINSURANCE DIR RATIO

- The DIR Ratio is unadjusted reinsurance cost divided by 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

CALCULATE BAYSIDE'S DIR RATIO

DIR_Ratio

DIR_Ratio = $2,250,000/($2,250,000 + $12,750,000)

DIR_Ratio = $2,250,000/$15,000,000

DIR_Ratio = 0.15

Results Report, DET Record		
Field No.	**Field Name**	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$ 2,250,000
18	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	$ 12,750,000
19	REINSURANCE DIR RATIO	0.15

STEP 2 – CALCULATE THE REINSURANCE PORTION OF DIR

- DIR Ratio is applied to the Part D Covered DIR to determine the Reinsurance Portion of DIR

CALCULATE BAYSIDE'S REINSURANCE PORTION OF DIR

Reinsurance Portion of DIR

Reinsurance Portion of DIR = $1,500,000 * .15

Reinsurance Portion of DIR = $225,000

Results Report, DET Record		
Field No.	**Field Name**	
19	REINSURANCE DIR RATIO	0.15
22	NET PART D COVERED DIR AMOUNT	$ 1,500,000
23	RESINSURANCE PORTION OF DIR AMOUNT	$ 225,000

STEP 3 - ALLOWABLE REINSURANCE COST

- To derive Allowable Reinsurance Cost, the Reinsurance Portion of DIR is subtracted from unadjusted reinsurance cost (GDCA)

CALCULATE BAYSIDE'S ALLOWABLE REINSURANCE COST

Allowable Reinsurance Cost

Allowable Reinsurance Cost = $2,250,000 - $225,000

Allowable Reinsurance Cost = $2,025,000

Results Report, DET Record

Field No.	Field Name	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$2,250,000
23	REINSURANCE PORTION OF DIR AMOUNT	$225,000
24	**ALLOWABLE REINSURANCE COST AMOUNT**	**$2,025,000**

STEP 4 – CALCULATE THE REINSURANCE SUBSIDY

- The plan-level reinsurance subsidy is eighty percent (80%) of the plan's Allowable Reinsurance Cost

CALCULATE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Subsidy

Reinsurance Subsidy = $2,025,000 * 0.8

Reinsurance Subsidy = $1,620,000

Results Report, DET Record

Field No.	Field Name	
24	ALLOWABLE REINSURANCE COST AMOUNT	$2,025,000
25	**CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,620,000**

STEP 5 – RECONCILE THE REINSURANCE SUBSIDY

- The reinsurance reconciliation is the difference between the actual reinsurance subsidy and the plan's prospective reinsurance subsidy

RECONCILE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Reconciliation Amount

Reinsurance Reconciliation Amount = $1,620,000 – $2,100,000

Reinsurance Reconciliation Amount = - $480,000

Results Report, DET Record

Field No.	Field Name	
25	CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,620,000
28	CURRENT PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
31	**CURENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**($480,000)**

RISK SHARING

- Calculate target amount
- Calculate risk corridor thresholds
- Determine adjusted allowable risk corridor costs (AARCC)
- Compare costs to thresholds and calculate payment adjustment

DETERMINE TARGET AMOUNT

- Sum the total direct subsidy payments and the Part D basic premiums
- Eliminate administrative costs using the administrative cost ratio

CALCULATE BAYSIDE'S TARGET AMOUNT

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

Results Report, DET Record

Field No.	Field Name	
37	DIRECT SUBSIDY AMOUNT	$3,078,000
38	PART D BASIC PREMIUM AMOUNT	$2,100,000
39	ADMINISTRATIVE COST RATIO	0.15
41	**TARGET AMOUNT**	$4,401,300

DETERMINE RISK CORRIDORS

- To calculate the four threshold limits, multiply target amount by the four risk threshold percentages

