RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help prescription drug plans, providers, physicians, and third party submitters locate information specific to prescription drug event data.

The purpose of this Resource Guide is to identify and supply resources that will simplify and clarify both the terminology and the processes employed in the submission of prescription drug event data. An emphasis is given to recent, policy-relevant material.

This Resource Guide is a helpful tool for those who need a quick reference for technical concepts, or for those who need to provide employees with an introductory presentation to the prescription drug event data process. Where possible and appropriate, "screen shots" of important resources on the Internet have been included. These pages may also be utilized as a suitable visual aid for prescription drug event data instructors to enhance their presentation.

The information listed in the Resource Guide is arranged in seven sections:

- PRESCRIPTION DRUG EVENT DATA ACRONYMS AND TERMS
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- REPORTS
- CSSC WEB RESOURCES
- CSSC REFERENCE DOCUMENTS
- APPLICATION FOR ACCESS

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Henry Thomas: henry.thomas@cms.hhs.gov
Jeff Grant: jeffrey.grant@cms.hhs.gov
Janice Keys: janice.keys@cms.hhs.gov
Sandra Anderson: sandra.anderson@cms.hhs.gov
Amanda Ryan: amanda.ryan@cms.hhs.gov
Tara Waters: tara.waters@cms.hhs.gov

CUSTOMER SERVICE AND SUPPORT CENTER (CSSC) – http://www.csscoperations.com
The CSSC website provides "one-stop shopping" for PDP and MA-PD plans regarding prescription drug event data submission needs. Visit www.csscoperations.com to register for email updates from the CSSC. The updates will serve as notification that new or updated information has been added to the website.

CSSC Contact Information
877-534-2772 (toll-free)
csscoperations@palmettogba.com

LEADING THROUGH CHANGE, INC. (LTC)
For general questions about training, please email LTC at PDERegistration@ltcinc.net.

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TABLE OF CONTENTS

PRESCRIPTION DRUG EVENT DATA ACRONYMS AND TERMS

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ACRONYM	TERM
AARCC	Adjusted Allowable Risk Corridor Costs
AE	Actuarially Equivalent
AGNS	AT&T Global Network Services
APPS	Automated Plan Payment System
ASCII	American Standard Code for Information Interchange
BA	Basic Alternative
BIC	Beneficiary Identification Code
CBC	CMS Center for Beneficiary Choices
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
COTS	Commercial Off the Shelf
CPP	Covered D Plan Paid Amount
CSMM	Customer Support for Medicare Modernization
CSSC	Customer Service and Support Center
DAW	Dispense as written
DCD	Drugs Claims Database
DDPS	Drug Data Processing System
DEA	Drug Enforcement Agency
DESI	Drug Efficacy Study Implementation
DIR	Direct and indirect remuneration
DOB	Date of Birth
DOS	Date of Service
EA	Enhanced Alternative
EACS	Enhanced Alternative Cost-Sharing
EBCDIC	Extended Binary Coded Interchange Code
EDI	Electronic Data Interchange
EGWP	Employer Group Waiver Plans
EIN	Employer Identification Number
EOB	Explanation of Benefits
FBDE	Full-Benefit Dual Eligible
FPL	Federal Poverty Level
FTP	File Transfer Protocol
GDCA	Gross Drug Cost Above the Out-of-Pocket Threshold
GDCB	Gross Drug Cost Below the Out-of-Pocket Threshold
GHP	Group Health Plan
HCCs	Hierarchical Condition Categories
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HPMS	Health Plan Management System
HRI	Health Related Item
IDR	Integrated Data Repository
ICD-9-CM	International Classification of Diseases-9th Edition-Clinical Modification
I/T/U	Indian Health Service/Tribe/Tribal organization/Urban Indian Program
LI	Low Income
LICS	Low Income Cost-Sharing
LIS	Low Income Subsidy
LTC	Leading Through Change, Inc.

ACRONYM	TERM
LTI	Long Term Institutionalized
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
MDCN	Medicare Data Communication Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP	Medicare as Secondary Payer
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NDM	Network Data Mover
NPI	National Provider Identifier
NPP	Non-covered Plan Paid Amount
OHI	Other Health Insurance
OON	Out-of-Network
OOP	Out-of-Pocket
OTC	Over-the-Counter
P2P	Plan-to-Plan
PACE	Program of All-Inclusive Care for the Elderly
PAP	Pharmaceutical Assistance Program
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDFS	Prescription Drug Front-End System
PDP	Prescription Drug Plan
PFFS	Private fee-for-service
PLRO	Patient Liability Reduction due to Other payer
POS	Point of sale
PRS	Payment Reconciliation System
RAPS	Risk Adjustment Processing System
RRB	Railroad Retirement Board
Rx BIN	Prescription Beneficiary Identification Number
Rx PCN	Prescription Processor Control Number
Rx ID	Prescription Identification Number
Rx Group	Prescription Group Number
SPAP	State Pharmaceutical Assistance Program
TIN	Tax Identification Number
TrOOP	True out-of-pocket
TRRs	Transaction Reply Reports
UPIN	Unique Provider Identification Number
UPN	Universal Product Number
URCC	Unadjusted Risk Corridor Costs
VDSA	Voluntary Data Sharing Agreements
YTD	Year to Date

CMS WEB RESOURCES

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CMS Main Page
http://www.cms.hhs.gov

Medicare Modernization Act - Prescription Drug Benefit/Medicare Advantage Programs Main Page
http://www.cms.hhs.gov/MMAUpdate/01_Overview.asp

Medicare Modernization Act - Prescription Drug Benefit/Medicare Advantage Programs - Prescription Drug Plan Information Page
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Advance Notice of Methodological Changes for Calendar Year (CY) 2007 Medicare Advantage (MA) Payment Rates and Part D Payment
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2007.pdf

Announcement of Calendar Year (CY) 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies (April 3, 2006)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2008 Medicare Advantage (MA) Payment Rates (45-Day Notice)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2008.pdf

Announcement of Calendar Year (CY) 2008 Medicare Advantage Payment Rates (April 3, 2007)
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf

Prescription Drug Event Data Guidance
http://www.cms.hhs.gov/DrugCoverageClaimsData/01_PDEGuidance.asp

Medicare Managed Care Manual
http://cms.hhs.gov/manuals/IOM/list.asp

Rate Book Information
http://cms.hhs.gov/MedicareAdvtgSpecRateStats/

Risk Adjustment Models
http://cms.hhs.gov/MedicareAdvtgSpecRateStats/

Healthplans Page
http://www.cms.hhs.gov/HealthPlansGenInfo/

Risk Adjustment Page
http://cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

Health Insurance Portability and Accountability Act (HIPAA) Page
http://www.cms.hhs.gov/HIPAAGenInfo/

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates/

HPMS Guidance History
http://www.cms.hhs.gov/PrescriptionDrugCovContra/HPMSGH/list.asp

Plan Communication User's Guide
http://www.cms.hhs.gov/MedicareMangCareSys/

Individuals with Access to CMS Systems (IACS) User Guide and Website
http://www.cms.hhs.gov/MMAHelp/07_IACS.asp#TopOfPage

CMS REFERENCE DOCUMENTS

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Accessing HPMS

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Health Plan Management System (HPMS)

HPMS is a CMS information system that provides plan-level information.

Accessing HPMS

- Access to HPMS is accomplished via the Medicare Data Communications Network (MDCN).
- A User ID is required for HPMS access. If you do not currently have access, complete the "Access to CMS Computer Systems" form available at http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/HPMSAccessform.pdf or at the end of this Resource Guide.

If plans experience difficulty logging into HPMS, please contact Don Freeburger (dfreeburger@cms.hhs.gov) 410-786-4586 or Neetu Balani (nbalani@cms.hhs.gov) 410-786-2548.

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Instructions: Requirements for Submitting Prescription Drug Event Data (includes Cover Letter)

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Center for Beneficiary Choices
Medicare Plan Payment Group

April 27, 2006

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Updated Instructions: Requirements for Submitting Prescription Drug Event Data (PDE)

Today, the Centers for Medicare & Medicaid Services (CMS) issued an updated version of the PDE Instructions: Requirements for Submitting Prescription Drug Event Data. This document contains a few clarifications and minor updates from the previous version posted in January and it is available on our website at http://www.cms.hhs.gov/DrugCoverageClaimsData/RxDrugEventDataGuidance.asp#TopOfPage The changes are as follows:

- In Sections 3 and 6, we updated the document to reflect the correct number of key fields (seven).

- In Section 7.4.1, we appended a new instruction as a note to Table 7A. In the exceptional case where Co-pay > Gross Drug Cost under an enhanced alternative plan, only one calculation is appropriate to determine enhanced alternative cost sharing and NPP Amount when mapping to the defined standard benefit. NPP Amount = (Plan-Paid at POS – CPP Amount).

- In Section 8, we clarify that Medicaid or other payments to subsidize the cost sharing of low-income residents of the U.S. territories under a waiver or grant approved under §1860D-42(a) of the Social Security Act are considered incurred costs for purposes of TrOOP accumulation. These subsidies count towards TrOOP and therefore should be reported in the field Other TrOOP Amount on the PDE record. Note that all other Medicaid payments on behalf of beneficiaries do not count towards TrOOP as is the case with most other government funded programs.

- In Section 10, we added material that clarifies and incorporates the agency's policy for determining low income cost sharing for Level III beneficiaries enrolled in zero deductible plans or in plans with deductibles that are less than the statutory amount ($50 in 2006). This material parallels the Q&As issued on this topic by CMS on February 10th and April 19th.

We will continue to work with plans and other entities to refine and clarify our PDE rules and to answer questions. Please continue to reference these Instructions, review the Training Materials posted on the website of our Customer Service and Support Center (CSSC) at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html, and utilize the support staff available to assist you at CSSC. The online PDE training material is a source of additional examples and is the only source of certain material such as report formats and editing rules.

Questions concerning the updated instructions may be addressed to Ann Marshall at (ann.marshall@cms.hhs.gov) or Sandra Anderson at (sandra.anderson@cms.hhs.gov).

/s/
Thomas E. Hutchinson
Acting Director
Medicare Plan Payment Group

INSTRUCTIONS: REQUIREMENTS FOR SUBMITTING PRESCRIPTION DRUG EVENT DATA

April 26, 2006

INSTRUCTIONS: REQUIREMENTS FOR SUBMITTING PRESCRIPTION DRUG EVENT DATA

Table of Contents

Introduction

i. Background

In December 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), amending the Social Security Act (herein referred to as "the Act") by adding Part D under Title XVIII. Under the new Medicare benefit, the Act allows Medicare payment to plans that contract with CMS to provide qualified Part D prescription drug coverage as described in 42 CFR §423.401. For simplicity in this paper, we use the term "plans" to refer to these entities that provide Part D benefits and that must submit claims data to CMS for payment calculations.

The Act provides four summary mechanisms for paying plans:

1. direct subsidies
2. premium and cost-sharing subsidies for qualifying low-income individuals (low-income subsidy)
3. federal reinsurance subsidies
4. risk sharing

As a condition of payment, all Part D plans must submit data and information necessary for CMS to carry out payment provisions (§1860D-15(c)(1)(C) and (d)(2) of the Act, and 42 CFR §423.322). This document describes how CMS will implement the statutory payment mechanisms by collecting a limited subset of data elements on 100 percent of prescription drug "claims" or events. We describe the required data submission per event, the mode and frequency of submission, and how the data will be used to make payment and conduct reconciliation. These requirements apply to all Part D plans as defined in §423.401 unless separate instructions are issued. PACE organizations, payment demonstration plans and employer/union-only group waiver plans should especially note Sections 14, 15, and 16 where we define special rules for submitting their data.

These instructions are the result of extensive communication and consultation both within and outside the agency. We have incorporated feedback from industry and other stakeholders obtained by both formal and informal means including the rulemaking process, Open Door Forums, and other consultation. In determining requirements, we applied four criteria:

1. Ability to pay plans timely and accurately under the four legislated payment mechanisms;
2. Minimal administrative burden on CMS, plans, and other entities including MA-PDs, PDPs, fallback plans, pharmacy benefit managers, pharmacies, and others;
3. Legislative authority; and
4. Validity and reliability of the data requested, to ensure that the information will be useful.

Much of the data, especially dollar fields, will be used primarily for payment. However, some of the other data elements such as pharmacy and prescriber identifiers will be used for validation of the claims as well as for other legislated functions such as quality

monitoring, program integrity, and oversight. In addition, we note that this paper only covers data collected on claims and does not cover data CMS may collect from plans through other mechanisms, for example monitoring plan formularies and beneficiary appeals.

ii. Overview of contents

Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary record called the prescription drug event (PDE) record to CMS. The PDE record contains prescription drug cost and payment data that will enable CMS to make payment to plans and otherwise administer the Part D benefit. Specifically, the PDE record will include covered drug costs above and below the out-of-pocket threshold; distinguish enhanced alternative costs from the costs of drugs provided under the standard benefit; and will record payments made by Part D plan sponsors, other payers, and by or on behalf of beneficiaries. Plans must also identify costs that contribute towards a beneficiary's true-out-of-pocket or TrOOP limit, separated into three categories: low-income cost-sharing subsidy amounts paid by the plan at the point of sale (POS), beneficiary payments, and all TrOOP-eligible payments made by qualified entities on behalf of a beneficiary.

The submitted data components fit together to allow calculation of payment under the four legislated payment mechanisms. Specifically, CMS will use the data to reconcile low-income cost-sharing subsidy and reinsurance payments and to implement risk sharing between the plan and the federal government through risk corridor payment adjustments. In future years, the drug utilization data may be added to the risk adjustment model for the direct subsidy. CMS will also use PDE data to verify plan administration of TrOOP.

Section 1 defines a PDE record. Many electronic transactions take place between plans, pharmacies, and intermediaries when an enrollee fills a prescription. This process allows determination of patient cost sharing at the point of sale by plan adjudication of the claim, and drives eventual plan payment to the pharmacy. In Section 1, CMS defines the summary claim record plans must submit to CMS, which only contains information that is vital for payment (and, in a few instances, quality oversight or program integrity). We also lay out submission deadlines and rules that apply if a plan fails to provide timely, adequate data for payment or reconciliation.

Section 2 lists the data elements that are required on PDE records submitted to CMS. We provide brief definitions of each data element and how the data field shall be populated. Section 3 lays out a subset of these data elements that together will enable CMS to identify a unique PDE record. CMS needs to be able to identify unique events in order to process adjustments and deletions for PDE record corrections.

Section 4 deals with the issue of how plans will submit PDE records to CMS when claims originate in a non-standard format, for example beneficiary submitted paper claims and 837 claim formats. In a limited number of instances, plans will receive claims from non-standard sources that will not include enough data to populate all data elements listed in

Section 2. Since the plan will then have incomplete data to pass on electronically to CMS for payment, CMS will waive the requirement for the full set of data elements and instead rely on selected elements and accept certain default values. This section lists the minimum required data set for this exceptional circumstance.

Section 5 defines drugs that are covered under the statute's Medicare Part D benefit and/or the Plan Benefit Package (PBP) versus those that are not. Modifiers on PDE records will enable CMS to distinguish costs that must be included or excluded from payment and/or true out-of-pocket costs (TrOOP).

In Section 6, we describe the process for making adjustments and deletions to previously submitted PDE records. Section 7 discusses the mechanisms to identify enhanced alternative (EA) benefits on PDE records. Medicare does not pay for enhanced alternative benefits (cost-sharing fill-in or coverage of non-Part D drugs) that extend beyond that standard or basic benefit defined in the Act; these benefits must not be counted towards TrOOP, low-income subsidies, or reinsurance or risk corridor payments. Therefore, we have developed a schema for disaggregating the costs that are attributable to enhanced alternative coverage. Section 7 also provides key instructions and examples for populating PDE dollar fields in accordance with specific rules for mapping standard versus EA benefits.

In Section 8, we define TrOOP and the process plans must use to segment out the dollar amounts that must be counted towards TrOOP. We provide a brief overview of the TrOOP facilitator and COB contracts, and describe a schema for identifying payments that count towards TrOOP and those that do not. Section 9 discusses the process for adjusting PDE records for revisions in TrOOP accounting within a coverage year.

Section 10 explains the low-income cost-sharing subsidy (LICS) payment provision of the law. We define LICS and describe how CMS will pay plans interim amounts in 2006. We then lay out the methodology for tracking actual LICS expenditures on the PDE record as they are incurred by plans, so that interim payments and incurred amounts can be reconciled. Finally, we provide some examples of how to populate PDE records for LICS-eligible beneficiaries under different plan benefit packages.

Section 11 addresses the requirements of the Act that covered drug costs must be incurred and actually paid by the Part D sponsor, net of any direct or indirect remuneration that decreases the costs incurred by the Part D sponsor for the drug (§1860D-15(b)(2) and (e)(1)(b), 42 CFR §423.308). CMS must exclude such direct and indirect remuneration (referred to in this document as DIR) from allowable reinsurance and risk corridor costs. In Section 11, we define DIR and detail reporting requirements. This section is not a comprehensive discussion of DIR cost accounting; rather, we only address aspects that are intrinsic to reinsurance and risk corridor calculations.

Sections 12 and 13 are devoted to reinsurance and risk corridors. Previous sections describe many of the data elements and calculations that will ultimately be used to conduct final reconciliation and calculate risk sharing dollars as detailed in Sections 12

and 13. Section 12 defines reinsurance and describes how we will determine allowable reinsurance costs from PDE data for reconciliation against interim payments. We describe how CMS will allocate DIR dollars in reconciling reinsurance. Section 13 is devoted to defining risk corridors and explaining how we will calculate adjusted allowable risk corridor costs from PDE data for payment adjustment in reconciliation. We also discuss how we will allocate DIR dollars to risk corridor costs.

In Sections 14 and 15, we provide special rules pertaining to PACE organizations and payment demonstration plans. Section 16 contains special instructions regarding employer-sponsored plans with rules for PDE data submission by employer/union-only group waiver plans. Section 17 provides calculation and reporting rules for PDEs when Medicare is the secondary payer (MSP). We conclude the document with a glossary of acronyms.

Section 1. Data Submission Requirements

1.1 Prescription Drug Event (PDE) Record
For each dispensing event, the plan must submit a prescription drug event or PDE record. Most organizations or sponsoring entities will use a pharmacy benefit manager (PBM) or other third party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates a claim for payment. The PDE is a summary record that documents the final adjudication of a dispensing event. Section 2 lists the required set of data elements for all PDE records (15 data elements from the NCPDP billing transaction, 5 data elements from the NCPDP billing response transaction, and 17 data elements defined by CMS for purposes of administering Part D, for a total of 37 data elements).

1.2Audit Trails
The PDE record summarizes multiple transactions. The plan must maintain audit trails to PDE source data. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted and replicate the summarization. All PDE data is expected to represent the service components as defined for coverage under a given data field. CMS intends to conduct audits of PDE data to ensure the accuracy of payment. CMS will publish further information on audit methodology at a later date.

1.3 Drug Data Processing System (DDPS)

The Drug Data Processing System (DDPS) is the information system that collects, validates, and stores PDE data received from plans or their designee.

DDPS Information Flow PDE records enter DDPS through the Prescription Drug Front-End System (PDFS) in a CMS defined record format. The PDFS initially performs format and face validity checks. Once the file has passed the front-end checks, it moves through the DDPS where detail level edits are performed and the data are stored.

1.4 Data submission requirements for payment and reconciliation
As a condition of payment, all Part D plans must submit data and information necessary for CMS to carry out payment provisions (§1860D-15(c)(1)(C) and (d)(2) of the Act, and 42 CFR §423.322). Plans may designate another entity to submit claims for them to CMS, but plans remain responsible for data submission and content as required under §423.505(k)(3). Note that data submission and payment recovery provisions apply even in the event of a change in ownership.

Plans must submit PDE records for events that fall within the coverage gap of the benefit, even if the plan makes no expenditure in this part of the benefit. Finally, note that by statutory definition, a coverage year corresponds to a calendar year (§1860D-15(b)(4)).

1.4.1 Data submission during the coverage year
In the first year of the benefit (2006), plans or a plan's designee must submit PDE records electronically to CMS according to the following schedule:

- Test file due to CMS by January 31, 2006
- First production file (actual records) due to CMS by the end of the first quarter (March 31, 2006)
- Thereafter, PDE records must be submitted to CMS electronically at least once a month.

Throughout the coverage year, CMS will monitor plan data submission levels to detect plans with submission volumes lower than expected. Low submission patterns often indicate technical or system problems. We will work with plans in an attempt to correct submission problems before the end of the year so they can meet reconciliation submission deadlines. However, the Act places ultimate responsibility on the plan to submit adequate data for payment.

1.4.2 Data submission at the end of the coverage year

PDE records, adjustments, or deletions that are received after the end of the fifth month of the subsequent coverage year will not be considered in reconciliation (§423.308). As prescribed in legislation, a coverage year corresponds to a calendar year. Thus, prescription drug claims including adjustments for all dates of service within calendar year 2006 must be submitted to CMS by May 31, 2007 in order to be processed for payment reconciliation.

Cost information (DIR, LICS, and risk corridor costs) is required within sixth months of the end of the coverage year (§423.343) in order to be considered for payment and reconciliation. Thus, DIR for all dates of service within calendar year 2006 must be submitted to CMS by June 30, 2007.

Late submission or submission of insufficient data to conduct reconciliation may result in payment recovery through a lump-sum recovery; by adjusting or ceasing monthly payments throughout the remainder of a coverage year; or by adjusting monthly payments in a subsequent year. These rules apply to all four types of Part D payment, including risk adjustment data although it is not discussed in this document. For requirements on submitting data for risk adjustment, see the Medicare Managed Care Manual Chapter 7 available at http://www.cms.hhs.gov/manuals/116_mmc/mc86c07.pdf.

- **LICS –** In 2006, since CMS is collecting cost data on LICS via PDE records instead of cost reports, Part D plans must provide documentation of LICS amounts on PDE records within the claims submission deadline (by the end of the fifth month of the next coverage year) to avoid recovery of interim amounts paid to plans for which no data are available.

- **Reinsurance –** If a Part D sponsor does not provide DIR data within six months of the end of the coverage year, CMS may recover interim monthly reinsurance payments for which no data are available.

- **Risk corridor payment –** For risk-sharing arrangements, if allowable costs submitted in the prescribed periods sum to less than 50 percent of the plan's target

amount, CMS will assume or impute that the entity's adjusted allowable risks corridor costs are 50 percent of the target amount (§423.343).

1.5 Appeals
As described in the final rule §423.350, Part D sponsors may appeal final payment decisions if the sponsor believes the payment methodology described in the final Part D rule and in interpretive guidance has not been applied correctly. Under no circumstances may this process be used to submit new payment information after established deadlines.

Section 2. Data Elements for PDE records

In this section, we list the required data elements that must be submitted on PDE records for payment. We employ the National Council for Prescription Drug Programs (NCPDP) industry standard whenever possible. Most data elements represent existing NCPDP fields where we employ the same definition and field values that are currently in use per the NCPDP version 5.1 drug claim standard. CMS has also drafted several new fields for data that are not currently collected on industry drug claims but that are necessary for us to pay plans in accordance with the new law. All fields are consistent with NCPDP formatting. It is not our intent to change NCPDP standards; the NCPDP format is developed independently from CMS.

This section defines each data element and its specific potential use for CMS's payment process:
1. Contract Number (Format cross reference - **BHD 3**)
This field contains the unique number CMS assigns to each contract that a Part D plan has with CMS. This data will be collected in the file header.

2. Plan Benefit Package (PBP) ID (Format cross reference - **BHD 4**)
This field will contain the unique number CMS assigns to identify a specific PBP within a contract. DDPS will utilize this data to ensure that each beneficiary's claims are being attributed to the appropriate PBP, i.e., the PBP in which the beneficiary is enrolled.

3. Claim Control Number (Format cross reference - **DET 3**)
This field is an optional, free-form field. It may be used by plans to identify unique events they have submitted to DDPS or for any other plan purpose. The data in this field will be reported back to a plan in the event a batch or individual record is rejected at some point in processing.

4. Health Insurance Claim Number (HICN) (Format cross reference - **DET 4**)
This field will contain the unique number that the Social Security Administration assigns to identify every Medicare beneficiary. For Railroad Retirement Board (RRB) beneficiaries, plans will use the RRB number in this field instead of a HICN. From here forward, when we refer to HICN, we mean HICN or RRB# as appropriate. Plans must use other identifiers as member numbers (e.g., for plan membership cards). Plans must then translate their member number or cardholder ID to the beneficiary's correct HICN.

All drug events submitted to DDPS must use the HICN, which ensures that DDPS assigns drug event data to the appropriate beneficiary. The HICN will also permit linkage of Part D drug event data to Parts A and B claims data, eligibility and enrollment data, and risk adjustment data.

5. Cardholder ID (Format cross reference - **DET 5**)
We will collect the plan-assigned number used to identify the beneficiary. This number verifies beneficiary identity and will be used to help plans map transactions to their databases and for program oversight functions.

6. Patient Date of Birth (DOB) (Format cross reference - **DET 6**)
Patient date of birth (DOB) is optional and will be used in conjunction with HICN and gender to verify beneficiary identity. It will be used as a cross-reference to ensure the event has identified the correct beneficiary.

7. Patient Gender (Format cross reference - **DET 7**)
Together with HICN and DOB (when reported), gender confirms the identity of the beneficiary.

8. Date of Service (DOS) (Format cross reference - **DET 8**)
Date of Service (DOS) is the date on which the prescription was filled. This field should **not** contain the date on which the plan pays for the services or subsequent adjustments to the original event.

9. Paid Date (Format cross reference - **DET 9**)
This field shall be populated with the date the plan originally paid the pharmacy for the prescription drug. (If the plan subsequently adjusts payment, the plan will report the original paid date in the adjustment PDE). Paid Date is a mandatory field for fallback plans, and is **optional** for all other plan types. CMS will use Paid Date to reconcile drug costs reported on PDE records to withdrawals for drug costs from the fallback plan's draw-down account.

The following two fields pertain to identifying the pharmacy where the prescription was dispensed:

10. Service Provider ID Qualifier (Format cross reference - **DET 13**)
This field indicates the type of provider identifier used in field 11 (Service Provider ID).

11. Service Provider ID (Format cross reference - **DET 14**)
This field identifies the pharmacy where the prescription was filled. This data helps CMS identify a unique prescription drug event (see Section 3). CMS will transition to use of the national provider identifier (NPI) when it is implemented. In the interim, this field will typically contain the NCPDP number, which all NCPDP billers are assigned. Some Part D service providers who submit in Non-Standard Format (e.g., home infusion, physicians when providing vaccines) will not have NCPDP numbers. For these providers, the UPIN, State License Number, federal Tax Identification Number (TIN) or

Employer Identification Number (EIN), or the default value of "PAPERCLAIM" will be the required identifier.

The following two fields pertain to identifying the prescriber:

12. Prescriber ID Qualifier (Format cross reference - **DET 21**)
This field indicates the type of identifier that is used in the Prescriber ID field.

13. Prescriber ID (Format cross reference - **DET 22**)
This field will contain the prescriber's unique identification number. CMS will transition to use of the national provider identifier (NPI) when it is implemented. In the interim, CMS requires use of a DEA number whenever it uniquely identifies the prescriber and is allowed by state law. In other cases, the prescriber's state license number or Unique Provider Identification Number (UPIN#) shall be used.

14. Prescription/Service Reference Number (Format cross reference - **DET 10**)
This field will contain the prescription reference number assigned by the pharmacy at the time the prescription is filled. It enables DDPS to identify a unique prescription drug event (see Section 3).

15. Product/Service ID (Format cross reference **- DET 12)**
This field identifies the dispensed drug using a National Drug Code (NDC). NDC will be reported in NDC11 format. In instances where a pharmacy formulates a compound containing multiple NDC drugs, the NDC of the most expensive drug shall be used.

DDPS will reject the following billing codes for legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996. If plans receive these codes from trading partners, the plan is responsible for reporting the NDC of the most expensive drug.

16. Compound Code (Format cross reference - **DET 17)**
This field will indicate whether or not the dispensed drug was compounded or mixed. This distinction will ensure that correct payments are made to the plan for mixed or compounded drugs. Plans may adjust the dispensing fee to include additional labor costs in the delivery of the compounded pharmaceutical item.

17. DAW/Product Selection Code (Format cross reference **- DET 18)**
This field will indicate the prescriber's instruction regarding substitution of generic equivalents or order to dispense the specific product written.

18. Quantity Dispensed (Format cross reference **- DET 19)**
This field indicates how many dosage units of the medication were dispensed in the current drug event (e.g., number of tablets, grams, milliliters, or other unit).

19. Days Supply (Format cross reference **- DET 20)**

This field indicates the number of days' supply of medication dispensed by the pharmacy and will consist of the amount the pharmacy enters for the prescription.

20. Fill Number (Format cross reference **- DET 15)**
This field indicates the number fill of the current dispensed supply.

21. Dispensing Status (Format cross reference **- DET 16)**
This field indicates how the pharmacy dispensed the complete quantity of the prescription. When the pharmacy partially fills a prescription, this field indicates a partial fill. When the full quantity is dispensed at one time, this field is blank.

When the pharmacy dispenses a partial fill, the plan has the option to submit two PDE records, one for the partial fill and a second for completion of the partial fill. If the plan prefers, the plan can defer PDE submission for a reasonable amount of time until the plan receives transactions for both the partial and complete fill. At that point, the plan may summarize the multiple transactions in a single PDE, reporting a blank in Dispensing Status.

22. Drug Coverage Status Code (Format cross reference **- DET 23)**
This field indicates whether or not the drug is covered under the Medicare Part D benefit and/or a specific PBP (see Section 5).

23. Adjustment/Deletion Code (Format cross reference **- DET 24)**
This field distinguishes original from adjusted or deleted PDE records so that the DDPS can adjust claims and make accurate payment for revised PDE records

24. Non-Standard Format Code (Format cross reference **- DET 25)**
This data element will be used by DDPS to identify PDE records that are compiled from non-standard sources. NCPDP is the standard format in which plans receive data from pharmacies. Section 4 identifies non-standard data sources in more detail and gives direction for compiling PDE records using data received in non-standard formats.

25. Pricing Exception Code (Format cross reference **- DET 26)**
This field indicates that the PDE reports an out-of-network or Medicare as Secondary Payer (MSP) service that is subject to unique pricing rules.

26. Catastrophic Coverage Code (Format cross reference **- DET 27)**
This field indicates that a beneficiary has reached the out-of-pocket (OOP) threshold or attachment point. At this point, catastrophic coverage provisions begin, namely reinsurance and reduced beneficiary cost sharing (see Section 8).

The following three data elements represent the amounts we will use from PDE records to determine costs that qualify for payment under the Medicare benefit:

27. Ingredient Cost Paid (Format cross reference **- DET 28)**

This field will contain the amount paid to the pharmacy for the drug itself. Dispensing fees or other costs shall not be included in this amount except as allowed on non-standard format claims as discussed in Section 4.

28. Dispensing Fee Paid (Format cross reference **- DET 29)**
This field will contain amounts paid to the pharmacy for dispensing the medication. Include only those activities related to the transfer of possession the drug from the pharmacy to the beneficiary, including charges associated with mixing drugs, delivery, and overhead as delineated in the final rule §423.100 and the preamble to the rule. No other costs shall be included in this field. The fee may be negotiated with pharmacies at the plan or PBM level.

29. Total Amount Attributed to Sales Tax (Format cross reference **- DET 30)**
This field shall contain the sum of all amounts paid to the pharmacy to cover sales tax.

Under Part D, benefits change for both the plan and beneficiary when a beneficiary reaches the out-of-pocket (OOP) threshold or attachment point. To facilitate reconciliation and monitoring benefit provisions on either side of the threshold, two fields on every PDE record will report total costs for covered drugs (see Section 5) as falling above or below the OOP threshold. For a PDE where a beneficiary reaches the OOP threshold or attachment point, there may be costs on either side of the threshold. The fields will be populated as follows:

30. Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB)
(Format cross reference **- DET 31)**
This field represents the gross drug cost (Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax) paid to the pharmacy below the OOP threshold for a given PDE for a covered drug as defined in Section 5. For claims before a beneficiary has reached the attachment point, this field will list a positive dollar amount. For claims above the attachment point, this field will have a zero dollar value. For a claim on which the attachment point is reached, there will be a positive dollar amount in this field and there is likely to be a positive dollar amount in the GDCA field.

31. Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)
(Format cross reference **- DET 32)**
This field represents the gross drug cost (Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax) paid to the pharmacy above the OOP threshold for a given PDE for a covered drug as defined in Section 5. For claims before a beneficiary has reached the attachment point, this field will list a zero dollar amount. For claims above the attachment point, this field will have a positive dollar value. For a claim on which the attachment point is reached, there is likely to be a positive dollar amount in this field and there will be a positive dollar amount in the GDCB field.

32. Patient Pay Amount (Format cross reference **- DET 33)**

This field lists the dollar amount the beneficiary paid that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts). This amount contributes to a beneficiary's TrOOP only when it is payment for a covered drug as defined in Section 5. Plans are responsible for ensuring that beneficiaries are charged amounts that are consistent with their benefit packages as approved in the bidding process.

Note: Payments actually made by a beneficiary shall be recorded in this field, and we expect amounts paid by friends or family to also be reported under Patient Pay Amount. However, other third party payments made on behalf of a beneficiary that contribute to TrOOP shall be reported in the Other TrOOP Amount or LICS fields, and payments that do not contribute to TrOOP shall be reported in the PLRO field.

The following three data elements distinguish sources of subsidized payments that may be made on behalf of beneficiaries to reduce their cost-sharing liability. DDPS separates beneficiary liability amounts into Patient Pay Amount and these three fields to allow distinctions that are important to TrOOP accumulation and risk corridor cost calculation:

33. Other TrOOP Amount (Format cross reference **- DET 34)**
This field records all qualified third party payments that contribute to a beneficiary's TrOOP, except for LICS and Patient Pay Amount. Examples include payments made on behalf of a beneficiary by qualified SPAPs, charities, or other TrOOP-eligible parties.

*Note: LICS amounts and payments by beneficiaries or friends or family, which count towards TrOOP, shall **not** be reported in this field; they are reported in the LICS and Patient Pay Amount fields. Also, the Other TrOOP field does **not** include payments by other parties that do not contribute to TrOOP; those amounts are reported in the PLRO field.*

34. Low-Income Cost-Sharing Subsidy Amount (LICS)
(Format cross reference **- DET 35)**
The Act provides for Medicare payments to plans to subsidize the cost-sharing liability of qualifying low-income beneficiaries at the point of sale (see Section 10). In accordance with statutory language, we refer to these amounts as Low-Income Cost-Sharing Subsidies or LICS amounts. The LICS field will contain plan-reported LICS amounts per drug event, so that CMS systems can reconcile prospective LICS payments made to plans with actual LICS amounts incurred by the plan at POS.

35. Patient Liability Reduction due to Other Payer Amount (PLRO)
(Format cross reference **- DET 36)**
This field takes into account coordination of benefits that results in reduced patient liability, excluding any TrOOP-eligible payers. This field shall contain amounts by which patient liability is reduced due to payments by other payers that do not participate in Part D and are not TrOOP-eligible (see Section 8). PLRO amounts are excluded from Part D payment, and the PLRO field documents these benefits so that CMS can exclude

them from risk corridor calculations and from TrOOP accumulation. Further instruction on populating the PLRO field is provided in Section 8.

*Note: This field should **not** include payments or other patient liability reductions due to coverage under qualified SPAPs or any other TrOOP-eligible third party payer. All TrOOP-eligible amounts should be reported in the Patient Pay Amount field (if paid by the beneficiary, family, or friends) or in Other TrOOP Amount (if paid by another qualified third party).*

To facilitate reconciliation, the following two fields report the net amount the plan has incurred on a PDE for standard or enhanced alternative benefits:

36. Covered D Plan Paid Amount (CPP) (Format cross reference **- DET 37)**
This field shall contain the net amount the plan paid for standard benefits (covered Part D drugs – see Sections 5, 7). In other words, the field reports the plan-paid amount for drugs with Drug Coverage Code = C. If Drug Coverage Code = E or O, the CPP field is zero. DDPS will use this field to facilitate reconciliation calculations, especially determining allowable risk corridor costs.

37. Non-covered Plan Paid Amount (NPP) (Format cross reference **- DET 38)**
This field shall contain the net amount paid by the plan for benefits beyond the standard benefit. Thus, this value includes all over-the-counter drugs, enhanced alternative drugs, and enhanced alternative cost-sharing amounts (see Sections 5, 7). The amount recorded in NPP is excluded from risk corridor payment and from TrOOP accumulation. DDPS may also use this data to assure that coverage provisions are in accordance with the approved plan benefit structure from its bid.

Section 3. Key fields to uniquely identify PDE record

Of the fields outlined above, we will use the following seven fields to identify a single unique prescription drug event. A change in any of the following seven fields indicates a different event:

HICN
Service Provider ID
Service Provider ID Qualifier
Prescription/Service Reference Number
Date of Service
Fill Number
Dispensing Status

We used the following rationale to identify the key fields. We included HICN because it is the basic beneficiary identifier in the Medicare program. In the majority of cases, the concatenation of Service Provider, Prescription/Service Reference Number and Fill

Number uniquely identify a prescription. Fill Number distinguishes original versus subsequent refills of the same prescription from the same pharmacy. We added Date of Service because some pharmacies report that they reuse prescription numbers. We added Dispensing Status to differentiate between a partial fill and the completion of partial fill. The industry concurred that the concatenation of these seven fields guarantees that we will uniquely identify a prescription. See Section 6 on the Adjustment/Deletion process for additional information about processing rules.

Section 4. PDE records with non-standard data format source

Since the pharmacy industry is highly automated, plans will almost always receive data electronically in NCPDP format. Therefore, we consider NCPDP 5.1 to be the standard data format for PDE record transactions. However, there are occasions when plans will receive claims in another data format that does not provide some of the information requisite for populating the full set of PDE data elements. For example, plans must accept X12 837 formatted claims from certain providers in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), but the current version of X12 does not disaggregate dispensing fee for populating the NCPDP Dispensing Fee Paid field. On this and other occasions when a plan receives input data from pharmacies in a non-standard format, plans will populate the Non-standard Data Format Code with one of four mutually exclusive values. These values are:

B – submitted by beneficiary
Example: a beneficiary purchases an emergency prescription at an out-of-network (OON) pharmacy and submits a receipt to the plan for reimbursement
X – submitted by provider in X12 format
Example: a home infusion pharmacy submits data in X12 format
P – submitted by provider on paper claim
Example: a physician office submits a hard-copy claim for a Part D covered vaccine or other Part D drug
Example: an I/T/U pharmacy faxes a claim to the plan
Example: a 340B pharmacy submits a paper claim to the plan
Blank – NCPDP

Plans shall make every attempt to populate a PDE record completely. CMS recognizes that claims submitted in non-standard data format may not include all data elements necessary to populate a PDE record and that additional processing to add contractual elements would be necessary to produce a PDE record. Therefore, DDPS will suspend certain edits and accept a reduced set of data elements for PDE records compiled from non-standard data sources according to the following instructions:

Optional fields – Prescriber ID Qualifier and Prescriber ID. **All other fields must be reported.**

Instructions for Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax – If the dispensing pharmacy does not disaggregate gross drug cost into these three cost components, the plan may report one dollar value for all three costs under the field Ingredient Cost Paid. However, plans must still populate Dispensing Fee Paid and Total Amount Attributed to Sales Tax with a value = zero; these are not optional fields. Also, any dispensing fee that is reported by the plan under Ingredient Cost Paid shall only consist of the dispensing service that is covered under Part D as defined in the final rule §423.100 and in the preamble to the rule (see Section 2, Data Elements for PDE records, Dispensing Fee Paid). Plans must ensure that PDE records compiled from infusion pharmacy claims or any other claims originating in X12 format comply with the Part D regulatory definition of dispensing fee and all other data elements.

Instructions for Fill Number, DAW, Compound Code, Service Provider ID, Prescription Service Reference Number, and Days Supply – If plans do not have source data to populate these fields, plans will use the following business rules to populate default values:

Fill number – default value is "00"
DAW – default value is "0-No Product Selection Indicated"
Compound Code – default value is "0-not a compound"
Service Provider ID – When a physician who is not registered with NCPDP dispenses a drug, the plan will report one of the following alternative values in lieu of the pharmacy's NCPDP (formerly NABP) number in the Service Provider ID field.

Service Provider ID	Service Provider ID Qualifier
UPIN	06
State License Number	08
Federal Tax ID	11
PAPERCLAIM	99

Prescription Service Reference Number – When not available, the plan must assign a unique reference number. A reference number must be unique for any given service provider/DOS combination.
Days Supply – default value = 000

DDPS will monitor submission rates of this reduced data set. We anticipate reviewing the volume of PDEs with non-standard data formats as a percentage of total PDEs. If this percentage is higher than expected, we will conduct further research and we may reconsider use of reduced data requirements for PDEs with source data in non-standard data formats.

Consistent with Section 1.2 Audit Trails, CMS expects a complete audit trail for any PDE compiled from claims that originate in non-standard data format.

Section 5. Drug Coverage Status

Under §1860D-2(e) of the Act, CMS can pay only for drugs that both meet the definition of a "Part D drug" and are approved for coverage under a specific PBP. **In this document, we use the term "covered" to refer to these drugs that a plan covers under its basic benefit.** Drugs that do not meet these criteria must be excluded from reinsurance subsidy (§1860D-15(b)(2)), risk corridor calculations (§1860D-15(e)(1)(B)), low-income cost-sharing subsidy (§1860D-14 and D-2), and true out-of-pocket costs or TrOOP (§1860D-2(b)(4)(C)(i)). In implementing these policies, we use the following terminology:

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

- **Covered Part D drug** – a drug that meets the definition of a Part D drug and is also covered under a PBP. Includes Part D drugs covered under an exception, transition, grievance, appeal or other coverage determination process as described in regulation (42 CFR Subparts C and M). **We refer to these drugs as "covered drugs" because they are included in the basic benefit.**

- **Non-covered Part D drug** - A drug that meets the definition of a Part D drug but the PBP does not cover it, usually because it is off-formulary or the plan does not find it is reasonable and necessary.

Non-Part D drug – any prescription or over-the-counter drug that is not a Part D drug or that is already covered under Medicare Parts A or B as prescribed, dispensed, or administered. **In this document, we refer to these drugs as "non-covered" even though a plan may cover some of these drugs as a supplemental benefit or as part of OTC step therapy under an approved formulary.** Except for smoking cessation agents, these drugs are described under §1927(d)(2) (e.g., benzodiazepines, weight loss agents, cough and cold relief) and §1862(a) (e.g., drugs used in cosmetic surgery).

Plans shall only pay for covered Part D drugs ("covered drugs"), with the following exceptions:

1. Supplemental drugs - Enhanced alternative plans may decide to offer some non-Part D prescription drugs as part of their enhanced alternative benefit package (see Section 7.1).

2. OTC drugs employed in step therapy – A plan may cover an over-the-counter (OTC) drug when it is included in approved step therapy protocols that satisfy CMS formulary review. Plans must submit PDE records to DDPS for these drugs, but the drugs will be paid for under plan administrative costs as reported in the bid and will be excluded from other Part D payment calculations based on PDE records. Plans shall not charge any beneficiary cost sharing for formulary OTCs.

Plans are not required to submit claim denials on PDE records. However, they must submit PDE records for any drug they cover, distinguishing three coverage categories:[1]

C – Covered Part D drug ("covered drug")
E – Enhanced alternative drug, a non-Part D drug covered by a plan as a supplement to the standard Part D benefit ("non-covered drug")
O – OTC drug, covered by a plan in keeping with approved formulary step edits ("non-covered drug")

The following examples clarify use of the Drug Coverage Status field values:

Example 1 – A beneficiary presents a prescription for a 30 day supply of hydrochlorothiazide 50 mg tablet, 30 tablets. Hydrochlorothiazide 50 mg tablet is on the plan's formulary. The plan requires no approval steps to dispense or pay. Drug Coverage Status = C.

Example 2 – A beneficiary presents a prescription for a 30 day supply (30 capsules) for Sporonox 200 mg (itraconazole) Capsules. Itraconazole is on the plan's formulary with prior authorization required. The beneficiary's physician prescribed itraconazole because the beneficiary has onychomycosis, confirmed by histological test (KOH, PAS stain) or culture. Treatment is limited to six months in duration. The clinical information provided by the physician met the authorization requirements. Drug Coverage Status = C.

Example 3 – A beneficiary presents a prescription for a 10 day supply (10 tablets) of Dalmane 15 mg (flurazepam), a benzodiazepine agent. The beneficiary is enrolled to an enhanced alternative plan that offers flurazepam on its plan formulary as a supplemental drug. Medicare Part D does not cover benzodiazepines. However, the plan covers this class of drugs as a supplemental benefit, appropriate for short-term use in healthy beneficiaries under the age of 75. Drug Coverage Status = E.

Example 4 – A plan's approved step therapy protocol requires a beneficiary to fail an initial course of OTC Prilosec before the plan will cover a prescription for proton pump inhibitors (Nexium). A beneficiary presents a prescription for Nexium at the retail pharmacy. The plan informs the pharmacist that the beneficiary must meet a step edit with OTC Prilosec. The pharmacist speaks with

[1] We omitted the value = X that designated EA drugs funded using A/B dollars.

the physician and the physician authorizes the pharmacy to change therapy to OTC Prilosec. Drug Coverage Status = O.

Section 6. Adjustment/Deletion Process

An adjustment or deletion is any change reported after the original PDE record was submitted. Adjustments and deletion records can report data changes that are critical to Part D. For example, an adjustment record can update delayed reporting of secondary health insurance payments that reduce TrOOP. Alternatively, an adjustment record can update delayed reporting of secondary coverage that does count towards TrOOP, e.g. retroactive determination of low-income subsidy eligibility, qualified SPAP eligibility, or a payment by a charity. When prescriptions are not picked up by the beneficiary and a PDE has already been submitted, the plan must submit a deletion record.

The DDPS will use the Adjustment/Deletion Code to trigger adjustment/deletion processing. Adjustment/Deletion matching logic requires a nine-field match: the seven key fields (see Section 3), Contract Number (reported in the header), and Plan Benefit Package ID. We added Contract Number and PBP ID to reserve adjust/delete rights exclusively to the Contract Number and PBP that authored the original PDE record.

When DDPS receives a PDE record with Adjustment/Deletion Code = A (adjustment) or D (deletion), DDPS will search the database for a current active PDE record with matching values in Contract Number, Plan Benefit Package ID, HICN, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, Date of Service, Fill Number, and Dispensing Status. If the matching current active record is not found, DDPS will return an error message to the plan. DDPS will not assume that the plan submitted an original PDE incorrectly identified as an adjustment or a deletion. If the Adjustment/ Deletion Code = D (deletion), DDPS will inactivate the current active record. If the Adjustment/ Deletion Code = A (adjustment), DDPS will inactivate the current active record and identify the adjustment PDE as the current active record. DDPS will exclude inactivated PDE records from any subsequent calculations for the beneficiary, PBP or Contract.

Since key fields cannot be changed, there is only one mechanism to correct a key field. The plan will submit a deletion PDE for the record in error and submit a new PDE with corrected data elements. This logic has implications for partial fills. DDPS cannot support multiple partial fills. Dispensing Status, the field that documents partial fills (see Section 2), is a key field (see Section 3). DDPS will reject a PDE documenting a multiple partial fill as a duplicate. If a plan receives multiple partial fill transactions, the plan will submit an adjustment record that, in effect combines all partial fill events.

DDPS adjustment processing logic observes several hierarchies. Once a PDE record has been marked as inactive, it cannot be adjusted. If a replacement record is necessary, the plan must submit a new PDE record for the prescription event.

A second hierarchy applies to PDEs reporting partial and complete fills:

- Dispensing Status = 'P' or 'C' cannot follow a value = 'blank' – When a PDE with Dispensing Status = 'P' or 'C' indicating partial fill or completion of partial fill is on file, DPPS will not accept a deletion record with Dispensing Status = 'blank'
- Dispensing Status = 'blank' cannot follow 'P' or 'C' – When a PDE with Dispensing Status = blank is on file, DPPS will not accept a deletion record with Dispensing Status = 'P' or 'C'

Plans may take steps to minimize adjustment volume. There are several ways to minimize the number of adjustments:

- Plans can delay submission until they have finalized the data necessary to populate a PDE **but within the submission deadlines detailed in Section 1.3.1.** For example, a plan may decide to defer PDE submission for a period of time (e.g., 15 days) to allow sufficient time for the beneficiary to pick up the prescription. Most pharmacies wait 10 days or 2 weeks before returning "no pick-up" prescriptions to stock. Alternatively, plans may decide to defer PDE submission for one month if the plan expects an update in other insurance coverage.

- Second, plans may report PDEs as they administer the benefit (see Section 9).

Finally, note that a PDE record, which may be an original event, an adjustment or a deletion, reports the most recent information as of the date of submission. DDPS will use the file submission date on a given PDE record as its identifier. Because DDPS uses submission date to identify a PDE, only one original record, adjustment, or deletion of an event can be submitted per day.

Section 7. Enhanced Alternative Benefits

7.1 Definition

Under §1860D-1 and D-2 of the Act, all Part D plans are required to provide "standard" (§1860D-2(b)) or "basic alternative" (§1860D-2(c)) prescription drug benefits. However, plans have the option to provide additional benefits that exceed the actuarially equivalent value of (i.e. are supplemental to) the basic benefit (§1860D-2(a)(2)). We refer to these plans as enhanced alternative plans and we refer to these benefits as enhanced alternative benefits.[2] Enhanced alternative benefits, which the statute refers to as supplemental benefits, can take two forms (§1860D-2(a)(2)(A)(i-ii)):

[2] The Act uses the term "supplemental" to describe benefits that exceed the standard benefit and that are offered by enhanced alternative plans (§1860D-2(a)(2)). In this document, we only use the term "supplemental" in its statutory sense to refer to enhanced alternative benefits. In contrast to common industry practice, we use the term "other health insurance" (OHI) rather than "supplemental benefits" when referring to non-Part D third-party payers or benefits discussed in Section 8 (TrOOP and Other Payers).

1. Reduced cost sharing (reduced coinsurance, copays, deductible, and/or an increase in the initial coverage limit), that is, additional payments by the plan beyond those provided under the basic benefit (applies only to covered Part D drugs). We refer to this supplemental benefit as enhanced alternative cost sharing (EACS); and/or

2. Coverage of non-Part D drugs that require a prescription (e.g., benzodiazepines, barbiturates). Over-the-counter products are not allowed as enhanced alternative benefits.

Per §1860D-15(e)(4), Medicare does not pay for these enhanced alternative benefits; rather, plans fund them from other sources such as supplemental premiums (§1860D-13(a)(1)(C)), A/B rebate dollars from the MA bidding process (see 42 CFR §422.266), and/or the negative premium as described in the Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates (http://www.cms.hhs.gov/healthplans/rates/2006/cover.pdf).

The Act does not allow enhanced alternative benefits to be included in calculating the following amounts:

- Reinsurance subsidies (§1860D-15(b)(2))
- Risk corridor payment adjustments (§1860D-15(e)(1)(B))
- LICS (§1860D-14)
- TrOOP (§1860D-2(b)(4)(C)(i)).

7.2 Identifying enhanced alternative benefits for exclusion from payment

As previously described, Medicare does not cover benefits beyond the standard benefit; they must be excluded from payment. CMS uses three data fields in the Prescription Drug Event (PDE) record to identify EA benefits in order to make correct payments:

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

7.2.1 Drug Coverage Status Code

The value of "E" in the drug coverage status code indicates when payments are for an EA drug.

(E) Enhanced Alternative Drug – a non-Part D drug that is covered under a Part D plan's benefit package, also referred to as a non-covered or supplemental drug. Only EA plans can report a value of "E" in the drug coverage status field.

When Drug Coverage Status Code = E, the Drug Data Processing System (DDPS) automatically excludes the gross drug cost from reinsurance subsidies, allowable risk corridor costs, True Out-of-Pocket costs (TrOOP), and low income cost-sharing (LICS)

payment calculations. DDPS uses the Drug Coverage Status Code to exclude supplemental drugs from payment.

7.2.2 Covered D Plan Paid Amount (CPP)

Plans administering a standard benefit cannot offer supplemental benefits. When these plans report a covered drug, the plan-paid amount is reported in full in CPP, and NPP is zero. EA plans can offer EACS on covered drugs, cost-sharing assistance that exceeds the standard benefit amount. So, when an EA plan reports a covered drug, the plan-paid amount is split into the amount the plan would have paid under the Defined Standard benefit (which is CPP) and the amount the plan pays in EACS (which is reported in NPP). We refer to this process as "mapping to the Defined Standard benefit," and we further discuss the rationale for mapping and the business rules to apply it in Section 7.4.

7.2.3 Non-Covered Plan Paid Amount (NPP)

The NPP field is used for reporting plan-paid amounts for non-covered drugs (supplemental drugs and over-the-counter (OTC) drugs) and for EACS. **Note:** the dollar amount in NPP is mutually exclusive of the dollar amounts reported in the other payment fields: CPP, Patient Pay Amount, LICS, Other TrOOP Amount, and Patient Liability Reduction due to Other Payer Amount (PLRO). These six payment fields record six mutually exclusive types of payment. When the PDE reports a covered drug, the sum of these six payment fields is the total covered drug cost, also called the gross drug cost.

If a plan reports a value of "C" in the Drug Coverage Status field and a dollar amount in the NPP field, DDPS automatically excludes the dollar amount in NPP from risk corridor and TrOOP calculations because it is EACS.

7.3 Business Rules for Reporting Enhanced Alternative Drugs

As described above, EA drugs are identified using the drug coverage status code = E. The plan and the beneficiary pay the pharmacy according to the provisions of the plan benefit package (PBP). The full plan-paid amount is reported in NPP so that it is excluded from allowable reinsurance and risk corridor costs. There is never a CPP amount because all plan payments for EA drugs are excluded from Medicare payment. Finally, recall that no LICS is paid on supplemental drugs and no out-of-pocket or third party payments on these drugs count toward TrOOP. Therefore, the LICS Amount and Other TrOOP Amount always = $0.00 on a PDE that reports an EA drug.

7.4 Business Rules for Calculating and Reporting Enhanced Alternative Cost Sharing

Enhanced alternative cost sharing (EACS) is a key component in administering benefits and reporting PDEs. It is more complicated than reporting EA drugs. Reporting for EA drugs is straightforward because CMS uses the Drug Coverage Status Code with a value of "E" to identify EA drugs and exclude them from payment. But because EACS includes an amount the plan would have paid under a basic benefit and an additional amount the plan pays in extra cost-sharing assistance, CMS uses a slightly more complicated process

to partition the two amounts and exclude the supplemental cost-sharing from Medicare payment.

7.4.1 Mapping to the Defined Standard Benefit

PDE reporting must be consistent with bid information. EA bids have a standard component and an enhanced alternative component. To align PDE reporting with the standard component of the bid, CMS maps payments that include EACS to the defined standard benefit using special rules for reporting CPP and NPP amounts.

Note that all EACS amounts are for covered drugs, so both supplemental and standard benefits are being reported in the same PDE (unlike a PDE for an EA drug, which only includes supplemental benefits identified as such). The following section delineates the business rules that allocate covered drug costs for a PDE into covered and non-covered amounts paid by the plan. The amount associated with the defined standard benefit is reported in CPP. The amount associated with the EA benefit is classified as the supplemental cost-sharing assistance, referred to as EACS, and is reported in the NPP amount.

Tables 7B and 7C delineate how to calculate and report PDEs that have EACS, focusing on the data fields Patient Pay Amount, CPP and NPP with special rules for calculating CPP.

TABLE 7A – REPORTING EACS

STEP	DESCRIPTION	PDE FIELD
1	Report the amount paid by the beneficiary at Point of Sale (POS) in the Patient Pay Amount field.	Patient Pay Amount
2	Calculate the amount to report in the CPP field. • CPP is determined by the defined standard benefit, and will not necessarily be the same as the amount paid by the plan at POS. • CPP equals total covered drug cost multiplied by the applicable percentage for calculating the defined standard benefit (see Table 7C).	CPP
3	Determine EACS, which is the amount to report in the NPP field. • NPP equals total covered drug cost minus the sum of Patient Pay Amount, CPP, PLRO, Other TrOOP, and LICS.† • Alternatively, NPP also equals plan-paid at POS minus CPP. • EACS is reported in NPP.	NPP

† This calculation assumes that the sum of costs and payments for the PDE are equal. In the exceptional circumstance of beneficiary copay > gross drug cost, plans shall not use this calculation to determine NPP because the assumption is violated. Instead, plans shall use the alternate equation of NPP = Plan-Paid at POS minus CPP.

TABLE 7B – MAPPING TO THE DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS

RULE #	YEAR-TO-DATE (YTD) TOTAL COVERED DRUG COST	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	≤ $250	0%
2	> $250 and ≤ $2,250	75%
3	> $2,250 and ≤ $5,100	0%
4	> $5,100 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Total Covered Drug Cost -$2/$5)

Note: For covered drug costs that fall above $5,100 but below the PBP's Out-of-Pocket (OOP) threshold, CMS maps to the 15 percent amount that the plan is at risk for under the standard portion of their bid (Rule #4). CMS only maps to 95 percent (15% risk payment plus 80% reinsurance payment) once the beneficiary crosses the OOP threshold of the EA plan, because reinsurance does not apply until the beneficiary crosses the OOP threshold (Rule #5).

The following patterns occur when costs are mapped to the defined standard benefit:

- When the plan pays more than what is covered in a given benefit phase under the defined standard benefit, the result is a positive EACS/NPP amount.

- When the plan and the defined standard benefit payment amounts happen to be the same, the result is a zero EACS/NPP amount.

- When the plan pays less than what is covered in a given phase under the defined standard benefit, the result is a negative EACS/NPP amount.

Definitions and terminology:

Total covered drug cost – the sum of Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax for a given PDE with Drug Coverage Status Code = C
Year-to-date (YTD) total covered drug cost – the sum of all total covered drug costs for a beneficiary to-date within a coverage year
Initial coverage period – the phase of the benefit above the deductible and at or below the initial coverage limit in the defined standard benefit
Enhanced coverage period – the phase of the benefit above the initial coverage limit in the defined standard benefit and up to and including the initial coverage limit in the EA plan. If the EA plan does not have an initial coverage limit, the enhanced coverage period extends up to the out-of-pocket threshold (TrOOP = $3,600).

7.5 PDE Examples

For purposes of illustration, these examples assume the simplest case. The beneficiary does not qualify for the low-income cost-sharing subsidy and the beneficiary has no other health insurance. (See Section 10.3 for examples on low-income cost-sharing subsidy eligible beneficiaries).

Plan A - EA Plan A retains the $250 deductible in the standard benefit but it eliminates the coverage gap and offers 25% cost sharing throughout the benefit until the beneficiary reaches catastrophic coverage. Because Plan A eliminates the coverage gap, a beneficiary does not reach the out-of-pocket threshold until YTD total covered drug costs equal $13,650.

Example 1 – The beneficiary's YTD total covered drug costs = $0. In Plan A's benefit structure, the beneficiary is in the deductible phase of the benefit. The beneficiary purchases a covered Part D drug for $100. Apply Rule #1.

YTD Total Covered Drug Cost ≤ $250 – Rule #1				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * 1	Plan Paid at POS (a) * 0	Covered D Plan Paid Amount (CPP) (a) * 0	EACS (a) - (b + d) or (c-d)
$100	$100	$0	$0	$0

Example 2 – The beneficiary's YTD total covered drug costs = $2,000. In Plan A's benefit structure, the beneficiary is in the initial coverage period. The beneficiary purchases a covered drug for $100. Apply Rule #2.

YTD Total Covered Drug Cost = $2000. – Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .75	EACS (a) - (b + d) or (c-d)
$100	$25	$75	$75	$0

Example 3 – The beneficiary's YTD total covered drug costs = $3,000. In Plan A's benefit structure, the beneficiary is in the enhanced coverage period. The beneficiary purchases a covered drug for $100. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000 - Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * 0	EACS (a) - (b + d) or (c-d)
$100	$25	$75	$0	$75

Example 4 – The beneficiary's YTD total covered drug costs = $6,000. In Plan A's benefit structure, the beneficiary is in the enhanced coverage period. The beneficiary purchases a covered drug for $100. Apply Rule #4. Note that above $5,100 of total covered drug cost, the amount reported in Covered D Plan Paid Amount is constrained to 15% of the total drug cost.

YTD Total Covered Drug Cost = $6,000 - Rule #4				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .15	EACS (a) - (b + d) or (c-d)
$100	$25	$75	$15	$60

Example 5 – The beneficiary's YTD total covered drug costs = $13,650. The beneficiary has reached $3,600 in true out-of-pocket costs, thus is in the catastrophic phase of the benefit where cost sharing is the greater of $2/$5 or 5%. The beneficiary purchases a covered drug for $100. Apply Rule #5.

YTD Total Covered Drug Cost = $13,650 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .05	Plan Paid at POS (a) * .95	Covered D Plan Paid Amount (CPP) (a) * .95	EACS (a) - (b + d) or (c-d)
$100	$5	$95	$95	$0

Plan B – EA Plan B alters cost sharing in the initial coverage period, offering tiered cost sharing (5% / 25% / 30%). (These amounts are only for purposes of illustration and are not necessarily representative of an actuarially equivalent benefit structure). Thus the initial coverage limit in this enhanced alternative plan is increased to $4,000.

Example 6 – The beneficiary's YTD total covered drug costs = $500. In Plan B's benefit structure, the beneficiary is in initial coverage phase of the benefit. The beneficiary purchases a covered drug in Tier 1 for $20. Apply Rule #2.

YTD Total Covered Drug Cost = $500 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .05	Plan Paid at POS (a) * .95	Covered D Plan Paid Amount (CPP) (a) * .75	EACS (a) - (b + d) or (c-d)
$20	$1	$19	$15	$4

Example 7 – The beneficiary's YTD total covered drug costs = $520. In Plan B's benefit structure, the beneficiary is in the initial coverage period. The beneficiary purchases a covered drug in Tier 2 for $100. Apply Rule #2.

YTD Total Covered Drug Cost = $520 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .75	EACS (a) - (b + d) or (c-d)
$100	$25	$75	$75	$0

Example 8 – The beneficiary's YTD total covered drug costs = $620. In Plan B's benefit structure, the beneficiary is in initial coverage phase of the benefit. The beneficiary purchases a covered drug in Tier 3 for $250. Apply Rule #2.

YTD Total Covered Drug Cost = $620.00 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .30	Plan Paid at POS (a) * .70	Covered D Plan Paid Amount (CPP) (a) * .75	EACS (a) - (b + d) or (c-d)
$250.00	$75.00	$175.00	$187.50	-12.50

Plan C – EA Plan C extends the initial coverage period by $2,000 from the standard benefit limitation of $2,250 to $4,250. Plan C retains the standard benefit deductible and 25% cost sharing. Because Plan C extends the initial coverage period, beneficiaries do not reach the out-of-pocket threshold until total covered drug costs equal $6,600.

Example 9 – The beneficiary's YTD total covered drug costs = $3,000. In Plan C's benefit structure, the beneficiary remains in the enhanced coverage period. The beneficiary purchases a covered drug for $100. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000 - Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * 0	EACS (a) - (b + d) or (c-d)
$100	$25	$75	$0	$75

Example 10 – The beneficiary's YTD total covered drug costs = $4,500. In Plan C's benefit structure, the beneficiary is in the coverage gap. The beneficiary purchases a covered drug for $100. Apply Rule #3.

YTD Total Covered Drug Cost = $4,500 - Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * 1	Plan Paid at POS (a) * 0	Covered D Plan Paid Amount (CPP) (a) * 0	EACS (a) – (b + d) or (c-d)
$100	$100	$0	$0	$0

Example 11 – The beneficiary's YTD total covered drug costs = $6,000. In Plan C's benefit structure, the beneficiary is in the coverage gap. The beneficiary purchases a covered drug for $100. Apply Rule #4. Note that above $5,100 of total covered drug cost, the amount reported in Covered D Plan Paid Amount is constrained to 15%. Also see Example 4.

YTD Total Covered Drug Cost = $6,000 - Rule #4				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * 1	Plan Paid at POS (a) * 0	Covered D Plan Paid Amount (CPP) (a) * .15	EACS (a) - (b + d) or (c-d)
$100	$100	$0	$15	-$15

Example 12 – The beneficiary's YTD total covered drug costs = $6,600. The beneficiary has just entered the catastrophic phase of the benefit. The beneficiary purchases a covered drug for $100. Apply Rule #5.

YTD Total Covered Drug Cost = $6,600 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .05	Plan Paid at POS (a) * .95	Covered D Plan Paid Amount (CPP) (a) * .95	EACS (a) - (b + d) or (c-d)
$100	$5	$95	$95	$0

Note: If a plan decides to offer reductions in cost sharing beyond the standard benefit in the catastrophic phase of the benefit, the plan must calculate the normal beneficiary cost sharing and count the remainder of drug cost as Covered D Plan Paid Amount. As in cases below the out-of-pocket threshold, the difference between the actual plan paid amount and the Covered D Plan Paid Amount will be considered EACS and reported under Non-covered Plan Paid Amount.

Section 8. True Out-of-Pocket (TrOOP) and Other Payers

8.1 What is TrOOP

TrOOP is a pivotal concept in the Part D benefit. TrOOP is defined as incurred allowable costs that are paid by the beneficiary or by specified third parties on their behalf within the limits of the standard benefit, up to a legislatively specified out-of-pocket threshold or attachment point (§1860D-2(b)(4) of the Act). The out-of-pocket threshold is set at $3,600 for 2006 and will increase annually each subsequent year as directed by §1860D-2(b)(4)(A)(ii).

8.2 Why TrOOP matters

When a beneficiary has accumulated TrOOP costs that reach the out-of-pocket threshold, catastrophic coverage provisions begin for both the beneficiary (§1860D-2(b)(4)) and the

plan (D-15(b)). In the catastrophic phase of the benefit, beneficiaries incur lower cost-sharing amounts, and benefits provided by plans are eligible for reinsurance subsidies. Reinsurance subsidies are subsequently excluded from risk corridor calculations.

8.3 What counts towards TrOOP

In order to administer the Part D benefit, plans must differentiate between payments that are and are not included in TrOOP. Note that all TrOOP-eligible payments must be for covered Part D drugs (see Section 5).

- Payments made by beneficiaries count towards TrOOP, including out-of-pocket payments for differentials (e.g. mail order/retail, generic/brand or out-of-network differentials).
- Payments made by qualified third parties on a beneficiary's behalf count towards TrOOP.
- LICS Amounts count towards TrOOP (see Section 10).
- Payments by group health plans, insurers, government-funded health programs, and similar third party arrangements do not count towards TrOOP. *Note:* Medicaid cost sharing subsidies for residents of the U.S. territories that are funded under §1860D-42(a) of the Act count towards TrOOP. In all other circumstances, Medicaid is not a TrOOP eligible insurance.

The following chart identifies frequently occurring OHI payers by TrOOP status:

TrOOP-eligible	**Not TrOOP-eligible**
Qualified SPAPs	Governmental programs (VA, Black Lung, TRICARE, I/T/U, other)[1]
Qualified charities and PAPs	Workers' Compensation
Payments by family, friends, or other qualified entities or individuals on behalf of a beneficiary	Automobile/No-Fault/Liability Insurances
Low-income cost-sharing subsidies[2]	Group health plans

[1]Medicaid cost sharing subsidies for residents of the U.S. territories that are funded under §1860D-42(a) of the Act count towards TrOOP. In all other circumstances, Medicaid is not a TrOOP eligible insurance.
[2]Counts towards TrOOP but is not OHI (see Section 10)

8.4 Plan accountability for TrOOP accounting

Given the important consequences of TrOOP both to the patient and to the plan, the Act requires the Secretary to implement measures for coordination of benefits among other payers, referred to in this document as other health insurance or OHI (§1860D-23 and D-24). Part D plans shall be responsible for maintaining accurate accounting of TrOOP on a day-to-day basis and for coordinating benefits to that end.

8.5 What CMS will do to assist plans in the coordination of benefits and TrOOP

CMS is currently developing a TrOOP process within the NCPDP standards framework to facilitate accurate OHI billing, payment and reporting at the point of sale (POS). To support the TrOOP facilitation process, CMS will implement processes and systems to capture and document beneficiary specific OHI coverage for drugs. CMS will leverage

existing Medicare COB processes and systems and extend the capability for capturing and verifying beneficiary OHI drug coverage information. Working in collaboration with the industry, CMS's TrOOP facilitation process will integrate the validated OHI drug coverage information within the current stream of real-time transactions between the POS pharmacy, routing intermediaries, OHI payers and the Part D Plan. Beneficiary OHI drug coverage information will be made available to the Part D plans as part of the enrollment file exchange with CMS and will accommodate any OHI information the Part D plan has discovered through their own enrollment process, when the beneficiary is asked to provide OHI coverage information.

The following is a brief overview of the process:

1. A Part D beneficiary enters a pharmacy to fill a prescription. If the beneficiary does not have a card and does not know which Part D plan they are in, the pharmacy can execute an NCPDP E1 request transaction to determine plan enrollment. The E1 response will return enrollment information, including payer-specific information about any OHI drug coverage;
2. The pharmacy submits the claim to the Part D plan;
3. The Part D plan returns a response file to the pharmacy with payment information;
4. If necessary, the pharmacy will then generate a secondary claim to any other OHI payers via the TrOOP facilitator(s);
5. The OHI payer(s) will send a response back to the pharmacy routed through the TrOOP facilitator(s), and;
6. The TrOOP facilitator(s) will build an NCPDP N1[3] reporting transaction from the response and sends it to the appropriate Part D Plan;

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

8.6 PDE fields that report TrOOP information

Catastrophic Coverage Code - The Catastrophic Coverage Code values are dependent upon the level of TrOOP accumulation and hence, the beneficiary's status in the benefit. When the beneficiary crosses the threshold from the coverage gap to the catastrophic phase of the benefit, the PDE will report a value = A in the Catastrophic Coverage Code. Provided that the beneficiary's status in the benefit does not change within a coverage year, subsequent PDEs will report a value = C in the Catastrophic Coverage Code field. The Catastrophic Coverage Code field will be blank on other PDEs. In other words, a PDE with Catastrophic Coverage Code = blank indicates that the beneficiary is in the deductible phase, the initial coverage period, or the coverage gap.

[3] NCPDP is in the process of adopting revisions that were made to the N1 transaction to provide additional OHI information sufficient for Part D.

Drug Coverage Status Code - The Drug Coverage Status Code identifies covered drugs. TrOOP accumulations only include covered drugs (see Section 5).

Six payment fields - Six payment fields report TrOOP information. The dollar amounts reported in these fields are mutually exclusive:

- Patient Pay Amount
- Other TrOOP Amount
- Low-Income Cost-sharing Subsidy Amount (LICS)
- Covered D Plan Paid Amount (CPP)
- Non-covered Plan Paid Amount (NPP)
- Patient Liability Reduction due to Other Payer Amount (PLRO)

The chart below shows the impact of each dollar field on TrOOP accounting:

Field Name	**TrOOP Inclusion**	**TrOOP Exclusion**
Patient Pay Amount	**X**	
Other TrOOP Amount	**X**	
LICS	**X**	
NPP		**X**
CPP		**X**
PLRO		**X**

The following examples show how a plan would populate Patient Pay Amount, Other TrOOP, LICS, NPP, CPP, and PLRO. Assume that a pharmacy dispenses a $100 covered Part D drug with a $20 co-pay under the standard benefit:

Example	TrOOP Inclusions			TrOOP Exclusions			TrOOP Impact
	Patient Pay Amount	Other TrOOP Amount	LICS	NPP	CPP	PLRO	
Example 1: non-LICS beneficiary enrolled in basic plan, no OHI	20	0	0	0	80	0	+$ 20
Example 2: LICS beneficiary enrolled in basic plan, no OHI	3	0	17	0	80	0	+$ 20
Example 3: LICS beneficiary enrolled in basic plan, qualified SPAP or other TrOOP-eligible payer pays $3 co-pay	0	3	17	0	80	0	+$ 20
Example 4: non-LICS beneficiary enrolled in basic plan, beneficiary has OHI that pays Part D co-pay in full	0	0	0	0	80	20	$0
Example 5: non-LICS beneficiary enrolled in basic plan, beneficiary has OHI that pays $10 of the Part D co-pay	10	0	0	0	80	10	+$ 10
Example 6: non-LICS beneficiary enrolled in enhanced alternative plan. Supplemental benefit (funded by additional premium) reduces beneficiary co-pay by $5 for this particular drug.	15	0	0	5	80	0	+$ 15
Example 7: Very late in the plan year the pharmacy dispensed a drug per the scenario in example 1 and submitted a PDE. Subsequently the plan learned that the beneficiary did not pick up the prescription so the plan submitted a deletion record†	0	0	0	0	0	0	-$20

Note: TrOOP (True Out-Of-Pocket), LICS (Low-Income Cost-sharing Subsidy), NPP (Non-covered Plan Paid Amount), CPP (Covered Plan Paid Amount), PLRO (Patient Liability Reduction due to Other Payer Amount), OHI (Other Health Insurance), PDE (Prescription Drug Event).

†In example 7, we indicate -$20 TrOOP Impact to indicate that the TrOOP accumulator works as a counter and will reduce TrOOP by $20 when the deletion PDE record is received. We list zero in each dollar field because these fields are not counters, and the deletion record will indicate to CMS to reduce the dollar amounts of the original record to zero (see Section 6).

In summary the interaction between and among payment fields has a direct impact on TrOOP accounting:

> If a plan failed to report OHI payments and included the PLRO amount in the Patient Pay Amount field, TrOOP would be overstated.
>
> If a plan included EACS in the Patient Pay Amount field, TrOOP would be overstated.
>
> If a Plan included LICS dollars in the Patient Pay Amount field, TrOOP would be counted accurately, but the plan would not receive payment to which it is entitled for paying the LICS (see Section 9).

Section 9. Retroactive changes in TrOOP

As of year-end, aggregate PDE data must be consistent with year-end TrOOP balances maintained by the plan.[4] When plans have to deal with retroactive changes that alter TrOOP accounting, the plan has two choices. The plan may submit adjustments for each PDE that was affected by the retroactive changes or the plan may report as they administer the benefit, provided that PDEs accurately report TrOOP balances by the end of the coverage year. When a retroactive TrOOP change occurs, the plan may reinstate cost sharing until the beneficiary has paid back the TrOOP balance.

In Tables 9A-9B, we provide an example in which the plan learns about a retroactive change that affects TrOOP. In this scenario, the pharmacy notified the plan late about a prescription that was not picked up. This PDE deletion has important TrOOP impact. By the time the correction was identified, the beneficiary had entered the catastrophic phase of the benefit. This correction suspends catastrophic benefits including reduced beneficiary cost sharing. The plan must react in two ways. The plan must update its day-to-day TrOOP accounting and the plan must act accordingly to assure that PDEs reflect accurate TrOOP status by year-end. In order to update day-to-day TrOOP accounting, this plan decided to implement a TrOOP account receivable. The plan will not resume catastrophic benefit cost sharing until the beneficiary has repaid additional cost sharing equal to the value of the account receivable. The example includes sample PDE records for two scenarios, both when the plan reports PDEs as it administers the benefit and when the plan submits adjustments. In a complex case like this one, when a single beneficiary crosses the OOP threshold twice, we expect two PDEs with a Catastrophic Coverage Code value = A. Typically, a beneficiary reaches the OOP threshold only once in any

[4] Unlike some commercial insurance, Part D plans shall not carry forward negative TrOOP (or co-pay) balances from one coverage year to the next because Part D payment reconciliation must be calculated on a coverage year basis.

given coverage year, and we expect only one active PDE record with a Catastrophic Coverage Code value = A per coverage year.

Table 9A. Retroactive TrOOP Changes: Reported as Administered

This table is an example of a plan reporting retroactive changes in true out-of-pocket costs (TrOOP) to CMS according to how the plan administers the benefit (see Section 9). On June 7 the pharmacy notified the plan that the beneficiary did not pick up a 4/15 prescription. The plan had already submitted a PDE record and incremented TrOOP based on the 4/15 prescription. The 4/15 PDE deletion has important TrOOP impact because the beneficiary had entered the catastrophic phase of the benefit by the time the correction was identified. In order to update day-to-day TrOOP accounting, this plan decided to implement a beneficiary account receivable. The plan will resume 100% coinsurance until the beneficiary has repaid additional cost sharing equal to the value of the account receivable. The plan implemented the correction on June 7. PDEs with service dates 6/15, 6/30 and 7/15 show that the beneficiary paid 100% coinsurance. The 7/30 PDE shows that the beneficiary has paid back the receivable and re-entered catastrophic coverage. By the time the plan adjudicated the 8/15 PDE, the TrOOP balance had been corrected. Note that if this scenario had occurred late in the coverage year when the plan expected insufficient PDE volume to net out the account receivable, the plan's only option would be to submit adjustment PDEs and recover the overpayment directly from the beneficiary (see example 4).

Clm ID	DOS	Note	YTD Ingredient Cost + Dispensing + Sales Tax	YTD TrOOP	TrOOP Payback	Claim-level Ingredient Cost + Dispensing + Sales Tax	Plan Paid	Pt Paid	LICS	EACS	PLRO	Cat Cov Flag	Gross Drug Cost Below OOP Threshold	Gross Drug Cost Above OOP Threshold
1	1/15/2006	*a*	610.00	340.00		610.00	270.00	340.00	0.00	0.00	0.00		610.00	0.00
2	1/30/2006		1,220.00	492.50		610.00	457.50	152.50	0.00	0.00	0.00		610.00	0.00
3	2/15/2006		1,830.00	645.00		610.00	457.50	152.50	0.00	0.00	0.00		610.00	0.00
4	2/28/2006	*b*	2,440.00	940.00		610.00	315.00	295.00	0.00	0.00	0.00		610.00	0.00
5	3/15/2006		3,050.00	1,550.00		610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
6	3/30/2006		3,660.00	2,160.00		610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
7	4/15/2006-orig		4,270.00	2,770.00		610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
8	4/30/2006		4,880.00	3,380.00		610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
9	5/15/2006	*c*	5,490.00	3,619.50		610.00	370.50	239.50	0.00	0.00	0.00	A	220	390
10	5/30/2006		6,100.00			610.00	579.50	30.50	0.00	0.00	0.00	C	0.00	610
		d			**610.00**				0.00	0.00	0.00			
		e	-610.00			-610.00		-610.00					-610.00	
11	6/15/2006	*F*	5690.00		**410.00**	200.00	0.00	200.00	0.00	0.00	0.00		200.00	0.00
12	6/30/2006	*F*	5,890.00		**210.00**	200.00	0.00	200.00	0.00	0.00	0.00		200.00	0.00
13	7/15/2006	*F*	6,090.00		**10.00**	200.00	0.00	200.00	0.00	0.00	0.00		200.00	0.00
14	7/30/2006	*g*	6,290.00		**0.00**	200.00	180.50	19.50	0.00	0.00	0.00	A	10.00	190.00
15	8/15/2006		6,490.00			200.00	190.00	10.00	0.00	0.00	0.00	C	0.00	200.00

a Beneficiary crosses from deductible to initial coverage period. Beneficiary pays $250 deductible + $90 coinsurance (.25*(610-250)). Plan pays $270 (.75*(610-250))

b Beneficiary crosses from initial coverage period to coverage gap. Beneficiary pays initial coverage period coinsurance of $105 (.25 * (2250-1830) + coverage gap coinsurance of $190 (1.0* (610 - (2250-1830))). Plan pays $315 (.75 * (2250 - 1830))

c Beneficiary crosses from initial coverage period to coverage gap. Beneficiary pays coverage gap coinsurance of $220.00 (1.0 * (3600-3380)) + catastrophic coinsurance of $9.00 (.05 * (200 - (3600-3580))). Plan pays catastrophic $370.50 (.95 * (610 - (3600-3380)))

d On June 7 plan discovers that the beneficiary did not pick up 4/15 prescription. It submits a PDE deletion record for the 4/15 PDE and establishes a receivable account.

e Corrections

f Beneficiary re-enters coverage gap

g Beneficiary re-enters catastrophic coverage

Table 9B. Retroactive TrOOP Changes: Reported as Adjustments

This table is an example of a plan reporting retroactive changes in a beneficiary's true out-of-pocket (TrOOP) costs by submitting pertinent adjustment records to CMS (see Section 9). On June 7 the pharmacy notified the plan that the beneficiary did not pick up a 4/15 prescription. The plan had already submitted a PDE record and incremented TrOOP based on the 4/15 prescription. The 4/15 PDE deletion has important TrOOP impact because the beneficiary had entered the catastrophic phase of the benefit by the time the correction was identified. In order to update day-to-day TrOOP accounting, this plan decided to recover the TrOOP overpayment directly from the beneficiary. On June 7 when the plan discovers the error, the plan deletes the 4/15 PDE and submits adjustments for PDEs with service dates 4/30, 5/15 and 5/30. By the time the plan submits the 6/15 PDE, all corrections have been completed.

Clm ID	DOS	Note	YTD Ingredient Cost + Dispensing + Sales Tax	YTD TrOOP	Claim-level Ingredient Cost + Dispensing + Sales Tax	Plan Paid	Pt Paid	LICS	EACS	PLRO	Cat Cov Flag	Gross Drug Cost Below OOP Threshold	Gross Drug Cost Above OOP Threshold
1	1/15/2006	*a*	610.00	340.00	610.00	270.00	340.00	0.00	0.00	0.00		610.00	0.00
2	1/30/2006		1,220.00	492.50	610.00	457.50	152.50	0.00	0.00	0.00		610.00	0.00
3	2/15/2006		1,830.00	645.00	610.00	457.50	152.50	0.00	0.00	0.00		610.00	0.00
4	2/28/2006	*b*	2,440.00	940.00	610.00	315.00	295.00	0.00	0.00	0.00		610.00	0.00
5	3/15/2006		3,050.00	1,550.00	610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
6	3/30/2006		3,660.00	2,160.00	610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
7	*4/15/2006*		*4,270.00*	*2,770.00*	*610.00*	*0.00*	*610.00*	*0.00*	*0.00*	*0.00*		*0.00*	*0.00*
		d	3,660.00	2,160.00									
8	*4/30/2006*		*4,880.00*	*3,380.00*	*610.00*	*0.00*	*610.00*	*0.00*	*0.00*	*0.00*		*0.00*	*0.00*
		e	4,270.00	2,770.00	610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
9	5/15/2006	*c*	*5,490.00*	*3,619.50*	*610.00*	*370.50*	*239.50*	*0.00*	*0.00*		*A*	*220.00*	*390.00*
		f	4,880.00	3,380.00	610.00	0.00	610.00	0.00	0.00	0.00		610.00	0.00
10	5/30/2006		*6,100.00*	*3,650.00*	*610.00*	*579.50*	*30.50*	*0.00*	*0.00*		*C*		*610.00*
		g, h	5,490.00	3,619.50	610.00	370.50	239.50	0.00	0.00	0.00	A	220.00	390.00
11	6/15/2006		5,690.00	3,629.50	200.00	190.00	10.00	0.00	0.00	0.00	C	0.00	200.00

a Beneficiary crosses from deductible to initial coverage period. Beneficiary pays $250 deductible + $90 coinsurance (.25*(610-250)). Plan pays $270 (.75*(610-250))

b Beneficiary crosses from initial coverage period to coverage gap. Beneficiary pays initial coverage period coinsurance of $105 (.25 * (2250-1830) + coverage gap coinsurance of $190 (1.0* (610 - (2250-1830))). Plan pays $315 (.75 * (2250 - 1830))

c Beneficiary crosses from coverage gap to catastrophic. Beneficiary pays coverage gap coinsurance of $220.00 (1.0 * (3600-3380)) + catastrophic coinsurance of $9.00 (.05 * (200 - (3600-3580))). Plan pays catastrophic $370.50 (.95 * (610 - (3600-3380)))

d Deleted PDE for 15-April-06 service date

e Adjusted PDE for 30-Apr-2006 service date

f Adjusted PDE for 15-May-2006 service date

g Adjusted PDE for 30-May-2006 service date

h Beneficiary re-enters catastrophic coverage

Section 10. Low Income Cost-Sharing Subsidy (LICS)

10.1 Definition

Section 1860D-14 of the Act provides for Medicare payments to plans to subsidize the cost-sharing liability of qualifying low-income beneficiaries, including plan premiums, deductibles, coinsurances, and late enrollment penalties. The statute divides these income-related subsidies into two categories: premium assistance and cost-sharing assistance. Premium subsidies are taken into account via other data streams and do not impose any PDE data reporting requirements on plans. However, LICS assistance is documented and reconciled using PDE data.

These cost-sharing subsidies, referred to as Low Income Cost-Sharing Subsidies (LICS), are applied at the point of sale (POS) and paid by the plan. CMS makes prospective LICS payments to plans to cover anticipated LICS at POS. The LICS payments plans make on behalf of beneficiaries at POS must be reported to CMS on PDE records. CMS will reconcile these actual paid amounts with the prospective payments.

Plans must implement business rules that apply LICS calculations to covered drugs and facilitate the accurate processing and timely submission of PDE records. Plans will adjudicate claims and report PDEs in accordance with the level of assistance for which the beneficiary is eligible. The table below outlines the four LICS assistance levels. LICS beneficiaries have continuous coverage for Part D covered drugs with one exception: Level III beneficiaries are assigned a $50 deductible that is indexed annually or, if less, the PBP deductible. They then have continuous coverage.

TABLE 10A LICS CATEGORIES

			Maximum LICS Beneficiary Cost Sharing, 2006			
LICS Level	**MBD Code**	**Income Category (% FPL)**	**Deductible**	**Initial Coverage Period**	**Coverage Gap**	**Catastrophic Phase**
I	2	≤100% and fbde	$0	$1-generic $3-brand	$1-generic $3-brand	$0
II	1	<135%, or >100% and fbde	$0	$2-generic $5-brand	$2-generic $5-brand	$0
III	4	<150%	$50	15%	15%	$2-generic $5-brand
Inst	3	Institutionalized fbde	$0	$0	$0	$0

Notes: MBD (Medicare Beneficiary Database); fbde (full benefit dual eligible); Inst (institutionalized).
To be eligible for LICS, beneficiaries must also pass certain asset tests. For a complete description of eligibility rules, see §1860D-14(a)(3)(D) and (E).
In general, there are two phases of low income cost sharing: the cost sharing that is assigned before catastrophic coverage and the cost sharing that is assigned during the catastrophic coverage period. Pre-catastrophic low income cost sharing begins when the beneficiary purchases his/her first Part D covered drug of the benefit year. The only exception is the Level III beneficiary in a plan with a deductible. These beneficiaries must first satisfy a deductible amount equal to the statutory amount or, if less, the plan deductible.
An MBD code of 0 (zero) means no LICS eligibility.
The values in this table are indexed annually as per §1860D-14(a)(4).

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

A **full-benefit dual eligible (fbde)** beneficiary is an individual who has prescription drug coverage for the month under a Prescription Drug Plan (PDP) or Medicare Advantage – Prescription Drug (MA-PD) plan and is determined eligible by the state for medical assistance under Title XIX of the Act (42 CFR 423.772).

For purposes of determining LICS level, an **institutionalized** beneficiary is a full-benefit dual eligible individual who is an inpatient in a medical institution or nursing facility for whom payment is made under Medicaid for a month (§1860D-14(a)(1)(D)(i)). When an individual enters such institution, community co-pay levels apply until the beneficiary has spent a continuous, full calendar month in the institution. The zero costing sharing provision only applies after a continuous stay of one calendar month.

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

- LICS only applies to covered Part D drugs; the low-income beneficiary pays the same cost sharing for non-covered drugs as any other beneficiary under their benefit package.

- The categories in Table 10A apply to all LIS eligible individuals except for beneficiaries residing in the U.S. territories to whom different low income subsidy provisions apply. In addition, calculations of LICS for the PACE program are unique as laid out in Section 14.

- LICS always counts towards True Out-of-Pocket (TrOOP) costs.

- Supplemental benefits provided under the PBP are always applied before LICS is calculated.

- LICS rules in this Section apply to low-income subsidy beneficiaries in both basic and enhanced plans.

10.2 Reporting requirements

Section 1860D-14(c) of the Act mandates that the Secretary notify plans when a beneficiary is eligible for LICS; the plan must then provide for appropriate beneficiary cost sharing and also submit information to the Secretary reporting the amount of the reduction. Finally, the Secretary shall reimburse the plan periodically and timely for these amounts. In order to pay the plan accurately, CMS has defined a Low Income Cost-Sharing Subsidy (LICS) Amount field.[5] Plans will populate the LICS Amount field with the amount they pay the pharmacy at the point of sale for an eligible beneficiary's cost sharing.

In formula:

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

When Non-LI cost sharing ≤ LI cost sharing, then LICS Amount = zero†

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

We refer to this formula as the LICS Amount formula. The non-low income (non-LI) cost sharing is the amount due from a non-low income subsidy beneficiary for a given dispensing event under the plan benefit package. The low-income (LI) cost sharing is the maximum allowable amount due under the Act from a low-income subsidy beneficiary for that same dispensing event (see Table 10A) or, if less, the cost sharing under the plan benefit package. The difference between the non-LI and LI cost sharing is the amount subsidized by the plan at point of sale and ultimately by CMS.

- **Lesser Of Test:** In accordance with statutory and regulatory provisions, if the applicable LI cost-sharing amount is greater than the amount of cost sharing that would be due under the plan benefit package (standard or enhanced) for a

[5] The low-income cost-sharing subsidy is unique to Medicare. There is no NCPDP field to capture this information.

beneficiary who is not LI, the beneficiary is only responsible for the non-LI (lesser) cost-sharing amount. This logic, referred to as the Lesser Of test, shall be used to determine all LI co-pays and coinsurances as well as any deductible applicable to a Level III beneficiary.

Specifically, when PBP deductible < Level III deductible: The Part D final rule in §423.782(b)(2) states that low-income cost sharing for the Level III beneficiary is a 15% coinsurance "after the annual deductible under the plan." Accordingly, in the LICS Amount formula, the Level III cost sharing shall include whichever is less: the statutory Level III deductible or a lower deductible amount if provided under the plan benefit package. In practice, this means that the LICS Amount formula shall not include a Level III deductible amount that is greater than that under the PBP.

In sum, in the LICS Amount formula and the lesser of test:

- Include the entire Level III deductible when PBP deductible ≥ statutory Level III amount ($50 in 2006).
- Include a partial Level III deductible equal to the PBP amount if the PBP deductible is < the statutory Level III amount and > $0.
- Exclude the entire Level III deductible when the PBP has a deductible = $0.

These rules apply to low-income subsidy beneficiaries in both basic and enhanced plans. Also note that year to date (YTD) total covered drug cost, not TrOOP cost, satisfies deductibles in Part D. Therefore, if the YTD gross covered drug cost ≥ the Level III deductible amount, even if a third party payment or the lesser of test has reduced actual beneficiary liability below that amount, the beneficiary has met his/her Level III deductible.

- If a beneficiary has any other health insurance, whether TrOOP-eligible or not, the LICS Amount formula must use cost sharing amounts as calculated *before* any wrap-around coverage is applied. However, this rule does not apply when Medicare is a secondary payer (MSP). See Section 17 for MSP calculations.

10.3 PDE Examples

The following examples demonstrate how plans will populate the PDE fields Patient Pay Amount, LICS Amount and Other TrOOP Amount. They also illustrate how plans will identify TrOOP-eligible dollars at the PDE level. We show a variety of benefit permutations, summarized as follows:

LICS Examples in Section 10

Example #	Deductible amount	Plan type	Structure	Other TrOOP	Covered drug	EA drug
All Levels (I, II, III, Inst)						
1-4	≥ statutory Level III amount[1]	basic	tiered	—	X	—
5	≥ statutory Level III amount	basic	tiered	X	X	—
6	≥ statutory Level III amount	EA	tiered	—	X	—
7	≥ statutory Level III amount	EA	tiered	—	—	X
Level III						
8	≥ statutory Level III amount	basic	defined standard	—	X	—
9	< statutory Level III amount and > 0	basic	coinsurance	—	X	—
10	zero	basic	coinsurance	—	X	—
11	zero	EA	copay	—	X	—

[1]$50 in 2006

Examples 1-7 show calculating and reporting for all four assistance levels under two plans with a deductible amount ≥ the statutory level III amount ($50 in 2006). Examples 1-5 show reporting for a basic plan with a 5% generic/25% preferred brand/30% non-preferred brand tiered cost sharing structure. In examples 1-4, we show a PDE for each benefit phase and the beneficiary has no other health insurance. In example 5, a TrOOP- eligible third party makes a payment on behalf of the low-income beneficiary.

Examples 6 and 7 show sample data for a low-income subsidy beneficiary in an enhanced alternative plan (see Section 7) with the same deductible assumptions and a tiered benefit structure. Example 6 demonstrates how enhanced alternative plans will report enhanced alternative cost sharing. Example 7 demonstrates how enhanced alternative plans will report enhanced alternative (supplemental) drugs for LI beneficiaries.

Examples 8-11 illustrate calculating and reporting for Level III beneficiaries in plans with deductibles that are greater than, less than or equal to the statutory Level III amount ($50 in 2006). In example 8, we begin with a plan deductible that is ≥ the statutory amount such that the L-III beneficiary pays the full statutory amount. In example 9, the plan's deductible is < the statutory Level III amount but > 0 such that the L-III beneficiary pays a portion of the statutory amount. In example 10, the plan has no deductible so the L-III beneficiary does not pay any deductible and their 15% coinsurance provision begins with the first covered drug of the year.

Examples 8-10 are basic plans. We add example 11 to show that the calculating and reporting rules for Level III deductibles do not change for enhanced plans.

Note the following definitions:
Total Covered Drug Cost – the sum of Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax for a given PDE
Year-to-date (YTD) Total Covered Drug Cost – the sum of all Total Covered Drug Costs for a beneficiary to-date within a coverage year

Initial coverage period – the phase above the deductible and at or below the defined standard initial coverage limit
LICS – reports the difference between Patient Pay Amount for a non-LI beneficiary and the Patient Pay Amount for a beneficiary under an LICS subsidy

Example 1 – This is the first claim for each beneficiary. YTD Total Covered Drug Cost = $0 which places the beneficiary in the deductible phase of the benefit. The beneficiary purchases a covered drug in Tier 2 (preferred brand) for $50.

	(a)	(b)	(c)	(d)	(e)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b) + (c)
Non-LI	$50	$50	n/a	$ 0	$50
L-I	$50	$ 3	$47	$ 0	$50
L-II	$50	$ 5	$45	$ 0	$50
L-III	$50	$50†	$ 0	$ 0	$50
Institutionalized	$50	$0	$50	$ 0	$50

†L-III beneficiary satisfies deductible

Example 2 – The beneficiary's YTD total covered drug cost = $500 which places the beneficiary in the initial coverage period. The beneficiary purchases a covered drug in Tier 1 (a generic drug) for $5.

	(a)	(b)	(c)	(d)	(e)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b) + (c)
Non-LI	$5.00	$.25	n/a	$ 4.75	$.25
L-I	$5.00	~~$1.00*~~ $.25	$ 0.00	$ 4.75	$.25
L-II	$5.00	~~$2.00~~* $.25	$ 0.00	$ 4.75	$.25
L-III	$5.00	~~$.75~~* $.25	$ 0.00	$ 4.75	$.25
Institutionalized	$5.00	$0.00	$ .25	$ 4.75	$.25

*Lesser Of logic

Example 3 – The beneficiary's YTD total covered drug cost = $3,000 which places the beneficiary in the coverage gap. The beneficiary purchases a covered drug in Tier 3 (non-preferred brand) for $250.

	(a)	(b)	(c)	(d)	(e)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b) + (c)
Non-LI	$250	$250	n/a	$ 0	$250
L-I	$250	$3	$ 247	$ 0	$250
L-II	$250	$5	$ 245	$ 0	$250
L-III	$250.00	$37.50	$ 212.50	$ 0.00	$250.00
Institutionalized	$250	$0	$ 250	$ 0	$250

Example 4 – The beneficiary reaches the out-of-pocket threshold (equivalent to $3,600 in TrOOP in 2006) and enters the catastrophic phase of the benefit. The beneficiary purchases a covered drug in Tier 2 for $150.

	(a)	(b)	(c)	(d)	(e)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b) + (c)
Non-LI	$150.00	$7.50	n/a	$ 142.50	$7.50
L-I	$150.00	$0.00	$ 7.50	$ 142.50	$7.50
L-II	$150.00	$0.00	$ 7.50	$ 142.50	$7.50
L-III	$150.00	$5.00	$ 2.50	$ 142.50	$7.50
Institutionalized	$150.00	$0.00	$ 7.50	$ 142.50	$7.50

Example 5 – This example is a modification of Example 3. The low-income beneficiary receives assistance from a qualified SPAP. Note the difference between Patient Pay Amount and Other TrOOP Amount. The qualified SPAP assumes responsibility for the cost-share on behalf of the low-income beneficiary. Since qualified SPAPs are TrOOP-eligible payers, the amount paid by the SPAP is reported in the PDE field named Other TrOOP and the Patient Pay Amount is reduced to zero.

	(a)	(b)	(c)	(d)	(e)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)+(e)	Patient Pay Amount	LICS	Other TrOOP Amount	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)+(d)
Non-LI	$250	$250	n/a	$0	$0	$250
L-I	$250	~~$3~~ $0	$247	$3	$0	$250
L-II	$250	~~$5~~ $0	$245	$5	$0	$250
L-III	$250.00	~~$37.50~~ $0.00	$212.50	$37.50	$0.00	$250.00
Institutionalized	$250	$0	$250	$0	$0	$250

Example 6 – Assume that the low-income beneficiary enrolls in an enhanced alternative (EA) plan. Unlike the plan referenced in Examples 1-5, this plan may charge a supplemental premium from which it funds benefits that exceed the basic benefit (see Section 7). In this example, the EA plan reduces cost sharing from 25% in the standard benefit to 15%. The difference of 10% is enhanced alternative cost sharing. The beneficiary is in the initial coverage period of the benefit and purchases a covered brand drug for $100.

	(a)	(b)	(c)	(d)	(e)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)+(e)	Patient Pay Amount	LICS	EACS*	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)
Non-LI	$100	$15	n/a	$10	$ 75	$15
L-I	$100	$ 3	$12	$10	$ 75	$15
L-II	$100	$ 5	$10	$10	$ 75	$15
L-III	$100	$15	$ 0	$10	$ 75	$15
Institutionalized	$100	$ 0	$15	$10	$ 75	$15

*Reported in Non-covered Plan Paid Amount (NPP) field on the PDE record

Example 7 – The same EA plan referenced in example 6 also offers a supplemental drug benefit (see Section 5). The beneficiary out-of-pocket under this plan remains 15% since 10% of cost sharing is subsidized by the plan as EACS. The beneficiary is in the initial coverage period and purchases a supplemental drug for $100. The drug coverage status code = E. Low-income beneficiaries pay the same cost sharing on these supplemental drugs as any other beneficiary because low-income cost-sharing subsidies do not apply to supplemental drugs. Also note that beneficiary cost sharing for these drugs does not count towards TrOOP.

	(a)	(b)	(c)	(d)	(e)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)+(e)	Patient Pay Amount	LICS	Non-Covered Plan Paid Amount (NPP)	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)
Non-LI	$0	$15	n/a	$85	$ 0	$ 0
L-I	$0	$15	$ 0	$85	$ 0	$ 0
L-II	$0	$15	$ 0	$85	$ 0	$ 0
L-III	$0	$15	$ 0	$85	$ 0	$ 0
Institutionalized	$0	$15	$ 0	$85	$ 0	$ 0

Example 8 – Assume a Level III beneficiary in a defined standard plan with a $250 deductible. Their 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, we include a $50 deductible for the first claim in the calculation on the Level III side. After the $50 deductible is met, we apply the 15% coinsurance provision to the remaining drug cost in Claim 1 and to the total drug cost in Claim 2.

	(a)	(b)	(c)	(d)	(f)
Beneficiary Type/Claim	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS Amount	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)
Non-LI Claim 1	$100	$100	n/a	$0	$100
Non-LI Claim 2	$100	$100	n/a	$0	$100
L-III Claim 1	$100	$57.50[1]	$42.50	$0	$100
L-III Claim 2	$100	$15[2]	$85	$0	$100

[1]$57.50 = $50.00 + (0.15 * $50.00)
[2]$15.00 = 0.15 * $100.00

Example 9 – Assume a Level III beneficiary in a basic PBP in 2006 that has a $30 deductible then 25% coinsurance in the initial coverage period. We show the first two claims of the year for the beneficiary, applying the lesser of rule by including a $30 deductible (not $50) in the calculation on the Level III side. The negotiated prices are $25 for a generic drug in the first claim and $200 for the second claim; both are covered drugs.

	(a)	(b)	(c)	(d)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)
Claim 1 Non-LI	$25	$25	n/a	$0	$25
Claim 2 Non-LI	$200	$53.75[1]	n/a	$146.25	$53.75
Claim 1 L-III	$25	$25[2]	$0	$0	$25
Claim 2 L-III	$200	$34.25[3]	$19.50	$146.25	$53.75

[1]$53.75 = $5 remaining deductible + (0.25*$195)
[2]L-III beneficiary pays $25 of the $30 PBP deductible
[3]$34.25 = $5 remaining deductible + (0.15*$195)

Example 10 – Assume a Level III beneficiary in a basic PBP with zero deductible and 25% cost sharing in the initial coverage period. This is the beneficiary's first claim of the year and the negotiated price (gross drug cost) is $100; it is a covered drug. In the lesser of test, we exclude any deductible from the calculation on the Level III side and only use 15% coinsurance. The L-III beneficiary receives the 15% coinsurance provision beginning with their first covered drug of the year.

	(a)	(b)	(c)	(d)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP)	TrOOP Amount (b)+(c)
Non-LI	$100	$25	n/a	$75	$25
L-III	$100	$15[1]	$10	$75	$25

[1]$15.00 = 0.15 * $100.00

Example 11 - Assume a Level III beneficiary who has paid a supplemental premium to enroll in an enhanced alternative plan. The plan has zero deductible and a copay of $25 for a $100 covered drug dispensed as the first claim of the year. We use the lesser of rule, including no deductible in the calculation on the Level III side; the beneficiary receives 15% coinsurance provision beginning with their first covered drug of the year. The calculations for LICS remain the same as in examples under basic plans. The only difference in calculating and reporting for the PDE record under this enhanced plan is that the gross drug cost is mapped to the defined standard benefit to determine CPP and NPP Amounts (see Section 7.4.1).

	(a)	(b)	(c)	(d)	(e)	(f)
Beneficiary Type	Total Covered Drug Cost (b)+(c)+(d)+(e)	Patient Pay Amount	LICS	Covered D Plan Paid Amount (CPP) (a) * 0	Non-covered Plan Paid Amount (NPP)	TrOOP Amount (b)+(c)
Non-LI	$100	$25	n/a	$0	$75	$25
L-III	$100	$15[1]	$10	$0	$75	$25

[1]$15.00 = 0.15 * $100.00

Section 11. Direct and Indirect Remuneration (DIR)

11.1 Definition

In order for covered drug costs to count towards allowable reinsurance or risk corridor costs, the Act and the final rule require the costs to be incurred and actually paid by the Part D sponsor, net of any direct or indirect remuneration which includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source, including manufacturers, pharmacies, enrollees, or any other person, that would serve to decrease the costs incurred by the Part D sponsor for the drug (§1860D-15(b)(2) and (e)(1)(b), 42 CFR §423.308). We refer to all such direct or indirect remuneration as DIR. DIR must be excluded from allowable reinsurance and risk corridor costs (see Sections 12-13).

11.2 Reporting requirements

Some DIR may already be reflected in the amount paid (sum of ingredient cost, dispensing fee, plus applicable sales tax) at the point of sale. However, all DIR that is not factored into the point of sale price and thus is not reflected in the costs reported on the PDE must be reported to CMS separately. These DIR will be excluded from allowable costs.