CALCULATE BAYSIDE'S RISK CORRIDORS

Risk Corridor Thresholds

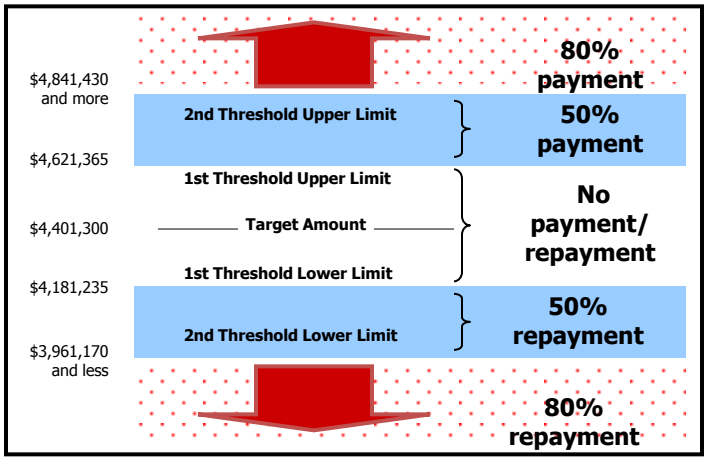
Second threshold upper limit (STUL)	= $4,401,300 *	1.10	=	$4,841,430
First threshold upper limit (FTUL)	= $4,401,300 *	1.05	=	$4,621,365
First threshold lower limit (FTLL)	= $4,401,300 *	0.95	=	$4,181,235
Second threshold lower limit (STLL)	= $4,401,300 *	0.90	=	$3,961,170

CALCULATE BAYSIDE'S RISK CORRIDORS (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
41	TARGET AMOUNT	$4,401,300
43	FIRST UPPER THRESHOLD PERCENT	1.05
44	SECOND UPPER THRESHOLD PERCENT	1.10
45	FIRST LOWER THRESHOLD PERCENT	0.95
46	SECOND LOWER THRESHOLD PERCENT	0.90
47	**FIRST UPPER THRESHOLD AMOUNT**	**$4,621,365**
48	**SECOND UPPER THRESHOLD AMOUNT**	**$4,841,430**
49	**FIRST LOWER THRESHOLD AMOUNT**	**$4,181,235**
50	**SECOND LOWER THRESHOLD AMOUNT**	**$3,961,170**

RISK CORRIDORS



CALCULATE AARCC

- To determine Adjusted Allowable Risk Corridor Costs:
  - Determine unadjusted allowable risk corridor costs (plan-level CPP)
  - Subtract plan-level reinsurance subsidy
  - Subtract Net Part D Covered DIR
  - For Enhanced Alternative (EA) plans only, reduce by the induced utilization factor

CALCULATE BAYSIDE'S AARCC

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

Results Report, DET Record

Field No.	Field Name	
22	PART D COVERED DIR AMOUNT	$1,500,000
25	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,620,000
34	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,120,000
35	INDUCED UTILIZATION RATIO	1.018
36	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,911,591**

DETERMINE RISK SHARING

- The last step in risk sharing is to determine where the Adjusted Allowable Risk Corridor Cost falls with respect to the thresholds and calculate the payment adjustment

DETERMINE BAYSIDE'S 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

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Risk Sharing Payment

Risk Sharing Payment = (.50 * $220,065) + (.80 * $70,161)

Risk Sharing Payment = $110,032 + $56,129

Risk Sharing Payment = $166,161

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
36	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,911,591
47	FIRST UPPER THRESHOLD AMOUNT	$4,621,365
48	SECOND UPPER THRESHOLD AMOUNT	$4,841,430
52	FIRST UPPER RISK SHARING RATE	0.8
53	SECOND UPPER RISK-SHARING RATE	0.5
56	**CURRENT RISK-SHARING AMOUNT**	**$166,161**
59	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$70,161
60	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$220,065

BUDGET NEUTRALITY

- The Budget Neutrality Adjustment Amount (BNAA):
  - Allows demonstration plans to achieve budget neutrality
  - Is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA)
  - Is subtracted from the sum of the three Part D reconciliations (LICS, reinsurance, and risk sharing)
  - Enhanced Alternative plans do not receive a budget neutrality adjustment

ADJUSTMENT DUE TO PAYMENT RECONCILIATION

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost-Sharing Subsidy Adjustment Amount	Field 14
+	Reinsurance Subsidy Adjustment Amount	Field 31
+	Risk Sharing Amount	Field 56
–	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 63
=	Adjustment Due to Payment Reconciliation Amount	Field 66