Plans must report these DIR to CMS within six months of the end of the year. DIR dollars must be reported in full with no reduction for administrative cost or any other fees. Plans will submit DIR amounts to CMS in the following three categories:

1) DIR dollars for non-covered drugs as defined in Section 5;

2) DIR dollars for covered Part D drugs as defined in Section 5; and
3) Total DIR (the sum of 1 and 2).

Non-covered drugs are benefits beyond the standard benefit while covered Part D drugs constitute a plan's basic benefit. Distinguishing DIR dollars for drugs in these two categories enables CMS to calculate reinsurance and risk corridor payments net of DIR and based only on the basic benefit, in accordance with legislation.

Section 12. Reinsurance

12.1 Definition
Reinsurance is designed to reduce the risk of participating in the Part D program, where the federal government subsidizes 80 percent of covered Part D drug costs incurred and actually paid by the plan in the catastrophic phase of the benefit, net of DIR (§1860D-15(b)(2), §423.308). A beneficiary enters the catastrophic phase of the benefit after accumulating $3,600 in true out-of-pocket costs (see Section 8). The $3,600 limit in TrOOP costs is referred to as the out-of-pocket threshold or attachment point. The amount of $3,600 is specific to 2006 and increases annually each subsequent year as per §1860D-2(b)(4)(B)(i).

Thus, the reinsurance subsidy applies to drug costs accumulated after the beneficiary reaches the attachment point, net of DIR. We also apply other statutory exclusions based on plan type, covered Part D drug status, and enhanced alternative benefits. After these exclusions have been applied, we refer to the remaining costs used in final reconciliation as Allowable Reinsurance Costs (§1860D-15(b)(2)).

Plan level exclusions – CMS will not calculate reinsurance for fallback plans because they do not receive reinsurance and are instead paid allowable costs under the standard benefit (§1860D-15(e)(1)(B)). Private fee-for-service (PFFS) plans will receive reinsurance according to separately legislated parameters as per §1860D-21(d)(4) and as set forth in the Advance and Final Notices of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates (http://www.cms.hhs.gov/healthplans/rates/).

Excluding enhanced alternative costs related to non-covered drugs –Allowable Reinsurance Costs only include those costs above the OOP threshold that would have been paid under the basic prescription drug coverage (§1860D-15(b)(2)). Thus we will exclude all costs related to drugs that the statute specifies as non-covered from our calculation of Allowable Reinsurance Costs, i.e., all drugs that have Drug Coverage Status Codes of E or O (see Section 5).

12.2 Calculating allowable reinsurance costs for reconciliation
As in all other Part D payment reconciliation, reinsurance calculations will be carried out at the individual beneficiary level with costs aggregated up to the plan (PBP) level. To calculate allowable reinsurance costs, we will use the Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA) and Catastrophic Coverage Code fields to identify all active PDE records for covered Part D drugs for beneficiaries who reached the attachment point.

We will aggregate each beneficiary's GDCA for PDEs with Catastrophic Coverage Codes = A or C. We will sum these at the plan level to determine the incurred reinsurance costs.

Next, we will apportion DIR to these incurred reinsurance costs by taking the ratio of costs above the out-of-pocket threshold to total covered drug costs then applying it to covered Part D DIR. We will subtract the DIR allocated to reinsurance costs (referred to as reinsurance DIR) from incurred reinsurance costs to derive the allowable reinsurance costs. Finally, we multiply the allowable reinsurance costs by 80 percent to determine the federal government liability.

In formula:
Reinsurance DIR = (Gross Drug Cost Above the Out-of-Pocket Threshold /Total Gross Drug Cost) * covered Part D DIR
Allowable reinsurance costs= (incurred reinsurance costs – reinsurance DIR)
Reinsurance payment = (allowable reinsurance costs*0.80)

Example
A plan had $1,000,000 in incurred reinsurance costs and total allowed costs of $6,100,000. Covered Part D DIR = $610,000.

Reinsurance DIR = ($1m/$6.1m)*$610,000 = $100,000
Allowable reinsurance costs = ($1m - $100,000) = $900,000
Reinsurance payment = ($900,000)*0.80 = $720,000

The resulting reinsurance payment amount ($720,000 in the example) will be reconciled with prospective reinsurance payment amounts made to plans during the coverage year (see Section 13).

Calculating and reconciling allowable reinsurance costs can also be considered as a 6-step process:

1. Plan level exclusions - We will use plan type to exclude drug data submitted by fallback and PFFS plans from allowable reinsurance cost processing.

2. In order to limit allowable reinsurance costs to basic prescription drug coverage we will use data in the Drug Coverage Status field, excluding PDE data reported as E or O.

3. To identify events with costs above the attachment point, we will sum GDCA (Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax) reported on all PDE records with Catastrophic Coverage Code = C or A.

4. We will sum the beneficiary totals calculated in step 3 to derive the plan total.

5. We will apportion DIR to the reinsurance part of the benefit and subtract this portion (referred to as reinsurance DIR) to derive allowable reinsurance costs.

6. We will multiply the allowable reinsurance costs by 80 percent to determine the federal government liability for reconciliation.

Section 13. Risk sharing (risk corridor payment adjustments)

13.1 Definition
As provided in §1860D-15(e) of the Act, risk sharing is designed to limit exposure to unexpected expenses not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits or losses resulting from expenses for the standard benefit within defined symmetrical risk corridors around a target amount (see Figure 1), and risk sharing is most generous in the first two years of the program.

Risk corridors work by determining the difference between (a) the target amount (what a plan was actually paid through the direct subsidy plus enrollee premium related to the standardized bid amount) and (b) a plan's actual allowable costs not including administrative expenses.

A plan's actual allowable costs are limited to those costs actually incurred or paid by the plan and must subtract out any DIR (see Section 11). Also, if a plan provides supplemental coverage CMS takes into account how the presence of such coverage increases utilization beyond what it would be if the coverage were defined standard coverage. CMS will also subtract out enhanced alternative cost-sharing amounts, all federal reinsurance payments, low-income subsidy payments related to cost sharing, and beneficiary cost sharing including TrOOP-eligible payments made on the beneficiary's behalf.

Note: Risk corridor provisions do not apply to fallback plans (§1860D-11(g)(5)) or PFFS plans (§1860D-21(d)(5)), and reduced risk sharing is applied to limited risk plans as detailed in Section 13.3 below.

13.2 Calculating risk-sharing payment adjustments for reconciliation
As in all other Part D payment reconciliation, risk corridor calculations will be carried out at the individual beneficiary level with costs aggregated up to the plan (PBP) level. Calculating risk corridor payment adjustments can be considered as a 4-step process:

- Calculate the plan's target amount
- Calculate associated risk corridor thresholds
- Calculate adjusted allowable risk corridor costs
- Determine where costs fall with respect to the risk corridor thresholds, then calculate payment adjustment

Calculate the target amount (§1860D-15(e)(3)(B))
The first step in determining risk corridor payment adjustments is to establish a plan's target amount. The target amount is the plan's total direct subsidy payments plus total beneficiary premiums related to the standardized bid amount minus administrative costs.

In formula:

Target amount = (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount) * (1.00 - administrative cost ratio), where:

- Total direct subsidy is the sum of all monthly direct subsidy amounts paid for the entire coverage year.
- Direct subsidy = (standardized bid * beneficiary risk adjustment factor) – beneficiary premium related to the standardized bid amount. Note that risk factors are calculated three times a year: initial calculation, mid-year correction, and final at year-end.
- The direct subsidy as used in this calculation will reflect all retroactive adjustments made based on changes in enrollment, relevant status (low income/long-term institutionalized), and final risk adjustment factors, for any month during the payment year.
- The total beneficiary premiums related to the standardized bid amount is the sum of all monthly basic beneficiary premiums for payment purposes plus any A/B rebate applied to the basic premium, for the entire coverage year. Beneficiary premiums include premiums due from enrollees or paid on their behalf, including low-income premium subsidies.
- Administrative cost ratio is calculated as follows from bid data: (Total Non-Pharmacy Expense + Gain/Loss) / Total Basic Bid

Example:

Total direct subsidy	$ 792,500
Total basic beneficiary premiums for payment purposes	$ 269,457
+ A/B rebate	$ 25,000
Target amount before administrative cost adjustment	$1,086,957
* (1 - Administrative cost ratio)	* 0.92
Target amount	$1,000,000

Note that CMS will have data to calculate the components that make up the target amount that will be used in reconciliation at the end of the year. For example, risk-adjusted direct subsidies that take into account any A/B rebates will be paid to plans monthly per beneficiary, and CMS will also know premium amounts and administrative costs. Beneficiary-level subsidies and premiums will be aggregated into plan-level data for reconciliation.

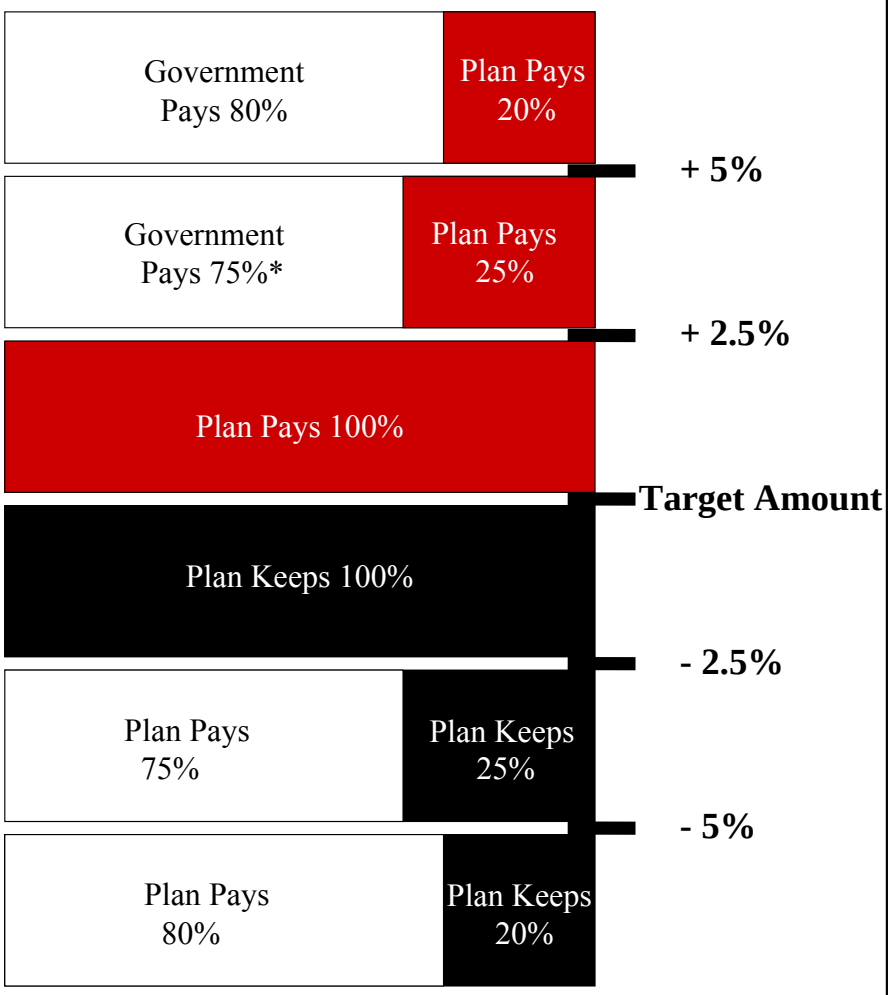
Calculate associated risk corridor threshold limits

Risk corridors are calculated based on the target amount plus or minus the threshold risk percentages associated with four symmetrical threshold limits. As illustrated below, in 2006 the first threshold upper limit is 102.5 percent of the target amount and the second threshold upper limit is 105 percent of the target amount; similarly, the first threshold lower limit is 97.5 percent of the target amount and the second threshold lower limit is 95 percent of the target amount. These percentages will be adjusted in future years according to legislation.

Example (target amount = $1,000,000):

The first threshold upper limit is $1,025,000 or $1,000,000 + (.025*$1,000,000)

Figure 1. Risk corridors for full risk plans, 2006 - 2007



The second threshold upper limit is $1,050,000 or $1,000,000 + (0.050*$1,000,000)
The first threshold lower limit is $975,000 or $1,000,000 – (.025* $1,000,000)
The second threshold lower limit is $950,000 or $1,000,000 – (0.050*$1,000,000)

***Note: The 75% changes to 90% if the conditions of the "60/60 rule" have been met.**

Calculate adjusted allowable risk corridor costs

CMS will calculate adjusted allowable risk corridor costs from PDE records as per §1860D-15(e)(1) of the Act. Adjusted allowable risk corridor costs include covered prescription drug costs actually incurred and paid by the plan within the limits of the standard benefit that are not covered by reinsurance payments or low-income cost-sharing subsidies, net of DIR. The term "actually paid by the plan" excludes coinsurance and copayments, LICS and EACS Amounts, and any payments by other health insurers or qualified entities.

Calculating adjusted allowable risk corridor costs can be considered as a 4-step process:

1. Include a plan's PDE records for covered Part D drugs, i.e. Drug Coverage Status value = C (see Section 5) and calculate allowable risk corridor costs for the basic benefit by summing CPP Amounts on those PDEs.
2. Exclude induced utilization vis-a-vis the standard benefit (applies only to enhanced alternative plans);
   Multiply result of formula above by (1.00 – induced utilization percentage)
3. Subtract plan-level reinsurance subsidy (see Section 12).
4. Subtract covered Part D DIR dollars (see Section 11) to determine adjusted allowable risk corridor costs.

Determine where costs fall with respect to the thresholds and calculate payment adjustment

If adjusted allowable risk corridor costs fall within 2.5 percent of the target amount (above or below it), there is no risk sharing of additional costs or "savings" compared to estimated (prepaid) amounts, so no payment adjustment will be made:

If adjusted allowable risk corridor costs > 97.5 percent and ≤ 102.5 percent of target amount, then no payment adjustment is made.

Example 1 (target amount = $1m and adjusted allowable risk corridor costs = $978,000):

No payment adjustment is made

Example 2 (target amount = $1m and adjusted allowable risk corridor costs = $1,005,000):

No payment adjustment is made

If adjusted allowable risk corridor costs are more than 2.5 percent outside the plan's target (above or below it), costs or savings will be shared in accordance with the following provisions:

If adjusted allowable risk corridor costs > 102.5 percent and ≤ 105 percent of target amount, then the government pays plan 75 percent of difference between adjusted allowable risk corridor costs and the 1st upper threshold limit. The plan covers remainder of costs.

Example (target amount = $1m and adjusted allowable risk corridor costs = $1,035,000):

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

If adjusted allowable risk corridor costs > 105 percent of target amount, then the government pays plan the sum of 75 percent of difference between 2nd and 1st upper threshold limits and 80 percent of the difference between the adjusted allowable risk corridor costs and the 2nd upper threshold limit. The plan covers remainder of costs.

Example (target amount = $1m and adjusted allowable risk corridor costs = $1,063,000):

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

If adjusted allowable risk corridor costs < 97.5 percent and ≥ 95 percent of target amount, then the plan pays government back 75 percent of difference between 1st

lower threshold limit and the adjusted allowable risk corridor costs. The plan retains 25 percent.
Example (target amount = $1m and adjusted allowable risk corridor costs = $973,000):
Payment adjustment = 0.75*($975,000-$973,000) = $1,500 (plan pays back to government)

If adjusted allowable risk corridor costs < 95 percent of target amount, then the plan pays government back the sum of 75 percent of difference between 1st and 2nd lower threshold limits and 80 percent of the difference between the 2nd lower threshold limit and the adjusted allowable risk corridor. The plan retains the remaining amount.
Example (target amount = $1m and adjusted allowable risk corridor costs = $945,000):
Payment adjustment = [0.75*($975,000-$950,000) + 0.80*($950,000-$945,000)] = $22,750 (plan pays back to government)

The "60/60 Rule"
Note that in 2006 and 2007, the 75 percent risk sharing for adjusted allowable risk corridor costs between the first and second upper threshold limits will change to 90 percent (or the higher percentage if negotiated as a limited risk plan) if the following two conditions have been met:

1. At least 60 percent of Part D plans subject to risk sharing have adjusted allowable risk corridor costs for the Part D plan for the year that are above 102.5 percent of their target amount; and
2. Such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA-PD plan.

CMS often refers to this as the "60/60 rule." Note that condition 1 excludes employer-sponsored plans that elect the 28% subsidy but includes all employers that are contracted Part D plans.

13.3 Limited Risk Plans
PDPs assuming limited risk may be approved in geographic areas where access requirements for a PDP region have not otherwise been met. The statute requires that regions contain at least two qualifying plans offered by different entities, one of which must be a PDP; also, these plans must offer basic coverage or basic and supplemental benefits without any accompanying supplemental premium. In regions where access requirements are not met, the minimum number of limited risk plans needed to satisfy the requirements may be approved. Note that only PDPs may act as limited risk plans and that they must at least provide basic coverage (§1860D-11(f)(4)(A), 42 CFR §423.104(f)(2)). MA-PD plan sponsors may not assume reduced risk.

In making risk corridor payments to limited risk PDPs, we will apply the reduced risk provisions approved in their bids. In accordance with the statute, reduction in risk may be accomplished by 1) symmetrical increases in the federal risk percentages assumed within either risk corridor or 2) symmetrical narrowing of the risk corridors by reducing the

threshold risk percentages. As required under § 423.272(c)(2), CMS shall not approve any bid with a de minimis level of risk. In the preamble to the final rule, we stated that our definition of de minimis in this context was a level of risk that was 10% or less of the statutory level of risk. We clarified in the Advance Notice of Payment Methodological Changes for 2006 that this means the risk after modification cannot be less than 10% of the risk before the risk corridors were moved or federal risk percentages were increased. For example, the lowest reduction in terms of plan threshold risk percentages would be a reduction in the first corridor from 25% to 2.5% and a reduction in the second corridor from 20% to 2%. If risk were reduced by narrowing the corridors, the threshold limits could not be reduced below one-tenth of 2.5% or one-tenth of 5%.

Section 14. Special rules for PACE organizations

Because of several statutory provisions unique to the PACE program, PACE organizations (POs) have several different rules for submitting PDE data. In this section, we describe requirements particular to POs. Note that unless otherwise specified, POs are subject to all other instructions for submitting PDE data.

Section 14.1 Two types of PACE plans

Sections 1894(b)(1)(A)(i) and 1934(b)(1)(A)(i) of the Act preclude PACE organizations from charging PACE enrollees any form of cost sharing. This provision must be reconciled with the global provisions in the MMA that require beneficiary out-of-pocket expenditures. Therefore, CMS will classify all PACE enrollees in two groups, each with its own plan benefit package; the distinction is made according to whether or not a beneficiary is dual eligible. (For further detail, see the 45-Day and Final Payment Notices for 2006 at http://www.cms.hhs.gov/healthplans/rates/).

Dual eligible enrollees – The majority of PACE enrollees are dually eligible for Medicare and Medicaid. These beneficiaries will be enrolled in a plan benefit package that generally maps to the defined standard benefit. They will also be deemed eligible for the low-income subsidy (LIS) to cover most of the standard beneficiary cost sharing. In addition, under the provisions of section 1894(d)(2) of the Act CMS will cover the nominal cost sharing due from non-institutionalized low-income beneficiaries by paying POs an additional monthly capitated payment. For 2006, we will determine the capitation amount to be two percent of costs below the out-of-pocket (OOP) threshold in an approved bid. In this document, we refer to this amount as the "2% capitation." Note that this 2 percent capitation results in a slight deviation from the defined standard benefit at the OOP threshold for catastrophic coverage.

Because LICS payments count towards TrOOP, dual eligible enrollees may reach the OOP threshold and catastrophic coverage provisions. For PACE calculation purposes in 2006, the threshold will be reached at $5,204 in total drug spending, corresponding to $3,600 in TrOOP costs as per the Part D benefit. Between $5,100 and $5,204 in spending, the plan is at risk for 15 percent of allowable costs plus the 2 percent in capitation (for a total of 17%), and 83 percent of costs will be covered as LICS. After the OOP threshold is crossed (>

$5,204), reinsurance covers 80 percent of costs; risk is still shared around 15 percent of costs; and LICS covers 5 percent of cost sharing on behalf of the beneficiary (see Section 12).

Risk corridor calculations remain largely unchanged (see Section 13); CMS will share risk with the plan around 75 percent of adjusted allowable risk corridor costs in the initial coverage period and 15 percent of adjusted allowable risk corridor costs above the OOP threshold. However, the federal government will also share risk with plans on the 2 percent capitation. The formula for the target amount will be (direct subsidy + premium + 2% capitation). Note that since POs do not bid on the A/B component of the benefit, there is no A/B rebate to apply to the target amount.

Note that PACE organizations will not submit a bid for any non-covered benefits they may provide to dual eligible beneficiaries (e.g., non-Part D drugs). These benefits cannot be covered by a supplemental premium or by Medicare, so bidding does not apply to them. POs may – but are not required to – submit PDE records for these drug events with Drug Coverage Status Code = E or O.

Medicare-only enrollees – A small number of PO enrollees are only eligible for Medicare. These beneficiaries will be enrolled in an enhanced alternative (EA) plan in which the PO covers all enrollee cost sharing as enhanced alternative cost sharing (EACS). Since the EA benefit is primary to most wrap-around coverage and will cover all enrollee cost sharing, Medicare-only enrollees who are eligible for LIS will not use any cost-sharing subsidy although they will receive premium assistance.

Medicare-only enrollees will never reach the OOP threshold or the catastrophic coverage phase of the standard benefit, because no TrOOP-eligible payments will be made by them or on their behalf. Thus, reinsurance provisions do not apply. However, risk will be shared around adjusted allowable risk corridor costs using the calculations in Section 13.

Note that the enhanced alternative Medicare-only PACE plans will submit a bid and report PDE data for all supplemental benefits that are funded through a supplemental premium, namely the enhanced alternative cost sharing and any non-Part D covered drugs.

No PACE organization of either plan type shall assume reduced risk (§1860D-11(f)(4)(A), 42 CFR §423.104(f)(2)).

Section 14.2 Rules for populating PDE fields

For both plan types, POs will always report the following fields with zero dollar values:

- Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)
- Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)
- Patient Pay Amount
- Other TrOOP Amount
- Low-Income Cost-Sharing Subsidy (LICS)
- Patient Liability Reduction Due to Other Payer (PLRO)

Note: All dollar fields must be populated with a zero dollar value and submitted in PDE records, even if there is no positive amount to report.

The Catastrophic Coverage Code will always be blank.

Drug Coverage Status Code (DCS), Covered D Plan Paid Amount (CPP), and Non-covered Plan Paid Amount (NPP) shall be populated as follows:

- When DCS = C, the total drug cost must be reported in the Covered D Plan Paid field (CPP); NPP will always = zero.
- When DCS = E or O, the total drug cost must be reported in the Non-covered Plan Paid field (NPP); CPP will always = zero.
- In both instances, CMS will apply an edit to verify that the sum of Ingredient Cost Paid + Dispensing Fee Paid + Amount Attributed to Sales Tax = the summary dollar value in the CPP or NPP field.

CMS will then array the costs reported by the plan in CPP or NPP into the payment categories.

Section 14.3 Arraying the costs of dual eligible enrollees

YTD Total Covered Drug Cost	LICS	Reinsurance	2% capitation	CPP	NPP
DCS = C					
Below the OOP threshold†					
≤ $250	98%	n/a	2%	0%	0
> $250 and ≤ $2,250	23%	n/a	2%	75%	0
> $2,250 and ≤ $5,100	98%	n/a	2%	0%	0
> $5,100 and ≤ $5,204	83%	n/a	2%	15%	0
Above the OOP threshold†					
> $5,204	5%	80%	n/a	15%	0
When DCS = E or O	n/a	n/a	n/a	$0	All drug cost amounts reported in NPP

†In 2006, the threshold is reached at $3,600 in true out-of-pocket costs and will correspond to $5,204 in total covered drug spending for PACE organizations.

Section 14.4 Arraying the costs of Medicare-only enrollees

YTD Total Covered Drug Cost†	CPP	NPP
When DCS = C		
≤ $250	0%	100%
> $250 and ≤ $2,250	75%	25%
> $2,250 and ≤ $5,100	0%	100%
> $5,100	15%	85%
When DCS = E or O	0	100%

†No out-of-pocket threshold or catastrophic coverage is reached

Section 14.5 Examples

The following chart shows the calculations CMS will perform to array beneficiary costs into standard benefit categories for payment reconciliation.

		Dual Eligible PACE Program The Dual Eligible PACE Program has submitted PDEs for Beneficiary A for Covered Part D drugs that total $6,000				Medicare PACE Program The Medicare PACE Program has submitted PDEs for Beneficiary B for Covered Part D drugs that total $6,000			
Standard Benefit Category	Total Covered Drug Cost	LICS	CPP	Portion of CPP eligible for Reinsurance	NPP	Standard Benefit Category	Total Covered Drug Cost	CPP	NPP
Deductible	The first $250	$245 (.98*250)	$5 (.02 * 250)	$0	$0	Deductible	The first $250	$0	$250
Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$460 (.23*2000)	$1,540 (.02 * 2000) + (.75 * 2000)	$0	$0	Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$1500	$500
Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$2,793 (.98*2850)	$57 (.02*2850)	$0	$0	Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$0	$2,850
Defined Standard Catastrophic Coverage	The next $104 > $5,100 and ≤ $5,204†	$86.32 (.83 * 104)	$17.68 (.15 * 104) + (.02 * 104)	$0	$0	Defined Standard Catastrophic Coverage	The remaining $900 > $5,100	$135	$765
PACE Catastrophic Coverage (Reinsurance)	The remaining $796 > $5,204† and ≤ $6,000	$39.80 (.05*796)	$756.20 (.15 * 796) + (.80 * 796)	$796	$0				
Total	$6,000	$3,624.12	$2,375.88	$796	$0			$1,635	$4,365
		CMS will build a beneficiary/plan level summary record totaling the dollars arrayed in LICS, CPP and the portion of CPP eligible for Reinsurance. • Plan level LICS total is the basis for reconciling Low-Income Cost-Sharing Subsidy (see Section 10). • Plan level total Reinsurance represents Allowable Reinsurance Costs used to reconcile the Reinsurance Subsidy (see Section 12). • Plan level total CPP represents the Allowable Risk Corridor Costs used in Risk Corridor calculations (see Section 13).				CMS will build a beneficiary/plan level summary record totaling the dollars arrayed in LICS, CPP and the portion of CPP eligible for Reinsurance. • LICS - none • Plan level total Reinsurance - none • Plan level total CPP represents the Allowable Risk Corridor Costs used in Risk Corridor calculations (see Section 13).			

† In 2006, the threshold is reached at $3,600 in true out-of-pocket costs and will correspond to $5,204 in total covered drug spending for PACE organizations.

Section 15. Special rules for payment demonstration plans

Section 15.1 Overview

In 2006 to 2010, Part D plans may participate in payment demonstrations to study the effects of providing supplemental insurance in the coverage gap. Plans may choose among three variant payment structures that are described in detail at http://www.cms.hhs.gov/pdps/PmntNtcNRskAdjMdl.asp:

1. The flexible capitation option;
2. The fixed capitation option; and
3. The MA rebate option

Since payment demonstration plans will have non-standard benefit structures and some variations in payment methodology, they have several different rules for submitting PDE data for payment calculations. In this section, we describe requirements particular to these plans. Note that unless otherwise specified, payment demonstration plans are subject to all other instructions for submitting PDE data.

In this section, we define rules for cost allocation that only apply to the flexible capitated option and the fixed capitated option, and we provide illustrative examples. Then we provide examples for special TrOOP accounting that only apply to the MA rebate option. In all the examples, we illustrate the simplest case where the beneficiary does not qualify for low income cost-sharing subsidy and the beneficiary has no other health insurance.[6]

Section 15.2 Rules for populating PDE records (flexible and fixed capitation options)

The PDE reporting rules for payment demonstration plans implementing either the flexible or the fixed capitated options are very similar to the rules for reporting enhanced alternative cost sharing (see Section 7). We require these rules because risk sharing for both options differs from risk sharing for other plans as they share risk based on all amounts they would have paid under the standard benefit, including the 80% reinsurance subsidy. These rules allocate all plan paid amounts, including those amounts that would otherwise be included in the reinsurance subsidy, as if the claim had been adjudicated according to the standard benefit. Plan paid dollars allocated to the standard benefit are included in risk corridor calculations. Plan paid dollars that exceed the standard benefit are considered supplemental benefits and are excluded from risk corridor calculations.

The fixed capitated option differs from the flexible capitated option in one important way. Fixed capitation plans will always administer catastrophic coverage at $5,100 of total covered drug spending, so the attachment point claim is always reported at $5,100. From that point forward, the plan will administer and report the benefit according to the standard catastrophic coverage rules.

The rules impact reporting in the following three fields: Patient Pay Amount, Covered D Plan Paid Amount (CPP) and Non-covered Plan Paid Amount (NPP). Note that there is no change in the business rules to populate three other related fields: Catastrophic Coverage Code, Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA) and Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB).

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[6] Payment demonstration plans calculate the low-income cost-sharing subsidy (LICS) in the same way that all other plans do (see Section 10).

Patient Pay Amount, Covered Plan Paid Amount (CPP), Non-covered Plan Paid Amount (NPP)

When reporting PDE records for covered drugs, payment demonstration plans will apply the following rules to calculate amounts submitted in Patient Pay Amount, Covered D Plan Paid Amount and Non-Covered Plan Paid Amount.

Definitions and terminology:
Total covered drug cost – the sum of Ingredient Cost, Dispensing Fee, and Sales Tax for a given PDE
Year-to-date (YTD) total covered drug cost – the sum of all total covered drug costs for a beneficiary to-date within a coverage year
Initial coverage period – the phase of the benefit above the deductible and at or below the initial coverage limit in the defined standard benefit
Payment demonstration coverage period – the phase of the benefit above the initial coverage limit in the defined standard benefit up to the point at which the beneficiary has reached $3,600 in true out-of-pocket (TrOOP) spending. If the plan does not completely fill in the coverage gap as defined by the standard benefit, the payment demonstration coverage period extends from the defined standard initial coverage limit up to the initial coverage limit in the demonstration plan's benefit package.

Rules to calculate CPP and NPP

1. Pay pharmacy according to plan's cost sharing formula and note the patient and plan paid amounts at POS.
2. Report patient cost share at point of sale (POS) in Patient Pay Amount field.
3. Calculate the amount to report in Covered D Plan Paid Amount (CPP). CPP Amount is determined by the standard benefit, and will not necessarily be the same as the plan paid amount at POS (as calculated in step 1). To calculate CPP Amount, multiply total covered drug cost by the applicable percentage in rules 1-4 below.

   Note that the purpose of the rules is to allocate plan paid dollars between two payment fields: Covered Plan Paid Amount (CPP) and Non-covered Plan Paid Amount (NPP). The CPP field captures allowable risk corridor costs. Costs in the NPP field are excluded from allowable risk corridor costs.

   When YTD total covered drug costs ≤$5,100, allocation rules are the same for both options.

   When YTD total covered drug costs > $5,100, the rules differ slightly for the two capitation options. Their different cost allocation rules reflect the fact that beneficiaries cross into catastrophic coverage (or reach the OOP threshold) at a higher YTD total drug costs in the flexible option compared to the fixed option. By way of illustration, the rules consider YTD total covered drug cost above $5,100 into two categories: costs > $5,100 but still ≤ the OOP threshold, and costs > the OOP threshold. Fixed capitated plans will never have costs in the former category, but both flexible and fixed plans will have costs in the latter category. Both rules have the same effect which is to allocate all plan-paid covered drug costs above $5,100 to CPP.

Rule #	YTD Total Covered Drug Cost	Percentage to calculate standard benefit	
		Flexible Capitated Option	Fixed Capitated Option
1	≤ $250*	0%	
2	> $250 and ≤ $2,250	75%	
3	> $2,250 and ≤ $5,100	0%	
4	> $5,100 and ≤ Out-of-Pocket Threshold	Lesser of 95% or (Total Covered Drug Cost - $2/$5)	N/A†
5	> Out-of-Pocket Threshold	Lesser of 95% or (Total Covered Drug Cost - $2/$5)	Lesser of 95% or (Total Covered Drug Cost - $2/$5)

***Not applicable to plans that retain the full $250 deductible*
†By definition, the Out-of-Pocket threshold will always coincide with $5,100 in YTD total covered drug costs in the fixed capitated option.

4. Determine the amount to report in Non-covered Plan Paid Amount (NPP). Subtract Patient Pay Amount (Step 2) and Covered D Plan Paid Amount (Step 3) from total covered drug cost.[7]

Section 15.3 Examples: flexible capitation option

Plan A – Plan A illustrates the flexible capitated option. Plan A retains the $250 deductible. After the deductible is satisfied, it offers 25% cost sharing throughout the benefit until the beneficiary reaches catastrophic coverage. Because Plan A eliminates the coverage gap, a beneficiary does not reach the out-of-pocket threshold until total covered drug costs equal $13,650.

Example 1 – The beneficiary's YTD total covered drug costs = $2,000. The beneficiary purchases a covered drug for $100. Apply Rule #2.

YTD Total Covered Drug Cost = $2,000 – Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .75	NPP (a) - (b + d) or (c-d)
$100	$25	$75	$75	$0

[7] If a beneficiary has other health insurance (reported in PLRO or Other TrOOP Amount) and/or Low-Income Cost-Sharing Subsidy (reported in LICS), we also subtract those amounts from total covered drug cost to determine NPP.

Explanation: According to the standard benefit the beneficiary is in the Initial Coverage Period where the beneficiary pays 25% cost sharing and the plan pays 75%. Plan A's benefit structure is the same. There is no difference between the plan's benefit structure and the standard benefit structure.

Example 2 – The beneficiary's total covered drug costs = $3,000. The beneficiary purchases a covered Part D drug for $100. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000 – Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * 0	NPP (a) - (b + d) or (c-d)
$100	$25	$75	$0	$75

Explanation: According to the standard benefit, the beneficiary is in the coverage gap where the beneficiary pays 100% cost sharing and the plan pays 0%. In Plan A's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan A the beneficiary pays 25% cost share and the plan pays 75%. The difference between the plan liability in the Plan's benefit structure (75%) and the standard benefit plan structure (0%) is a supplemental benefit. This amount is reported in the NPP field.

Example 3 – The beneficiary's YTD total covered drug costs = $6,000. The beneficiary purchases a covered Part D drug for $100. Apply Rule #4.

YTD Total Covered Drug Cost = $6,000 – Rule #4				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .95	NPP (a) - (b + d) or (c-d)
$100	$25	$75	$95	-$20

Explanation: According to the standard benefit the beneficiary is in the catastrophic phase of the benefit where the beneficiary cost sharing is the greater of $2/$5 or 5%. In Plan A's benefit structure, the beneficiary is in the payment demonstration coverage period where the beneficiary pays 25% cost share and the plan pays 75%. As with prior examples, the amount reported in the CPP field is the amount the plan would pay under the standard benefit, $95. This constraint results in a negative NPP amount to account for the difference between what the plan actually paid at POS and what the plan would have paid under the standard benefit. Note also that Plan A would be reporting a Catastrophic Coverage Code = blank for this event, indicating that the beneficiary has not reached catastrophic coverage under Plan A's benefit structure. All drug costs would be reported as below the out-of-pocket threshold in the GDCB field.

Example 4 – The beneficiary's YTD total covered drug costs = $13,651. The beneficiary purchases a covered drug for $100. Apply Rule #5.

YTD Total Covered Drug Cost = $13,651 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .05	Plan Paid at POS (a) * .95	Covered D Plan Paid Amount (CPP) (a) * .95	NPP (a) - (b + d) or (c-d)
$100	$5	$95	$95	$0

Explanation: The beneficiary has reached $3,600 in true out-of-pocket costs, thus is in the catastrophic phase of the benefit where cost sharing is the greater of $2/$5 or 5%. Plan A must provide catastrophic coverage under the standard benefit provisions from here forward, so there is no difference between the Plan's benefit structure and the standard benefit plan structure. Also note that Plan A would be reporting a Catastrophic Coverage Code = C for this event, indicating that this is catastrophic coverage under Plan A's benefit structure, and all drug costs would be reported as above the out-of-pocket threshold in the GDCA field.

Section 15.4 Examples: fixed capitation option

Plan B - Plan B illustrates the fixed capitated option; it eliminates both the $250 deductible and cost sharing in the coverage gap. This plan offers tiered cost sharing in the following structure: $5/$20/$40 (these amounts are for illustration only and are not necessarily representative of an actuarially equivalent benefit structure. Also note that a flexible Capitated plan can offer a tiered cost-sharing arrangement). In the fixed capitated option, the beneficiary reaches catastrophic coverage at $5,100 of YTD total drug spending rather than $3,600 of TrOOP.

Example 1 – The beneficiary's YTD total covered drug costs = $50. The beneficiary purchases a covered Part D drug for $40. The copay for this drug is $5. Apply Rule #1.

YTD Total Covered Drug Cost = $50 - Rule #1				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d) or (c-d)
$40	$5	$35	$0	$35

Explanation: According to the standard benefit, the beneficiary is in the deductible phase where the beneficiary pays 100% cost sharing and the plan pays 0%. In Plan B's benefit structure, the beneficiary cost sharing is reduced to a flat $5 copay. The difference between the plan liability in the plan's actual benefit structure ($35) and the plan's payment under standard benefit plan structure ($0) is a supplemental benefit. This amount is reported in the NPP field.

Example 2 – The beneficiary's YTD total covered drug costs = $1,400. The beneficiary purchases a covered Part D drug for $100. The copay for this drug is $20. Apply Rule #2.

YTD Total Covered Drug Cost = $1,400 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d) or (c-d)
$100	$20	$80	$75	$5

Explanation: According to the standard benefit, the beneficiary is in the initial coverage period where the beneficiary pays 25% cost share and the plan pays 75%. In Plan B's benefit structure, the beneficiary has a flat $20 copay, which is 20% of the total drug cost. The plan liability is $80 under Plan B's benefit structure as compared with $75 under the standard defined benefit. The difference between the plan liability in the plan's benefit structure and the standard benefit plan structure is a supplemental benefit. This amount is reported in the NPP field.

Example 3 – The beneficiary's YTD total covered drug costs = $1,500. The beneficiary purchases a covered Part D drug for $100. The copay for this drug is $40. Apply Rule #2.

YTD Total Covered Drug Cost = $1,500 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d) or (c-d)
$100	$40	$60	$75	-$15

Explanation: According to the standard benefit, the beneficiary is in the initial coverage period where the beneficiary pays 25% cost share and the plan pays 75%. In Plan B's benefit structure, the beneficiary has a flat $40 copay, which is 40% of the total drug cost. The plan liability is $60 under Plan B's benefit structure as compared with $75 under the standard defined benefit. The difference between the plan liability in the Plan's benefit structure and the standard benefit plan structure is a supplemental benefit. In this case, the amount is negative because the plan paid less than under the defined standard. This amount is reported in the NPP field.

Example 4 – The beneficiary's YTD total covered drug costs = $3,000. The beneficiary purchases a covered Part D drug for $100. The copay for this drug is $40. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000 - Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d) or (c-d)
$100	$40	$60	$0	$60

Explanation: According to the standard benefit, the beneficiary is in the coverage gap where the beneficiary pays 100% cost sharing and the plan pays 0%. In Plan B's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan B the beneficiary has a flat $40 copay, which is 40% of the total drug cost. The plan liability is $60 under Plan B's benefit structure as compared with $0 under the standard defined benefit. The difference between the plan liability in the plan's benefit structure and the standard benefit plan structure is a supplemental benefit. This amount is reported in the NPP field.

Example 5 – The beneficiary's YTD total covered drug costs = $6,000. The beneficiary purchases a covered Part D drug for $100. Apply Rule #5.

YTD Total Covered Drug Cost = $6,000 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d) or (c-d)
$100	$5	$95	$95	$0

Explanation: According to the standard benefit, the beneficiary is in the catastrophic phase of the benefit where the beneficiary cost sharing is the greater of $2/$5 or 5%. Since Plan B is a fixed capitation plan, the OOP threshold is reached and catastrophic coverage commences when total covered drug cost reaches $5,100 regardless of accumulated TrOOP. Plan B should report a Catastrophic Coverage Code = C for this event, indicating that the beneficiary has reached catastrophic coverage under Plan B's benefit structure. All drug costs would be reported as above the out of pocket threshold in the GDCA field.

Section 15.5 Examples: MA rebate option

Payment demonstration plans that implement the MA rebate option are considered to be the same as the standard benefit with one qualifier. These plans reduce or eliminate the coverage gap, with all plan spending in that phase of the benefit funded by A/B rebates which count towards TrOOP. In the coverage gap, all plan spending shall be attributed to Other TrOOP amount and therefore counted toward cumulative TrOOP (see example 2). These plans may offer tiered cost sharing in the initial coverage period provided the cost sharing is actuarially equivalent to the defined standard. On average, the cumulative TrOOP will reach $3,600 at the same time that total covered drug spend reaches $5,100. Above $3,600 TrOOP, these plans must offer the standard catastrophic coverage.

Reporting in the initial coverage period and in the catastrophic phase of the benefit will be the same as for any plan that offers basic Part D coverage, that is, all plan spending for covered drugs is considered covered plan paid amounts.

Plan C –Plan C retains the deductible and it eliminates the coverage gap, funding the additional coverage with A/B rebate dollars. The plan offers tiered cost sharing that is actuarially equivalent to the defined standard, but carries this cost sharing throughout the benefit up until catastrophic coverage. The plan offers the following cost sharing structure: $5/$20/$40 (these amounts are for illustration only and are not necessarily representative of an actuarially equivalent benefit structure).

Example 1 – The beneficiary's YTD total covered drug costs = $1,650. The beneficiary purchases a covered Part D drug for $100. The copay for this drug is $40.

YTD Total Covered Drug Cost = $1,650				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d) or (c-d)
$100	$40	$60	$60	$0

Explanation: According to the standard benefit, the beneficiary is in the initial coverage period, which for a MA Rebate Option plan must be actuarially equivalent to the standard defined benefit. In this phase of the benefit, all plan spending is reported as Covered Plan Paid Amount.

Example 2 – The beneficiary's YTD total covered drug costs = $3,000. The beneficiary purchases a covered Part D drug for $100. The copay for this drug is $5.

YTD Total Covered Drug Cost = $3,000				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d) or (c-d)
$100	$5	$95	$0	$95

Explanation: According to the standard benefit, the beneficiary is in the coverage gap where the beneficiary pays 100% cost sharing and the plan pays 0%. In Plan C's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan C, the beneficiary has a flat $5 copay for this drug, which is 5% of the total drug cost. The plan liability is $95 under Plan C's benefit structure as compared with $0 under the standard defined benefit. The plan liability of $95 is reported in the Other TrOOP field.

Example 3 – The beneficiary's YTD total covered drug costs = $5,200. The beneficiary purchases a covered Part D drug for $150. The copay for this drug is $40 normally, but is the greater of 5% or $2/$5 in the catastrophic phase (in this case, 5% is greater).

YTD Total Covered Drug Cost = $5,200				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d) or (c-d)
$150.00	$7.50	$142.50	$142.50	$0.00

Explanation: The beneficiary is in the catastrophic phase of the benefit, and Plan C must administer and report the benefit in a manner consistent with the rules governing catastrophic coverage.

Section 15.6 Payment reconciliation: flexible and fixed capitation options

Payment reconciliation for the flexible capitated option and the fixed capitated option differ from other plan types in two ways. There is no reinsurance reconciliation and the target amount is computed differently.

Target amount

The capitated reinsurance payment is added to the target amount since risk sharing is applied to reinsurance. Thus, the calculation for the target amount outlined in Section 13 changes to:

Direct subsidy
+ Beneficiary premiums for payment purposes
+ A/B rebate
+ Capitated reinsurance payment
= Target amount before administrative cost adjustment
* (1 - Administrative cost ratio)
= Target amount

Adjusted allowable risk corridor costs

Reinsurance calculations outlined in Section 12 do not apply. Therefore, the reinsurance subsidy amount subtracted in the calculation for adjusted allowable risk corridor costs is always zero (see Section 13).

Section 16. Special Instructions for Employer/Union-Only Group Waiver Plans

This Section applies to employer/unions that directly contract with Medicare to become prescription drug plans (PDPs) and to MA-PDs, PDPs and section 1876 cost plans that offer employer/union-only group plans. These plans are authorized under §1857(i) and §1860D-22(b) of the Act which provides that CMS may waive or modify requirements that "hinder the design of, the offering of, or the enrollment in" such employer sponsored plans. CMS refers to employer or union-sponsored plans in these arrangements as employer/union-only group waiver plans (EGWPs) and to the subset of directly contracted plans as Direct EGWPs. These instructions apply to both types of EGWPs and are applicable to these plans pursuant to CMS's waiver authority and to the executed Part D contractual agreements between CMS and these entities.

Section 16.1 Background

Employers and unions that offer retiree medical coverage that includes prescription drug benefits have several options under the MMA beginning in the 2006 coverage year. As referenced above, under CMS statutory waiver authority, these options include becoming Part D plans through direct contracting with CMS or obtaining customized coverage for their retirees through special arrangements with Part D plan sponsors.

All EGWPs must report PDE data according to the requirements in this Section. These plans remain subject to the requirements of 42 CFR §423.104(d) and (e) to provide standard coverage or a benefit that has the same gross value, and these plans may also offer an enhanced package with a value above the standard benefit. Due to unique payment provisions and waivers for EGWPs, we are providing clarification of the rules for data submission by these plans. Note that all PDE submission rules apply unless plans are instructed otherwise.

Note: Employers and unions also have the option to elect to receive a 28 percent federal subsidy to apply towards their non-Part D retiree drug coverage. We refer to these plans as Retiree Drug Subsidy (RDS) plans. RDS plans will not submit data to CMS at the PDE level and should follow separate guidance from CMS for their cost submission requirements.

Section 16.2 Plan types

Only for purposes of PDE reporting instructions, all EGWPs will be considered enhanced alternative plans as defined and described in Section 7. They will use the same instructions provided in Section 7.3 to report supplemental drugs for exclusion from payment. They will report enhanced alternative cost sharing benefits in accordance with the instructions in Section 7.4 for mapping to the defined standard benefit. The mapping enables CMS to distinguish standard from enhanced cost sharing benefits for payment purposes.

Section 16.3 Tracking TrOOP and Gross Covered Drug Costs

EGWPs are responsible for tracking their enrollees' true out-of-pocket costs (TrOOP) and gross covered drug costs (GDCA and GDCB). Like all Part D plans, EGWPs must track enrollee balances in these two categories because they are required to transfer these amounts to a new

plan if a beneficiary changes enrollment during the year. The beneficiary's accumulated TrOOP costs determines when they would reach catastrophic coverage in the new plan, and the beneficiary's accumulated gross covered drug costs determine what phase of the new plan's PBP they are placed into. The balances must be tracked on a calendar year basis even if the EGWP operates on a non-calendar year basis, because the Part D benefit is paid and administered on a calendar year basis.

Section 16.4 Reinsurance

EGWPs are only eligible for the federal reinsurance subsidy if they operate on a calendar year basis. Those that administer benefits on a calendar year basis are subject to all reporting and payment provisions in Section 12 except that they will not receive prospective reinsurance payments during the year. Instead, CMS will make retrospective payment in reconciliation after the end of the year, based on allowable costs reported on PDEs. EGWPs that operate on a non-calendar year basis are not eligible for reinsurance. However, they are still required to administer all catastrophic coverage provisions prescribed by the MMA, in regulation, and in these Instructions. Specifically, once the beneficiary reaches the OOP threshold by accumulating $3,600 in TrOOP costs (see Section 8), beneficiary cost sharing is limited to the statutory amount or an alternative amount that was approved by CMS in the plan's bid. Also, above the OOP threshold, non-calendar year EGWPs must report gross covered drug costs above the threshold (GDCA) and must populate the Catastrophic Coverage Code field with "A" or "C" as appropriate.

Section 16.5 Risk sharing

EGWPs are not subject to risk sharing. Therefore, the payment and reconciliation calculations in Section 13 do not apply to these plans. However, EGWPs must still report covered plan-paid amounts (CPP) to CMS as described in Section 7, to distinguish covered and non-covered benefits.

Section 17. Medicare as Secondary Payer (MSP)

17.1 Background

This Section is a follow-up to our Coordination of Benefits (COB) guidance issued July 1, 2005 (http://www.cms.hhs.gov/pdps/cob.asp). In Sections E and J of the COB guidance, we provided an introduction to the role of Medicare as Secondary Payer (MSP) in coordinating benefits under the MMA. This document extends that early guidance by describing certain MSP scenarios in greater detail and delineating rules for calculating and reporting PDE data in MSP situations.

The Part D benefit is structured with Medicare as a primary payer and in most cases of other health insurance coverage, Medicare will be primary. However, there will be times when other insurers are primary. Clarification regarding a limited number of MSP situations is provided below; however, all MSP laws shall be properly applied whether or not they are mentioned in this document. Part D plans should reference other CMS guidance for detailed rules about establishing payer precedence and interacting with the Coordination of Benefits Contractor (COBC) to establish, verify or manage an MSP situation.

The MMA extended MSP laws applicable to MA organizations to Part D sponsors (§1860D-2(a)(4)). Accordingly, Part D sponsors will have the same responsibilities under MSP laws as do MA plans, including collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities; and the interaction of MSP rules with State laws. Part D plans must properly apply MSP laws and regulations to their payments (e.g., working aged, worker's compensation, other).

17.2 Verifying and establishing MSP

The COBC is the central repository for verifying and establishing an MSP situation. It has sole responsibility for establishing an MSP record for a beneficiary in the Medicare Beneficiary Database (MBD), although Part D plans and beneficiaries have various responsibilities to exchange COB information with each other, with other payers, and with the COBC (http://www.cms.hhs.gov/pdps/cob.asp).

The COBC uses a variety of investigational tools, such as MSP questionnaires, telephone contacts, and data exchanges to determine if there is an MSP situation. Once the COBC updates the Medicare Beneficiary Database (MBD) with an MSP record indicating that Medicare is the secondary payer for a beneficiary, Part D plans are responsible for adjudicating enrollees' claims and submitting prescription drug event (PDE) records in accordance with the following MSP rules. Also, the plans are then responsible for identifying and recovering any MSP-related mistaken payments and submitting associated adjustments to CMS.

According to law, Medicare is the secondary payer in the following situations:

1. Employer group health plans (EGHP) MSP
    a. Working Aged GHP – The beneficiary is actively working and is covered under the employer's GHP or the beneficiary's spouse is actively working and the

beneficiary is covered under the spouse's employer GHP (≥20 employees; or another employer in GHP≥ 20 employees.) (42 U.S.C. §1395(y)(b))

b. Disability with GHP – The beneficiary is actively working for a large employer and is covered under the employer's GHP, or a beneficiary's family member is actively working for a large employer and the beneficiary is covered under the family member's employer GHP (LGHP, ≥100 employees)
c. End Stage Renal Disease (ESRD) GHP – GHP (any size) is primary for the first 30 months when an individual also becomes eligible for Medicare Part A due to ESRD status. After thirty months of Part A eligibility, Medicare becomes primary.

2. Non-GHP MSP
    a. Worker's Compensation (WC) – Beneficiary covered under WC due to job-related illness or injury
    b. Black Lung (BL) – The beneficiary has black lung disease and is covered under the Federal Black Lung Program
    c. No-Fault/Liability – The beneficiary is covered by no-fault or liability insurance due to an accident

However, Part D plans should not immediately pay only as secondary. The action required of the Part D plan is dependent on the type of other primary payer as follows:

1. For the types of Employer Group Health Plans (EGHP) listed above, the Part D plan will always deny primary claims that fall within the EGHP's applicable coverage dates and default to MSP. The types as listed above include: working aged GHP, disability GHP, and ESRD GHP for first 30 months of Medicare Part A eligibility.

2. For Worker's Compensation (WC), Black Lung (BL), and No-Fault or Liability coverage the plan will always make conditional primary payment unless the plan is aware that the enrollee has WC/BL/No-Fault/Liability coverage and has previously established that a certain drug is being used exclusively to treat a related injury. For example, when a beneficiary refills a prescription previously paid for by WC, the Part D plan may deny primary payment and default to MSP.

    In all other instances, the Part D plan is required to make conditional primary payment then recover any mistaken payments where it should have only paid secondary to WC/BL/No-Fault/Liability coverage. For example, if a plan does not know whether a given drug for which it is billed is related to the covered injury, the plan must pay for the drug (if it is covered) and later retrieve any amounts that the other insurance was supposed to cover.

17.3 Mistaken payment recovery

Once a Part D plan has determined that a non-EGHP settlement has occurred for a beneficiary for whom the plan has reported PDE records, the plan must determine and recover any payments that should have been covered by the other party. Once the other party has adjudicated related

claims, the Part D plan must submit adjustment and/or deletion PDEs for those claims to CMS. The plan must also re-determine beneficiary liability for those claims.

CMS instructs plans to submit adjustments only after the primary payer has reimbursed the plan for mistaken payments. However, plans should report these data as soon as possible and exert every effort so that adjusted PDEs may be included in the next reconciliation.

CMS will issue additional guidance to plans on rules for mistaken payment recovery, for example reporting settlements that are received after a given coverage year has been closed out for reconciliation.

17.4 Populating the PDE record as MSP

Once an MSP situation has been established, Part D plans will use the following rules to calculate and report MSP payments on PDE records.

17.4.1 Pricing Exception Code

CMS renamed the field Out-of-Network Code to Pricing Exception Code. It now has two values:
O = Out-of-network claim, non-MSP
M = Medicare as Secondary Payer (MSP) claim (includes OON claims where Medicare is secondary payer)

Plans will populate this field with 'M' to indicate that the PDE has been paid in accordance with MSP rules. If both codes 'O' and 'M' apply for a given PDE, report 'M' as the overriding code because it has the greater effect in payment calculations. Only report value = 'O' when an event is out-of-network and there is no MSP for the event.

17.4.2 Pricing and calculation rules

In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan's negotiated price for the drug. Payments are applied to this price in the following order: primary insurer's payment, beneficiary cost sharing liability under the Part D PBP, and finally the Part D plan picks up any remaining balance. In other words, the primary payment reduces plan-paid amounts first, then beneficiary liabilities. If the primary payment is greater than or equal to the negotiated price, no other payments are made. In particular, plans shall use the following steps to price an MSP claim and populate a PDE record:

1. Price or re-price the claim according to the Part D plan's negotiated price for the drug. In the GDCB or GDCA field, report the negotiated price if the drug is covered or $0 if the drug is non-covered.

2. Report the primary payment amount in the PLRO field. Note that if PLRO ≥ gross drug cost (negotiated price), all other payment amounts on the PDE record are $0.

3. Determine the beneficiary and Part D plan liabilities under the PBP.

4. Subtract the primary payment from the negotiated price.

5. Determine Patient Pay Amount. The beneficiary will actually be responsible for either the amount from Step 3 or the remainder in Step 4, whichever is less. Report the lesser amount in Patient Pay Amount; if the lesser amount is negative, report $0 in Patient Pay Amount.

6. Calculate Part D Plan Paid amount at POS. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price.

7. Report this payment, Part D Plan Paid, in CPP, NPP and/or LICS as follows:

a) If the PBP only provides basic coverage or if the drug is a supplemental drug, the Plan-Paid amount at POS is reported in CPP (for covered drugs) or NPP (for non-covered drugs).

b) The calculations to determine LICS Amount do not change under MSP (see Section 10).

c) If the PBP provides enhanced alternative cost-sharing, use the following rules to calculate and report CPP Amount and NPP Amount:

i. Use the mapping rules in Section 7 to calculate what CPP would be under non-MSP rules; we refer to this value as CPP_c.
ii. Subtract the primary payment from CPP_c to determine CPP_r, the value to report in CPP Amount on the PDE record. Note that if primary payment $\geq CPP_c$, $CPP_r = \$0$; CPP_r shall not be a negative amount.
iii. (Part D Plan Paid - CPP_c) = NPP_r, the value to report in NPP Amount on the PDE record.

Notes:

- If PLRO $\geq CPP_c$, then NPP_r Amount = Part D Plan-Paid
  and CPP_r Amount = $0

- If PLRO $< CPP_c$, then CPP_r Amount = (CPP_c – PLRO)
  and NPP_r Amount = (Part D Plan Paid – CPP_r)

LICS Amounts reduce NPP Amounts when there is enhanced alternative cost sharing. Specifically:

- If PLRO $\geq CPP_c$, then NPP_r Amount = (Part D Plan-Paid – LICS Amount)
  and CPP_r Amount = $0

- If PLRO $< CPP_c$, then CPP_r Amount = (CPP_c – PLRO)
  and NPP_r Amount = (Part D Plan-Paid - LICS Amount – CPP_r Amount).

8. Report a value = M in the Pricing Exception Code field.

17.4.3 Non-standard data format

If a Part D plan receives notice of a primary payment via a beneficiary-submitted claim, Explanation of Benefits, pharmacy receipt or other non-standard method, the plan will follow the instructions in Section 4 to submit a non-standard format PDE record.

17.4.4 PDE Examples

The following examples illustrate how a plan will use these steps to price a claim and populate a PDE record when a primary payment has already been made. In each example, a Part D plan receives a COB segment or non-standard format claim indicating payment by a primary payer.

Examples 1 – 4 Defined standard benefit

In examples 1-4, the beneficiary is enrolled in a defined standard PBP and the drug is a covered Part D drug. In examples 1-3, the beneficiary is in the initial coverage period; in example 4, the beneficiary is in the coverage gap and is eligible for LICS at Level 2 (see Section 10). The examples are summarized in the following table and are then described in detail in the text below it.

MSP: Defined Standard Benefit				
	Ex #1	**Ex #2**	**Ex #3**	**Ex #4**
Primary Payer Payment	$75	$65	$90	$40
Part D Plan Negotiated Price (based on NDC on COB segment)	$100	$100	$100	$100
Part D Plan Liability under the PBP	$75	$75	$75	$0
Beneficiary Liability under the PBP	$25	$25	$25	~~$100~~ $5
Part D Plan pays pharmacy	$0	$10	$0	$55
PDE field: CPP Amount	$0	$10	$0	$0
PDE field: Patient Pay Amount	$25	$25	$10	$5
PDE field: PLRO	$75	$65	$90	$40
PDE field: GDCB	$100	$100	$100	$100
PDE field: LICS Amount	$0	$0	$0	$55

Example 1
The primary payment was $75 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $75 in PLRO. (Steps 3 and 6-7 describe how this payment reduces the plan liability by $75).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $75 = $25.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3) or the difference between the negotiated price and the amount paid by the primary payer

(from Step 4). In this example, the amounts are the same, $25. The plan reports $25 in the Patient Pay Amount field.
6. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. Since the primary paid $75 and the beneficiary liability is $25, the full negotiated price has been covered and Plan-Paid at POS is zero.
7. This is a basic plan and a covered drug, so CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Example 2
The primary payment was $65 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $65 in PLRO. (Steps 3 and 6-7 describe how this payment reduces the plan liability by $65).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $65 = $35.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $35). The plan reports $25 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($65) and beneficiary liability ($25) = $90. The plan pays the pharmacy the remaining $10 of the negotiated price ($100 - $90 = $10).
7. This is a covered drug under a basic plan, so the Plan-Paid amount at POS is reported as CPP Amount = $10 on the PDE.
8. The plan reports Pricing Exception field = 'M'.

Example 3
The primary payment was $90 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $90 in PLRO. (Steps 3 and 5-7 describe how this payment reduces the plan liability by $75 and the beneficiary liability by $15, for a total liability reduction of $90).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $90 = $10.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $10). The plan reports $10 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($90) and beneficiary liability ($25) = $115,

exceeding the negotiated price. Since the full negotiated price has been covered; there is no remaining amount to be paid by the plan.
7. The plan reports CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Example 4
The primary payment was $40 on a brand name covered drug. The beneficiary is in the coverage gap and is eligible for LICS at Level 2.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $40 in PLRO. (Steps 3 and 6-7 describe how the plan's liability including LICS is reduced by $40, from $100 to $55).
3. It determines the beneficiary's liability of $5 (see Section 10) and plan liability of $0 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $40 = $60.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $5) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $60). The plan reports $5 in the Patient Pay Amount field.
6. At POS, the Part D plan pays any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($5) = $45. Even though the beneficiary is in the coverage gap, he/she is eligible for LICS so the plan pays the pharmacy the remaining $55 of the negotiated price ($100 - $45 = $55).
7. It reports this payment in LICS Amount.
8. The plan reports Pricing Exception field = 'M'.

Example 5 Primary payment > negotiated price

In example 5, we illustrate calculating and reporting rules in an MSP situation where the primary payment exceeds the negotiated price of the drug. The plan is an alternative plan (either basic or enhanced). We also use this example to show calculations in a case where a beneficiary has no cost sharing for a particular drug under their PBP. The example is summarized in the following table and then described in detail in the text below it.

MSP: Primary Payment > Negotiated Drug Price	
	Ex #5
Primary Payer Payment	$15
Part D Plan Negotiated Price (based on NDC on COB segment)	$10
Part D Plan Liability under the PBP	$10
Beneficiary Liability under the PBP	$0
Part D Plan-Paid at POS	$0
PDE field: Patient Pay Amount	$0
PDE field: CPP Amount	$0
PDE field: NPP Amount	$0
PDE field: PLRO	$15
PDE field: GDCB	$10
PDE field: LICS Amount	$0

Example 5
A beneficiary is in the pre-catastrophic phase of his/her benefit and fills a prescription for a generic covered drug with zero beneficiary cost sharing. The primary payment was $15 which is greater than the negotiated price of the drug.

1. The plan prices the claim at its negotiated price of $10 and reports this amount in the GDCB field.
2. The plan reports the primary payment of $15 in PLRO. Note that all other payment fields will equal $0 since PLRO > gross drug cost (negotiated price).
3. It determines that there is no beneficiary liability for a generic drug under the PBP, so plan liability is $10.
4. The difference between the negotiated price and the primary payment is $10 - $15 = -$5.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $0) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, -$5). However, the beneficiary cannot have a negative cost-share so the plan reports $0 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($15) and beneficiary liability ($0) = $15, exceeding the negotiated price. Since the full negotiated price has been covered; there is no remaining amount to be paid by the plan.
7. Therefore, CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Examples 6 – 9 Enhanced alternative benefits

In examples 6-9, the beneficiary is in an enhanced alternative (EA) plan (see Section 7). We illustrate the MSP rules and rules for reporting EA benefits to populate a PDE record for covered and non-covered drugs. Note that third party payments are applied to covered benefits

before non-covered benefits; specifically, they reduce CPP amounts before NPP amounts. Also, NPP can be negative as described in Section 7, but CPP cannot be reduced below zero.

The enhanced PBP has no coverage gap and the enhanced initial coverage period has a tiered cost sharing structure of $5/$20/$40/25%. The beneficiary purchases a Tier 2 drug. The examples are summarized in the following table and are then described in detail in the text below it.

MSP: Enhanced alternative benefits				
	Ex #6	**Ex #7**	**Ex #8**	**Ex #9**
Primary Payer Payment	$60	$40	$50	$10
Part D Plan Negotiated Price (based on NDC on COB segment)	$100	$100	$100	$100
Part D Plan Liability under the PBP (non-LI)	$80	$80	$80	$80
Beneficiary Liability under the PBP	$20	$20	$20	~~$20~~ $2
Part D Plan-Paid at POS	$20	$40	$30	$88
CPP_c	$75	N/A	$15	$15
CPP_r	$15	N/A	$0	$5
NPP_r	$5	N/A	$30	$65
PDE field: Patient Pay Amount	$20	$20	$20	$2
PDE field: CPP Amount	$15	$0	$0	$5
PDE field: NPP Amount	$5	$40	$30	$65
PDE field: PLRO	$60	$40	$50	$10
PDE field: GDCB	$100	$0	$100	$100
PDE field: LICS Amount	$0	$0	$0	$18

Example 6
Year-to-date (YTD) total covered drug costs = $300 and the drug is a covered Part D drug.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $60 in PLRO. (Steps 3 and 6-7 describe how CPP is reduced by this amount).
3. Under the PBP, the beneficiary is in the initial coverage period and is liable for a co-pay of $20. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $40 (100 - $60).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $60). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($60) and beneficiary liability ($20) = $80. So at POS, the plan-paid amount is $20.

7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $75 by mapping to the defined standard benefit (Section 7, Rule #2).

- PLRO < CPP_c, so CPP_r Amount = (CPP_c -PLRO) = ($75-$60) = $15.
- NPP Amount = (Patient Pay Amount + LICS Amount – CPP_r) = ($20-$15) = $5.

8. The plan reports Pricing Exception field = 'M'.

Example 7
YTD total covered drug costs = $4,600 and the drug is a supplemental drug.

1. The plan prices the claim at its negotiated price of $100. Because the drug is non-covered, the plan reports $0 in the GDCB field.
2. The plan reports the primary payment of $40 in the PLRO field.
3. Under the PBP, the beneficiary is still in the initial coverage period so is liable for a $20 co-pay. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $60 (100 - $40).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $60). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($20) = $60. So at POS, the plan-paid amount is $40.
7. Since this is a supplemental drug, this $40 payment is reported in NPP Amount.
8. The plan reports Pricing Exception field = 'M'.

Example 8
YTD total covered drug costs = $6,000, beneficiary is in the enhanced initial coverage period, and the drug is a covered drug.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $50 in the PLRO field.
3. Under the PBP, the beneficiary is still in the initial coverage period so is liable for a $20 co-pay. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $50 (100 - $50).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $50). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($50) and beneficiary liability ($20) = $70, so Plan-Paid at POS = $30.
7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $15 by mapping to the defined standard benefit (Section 7, Rule #4).

- PLRO > CPP_c, so NPP Amount = Plan-Paid at POS = $30.
- CPP Amount = $0.

(Note: Due to the primary payment, CPP and NPP have been reduced by $15 and $35 respectively ($50 total) from what they would otherwise have been under Section 7 rules. CPP was reduced first).
8. The plan reports Pricing Exception field = 'M'.

Example 9
The conditions are the same as in Example 8 except the beneficiary is eligible for LICS at Level II (see Section 10) and the primary payment is $10.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $10 in the PLRO field. (Steps 3, 6, and 7 show how CPP and NPP were reduced by this amount).
3. Under the PBP, the beneficiary is liable for a $20 co-pay, reduced to $2 because of LICS. The plan liability is $80 (not taking LICS into account).
4. The difference between the negotiated price and the primary payment is $90 (100 - $10).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $2) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $90). The plan reports $2 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($10) and beneficiary liability ($2) = $12, so Plan-Paid at POS = $88.
7a) LICS calculations do not change under MSP, so LICS Amount is the difference between the non-LI cost sharing and the LI cost sharing under the PBP (see Section 10). LICS Amount = ($20 - $2) = $18.
7b) Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $15 by mapping to the defined standard benefit (Section 7, Rule #4).

- PLRO < CPP_c, so NPP Amount = (Plan-Paid at POS – LICS) = ($88 - $18) = $65. CPP_r Amount = $5.

(Note: Due to the primary payment, CPP was reduced by $10and NPP remained the same).
8. The plan reports Pricing Exception field = 'M'.

17.5 MSP and progression through the Part D benefit

In an MSP situation, payments by both the primary party and Medicare contribute in certain ways to a beneficiary's progression through their Part D benefit. If the drug is a Part D covered drug, the price that the Part D plan allows for the drug (the negotiated price) will count towards total covered drug costs for purposes of moving a beneficiary through their Part D benefit.

Patient Pay Amounts and other applicable payments for Part D covered drugs (e.g., LICS) will count towards TrOOP costs. Payments by a primary payer never count towards TrOOP. However, they must be reported on the PDE record as reductions to beneficiary and/or Part D plan liability, in the PLRO field. These data assure that TrOOP costs and plan-paid amounts for risk sharing are accurate.

When a beneficiary has Part D coverage, CMS recommends that primary insurers always file a secondary claim with the Part D plan. Much of the time, beneficiaries will have benefits under their Part D plan that can only be claimed by filing a PDE record with CMS. However, even if a beneficiary does not have coverage for a given drug under their Part D plan, it is beneficial for other insurers to report all utilization to the Part D plan to ensure coordination under any Part D medication therapy monitoring program or utilization management program. The Part D plan may deny the claim, but the plan will have more comprehensive utilization information about their enrollee for use in such programs.

17.6 Reinsurance under MSP

We anticipate having few beneficiaries in the catastrophic coverage phase with Medicare as a secondary insurance. However, in those instances CMS will not calculate reinsurance on amounts paid by a primary insurer. Instead, CMS will use adjusted GDCA which will be calculated as:

Adjusted GDCA = GDCA – PLRO

The reinsurance calculation will be:

0.80 * (Adjusted GDCA – reinsurance DIR)

Note: If Adjusted GDCA includes both a Part D plan-paid amount (CPP) and a Patient Pay Amount, reinsurance will cover 80 percent of the sum of these amounts, net of direct and indirect remuneration (DIR). If the Part D plan has no liability and there is only a Patient Pay Amount, the Patient Pay Amount is the only component of Adjusted GDCA and reinsurance will cover 80 percent of the Patient Pay Amount net of DIR.

17.7 Sample Q&As

1. If a beneficiary has Workers' Compensation (WC) coverage, is WC the primary payer or is Part D?

If the Part D Plan knows that the drug used to treat the condition is related to the WC injury and claim, WC would be primary. However, Part D plans should not deny all incoming primary claims simply because a beneficiary has WC coverage. Part D plans will make primary payment in all situations where they do not know whether or not the drug on the claim is related to the WC injury, and should only deny a primary claim when the Part D plan has confidence that the drug is related to the WC injury. If WC was primary, the plan must recover any mistaken payment and submit an adjustment or deletion record to CMS reflecting the change in claim adjudication.

2. If WC or another payer is primary, would the amounts paid by the primary count towards a beneficiary's Part D TrOOP costs and/or total drug costs?

Payments by a primary payer never count towards TrOOP. However, they must be reported on the PDE record as reductions to beneficiary and/or Part D plan liability, in the PLRO field.

If the drug is a Part D covered drug, the price that the Part D plan allows for the drug (the negotiated price) will count towards total covered drug costs for purposes of moving a beneficiary through their Part D benefit. If the drug is covered under a Part D supplemental benefit, the price that the Part D plan allows will count towards supplemental (non-covered) drug costs.

3. Does CMS want PDE records submitted for prescriptions covered under WC or another liability case such as automobile insurance?

In general, yes. Technically, if the drug is not covered at all under the beneficiary's Part D plan, the plan will deny any claim and a PDE does not need to be submitted. Similarly, where a Part D plan denies a claim because it knows that the drug on the claim is related to the WC injury, it would not submit a PDE record to CMS. However, much of the time beneficiaries will have benefits under their Part D plan that need to be claimed by filing an PDE record with CMS. If a beneficiary files a claim with Part D after WC or other liable party pays, or if a claim is automatically filed under the COB system, the drug costs may count towards TrOOP or other progression by a beneficiary through their Part D benefit (see #2) and should therefore be reported.

In addition, even if a beneficiary does not have coverage for a given drug under their Part D plan, it is beneficial to report all utilization to the Part D plan to ensure coordination under any Part D medication therapy monitoring program or utilization management program. The Part D plan would deny the claim and would not submit a PDE record, but it would have more comprehensive utilization information about their enrollee for use in such programs.

4. If a beneficiary has coverage under AIDS Drug Assistance Program (ADAP), would the ADAP be primary or secondary to Part D?

ADAPs do not fall into any of the categories of primary payers under the MSP laws (GHP, no-fault, liability, or worker's compensation), so they will always be secondary to Part D; there is no MSP with regard to ADAPs. In general, when a plan discovers information about any other health insurance possessed by a beneficiary, it should first report that information to the COBC according to the rules found in the forthcoming Electronic Correspondence Referral System (ECRS) Welcome Packet. The COBC will then follow federal, state, National Association of Insurance Commissioners (NAIC), and other guidelines to determine payer of precedence. If a payer is primary to Part D, the COBC will post an MSP record in MBD as notice to the Part D plan.

Glossary of Acronyms

Because we refer to many organizations and terms by acronym in this document, we list these acronyms and their corresponding terms in alphabetical order as follows:

ADAP	AIDS Drug Assistance Program
BL	Black Lung
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of benefits
COBC	Coordination of Benefits Contractor
CPP	Covered D Plan Paid Amount
DAW	Dispense as written
DCB	Drug Claims Database
DDPS	Drug Data Processing System
DEA	Drug Enforcement Administration
DIR	Direct and indirect remuneration
DOB	Date of Birth
DOS	Date of Service
EA	Enhanced alternative
EACS	Enhanced alternative cost sharing
ECRS	Electronic Correspondence Referral System
EGHP	Employer group health plan
EGWP	Employer/Union-Only Group Waiver Plan
EIN	Employer Identification Number
ESRD	End stage renal disease
FBDE	Full benefit dual eligible
GDCA	Gross Drug Cost Above the Out-Of-Pocket Threshold
GDCB	Gross Drug Cost Below the Out-Of-Pocket Threshold
GHP	Group health plan
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
I/T/U	Indian Health Service/Tribe/Tribal organization/Urban Indian program
LGHP	Large group health plan
LI	Low income
LICS	Low income cost-sharing subsidy
LIS	Low income subsidy
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug plan
MBD	Medicare Beneficiary Database
MMA	Medicare Prescription Drug Benefit, Improvement and Modernization Act of 2003
MSP	Medicare as Secondary Payer
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NPP	Non-covered Plan Paid Amount

OHI	Other Health Insurance
OON	Out-of-Network
OOP	Out-of-Pocket
OTC	Over-the-counter
PACE	Program of All Inclusive Care for the Elderly
PAP	Pharmaceutical Assistance Program
PBM	Pharmacy benefit manager
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDFS	Prescription Drug Front-End System
PDP	Prescription drug plan
PFFS	Private fee-for-service
PLRO	Patient Liability Reduction due to Other Payer Amount
PO	PACE organization
POS	Point of sale
RDS	Retiree drug subsidy
RRB	Railroad Retirement Board
SPAP	State Pharmaceutical Assistance Program
TIN	Tax Identification Number
TrOOP	True out-of-pocket
UPIN	Unique Provider Identification Number
WC	Worker's Compensation
YTD	Year to date

Prescription Drug Event Record Layout

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PDE RECORD LAYOUT

HDR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'HDR'
2	SUBMITTER-ID	4 – 9	X(6)	'SXXXXX'
3	FILE-ID	10 – 19	X(10)	
4	TRANSACTION-DATE	20 – 27	9(8)	CCYYMMDD
5	PROD-TEST-CERT-IND	28 – 31	X(4)	'PROD' 'CERT' OR 'TEST'
6	FILLER	32 - 512	X(481)	SPACES

BHD RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BHD'
2	SEQ-NO	4 – 10	9(7)	MUST BEGIN WITH 0000001
3	CONTRACT NO	11 – 15	X(5)	ASSIGNED BY CMS
4	PBP ID	16 – 18	X(3)	ASSIGNED BY CMS
5	FILLER	19 – 512	X(494)	SPACES

DET RECORD

DET RECORDS FOLLOW BHD RECORDS AND ARE FOLLOWED BY ADDITIONAL DET RECORDS OR BTR RECORDS.

DET RECORD

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE	
1	RECORD-ID		1 – 3	X(3)	'DET'	
2	SEQUENCE NO		4 – 10	9(7)	MUST BEGIN WITH 0000001	
3	CLAIM CONTROL NO		11 – 50	X(40)	OPTIONAL	
4	HICN		51 – 70	X(20)	HICN OR RRB#	
5	CARDHOLDER ID	302-C2	71 – 90	X(20)	PLAN IDENTIFICATION OF BENEFICIARY	
6	PATIENT DOB	304-C4	91 – 98	9(8)	CCYYMMDD/OPTIONAL	
7	PATIENT GENDER	305-C5	99 – 99	9(1)	1=MALE 2=FEMALE	
8	DATE OF SERVICE	401-D1	100 – 107	9(8)	CCYYMMDD	
9	PAID DATE		108 – 115	9(8)	CCYYMMDD/FALLBACK ONLY	
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 – 124	9(9)	00NNNNNNN	
11	FILLER		125 – 126	X(2)	SPACES	
12	PRODUCT SERVICE ID	407-D7	127 – 145	X(19)	'MMMMMDDDDPP'	
13	SERVICE PROVIDER ID QUALIFIER	202-B2	146 – 147	X(2)	STANDARD '01'=NPI '07'=NCPDP #	NON-STANDARD '01'=NPI '06'=UPIN '07'=NCPDP # '08'=STATE LICENSE '11'=FEDERAL TAX ID '99'=OTHER
14	SERVICE PROVIDER ID	201-B1	148 – 162	X(15)		
15	FILL NO	403-D3	163 – 164	9(2)	0=NOT AVAILIABLE 1-99=NUMBER OF FILLS	
16	DISPENSING STATUS	343-HD	165 – 165	X(1)	<BLANK>=NOT SPECIFIED 'P'=PARTIAL FILL 'C'=COMPLETION OF PARTIAL FILL	
17	COMPOUND CODE	406-D6	166 – 166	9(1)	0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND (MULTIPLE)	

PDE RECORD LAYOUT

DET RECORD (CONTINUED)

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
18	DISPENSE AS WRITTEN (DAW)	408-D8	167 – 167	X(1)	'0'=NO PRODUCT SELECTION INDICATED '1'=SUB NOT ALLOWED BY PRESCRIBER '2'=SUB ALLOWED; PATIENT REQUESTED PRODUCT DISPENSED '3'=SUB ALLOWED – PHARMACIST SELECTED PRODUCT DISPENSED '4'=SUB ALLOWED – GENERIC DRUG NOT IN STOCK '5'=SUB ALLOWED – BRAND DRUG DISPENSED AS GENERIC '6'=OVERRIDE '7'=SUB NOT ALLOWED – BRAND DRUG MANDATED BY LAW '8'=SUB ALLOWED GENERIC DRUG NOT AVAILABLE IN MARKETPLACE '9'=OTHER
19	QUANTITY DISPENSED	442-E7	168 – 177	9(7)V999	# OF UNITS, GRAMS, MILILITER, OTHER.
20	DAYS SUPPLY	405-D5	178 – 180	9(3)	0-999
21	PRESCRIBER ID QUALIFIER	466-EZ	181 – 182	X(2)	'01'=NPI '06'=UPIN '08'=STATE LICENCE NO '12'=DEA #
22	PRESCRIBER ID NO	411-DB	183 – 197	X(15)	
23	DRUG COVERAGE STATUS CODE		198 – 198	X(1)	'C'=COVERED 'E'=ENHANCED 'O'=OTC DRUGS
24	ADJUSTMENT/DELETION CODE		199 – 199	X(1)	'A'=ADJUSTMENT 'D'=DELETION <BLANK>=ORIGINAL PDE RECORD
25	NON-STANDARD FORMAT CODE		200 – 200	X(1)	'X'=X12 837 'B'=BENEFICIARY SUBMITTED CLAIM 'P'=PAPER CLAIM FROM PROVIDER <BLANK>=NCPDP FORMAT
26	PRICING EXCEPTION CODE		201 – 201	X(1)	'M'=MEDICARE AS SECONDARY PAYER (MSP) IN NETWORK OR OUT-OF-NETWORK 'O'=OUT-OF-NETWORK PHARMACY (NON-MSP) <BLANK>=IN NETWORK PHARMACY AND MEDICARE PRIMARY
27	CATASTROPHIC COVERAGE CODE		202 – 202	X(1)	'A'=ATTACHMENT POINT MET ON THIS EVENT 'C'=ABOVE ATTACHMENT POINT <BLANK>=ATTACHMENT POINT NOT MET
28	INGREDIENT COST PAID	506-F6	203 – 210	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
29	DISPENSING FEE PAID	507-F7	211 – 218	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
30	AMOUNT ATTRIBUTED TO SALES TAX		219 – 226	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
31	GDCB		227 – 234	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
32	GDCA		235 – 242	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
33	PATIENT PAY AMOUNT	505-F5	243 – 250	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
34	OTHER TrOOP AMOUNT		251 – 258	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS

PDE RECORD LAYOUT

DET RECORD (CONTINUED)

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
35	LICS AMOUNT		259 – 266	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
36	PLRO		267 – 274	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
37	CPP		275 – 282	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
38	NPP		283 – 290	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
39	ESTIMATED REBATE AT POS		291 – 298	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
40	VACCINE ADMINISTRATION FEE		299 – 306	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
41	FILLER		307 – 415	X(108)	SPACES
42	PBP OF RECORD*		416 – 418	X(3)	SPACES
43	ALTERNATE SERVICE PROVIDER ID QUALIFIER*		419 – 420	X(2)	SPACES
44	ALTERNATE SERVICE PROVIDER ID*		421 – 435	X(15)	SPACES
45	ORIGINAL SUBMITTING CONTRACT*		436 – 440	X(5)	SPACES
46	P2P CONTRACT OF RECORD*		441 – 445	X(5)	SPACES
47	CORRECTED HICN*		446 – 465	X(20)	SPACES
48	ERROR COUNT*		466 – 467	9(2)	SPACES
49-58	ERROR CODE FIELDS*		468 – 497	X(3)	SPACES
59	FILLER		498 – 512	X(15)	SPACES

BTR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BTR'
2	SEQ-NO	4 – 10	9(7)	MUST BEGIN WITH 0000001
3	CONTRACT NO	11 – 15	X(5)	MUST MATCH BHD
4	PBP ID	16 – 18	X(3)	MUST MATCH BHD
5	DET RECORD TOTAL	19 – 25	9(7)	TOTAL COUNT OF DET RECORDS
6	DET ACCEPTED RECORD TOTAL*	26 – 32	9(7)	SPACES
7	DET INFORMATIONAL RECORD TOTAL*	33 – 39	9(7)	SPACES
8	DET REJECTED RECORD TOTAL*	40 – 46	9(7)	SPACES
9	FILLER	47 – 512	X(466)	SPACES

TLR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'TLR'
2	SUBMITTER-ID	4 – 9	X(6)	MUST MATCH HDR
3	FILE-ID	10 – 19	X(10)	MUST MATCH HDR
4	TLR BHD RECORD TOTAL	20 – 28	9(9)	TOTAL COUNT OF BHD RECORDS
5	TLR DET RECORD TOTAL	29 – 37	9(9)	TOTAL COUNT OF DET RECORDS
6	TLR DET ACCEPTED RECORD TOTAL*	38 – 46	9(9)	SPACES
7	TLR DET INFORMATIONAL RECORD TOTAL*	47 – 55	9(9)	SPACES
8	TLR DET REJECTED RECORD TOTAL*	56 – 64	9(9)	SPACES
9	FILLER	65 – 512	X(448)	SPACES

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

PDE Record File Structure Summary

RT HDR – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BHD.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test/Certification Indicator
- Filler

RT BHD – BATCH HEADER (Plan Info)
Must follow RT HDR or RT BTR and must be followed by RT DET.

- Record ID
- Sequence Number
- Contract Number
- PBP ID
- Filler

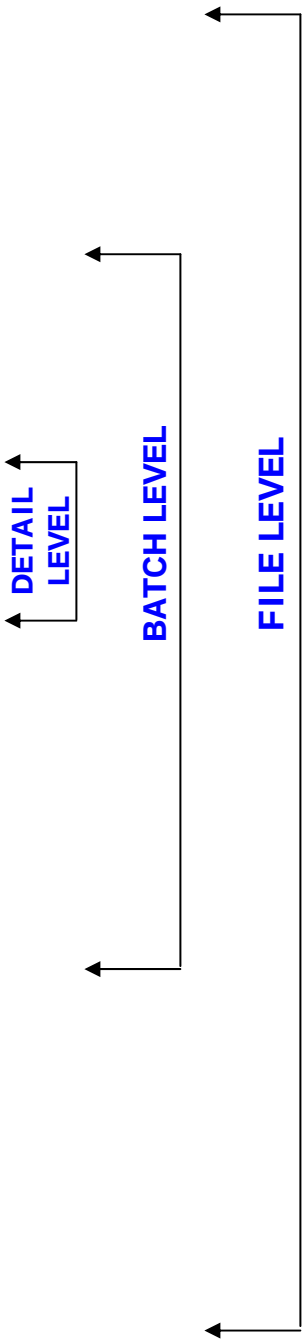
RT DET – DETAIL RECORD (Drug Event Information)
Must follow RT BHD or RT DET and may be followed by another RT DET or RT BTR. The detail record contains 39 data elements that must be populated with data in order to provide CMS with the information required for identifying each unique prescription drug event and calculating payment.

RT BTR – BATCH TRAILER
Must follow RT DET and may be followed by a RT BHD or RT TLR.

- Record ID
- Sequence Number
- Contract No
- PBP ID
- DET Record Total
- DET Accepted Record Total
- DET Informational Record Total
- DET Rejected Record Total
- Filler

RT TLR – FILE TRAILER
Must follow RT BTR, and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- TLR BHD Record Total
- TLR DET Record Total
- TLR DET Accepted Record Total
- TLR DET Informational record total
- TLR DET Rejected Record Total
- Filler



Prescription Drug Event (PDE) Counting Rules

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR BENEFICIARY CHOICES

DATE: February 12, 2007

TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Other Interested Parties

FROM: Thomas Hutchinson
Director, Medicare Plan Payment Group

SUBJECT: Prescription Drug Event (PDE) Counting Rules.

As changes have been made in the Drug Data Processing System throughout the year to accommodate scenarios such as Plan-to-Plan Reconciliation (P2P), there became a need to better define the rules for counting PDE records on the monthly reports. As a PDE goes through its life cycle, there is the potential for the PDE to change P2P status and/or Drug Coverage Status Code. The previous counting rules did not best represent these changes. The new counting methodology will document certain PDE counts to reflect the change in PDE classification.

The new PDE counting methodology will first appear on the monthly reports for December. The new counting methodology only changes how PDE counts are reported and does not affect the reporting of financial amounts on the reports.

Information explaining the new counting methodology can be found on the customer service website at http://www.csscoperations.com. This information provides detailed examples for each possible scenario that could be affected by the new counting methodology.

Questions regarding the new PDE counting methodology should be directed to either Amanda.Ryan@cms.hhs.gov or Jeffrey.Grant@cms.hhs.gov.

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Prescription Drug Event (PDE)
Counting Rule Changes for Contracts

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Prescription Drug Event (PDE) Counting Rule changes for Contracts

As changes have been made to the Drug Data Processing System (DDPS) throughout the year to accommodate for new scenarios such as the Plan-to-Plan Reconciliation Process (P2P), there became a need to better define rules on how to count PDEs on the monthly reports. The rules have been defined and will be used beginning with the reports that Contracts will be receiving for December.

There are various monthly reports based on whether a PDE is P2P vs. non-P2P or on its drug coverage status code. The monthly reports are Report 4 (Covered, Enhanced, and Over-the-Counter Drugs) and Reports 40 (Covered, Enhanced, and Over-the-Counter Drugs) through 43. The rules to determine on which report a PDE will be counted have been refined to reflect changes to these classifications (i.e., adjustments may change the P2P status of a PDE or the drug coverage code on a PDE) as the PDE goes through its life cycle.

In order to understand the new rules, it is important to understand the terminology used when documenting counts on the monthly reports. There are gross counts and net counts that will need to be tracked as a result of changes to a PDE.

The Gross Count Fields will report the status of the PDE when it was accepted into the system. However the PDE was classified (P2P versus non-P2P; Covered, Enhanced or OTC) when it was accepted, will reflect which report that PDE will be counted on. The one exception to this rule involves deletion records which are accepted but contain different values than the record it is deleting. In this case, the deletion will be counted on the same report as the record it was deleting, regardless of the values on the delete record. Gross Count Fields include:

- Number of Original PDEs
- Number of Adjustment PDEs
- Number of Deletion PDEs

All fields that are defined as Net Counts will be the distinct count of the PDE records that are reported for the beneficiary on the specific report. Net Count Fields include:

- Rx Count
- Net Number of Catastrophic PDEs
- Net Number of Attachment Point PDEs
- Net Number of Non-Catastrophic PDEs
- Net Number of Non-Standard Format PDEs
- Net Number of Out-of-Network (OON) PDEs

The new counting methodology works as follows:

1. Original, adjustment and deletion records are categorized as “gross” counts.

    a. Each original and adjustment PDE record is counted and reported under the classifications contained on that PDE record, regardless of subsequent

activity related to the PDE. For example, if a non-P2P PDE is entered and deleted in the same month, Report 4 will show 1 original "gross" count and 1 deleted "gross" count.

b. Each deletion PDE record is counted and reported under the classifications contained on the PDE record that the deletion record relates to, regardless of the classifications on the delete record itself. This rule is not new to the new counting methodology. Deletion records were always counted in this manner. For example, if an Original PDE came is and was accepted with a Drug Coverage Status Code "C" and later the Deletion PDE is accepted and on that PDE the Drug Coverage Status Code was changed from "C" to "O", then the deletion gross count will appear on Report 4 for Covered Drugs.

2. The net counts will follow the currently active, non-delete record and be reported under the classifications contained on that PDE record. When the delete record is the active record, the PDE will not be included in the net counts. For example, if a non-P2P PDE is entered and deleted within the same month, the "gross" counts will display 1 original count and 1 delete count but the net counts will be zero.

The following examples below will explain other scenarios that Contracts may see on the monthly reports:

Scenario 1:
A P2P PDE for a covered drug is accepted by CMS then deleted by the Contract within the same month. Although the record was deleted, the Contract of Record will receive a detail record for this beneficiary on Report 42. All amounts for this beneficiary will be zero.

Reports Affected:	Report 40 Covered
	0 Rx Count
	1 Original Gross Count
	1 Deletion Gross Count

Scenario 2:
A P2P PDE for a covered drug is accepted by CMS in one month and then deleted by the Contract in another month. Although the record was deleted, the Contract of Record will receive a detail record for this beneficiary on Report 42. All amounts for this beneficiary will be zero.

Reports affected:	Report 40 Covered
Month 1:	1 Rx Count
	1 Original Gross Count
Month 2:	0 Rx Count
	1 Original Gross Count
	1 Deletion Gross Count

Scenario 3:
A non-P2P PDE for a covered drug is accepted by CMS and deleted by the Contract in the same month

Reports Affected:	Report 4 Covered
	0 Rx Count
	1 Original Gross Count
	1 Deletion Gross Count

Scenario 4:
A non-P2P PDE for a covered drug is accepted by CMS in one month and deleted by the Contract in another month.

Reports affected:	Report 4 Covered
Month 1:	1 Rx Count
	1 Original Gross Count
Month 2:	0 Rx Count
	1 Original Gross Count
	1 Deletion Gross Count

Scenario 5:
A PDE is accepted by CMS as a P2P PDE for a covered drug. In that same month, the PDE is submitted by the Contract as an adjusted PDE, which changes the PDE to a non-P2P PDE. Since the PDE was originally a P2P PDE, Report 42 will display a detail record for the beneficiary but will show zero amounts.

Reports affected:	Report 4 Covered	Report 40C
	1 Rx Count 1 Adjusted Gross Count	0 Rx Count 1 Original Gross Count

Scenario 6:
A PDE is accepted by CMS as a P2P PDE for a covered drug and then is submitted by the Contract as an adjusted PDE in a later month which changes the PDE to a non-P2P PDE. Although the record was changed to non-P2P, the Contract of Record will continue to receive a detail record for this beneficiary on Report 42. All amounts for this beneficiary will be zero.

Reports affected:	Report 4Covered	Report 40C
Month 1:		1 Rx Count 1 Original Gross Count
Month 2:	1 Rx Count 1 Adjusted Gross Count	0 Rx Count

Scenario 7:
A PDE is accepted by CMS as a non-P2P PDE for a covered drug and in that same month an adjusted PDE is submitted by the Contract, which changes the PDE to a P2P PDE.

Reports affected:	Report 4 Covered	Report 40C
Month 1:	0 Rx Count	1 Rx Count
Month 2:	1 Original Gross Count	1 Adjusted Gross Count

If a PDE is accepted and the Submitting Contract = Contract of Record and the Drug Coverage = C, then the PDE amounts and counts appear on Report 4 Covered.

Previously, if an adjustment came in for the PDE and the Submitting Contract no longer equaled the Contract of Record, then Report 4 Covered counted the PDE in the Rx Count Field, Original PDE Count and Adjusted PDE Count, but the Dollar Amounts for the PDE appeared on Report 40 Covered.

With the new rules, the Original Count will stay on Report 4 Covered, but the Rx Count will be reduced by one on that report. On Report 40 (P2P Report) Covered, the Rx Count and the Adjusted PDE Count will increase by 1 for that beneficiary.

Scenario 8:
The PDE is submitted to CMS as a non-P2P PDE for a covered drug and then is sent in by the Contract as an adjusted P2P PDE in a later month. This PDE will not appear on the P2P reports until the month in which the adjustment is accepted by CMS.

Reports affected:	Report 4 Covered	Report 40C
Month 1:	1 Rx Count 1 Original Gross Count	----
Month 2:	0 Rx Count 1 Original Gross Count	1 Rx Count 1 Adjusted Gross Count

Scenario 9:
The PDE is accepted by CMS as a P2P Covered drug and then is sent in by the Contract as an adjusted PDE in a later month. The adjustment changes the PDE to a P2P Enhanced or Over-the-Counter PDE. For the Submitting Contract, the adjustment will appear on Report 40 E or O. The Contract of Record will continue to receive a detail record for this beneficiary on Report 42. All amounts for this beneficiary will be zero.

Reports affected:	Report 40C	Report 40 E/O
Month 1:	1 Rx Count 1 Original Gross Count	
Month 2:	0 Rx Count 1 Original Gross Count	1 Rx Count 1 Adjusted Gross Count

Scenario 10:
A PDE is accepted by CMS as a P2P Covered Drug PDE one month and then is sent in by the Contract as an adjusted PDE in a later month to make it a non-P2P Covered Drug PDE. Although the record was changed to non-P2P, the Contract of Record will continue to receive a detail record for this beneficiary on Report 42. All amounts for this beneficiary will be zero.

Reports affected:	Report 4 Covered	Report 40C
Month 1:	----	1 Rx Count 1 Original Gross Count
Month 2:	1 Rx Count 1Adjusted Count	0 Rx Count 1 Original Count

Scenario 11:
A PDE is accepted by CMS as a non-P2P Covered drug and in a later month the Contract submits an adjustment to make the PDE a P2P Covered PDE.

Reports affected:	Report 4 Covered	Report 40C
Month 1:	1 Rx Count 1 Original Gross Count	----
Month 2:	0 Rx Count 1 Original Gross Count	1 Rx Count 1 Adjusted Gross Count

Scenario 12:
A PDE is accepted by CMS as a non-P2P Covered drug and in a later month the Contract submits an adjustment that makes the PDE a non-P2P Enhanced (E) or Over-the-Counter (O) drug.

Reports affected:	Report 4 Covered	Report 4E or O
Month 1:	1 Rx Count	----
	1 Original Gross Count	----
Month 2:	O Rx Count	1 Rx Count
	1 Original Gross Count	1 Adjusted Gross Count

If a PDE is accepted and the Drug Coverage Code = C, then the PDE amounts and counts appear on Report 4 Covered.

Previously, if an adjustment came in for that PDE which changed the Drug Coverage Code = E, then Report 4 Covered counted the PDE in the Rx Count field, Original PDE Count and Adjusted PDE Count, but the Dollar Amounts for the PDE appeared on Report 4 Enhanced.

With the new rules, the Original PDE Count will stay on Report 4 Covered, but the Rx Count will be reduced by one on that report. On Report 4 Enhanced, the Rx Count and the Adjusted PDE Count will increase by 1 for that beneficiary.

Plan-to-Plan (P2P) Reconciliation Process Final (Combined Instructions)

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Plan-to-Plan (P2P) Reconciliation Process Final (Combined Instructions)

110 Plan-to-Plan Reconciliation

110.1 Overview:

Plan-to-Plan (P2P) reconciliation is a financial settlement process between two Part D Sponsors in which the Contract of Record compensates the Submitting Contract for claims paid on a beneficiary that belongs to the Contract of Record. CMS originally implemented P2P in three phases but P2P should be viewed as an ongoing process that will occur throughout each coverage year. This process will identify submitted PDEs for a possible P2P condition and report the affected PDEs to the Sponsors for financial settlement. Throughout the year, Sponsors will receive P2P reports on a monthly basis. The reports show payables and receivables, which Sponsors are responsible for reconciling the full financial amount with one another. Prior to the Annual Part D Payment Reconciliation, CMS will update previously accepted PDEs for any changes in Contract and/or PBP of Record. These changes will appear on monthly reports and may establish payables or receivables that must be reconciled in full. This process is done prior to the Part D Payment Reconciliation to ensure that the Contract of Record has paid all of the claims for each beneficiary enrolled in their Contract.

110.2 Definitions:

The following definitions will help to clarify specific terminology that is used when discussing the P2P Process.

P2P PDEs: P2P PDEs are PDEs in which the Submitting Contract differs from the Contract of Record, according to CMS databases, on the date of service documented on the PDE. P2P PDEs for covered drugs are the only PDEs that are subject to P2P financial settlement and Part D Payment Reconciliation. P2P applies only to basic Part D benefits, as defined in the statue. Note that formulary status, contractual status of pharmacy, utilization management edits, etc. are not relevant as payment of all such costs fall under CMS transition policy requirements.

P2P Reconciliation: P2P reconciliation is the financial settlement process between two Part D Sponsors in which each Contract of Record compensates each Submitting Contract for all Covered Plan Paid (CPP) amounts and Low Income Cost-Sharing Subsidies (LICS) paid for by the Submitting Contract for beneficiaries that belong to the Contract of Record, according to CMS databases. This settlement process will occur each month after receiving the monthly P2P reports from CMS.

P2P Contract/PBP Update: Prior to the Part D Payment Reconciliation, CMS will update Contract and/or PBP of Record on saved PDE data if there were changes in this information from the time the PDE was processed and accepted by CMS. This process only affects saved PDEs that have changes to Contract and/or PBP of Record. If the update results in a P2P condition or a change from a P2P condition to a non-P2P condition, the affected Sponsors will go through P2P Reconciliation.

Submitting Contract: The Submitting Contract is submitting PDE data for which they may or may not be the Contract of Record at the time that they are submitting the PDE, according to beneficiary enrollment information documented in the CMS databases.

Submitting PBP: The Submitting Plan Benefit Package (PBP) is submitting PDE data under the Submitting Contract.

Original Contract of Record: This is the Contract that is the Part D Sponsor with the beneficiary enrollment as documented in CMS databases, when the PDE was accepted and saved by CMS.

Original PBP of Record: This is the PBP listed under the Original Contract of Record as documented in CMS databases, when the PDE was accepted and saved by CMS.

Updated Contract of Record: The new Contract of Record after CMS performs the Contract/PBP Update that affects saved PDE data.

Updated PBP of Record: The new PBP of Record after CMS performs the Contract/PBP Update that affects saved PDE data.

Part D Payment Reconciliation: Part D Payment Reconciliation is the statutorily defined reconciliation. It is conducted on a benefit year basis, after the completion of the benefit year. In Part D Payment Reconciliation, all PDE-reported costs must be attributed to the Contract of Record.

Rollover Process: If a Contract/PBP that is offered in a current benefit year will not be offered in the following benefit year, the beneficiary may be removed from the terminating PBP and placed into a PBP that will be offered in the following benefit year. When this process is done automatically by CMS, it is described as a Rollover Process. The beneficiary will be under the new PBP effective January 1 of the following benefit year. For example, if a Contract/PBP is offered in 2006 but not in 2007, the beneficiary will be placed in another PBP effective January 1, 2007. A beneficiary enrollment record that was created during the rollover process can be identified by Enrollment Source ID Code = D.

110.3 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. The P2P process provides a means to coordinate correction of claims payments made by a Sponsor other than the Contract of Record. CMS requires that all Part D Sponsors participate in the P2P process.

Under the same authority established under 423.464(a), CMS established an initial transition period effective end date policy in order to align the P2P reconciliation process with plan formulary transition periods to ensure that all drug costs included in the Summary Reports are covered Part D drugs with respect to each Part D Sponsor. The start date of this transition period begins with the effective date of enrollment in a specific Contract/PBP. In order to coordinate benefits between the Submitting Contract and the Contract of Record in a fair and equitable manner, CMS established the policy that the effective end date of the minimum transition period occurs on the later of:

(1) 30 days after the effective date of coverage, or
(2) 30 days after the date the new Contract of Record submits the enrollment to CMS.

This policy protects the Submitting Contract from exposure to costs that would otherwise be incurred outside the Contract of Record's initial transition period when, without its knowledge and beyond its control, that new Part D Sponsor has delayed submitting the enrollment transaction to CMS. Since the submission and processing of the new enrollment transaction generates the disenrollment to the Disenrolling (Submitting) Contract, it would not be appropriate to limit the Disenrolling (Submitting) Contract's ability to recover costs to only the first 30 days of coverage in the new contract (Contract of Record).

CMS has already established the requirement that enrollments be submitted within at least 14 days of the application date. This P2P transition period now provides an additional incentive to submit enrollments to CMS as rapidly as possible, and ideally on a daily basis, in order to minimize potential P2P liabilities. For example, a Part D Sponsor that submits enrollments to CMS within 24 hours of receipt will incur almost no additional P2P transition period liabilities under this policy. However, a Part D Sponsor that batches enrollments and sends them in to CMS just before payment cut-off in the following month will subject itself to an approximate 45 day potential transition period liability for P2P reimbursements. Even later submissions would expose the new Contract of Record to even longer potential P2P transition periods and greater potential financial liability.

In the P2P Process, each party involved has specific roles and responsibilities. The parties involved in P2P are the Submitting Contract, the Contract of Record, and CMS. The roles and responsibilities include:

- CMS provides the capacity to accept the data and report back to each affected Sponsor the appropriate information to facilitate P2P reconciliation.
- CMS provides all Sponsors with CPP and LICS on the P2P Monthly Reports. CMS cannot disclose proprietary data so additional data cannot be provided.
- All Sponsors are required to submit accurate and timely PDEs that represent all Part D covered claims paid, making adjustments and reversals where appropriate.
- The Submitting Contract must attest to the accuracy of all submitted PDEs, including those for P2P reconciliation. All submitted PDE data is subject to audit.
- The Submitting Contract must retain (and report as DIR) any rebates earned for P2P claims.
- The Contract of Record is required to make timely payment to the Submitting Contract for all CPP and LICS reported on the monthly reports as outlined below. The Contract of Record has no authorization to require any additional documentation or attestations regarding the accuracy of the Submitting Contract's financial data on the P2P reports. The Contract of Record must pay the full amount displayed on the monthly payables report.
- The Contract of Record is required to certify payment of all P2P amounts due to all Part D Sponsors. CMS will not reconcile P2P amounts that have not been certified as paid.
- The Contract of Record must pay P2P payables to the Submitting Contract within thirty days of the date on which CMS distributes P2P reports.
- Part D Sponsors must promptly open and review monthly reports in order to meet P2P payment timeframes.
- Part D Sponsors make payments without intervention from CMS. CMS does not dictate the manner in which the payment is made.

110.4 P2P Process

110.4.1 P2P PDE Processing

The following steps describe P2P processing within the PDE processing through the Drug Data Processing System (DDPS). Diagram 1 below illustrates the steps. The numbers below correspond to the numbers within the diagram.

1. DDPS compares the Submitting Contract to the Contract of Record.

   Submitting Contract = Contract of Record

If the Submitting Contract is the Contract of Record, DDPS will evaluate whether the Submitting Plan is the Plan of Record. This process is illustrated below in blue and is part of the non-P2P processing already in place in DDPS.

If the Submitting Contract is not the Contract of Record, the PDE follows the P2P edits which are illustrated below in pink.

2. DDPS evaluates DOS on PDEs in which the Submitting Contract is not the Contract of Record to determine if a valid P2P period exists.

a. DOS > 06/30/07

If the DOS is within the time period of January 1, 2006 through June 30, 2007, the PDE will bypass the edits for the initial transition period. The initial transition period does not apply to PDEs with DOS within this time period.

If the DOS is after June 30, 2007, the PDE will follow DDPS editing to evaluate whether or not the PDE falls within the initial transition period.

b. DDPS compares DOS to the Enrollment Effective Date plus 30 days or the CMS Process Date plus 30 days.