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

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**

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION (CONTINUED)

Bayside's ARA – Results Report, DET Record

Field No.	Field Name	
14	CURRENT LOW INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
31	CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$480,000
56	CURRENT RISK SHARING AMOUNT	$166,161
63	CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	$0
66	**CURRENT ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**-$193,839**

PRS REPORTS TO PLANS

- Plans active within the coverage year will receive two reconciliation reports from PRS:
  - PRS Inputs Report to Plans
  - PRS Reconciliation Results Report to Plans
- PRS reports were updated in April 2008
- PRS reports are used for initial Part D payment reconciliation and re-opened reconciliation

PRS INPUTS REPORT TO PLANS

- Provides plans with beneficiary-level inputs from MARx and DDPS
- Allows plans to validate the beneficiary-level inputs used in the Part D reconciliation

LAYOUT OF THE PRS INPUTS REPORT TO PLANS

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 one (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

PRS RECONCILIATION RESULTS REPORT TO PLANS

- Provides the results of the three Part D payment reconciliations:
  - Low Income Cost-Sharing Subsidy (LICS)
  - Reinsurance
  - Risk sharing
- Provides the final reconciliation amount
- Provides plan-level inputs from HPMS and program-level inputs from CMS
- Allows plans to understand how their Part D reconciliation was calculated

PRS RECONCILIATION RESULTS REPORT TO PLANS FILE LAYOUT

Record Indicator	Record Definition	Notes
CHD	Contract-level file header	Occurs once per Contract
DET	Detail records at plan-level for the report	Occurs one (1) to many times per CHD record
CTR	Contract-level file trailer	Occurs once per CHD

RECONCILIATION NUMBER

- Contracts can determine if the Results Report is for an initial or re-opened reconciliation through:
  - Current Reconciliation Number
  - Previous Reconciliation Number
- Current Reconciliation Number:
  - Previously called Reconciliation Number
  - Will always be populated as 001 on an initial reconciliation
- Previous Reconciliation Number:
  - Is set to 0 in an initial reconciliation
  - Is greater than 0 in a re-opened reconciliation

FIELDS PASSED FROM INPUTS TO 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

FIELDS PASSED FROM INPUTS TO RESULTS REPORT (CONTINUED)

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
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

HPMS INPUTS ON THE RESULTS REPORT

- Plan-level HPMS inputs include:
  - Reported Part D Covered DIR
  - Administrative Cost Ratio
  - Induced Utilization Ratio (for Enhanced Alternative plans)

CMS PROVIDED INPUTS ON THE RESULTS REPORT

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

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES

- Certain key data elements on the Reconciliation Results Report will have fields for:
  - Previous values (values from the previous reconciliation or re-opening in which there was a payment adjustment)
  - Current values used to calculate the reconciliation in progress
  - Difference between the previous and current values, known as the Delta values

INTERPRETING RESULTS REPORT IN AN INITIAL RECONCILIATION

- In an initial Part D payment reconciliation:
  - Previous values are set to 0
  - Delta values are equal to current values

INTERPRETING RESULTS REPORT IN A RE-OPENED RECONCILIATION

- Previous values of input data elements (e.g., Previous Prospective Reinsurance Subsidy Amount) help show the net change between the inputs of the initial reconciliation or prior re-opening and the current re-opening
- Previous values of results data elements (e.g., Previous Risk Sharing Amount) help plans understand how CMS calculates the adjustment to the final payment determination

EXAMPLE OF REOPENED LICS RECONCILIATION

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

Delta Low Income Cost-Sharing Subsidy Adjustment Amount (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

RE-OPENED RECONCILIATION ADJUSTMENT ON RECONCILIATION RESULTS REPORT

	Reconciliation Amounts	Results Report DET Record Field
	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

SUMMARY

- Understands the systems and processes used in payment reconciliation
- Understands the relationship of reported data to payment
- Described the reconciliation reports plans will receive from PRS
- Determined how the organization can use the PRS reports to understand their Part D reconciliation

Evaluation

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

Your Feedback is Important! Thank you!