DOS ≤ (Later of Enrollment Effective Date or CMS Process Date) + 30 days

If the DOS is not equal to or earlier than the Enrollment Effective date plus 30 days or the CMS Process date plus 30 days, the PDE does not meet P2P Criteria and the system will generate a 706 rejection code. The 706 code is generated when the DOS does not fall within a valid P2P period. When the DOS occurs later, the beneficiary must be enrolled in the Submitting Contract on the DOS.

Example: The Submitting Contract sends a PDE for John Doe, who they believe is enrolled in their Plan A. Within the CMS Database, John Doe's enrollment effective date is 8/1/07 for Plan B under a different Contract (the Contract of Record). CMS processed the enrollment on 9/4/07. DDPS will compare the DOS to the CMS Process Date + 30 days, which is 10/4/07. DOS on the PDE is 10/30/07. The Submitting Contract will receive a 706 rejection code. The Submitting Contract should not have John Doe in their enrollment database 30 days after CMS processes the enrollment.

If the DOS is equal to or earlier than the Enrollment Effective date plus 30 days or the CMS Process date plus 30 days, the record meets P2P criteria.

Example: The Submitting Contract sends a PDE for Jane Smith, who they believe is in their Plan A. Within the CMS Database, Jane Smith's enrollment effective date is 8/1/07 for Plan B under a different Contract (the Contract of Record). CMS processed the enrollment on 8/15/07. DDPS will compare the DOS to the CMS Process Date + 30 days, which is 9/14/07. The DOS on the PDE is 9/6/2007. This PDE will continue to process through additional validity edits for P2P within DDPS.

c. DDPS evaluates the Enrollment Source ID.

If the Enrollment Source ID code = D (Rollover).

If the Enrollment Source ID code is D, a beneficiary enrollment record was created during the Rollover Process. PDEs submitted for a beneficiary involved in the Rollover Process are not part of P2P processing. The Submitting Contract will receive a rejection edit code of 706.

If the Enrollment Source ID Code is not D, the PDE will continue to process through P2P edits within DDPS.

3. DDPS then compares the Submitting Contract to the Prior Contract of Record.

Submitting Contract = Prior Contract of Record

The P2P situation will frequently occur when the Submitting Contract is the Prior Contract of Record. The Submitting Contract will continue to submit PDE data for a beneficiary until they receive disenrollment data for that beneficiary. Frequently, the Submitting Contract receives the disenrollment data after they have processed pharmacy claims for the disenrolled beneficiary. All PDE data submitted by the Contract that was the Prior Contract of Record will process through DDPS as P2P PDE data. This process is displayed in yellow in the diagram below. When the Submitting Contract is the Prior Contract of Record, the PDE will then be edited based on the Drug Coverage Status Code. If the drug is a covered drug (Drug Coverage Status Code = 'C'), the Submitting Contract will receive a 708 informational edit code. This code identifies PDEs that will be included in the Submitting Contract's P2P reconciliation with the Contract of Record. If the Drug Coverage Status Code is either 'E' (for enhanced alternative drugs) or 'O' (for Over-the-Counter Drugs) the Submitting Contract will receive a 709 edit code. This code identifies PDEs that will be excluded from the Submitting Contract's P2P reconciliation with the Contract of Record.

CMS will send an informational edit code of 712 when the PDE data has processed yet the Submitting Contract is not the Prior Contract of Record. In this situation, CMS defines the Prior Contract of Record to be the Contract of Record immediately preceding the Contract of Record as documented in CMS databases. The term does not refer to all Prior Contracts of

Record. Since this situation occurs less frequently, the Part D Sponsor receiving the informational code 712 should check their database to investigate why they submitted PDE data for the beneficiary. Upon receiving the 712 code, the Sponsor should determine if they need to update their enrollment information on this beneficiary. This code is sent only to inform Sponsors. The PDE data will continue to process through P2P editing which evaluates the Drug Coverage Status Code. In addition to receiving the code 712, the Submitting Contract will also receive either a code 708 if the drug is a covered drug or a code 709 if the drug is either an enhanced alternative drug or over-the-counter drug.

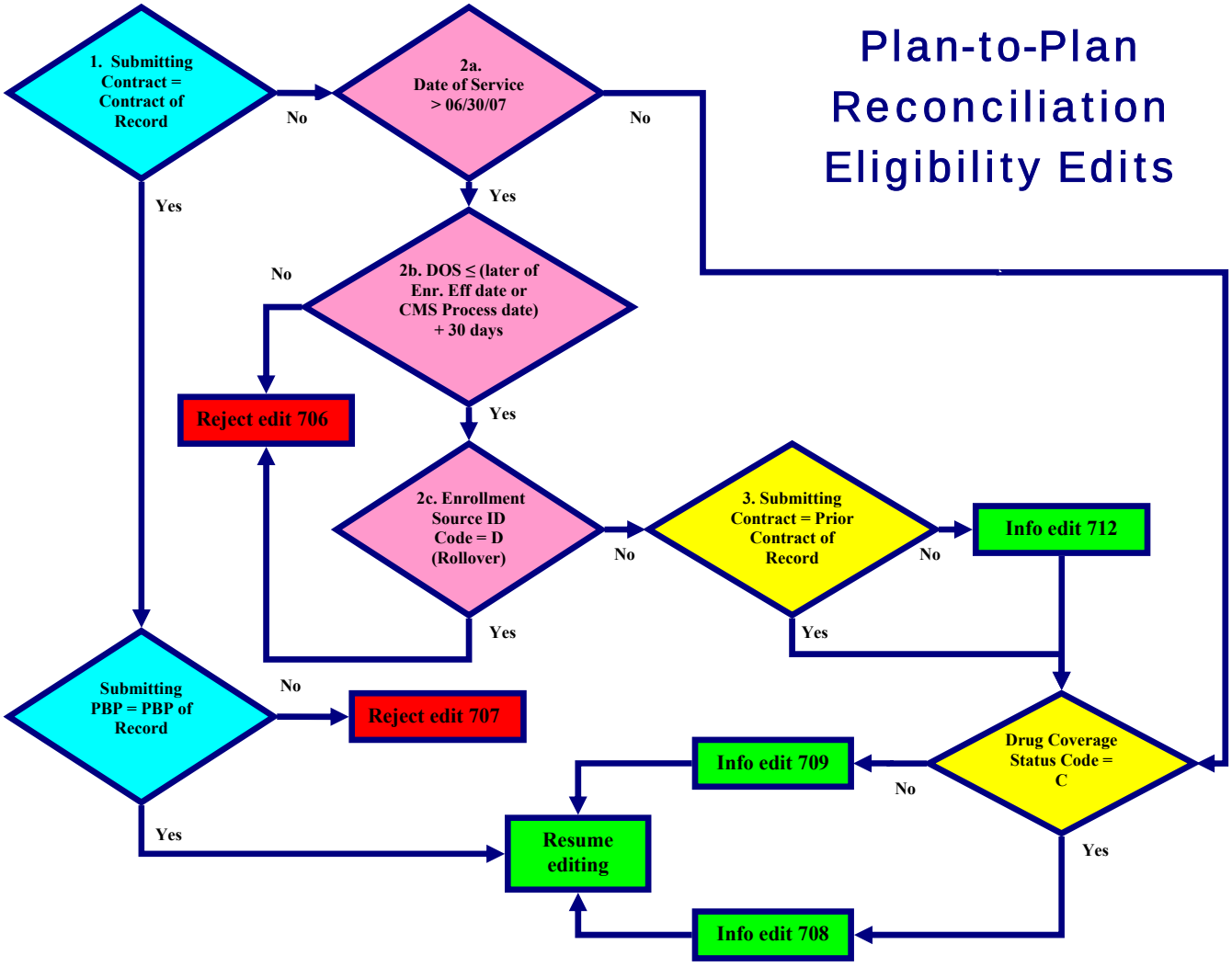

Diagram 1

After a PDE is processed through this P2P processing, the PDE continues through the standard PDE processing and editing that applies for all PDEs submitted to CMS. Once this process is complete, DDPS will store the Contract of Record and the PBP of Record with the P2P PDEs to support reporting, P2P reconciliation, and Part D Payment Reconciliation.

110.4.2 Return File

After the PDEs are processed, a return file will be sent to the Submitting Contract. This Return file is the standard Return file that is received on a monthly basis. This return file should not be confused with the special Return file that will be generated after CMS performs the P2P Contract/PBP Update that occurs prior to the Part D Payment Reconciliation. If edits 708, 709, or 712 apply to the P2P PDEs, DDPS changes the record type to informational (INF). If edit 708 applies, DDPS also annotates the Contract of Record number in positions 441-445 (before corrected HICN). DDPS does not report Contract of Record on PDEs receiving 709 because these PDEs are exempt from P2P reconciliation.

110.4.3 P2P Reporting

P2P Reports provide the documentation for PDE accounting, P2P financial settlement, and Part D Payment Reconciliation. The P2P Reports that the Submitting Contract receives are for PDE accounting and P2P Reconciliation. The P2P reports that the Contract of Record receives are for P2P Reconciliation and Part D Payment Reconciliation. The P2P Reports will summarize claims data at the beneficiary level without revealing negotiated prices, which the pharmacy industry considers to be proprietary data. The Reports display CPP amounts and LICS amounts only.

If a Contract of Record receives the P2P Monthly Reports but does not receive the EOB Transfer Report, which displays the TrOOP Balance Transfer or if the EOB Transfer Report shows a different amount from the P2P Reports they should contact the Submitting Contract. The P2P Reports are not a proxy for the TrOOP Balance Transfers.

DDPS distributes the report data in flat files. The report structure consists of a contract header, batch header, detail records, batch trailer, additional batch header, detail record, batch trailer sequences when necessary and a contract trailer. The batch trailer record subtotals the financial data for the detail records within the batch. The contract trailer record has the grand total for all of the batches in the file. We retain header and trailer data elements in the same positions as the existing cumulative management reports. However, the batch level records have new identifiers in two of the reports to account for the special batching that is being done to facilitate the P2P reconciliation.

The report layouts, contents, and purpose are summarized below.

Submitting Contract Reports: The Submitting Contract reports document the amounts the Submitting Contract paid for drugs when the Submitting Contract was not the Contract of Record, according to CMS databases. The Submitting Contract will receive two reports: the P2P PDE Accounting Report (Report 40) and the P2P Receivable Report (Report 41). There is a P2P PDE Accounting Report for each of the three drug coverage status codes ("C"-covered, "E"-enhanced, and "O"-over the counter).

P2P PDE Accounting Report (Report 40COV, 40ENH, and 40OTC)-
Report 40 is a YTD cumulative report that documents cumulative financial amounts reported by the Submitting Contract. Similar to the existing Report 4 "YTD Cumulative Beneficiary Summary Report", there is a detail record for each beneficiary. As in Report 4, the batch level summarizes by each of the Submitting Contract's PBPs, and the header level summarizes by the Contract.

The P2P PDE Accounting Report for Covered Drugs (Report 40COV) generally uses the same format in Report 4, but adds Contract of Record contract number to the end of the detail record.

The P2P PDE Accounting Reports for Enhanced Drugs and Over the Counter Drugs (Reports 40ENH and 40OTC) do not report the Contract of Record on the detail record because there will be no P2P reconciliation for these drugs. (These reports are provided for plan convenience to assist in PDE accounting.) We expect a low volume of E and O drugs in this process because not all plans offer E and O drugs. No other P2P report will carry these records.

For purposes of PDE accounting, the Submitting Contract should confirm that the totals on Report 4 and the P2P PDE Accounting Reports equal the net totals for all PDEs accepted in DDPS (i.e. ACC and INF PDEs on the return file). Totals should match at the beneficiary level, the contract/PBP level and the contract level.

General layout is as follows:

Submitting Contract= Contract A
Contract of Record = Contract of Record B-1, B-2, B-3, etc.
Report Recipient = Contract A
File Structure:
CHD
Contract A
PHD

Contract A/PBP
DET
Bene/ Contract of Record B-1
Bene/ Contract of Record B-2
Bene/ Contract of Record B-3
PTR
Contract A/PBP
CTR
Contract A

P2P Receivable Report (Report 41COV)-
This report is a monthly report that documents the net change in P2P reconciliation receivable amounts. This report is substantially smaller than Report 4 and the P2P PDE Accounting Report. The detail records display the twelve fields necessary for P2P reconciliation and the Contract of Record's Part D Payment Reconciliation. This report is batched by Contract of Record contract numbers. The summary data on the batch trailer record serves as the Submitting Contract's record of the accounts receivable due from each Contract of Record. Upon receipt the Submitting Contract reviews that P2P Amount field and the Contract of Record to learn how much money it will receive and from whom. The Submitting Contract expects to receive that payment within thirty days of the date that CMS distributed the report.

In the unusual event of a net overpayment to the Submitting Contract, the P2P amount will be negative. In other words interpret a negative P2P amount on this report as a Submitting Contract payable. The Submitting Contract must pay back the Contract of Record within 30 days of the date CMS distributes this report.

General layout is as follows:

Submitting Plan = Contract A
Contract of Record = Contract of Record B-1, B-2, B-3, etc.
Report Recipient = Contract A

File Structure:
CHD
Contract A
PHD
Contract of Record B-1
DET
Bene
PTR
Summary of monthly amounts due from Contract of Record B-1

PHD
Contract of Record B-2
DET
Bene
PTR
Summary of monthly amounts due from Contract of Record B-2
PHD
Contract of Record B-3
DET
Bene
PTR
Summary of monthly amounts due from Contract of Record B-3
CTR
Summary of all monthly amounts due to Contract A

Contract of Record Reports: The Contract of Record receives the P2P Part D Payment Reconciliation Report (Report 42COV) and the P2P Payable Report (Report 43COV). The Contract of Record reports are extracted from the data in the covered drug version of the P2P PDE Accounting Report (Report 40COV) and are sorted in two different ways. When the Contract of Record owes money to multiple Submitting Contracts, the Contract of Record reports combine the covered drug version of the P2P PDE Accounting Report data from each Submitting Contract.

P2P Part D Payment Reconciliation Report (Report 42COV)-
Report 42 is the YTD cumulative report of all financial amounts reported by Submitting Contracts that will be used in the Contract of Record's Part D Payment Reconciliation. The detail records in this report have the same data as the detail records in Report 41, with the addition of Submitting Contract's contract number. The report is batched by Contract of Record's PBPs, allowing for incorporation in Contract of Record's Part D Payment Reconciliation (which is always performed at the Contract/PBP level).

To understand the status of Part D Payment Reconciliation, the Contract of Record will sum the totals on Report 4 and the P2P Part D Payment Reconciliation Report (Report 42). These combined totals, in comparison to the Plan's prospective payments reported on the MMR are the basis for Part D Payment Reconciliation.

General layout is as follows:

Submitting Contract = Contract A-1, A-2, A-3, A-etc.
Contract of Record = Contract B

Report Recipient = Contract B

File Structure:
CHD
Contract B
RHD
PBP B 001
DET
Bene/Contract A-1
DET
Bene /Contract A-2
DET
Bene /Contract A-1
RTR
YTD Part D Payment Reconciliation amounts for PBP B 001
RHD
PBP B 002
DET
Bene /Contract A-1
DET
Bene /Contract A-3
RTR
YTD Part D Payment Reconciliation amounts for PBP B 002
CTR
YTD Part D Payment Reconciliation amounts for Contract of Record B

P2P Payable Report (Report 43COV)-
This report serves as the Contract of Record's invoice for P2P reconciliation. The detail records are precisely the same as those in Report 41COV but the batching is different. This report is batched by Submitting Contract identity. The batching in this report is by Submitting Contract, allowing summary records of amounts owed to be created at the batch level. Upon receipt the Contract of Record reviews the P2P amount field and the Submitting Contract on this report to learn how much money it must pay and to whom. A negative payable would mean that the Submitting Contract owes the Contract of Record. The Contract of Record makes payments to each Submitting Contract within thirty days of the date that CMS distributed the report.

General layout is as follows:

Submitting Contract = Contract A-1, A-2, A-3, A-etc.
Contract of Record = Contract B

Report Recipient = Contract B

File Structure:

CHD
Contract B
SHD
Contract A-1
DET
Bene
STR
Summary of monthly amounts owed to Contract A-1
SHD
Contract A-2
DET
Bene
STR
Summary of monthly amounts owed to Contract A-2
SHD
Contract A-3
DET
Bene
STR
Summary of monthly amounts owed to Contract A-3
CTR
Contract of Record B's total monthly amounts owed to all contracts

110.4.4 P2P Contract/PBP Update Prior to Part D Payment Reconciliation

Overview

Throughout the benefit year, CMS may receive retroactive enrollments that will not be updated on PDEs for claims that were already accepted into DDPS by CMS. In order for CMS to perform an accurate Part D Payment Reconciliation, the accepted PDEs will have to be attributed to the appropriate Contract and PBP of Record prior to running the Part D Payment Reconciliation. The last step in the P2P Process performs the final update to Contract and/or PBP of Record on saved PDEs. This update only occurs if there are changes to Contract and/or PBP of Record after a PDE has been processed and saved by CMS. If changes are made and a P2P condition occurs or if a P2P condition now results in a non-P2P condition, the affected Part D Sponsors will go through P2P reconciliation. The Sponsors will receive the financial amounts on the P2P Reports and financial settlement will occur between Sponsors. The Submitting

Contract will receive a special return file that contains the affected PDE records. This Contract/PBP Update process may occur more than once but will always occur prior to Part D Payment Reconciliation.

P2P Contract/PBP Update Processing:

P2P Contract/PBP Update will allow the Drug Data Processing System (DDPS) to query the CMS Medicare Advantage and Prescription Drug System (MARx) for changes to Contract and PBP of Record. If this query results in changes, DDPS will update affected PDE data to reflect the changes. If this query does not result in a change, no update will occur on the saved PDE data. This process will update all changes to enrollment information; it is not limited to changes that affect P2P. This process will also update enrollment information when the beneficiary moves from one PBP to another PBP within the same Contract.

CMS developed update codes that will generate as a result of the P2P Contract/PBP Update. The update codes will be received by the Submitting Contract on a special Return File. The update codes will only be sent to the Submitting Contract and will not be sent to the Updated Contract of Record or the Original Contract of Record. The Submitting Contract will also receive informational edit code 710 if the HICN has changed from when CMS accepted and saved the PDE record. The corrected HICN will appear in positions 446-465 on the Special Return File. The update codes and the informational edit code 710 only apply to examples 1 through 5 below.

The Contract/PBP update to saved PDEs will result in changes that appear on the monthly reports. The monthly reports will show any new payables and receivables that result from the P2P Contract/PBP Update. Any financial amounts resulting from this process will appear the same as any other financial amounts would appear on a monthly report. Since the financial amounts from the P2P Contract/PBP Update will not be reported differently, the monthly reports should be thoroughly reviewed. The layout of the monthly reports will not change. The Updated Contract of Record and the Original Contract of Record will only be aware of changes by reviewing the monthly reports. All of the changes resulting from the P2P Contract/PBP Update are explained in detail below.

P2P Contract/PBP Update Codes: The Submitting Contract will receive an update code on the special Return File when enrollment changes result in a change in Part D financial dollar amounts. The change may result in either a payable or receivable. Each update code is meant to provide the Submitting Contract with an explanation of how the enrollment changes affect the saved PDE. The explanation will assist the Submitting Contract when evaluating the monthly reports for changes.

- **Update Code 851:** The Contract of Record has been updated; a P2P condition *now* exists.

- **Update Code 852:** The Submitting Contract/PBP is now the Contract/PBP of Record; a P2P condition *no longer* exists.
- **Update Code 853:** PBP of Record has been updated. This PDE *continues* to be a non-P2P PDE.
- **Update Code 854:** The Contract of Record and PBP of Record have been updated. A *new* P2P condition is established.
- **Update Code 855:** The Submitting Contract is now the Contract of Record but the Updated PBP of Record is different from the Submitting PBP. A P2P condition *no longer* exists.

Return File: The Submitting Contract will receive a special Return File that includes all PDEs that were sent and accepted from the Submitting Contract but now have a change in Contract and/or PBP of Record resulting from the P2P Contract/PBP Update. This file will be in the same basic format as the existing Return File but will have a different file name so that it is not confused with the standard Return File.

Although the basic format remains the same, one existing field will be used and a new field will be added to this special Return file. The existing Contract of Record field will be populated with the Updated Contract of Record, when appropriate. There will be a new field for Updated PBP of Record in positions 416-418. This field will be populated when appropriate.

Upon receiving a Return File, the Submitting Contract should update their database to reflect the changes. Scenarios 1-5 below will show when the Return file will be populated with a PDE that displays Updated Contract of Record or Updated PBP of Record. The columns for "Contract of Record Update Reported on Return File" and "PBP of Record Update Reported on Return File" will display "Y" when the file is populated and "N" when the file is not populated. The only example below that will not generate a Return File is Scenario #6. This update does not affect P2P reconciliation between the Contracts and does not affect Part D Payment Reconciliation. On the return file, the Submitting Contract will receive update codes 851-855, which explain the change that occurred during the P2P Contract/PBP Update. As stated above, the Submitting Contract will also receive informational edit code 710 if there is an updated HICN on the record.

P2P Contract/PBP Update Changes: The following six examples will explain the potential scenarios that can occur with the Contract/PBP Update process. Within each example, there will be two sets of tables. The first table will describe the scenario and will show which updates will appear in the special Return File and the second table will display the reports affected by the enrollment change and will show how the financial data will change between reports using Covered Plan Paid Amount (CPP) as an example.

In order to understand the changes, the examples show how the Monthly Reports will appear for the month in which the Submitting Contract submits the PDE and the PDE is accepted (the

Submission Month), the month after Submission, and the Update Month (month in which CMS performs the Contract/PBP Update).

Example 1:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	A	1	B	1	Y	N

Initially a P2P condition did not exist when the PDE was accepted by CMS. Contract A was submitting PDE data for a beneficiary who was enrolled in Contract A, according to the CMS database. The P2P Contract/PBP Update changed the Contract and PBP of Record. A P2P condition now exists. Update code 851 will be sent to the Submitting Contract. In the Return file, the Submitting Contract (Contract A) will receive the PDEs for dates of service for which the beneficiary should now be enrolled under Contract B. The Updated PBP of Record will not be sent on the Return File. The P2P condition is established based on the Contract change so it is not necessary to send the PBP update to Contract A.

Reports – Change in CPP

Report	Submission Month	Month after Submission	Update Month
4	$100	$100	$0
40	$0	$0	$100
41	$0	$0	$100
42	$0	$0	$100
43	$0	$0	$100

Prior to P2P Contract/PBP Update, Contract A was the only Contract that had this PDE on a Monthly Report. The PDE will be documented on Report 4 for the month in which the PDE was submitted and accepted and the month after submission. After the P2P Contract/PBP Update, the PDE will appear on Monthly Reports for both Contract A and Contract B. The Updated Report 4 will display $0 since the PDE will be documented on P2P Reports. The Updated Contract of Record now owes the Submitting Contract $100 as shown in the P2P Reports 40 through 43.

Example 2:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	B	1	A	1	N	N

Initially a P2P condition existed; Contract A was submitting PDE data for a beneficiary that was enrolled in Contract B. The P2P Contract/PBP Update resulted in a change in Contract and PBP of Record. The update code 852 will be sent to the Submitting Contract. A P2P condition no longer exists. The Contract/PBP that submitted the PDE is now the Contract/PBP of Record. The Contract of Record and PBP of Record fields will not be populated on the Return File.

Reports – Change in CPP

Report	Submission Month	Month after Submission	Update Month
4	$0	$0	$100
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

When the P2P condition existed, Contract B paid Contract A $100, as shown in the Original Monthly Reports. In the Updated Monthly Reports, the PDE will appear on Report 4 for Contract A. Contract A will see ($100) on Report 41. Contract B will see ($100) on Report 43. A negative receivable amount means that Contract A will owe Contract B. In this example, Contract A owes Contract B $100.

Example 3:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP Update Reported on Return File
A	1	A	1	A	2	N	Y

In this situation, a P2P condition did not exist originally and does not exist after the P2P Contract/PBP Update. This situation is still described as a possible scenario because P2P Contract/PBP Update is meant to update all enrollment changes, including PBP-only changes. A Return File will be sent to Contract A to notify them of the PBP Change. An update code 853 will be sent to inform Contract A of the change in PBP. The change in PBP will be seen on the Monthly Reports.

Reports – Change in CPP

Report	Submission Month	Month after Submission	Update Month
4 (PBP 1)	$100	$100	$0
4 (PBP 2)	$0	$0	$100

Although the financial information will remain on Report 4, the information will be found under the new PBP of Record.

Example 4:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP Update Reported on Return File
A	1	B	1	C	1	Y	N

In this situation, a P2P condition existed between Contract A and Contract B. Once the P2P Enrollment information was updated, a *new* P2P condition now exists between Contract A and

Contract C. An update code of 854 will be sent to the Submitting Contract on the Return File. This file will include all PDEs for the affected dates of service where Contract C is the Contract of Record.

Reports – Change in CPP between Contracts A and B

Report	Submission Month	Month after Submission	Update Month
40	**$100**	**$100**	**$0**
41	**$100**	**$0**	**($100)**
42	**$100**	**$100**	**$0**
43	**$100**	**$0**	**($100)**

In the P2P condition that was originally on the monthly reports, Contract B paid Contract A $100 in CPP for this PDE. After CMS performed the Contract/PBP update, the new Contract of Record is Contract C. Contract A will pay Contract B $100. Contract A is returning the money that initially exchanged hands in the Original Monthly Reports. This is shown by negative dollar amounts on Reports 41 and 43 for Contracts A and B.

Reports – Change in CPP between Contracts A and Contract C

Report	Submission Month	Month after Submission	Update Month
40	**$0**	**$0**	**$100**
41	**$0**	**$0**	**$100**
42	**$0**	**$0**	**$100**
43	**$0**	**$0**	**$100**

In the new P2P condition between Contract A and Contract C, Contract C is now the Contract of Record. Contract C owes Contract A $100 in CPP for this PDE. Contract C will be aware of the P2P liability through the P2P Monthly Reports generated during the P2P Contract/PBP Update month.

This update will cause two changes on the P2P Reports for Contract A. They will see changes in the DET rows for Contract of Record B and Contract of Record C on Reports 40 and 41. Contract A owes Contract B $100 and Contract A will receive $100 from Contract C.

Example 5:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP Update Reported on Return File
A	1	B	1	A	2	N	Y

Prior to P2P Contract/PBP Update, a P2P condition existed between Contract A and Contract B. After the P2P Contract/PBP Update, Contract A was found to be the Contract of Record. The PBP is different from the PBP that originally submitted the PDE. An update code of 855 will be sent to the Submitting Contract. Only the Updated PBP of Record field will be populated on the Return File.

Reports – Change in CPP

Report	Submission Month	Month after Submission	Update Month
4	$0	$0	$100
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

Originally Contract B paid Contract A $100 in CPP for the PDE. Once CMS performs the Contract/PBP update, a P2P condition no longer exists. Contract A now owes Contract B the $100 that was initially paid. This is displayed as a negative amount on the Updated P2P Monthly Reports. For Contract A, Report 4 will now display the CPP amount under the Updated PBP.

Example 6:
Scenario

Submitting Contract	Submitting PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP Update Reported on Return File
A	1	B	1	B	2	N	N

A P2P condition remains between Contract A and Contract B, only the PBP of Record changes. This does not change the financial information that was exchanged previously with Contract A and B so Contract A will not receive a Return file showing this change.

Reports – Change in CPP

Report	Submission Month	Month after Submission	Update Month
40	$100	$100	$100
41	$100	$0	$0
42	$100	$100	$100
43	$0	$0	$0

This update will not result in a change in financial dollar amounts on the monthly reports. The financial amounts will now be found under the Original Contract of Record but under the Updated PBP of Record.

110.4.5 P2P involvement in Part D Payment Reconciliation

Contract of Record
The goal of the monthly P2P financial settlement process is to ensure that the Contract of Record is financially responsible for PDEs that were submitted to CMS for each beneficiary that is enrolled in the Contract of Record according to CMS databases. Each month, the Contract of Record shall reimburse each of the Submitting Contracts for the full P2P financial amounts that appear on Report 43COV. In addition to making payments each month, the Contract of Record is also required to certify payment of all P2P amounts due to all Part D sponsors. CMS will not reconcile (Part D Payment Reconciliation) P2P amounts that have not been certified as paid.

Report 42COV will display the year-to-date financial totals for P2P conditions between the Contract of Record and Submitting Contracts. This report is a sum of each monthly Report 43

received by the Contract of Record. For Part D Payment Reconciliation, the totals from Report 42COV and Report 4 will be summed for the Contract of Record.

Submitting Contract
The Submitting Contract will have rebates for some PDEs that were submitted to CMS and resulted in a P2P condition. The Submitting Contract will report the DIR earned for any P2P claims to CMS. DIR is the only P2P financial amount paid by the Submitting Contract that will be included in the annual Part D Payment Reconciliation.

110.5 Example of the P2P Reconciliation Process

Beneficiary 1 changes from Contract A to Contract B during the coverage year. This example displays what will occur throughout the entire P2P Reconciliation Process.

Enrollment Information

Contract	Start Date	End Date
Contract A	07/01/07	09/30/07
Contract B	10/01/07	

Beneficiary 1 disenrolls from Contract A. Contract B submits the enrollment to CMS on 10/11/07 and CMS processed the enrollment on 10/13/07.

PDE activity for Beneficiary 1

Submitting Contract	DOS	CPP	CMS Processed Date
Contract A	09/28/07	$42.50	09/29/07
Contract A	09/28/07	$23.42	09/29/07
Contract A	10/02/07	$18.36	10/03/07
Contract A	10/02/07	$12.20	10/03/07
Contract A	10/09/07	$14.72	10/25/07
Contract A	10/09/07	$23.42	10/25/07
Contract A	10/15/07	$15.45	10/25/07
Contract A	11/16/07	$42.50	11/18/07

Non-P2P PDEs

The first two PDEs are non-P2P. Contract A is the Contract of Record, according to CMS databases. The PDEs will process and will be viewed on Report 4.

The last PDE is non-P2P. CMS processed the enrollment on 10/13/07. Contract A has thirty days beyond this process date to submit PDE data to CMS. The PDE with a DOS of 11/16/07 is beyond this thirty day period. Contract A will receive a rejection code of 706 for this PDE.

P2P PDEs

The third and the fourth PDE were processed on 10/3/07. On the date that CMS processed the PDEs, Contract A was known as the Contract of Record for the DOS of 10/2/07. The PDEs will appear on Report 4 but will process through the P2P Contract/PBP Update that occurs annually prior to Part D Payment Reconciliation.

The fifth and sixth PDE were processed on 10/25/07. At this time, the CMS database shows Contract B as the Contract of Record, effective 10/1/07. The Submitting Contract is no longer the Contract of Record. The DOS of 10/9/07 occurs during the P2P transition period. The PDEs will appear on the P2P Reports.

The seventh PDE was processed on 10/25/07. At this time, the CMS database shows Contract B as the Contract of Record, effective 10/1/07. The Submitting Contract is no longer the Contract of Record. The DOS of 10/15/07 occurs during the P2P transition period. The PDE will appear on the P2P Reports.

Monthly Reports

September Monthly Reports
Contract A

Report 4

DOS	CPP
09/28/07	$42.50
09/28/07	$23.42

October Monthly Reports
Contract A

Report 4

DOS	CPP
10/02/07	$18.36
10/02/07	$12.20

Reports 40 and 41

DOS	CPP	Contract of Record
10/09/07	$14.72	Contract B
10/09/07	$23.42	Contract B
10/15/07	$15.45	Contract B

Contract B

Reports 42 and 43

DOS	CPP
10/09/07	$14.72
10/09/07	$23.42
10/15/07	$15.45

Contract B has thirty days from the day CMS distributed the P2P reports to pay Contract A.

Contract/PBP Update

In July 2008, CMS performs the P2P Contract/PBP Update on previously accepted PDEs.

Contract A will receive a return file that contains affected PDEs.

DOS	CPP	Contract of Record	Update Code
10/02/07	$18.36	Contract B	851
10/02/07	$12.20	Contract B	851

The update code 851 is sent to the Submitting Contract to inform them that the Contract of Record has been updated; a P2P condition now exists.

July Monthly Reports

The amounts that were previously documented on Report 4 will now be documented on the P2P amounts.

Reports 40 and 41 for Contract A

DOS	CPP	Contract of Record
10/02/07	$18.36	Contract B
10/02/07	$12.20	Contract B

Reports 42 and 43 for Contract B

DOS	CPP
10/02/07	$18.36
10/02/07	$12.20

Contract B owes Contract A $30.56.

Part D Payment Reconciliation

Amounts from Reports 4 and 42 will be summed.

Contract A

Report Totals	Total CPP
Report 4	$65.92
Report 42	$0.00

Contract B

Report Totals	Total CPP
Report 4	$0.00
Report 42	$84.15

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National Provider Identifier Memo

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

Date: April 4, 2007

To: All Part D Plans

Subject: National Provider Identifier

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

On April 2, 2007, CMS issued a release clarifying the guidelines for implementation of the National Provider Identifier (NPI) regulations. In this release, we announced that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows. Guidance for the industry concerning the contingency plan is available on the CMS Web-site at http://www.cms.hhs.gov/NationalProvIdentStand/ in a document entitled "Guidance on Compliance with the HIPAA National Provider Identifier Rule." The site also contains additional information on NPI.

What are the implications of this guidance for Part D plan sponsors?

Plans are not required to use NPI in submitting prescription drug event (PDE) data. However, if plans receive an NPI, they must report an NPI. In the Standard Format, the Drug Data Processing System (DDPS) accepts NCPDP # or NPI in the Service Provider ID field. Detailed information concerning the PDE data requirements is available at http://www.cms.hhs.gov/DrugCoverageClaimsData/Downloads/PDEGuidance.pdf.

In addition, CMS expects plan sponsors to urge their contract providers who have not yet done so to obtain and use NPIs in their HIPAA transactions. Part D plan sponsors and their subcontractors are required to adhere to all applicable Federal rules. Therefore, CMS expects that plan sponsors will continue to assess the readiness of their contract providers relative to NPI implementation, and we will be monitoring Part D sponsor compliance with the NPI requirements.

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National Provider Identifier (NPI) Implementation for Prescription Drug Events (PDEs)

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DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR BENEFICIARY CHOICES

DATE: April 16, 2007

TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Other Interested Parties

FROM: Thomas Hutchinson
Director, Medicare Plan Payment Group

SUBJECT: National Provider Identifier (NPI) Implementation for Prescription Drug Events (PDEs)

The attached instructions detail the operational implementation of NPI in the Drug Data Processing System (DDPS), as well as Part D sponsor requirements for NPI submission of NPI on PDEs. CMS anticipates that the new NPI process will go live in DDPS by May 15. The implementation will be announced through the Customer Service and Support Center email distribution when the precise date is known.

If you have any questions regarding this process please contact sandra.anderson@cms.hhs.gov.

National Provider Identifier (NPI) Implementation and Drug Data Processing System (DDPS)

CMS has recently issued contingency guidance for National Provider Identifier implementation. This contingency guidance provides that, for a period of 12 months after the NPI Rule compliance date of May 23, 2007, CMS will not impose civil money penalties on covered entities that deploy contingency plans, including (in order to ensure the smooth flow of payments) continuing to use and accept legacy identifiers on HIPAA transactions, if they have made reasonable and diligent efforts to become compliant and, in the case of health plans (that are not small health plans), in order to facilitate the compliance of their trading partners.

CMS remains committed to implement NPI processing in DDPS to support plans as they work with trading partners to achieve compliance during the contingency period. These instructions lay out the processing that CMS will utilize and the plan requirements for submission of NPI.

Submission requirements

Service Provider ID

CMS requires that plans submit the NPI when it is received on an original claim. Plans may submit NPI on a claim that was originally submitted under NCPDP but has since been reversed/rebilled or adjusted using NPI. However, CMS is leaving this decision to the plan. If a pharmacy reverses/rebills or adjusts in any way a claim that was originally submitted with NCPDP as the service provider identifier, NCPDP may be submitted on all PDEs related to that claim, even if any reversals/rebills or adjustments to that claim are done using NPI. CMS also allows plans to submit NCPDP IDs when that is the only ID that the pharmacy submitted for claims after May 23.

Prescriber ID

CMS again requires that plans submit the NPI as prescriber ID when NPI is submitted. Even if NPI is not on the original claim, prescriber ID remains a required field on standard format PDEs, and one of the acceptable alternate prescriber IDs must be submitted. For non-standard format PDEs, prescriber ID should be submitted when received but remains an optional data element.

DDPS processing of NPIs

DDPS will provide new functionality on or around May 1 in order to handle the NPI for all core system processes. The objective of the DDPS implementation of NPI is to apply consistent rules across all PDE transactions regardless of whether NPI or NCPDP ID is submitted. Current DDPS processing treats NPIs and NCPDP IDs as distinct identifiers, and does not crosswalk between the two identification systems. When the new process is implemented, CMS will use the NCPDP to NPI crosswalk from the NCPDP version 2.1 file to map NPIs to NCPDP numbers. The new process will work as follows:

- DDPS will translate all NPI numbers to NCPDP numbers prior to performing duplicate checking and adjustment/deletion logic. Note that for non-standard format claims, the NPI may not relate to a specific NCPDP ID. Until DDPS

has a full NPI roster (including NPIs that have no associated NCPDP ID), special processing rules (outlined below) will apply to NPIs on non-standard format PDEs that do not successfully crosswalk to NCPDP.

- The duplicate check logic will be modified to perform as follows:
  - When NCPDP is submitted, always use NCPDP ID for duplicate checking.
  - When NPI is submitted and is successfully translated to NCPDP ID, again use the NCPDP ID for duplicate checks.
  - If PDE is non-standard format, NPI is submitted, and NPI does not crosswalk to NCPDP ID, then perform duplicate check using NPIs.
- Modify Edit 615: Modify the Edit message from "The Service Provider ID is missing" to "The Service Provider ID is missing or invalid". Validity checks will be added for both NPIs and NCPDP IDs that do not match our reference table.
- Modify Adjustment/Deletion logic for existing Edits 661, 662, and 663: add cross-reference check on Service Provider ID Qualifier and Service Provider Identifier between the incoming and existing PDE using '07' for qualifier and NCPDP number for all checks where possible. As with duplicate checking, the only time NPI shall be used for adjustment/deletion logic is on a non-standard format PDE with NPI as the service provider ID, when that NPI does not translate successfully to an NCPDP ID.
- When performing the service provider ID look-up function and associated editing, DDPS will modify program logic to include look-up for NPI and add Check Digit algorithms to PDE Edit programs for both, NCPDP Provider Number and NPI validation.
  - **The following will occur for Standard PDES**:
    - When the NCPDP or NPI number is not on the Provider table and the provider number provided on the PDE passes the Check Digit algorithm, edit 781 will be returned.
    - When the NCPDP or NPI number is not on the Provider table and the provider number provided on the PDE fails the Check Digit algorithm, edit 615 will be returned.
  - **The following will occur for Non-Standard PDES:**
    - If NCPDP number is provided, edit the same as for standard format PDEs. The number must be on the NCPDP table; if it is not present, generate the 615 or 781 as appropriate.
    - When the NPI number is not on the Provider table and the provider number provided on the PDE passes the Check Digit algorithm, the PDE will be accepted.
    - When the NPI number is not on the Provider table and the provider number provided on the PDE fails the Check Digit algorithm, edit 615 will be returned.
- Add Alternate Service Provider ID and Alternate Service Provider ID Qualifier to the PDE Return file. When NPI is submitted and successfully crosswalks to an NCPDP ID, 07 will be the alternate service provider ID qualifier and the associated NCPDP ID will be the alternate service provider

ID. When a valid NCPDP ID is submitted, 01 will be returned as the alternate service provider ID qualifier and the associated NPI will be in the alternate service provider ID. These numbers are being provided to assist plans in understanding our duplicate check and adjustment/deletion logic as applied to each PDE.

National Provider Identifier Memo Regarding Contingency Plans

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DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR BENEFICIARY CHOICES

DATE: April 17, 2007

TO: All Medicare Advantage Organizations, Cost Plans, and Demonstrations

FROM: David A. Lewis
Director, Medicare Advantage Group

SUBJECT: National Provider Identifier

On April 2, 2007, CMS issued a release clarifying the guidelines for implementation of the National Provider Identifier (NPI) regulations. In this release, we announced that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows. Guidance for industry concerning the contingency plan is available on the CMS web-site at http://www.cms.hhs.gov/NationalProvIdentStand/ in a document entitled "Guidance on Compliance with the HIPAA National Provider Identifier Rule." The site also contains additional information on NPI.

We expect MAOs and cost plan sponsors to urge their contract providers who have not yet done so to obtain and use NPIs in their HIPAA transactions. Medicare Advantage Organizations and cost plan sponsors and their subcontractors are required to adhere to all applicable Federal rules. We expect that MAOs and cost plan sponsors will continue to assess the readiness of their contract providers to implement the NPI requirements, and we will be monitoring compliance with these requirements.

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DDPS Error Code Resolution

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DDPS Error Resolution

Error Code	Error Message	Description	Resolution
603-659	Various Messages identifying missing or invalid values	Identifies invalid or missing values. If blank is an allowed value, the missing edit does not apply.	Check formatting – certain fields require specific format. Rule out illegal values - for example, legal values for gender are 1 or 2 (not 0, M or F). Omit Optional fields – 605 (DOB) is optional for all Plans; 610 (Paid Date) is optional for all plans except Fallback plans. Correct the data issue and resubmit.
660-669	Various Messages for adjustment/deletion issues	Adjustment/deletion code inconsistent with stored data. Edits in a hierarchy using nine fields (Contract number, PBP ID, HICN, Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status)	General Resolution - Correct inconsistency and resubmit if necessary. All nine fields must match the existing PDE record. Also, determine if an original has already been accepted and confirm that the Adjustment/Deletion Code on the submitted PDE is correct. 662 - Data is already deleted and no further action is required. 663 – Confirm that Dispensing Status is reported correctly. Dispensing Status is the only field that edit 663 questions.
670-689	Various messages with errors for PDEs with Catastrophic Coverage Code	Edits that test the relationship between Catastrophic Coverage Code and the summary cost fields for GDCB and GDCA, so that allowable reinsurance costs are summed correctly. (Applies only to PDEs for Part D Covered Drugs)	Confirm that the drug is correctly reported as a Part D Covered Drug. Determine the cause of the inconsistency, correct, and resubmit.
690-699	Various messages with errors between cost and payment fields	Cost edits perform basic accounting functions to confirm that 1.) the summary cost fields and the detail cost fields balance and that 2.) the detail cost fields and payment fields balance. The summary cost field for GDCA is used to sum allowable reinsurance cost fields. Note that cost edits allow a $.05 rounding error.	Confirm that Dispensing Status is reported correctly. 690 excludes Dispensing Status = 'C' (i.e. completion of partial fill) 692 applies exclusively to Dispensing Status = ' ' (i.e. regular fill) 693 applies exclusively to Dispensing Status = 'P' (i.e. Partial Fills.) 691 – Confirm that the drug is correctly reported as a Part D Covered Drug. Determine the cause of the inconsistency, correct, and resubmit

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
700-714	Various messages related to Eligibility Edits	Eligibility Edits verify the HICN and the beneficiary's eligibility for Part D.	General Resolution – compare submitted Eligibility data to Eligibility data within CMS database. Correct discrepancy and resubmit.
			700 - Determine if HICN is correct for the beneficiary with the claim (husband and wife often have same claim account number with different beneficiary identification code at the end). If the plan's processor administers Medicare and Commercial products confirm that Part D eligibility files are used for Part D claims administration and PDE reporting. 701 - DOB discrepancy. 1. Do not submit DOB. DOB is an optional field. 2. If submitting DOB, update DOB on PDE to the DOB on the CMS files.
			702 – Gender discrepancy. Determine if HICN is correct for the beneficiary with the claim (husband and wife often have same claim account number with different beneficiary identification code at the end). If correct, update gender to match CMS files; if incorrect, correct the HICN.
			704 - DOS > DOD by more than 32 days. This error cannot generally be corrected. If DOD is incorrect on CMS files, beneficiary will need to work with Social Security Administration to update their Master Beneficiary Record.
			705 – Beneficiary must be enrolled in Part D on DOS. Research TRRS and determine if enrollment transaction failed to process successfully at CMS, or if a disenrollment TRC was missed, and take appropriate action.
			706 - DOS does not fall in valid P2P Period. Beneficiary must be enrolled in this Contract on DOS. As with 705, research TRRS and determine if enrollment transaction failed to process successfully at CMS and take appropriate action.
			707 – Beneficiary must be enrolled in this Part D Plan Benefit Package on the DOS. Compare the PBP reported on the PDE and PBP reported in enrollment and resubmit with correct PBP. If PBP is correct on PDE and incorrect on CMS databases, submit 71 transaction to correct the PBP. 713 - Confirm that contract and PBP number were active on the DOS.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
715-734	Various messages related to Low Income Cost-Sharing Subsidy (LICS)	LICS edit 715 confirms that **CMS** documents the beneficiary's LICS status. LICS edits 716-718 and 720-721 are excessive cost-sharing edits. They validate that beneficiary cost-sharing never exceeds statutorily defined maximum amounts. Edits 717 and 718 test pre-catastrophic LI cost-sharing. Edits 720 and 721 test catastrophic LI cost-sharing. Edit 716 applies to both pre-catastrophic and catastrophic cost-sharing. LICS edits apply to Part D Covered Drugs only. Dollars reported in LICS are used to reconcile LICS.	715- Dollars reported in LICS are greater than 0; beneficiary is not eligible for LICS. If plan has used best available information policy and updated beneficiary status, work with CMS to correct CMS status. If plan has not followed the proper policy, LICS must be converted to patient pay, and payment recovery policies at plan must be implemented.
			716-718, 720-721 – Plan cost-sharing was less generous than the level set by CMS. Plan should correct LICS levels in their system, refund the beneficiary for excessive cost-sharing, and resubmit PDE with correct LICS cost-sharing amount.
735-754	Various messages related to NDC	NDC edits confirm that an NDC exists. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered drugs are excluded from TrOOP, LICS, and payment calculations.	735 – The NDC code is invalid. The NDC code does not match a valid code on the NDC database. If plan believes this edit was generated in error, report NDC to CSSC.
			737 – Inappropriate Drug Coverage. Drug Coverage Status Code is not "O" although the drug is on the OTC list. If plan believes this edit was generated in error, report the NDC to CSSC. Edit 737 excludes supplies used for insulin administration; they must be submitted with Drug Coverage Status Code = 'C'.
			738 – Inappropriate Drug Coverage. Drug Coverage Status Code is 'C' although the drug is on the exclusion list. If plan believes this edit was generated in error, report the NDC to CSSC.
			740 - NDC is DESI drug. If plan believes this edit was generated in error, report the NDC to CSSC.
			741 - The drug is always excluded from Part D; the drug is always covered by Part B. If plan believes this edit was generated in error, report the NDC to CSSC.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
755-774	Various edit messages related to Drug Coverage Status Code	Edits that test the relationship between non-covered drugs, the Catastrophic Coverage Code field, and dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, and payment calculations.	Plans should evaluate the PDE. Confirm that Drug Coverage Status Code is reported correctly. Certain fields should not be populated when the drug coverage status code is "E" or "O". Correct the discrepancy and resubmit data.
775-799, 900-999	Various messages on miscellaneous data elements	Edits on Miscellaneous data elements.	777 – Duplicate PDE records have the same values in the following seven fields: HICN, Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status. Edit 777 identifies two types of dupes. When duplicates are submitted within the same file, all duplicate records are rejected. If this occurs, the plan must resubmit a single PDE; if that PDE passes all other editing it will be accepted. In the second case a newly submitted PDE that is being edited duplicates a saved PDE. If this occurs the new PDE fails editing and is rejected. There is no further action if the plan sent the duplicate in error. However, if the plan intended to modify the saved PDE it should change the Adjustment/Deletion Code on the rejected PDE and resubmit.
			779 - Submitting Plan cannot report NPP for Covered Part D Drug. Plan should confirm plan type; plans shall only map CPP/NPP for Enhanced Alternative plans or plans that were told to submit as Enhanced Alternative (e.g., employer plans, payment demonstrations).
			781 – Service Provider ID is not on master provider file. If plan believes this edit was generated in error, report the provider ID number to CSSC.
			783 – Service Provider ID was not an active pharmacy on DOS. CMS is preparing to bypass this edit for 2006, while refining it for 2007 to eliminate circumstances where the edit triggers inappropriately.
			784 – Duplicate PDE Record, originally submitted by a different Contract. CMS has created this edit to provide information on the original submitting contract. The contract that receives this edit must contact the original submitting contract to determine how to resolve. If pharmacy billed multiple contracts, one of the plans must reverse the claim. If the original submitting contract reversed the claim to the pharmacy previously and failed to submit a deletion PDE, the original submitting contract must submit a deletion PDE; then the contract that received the 784 reject can resubmit.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
775-799, 900-999 (continued)			999 – Internal CMS system issue encountered. This edit code triggers when the enrollment databases have inconsistent information, preventing PDEs from processing. Most cases have been resolved. If this code was triggered, allow several weeks for data to be updated and resubmit PDEs.

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Medicare Part D DIR Reporting Requirements for Payment Reconciliation

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Center for Beneficiary Choices
Medicare Plan Payment Group

Date: May 14, 2007

To: All Part D Plan Sponsors

From: Tom Hutchinson, Director
Medicare Plan Payment Group

Subject: Medicare Part D DIR Reporting Requirements for Payment Reconciliation

Part D sponsors are required to report their direct and indirect remuneration (DIR) data for the Medicare Prescription Drug Benefit to CMS within six months of the end of the coverage year for the purposes of payment reconciliation. In the attached document, "Medicare Part D DIR Reporting Requirements for Payment Reconciliation", CMS provides proposed guidance for Part D sponsors on reporting DIR data for contract year 2006. This guidance is effectively final; however CMS will accept comments for review on this proposed guidance until Monday, May 21, 2007. We will notify Part D sponsors if any major changes result from the comments. Part D sponsors must submit the 2006 DIR Report for Payment Reconciliation to CMS by July 2, 2007.

Comments may be submitted electronically to the following address: Meghan.elrington@cms.hhs.gov. Comments also may be mailed to:
Meghan Elrington
Centers for Medicare & Medicaid Services
7500 Security Boulevard S2-24-27
Baltimore, Maryland 21244

Further Information

If you have questions about this guidance, please contact Meghan Elrington at (410) 786-8675.

MEDICARE PART D DIR REPORTING REQUIREMENTS FOR PAYMENT RECONCILIATION- CONTRACT YEAR 2006

I. Introduction

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing coverage of outpatient prescription drugs under the new Medicare Part D benefit. Reinsurance payments and risk sharing are two of the payment mechanisms by which the Medicare Program reimburses Part D sponsors for providing prescription drug coverage under Medicare Part D. CMS is required by statute to calculate these payments using "allowable reinsurance costs" and "allowable risk corridor costs", which must be "actually paid". As defined at 42 C.F.R. 423.308, "actually paid" costs must be actually incurred and net of any applicable direct or indirect remuneration (DIR). Section 1860D-15(f)(1)(A) of the Act requires Part D sponsors to fully disclose to CMS any information necessary for carrying out the payment provisions of Part D, including reinsurance and risk sharing. Therefore, Part D sponsors are required to report drug costs and DIR associated with the Medicare prescription drug benefit to CMS for the purposes of determining reinsurance payments and risk sharing.

The purpose of this document is to provide an overview of CMS' DIR reporting requirements for Medicare Part D payment and the format of the DIR Report for Payment Reconciliation. This document explains the data elements to be reported by Part D sponsors at the distinct Plan level (i.e., data will be reported for each Plan Benefit Package or PBP offered under each Part D Contract) and the established reporting timeframes. Per Section 1860D-15(d)(2)(a) of the Act, CMS payments to a Part D sponsor are conditioned upon the provision of data necessary to determine payment, which include the requisite DIR data. CMS' goal is to ensure a common understanding of DIR reporting requirements and how these data will be used to determine Medicare Part D payments. These requirements will be in effect for Contract Year 2006.

II. Defining Direct and Indirect Remuneration (DIR)

Per 42 C.F.R. Section 423.308, direct and indirect remuneration (DIR) is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person) that serves to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes rebates, discounts, and other price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmaceutical benefit managers (PBM), if they are retained by the subcontractor in lieu of higher service fees from the Part D sponsor. As stated in the 2007 Call letter, CMS must assume that if a PBM retains a portion of the manufacturer rebates it negotiates on behalf of a Part D sponsor, the direct payment the sponsor pays the PBM for its services will be less, such that the sponsor receives a price concession from the PBM. Thus, as a price concession received by the Part D sponsor, these retained rebates must be reported as DIR for payment purposes.

However, since this policy was released on April 4, 2006 in the Call Letter for contract year 2007, Part D sponsors are permitted for contract year 2006 only to report these rebate, discounts, and other price concessions in accordance with Q&A 5002 issued on June 21, 2005. Per Q&A 5002, Part D sponsors must only report rebates, discounts, and other price concessions from pharmaceutical manufacturers which are actually received by the Part D sponsor for purchases under the Medicare prescription drug benefit, whether directly from the pharmaceutical manufacturer or indirectly through a PBM. Thus, for contract year 2006, Part D sponsors are only required to report those rebates, discounts, and other price concessions which are actually passed through to the sponsor. If a PBM is acting as the Part D sponsor, or is affiliated with the Part D sponsor, CMS expects that 100% of the pharmaceutical manufacturer rebates, discounts, and other price concessions received by the PBM for the sponsor's Medicare prescription drug benefits will be passed through to the Part D sponsor and, thus, must be reported to CMS as DIR.

In cases where the PBM serves as an independent subcontractor and is not the entity acting as the Part D sponsor and reporting to CMS, the Part D sponsor must report any rebate dollars, discounts, and other price concessions it has actually received from the PBM as DIR for contract year 2006. The total amount of rebate dollars, discounts, and other price concessions received by the sponsor and reported to CMS is dependent upon the provisions of the contract between the Part D sponsor and the PBM and may be less than the total amount of rebate dollars, discounts, and other price concessions the manufacturer provides to the PBM. For contract year 2006, if the contract between the PBM and pharmaceutical manufacturer does not explicitly mention the Part D plan, then the Part D sponsor must report the rebate dollars, discounts, and other price concessions the sponsor received as established under the contract between the sponsor and the PBM. Conversely, if the contract between the PBM and manufacturer explicitly mentions the plan and the determination of the rebates, discounts, and other price concessions, then 100% of the rebates, discounts, and

other price concessions received by the PBM for the sponsor's Medicare prescription drug benefits should be reported to CMS as DIR.

Starting with contract year 2007, Part D sponsors must report these price concessions in accordance with the "Reporting of Manufacturer Rebates in Part D" guidance provided in the 2007 call letter and therefore, must report 100% of the manufacturer rebates, discounts, and other price concessions retained by the PBM as DIR, regardless of the relationship between the sponsor and the PBM and the provisions of the contracts between the sponsor and the PBM.

In accordance with CMS guidance, sponsors may enter into risk sharing arrangements with entities other than CMS. Any risk sharing arrangement between the sponsor and other parties must be based on the cost of Part D covered drugs. Under no circumstances could a risk sharing relationship be developed around administrative costs. (Please refer to Q&A 4877 issued on June 6, 2005). All risk sharing amounts received from or credited to other parties constitute DIR and must be fully disclosed by the Part D sponsor to CMS and offset against prescription drug costs in the calculation of reinsurance and risk corridor allowable costs. As with other types of DIR, the value can be negative.

Dispensing incentive payments and adjustments to dispensing incentive payments made to pharmacies after the point of sale dispensing event are also considered DIR. Please note that dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

III. Reporting Requirements

Part D sponsors must report DIR associated with purchases under the Medicare prescription drug benefit on the DIR Report for Payment Reconciliation. The DIR included on the DIR Report for Payment Reconciliation will be excluded from allowable reinsurance costs and allowable risk corridor costs when CMS calculates reinsurance and risk sharing payments during the Part D payment reconciliation process. As a result, Part D sponsors should consider their best expectation of DIR when developing their bids.

Some DIR is reflected in the amount paid at the point of sale (sum of ingredient cost, dispensing fee, and applicable sales tax). As a result, this DIR is already taken into account for payment purposes in the gross drug cost reported to CMS on the prescription drug event (PDE) record and therefore, should not be reported on the DIR Report for Payment Reconciliation. Part D sponsors must establish mechanisms to distinguish point of sale price concessions that reduce the gross drug cost reported on the PDE record, and exclude this DIR from the

DIR Report for Payment Reconciliation. Please note, however, that price concessions that are applied to beneficiary cost-sharing at point of sale but do not reduce the gross drug cost reported on the PDE record must be reported on the DIR Report for Payment Reconciliation.

CMS provides reinsurance or risk sharing for costs associated with covered Part D drugs only. Covered Part D drugs, as defined in 42 C.F.R. 423.100, are Part D drugs that are included in a Part D plan's formulary or treated as included in the formulary as a result of the plan's exceptions process, a coverage determination appeal, or a transition period. Please refer to 42 C.F.R. 423.100 for the definitions of Part D drug and covered Part D drug. When calculating allowable reinsurance and risk sharing costs, CMS will only apply DIR dollars for covered Part D drugs. Therefore, Part D sponsor are required to submit DIR for covered Part D drugs only on the DIR Report for Payment Reconciliation. DIR for non-Part D covered drugs (drugs covered by the Part D sponsor which are not Part D drugs) should not be included on this report.

All applicable DIR must be reported in full on the DIR Report for Payment Reconciliation with no reduction for administrative cost or any other fees. This DIR will be excluded from allowable costs when CMS determines final reinsurance and risk sharing payments. Part D sponsors are required to report this DIR to CMS in a report format similar to that provided below (please see section V. Report Format).

Part D sponsors must submit their DIR data at the plan benefit package (referred to as "plan") level on the DIR Report for Payment Reconciliation within 6 months of the end of the coverage year. All applicable DIR received for Part D plan expenditures during the contract year must be reported. In addition, Part D sponsors should include estimates for DIR that has not yet been received but is expected for the applicable contract year. This DIR should be reported on line 7 of the DIR Report for Payment Reconciliation, "All Other DIR". Please note that data reported on the DIR Report for Payment Reconciliation is subject to audit. Plan sponsors are required to maintain records of all related transactions, claims, contracts, and other materials.

The 2006 DIR Report for Payment Reconciliation can be downloaded from HPMS starting on Monday, June 18, 2007 using the following navigation path: HPMS Homepage > Plan Bids > DIR Reporting > Contract Year 2006 > DIR Reporting (for Payment Reconciliation). This report will be downloadable to a MS Excel spreadsheet and look similar to the format provided below in Section V: Report Format. Part D sponsors must prepare and upload to HPMS the 2006 DIR Report for Payment Reconciliation for each of their Part D plans by **July 2, 2007**. Sponsors may upload this report as many times as they choose between June 18, 2007 and 11:59 p.m. EDT on Monday, July 2, 2007. CMS will use the DIR reported on the most recently uploaded report during payment reconciliation. For technical assistance, Part D sponsors can contact the HPMS Help Desk at

either 1-800-220-2028 or hpms@cms.hhs.gov. For other questions, sponsors can contact Meghan Elrington at (410) 786-8675 or meghan.elrington@cms.hhs.gov.

IV. Summary of Reporting Elements

Part D sponsors will be responsible for reporting multiple data elements related to DIR. DIR will be reported at the CMS Part D plan level. DIR data should be summarized for each plan and reported in aggregate to include multiple drugs and price concessions. DIR that is not generated from the sponsor's Medicare Part D book of business should not be reported.

Line Items:

Line 1. Rebates for Reimbursed Coordination of Benefits (COB) Claims
Per 42 C.F.R. 423.464, Part D sponsors are required to coordinate benefits with State Pharmaceutical Assistance Programs (SPAPs) and entities providing other prescription drug coverage (described in 42 C.F.R. 423.464(f)(1)). CMS has taken many steps to help facilitate the coordination of benefits between Part D sponsors and third party providers of prescription drug coverage. However, there are instances in which Part D sponsors must reimburse third party payers for Part D claims due to COB errors. All rebates associated with these incurred Part D drug costs (for example, rebates for State-to-Plan claims) must be reported in this line item with the exception of those associated with Plan-to-Plan (P2P) claims. Under the current process for reimbursing P2P claims, the plan sponsor actually incurring the Part D drug costs (the plan of record) does not have claim level data and therefore is unable to receive rebates for these claims. The submitting plan, however, may receive rebates for these claims and is required to report them to CMS. Rebates received by the submitting plan for P2P claims must be reported on Line 7, "All Other DIR", and are therefore not included in this line item (Line 1).

Line 2. All Other Rebates
All rebates associated with the Medicare prescription drug benefit are reported in this line item with the exception of those associated with plan reimbursed coordination of benefits (COB) claims. Included in this line item are rebates that the Part D sponsor receives from pharmaceutical manufacturers for Part D purchases such as market share rebates. Please note that rebates received by long term care (LTC) pharmacies are not reported on the DIR Report for Payment Reconciliation and therefore are not included in this line item. Part D sponsors are not required to report LTC pharmacy rebates for contract year 2006. For contract years 2007 and forward, Part D sponsors are required to report LTC pharmacy rebates to CMS for oversight purposes as described in the Call Letter for 2007. Please see the Medicare Part D Reporting Requirements for contract year 2007, for information on the quarterly reporting of these LTC rebates to CMS.

Line 3. Price Concessions for Administrative Services
Part D sponsors must report price concessions for administrative services associated with the Part D benefit in this line item. This includes administrative services received by the Part D sponsor at a cost below market value. The difference between the market value of the administrative service and the price paid by the Part D sponsor should be reported in this line item. Also reported in this line item are grants received by the Part D sponsor for services and programs such as utilization management and medical education grants. Price concessions for administrative services that are not associated with a specific drug must be reported in full in this line item with no portion allocated for non-Part D Covered drugs. This DIR must fully accrue to the government and beneficiaries and cannot be kept by the Part D sponsor.

Line 4. Generic Dispensing Incentive Payments and Adjustments
Generic dispensing incentive payments are payments made to pharmacies to encourage the dispensing of generic drugs. If a Part D sponsor makes a generic dispensing incentive payment to the pharmacy at the point of sale (POS), CMS considers it part of the dispensing fee and the sponsor or its third party submitter must report this cost as part of the dispensing fee on their PDE. This payment is not reported as DIR and therefore is not included in this line item.

However, if the sponsor should pay the pharmacy a generic dispensing incentive payment after the point of sale or make any post-POS adjustments to prospective generic dispensing incentive payments, the sponsor must report the post- POS payments or adjustments as DIR and include them in this line item. Specifically, if the plan pays the pharmacy a prospective dispensing fee per event but recoups some of the cost if the pharmacy does not meet a target dispensing rate, the amount recouped by the plan must be reported to CMS as a positive adjustment that will reduce the cost of the drug to the plan sponsor. Conversely, the sponsor should report payments made to the pharmacy after the point of sale as a negative adjustment. For example, if the plan pays the pharmacy more than the prospective amount based on meeting or exceeding a dispensing target, the plan should report the later payment to the pharmacy as a negative adjustment that will decrease the total for this line item.

Line 5. Risk Sharing Arrangement Payments and Adjustments
Any gains or losses that the Part D sponsor may receive as a result of risk sharing arrangements with entities other than CMS and in accordance with CMS guidance for Part D are reported in this line item. Part D sponsors may negotiate certain risk-sharing arrangements with employers, suppliers, or other parties based on the cost of covered prescription drugs. Please refer to Q&A 4877 issued on June 6, 2005 for further guidance on permissible risk-sharing arrangements. All risk sharing amounts received from other parties must be reported in this line item as a positive adjustment to reduce prescription drug costs in the calculation of allowable reinsurance and risk corridor costs. All risk

sharing amounts credited to other parties must be reported in this line item as a negative adjustment to increase prescription drug costs in the calculation of allowable reinsurance and risk corridor costs. Part D sponsors must reconcile these risk sharing amounts before reporting them to CMS for purposes of Part D payment reconciliation.

Line 6. Pharmacy Payment Adjustments

With the exception of adjustments to dispensing incentive payments, which are reported in Line 4, adjustments made to pharmacy payments after the point-of-sale that are not reflected in the PDE data are reported in this line item. This includes penalties or pharmacy repayments stipulated in the Part D sponsor's contract with its network pharmacies. These penalties may result from pharmacy non-compliance with best practice rules or state law. Adjustments that reduce the total payments made to the pharmacy should be reported as a positive adjustment that will serve to reduce the plan's drug costs. Adjustments that increase the total payments made to the pharmacy should be reported as a negative adjustment. Please note that adjustments that affect the point-of-sale price of the drug (the gross drug cost) are not included on the DIR Report for Payment Reconciliation, and therefore should not be reported in this line item. For example, if the plan recoups an overpayment to the pharmacy due to an error in POS drug price, the recouped amount should be reported to CMS via an adjusted PDE record with a revised gross drug cost, rather than as a pharmacy payment adjustment on the DIR Report for Payment Reconciliation. Adjustments made to beneficiary cost-sharing due to changes in low-income subsidy eligibility status are also not reported as DIR and therefore are not reflected in this line item.

To the extent that these payments are not reflected in the covered plan paid (CPP) amounts reported on the PDE data, amounts credited to the Part D plan by the pharmacy due to beneficiary cost-sharing that exceeds the gross drug cost are also reported in this line item. This may occur when the beneficiary's copayment exceeds the negotiated drug price and the pharmacy credits the differential amount to the Part D sponsor. If this payment is not reflected in the CPP amount reported on the PDE data, this amount must be reported as DIR to reduce the plan's allowable costs. Please note that in cases where the pharmacy retains this differential amount, this amount is considered payment to the pharmacy and, thus, is not included on this report as DIR.

Line 7. All Other DIR

All applicable DIR (as well as adjustments to DIR) that is not reported in the previous line items must be included in this line item. This includes rebates associated with Plan-to-Plan (P2P) claims. Under the current process for reimbursing P2P claims, the submitting plan may receive rebates for these claims and is required to report them to CMS in this line item. Also reported in this line item is estimated DIR that is expected for the applicable contract year, but has not yet been received. Part D sponsors should also include penalty

payments or PBM repayments stipulated in their contracts with PBMs that (i) occur after the point of sale and (ii) are due to incorrect coverage determinations. For example, if a PBM (instead of the Part D sponsor) is required to pay the entire cost of a claim due to an error associated with allowing coverage of a drug on step 2 of a step-therapy program, when a drug on step 1 of the same program should have been required, the Part D sponsor must report the amount of this claim as DIR. This is required because the PDE data submitted to CMS would not reflect this reduction in drugs costs for the Part D sponsor. Please note that in cases where the PBM has administered the benefit incorrectly, the Part D sponsor must submit a corrected PDE record. The Part D sponsor should not report the associated claim amount as DIR. A short description along with the dollar amount is required for each price concession or DIR adjustment included in this line item. DIR included in this line item that is not associated with a specific drug, must be reported in full on the DIR Report for Payment Reconciliation with no portion allocated to non-Part D covered drugs. This DIR must fully accrue to the government and beneficiaries and cannot be kept by the Part D sponsor.

V. Report Format

DIR Report for Payment Reconciliation

	+/-	**Direct and Indirect Remuneration for Covered Part D Drugs**
1. Rebates for Reimbursed Coordination of Benefits Claims		
2. All Other Rebates		
3. Price Concessions for Administrative Services		
4. Generic Dispensing Incentive Payments and Adjustments		
5. Risk Sharing Arrangement Payments and Adjustments		
6. Pharmacy Payment Adjustments		
7. All Other DIR (Description Required)		
8. Total		

V. Appendix

Q&A 5002

(Please note that this Q&A is only applicable to the 2006 contract year.)
Question: If a Part D plan contracts for drug company rebates through a PBM, does the plan report 100% of the rebate dollars paid by the manufacturer, or just those rebate dollars paid to the plan by the PBM?

Answer: Section 1860D-15(d)(2) of the Social Security Act requires disclosure to CMS of any information necessary for carrying out the payment provisions of Part D. For the purposes of reinsurance payments and risk sharing 42 CFR §423.308 defines actually paid allowable costs as those that are "net of any direct or indirect remuneration (including discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, good in kind, free or reduced price services, grants, or other price concessions or similar benefits offered to some or all purchasers) from any source." Accordingly, a Part D sponsor is required to report 100% of the rebates it receives--whether directly by a manufacturer or indirectly through a PBM. Thus, if the PBM is acting as the Part D sponsor, or is affiliated with the Part D sponsor, we expect 100% of rebates to be passed through and reported. However, we are aware that in some cases the PBM will be serving as an independent subcontractor and will be neither a direct agent of the plan in negotiating rebates, nor affiliated with the Part D sponsor. In such cases, the independent PBM is not the entity acting as the Part D sponsor and reporting to CMS, and the PBM may not necessarily pass through 100% of rebates it receives to the Part D sponsors. The PBM's retention of any rebate dollars is subject to the negotiations between the PBM and the Part D sponsor. Thus, although a Part D sponsor must report any price concessions it has received, in some cases these price concessions could be less than the price concessions the manufacturer paid to the PBM. We note our expectation that in a competitive marketplace Part D sponsors will seek to obtain the maximum price concessions possible. However, if a Part D sponsor contracts with a PBM to require passing through 100% of the rebates received, then, obviously, all of the rebates would need to be reported. In cases where a PBM is a corporate affiliate of a Part D sponsor, we expect that all price concessions received from manufacturers would be passed through to the sponsor and reported to CMS. In other words, the allocation of rebates or "direct and indirect remuneration" (or "DIR" as defined in the Advance Notice of Payment Methodology available online at www.cms.hhs.gov/healthplans/rates/2006/45day-cover.asp) depends on the provisions of the contract between the PBM and the manufacturer: (1) If the contract with the manufacturer explicitly mentions the plan and the determination of its DIR, then the entire DIR realized by the PBM should be allocated to the plan; (2) If the contract between the PBM and the manufacturer does not explicitly mention the plan, then the DIR allocated to the plan is determined by the provisions of the contract between the plan and the PBM. We note that, as

discussed in the final rule, rebates may not been hidden in administrative fees. Moreover, we emphasize that this guidance in no way overrides a Part D sponsor's obligations to ensure that all cost-savings are reported, or precludes CMS or OIG auditing of sponsor and PBM records to determine that rebates have been appropriately allocated and reported.

Vaccine Administration

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

TO: Medicare Advantage-Prescription Drug Organizations
Cost-Based Plans
Stand-Alone Prescription Drug Plans
Employer/Union-Sponsored Group Health Plans

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

RE: Vaccine Administration

DATE: May 14, 2007

As we stated in our 2008 Final Call Letter, we received a significant number of comments in response to our Draft 2008 Call Letter language related to the statutory shift of Part D vaccine administration reimbursement from Part B to Part D in 2008. Given the extensive nature of these comments, we indicated we were taking additional time to consider them and finalize our operational guidance on administration fees for Part D vaccines. This detailed operational guidance is contained in the following attachment. Sponsors should take time to thoroughly familiarize themselves with this guidance and ensure that appropriate costs are considered in their 2008 bids.

If you have any questions on the treatment of vaccine administration under Part D, please contact Greg Dill at Gregory.Dill@cms.hhs.gov or 312 -353-1754.

Vaccine Administration under Medicare Part D in 2008

1. Relationship of vaccine administration to the vaccine:

The Tax Relief and Health Care Act of 2006 (TRHCA) modified the definition of a Part D drug to include "for [Part D] vaccines administered on or after January 1, 2008, its administration." Consequently, beginning on January 1, 2008, the Part D program will cover vaccine administration costs associated with Part D vaccines. The Centers for Medicare & Medicaid Services (CMS) interprets this new statutory requirement to mean that the Part D vaccine administration costs are a component of the negotiated price for a Part D-covered vaccine. In other words, the negotiated price for a Part D vaccine will be comprised of the vaccine ingredient cost, a dispensing fee (if applicable), and a vaccine administration fee. This interpretation recognizes the intrinsic linkage that exists between the vaccine and its corresponding administration, since a beneficiary would never purchase a vaccine without the expectation that it would be administered.

In general, CMS believes that Part D vaccines, including the associated administration costs, should be billed on one claim for both in- and out-of-network situations. For example, if an in-network pharmacy dispenses and administers the vaccine in accordance with State law, the pharmacy would process a single claim to the Part D sponsor and collect from the enrollee any applicable cost-sharing on the vaccine and its administration. Alternatively, if a vaccine is administered out-of-network in a physician's office, the physician would provide the vaccine and its administration and then bill the beneficiary for the entire charge, including all components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement for both the vaccine ingredient cost and administration fee.

2. Cost-Sharing Considerations:

Since the vaccine administration fee is a component of a vaccine's negotiated price, any cost-sharing applied to a vaccine should be applied relative to the negotiated price of the vaccine and its related component costs. If a sponsor structures its vaccine cost-sharing as coinsurance, including 100 percent cost-sharing in any applicable deductible or coverage gap, the coinsurance should be applied relative to the entire negotiated price (including the vaccine administration fee). Similarly, if a sponsor structures its vaccine cost-sharing as a copay, the copay should be applied relative to the entire negotiated price. In other words, a sponsor should not charge separate copays for the vaccine ingredient cost and its related component costs, respectively (i.e., the vaccine administration fee and dispensing fee, if applicable) since we view the vaccine and its administration as intrinsically linked. Similarly, low income subsidy eligible individuals with copays set by statute (see section 1860D-14(a)(1)(D) of the Social Security Act) will pay only one copay for a vaccine and all related charges Thus, for example, a low income subsidy eligible individual entitled to $1.05/$3.10 copays in 2008 would pay only

$3.10 for both the vaccine and its administration (and any applicable dispensing fee) even if the components are billed separately.[1]

3. Separate billing of the vaccine and vaccine administration:

Although CMS would prefer that all Part D vaccines be billed on one claim for both the vaccine and its administration, we recognize there are circumstances that might require vaccine administration to be billed and reimbursed separately from the vaccine. For example, a Part D vaccine might have very specific storage conditions that would impede most physicians' offices from maintaining a ready inventory for their patients. It might be more efficient for the physician to have a pharmacy dispense and deliver the vaccine for administration. The pharmacy will submit the vaccine ingredient cost and dispensing fee to the Part D Sponsor for reimbursement and the physician will bill the beneficiary for the administration. Part D sponsors should establish processes necessary to separately reimburse the pharmacy for the vaccine ingredient cost/dispensing fee and the beneficiary for physician's administration charge.

CMS has concerns about separate billing of Part D vaccines and vaccine administration fees because it provides an opportunity for both inappropriate and duplicate billing of administration fees. Separate billing is more challenging for Part D sponsors to process and track, and there is greater potential for programmatic fraud and abuse when the vaccine and its administration are not linked at time of reimbursement. Consequently, we strongly encourage Part D sponsors to link billing of a vaccine and its administration wherever possible. Where this is not possible, and separate billing occurs, we expect Part D sponsors to closely scrutinize the separate claims to ensure the beneficiary has received reimbursement for both elements and that the sponsor has neither over- nor underpaid for both the vaccine and the vaccine administration fee. We plan on monitoring Part D sponsors to ensure that when separate billing does occur, there is a reasonable correlation

[1] In cases involving defined standard coverage and out-of-network vaccine administration, cost-sharing for a vaccine is based on the usual and customary price for both the vaccine ingredient cost and vaccine administration fee. This is because, given the cost-sharing requirements for defined standard coverage – under which the cost-sharing between the deductible and initial coverage limit must always be 25 percent of the actual cost of a drug at the point of sale – Part D sponsors offering defined standard coverage may not charge enrollees any out-of-network differential. However, sponsors offering other benefit designs (e.g., actuarially equivalent standard coverage, basic alternative coverage, or enhanced alternative coverage), may require enrollees being administered a vaccine out-of-network (e.g., in physician's office) to be responsible for any cost-sharing that would have otherwise applied had the drug been purchased at a network pharmacy, and also any differential between the provider's usual and customary price for the vaccine and vaccine administration fee and the plan allowance for the vaccine and vaccine administration (see section 60.1 of Chapter 5 of the *Prescription Drug Benefit Manual* for more information).

of prescription drug event (PDE) records for vaccines dispensed to PDE records for vaccine administration.

4. Elements of vaccine administration:

Vaccine administration fees should be subject to negotiations between Part D sponsors and pharmacies. We expect that sponsors will take into consideration the elements reflected in existing 2007 Part B vaccine administration fees when establishing their own vaccine administration fees for 2008. For example, Part B considers the immunizing professional's time in physically delivering the vaccine to a beneficiary, the resources encompassing the supplies (syringe, gauze, band-aid, alcohol prep pad, etc.), the indirect costs of the office, and professional liability.

5. Establishment of multiple vaccine administration fees:

Sponsors will have the discretion to implement either a single vaccine administration fee for all vaccines or multiple administration fees based on type of vaccine, variance in provider type, and product administration complexity. CMS plans to retrospectively review vaccine administration fees to look for outliers and potentially discriminatory practices that would impact beneficiary access to Part D vaccines.

6. Other Vaccine Administration Considerations

Part D sponsors may implement drug utilization management tools to determine if a vaccine is necessary; however, in the absence of any information showing previous immunization (i.e., claims data), the Part D plan should make payment available for a vaccine and its administration in consideration with ACIP recommendations.

7. Claims processing considerations:

Part D sponsors will implement a process that helps ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) vaccine billing requirements. Under the Tax Relief and Healthcare Act of 2006 (TRHCA), a "covered Part D drug" is defined to include the vaccine and, for vaccines administered on or after January 1, 2008, the administration of the vaccine. For purposes of billing for vaccines, Part D vaccine administration therefore is unique. As defined by statute, the "drug" incorporates both the vaccine and its administration. Consequently, billing of the Part D drug vaccine must be conducted using the NCPDP 5.1 standard for both the vaccine and its administration. When the administration is performed by the pharmacy or facilitated by the pharmacy through an established relationship with physician or immunizer, the administration will be included in one standardized field in the billing transaction as part of the vaccine prescription request to the Part D sponsor.[2] In other words, the pharmacy

[2] Relative to the establishment of relationships between pharmacies and immunizers, the parties must ensure that such arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other applicable Federal or State law or regulation.

should submit the vaccine and its administration, if they are involved with the administration, as a single claim and not as two separate claims. CMS will look to NCPDP to issue formal guidance regarding the standardized field to be used for vaccine administration in the billing transaction.

When administration is billed separately from the dispensing of the vaccine, Part D sponsors or their subcontracted PBM should review existing claims for the presence of a vaccine charge. Should no vaccine charge be present in their claims history, the Part D sponsor should work with the beneficiary to ensure the beneficiary did not forget to submit a paper receipt for the vaccine and that appropriate reimbursement has been paid. For example, a sponsor could generate a letter to an enrollee whenever it receives a claim for a vaccine but does not receive a claim for vaccine administration within a certain time period.

A new, unique vaccine administration field will be added to the PDE in 2008 for Part D sponsor submission of vaccine administration. This specific vaccine administration field will allow a one-to-one claim to PDE relationship. For instance, if a sponsor receives a single claim from a network pharmacy inclusive of the vaccine and its administration it will need to need to attribute the vaccine ingredient cost, dispensing fee (if applicable), and administration to the appropriate fields of the PDE for submission to CMS. If separate billing by a pharmacy for the dispensing of the vaccine and by a physician for its administration occurs, the sponsor will submit one PDE based on the pharmacy claim inclusive of the vaccine and dispensing fee and a separate PDE based on the out-of-network claim from the beneficiary inclusive of the vaccine administration costs attributable to physician's administration. For this second separate PDE, the vaccine ingredient NDC would still be identified, but the vaccine ingredient cost and dispensing fee would be set to zero dollars. The format will be published shortly on www.csscoperations.com.

8. Vaccine Administration Access

Part D sponsors will allow any provider so authorized by State law to administer a Part D vaccine. Where it is safe to dispense and administer vaccines in a pharmacy, sponsors could explore utilization of their network pharmacists as providers of adult Medicare Part D vaccines (pediatric vaccines should continue to be provided by physicians). Out-of-network vaccines administered in a physician's office or by other non-network providers may be covered under our out-of-network access rules where a Part D enrollee may self-pay for the vaccine cost and its administration and submit a paper claim for reimbursement to his or her Part D plan.

We remind Part D sponsors of their continuing responsibility to implement measures to increase access to Part D vaccines. While an in-network solution provides the greatest advantages to the beneficiary and the Part D program given that the beneficiary is provided access to the D sponsor's negotiated rate and real-time information on his/her applicable cost-sharing, we understand that beneficiaries will continue look to their physician for information on vaccines. Reimbursement of vaccine administration by the

Part D program only heightens the need for Part D sponsors to continue to aggressively seek and to implement processes that increase access to novel vaccines that are available now or will become available in coming years.

Reporting Estimated Rebates Applied to the Point of Sale (POS) Price

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Center for Beneficiary Choices
Medicare Plan Payment Group

Date: June 1, 2007

To: All Part D Plan Sponsors

From: Tom Hutchinson, Director
Medicare Plan Payment Group

Subject: Reporting Estimated Rebates Applied to the Point-of-Sale Price

Per section 1860D-2(d)(1)(B) of the Medicare Modernization Act and 42 CFR 423.100, the negotiated prices made available to Part D beneficiaries at the point of sale shall take into account negotiated price concessions for covered Part D drugs such as discounts and rebates which the Part D sponsor has elected to pass through to their enrollees at the point of sale, as well as any applicable dispensing fees. While several Part D sponsors include discounts in the negotiated prices made available to their enrollees in order to reduce beneficiary cost sharing, they are often unable to pass actual rebates through to their enrollees at the point of sale because rebates from drug manufacturers are typically awarded retrospectively based on market share or utilization. For this reason, Part D sponsors, who choose to make rebates available to their beneficiaries at the point of sale, may elect to apply a reasonable estimate of expected rebates, referred to as estimated rebates, to the negotiated price at the point of sale. Please note that Part D sponsors are not required to apply rebates or an estimate of expected rebates to the negotiated price at the point of sale. This guidance is only applicable for those Part D sponsors who elect to pass rebates through to their Part D enrollees at the point of sale.

As defined in 42 CFR 423.100, negotiated prices are "prices for covered Part D drugs" that "[a]re available to beneficiaries at the point of sale at network pharmacies" and that "[a]re reduced by those discounts,… rebates, …and direct or indirect remunerations that the Part D sponsor has elected to pass through to Part D enrollees at the point of sale" and "[i]nclude[] any dispensing fees." Rebates which Part D sponsors elect to pass through to beneficiaries at the point of sale serve to reduce the negotiated price and, thus, the gross drug cost reported to CMS. Part D sponsors must use the reduced negotiated price to administer their plan(s). Specifically, the reduced negotiated price and gross drug cost must be used consistently to (i) calculate beneficiary cost-sharing, (ii) accumulate gross covered drug costs and advance the beneficiary through the benefit, (iii) calculate true out-of-pocket costs (TrOOP), (iv) report drug costs on the PDE record, (v) determine the low-income cost sharing subsidy amounts reported to CMS, and (vi) develop the Part D bid. Thus, any rebates applied at the point of sale reduce both plan liability and

beneficiary cost sharing by reducing the negotiated price used to administer the prescription drug benefit.

To ensure that the Prescription Drug Event (PDE) record accurately reflects the gross drug costs used to administer the prescription drug benefit, CMS is adding a new field to the PDE record for contract year 2008. Beginning in contract year 2008, Part D sponsors, who elect to pass estimated rebates through to their Part D enrollees at the point of sale, will be required to report these estimated rebates in a new field, "Estimated Rebate at POS". The addition of this field to the PDE record will help to ensure that the estimated rebates applied to the point of sale price are used appropriately to reduce the negotiated price, plan liability, and beneficiary cost sharing. Provided below is additional guidance regarding the reporting of these estimated rebates.

Coverage Year 2008 and Forward

Starting in contract year 2008, Part D sponsors must report the amount of any estimated rebates, which they have elected to apply at the point of sale to CMS in the Estimated Rebate at POS field. In addition, the gross drug cost reported to CMS on the PDE record must be net of the estimated rebates applied to the point-of-sale price. Specifically, these estimated rebates must be used to reduce all five cost fields: "Ingredient Cost", "Dispensing Fee Paid", "Amount Attributed to Sales Tax", "Gross Drug Cost Below the Out-of-Pocket Threshold"(GDCB) and Gross Drug Cost Above the Out-of-Pocket Threshold"(GDCA). The Part D sponsor must first use the estimated rebates applied at the point of sale to reduce the ingredient cost reported to CMS. If the estimated rebates applied to the point-of-sale price are greater than the total ingredient cost, any remaining estimated rebates must then be used to reduce the dispensing fee next and then finally the sales tax. The payments made by or on behalf of the beneficiary and plan paid amounts reported to CMS on the PDE record must be based on the reduced negotiated price and reflect the cost sharing established in the Plan Benefit Package (PBP). The examples provided below demonstrate how estimated rebates applied to the point-of-sale price should be reported to CMS on the PDE records.

For payment reconciliation, Part D sponsors will be required to report all applicable rebates for covered Part D drugs on the DIR Report for Payment Reconciliation, including the actual rebate amounts for the rebates which were estimated and applied at the point of sale. When determining the appropriate DIR amount for the calculation of allowable reinsurance costs and adjusted allowable risk corridor costs, CMS will subtract the amounts reported in the Estimated Rebate at POS field for covered Part D drugs from the total DIR amount (for covered Part D drugs) reported on the DIR Report For Payment Reconciliation. This will capture any difference between the estimated rebates and the actual rebates and ensure that only price concessions which were not already included in the gross covered drug costs reported to CMS are included in the DIR amount used to calculate allowable reinsurance costs and adjusted allowable risk corridor costs.

Coverage years 2006 and 2007

As stated previously, Part D sponsors who elect to apply estimated rebates to the point-of-sale price must use the negotiated price net of the estimated rebates to administer the

Part D benefit and calculate beneficiary cost sharing. However, for coverage years 2006 and 2007, Part D sponsors are required to report the gross drug cost prior to the application of these estimated rebate amounts on the PDE record instead of the gross drug cost net of these estimated rebates. Specifically, the gross drugs costs reported in the "Ingredient Cost Paid, Dispensing Fee Paid," "Amount Attributed to Sales Tax," "Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)," and "Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)" fields must be based on the gross drug costs prior to the application of any estimated rebates. Since there is no separate field on the PDE record for estimated rebates in contract years 2006 and 2007, Part D sponsors are required to report any estimated rebates applied to the negotiated price at the point of sale in either the Covered D Plan Paid Amount (CPP) field for covered Part D drugs or the Non-covered Plan Paid Amount (NPP) field for non-Part D covered drugs. For payment reconciliation, Part D sponsors will be required to report all applicable rebates for covered Part D drugs on the DIR Report for Payment Reconciliation including the actual rebate amounts for the rebates which were estimated and applied at the point of sale. The examples provided below demonstrate how estimated rebates applied at point of sale should be reported to CMS on PDE records for contract years 2006 and 2007.

Example 1:
A Part D beneficiary is enrolled in a defined standard plan and has year-to-date gross covered drug costs of $1,000. The beneficiary is not eligible for the low-income subsidy and does not have additional prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 to the point-of-sale price. The actual rebate amount received by the Part D sponsor at the end of the coverage year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE record for coverage years 2007 and 2008.

PDE Field Values for Example 1

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	0	0
Patient Pay Amount	$25	$25
Covered D Plan Paid Amount	$125	$75
Non-Covered Plan Paid Amount	0	0
Estimated Rebate at POS	N/A	$50

For both coverage years 2007 and 2008, the Part D sponsor uses a reduced negotiated price of $100 ($150- $50 estimated rebate amount) to determine beneficiary cost sharing. However, the gross drug costs reported for coverage year 2007 are the drug costs prior to the application of the estimated rebates ($150) and the gross drug costs reported for

coverage year 2008 will be net of the estimated rebates ($100). Since this beneficiary is in the initial coverage period, the beneficiary pays 25% of the negotiated price ($25) and the plan is responsible for 75% of the negotiated price ($75) in both coverage years. For coverage year 2007, the Covered D Plan Paid Amount field includes both the $75 plan liability and the estimated rebate amount ($50) applied at the point-of-sale. However, for coverage year 2008, only the $75 plan liability is included in the Covered D Plan Paid Amount field. The $50 estimated rebate amount is reported in the Estimated Rebate at POS field instead. In both coverage years, the Part D sponsor reports the actual rebate amount of $60 on the DIR Report for Payment Reconciliation.

Example 2:
A Part D beneficiary is enrolled in a defined standard plan, is not eligible for the low-income subsidy, and has year-to-date gross covered drug costs of $2,600. The beneficiary does not have prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $35 ($20 ingredient cost, $10 dispensing fee, and $5 sales tax). The Part D sponsor chooses to apply an estimated rebate of $25 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of the year is $20 for this claim. The table below illustrates how the Part D sponsor would populate the following nine data elements on the PDE for coverage years 2007 and 2008.

PDE Field Values for Example 2

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$20	$0
Dispensing Fee Paid	$10	$5
Amount Attributed to Sales Tax	$5	$5
GDCB	$35	$10
GDCA	$0	$0
Patient Pay Amount	$10	$10
Covered D Plan Paid Amount	$25	$0
Non-Covered Plan Paid Amount	$0	$0
Estimated Rebate at POS	N/A	$25

For both coverage years 2007 and 2008, the Part D sponsor uses the reduced negotiated price of $10 ($35- $25 estimated rebate amount) to determine beneficiary cost sharing and administer the prescription drug benefit. However, the gross drug costs reported for coverage 2007 are the drug costs prior to the application of the estimated rebates and the gross drug costs reported for coverage year 2008 are net of the estimated rebates. For coverage year 2008, the estimated rebates are used to reduce the ingredient cost reported to $0.00 before the remaining estimated rebates are applied to reduce the dispensing fee to $5.00. Since this beneficiary is in the coverage gap phase of the prescription drug benefit, the beneficiary pays 100% of the negotiated price ($10) and the plan is responsible for 0% of the negotiated price ($0) in both coverage years. For coverage year 2007, the Covered D Plan Paid Amount field includes both the $0 plan liability and the

estimated rebate amount ($25) applied at the point-of-sale. For coverage year 2008, only the $0 plan liability is reported in the Covered D Plan Paid Amount field. The $25 estimated rebate amount is reported in the Estimated Rebate at POS field. In both coverage years, the Part D sponsor would report the actual rebate amount of $20 on the DIR Report for Payment Reconciliation.

Example 3:
A Part D beneficiary is enrolled in an enhanced alternative (EA) plan that fills in the coverage gap and has tiered cost-sharing ($10/$20/$30). The beneficiary is not eligible for the low-income subsidy and does not have prescription drug coverage through a third-party. In this example the beneficiary's year-to-date gross covered drug cost is $3,000. The beneficiary purchases a covered Part D drug in Tier 3 that costs $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE for coverage years 2007 and 2008.

PDE Field Values for Example 3

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$30	$30
Covered D Plan Paid Amount	$50	$0
Non-Covered Plan Paid Amount	$70	$70
Estimated Rebate at POS	N/A	$50

First, the Part D sponsor determines cost-sharing based on its own enhanced benefit design; the beneficiary pays $30. For EA plans, the sponsor must map to the defined standard benefit in order to determine the covered D plan paid amount (CPP) and the non-covered plan paid amount (NPP). For both 2007 and 2008, Part D sponsors must use the gross drug cost net of the estimated rebate amount ($100) when doing this mapping to determine the CPP and NPP. This claim would fall in the defined standard coverage gap so the mapped amount for CPP is $0 and the Non-Covered Plan Paid Amount (NPP) is $70. (For additional information about mapping see the CMS PDE Training Participant Guide located at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.) For coverage year 2007 plans also report Estimated Rebate at POS in the CPP field. In 2007 the mapped amount is $0 and the Estimated Rebate is $50 so the plan reports $50 in CPP. For coverage year 2008, the Covered D Plan Paid Amount field reports only the mapped amount which is $0. The $70 NPP amount is the same in both years. In 2008, the $50 estimated rebate amount is reported in the Estimated Rebate at POS field. In both coverage years, the Part D sponsor would report the actual rebate

amount of $60 on the DIR Report for Payment Reconciliation.

Example 4:
A beneficiary who is enrolled in an enhanced alternative plan purchases a supplemental drug that costs $150 ($140 ingredient cost and $10 dispensing fee) and pays a $20 co-payment. The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE for coverage years 2007 and 2008. (Please note that the Drug Coverage Status Code is 'E'.)

PDE Field Values for Example 4

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$0	$0
GDCA	$0	$0
Patient Pay Amount	$20	$20
Covered D Plan Paid Amount	$0	$0
Non-Covered Plan Paid Amount	$130	$80
Estimated Rebate at POS	N/A	$50

First, the Part D sponsor determines cost-sharing based on its own enhanced benefit design; the beneficiary co-payment which is $20 for this drug, is reported in Patient Pay Amount. Since this claim is for a non-Part D covered drug, the entire plan paid amount is reported in the NPP field and $0 is reported in the CPP field for both 2007 and 2008. For 2007, however, the estimated rebate amount of $50 is also reported in the NPP field because the drug is a non-Part D covered drug. Thus, in 2007 the Part D sponsor would report a total of $130 in the NPP field for this claim. For coverage year 2008, the NPP field would only include the plan paid amount ($80). The $50 estimated rebate amount is reported in the Estimated Rebate at POS field instead for coverage year 2008. In both coverage years, the actual rebate amount of $60 is excluded from the DIR Report for Payment Reconciliation. The EA plan includes rebates for non-covered drugs in its accounting for the supplemental premium.

Further Information
If you have questions about this guidance, please contact Meghan Elrington at (410) 786-8675.

CMS 2007 Low-Income Subsidy (LIS) Information and Reconciling LIS Status

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: January 23, 2007

To: All Part D Plan Sponsors

Subject: CMS 2007 Low Income Subsidy (LIS) Information and Reconciling LIS Status

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

CMS issued two memoranda dated December 6, 2006 regarding LIS status for 2007. These issuances directed plans to use the full enrollment file from December 14, 2006 to:

- Identify beneficiaries for whom LIS status had been defaulted and who had either lost LIS or have a less favorable status for 2007; and,
- Identify beneficiaries who became LIS eligible in 2007 and to whom an LIS Rider must be sent no later than January 31, 2007.

Subsequently, in a January 8, 2007 communication sent via the Health Plan Management System (HPMS), the CMS Office for Information Services (OIS) notified all Part D plan sponsors that, while the Full Enrollment Eligibility File transmitted on December 14, 2006 contained accurate enrollment data, the file may not have reflected all the beneficiaries in your plan who are eligible for LIS in 2007. Because of a timing issue, the updates to the 2007 LIS for less than 50,000 beneficiaries were not reflected in the file.

Thus, rather than relying on the December 14 file for definitive LIS information, plans were directed to refer to their December 20, 2006 Bi-Weekly LIS File, as well as their weekly Transaction Reply Reports (TRRs), all of which accurately reflect the plan's LIS beneficiaries, LIS effective dates, and subsidy data.

Consistent with the January 8 communication, plans should consult these latter reports to establish their members' current LIS status. The ongoing use of the bi-weekly LIS reports, full enrollment files, and weekly TRRs enables plans to identify members who become newly LIS eligible and to whom an LIS Rider must be sent. Furthermore, in the event that a member does not appear on CMS' LIS files, and your organization has evidence of that member's LIS eligibility consistent with CMS' 2007 best available data policy outlined in the December 6th, 2006 memo, plans are required to maintain that beneficiary's LIS status. Additional details about the 2007 best available data policy and procedures for correcting LIS levels are forthcoming.

We also want to take this opportunity to make sure you are aware that CMS is continuing the same protection against the late enrollment penalty for low income beneficiaries as was available last year. Therefore, beneficiaries who qualify for LIS can join a Part D plan at anytime

throughout 2007 without penalty. Finally, for those beneficiaries you identify who had deemed LIS status in 2006, but have lost deemed status for 2007, please encourage these individuals to apply for the low-income subsidy.

If you have any questions concerning best available data policy and reconciling LIS cost-sharing, please contact Deborah Larwood at 410-786-9500.

2007 Medicare Part D Low-Income Subsidy (LIS) Income and Resource Standards

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

TO: All Prescription Drug Plan Sponsors, Medicare Advantage Organizations, Cost Plans, and PACE and Demonstration Organizations

FROM: Anthony J. Culotta, Director
Medicare Enrollment and Appeals Group

DATE: January 23, 2006

SUBJECT: 2007 Medicare Part D Low-Income Subsidy (LIS) Income and Resource Standards

The purpose of this memorandum is to provide you with updated income and resource standards for individuals who apply for the low-income subsidy for Medicare Part D. CMS is required by law to update the Part D income and resource limits each year. Attached are tables illustrating the 2007 Federal Poverty Income Levels for the 48 States and the District of Columbia, Alaska, and Hawaii. We have also attached a description of the methodology that CMS used to update resource limits for 2007. (These were previously released to plans on December 20, 2006, but are attached here for convenience.) The new income and resource standards should be applied to all LIS applications filed on or after January 1, 2007.

If you have any questions about this information, contact Katherine Pokrzywa at (410) 786-5530 or katherine.pokrzywa@cms.hhs.gov.

Attachments (2)

ATTACHMENT 1

2007 POVERTY LEVEL GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

Income Guidelines as Published in the Federal Register on January 24, 2007

ANNUAL GUIDELINES

FAMILY	PERCENT OF POVERTY				
SIZE	100%	135%	140%	145%	150%
1	10,210.00	13,783.50	14,294.00	14,804.50	15,315.00
2	13,690.00	18,481.50	19,166.00	19,850.50	20,535.00
3	17,170.00	23,179.50	24,038.00	24,896.50	25,755.00
4	20,650.00	27,877.50	28,910.00	29,942.50	30,975.00
5	24,130.00	32,575.50	33,782.00	34,988.50	36,195.00
6	27,610.00	37,273.50	38,654.00	40,034.50	41,415.00
7	31,090.00	41,971.50	43,526.00	45,080.50	46,635.00
8	34,570.00	46,669.50	48,398.00	50,126.50	51,855.00

For family units of more than 8 members, add $3,480 for each additional member.

MONTHLY GUIDELINES

FAMILY	PERCENT OF POVERTY				
SIZE	100%	135%	140%	145%	150%
1	850.83	1,148.63	1,191.17	1,233.71	1,276.25
2	1,140.83	1,540.13	1,597.17	1,654.21	1,711.25
3	1,430.83	1,931.63	2,003.17	2,074.71	2,146.25
4	1,720.83	2,323.13	2,409.17	2,495.21	2,581.25
5	2,010.83	2,714.63	2,815.17	2,915.71	3,016.25
6	2,300.83	3,106.13	3,221.17	3,336.21	3,451.25
7	2,590.83	3,497.63	3,627.17	3,756.71	3,886.25
8	2,880.83	3,889.13	4,033.17	4,177.21	4,321.25

ATTACHMENT 1

2007 POVERTY LEVEL GUIDELINES

ALASKA

Income Guidelines as Published in the Federal Register on January 24, 2007

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	12,770.00	17,239.50	17,878.00	18,516.50	19,155.00
2	17,120.00	23,112.00	23,968.00	24,824.00	25,680.00
3	21,470.00	28,984.50	30,058.00	31,131.50	32,205.00
4	25,820.00	34,857.00	36,148.00	37,439.00	38,730.00
5	30,170.00	40,729.50	42,238.00	43,746.50	45,255.00
6	34,520.00	46,602.00	48,328.00	50,054.00	51,780.00
7	38,870.00	52,474.50	54,418.00	56,361.50	58,305.00
8	43,220.00	58,347.00	60,508.00	62,669.00	64,830.00

For family units of more than 8 members, add $4,350 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	1,064.17	1,436.63	1,489.83	1,543.04	1,596.25
2	1,426.67	1,926.00	1,997.33	2,068.67	2,140.00
3	1,789.17	2,415.38	2,504.83	2,594.29	2,683.75
4	2,151.67	2,904.75	3,012.33	3,119.92	3,227.50
5	2,514.17	3,394.13	3,519.83	3,645.54	3,771.25
6	2,876.67	3,883.50	4,027.33	4,171.17	4,315.00
7	3,239.17	4,372.88	4,534.83	4,696.79	4,858.75
8	3,601.67	4,862.25	5,042.33	5,222.42	5,402.50

ATTACHMENT 1

2007 POVERTY LEVEL GUIDELINES

HAWAII

Income Guidelines as Published in the Federal Register on January 24, 2007

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	11,750.00	15,862.50	16,450.00	17,037.50	17,625.00
2	15,750.00	21,262.50	22,050.00	22,837.50	23,625.00
3	19,750.00	26,662.50	27,650.00	28,637.50	29,625.00
4	23,750.00	32,062.50	33,250.00	34,437.50	35,625.00
5	27,750.00	37,462.50	38,850.00	40,237.50	41,625.00
6	31,750.00	42,862.50	44,450.00	46,037.50	47,625.00
7	35,750.00	48,262.50	50,050.00	51,837.50	53,625.00
8	39,750.00	53,662.50	55,650.00	57,637.50	59,625.00

For family units of more than 8 members, add $4,000 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	135%	140%	145%	150%
1	979.17	1,321.88	1,370.83	1,419.79	1,468.75
2	1,312.50	1,771.88	1,837.50	1,903.13	1,968.75
3	1,645.83	2,221.88	2,304.17	2,386.46	2,468.75
4	1,979.17	2,671.88	2,770.83	2,869.79	2,968.75
5	2,312.50	3,121.88	3,237.50	3,353.13	3,468.75
6	2,645.83	3,571.88	3,704.17	3,836.46	3,968.75
7	2,979.17	4,021.88	4,170.83	4,319.79	4,468.75
8	3,312.50	4,471.88	4,637.50	4,803.13	4,968.75

ATTACHMENT 2

Resource Limits for the Medicare Part D Low-Income Subsidy:
Annual Adjustment for 2007

To apply and qualify for the Part D low-income subsidy, Medicare beneficiaries must have resources no greater than the resource limits established by the Medicare Modernization Act (MMA). In 2006, to qualify for the full low-income subsidy, Medicare beneficiaries are required to have resources below or equal to $6,000 ($9,000 if married). Medicare beneficiaries are required to have resources below or equal to $10,000 ($20,000 if married) to qualify for other low-income subsidies. When determining whether a beneficiary qualifies for the Medicare Part D low income subsidy, $1,500 per person in resources are excluded from consideration if the beneficiary indicates that they expect to use some of their resources for burial expenses. Therefore, these resource limits are increased by $1,500 per person if the beneficiary expects to use some of their resources for burial expenses.

The MMA directs CMS to update the resource limits for the low-income subsidy each year. This notice provides: (i) the methodology for updating the resource limits, (ii) the 2007 low-income subsidy resource limits, and (iii) the 2007 cost-sharing for low-income subsidy eligible enrollees.

I. Calculation Methodology

Section 1860D-14(a)(3)(D) of the MMA requires CMS to use the annual percentage increase in the Consumer Price Index, All Urban Consumers (all items, U.S. city average) as of September of the previous year to update the resource limits for the low-income subsidy. CMS used the September, 2005 and the September, 2006 CPI values from the Bureau of Labor Statistics to calculate the annual percentage increase. The annual percentage increase in CPI for contract year 2007 is calculated as follows:

$$\frac{\text{September 2006 CPI}}{\text{September 2005 CPI}} \; or \; \frac{202.9}{198.8} = 1.0206$$

(Source: Bureau of Labor Statistics, Department of Labor)

Thus, the 2007 increase factor for the low-income subsidy resource limits is 2.06%. Per the statute, the resource limits are increased by 2.06% for 2007 and rounded to nearest multiple of $10. Therefore, the resource limit required for beneficiaries to qualify for the full low-income subsidy is increased from $6,000 ($9,000 if married) to $6,120 ($9,190 if married) for 2007. The resource limit required to qualify for partial low-income subsidies is increased from $10,000 ($20,000 if married) to $10,210 ($20,410 if married) for 2007.

II. Table of Resource Limits Used to Determine Eligibility for Low-Income Subsidy (LIS)

LIS Level	**Marital Status**	**2006 LIS Resource Limit***	**2007 LIS Resource Limit***
Full Subsidy LIS	Single	$7,500	$7,620
	Married	$12,000	$12,190
All Other LIS	Single	$11,500	$11,710
	Married	$23,000	$23,410

*These resource limits include $1,500 per person for burial expenses.

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Part D Plan Sponsor's Obligation to Reconcile State Pharmaceutical Assistance Program (SPAP) Claims

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: April 6, 2007

TO: Part D Plan Sponsors

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

SUBJECT: Part D Plan Sponsors' Obligation to Reconcile State Pharmaceutical Assistance Program (SPAP) Claims

The 402 Demonstration Project (State-to-Plan Reconciliation Project) was limited to the reconciliation of state claims for full benefit dual eligible beneficiaries and low-income subsidy-entitled beneficiaries for the first quarter of calendar year 2006. This memorandum serves as a reminder to Part D plan sponsors that they are obligated to work with State Pharmaceutical Assistance Programs (SPAPs) to coordinate benefits outside of the 402 Demonstration Project. Although the Centers for Medicare & Medicaid Services (CMS) does not have an accounting of the number of claims that require reconciliation between Part D plan sponsors and SPAPs outside of the State-to-Plan Reconciliation Project, SPAP sources estimate that there are potentially several million claims that fall into this category.

Under our regulations at 42 CFR § 423.464 and Chapter 14 of the Prescription Drug Benefit Manual on the coordination of benefits, Part D plans sponsors are required to reconcile the payment of claims with other payers, including SPAPs, when those payers have paid in the place of the Part D plan sponsor. Since there is no industry standard for a post point-of-sale adjudication process for reconciling claims among payers (excluding reversal and rebilling to pharmacies), this coordination has proved challenging. CMS is pleased that several Part D plan sponsors, despite technical challenges, have begun working with SPAPs to reconcile the non-demonstration claims. We remind all other Part D sponsors that they must coordinate benefits, regardless of when the claim is filed, and whether the claim's cost is submitted in time for 2006 payment reconciliation with CMS. While we are not enforcing the March 31, 2007 deadline for receipt and payment of certain claims by plans, we remind sponsors that they are still subject to established data submission deadlines to CMS. We note, however, that these deadlines do not place any limits on the SPAPs' ability to seek and obtain reimbursement from the Part D plans once those dates have passed.

In order to help facilitate the resolution of these claims, we have outlined a range of options (attached) to undertake the reconciliation process between SPAPs and Part D plan sponsors, without endorsing any particular approach over another. States and plan sponsors may also adopt other approaches, if agreed to by both parties. If you have not already begun working with SPAPs, it would be in your best interest to begin reconciliation quickly, since further delay in reconciliation may result in these claim costs not being included in your 2006 payment reconciliation. CMS is pleased to report that some of the suggested reconciliation approaches outlined below are already being actively pursued by SPAPs and Part D sponsors, with some reconciliation payments already made.

Further guidance regarding coordination of benefits is provided in Chapter 14. If you have questions regarding coordination of benefits, please contact Christine Hinds at (410) 786-4578.

Options	Background	Timeframe Required	Costs Involved
1. Contract with contractor used by Federal Government for the 402 Demonstration	For the demonstration, Public Consulting Group (PCG) has been customizing the claims files sent by States and SPAPs for each processor. Where processors require specific fields that were not included in the State data, PCG has worked with each processor to populate default values in those fields. If contracting with PCG, states can utilize this experience.	States may submit their claims files to PCG, and have their claims paid relatively quickly because of the processor-specific processes PCG has developed for the State-to-Plan demonstration. Processors will also be ready to receive these files because of the programming they have already put in place in order to adjudicate the demonstration claims.	States will be charged fees for using PCG or HMS. Plans can consider sharing these costs with SPAPs in order to minimize administrative costs and expedite resolution (in time to submit costs to CMS for 2006 reconciliation).
2. Contract with third party liability (TPL) contractor similar to ones currently used by Medicaid	There are a number of TPL contractors that have the processes in place to recover payments on behalf of the SPAP. Medicaid agencies contract with recovery agents to identify other payer liabilities for recovery. These recovery agents take the Medicaid mistakenly paid claims and customize them for processors in the same way pharmacy software does at the point-of-sale.	This option would not be expected to be as quick as Option 1. States may need to competitively bid the contract, unless this option can be accommodated under the State's Medicaid TPL contract. Additionally, Plans will need time to program their systems to receive and adjudicate these claims. For comparison, the time necessary for plan programming in the	Contractor will need to be reimbursed. (Proposed fees of between 4% and 9% of the recovered amount have been reported by SPAPs.) Plans will also incur costs for system programming. Plans can consider sharing these costs with SPAPs in order to minimize administrative costs and expedite resolution (in time to submit costs to CMS for 2006 reconciliation).

Options	Background	Timeframe Required	Costs Involved
		demonstration project has been six months.	
3. Submit claims in NCPDP batch 1.1 format directly to plans	States could use the NCPDP 1.1 batch format file layout that was used under the demonstration. Plans would have to establish either a secure file transfer protocol (SFTP) web site for these files, or, accept the files on other media (e.g. encrypted CD/DVD).	Similar to #2, Plans will need time to program their systems to receive and adjudicate these new files. Plans may have to discuss files and data issues with SPAP technical staff to resolve data and processing questions. This will be a time consuming process on the part of the plans, and expected to result in some delay in payment to the SPAPs.	Plans will incur the additional cost of programming to receive and process state files.
4. Submit paper claims	States would produce paper claims and send to plans through the plan COB contact.	Plans would require the time necessary to utilize their existing processes (largely manual) for entering and adjudicating manual claims. Discussions with SPAP technical staff may be required to resolve data and processing questions.	States would incur costs of producing paper claims. Plans would incur costs associated with manual data entry and problem resolution.
5. Other unique process between the state and plan	Another agreed upon process by both the plans and the state that would result in the reconciliation of state claims.	Unknown	Unknown

Prescription Drug Event (PDE) – Coordination of Benefits

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

Date: April 26, 2007

To: All Part D Plans

Subject: Prescription Drug Event (PDE) – Coordination of Benefits

From: Thomas Hutchinson, Director
Medicare Plan Payment Group

CMS requires Part D plans to coordinate benefits with non Part D payers and to submit Prescription Drug Event (PDE) records for these claims. We have received inquiries from plans asking how to report COB PDEs. The following memo provides instructions for reporting these claims prior to the issuance of updated PDE Instructions.

When reporting PDEs for benefit coordination claims, CMS instructs plans to submit the value of "P" in the Non-Standard Format Code field. Currently plans use this same value to report PDEs compiled from paper claims. Plans receive COB claims in several different ways including paper claims from beneficiaries and electronic transmissions in the NCPDP batch 1.1 format. At a later date CMS will create an additional Non-Standard Format Code value to uniquely identify COB claims.

In addition, plans should adjudicate COB claims in "order received", not Date of Service order. In "order received" processing plans apply cost-sharing based on the benefit phase on the date the claim was received. For example, assume a COB claim with a February 15 date of service was submitted on June 15. On February 15 the beneficiary was in the deductible phase of the benefit. On June 15 the beneficiary is in the initial coverage period (ICP). The plan applies ICP cost-sharing. By allowing plans to process in order received, CMS expects to minimize reordering and reprocessing of claims.

Please note that adjudication rules for a COB claim differ from rules for handling reversal claims. The COB claim is being processed for the first time. It has not yet impacted the beneficiary's progression through the benefit. In contrast, reversal claims may move the beneficiary back into an earlier benefit phase with different cost-sharing. CMS has issued separate guidance for processing reversal claims. Plans must have a process to assess the impact of a reversed claim and make corrections, as necessary, to ensure that they administered the benefit correctly. For additional information about reversal claims see the 2006 PDE Participant Guide, Module 4 - Calculating and Reporting the Basic Benefit and Module 5 - Calculating and Reporting True Out-Of-Pocket Costs (TrOOP).

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Status of 2006 Premium Withholding Reconciliation

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C4-23-07
Baltimore, Maryland 21244-1850
CENTER FOR BENEFICIARY CHOICES

DATE: May 4, 2007

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations

FROM: Thomas E. Hutchinson
Director, Medicare Plan Payment Group

SUBJECT: Status of 2006 Premium Withholding Reconciliation

During coverage year 2006 some beneficiaries in Social Security premium withholding status had incorrect amounts taken out of their benefit. In other cases correct amounts were withheld, but not forwarded in the CMS monthly plan payment. CMS previously noted the need for a complete beneficiary level reconciliation of premium amounts withheld from Social Security benefits in our January 26, 2007 memorandum to plans on premium withholding cleanups. We are taking this opportunity to update you on the progress of that effort.

To date, CMS has conducted a preliminary examination comparing the following: 1) "Expected Withholding" information extracted from MARx Premium Profile table; 2) "Actual Withholding" information loaded from the 2006 Social Security Administration monthly actual withholding files; and 3) "Paid information" from the Monthly Premium Withholding Extract (MPWE) files used to pay the plans. It was determined that the results of this analysis would be substantively impacted by the Enrollment Reconciliation described in more detail elsewhere.[1] Accordingly, CMS will wait until the 2006 Enrollment Reconciliation is complete before initiating the 2006 Premium Withholding Reconciliation (PWR). CMS will issue additional guidance on the PWR once our final analysis is complete.

Questions or comments should be addressed to either Mark Newsom at 410-786-3198 mark.newsom@cms.hhs.gov or Bobbie Knickman at 410-786-4161 bobbie.knickman@cms.hhs.gov

[1] See guidance release available online at:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/MemoEnrollmentReconUpdate_03.06.07.pdf

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Part D Premium Billing for "de minimis" Plans

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C4-23-07
Baltimore, Maryland 21244-1850
CENTER FOR BENEFICIARY CHOICES

DATE: May 24, 2007

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations

FROM: Abby L. Block, Director

SUBJECT: **Part D premium billing for "de minimis" plans**

CMS provided clarifying guidance on the "de minimis" premium policy in our October 27, 2006 memorandum[1] to plans. Under this policy all Part D plans, except enhanced alternative products and employer group waiver plans, are required to charge full-premium subsidy eligible beneficiaries a 2007 Part D monthly beneficiary premium equal to the applicable regional low-income premium subsidy amount, if the plan's beneficiary premium for basic prescription drug coverage exceeds the low-income premium subsidy amount by $2 or less ($1 for CY2008[2]). This policy has no impact on Part C or Part D supplemental premiums.

Definitions

For the purposes of this memorandum we are using the following definitions:

1) ***"de minimis" plan*** refers to any plan (excluding enhanced alternative plans and employer group waiver plans) with a Part D basic premium above the applicable regional low-income premium subsidy amount up to $2.

2) ***"de minimis" differential*** refers to the amount by which the "de minimis" plan's Part D basic premium exceeds the applicable regional low-income premium subsidy amount not exceeding the established threshold (e.g. $2 in CY2007).

3) ***"de minimis" amount*** refers to the threshold or maximum amount that the plan's Part D basic premium can exceed the regional low-income premium subsidy amount by ($2 for CY2007 and $1 for CY2008)

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[1] Available online at:
www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/MemoDeMinimisClarification_10.27.06.pdf
[2] Available online at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/PartDannouncement2008.pdf

De Minimis Premium Examples

	Part D Basic Premium	D Basic with 100% LIS	Part C premium	De minimis differential	Total premium for full LIS
PDP (basic plan)	$25.00	$0.00	Not applicable	$0.55	$0.00
MA-PD (basic D benefit)	$25.00	$0.00	$30	$0.55	$30

Examples based on a regional low-income premium subsidy amount that is $24.45 and a de minimis amount not to exceed $2.00

Part D low-income premium subsidy does not cover Part C or Part D supplemental premiums

Current implementation issues

Conceptually, the implementation issues for "de minimis" adjusted premiums are similar to those discussed in the March 8, 2007 memorandum entitled, "Social Security Premium Withholding and Secondary Coverage for Plan Premiums".[3] In other words, the "de minimis" policy represents a beneficiary level adjustment to plan premiums currently not accounted for in CMS and Social Security Administration calculations of premiums. This means that if a low-income member in a "de minimis" plan has selected Social Security Premium Withholding the "de minimis" amount will be deducted from that member's Social Security benefit.

If a full low-income member is in a stand alone "de minimis" PDP (i.e. with a basic premium only) the member has no premium to pay. Therefore, this member should not be in Social Security withholding status. In any other cases (e.g. a MA-PD with a Part C premium) where the member does have a premium to pay, the member is entitled to request Social Security withholding as a payment method. As CMS explained in the March 8, 2007 memorandum, this beneficiary right to Social Security withholding does not prohibit plans from encouraging the selection of direct bill status when appropriate. In this case, it should be explained to full low-income members of "de minimis" plans that if they select Social Security withholding the "de minimis" amount will be erroneously deducted from their Social Security benefit. If the member still chooses Social Security withholding the plan must refund the excess amounts.

Please note that if a plan has linked their direct billing process to MARx data they will erroneously be including the "de minimis" amount. "De minimis" plans should make certain that the appropriate reduction for full low-income members is made for the "de minimis" amount.

Next steps

CMS is working to develop new capabilities that will permit appropriate Social Security withholding for impacted members. CMS is also working to ensure that all applicable

[3] Available online at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/WithholdingandSecondaryCoverage_03.08.07.pdf

MARx reports account for the de minimis adjustment for applicable beneficiaries. Additional guidance will be released on this matter when this work is complete.

Questions concerning this matter should be addressed to either Meghan Elrington at (410) 786-8675 meghan.elrington@cms.hhs.gov or Mark Newsom at (410) 786-3198 mark.newsom@cms.hhs.gov

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Part D Payment Reconciliation

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C4-23-07
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CENTER FOR BENEFICIARY CHOICES

Date: June 7, 2007

To: ALL Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Other Interested Parties

From: Thomas Hutchinson
Director, Medicare Plan Payment Group

Subject: Payment Reconciliation System (PRS) Part D Payment Reconciliation Reports

As part of the yearly Part D payment reconciliation, plans active within the coverage year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing inputs and results of the reconciliation process for the coverage year. The PRS reports, the PRS Inputs Report to Plans and the PRS Reconciliation Results Report to Plans, will provide plans with information regarding the inputs and values used to calculate the three Part D payment reconciliations: the Low Income Cost-Sharing Subsidy (LICS) reconciliation, the reinsurance reconciliation, and the risk sharing reconciliation.

Questions regarding the PRS Part D Payment Reconciliation Reports should be directed to either Tara.Waters@cms.hhs.gov or Jeffrey.Grant@cms.hhs.gov.

Attachment

The Payment Reconciliation System (PRS) Part D Payment Reconciliation Reports

As part of the yearly Part D payment reconciliation, plans active within the coverage year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the reconciliation process for the coverage year. The layout and data elements in the reports, the PRS Inputs Report to Plans and the PRS Reconciliation Results Report to Plans, are explained here. To provide a framework for the PRS reports, an explanation of how the data elements within the reports operate in the Part D payment reconciliation calculations performed by the PRS is also outlined below.

The PRS Inputs Report to Plans provides plans with the beneficiary-level inputs received from the Medicare Advantage and Prescription Drug System (MARx) and the Drug Data Processing System (DDPS). These inputs provide data on the prospective payments and the actual payments made on behalf of a beneficiary. The PRS Inputs Report to Plans allows plans to validate the beneficiary-level inputs received from DDPS and MARx that will be used in their Part D payment reconciliation.

The PRS Reconciliation Results Report to Plans provides plan-level inputs received from the Health Plan Management System (HPMS), totaled plan-level inputs passed from the PRS Inputs Report to Plans, and the results of the three Part D payment reconciliations: the Low Income Cost-Sharing Subsidy (LICS) reconciliation, the reinsurance reconciliation, and the risk-sharing reconciliation. The PRS Reconciliation Results Report to Plans is meant to provide plans with all of the inputs plans would need to understand how their Part D payment reconciliation is calculated, in addition to the results of the Part D payment reconciliations and the final reconciliation adjustment amount.

The PRS Inputs Report To Plans

The PRS Inputs Report to Plans provides plans with the prospective payment and actual payment inputs at the beneficiary/plan-level from MARx and DDPS. Because a beneficiary could be in more than one contract and/or more than one Plan Benefit Package (PBP) within a contract within a specific coverage year, beneficiary/plan-level data indicates the beneficiary-level data for a specific plan only. In this document, beneficiary-level and beneficiary/plan-level are used interchangeably. Plan-level and contract/PBP-level are also used interchangeably.

PRS Inputs Report to Plans File Layout

The layout of the PRS Inputs Report to Plans follows a similar file structure as the DDPS management reports (Report 4, Reports 40-43) that plans are already receiving.

The PRS Inputs Report to Plans file contains a contract header (CHD) record, followed by a plan header (PHD) record which sets up cumulative reporting at both the contract-level and at the plan-level. The CHD and PHD records identify the contract and PBP,

respectively. Each has the file name on the record, allowing the distribution of reports at the contract-level, and a contract to treat plan-level reports as unique reports. The CHD record also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first to be run or if the reconciliation has been re-run.

The detail (DET) record provides the beneficiary/plan-level reporting. The DET record establishes the basic format for the rest of the file. It is important to note that on the DET record, beneficiaries are identified by their most current HICN as reported on the DDPS management files.

The plan trailer (PTR) record has the same basic layout as the DET record. However, in place of the beneficiary ID, there is a contract number and a PBP ID. This record will sum all of the amounts in each of the DET records for the contract/PBP. Table 1 provides the definitions and descriptions of the records in the PRS Inputs Report to Plans.

TABLE 1 - PRS INPUTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Plan-level file trailer	Occurs once per PHD on the file
CTR	Contract-level file trailer	Occurs once per CHD

PRS Inputs Report to Plans – Data Elements and Report Fields

Only beneficiary/plan-level information is present on the Inputs Report. Plan-level inputs needed to calculate reconciliation amounts are found on the PRS Reconciliation Results Report to Plans discussed in a later section.

P2P and Non-P2P Fields

The Inputs Report to Plans contains both Plan-to-Plan (P2P) amounts and non-P2P amounts for the following four fields: Actual Low Income Cost-Sharing Subsidy Amount (ALICSA), Gross Drug Cost Below the Out of Pocket Threshold Amount (GDCBA), Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA), and Covered Part D Plan Paid Amount (CPPA). These four fields represent data received from the Drug Data Processing System (DDPS). Table 2 provides the names and field locations on the DET record of the data elements which have both P2P and non-P2P amounts.

TABLE 2: P2P AND NON-P2P FIELDS ON PRS INPUTS REPORT

DATA ELEMENT	SHORT NAME	FIELD NUMBER		
		NON P2P	P2P	TOTAL
ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	4	5	6
GROSS DRUG COST BELOW THE OUT OF POCKET THRESHOLD	GDCBA	8	9	10
GROSS DRUG COST ABOVE THE OUT OF POCKET THRESHOLD	GDCAA	11	12	13
COVERED PART D PLAN PAID AMOUNT	CPPA	14	15	16

The P2P amounts represent amounts paid for which the plan was not the submitting plan. Since the Plan of Record (POR) has repaid the submitting plan during the P2P process, the P2P amounts incurred will be on the POR's reconciliation. Plans will only be reconciled for amounts incurred when they are the POR.

PRS sums the P2P and non-P2P amounts for these fields at the beneficiary-level. The beneficiary/plan-level sums of these four fields are on the DET record and are aggregated to the plan and contract levels in the Inputs Report. Plans should also refer to the DDPS Management Report 4 COV and Report 42 for the non-P2P and P2P amounts for these fields. Prior to reconciliation, CMS will release Report 4 COV and Report 42 with the coverage year's cumulative results as they will be used in the Part D reconciliation. These reports are critical for the plan to review and refer to in understanding their Part D payment reconciliation.

PRS Reconciliation Results Report To Plans

The PRS Reconciliation Results Report to Plans provides plans with the results of the three Part D payment reconciliations and the final reconciliation payment adjustment amount. The Results Report also provides the contract/PBP-level inputs received from HPMS and the totaled plan-level inputs from DDPS that are necessary for plans to understand how their Part D payment reconciliation is calculated.

The PRS Reconciliation Results Reports to Plans File Layout

The PRS Reconciliation Results Report to Plans file layout is similar to that of the PRS Inputs Report, but there are key differences. The Results Report file begins with the CHD record. In the Results Report, there are no beneficiary-level records; the DET record in the Results Report provides the reconciliation results at the contract/PBP-level. As with the Inputs Report, each report also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first run for the coverage year or if the reconciliation has been re-run. Table 3 provides the definitions and descriptions of the records in the PRS Reconciliation Results Report to Plans.

TABLE 3 - PRS RECONCILIATION RESULTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
DET	Detail records at the plan-level for the report	Occurs 1 to many times per CHD record
CTR	Contract-level file trailer	Occurs once per CHD

The CTR record provides reconciliation results summarized to the contract level and represents the activity of all PBPs under one contract number. It is important to note here that the totals in this CTR record are not the totals used for any Part D payment reconciliation. All payment reconciliation is at the contract/PBP-level which is reported in the DET record. The CTR record may provide a useful contract-level summary, but will not directly impact any payment calculation.

Inputs on the Results Report

Inputs Report Fields Passed to the Results Report
Certain fields from the Inputs Report are carried through to the Reconciliation Results Report. The elements passed are summed to the contract/PBP-level on the PRS Inputs Report PTR record. The data elements that are passed from the Inputs Report to the Results Report are values that are necessary inputs into the payment reconciliation calculations PRS performs. For example, the plan-level Total Actual Low Income Cost-Sharing Subsidy Amount (ALICSA) and the plan-level Prospective Low Income Cost-

Sharing Subsidy Amount (PLICSA) are the only data elements used to calculate the LICS Reconciliation Adjustment Amount (LICSAA) and therefore, are passed to the Results Report from the Inputs Report. Other data elements passed from the Inputs Report to the Results Report also comprise values in the Part D payment reconciliation calculations. These data elements are shown in Table 4.

TABLE 4: DATA ELEMENTS PASSED FROM THE PRS INPUTS REPORT TO THE PRS RESULTS REPORT

DATA ELEMENT	SHORT NAME	SOURCE SYSTEM
TOTAL ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	DDPS
TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	GDCBA	DDPS
TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	GDCAA	DDPS
TOTAL COVERED PART D PLAN PAID AMOUNT	CPPA	DDPS
PROSPECTIVE LOW INCOME COST-SHARING SUBSIDY AMOUNT	PLICSA	MARx
PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	PRSA	MARx
PART D BASIC PREMIUM AMOUNT	PA	MARx
DIRECT SUBSIDY AMOUNT	DSA	MARx
PACE COST-SHARING ADD-ON AMOUNT	PCAA	MARx

Plan-level HPMS Inputs

Plan-level inputs needed to calculate reconciliation amounts are only found on the PRS Reconciliation Results Report to Plans. These plan-level inputs are HPMS inputs and include: the Part D Covered DIR Amount, the Administrative Cost Ratio, and the Induced Utilization Ratio (for Enhanced Alternative plans only). The Part D Covered DIR Amount is adjusted within HPMS to account for the Part D Covered Incentive Payment Amount prior to being passed to PRS. These data elements are show in Table 5.

TABLE 5: HPMS PLAN-LEVEL INPUTS FOUND ON THE PRS RECONCILIATION RESULTS REPORT TO PLANS

DATA ELEMENT	SHORT NAME
PART D COVERED DIR AMOUNT	DDIRA
ADMINISTRATIVE COST RATIO	ACR
INDUCED UTILIZATION RATIO	IUR

Program Level CMS Inputs
The last set of reconciliation inputs that are found in the Results Report are CMS provided, program-wide data elements. These fields are necessary to perform the risk sharing portion of reconciliation. The values for these data elements will be the same for all plans that participate in risk sharing. CMS provided, program-wide inputs are shown in Table 6.

TABLE 6: CMS PROVIDED PROGRAM LEVEL INPUTS ON THE PRS RESULTS REPORT TO PLANS

DATA ELEMENT	SHORT NAME
FIRST UPPER THRESHOLD PERCENT	FUTP
SECOND UPPER THRESHOLD PERCENT	SUTP
FIRST LOWER THRESHOLD PERCENT	FLTP
SECOND LOWER THRESHOLD PERCENT	SLTP
FIRST UPPER RISK SHARING RATE	FURSR
SECOND UPPER RISK SHARING RATE	SURSR
FIRST LOWER RISK SHARING RATE	FLRSR
SECOND LOWER RISK SHARING RATE	SLRSR

Payment Reconciliation Plan Type Code
The Payment Reconciliation Plan Type Code (PRPTC) indicates which of the three reconciliations (LICS, reinsurance, and risk sharing) a plan may participate in and how those reconciliations will be calculated. The PRS contains a decision process to determine Payment Reconciliation Plan Type Code which considers the HPMS Plan Benefit Package Type Code (PBPTC), among other plan type flags and indicators to arrive at one of 14 distinct PRS reconciliation plan types. See Table 7 for a list of the PRS plan types and their allowed reconciliations.

TABLE 7: PART D PLANS AND ALLOWED RECONCILIATION CALCULATIONS

Payment Reconciliation Plan Types	Unique PRS Plan Type Code	LICS Reconciliation	Reinsurance Reconciliation	Risk Corridor Analysis
Defined Standard Benefit Plan*	1	Yes	Yes	Yes
Actuarially Equivalent Plan*	2	Yes	Yes	Yes
Basic Alternative Plan*	3	Yes	Yes	Yes
Enhanced Alternative Plan*	4	Yes	Yes	Yes
Employer Group Waiver Plan (EGWP) Calendar Year	5	Yes	Yes	No
Employer Group Waiver Plan (EGWP) Non-Calendar Year	6	Yes	No	No
Dual-eligible PACE Plan	7	Yes	Yes	Yes
Medicare-only PACE Plan	8	Yes	Yes	Yes
Flexible Capitated Payment Demonstration Option	9	Yes	No	Yes
Fixed Capitated Payment Demonstration Option	10	Yes	No	Yes
MA Rebate Payment Demonstration Option	11	Yes	Yes	Yes
Non-Payment Demonstration Private Fee-for-Service (Non-Demo PFFS)	12	Yes	Yes	No
Limited Risk	13	Yes	Yes	Yes
Fallback	99	TBD	TBD	TBD

* **Mutually exclusive of all other plan types.**

Note: All plans are required to bid as one of the four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative), but if the plan also falls into another category in addition to the HPMS PBP Type Code, such as a payment demonstration or an employer group, for PRS and reconciliation purposes, that is the designation to which the plan is assigned.

All PRS plan types participate in LICS reconciliation. Non-Calendar Year Employer Group Waiver Plans and Fixed and Flexible Capitated Payment Demonstration Plans do

not receive reinsurance reconciliation. Calendar Year and Non-Calendar Year Employer Group Waiver Plans and Non-Payment Demonstration Private Fee-For-Service Plans do not participate in risk sharing. During the 2006 reconciliation process, CMS will calculate the reinsurance subsidy for Non-Payment Demonstration Private Fee-for-Service (Non-Demo PFFS) plans using the same methodology used to determine the reinsurance subsidy for MA-PD plans.[1]

PRS Payment Calculations, Interim Calculated Values, and Reconciliation Results

This section provides an explanation of how the various inputs identified on the Inputs Report and on the Results Report operate within the PRS reconciliation calculations. In addition to values received from source systems, the Reconciliation Results Report to Plans has PRS interim calculated values used in the reinsurance and risk sharing reconciliations. More information on the PRS interim calculated values can be found in the sections below.

More importantly, this section explains how the three Part D payment reconciliation calculations operate within the PRS and how the inputs and interim calculated values operate within the calculations to provide plans with the final reconciliation values for the three Part D payment reconciliations (LICS reconciliation, reinsurance reconciliation, and risk sharing reconciliation) and the final reconciliation payment adjustment value, the Adjustment Due to Payment Reconciliation Amount (ARA). This section explains how PRS arrives at the these final reconciliation values and tells plans where to find specific values on the plan-level DET record of the Results Report.

Low Income Cost-Sharing Subsidy (LICS) Reconciliation:

The LICS reconciliation is the most straightforward of the reconciliations. In the LICS reconciliation, prospective payments are compared to actual payments to determine the Low Income Cost-Sharing Subsidy Adjustment Amount (LICSAA). The values that go into the LICS reconciliation calculations are totaled DDPS and MARx values passed from the Inputs Report to the Results Report. No calculated interim PRS values are used in the LICS reconciliation:

$$LICSAA=ALICSA-PLICSA$$

The Actual Low Income Cost-Sharing Subsidy Amount minus the Prospective Low Income Cost-Sharing Subsidy Amount provides the Low Income Cost-Sharing Subsidy Adjustment Amount.

[1] After initial reconciliation payments have been made, CMS will conduct analysis to determine how closely the reinsurance payments made to PFFS plans approximate the reinsurance payments that they would have received if they were MA-PD plans with populations of similar risk. If appropriate, CMS may adjust the reinsurance subsidies paid PFFS plans to more accurately reflect the reinsurance subsidies they would have received as MA-PD plans with populations of similar risk.

The Low Income Cost-Sharing Subsidy Adjustment Amount is Field 9 on the PRS Reconciliation Results Report to Plans DET record. This amount can be positive or negative.

Reinsurance Reconciliation:

As with the LICS reconciliation, the reinsurance reconciliation compares the Prospective Reinsurance Subsidy Amount to the Actual Reinsurance Subsidy Amount to determine the Reinsurance Subsidy Adjustment Amount (RSAA). Calculating the reinsurance subsidy reconciliation is a 5 step process. PRS uses GDCAA and GDCBA values from DDPS and the Prospective Reinsurance Subsidy Amount (PRSA) from MARx which are passed to the Results Report from the Inputs Report as totaled plan-level values.

PRS uses these values to determine the interim calculated values, such as the Reinsurance DIR Ratio (RDIRR), the Reinsurance Portion of DIR Amount (RPDIRA), the Allowable Reinsurance Cost Amount (ARCA), and the Actual Reinsurance Subsidy Amount (ARSA), used in the reinsurance reconciliation calculations and which are further explained below:

1. **The first step in determining the reinsurance reconciliation is to calculate the Reinsurance DIR Ratio (RDIRR).** The Total Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA) is divided by total drug costs (the sum of GDCAA and the Total Gross Drug Cost Below the Out-of-Pocket Threshold Amount (GDCBA)) to determine RDIRR, the Part D Direct and Indirect Remuneration Ratio. (RDIRR is a PRS interim calculated value and is found on Field 12 of the DET record on the PRS Reconciliation Results Report to Plans).

   RDIRR=GDCAA/(GDCAA+GDCBA)

2. **The second step is to calculate the Reinsurance Portion of DIR Amount (RPDIRA)**. The DIR ratio is multiplied by the Part D Covered DIR Amount (DDIRA) which is a contract/PBP-level value received from HPMS, and identified on the Results Report, to produce the Reinsurance Portion of DIR. (RPDIRA is a PRS interim calculated value and is found on Field 14 of the DET record on the PRS Reconciliation Results Report to Plans.)

   RPDIRA=RDIRR x DDIRA

3. **In the third step, PRS calculates the allowable reinsurance cost (ARCA).** The Reinsurance Portion of DIR is subtracted from the Total Gross Drug Cost Above the Out of Pocket Threshold to determine the Allowable Reinsurance Cost Amount. (ARCA is a PRS interim calculated value in Field 15 of the DET record on the PRS Reconciliation Results Report to Plans.)

   ARCA=GDCAA-RPDIRA

4. **In the fourth step, PRS determines the Actual Reinsurance Subsidy Amount (ARSA).** The Allowable Reinsurance Cost Amount is multiplied by .8 to determine the Actual Reinsurance Subsidy Amount. (ARSA is found in Field 16 of the DET record on the PRS Reconciliation Results Report to Plans.)

   ARSA=ARCA x 0.80

5. **In the fifth step, the reinsurance subsidy is reconciled to determine the Reinsurance Subsidy Adjustment Amount (RSAA).** The Reinsurance Subsidy Adjustment Amount is determined by subtracting the Prospective Reinsurance Subsidy Amount received from MARx and identified on the Inputs Report from the Actual Reinsurance Subsidy Amount (ARSA).

   RSAA=ARSA-PRSA

The Reinsurance Subsidy Adjustment Amount is Field 18 on the PRS Reconciliation Results Report to Plans DET Record. This amount can be positive or negative.

Risk Sharing Reconciliation:

Calculating the risk sharing reconciliation is a more involved process than the previous two reconciliations. Most of the risk sharing reconciliation is performed at the plan-level with the exception of the 60/60 rule calculation portion which is conducted at the program level. There are essentially five steps to calculate risk sharing:

1. Calculate the plan's Target Amount (TA).
2. Calculate the risk threshold amounts.
3. Calculate the Adjusted Allowable Risk Corridor Cost Amount (AARCCA).
4. Determine if the 60/60 rule applies (for years 2006 and 2007 only).
5. Determine where costs fall with respect to the thresholds and calculate payment adjustment.

Essentially, the purpose of the risk sharing reconciliation is to perform a comparison of the Target Amount, the total projected revenue necessary for the basic benefit (reduced for administrative costs) and the Adjusted Allowable Risk Corridor Cost Amount which represents actual costs that have been adjusted to determine if there is any risk sharing.

The risk sharing reconciliation uses the Direct Subsidy Amount (DSA), the Part D Basic Premium Amount (PA), the Administrative Cost Ratio (ACR), the Pace Cost Sharing Add-on Amount (PCAA), the Covered Part D Plan Paid Amount (CPPA), the Direct and Indirect Remuneration Amount (DIRRA), and the Induced Utilization Amount (IUR) from DDPS, MARx, and HPMS to calculate the interim values needed for the risk sharing reconciliation.

1. **The first step is to calculate the plan's Target Amount (TA).** The Direct Subsidy Amount and the Part D Basic Premium Amount are summed and then adjusted by the Administrative Cost Ratio to determine the TA, the first PRS calculated value used in the risk sharing calculations. For plan type 7, the Pace Cost-sharing Add-on Amount (PCAA) is added to that amount. For plan types 9 and 10, the Prospective Reinsurance Subsidy Amount (PRSA) is added. Note: The reconciliation calculations are using the Direct Subsidy as it relates to the risk adjusted standardized bid minus the beneficiary premium and the A/B rebates.

   TA = (DSA+PA) x (1-ACR)

   For PRS plan type 7 (Dual Eligible PACE plan), then

   TA = (DSA+PA) x (1-ACR) + PCAA

   For PRS plan type 9 or 10 (Flexible Capitated Payment Demonstration or Fixed Capitated Payment Demonstration), then

   TA = (DSA+PA) x (1-ACR) + PRSA

2. **The second step is to calculate the risk corridor thresholds.** The Target Amount is multiplied by the threshold risk percentages (the First Upper Threshold Percent, Second Upper Threshold Percent, First Lower Threshold Percent, Second Lower Threshold Percent) provided by CMS to determine the First Upper Threshold Amount (FUTA), the Second Upper Threshold Amount (SUTA), the First Lower Threshold Amount (FLTA), and the Second Lower Threshold Amount (SLTA).

   FUTA = FUTP x TA

   SUTA = SUTP x TA

   FLTA = FLTP x TA

   SLTA = SLTP x TA

3. **In the third step, the PRS calculates the Adjusted Allowable Risk Corridor Cost Amount (AARCCA).** The Actual Reinsurance Subsidy Amount (ARSA) and the Part D DIR Amount (DDIRA) are subtracted from the Covered Part D Plan Paid Amount (CPPA). This amount is adjusted by the Induced Utilization Ratio (IUR). Note: The Induced Utilization Ratio is set to 1 for all plans except EA plans. For EA plans, including payment demonstrations, the HPMS IUR value will be used which will be equal to or greater than 1.

   AARCCA = (CPPA – ARSA – DDIRA)/IUR

4. **In the fourth step, the PRS determines if the 60/60 rule applies.** When the 60/60 rule is applicable, at least 60 percent of Part D plans subject to risk sharing have AARCCA above the First Upper Threshold Amount and those plans represent at least 60 percent of Part D enrollees. If the 60/60 rule is applicable *and* if CMS chooses to utilize it, then the government will increase the risk sharing percentage between the First Threshold Upper Limit and the Second Threshold Upper Limit from 75 percent to 95 percent. The 60/60 Rule Met Indicator in Field 27 on the Results Report will report ***Y*** for Yes or ***N*** for No to indicate whether the 60/60 rule applies.

   The Cost Over First Upper Threshold Indicator, Field 36 on the Results Report, denotes whether an individual plan's AARCCA is over the First Upper Threshold Amount. This field will report either a ***0*** *for No or a* ***1*** *for Yes.*

5. **In the last step, PRS determines where costs fall with respect to the thresholds and calculates payment adjustment.** The Adjusted Allowable Risk Corridor Costs are matched against the thresholds to determine where costs fall and to calculate the Risk Sharing Adjustment. The risk sharing rates (the First Upper Risk Sharing Rate, Second Upper Risk Sharing Rate, First Lower Risk Sharing Rate, Second Lower Risk Sharing Rate) are applied, as appropriate. The Risk Sharing Adjustment (RA) is the last calculated PRS value in the risk sharing reconciliation.

   If FUTA < AARCCA < or = SUTA then
   RA = FURSR x (AARCCA – FUTA)

   If SUTA < AARCCA then
   RA = [FURSR x (SUTA - FUTA)] + [SURSR x (AARCCA - SUTA)]

   If FLTA > AARCCA > or = SLTA then
   RA = FLRSR x (AARCCA - FLTA)

   If SLTA > AARCCA then
   RA = [FLRSR x (SLTA - FLTA)] + [SLRSR x (AARCCA - SLTA)]

   If FUTA > or = AARCCA > or = FLTA then
   RA = 0

On the PRS Reconciliation Results Report to Plans, there are two fields that indicate the contributions to the Risk Sharing Amount (RA), the Risk Sharing Portion from Costs Beyond the Second Limit, Field 42, and the Risk Sharing Portion from Costs Between the First and Second Limits, Field 43. The first field indicates the contribution to the Risk Sharing Amount from plan costs beyond either the Second Upper Threshold Amount or the Second Lower Threshold Amount. The second field indicates the contribution to the Risk Sharing Amount from plan costs between the First and Second Threshold Amounts. These fields are signed and will be used to show any positive contributions to risk

sharing or negative contributions to risk sharing. Positive values and negative values in these fields are mutually exclusive. In other words, a plan will not have a positive value in one and a negative value in the other.

The Risk Sharing Amount is Field 41 on the PRS Reconciliation Results Report to Plans DET Record. This amount can be positive or negative.

The Final Reconciliation Payment Adjustment

The Adjustment Due to Payment Reconciliation Amount (ARA) is the last field found on the DET record of the PRS Reconciliation Results Report to Plans. This amount is the net reconciliation amount for the plan for the coverage year. The following fields identified in Table 8 are used to calculate the final reconciliation payment adjustment amount:

TABLE 8: PART D RECONCILIATION ADJUSTMENT AMOUNTS AND FIELD LOCATIONS

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost-Sharing Subsidy Amount	Field 9
+	**Reinsurance Subsidy Adjustment Amount**	Field 18
+	**Risk Sharing Amount**	Field 41
–	**Budget Neutrality Adjustment Amount (Demonstration Plans Only)**	Field 46
=	**Adjustment Due to Payment Reconciliation Amount**	Field 47

The first three fields are critical for the plans because they represent the final reconciliation amounts for LICS, reinsurance, and risk sharing. The adjustment due to reconciliation amount is the total of the three reconciliations (LICS, reinsurance, and risk sharing/risk corridor) minus the Budget Neutrality Adjustment Amount (BNAA, Field 46). The BNAA applies only for demonstration plans and is the product of unique member per year (UMPY) and the Annual Budget Neutrality Dollar Amount (ABNDA).

ARA = LICSAA + RSAA + RA – BNAA

The ARA is summed to the contract-level for all plans in a contract. This value can be found in the CTR record in the Results Report. However, since the Part D payment reconciliation is conducted at the plan level, the Adjustment Due to Payment Reconciliation Amount (ARA) is calculated at the contract/PBP-level.

The Adjustment Due to Payment Reconciliation Amount is Field 47, the last field found on the DET record of the PRS Reconciliation Results Report to Plans. This amount can be positive or negative.

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REPORTS

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PDFS Response Report

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PDFS RESPONSE REPORT
EXAMPLE OF REJECTED PDFS RESPONSE REPORT

```
[1]REPORT: PDFS-RESP                [2]PRESCRIPTION DRUG FRONT END SYSTEM
[3]RUN DATE: 20060513                        PDFS RESPONSE REPORT

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

[7]         [8]        [9]
RECORD   SEQ        ERROR      [10]
TYPE        NO        CODE       ERROR DESCRIPTION
HDR                   132        FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE
                                 THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.
END OF REPORT
*****END OF TRANSMISSION*****
```

FIELD NO.	FIELD NAME	FIELD DESCRIPTION
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Report Date	Date the report was generated by Palmetto (CCYYMMDD format).
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one plan. A different report is generated for each plan.
5	File ID	The 10-digit file identification number.
6	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST or PRODUCTION.
7	Record Type	Identifies the level of the error (File, Batch, or Detail record level).
8	Sequence Number	Identifies the batch or detail-level record where the error occurred.
9	Error Code	Identifies the 3-digit error code that caused the file to reject.
10	Error Code Description	Explains the error code.

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DDPS Return File

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DDPS RETURN FILE

RECORD DEFINITION/DESCRIPTION

RECORD ID	RECORD DEFINITION	NOTES
HDR	File header created by the Submitter	Occurs once per file. In addition to all fields from the submitted HDR, includes the following: DDPS-SYSTEM-DATE (positions 32-39) DDPS-SYSTEM-TIME (positions 40-45) DDPS-REPORT-ID (positions 46-50)
BHD	Contract/PBP level file header created submitter	Occurs once per Contract/PBP on file. In addition to all fields from the submitted BHD, includes the following: DDPS-SYSTEM-DATE (positions 19-26) DDPS-SYSTEM-TIME (positions 27-32) DDPS-REPORT-ID (positions 33-37)
ACC*	Accepted PDE records written by DDPS	All fields from ACC records.
INF*	Informational PDE records written by DDPS	All fields from DET records with information data and edit codes appended in fields 49-58 (positions 468-497).
REJ*	Reject PDE records written by DDPS	All fields from DET records with information data (if applicable) and error codes appended in fields 49-58 (positions 468-497).
BTR	Contract/PBP level file trailer created by submitter (modified by DDPS)	Occurs once per each BHD on the file. Contains all fields from submitted BTR (including counts of original number of DET records) plus ACC, INF, and REJ record counts.
TLR	File trailer created by submitter (modified by DDPS)	Occurs once per each HDR on the file. Contains all fields from submitted TLR (including counts of original number of DET records) plus ACC, INF, and REJ record counts.

* ACC, INF and REJ records will be sorted by sequence number and appear in the same sequence as on the submitted file.

HDR RECORD

FIELD NO.	COPYBOOK FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD-ID	1 - 3	X(3)	3	"HDR"
2	SUBMITTER-ID	4 - 9	X(6)	6	Unique ID assigned by CMS.
3	FILE-ID	10 - 19	X(10)	10	Unique ID provided by Submitter.
4	TRANS-DATE	20 - 27	9(8)	8	Date of file transmission to PDFS.
5	PROD-TEST-CERT-IND	28 - 31	X(4)	4	TEST, PROD, or CERT
6	DDPS-SYSTEM-DATE	32 - 39	9(8)	8	CCYYMMDD = DDPS file creation date
7	DDPS-SYSTEM-TIME	40 - 45	9(6)	6	HHMMSS = DDPS file creation time
8	DDPS-REPORT-ID	46 - 50	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
9	FILLER	51 - 512	X(462)	462	SPACES

DDPS RETURN FILE (CONTINUED)

BHD RECORD

FIELD NO.	COPYBOOK FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD-ID	1 - 3	X(3)	3	"BHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract Number from submitted batch
4	PBP-ID	16 - 18	X(3)	3	Plan Benefit Package (PBP) ID
5	DDPS-SYSTEM-DATE	19 - 26	9(8)	8	CCYYMMDD = DDPS file creation date
6	DDPS-SYSTEM-TIME	27 - 32	9(6)	6	HHMMSS = DDPS file creation time
7	DDPS-REPORT-ID	33 - 37	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
8	FILLER	38 - 512	X(475)	475	SPACES

ACC/INF/REJ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION/VALUES*
1	RECORD-ID	1 - 3	X(3)	3	"ACC", "INF" or "REJ"
2	SEQUENCE-NO	4 - 10	9(7)	7	
3	CLAIM-CONTROL-NUMBER	11 - 50	X(40)	40	
4	HEALTH-INSURANCE-CLAIM-NUMBER-(HICN)	51 - 70	X(20)	20	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER-ID	71 - 90	X(20)	20	Plan identification of the enrollee. Assigned by plan.
6	PATIENT-DATE-OF-BIRTH-(DOB)	91 - 98	9(8)	8	CCYYMMDD
7	PATIENT-GENDER	99 - 99	9(1)	1	1 = M 2 = F
8	DATE-OF-SERVICE-(DOS)	100 - 107	9(8)	8	CCYYMMDD
9	PAID-DATE	108 - 115	9(8)	8	CCYYMMDD
10	PRESCRIPTION-SERVICE-REFERENCE-NO	116 - 124	9(9)	9	
11	FILLER	125 - 126	X(2)	2	SPACES
12	PRODUCT-SERVICE-ID	127 - 145	X(19)	19	
13	SERVICE-PROVIDER-ID-QUALIFIER	146 - 147	X(2)	2	
14	SERVICE-PROVIDER-ID	148 - 162	X(15)	15	
15	FILL-NUMBER	163 - 164	9(2)	2	
16	DISPENSING-STATUS	165 - 165	X(1)	1	
17	COMPOUND-CODE	166 - 166	9(1)	1	

DDPS RETURN FILE (CONTINUED)

ACC/INF/REJ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES*
18	DISPENSE-AS-WRITTEN-(DAW)-PRODUCT-SELECTION-CODE	167 - 167	X(1)	1	
19	QUANTITY-DISPENSED	168 - 177	9(7)V999	10	
20	DAYS-SUPPLY	178 - 180	9(3)	3	
21	PRESCRIBER-ID-QUALIFIER	181 - 182	X(2)	2	
22	PRESCRIBER-ID	183 - 197	X(15)	15	
23	DRUG-COVERAGE-STATUS-CODE	198 - 198	X(1)	1	
24	ADJUSTMENT-DELETION-CODE	199 - 199	X(1)	1	
25	NON--STANDARD-FORMAT-CODE	200 - 200	X(1)	1	
26	PRICING-EXCEPTION-CODE	201 - 201	X(1)	1	
27	CATASTROPHIC-COVERAGE-CODE	202 - 202	X(1)	1	
28	INGREDIENT-COST-PAID	203 - 210	S9(6)V99	8	
29	DISPENSING-FEE-PAID	211 - 218	S9(6)V99	8	
30	AMOUNT-ATTRIBUTED-TO-SALES-TAX	219 - 226	S9(6)V99	8	
31	GROSS-DRUG-COST-BELOW-OUT-OF-POCKET-THRESHOLD-(GDCB)	227 - 234	S9(6)V99	8	
32	GROSS-DRUG-COST-ABOVE-OUT-OF-POCKET-THRESHOLD-(GDCA)	235 - 242	S9(6)V99	8	
33	PATIENT-PAY-AMOUNT	243 - 250	S9(6)V99	8	
34	OTHER-TROOP-AMOUNT	251 - 258	S9(6)V99	8	
35	LOW-INCOME-COST-SHARE-SUBSIDY-AMOUNT-(LICS)	259 - 266	S9(6)V99	8	
36	PATIENT-LIABILITY-REDUCTION-DUE-TO-OTHER-PAYER-AMOUNT-(PLRO)	267 - 274	S9(6)V99	8	
37	COVERED-D-PLAN-PAID-AMOUNT-(CPP)	275 - 282	S9(6)V99	8	
38	NON-COVERED-PLAN-PAID-AMOUNT-(NPP)	283 - 290	S9(6)V99	8	
39	ESTIMATED REBATE AT POS	291 - 298	S9(6)V99	8	
40	VACCINE ADMINISTARATION FEE	299 - 306	S9(6)V99	8	
41	FILLER	307 - 415	X(108)	108	SPACES

DDPS RETURN FILE (CONTINUED)

ACC/INF/REJ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES*
42	PBP OF RECORD*	416 - 418	X(3)		SPACES
43	ALTERNATE SERVICE PROVIDER ID QUALIFIER*	419 – 420	X(2)		SPACES
44	ALTERNATE SERVICE PROVIDER ID*	421 – 435	X(15)		SPACES
45	ORIGINAL SUBMITTING CONTRACT*	436 – 440	X(5)		SPACES
46	P2P CONTRACT-OF-RECORD	441 - 445	X(5)	5	The contract number of the Plan of Record
41	CORRECTED-HICN	446 – 465	X(20)	20	Current HICN provided by MBD during editing – informational
42	ERROR-COUNT	466 - 467	9(2)	2	Value between 00 and 11. If DDPS generates more than 10 edits during processing, this field will read 11
43	ERROR-1	468 - 470	X(3)	3	Error code from DDPS
44	ERROR-2	471 - 473	X(3)	3	Error code from DDPS
45	ERROR-3	474 - 476	X(3)	3	Error code from DDPS
46	ERROR-4	477 - 479	X(3)	3	Error code from DDPS
47	ERROR-5	480 - 482	X(3)	3	Error code from DDPS
48	ERROR-6	483 - 485	X(3)	3	Error code from DDPS
49	ERROR-7	486 - 488	X(3)	3	Error code from DDPS
50	ERROR-8	489 - 491	X(3)	3	Error code from DDPS
51	ERROR-9	492 - 494	X(3)	3	Error code from DDPS
52	ERROR-10	495 - 497	X(3)	3	Error code from DDPS
53	FILLER	498 - 512	X(15)	15	SPACES

* Most fields will be exactly as submitted by the plan. See PDE Record Layout and PDE file submission instructions for detailed descriptions of any fields that have no descriptions provided here.

BTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"BTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must match BHD
3	CONTRACT-NO	11 - 15	X(5)	5	Must match BHD
4	PBP-ID	16 - 18	X(3)	3	Must match BHD
5	DET-RECORD-TOTAL	19 - 25	9(7)	7	Total count of DET records
6	DET-ACCEPTED-RECORD-TOTAL	26 - 32	9(7)	7	Total count of ACC records as determined by DDPS processing
7	DET-INFORMATIONAL-RECORD-TOTAL	33 - 39	9(7)	7	Total count of INF records as determined by DDPS processing
8	DET-REJECTED-RECORD-TOTAL	40 - 46	9(7)	7	Total count of REJ records as determined by DDPS processing
9	FILLER	47 - 512	X(466)	466	SPACES

DDPS RETURN FILE (CONTINUED)

TLR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"TLR"
2	SUBMITTER-ID	4 - 9	X(6)	6	Must match HDR
3	FILE-ID	10 - 19	X(10)	10	Must match HDR
4	TLR-BHD-RECORD-TOTAL	20 - 28	9(9)	9	Total count of BHD records
5	TLR-DET-RECORD-TOTAL	29 - 37	9(9)	9	Total count of DET records
6	TLR-DET-ACCEPTED-RECORD-TOTAL	38 - 46	9(9)	9	Total count of ACC records
7	TLR-DET-INFORMATIONAL-RECORD-TOTAL	47 - 55	9(9)	9	Total count of INF records
8	TLR-DET-REJECTED-RECORD-TOTAL	56 - 64	9(9)	9	Total count of REJ records
9	FILLER	65 - 512	X(448)	448	SPACES

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DDPS Transaction Error Summary

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DDPS TRANSACTION ERROR SUMMARY

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
HDR	Submitter file header	Occurs once per unique submitter on the file
BHD	Contract/PBP level file header	Occurs once per Contract/PBP for each plan/package on file
DET	Detail records for the report	Occurs 1 to many times per BHD record
BTR	Contract/PBP level file trailer	Occurs once per each BHD on the file
TLR	Submitter file trailer	Occurs once per each HDR on the file

HDR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION
1	RECORD-ID	1 - 3	X(3)	3	"HDR"
2	SUBMITTER-ID	4 - 9	X(6)	6	Unique ID assigned by CMS.
3	FILE-ID	10 - 19	X(10)	10	The unique ID provided by Submitter.
4	TRANS-DATE	20 - 27	9(8)	8	Date of file transmission to PDFS.
5	PROD-TEST-CERT-IND	28 - 31	X(4)	4	TEST, PROD, or CERT
6	DDPS-SYSTEM-DATE	32 - 39	9(8)	8	'CCYYMMDD' = DDPS File creation date.
7	DDPS-SYSTEM-TIME	40 - 45	9(6)	6	'HHMMSS' = DDPS File creation time.
8	DDPS-REPORT-ID	46 - 50	X(5)	5	DDPS report identifier (Always '03'). Field is right-padded with spaces
9	FILLER	51 - 512	X(462)	462	SPACES

DDPS TRANSACTION ERROR SUMMARY (CONTINUED)

BHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION
1	RECORD-ID	1 - 3	X(3)	3	"BHD"
2	BATCH-SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract number from submitted batch
4	PBP-ID	16 - 18	X(3)	3	Plan Benefit Package (PBP) ID
5	DDPS-SYSTEM-DATE	19 - 26	9(8)	8	'CCYYMMDD' = DDPS File creation date.
6	DDPS-SYSTEM-TIME	27 - 32	9(6)	6	'HHMMSS' = DDPS File creation time.
7	DDPS-REPORT-ID	33 - 37	X(5)	5	DDPS report identifier (Always '03'). Field is right-padded with spaces
8	FILLER	38 - 512	X(475)	475	SPACES

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	ERROR-CODE	11 - 13	X(3)	3	Identification Number of the Error Code
4	ERROR-CODE-DESCRIPTION	14 - 363	X(350)	350	Description of Error Code
5	FREQUENCY-OF-OCCURRENCE	364 - 370	9(7)	7	Count of each Error Code
6	PERCENTAGE-OF-ALL-EDITS	371 - 374	S9(1)V3	4	Percentage of each Error Code's frequency to the frequency of all Error Codes. The formula is: Frequency Count of the specific error code divided by Frequency Count of all error codes
7	FILLER	375 - 512	X(138)	138	SPACES

DDPS TRANSACTION ERROR SUMMARY (CONTINUED)

BTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"BTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must match BHD
3	CONTRACT-NO	11 - 15	X(5)	5	Must match BHD
4	PBP-ID	16 - 18	X(3)	3	Must match BHD
5	DET-RECORD-TOTAL	19 - 25	9(7)	7	Total count of DET records
6	FILLER	26 - 512	X(487)	487	SPACES

TLR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"TLR"
2	SUBMITTER-ID	4 - 9	X(6)	6	Must match HDR
3	FILE-ID	10 - 19	X(10)	10	Must match HDR
4	TLR-BHD-RECORD-TOTAL	20 - 28	9(9)	9	Total count of BHD records
5	TLR-DET-RECORD-TOTAL	29 - 37	9(9)	9	Total count of DET records
6	FILLER	38 - 512	X(475)	475	SPACES

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DDPS 04COV, 04ENH, and 04OTC: Cumulative Beneficiary Summary Reports

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DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract level file header	Occurs once per Contract for each plan on file
PHD	Contract/Package level file header	Occurs once per Contract/PBP for each plan/package on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Contract/Package level file trailer	Occurs once per each PHD on the file
CTR	Contract level file trailer	Occurs once per each CHD on the file

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract No. from original file
4	FILE-ID	16 - 31	X(16)	16	04COVCCYY###, 04ENHCCYY### or 04OTCCCYY### (Where COV / ENH / OTC indicates the drug coverage status being reported on CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-CERT IND	32 - 35	X(4)	4	TEST, PROD, or CERT
6	AS-OF-YEAR	36 - 39	9(4)	4	Identifies "data reported through" year. Format is CCYY.
7	AS-OF-MONTH	40 - 41	9(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
8	DDPS-SYSTEM-DATE	42 - 49	9(8)	8	'CCYYMMDD' = DDPS File creation date.
9	DDPS-SYSTEM-TIME	50 - 55	9(6)	6	'HHMMSS' = DDPS File creation time.
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier (Either '04COV', '04ENH' or '04OTC'.
11	FILLER	61 - 512	X(1)	1	SPACES

DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

PHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract No. from original file
4	PBP-ID	16 - 20	X(5)	5	PBP ID from original file
5	FILE-ID	21 - 36	X(16)	16	04COVCCYY###, 04ENHCCYY### or 04OTCCCYY### (Where COV / ENH / OTC indicates the drug coverage status being reported on CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
6	PROD-TEST-CERT IND	37 - 40	X(4)	4	TEST, PROD, or CERT
7	AS-OF-YEAR	41 - 44	9(4)	4	Identifies "data reported through" year. Format is CCYY.
8	AS-OF-MONTH	45 - 46	9(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
9	DDPS-SYSTEM-DATE	47 - 54	9(8)	8	'CCYYMMDD' = DDPS File creation date.
10	DDPS-SYSTEM-TIME	55 - 60	9(6)	6	'HHMMSS' = DDPS File creation time.
11	DDPS-REPORT-ID	61 - 65	X(5)	5	DDPS Report identifier (Either '04COV', '04ENH' or '04OTC'.
12	FILLER	66 - 512	X(447)	447	SPACES

DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	DRUG-COVERAGE-STATUS-CODE	11 - 11	X(1)	1	
4	CURRENT-CMS-HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN.
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary.
6	LAST-SUBMITTED-CARDHOLDER-ID	52 - 71	X(20)	20	Plan identification of the enrollee, as reported on the most recent PDE for the benefit year.
7	EARLIEST-PDE-ATTACHMENT-POINT-DATE	72 - 79	9(8)	8	Date of service from the earliest attachment point PDE associated with the PBP - CCYYMMDD
8	RX-COUNT	80 - 90	9(11)	11	Number of Prescriptions net of deleted and adjusted PDEs, as well as partial fill transactions
9	NET-INGRED-COST	91 - 104	S9(12)V99	14	
10	NET-DISPENS-FEE	105 - 118	S9(12)V99	14	
11	NET-SALES-TAX	119 - 132	S9(12)V99	14	
12	NET-GDCB	133 - 146	S9(12)V99	14	
13	NET-GDCA	147 - 160	S9(12)V99	14	
14	NET-TOTAL-GROSS-DRUG-COST	161 - 174	S9(12)V99	14	
15	NET-PATIENT-PAY-AMOUNT	175 - 188	S9(12)V99	14	
16	NET-OTHER-TROOP-AMOUNT	189 - 202	S9(12)V99	14	
17	NET-LICS-AMOUNT	203 - 216	S9(12)V99	14	
18	NET-TrOOP-AMOUNT	217 - 230	S9(12)V99	14	
19	NET-PLRO-AMOUNT	231 - 244	S9(12)V99	14	
20	NET-CPP-AMOUNT	245 - 258	S9(12)V99	14	
21	NET-NPP-AMOUNT	259 - 272	S9(12)V99	14	
22	NUMBER-OF-ORIGINAL-PDES	273 - 284	9(12)	12	
23	NUMBER-OF-ADJUSTED-PDES	285 - 296	9(12)	12	

DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
24	NUMBER-OF-DELETION-PDES	297 - 308	9(12)	12	
25	NET-NUMBER-OF-CATASTROPHIC-COVERAGE-PDES	309 - 320	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “C”
26	NET-NUMBER-OF-ATTACHMENT-PDES	321 - 332	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “A”
27	NET-NUMBER-OF-NON-CATASTROPHIC-PDES	333 - 344	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “blank”
28	NET-NUMBER-OF-NON-STANDARD-FORMAT-PDES	345 - 356	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
29	NET-NUMBER-OF-OON-PDES	357 - 368	9(12)	12	Count of PDEs with pricing-exception-code code equal “O”
30	FILLER	369 - 512	X(144)	144	SPACES

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Same as PHD
4	PBP-ID	16 - 18	X(3)	3	Same as PHD
5	DRUG-COVERAGE-STATUS-CODE	19 - 19	X(1)	1	
6	BENEFICIARY-COUNT	20 - 30	9(11)	11	Count of beneficiaries with utilization in the reporting period.
7	RX-COUNT	31 - 41	9(11)	11	Number of Prescriptions net of deleted and/or adjusted PDEs, as well as partial fill transactions).
8	NET-INGRED-COST	42 - 55	S9(12)V99	14	
9	NET-DISPENS-FEE	56 - 69	S9(12)V99	14	
10	NET-SALES-TAX	70 - 83	S9(12)V99	14	
11	NET-GDCB-AMOUNT	84 - 97	S9(12)V99	14	
12	NET-GDCA-AMOUNT	98 - 111	S9(12)V99	14	
13	NET-TOTAL-GROSS-DRUG-COST	112 - 125	S9(12)V99	14	
14	NET-PATIENT-PAY-AMOUNT	126 - 139	S9(12)V99	14	
15	NET-OTHER-TROOP-AMOUNT	140 - 153	S9(12)V99	14	

DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
16	NET-LICS-AMOUNT	154 - 167	S9(12)V99	14	
17	NET-PLRO-AMOUNT	168 - 181	S9(12)V99	14	
18	NET-CPP-AMOUNT	182 - 195	S9(12)V99	14	
19	NET-NPP-AMOUNT	196 - 209	S9(12)V99	14	
20	NUMBER-OF-ORIGINAL-PDES	210 - 221	9(12)	12	The count of original PDEs.
21	NUMBER-OF-ADJUSTED-PDES	222 - 233	9(12)	12	The count of adjusted PDEs.
22	NUMBER-OF-DELETION-PDES	234 - 245	9(12)	12	The count of deleted PDEs.
23	NET-NUMBER-OF-CATASTROPHIC-COVERAGE-PDES	246 - 257	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “C”.
24	NET-NUMBER-OF-ATTACHMENT-PDES	258 - 269	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “A”
25	NET-NUMBER-OF-NON-CATASTROPHIC-PDES	270 - 281	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “blank”.
26	NET-NUMBER-OF-NON-STANDARD-FORMAT-PDES	282 - 293	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
27	NET-NUMBER-OF-OON-PDES	294 - 305	9(12)	12	Count of PDEs with Pricing Exception Code equal “O”
28	FILLER	306 – 317	X(12)	12	SPACES
29	DET-RECORD-TOTAL	318 - 325	9(8)	8	Total count of DET records
30	FILLER	326 - 512	X(187)	187	SPACES

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Must match CHD
4	DRUG-COVERAGE-STATUS-CODE	16 - 16	X(1)	1	
5	BENEFICIARY-COUNT	17 - 36	X(20)	20	Count of beneficiaries with utilization in the reporting period.
6	RX-COUNT	37 - 47	9(11)	11	Number of Prescriptions net of deleted and/or adjusted PDEs, as well as partial fill transactions.
7	NET-INGRED-COST	48 - 61	S9(12)V99	14	
8	NET-DISPENS-FEE	62 - 75	S9(12)V99	14	
9	NET-SALES-TAX	76 - 89	S9(12)V99	14	

DDPS 04COV, 04ENH, AND 04OTC: CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
10	NET-GDCB	90 - 103	S9(12)V99	14	
11	NET-GDCA	104 - 117	S9(12)V99	14	
12	NET-TOTAL-GROSS-DRUG-COST	118 - 131	S9(12)V99	14	
13	NET-PATIENT-PAY-AMOUNT	132 - 145	S9(12)V99	14	
14	NET-OTHER-TROOP-AMOUNT	146 - 159	S9(12)V99	14	
15	NET-LICS-AMOUNT	160 - 173	S9(12)V99	14	
16	NET-PLRO-AMOUNT	174 - 187	S9(12)V99	14	
17	NET-CPP-AMOUNT	188 - 201	S9(12)V99	14	
18	NET-NPP-AMOUNT	202 - 215	S9(12)V99	14	
19	NUMBER-OF-ORIGINAL-PDES	216 - 227	9(12)	12	The count of original PDEs.
20	NUMBER-OF-ADJUSTED-PDES	228 - 239	9(12)	12	The count of adjusted PDEs.
21	NUMBER-OF-DELETION-PDES	240 - 251	9(12)	12	The count of deleted PDEs.
22	NET-NUMBER-CATASTROPHIC-PDES	252 - 263	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “C”
23	NET-NUMBER-ATTACHMENT-PDES	264 - 275	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “A”
24	NET-NUMBER-NON-CATASTROPHIC-PDES	276 - 287	9(12)	12	Count of PDEs with Catastrophic Coverage Code not equal “A” or “C”
25	NET-NUMBER-NON-STANDARD-FORMAT-PDES	288 - 299	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
26	NET-NUMBER-OON-PDES	300 - 311	9(12)	12	Count of PDEs with Pricing Exception Code equal “O” (out-of-network).
27	FILLER	312 – 323	X(12)	12	SPACES
28	DET-RECORD-TOTAL	324 - 331	9(8)	8	Total count of DET records
29	FILLER	332 - 512	X(181)	181	SPACES

P2P 40COV, 40ENH, and 40OTC: Accounting Report

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P2P 40COV, 40ENH, AND 40OTC: ACCOUNTING REPORT

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Submitting Contract level file header	Occurs once per Submitting Contract for each one on file
PHD	Submitting PBP level file header	Occurs once per Submitting PBP for each one on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Submitting PBP level file trailer	Occurs once per each PHD on the file
CTR	Submitting Contract level file trailer	Occurs once per each CHD on the file

DET SORT ORDER

FIELD NO.	FIELD NAME
3	DRUG COVERAGE STATUS CODE
30	P2P-CONTRACT
4	CURRENT-CMS-HICN

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Submitting Contract number
4	FILE-ID	16 - 31	X(16)	16	40COVCCYY###, 40ENHCCYY### or 40OTCCCYY### (Where 40 = Due from Contracts of Record - YTD Report COV / ENH / OTC indicates the drug coverage status being reported on CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-IND	32 - 35	X(4)	4	TEST or PROD
6	AS-OF-YEAR	36 - 39	X(4)	4	Identifies "data reported through" year. Format is CCYY.
7	AS-OF-MONTH	40 - 41	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
8	DDPS-SYSTEM-DATE	42 - 49	X(8)	8	'CCYYMMDD' = DDPS File creation date.
9	DDPS-SYSTEM-TIME	50 - 55	X(6)	6	'HHMMSS' = DDPS File creation time.
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier (Either '40COV', '40ENH' or '40OTC').
11	FILLER	61 - 512	X(452)	452	SPACES

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

PHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Submitting Contract number
4	PBP-ID	16 - 18	X(3)	3	Submitting PBP ID
5	FILE-ID	19 - 34	X(16)	16	40COVCCYY###, 40ENHCCYY### or 40OTCCCYY### (Where 40 = Due from Contracts of Record - YTD Report COV / ENH / OTC indicates the drug coverage status being reported on CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
6	PROD-TEST-IND	35 - 38	X(4)	4	TEST or PROD
7	AS-OF-YEAR	39 - 42	X(4)	4	Identifies "data reported through" year. Format is CCYY.
8	AS-OF-MONTH	43 - 44	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
9	DDPS-SYSTEM-DATE	45 - 52	X(8)	8	'CCYYMMDD' = DDPS File creation date.
10	DDPS-SYSTEM-TIME	53 - 58	X(6)	6	'HHMMSS' = DDPS File creation time.
11	DDPS-REPORT-ID	59 - 63	X(5)	5	DDPS Report identifier (Either '40COV', '40ENH' or '40OTC').
12	FILLER	64 - 512	X(449)	449	SPACES

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	DRUG-COVERAGE-STATUS-CODE	11 - 11	X(1)	1	Code to identify whether drug is covered (C), supplemental (E) or over-the-counter (O).
4	CURRENT-CMS-HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN.
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary.
6	LAST-SUBMITTED-CARDHOLDER-ID	52 - 71	X(20)	20	Plan identification of the enrollee, as reported on the most recent PDE for the benefit year.
7	EARLIEST-PDE-ATTACHMENT-POINT-DATE	72 - 79	9(8)	8	Date of service from the earliest attachment point PDE associated with the PBP - CCYYMMDD
8	RX-COUNT	80 - 90	9(11)	11	Number of Prescriptions net of deleted and adjusted PDEs, as well as partial fill transactions. Partial and Complete PDEs are each counted as 1.
9	NET-INGRED-COST	91 - 104	S9(12)V99	14	Self-explanatory
10	NET-DISPENS-FEE	105 - 118	S9(12)V99	14	Self-explanatory
11	NET-SALES-TAX	119 - 132	S9(12)V99	14	Self-explanatory
12	NET-GDCB-AMOUNT	133 - 146	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
13	NET-GDCA-AMOUNT	147 - 160	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
14	NET-TOTAL-GROSS-DRUG-COST	161 - 174	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
15	NET-PATIENT-PAY-AMOUNT	175 - 188	S9(12)V99	14	Self-explanatory
16	NET-OTHER-TROOP-AMOUNT	189 - 202	S9(12)V99	14	Net Other True Out-of-Pocket Amount
17	NET-LICS-AMOUNT	203 - 216	S9(12)V99	14	Net Low Income Cost Sharing Amount
18	NET-TrOOP-AMOUNT	217 - 230	S9(12)V99	14	Sum of Net Patient Pay Amount, Net Other Troop Amount and Net LICS Amount
19	NET-PLRO-AMOUNT	231 - 244	S9(12)V99	14	Net Patient Liability Reduction Due to Other (non-TrOOP) Payers
20	NET-CPP-AMOUNT	245 - 258	S9(12)V99	14	Net Covered Plan Paid Amount
21	NET-NPP-AMOUNT	259 - 272	S9(12)V99	14	Net Non-covered Plan Paid Amount
22	NUMBER-OF-ORIGINAL-PDES	273 - 284	9(12)	12	Self-explanatory
23	NUMBER-OF-ADJUSTED-PDES	285 - 296	9(12)	12	Self-explanatory
24	NUMBER-OF-DELETION-PDES	297 - 308	9(12)	12	Self-explanatory

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
25	NET-NUMBER-OF-CATASTROPHIC-COVERAGE-PDES	309 - 320	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “C”
26	NET-NUMBER-OF-ATTACHMENT-PDES	321 - 332	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “A”
27	NET-NUMBER-OF-NON-CATASTROPHIC-PDES	333 - 344	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “blank”
28	NET-NUMBER-OF-NON-STANDARD-FORMAT-PDES	345 - 356	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
29	NET-NUMBER-OF-OON-PDES	357 - 368	9(12)	12	Count of PDEs with pricing-exception-code code equal “O”
30	P2P-CONTRACT	369 - 373	X(5)	5	The contract number of the Plan of Record associated with the P2P reconciliation condition. (Appears on Covered Drug version of the report only.)
31	P2P-AMOUNT	374 - 387	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-from" all Contracts of Record to this Submitting PBP for this beneficiary. This field is the sum of the LICS Amount and CPP Amount. Value is zero in Reports 40ENH and 40OTC.
32	FILLER	388 - 512	X(125)	125	SPACES

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Same as PHD
4	PBP-ID	16 - 18	X(3)	3	Same as PHD
5	DRUG-COVERAGE-STATUS-CODE	19 - 19	X(1)	1	Code to identify whether drug is covered (C), supplemental (E) or over-the-counter (O).
6	BENEFICIARY-COUNT	20 - 30	9(11)	11	Total count of DET records.
7	RX-COUNT	31 - 41	9(11)	11	Number of Prescriptions net of deleted and/or adjusted PDEs, as well as partial fill transactions. Partial and Complete PDEs are each counted as 1.
8	NET-INGRED-COST	42 - 55	S9(12)V99	14	Self-explanatory
9	NET-DISPENS-FEE	56 - 69	S9(12)V99	14	Self-explanatory
10	NET-SALES-TAX	70 - 83	S9(12)V99	14	Self-explanatory

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
11	NET-GDCB-AMOUNT	84 - 97	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
12	NET-GDCA-AMOUNT	98 - 111	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
13	NET-TOTAL-GROSS-DRUG-COST	112 - 125	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
14	NET-PATIENT-PAY-AMOUNT	126 - 139	S9(12)V99	14	Self-explanatory
15	NET-OTHER-TROOP-AMOUNT	140 - 153	S9(12)V99	14	Net Other True Out-of-Pocket Amount
16	NET-LICS-AMOUNT	154 - 167	S9(12)V99	14	Net Low Income Cost Sharing Amount
17	NET-TrOOP-AMOUNT	168 - 181	S9(12)V99	14	Sum of Net Patient Pay Amount, Net Other Troop Amount and Net LICS Amount
18	NET-PLRO-AMOUNT	182 - 195	S9(12)V99	14	Net Patient Liability Reduction Due to Other (non-TrOOP) Payers
19	NET-CPP-AMOUNT	196 - 209	S9(12)V99	14	Net Covered Plan Paid Amount
20	NET-NPP-AMOUNT	210 - 223	S9(12)V99	14	Net Non-covered Plan Paid Amount
21	NUMBER-OF-ORIGINAL-PDES	224 - 235	9(12)	12	The count of original PDEs.
22	NUMBER-OF-ADJUSTED-PDES	236 - 247	9(12)	12	The count of adjusted PDEs.
23	NUMBER-OF-DELETION-PDES	248 - 259	9(12)	12	The count of deleted PDEs.
24	NET-NUMBER-OF-CATASTROPHIC-COVERAGE-PDES	260 - 271	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “C”.
25	NET-NUMBER-OF-ATTACHMENT-PDES	272 - 283	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “A”
26	NET-NUMBER-OF-NON-CATASTROPHIC-PDES	284 - 295	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal to “blank”.
27	NET-NUMBER-OF-NON-STANDARD-FORMAT-PDES	296 - 307	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
28	NET-NUMBER-OF-OON-PDES	308 - 319	9(12)	12	Count of PDEs with Pricing Exception Code equal “O”
29	FILLER	320 - 331	X(12)	12	SPACES
30	DET-RECORD-TOTAL	332 - 339	9(8)	8	Total count of DET records

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
31	P2P-AMOUNT-DUE-FROM-ALL-PLANS-OF-RECORD	340 - 353	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-from" all Contracts of Record to this PBP. This field is the sum of the LICS Amount and CPP Amount. Value is zero in Reports 40ENH and 40OTC.
32	FILLER	354 - 512	X(159)	159	SPACES

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Must match CHD
4	DRUG-COVERAGE-STATUS-CODE	16 - 16	X(1)	1	Code to identify whether drug is covered (C), supplemental (E) or over-the-counter (O).
5	BENEFICIARY-COUNT	17 - 27	9(11)	11	Total count of DET records.
6	FILLER	28 - 36	X(9)	9	SPACES
7	RX-COUNT	37 - 47	9(11)	11	Number of Prescriptions net of deleted and/or adjusted PDEs, as well as partial fill transactions. Partial and Complete PDEs are each counted as 1.
8	NET-INGRED-COST	48 - 61	S9(12)V99	14	Self-explanatory
9	NET-DISPENS-FEE	62 - 75	S9(12)V99	14	Self-explanatory
10	NET-SALES-TAX	76 - 89	S9(12)V99	14	Self-explanatory
11	NET-GDCB-AMOUNT	90 - 103	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
12	NET-GDCA-AMOUNT	104 - 117	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
13	NET-TOTAL-GROSS-DRUG-COST	118 - 131	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
14	NET-PATIENT-PAY-AMOUNT	132 - 145	S9(12)V99	14	Self-explanatory
15	NET-OTHER-TROOP-AMOUNT	146 - 159	S9(12)V99	14	Net Other True Out-of-Pocket Amount
16	NET-LICS-AMOUNT	160 - 173	S9(12)V99	14	Net Low Income Cost Sharing Amount
17	NET-TrOOP-AMOUNT	174 - 187	S9(12)V99	14	Sum of Net Patient Pay Amount, Net Other Troop Amount and Net LICS Amount
18	NET-PLRO-AMOUNT	188 - 201	S9(12)V99	14	Net Patient Liability Reduction Due to Other (non-TrOOP) Payers
19	NET-CPP-AMOUNT	202 - 215	S9(12)V99	14	Net Covered Plan Paid Amount
20	NET-NPP-AMOUNT	216 - 229	S9(12)V99	14	Net Non-covered Plan Paid Amount

P2P 40COV, 40ENH, AND 40OTC: PDE ACCOUNTING REPORT (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
21	NUMBER-OF-ORIGINAL-PDES	230 - 241	9(12)	12	The count of original PDEs.
22	NUMBER-OF-ADJUSTED-PDES	242 - 253	9(12)	12	The count of adjusted PDEs.
23	NUMBER-OF-DELETION-PDES	254 - 265	9(12)	12	The count of deleted PDEs.
24	NET-NUMBER-CATASTROPHIC-PDES	266 - 277	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “C”
25	NET-NUMBER-ATTACHMENT-PDES	278 - 289	9(12)	12	Count of PDEs with Catastrophic Coverage Code equal “A”
26	NET-NUMBER-NON-CATASTROPHIC-PDES	290 - 301	9(12)	12	Count of PDEs with Catastrophic Coverage Code not equal “A” or “C”
27	NET-NUMBER-NON-STANDARD-FORMAT-PDES	302 - 313	9(12)	12	Count of PDEs with Non-standard Format Code other than blank
28	NET-NUMBER-OON-PDES	314 - 325	9(12)	12	Count of PDEs with Pricing Exception Code equal “O” (out-of-network).
29	FILLER	326 - 337	X(12)	12	SPACES
30	DET-RECORD-TOTAL	338 - 345	9(8)	8	Total count of DET records
31	P2P-AMOUNT-DUE-FROM-ALL-PLANS-OF-RECORD	346 - 359	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-from" all Contracts of Record to this Submitting Contract. This field is the sum of the LICS Amount and CPP Amount. Value is zero in Reports 40ENH and 40OTC
32	FILLER	360 - 512	X(153)	153	SPACES

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P2P 41COV:
Receivable Report

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P2P 41COV:
RECEIVABLE REPORT

RECORD DEFINITION/DESCRIPTION

RECORD INDICATORS	RECORD DEFINITION	NOTES
CHD	Submitting Contract level file header	Occurs once per Submitting Contract for each one on file
RHD	Contract of Record level file header	Occurs once per Contract of Record for each one on file
DET	Detail records for the report	Occurs 1 to many times per RHD record
RTR	Contract of Record level file trailer	Occurs once per each RHD on the file
CTR	Submitting Contract level file trailer	Occurs once per each CHD on the file

DET SORT ORDER

FIELD NO.	FIELD NAME
4	CURRENT-CMS-HICN

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Submitting Contract number
4	FILE-ID	16 - 31	X(16)	16	41COVCCYY### (Where 41 = Due from Contracts of Record - Current Month Report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-IND	32 - 35	X(4)	4	TEST or PROD
6	AS-OF-YEAR	36 - 39	X(4)	4	Identifies "data reported through" year. Format is CCYY.
7	AS-OF-MONTH	40 - 41	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
8	DDPS-SYSTEM-DATE	42 - 49	X(8)	8	'CCYYMMDD' = DDPS File creation date.
9	DDPS-SYSTEM-TIME	50 - 55	X(6)	6	'HHMMSS' = DDPS File creation time.
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier ('41COV')
11	FILLER	61 - 512	X(452)	452	SPACES

P2P 41COV:
RECEIVABLE REPORT (CONTINUED)

RHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"RHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract number of the Plan of Record
4	FILLER	16 - 18	X(3)	3	SPACES
5	FILE-ID	19 - 34	X(16)	16	41COVCCYY### (Where 41 = Due from Contracts of Record - Current Month Report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
6	PROD-TEST-IND	35 - 38	X(4)	4	TEST or PROD
7	AS-OF-YEAR	39 - 42	X(4)	4	Identifies "data reported through" year. Format is CCYY.
8	AS-OF-MONTH	43 - 44	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
9	DDPS-SYSTEM-DATE	45 - 52	X(8)	8	'CCYYMMDD' = DDPS File creation date.
10	DDPS-SYSTEM-TIME	53 - 58	X(6)	6	'HHMMSS' = DDPS File creation time.
11	DDPS-REPORT-ID	59 - 63	X(5)	5	DDPS Report identifier ('41COV')
12	FILLER	64 - 512	X(449)	449	SPACES

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	DRUG-COVERAGE-STATUS-CODE	11 - 11	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report.
4	CURRENT-CMS-HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN.
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary.
6	LAST-SUBMITTED-CARDHOLDER-ID	52 - 71	X(20)	20	Plan identification of the enrollee, as reported on the most recent PDE for the benefit year.

P2P 41COV:
RECEIVABLE REPORT (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
7	CURRENT-MONTH-GDCB-AMOUNT	72 - 85	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
8	CURRENT-MONTH-GDCA-AMOUNT	86 - 99	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
9	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	100 - 113	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	CURRENT-MONTH-LICS-AMOUNT	114 - 127	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount
11	CURRENT-MONTH-CPP-AMOUNT	128 - 141	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
12	CURRENT-MONTH-P2P-AMOUNT	142 - 155	S9(12)V99	14	The amount related to the P2P reconciliation condition. This amount represents the amount "due-from" this Contract of Record to this Submitting Contract for this beneficiary. This field is the sum of the LICS Amount and CPP Amount.
13	FILLER	156 - 512	X(357)	357	SPACES

RTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"RTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Same as RHD
4	FILLER	16 - 18	X(3)	3	SPACES
5	DRUG-COVERAGE-STATUS-CODE	19 - 19	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report.
6	BENEFICIARY-COUNT	20 - 30	9(11)	11	Total count of DET records.
7	CURRENT-MONTH-GDCB-AMOUNT	31 - 44	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
8	CURRENT-MONTH-GDCA-AMOUNT	45 - 58	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
9	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	59 - 72	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	CURRENT-MONTH-LICS-AMOUNT	73 - 86	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount

P2P 41COV:
RECEIVABLE REPORT (CONTINUED)

RTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
11	CURRENT-MONTH-CPP-AMOUNT	87 - 100	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
12	DET-RECORD-TOTAL	101 - 108	9(8)	8	Total count of DET records
13	CURRENT-MONTH-P2P-AMOUNT-DUE-FROM-ALL-PLANS-OF-RECORD	109 - 122	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-from" this Contract of Record to this Submitting Contract. This field is the sum of the LICS Amount and CPP Amount.
14	FILLER	123 - 512	X(390)	390	SPACES

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	FIELD DESCRIPTION / VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Must match CHD
4	DRUG-COVERAGE-STATUS-CODE	16 - 16	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report.
5	BENEFICIARY-COUNT	17 - 27	9(11)	11	Total count of DET records.
6	FILLER	28 - 36	X(9)	9	SPACES
7	CURRENT-MONTH-GDCB-AMOUNT	37 - 50	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
8	CURRENT-MONTH-GDCA-AMOUNT	51 - 64	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
9	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	65 - 78	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	CURRENT-MONTH-LICS-AMOUNT	79 - 92	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount
11	CURRENT-MONTH-CPP-AMOUNT	93 - 106	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
12	DET-RECORD-TOTAL	107 - 114	9(8)	8	Total count of DET records
13	CURRENT-MONTH-P2P-AMOUNT-DUE-FROM-ALL-PLANS-OF-RECORD	115 - 128	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-from" all Contracts of Record to this Submitting Contract. This field is the sum of the LICS Amount and CPP Amount.
14	FILLER	129 - 512	X(384)	384	SPACES

P2P 42COV:
Part D Payment Reconciliation

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P2P 42COV:
PART D PAYMENT RECONCILIATION REPORT

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract level file header	Occurs once per Contract of Record for each one on file
PHD	Contract/Package level file header	Occurs once per PBP of Record for each one on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Contract/Package level file trailer	Occurs once per each PHD on the file
CTR	Contract level file trailer	Occurs once per each CHD on the file

DET SORT ORDER

FIELD NO.	FIELD NAME
4	CURRENT-CMS-HICN

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract number of the Plan of Record
4	FILE-ID	16 - 31	X(16)	16	42COVCCYY### (Where 42 = Due To Submitting Contracts - YTD report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-CERT IND	32 - 35	X(4)	4	TEST or PROD
6	AS-OF-YEAR	36 - 39	X(4)	4	Identifies "data reported through" year. Format is CCYY
7	AS-OF-MONTH	40 - 41	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12
8	DDPS-SYSTEM-DATE	42 - 49	X(8)	8	'CCYYMMDD' = DDPS File creation date
9	DDPS-SYSTEM-TIME	50 - 55	X(6)	6	'HHMMSS' = DDPS File creation time
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier ('42COV')
11	FILLER	61 - 512	X(452)	1	SPACES

P2P 42COV:
PART D PAYMENT RECONCILIATION REPORT (CONTINUED)

PHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract Number of the Plan of Record
4	PBP-ID	16 - 18	X(3)	3	Plan of Record's PBP ID
5	FILE-ID	19 - 34	X(16)	16	42COVCCYY### Where 42 = Due To Submitting Contracts - YTD report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
6	PROD-TEST IND	35 - 38	X(4)	4	TEST or PROD
7	AS-OF-YEAR	39 - 42	X(4)	4	Identifies "data reported through" year. Format is CCYY.
8	AS-OF-MONTH	43 - 44	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12
9	DDPS-SYSTEM-DATE	45 - 52	X(8)	8	'CCYYMMDD' = DDPS File creation date
10	DDPS-SYSTEM-TIME	53 - 58	X(6)	6	'HHMMSS' = DDPS File creation time
11	DDPS-REPORT-ID	59 - 63	X(5)	5	DDPS Report identifier ('42COV')
12	FILLER	64 - 512	X(449)	449	SPACES

P2P 42COV:
PART D PAYMENT RECONCILIATION REPORT (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	DRUG-COVERAGE-STATUS-CODE	11 - 11	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
4	CURRENT-CMS-HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary
6	NET-GDCB-AMOUNT	52 - 65	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
7	NET-GDCA-AMOUNT	66 - 79	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
8	NET-TOTAL-GROSS-DRUG-COST	80 - 93	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
9	NET-LICS-AMOUNT	94 - 107	S9(12)V99	14	Net Low Income Cost Sharing Amount
10	NET-CPP-AMOUNT	108 - 121	S9(12)V99	14	Net Covered Plan Paid Amount
11	P2P-CONTRACT	122 - 126	X(5)	5	The contract number of the Submitting Contract associated with the P2P reconciliation condition
12	P2P-AMOUNT	127 - 140	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-to" all Submitting Contracts from this PBP of record for this beneficiary. This field is the sum of the LICS Amount and CPP Amount
13	FILLER	141 - 512	X(372)	372	SPACES

P2P 42COV:
PART D PAYMENT RECONCILIATION REPORT (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Same as PHD
4	PBP-ID	16 - 18	X(3)	3	Same as PHD
5	DRUG-COVERAGE-STATUS-CODE	19 - 19	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
6	BENEFICIARY-COUNT	20 - 30	9(11)	11	Total count of DET records
7	NET-GDCB-AMOUNT	31 - 44	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
8	NET-GDCA-AMOUNT	45 - 58	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
9	NET-TOTAL-GROSS-DRUG-COST	59 - 72	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	NET-LICS-AMOUNT	73 - 86	S9(12)V99	14	Net Low Income Cost Sharing Amount
11	NET-CPP-AMOUNT	87 - 100	S9(12)V99	14	Net Covered Plan Paid Amount
12	DET-RECORD-TOTAL	101 - 108	9(8)	8	Total count of DET records
13	P2P-AMOUNT-DUE-TO-ALL-SUBMITTING CONTRACTS	109 - 122	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-to" all Submitting Contracts from this PBP of Record. This field is the sum of the LICS Amount and CPP Amount
14	FILLER	123 - 512	X(390)	390	SPACES

P2P 42COV:
PART D PAYMENT RECONCILIATION REPORT (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Must match CHD
4	DRUG-COVERAGE-STATUS-CODE	16 - 16	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
5	BENEFICIARY-COUNT	17 - 27	9(11)	11	Total count of DET records
6	FILLER	28 - 36	X(9)	9	SPACES
7	NET-GDCB-AMOUNT	37 - 50	S9(12)V99	14	Net Gross Drug Cost Below the Catastrophic Coverage Threshold
8	NET-GDCA-AMOUNT	51 - 64	S9(12)V99	14	Net Gross Drug Cost Above the Catastrophic Coverage Threshold
9	NET-TOTAL-GROSS-DRUG-COST	65 - 78	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	NET-LICS-AMOUNT	79 – 92	S9(12)V99	14	Net Low Income Cost Sharing Amount
11	NET-CPP-AMOUNT	93 – 106	S9(12)V99	14	Net Covered Plan Paid Amount
12	DET-RECORD-TOTAL	107 – 114	9(8)	8	Total count of DET records
13	P2P-AMOUNT-DUE-TO-ALL-SUBMITTING-CONTRACTS	115 – 128	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount “due-to” all Submitting Contracts from this Contract of Record. This field is the sum of the LICS Amount and CPP Amount
14	FILLER	129 – 512	X(384)	384	SPACES

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P2P 43COV:
Payable Report

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P2P 43COV:
PAYABLE REPORT

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract level file header	Occurs once per Contract of Record for each one on file
SHD	Submitting Contract level file header	Occurs once per Submitting Contract for each one on file
DET	Detail records for the report	Occurs 1 to many times per SHD record
STR	Submitting Contract level file trailer	Occurs once per each SHD on the file
CTR	Contract of Record level file trailer	Occurs once per each CHD on the file

DET SORT ORDER

FIELD NO.	FIELD NAME
4	CURRENT-CMS-HICN

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract number of the Plan of Record
4	FILE-ID	16 - 31	X(16)	16	43COVCCYY### (Where 43 = Due To Submitting Contracts - Current Month report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-IND	32 - 35	X(4)	4	TEST or PROD
6	AS-OF-YEAR	36 - 39	X(4)	4	Identifies "data reported through" year. Format is CCYY
7	AS-OF-MONTH	40 - 41	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
8	DDPS-SYSTEM-DATE	42 - 49	X(8)	8	'CCYYMMDD' = DDPS File creation date
9	DDPS-SYSTEM-TIME	50 - 55	X(6)	6	'HHMMSS' = DDPS File creation time
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier ('43COV')
11	FILLER	61 - 512	X(452)	452	SPACES

P2P 43COV:
PAYABLE REPORT (CONTINUED)

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Contract number of the Plan of Record
4	FILE-ID	16 - 31	X(16)	16	43COVCCYY### (Where 43 = Due To Submitting Contracts - Current Month report COV indicates the drug coverage status being reported on (covered drugs only) CCYY indicates the benefit year ### indicates sequential versions of this file. The 4 right-most positions are populated with spaces.)
5	PROD-TEST-IND	32 - 35	X(4)	4	TEST or PROD
6	AS-OF-YEAR	36 - 39	X(4)	4	Identifies "data reported through" year. Format is CCYY
7	AS-OF-MONTH	40 - 41	X(2)	2	Identifies "data reported through" month. Valid values are 01 through 12.
8	DDPS-SYSTEM-DATE	42 - 49	X(8)	8	'CCYYMMDD' = DDPS File creation date
9	DDPS-SYSTEM-TIME	50 - 55	X(6)	6	'HHMMSS' = DDPS File creation time.
10	DDPS-REPORT-ID	56 - 60	X(5)	5	DDPS Report identifier ('43COV')
11	FILLER	61 - 512	X(452)	452	SPACES

P2P 43COV:
PAYABLE REPORT (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	DET
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	DRUG-COVERAGE-STATUS-CODE	11 - 11	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
4	CURRENT-CMS-HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN
5	LAST-SUBMITTED-HICN	32 - 51	X(20)	20	HICN from the most recent accepted PDE in the DDPS database for that plan/beneficiary
6	CURRENT-MONTH-GDCB-AMOUNT	52 - 65	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
7	CURRENT-MONTH-GDCA-AMOUNT	66 - 79	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
8	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	80 - 93	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax.
9	CURRENT-MONTH-LICS-AMOUNT	94 - 107	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount
10	CURRENT-MONTH-CPP-AMOUNT	108 - 121	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
11	P2P-CONTRACT	122 - 126	X(5)	5	The contract number of the Submitting Contract associated with the P2P reconciliation condition
12	CURRENT-MONTH-P2P-AMOUNT	127 - 140	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-to" this Submitting Contract from this Contract of Record for this beneficiary. This field is the sum of the LICS Amount and CPP Amount
13	FILLER	141 - 512	X(372)	372	SPACES

P2P 43COV:
PAYABLE REPORT (CONTINUED)

STR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"STR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Same as SHD
4	PBP-ID	16 - 18	X(3)	3	Same as SHD
5	DRUG-COVERAGE-STATUS-CODE	19 - 19	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
6	BENEFICIARY-COUNT	20 - 30	9(11)	11	Total count of DET records
7	CURRENT-MONTH-GDCB-AMOUNT	31 - 44	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
8	CURRENT-MONTH-GDCA-AMOUNT	45 - 58	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
9	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	59 - 72	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	CURRENT-MONTH-LICS-AMOUNT	73 - 86	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount
11	CURRENT-MONTH-CPP-AMOUNT	87 - 100	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
12	DET-RECORD-TOTAL	101 - 108	9(8)	8	Total count of DET records
13	CURRENT-MONTH-P2P-AMOUNT-DUE-TO-ALL-SUBMITTING CONTRACTS	109 - 122	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-to" this Contract of Record. This field is the sum of the LICS Amount and CPP Amount
14	FILLER	123 - 512	X(390)	390	SPACES

P2P 43COV:
PAYABLE REPORT (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT-NO	11 - 15	X(5)	5	Must match CHD
4	DRUG-COVERAGE-STATUS-CODE	16 - 16	X(1)	1	Note: Only PDEs with a value of 'C' (Covered Drug) will be included on this report
5	BENEFICIARY-COUNT	17 - 27	9(11)	11	Total count of DET records
6	FILLER	28 - 36	X(9)	9	SPACES
7	CURRENT-MONTH-GDCB-AMOUNT	37 - 50	S9(12)V99	14	Monthly change in Gross Drug Cost Below the Catastrophic Coverage Threshold
8	CURRENT-MONTH-GDCA-AMOUNT	51 - 64	S9(12)V99	14	Monthly change in Gross Drug Cost Above the Catastrophic Coverage Threshold
9	CURRENT-MONTH-TOTAL-GROSS-DRUG-COST	65 - 78	S9(12)V99	14	Sum of Net Ingred Cost, Net Dispens Fee and Net Sales Tax
10	CURRENT-MONTH-LICS-AMOUNT	79 – 92	S9(12)V99	14	Monthly change in Low Income Cost Sharing Amount
11	CURRENT-MONTH-CPP-AMOUNT	93 – 106	S9(12)V99	14	Monthly change in Covered Plan Paid Amount
12	DET-RECORD-TOTAL	107 – 114	9(8)	8	Total count of DET records
13	CURRENT-MONTH-P2P-AMOUNT-DUE-TO-ALL-SUBMITTING CONTRACTS	115 – 128	S9(12)V99	14	The amount related to the Plan-to-Plan reconciliation condition. This amount represents the amount "due-to" this Contract of Record. This field is the sum of the LICS Amount and CPP Amount
14	FILLER	129 – 512	X(384)	384	SPACES

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Payment Reconciliation System (PRS) Inputs Report to Plans

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PRS INPUTS REPORT TO PLANS

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
FHD	File header	Occurs once per file
CHD	Contract level file header	Occurs once per Contract for each one on file
PHD	Contract/Plan level file header	Occurs once per Contract/Plan for each one on file
DET	Detail records for the report	Occurs 1 to many times per Contract/Plan record
PTR	Contract/Plan level file trailer	Occurs once per each PHD on the file

FHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"FHD"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	COVERAGE YEAR DATE	11 - 14	X(4)	4	Year for which a specific Part D payment reconciliation is conducted. The coverage year is always the calendar year.
4	RECONCILIATION NUMBER	15 - 18	9(4)	4	Reconciliation Iteration number.
5	PRS SYSTEM DATE	19 - 26	DATE	8	'CCYYMMDD' = PRS File creation date.
6	PRS SYSTEM TIME	27 - 32	TIME	6	'HHMMSS' = PRS File creation time.
7	PRS REPORT ID	33 - 41	X(9)	9	PRS Report identifier (INPUTSCONTRACT)
8	FILLER	42 - 1024		983	SPACES

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Unique identifier enabling an entity to provide coverage to eligible Medicare beneficiaries.
4	COVERAGE YEAR DATE	16 - 19	X(4)	4	Year for which a specific Part D payment reconciliation is conducted. The coverage year is always the calendar year.
5	RECONCILIATION NUMBER	20 - 23	9(4)	4	Reconciliation Iteration number.
6	PRS SYSTEM DATE	24 - 31	DATE	8	'CCYYMMDD' = PRS File creation date.
7	PRS SYSTEM TIME	32 - 37	TIME	6	'HHMMSS' = PRS File creation time.
8	PRS REPORT ID	38 - 51	X(14)	14	PRS Report identifier ('INPUTSCONTRACT'.)
9	FILLER	52 - 1024		973	SPACES

PRS INPUTS REPORT TO PLANS (CONTINUED)

PHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"PHD"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Unique identifier enabling an entity to provide coverage to eligible Medicare beneficiaries.
4	PLAN BENEFIT PACKAGE IDENTIFIER	16 - 18	X(3)	3	Three digit code identifying the Plan Benefit Package in which the beneficiaries in the detail record are enrolled.
5	PRS SYSTEM DATE	19 - 26	DATE	8	'CCYYMMDD' = PRS File creation date.
6	PRS SYSTEM TIME	27 - 32	TIME	6	'HHMMSS' = PRS File creation time.
7	PRS REPORT ID	33 - 46	X(14)	14	PRS Report identifier ('INPUTSCONTRACT'.)
8	FILLER	47 - 1024		978	SPACES

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	DET
2	SEQUENCE NO	4 - 10	9(7)	7	Must start with 0000001
3	CURRENT CMS HICN	11 - 30	X(20)	20	The number uniquely identifying the primary beneficiary under the Social Security Administration (SSA) or the Railroad Retirement Board (RRB) program.
4	NON P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	31 - 44	S9(12)V99	14	Amount, submitted by the Contract of record, that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status.
5	P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	45 - 58	S9(12)V99	14	Amount submitted, by other than the Contract of record, that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status.
6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	59 - 72	S9(12)V99	14	Amount that the plan reduced patient liability during a coverage year due to a beneficiary's low income cost-sharing subsidy (LICS) status. This is a summation of Report 4 COV and Report 42.
7	FILLER	73 - 86	S9(12)V99	14	SPACES

PRS INPUTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/values
8	NON P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	87 - 100	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by the Contract of record. Applies only to covered drugs. NOTE: All allowable costs are accounted for by GDCAA and GDCBA.
9	P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	101 - 114	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by other than the Contract of record. Applies only to covered drugs. NOTE: All allowable costs are accounted for by GDCAA and GDCBA.
10	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	115 - 128	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters). Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
11	NON P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	129 - 142	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), as submitted by the Contract of record. Applies only to covered drugs. NOTE: All allowable costs are accounted for by GDCAA and GDCBA.

PRS INPUTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/values
12	P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	143 - 156	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), as submitted by other than the Contract of record. Applies only to covered drugs. NOTE: All allowable costs are accounted for by GDCAA and GDCBA.
13	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	157 - 170	S9(12)V99	14	Amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters). Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
14	NON P2P COVERED PART D PLAN PAID AMOUNT	171 - 184	S9(12)V99	14	Medicare covered amount, submitted by the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
15	P2P COVERED PART D PLAN PAID AMOUNT	185 - 198	S9(12)V99	14	Medicare covered amount, submitted by other than the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
16	TOTAL COVERED PART D PLAN PAID AMOUNT	199 - 212	S9(12)V99	14	Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field. This is a summation of Report 4 COV and Report 42.

PRS INPUTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/values
17	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	213 - 226	S9(12)V99	14	Dollar amount of Part D Low Income Prospective Payment, net of all adjustments for coverage year under a given plan.
18	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	227 - 240	S9(12)V99	14	Dollar amount of Part D Reinsurance Prospective Payment, net of all adjustments for coverage year under a given plan.
19	PART D BASIC PREMIUM AMOUNT	241 - 254	S9(12)V99	14	Total Part D basic premium dollar amount, net of adjustments for coverage year, related to standardized bid, based on the number of months in the plan. Also, the premium amount is used to calculate the direct subsidy. This amount can be negative, and would then be expressed as a negative value.
20	DIRECT SUBSIDY AMOUNT	255 - 268	S9(12)V99	14	Total dollar amount of Part D Direct Subsidy, net of adjustments, for coverage year under a given plan. A direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount. This amount can be negative, and would then be expressed as a negative value.
21	PACE COST-SHARING ADD-ON AMOUNT	269 - 282	S9(12)V99	14	A percentage amount of a capitated payment paid for PACE dual eligible plans only, net of adjustments, for coverage year under a given plan (will be zero for non-PACE plans).
22	FILLER	283 - 1024		742	SPACES

PRS INPUTS REPORT TO PLANS (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"PTR"
2	SEQUENCE-NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Must match PHD
4	PLAN BENEFIT PACKAGE IDENTIFIER	16 - 18	X(3)	3	Must match PHD
5	NON P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	19 - 32	S9(12)V99	14	Total Beneficiary PBP Actual Low Income Cost-Sharing Subsidy Amount at the plan level (submitted by the Contract of record) that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status for all beneficiaries enrolled in the plan benefit package during the coverage year.
6	P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	33 - 46	S9(12)V99	14	Total Beneficiary PBP Actual Low Income Cost-Sharing Subsidy Amount (submitted by other than the Contract of record) that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status for all beneficiaries enrolled in the plan benefit package during the coverage year.
7	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	47 - 60	S9(12)V99	14	Total amount that the plan reduced patient liability during a coverage year due to a beneficiary's low income cost-sharing subsidy (LICS) status for all beneficiaries enrolled in the plan benefit package. This is a summation of Report 4 COV and Report 42.
8	FILLER	61 - 74	S9(12)V99	14	SPACES
9	NON P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	75 - 88	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by the Contract of record for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.

PRS INPUTS REPORT TO PLANS (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
10	P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	89 - 102	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by other than the Contract of record for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.
11	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	103 - 116	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters) for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
12	NON P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	117 - 130	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by the Contract of record for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.
13	P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	131 - 144	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), as submitted by other than the Contract of record for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.

PRS INPUTS REPORT TO PLANS (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
14	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	145 - 158	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters) for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
15	NON P2P COVERED PART D PLAN PAID AMOUNT	159 - 172	S9(12)V99	14	Total of Medicare covered amount, submitted by the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit for all beneficiaries enrolled in the plan benefit package for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
16	P2P COVERED PART D PLAN PAID AMOUNT	173 - 186	S9(12)V99	14	Total of Medicare covered amount, submitted by other than the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit for all beneficiaries enrolled in the plan benefit package for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
17	TOTAL COVERED PART D PLAN PAID AMOUNT	187 - 200	S9(12)V99	14	Total of Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit for all beneficiaries enrolled in the plan benefit package for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field. This is a summation of Report 4 COV and Report 42.
18	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	201 - 214	S9(12)V99	14	Total dollar amount of Part D Low Income Prospective Payment for all beneficiaries enrolled in the plan benefit package, net of all adjustments for coverage year.

PRS INPUTS REPORT TO PLANS (CONTINUED)

PTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
19	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	215 - 228	S9(12)V99	14	Total dollar amount of Part D Reinsurance Prospective Payment, net of all adjustments, for the coverage year for all beneficiaries enrolled in the plan benefit package.
20	PART D BASIC PREMIUM AMOUNT	229 - 242	S9(12)V99	14	Total Part D basic premium dollar amount, net of adjustments, related to standardized bid, based on number of months in the plan for all beneficiaries in plan benefit package during the coverage year. This is an annualized amount that corresponds to the premium amount used to calculate the Direct Subsidy. This amount can be negative.
21	DIRECT SUBSIDY AMOUNT	243 - 256	S9(12)V99	14	Total dollar amount of Part D Direct Subsidy, net of adjustments, for all beneficiaries enrolled in the plan benefit package during the coverage year. A direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount. This amount can be negative.
22	PACE COST-SHARING ADD-ON AMOUNT	257 - 270	S9(12)V99	14	Total Beneficiary PBP PACE Cost Sharing Add-On Amount for all beneficiaries enrolled in the plan benefit package during the coverage year.
23	COUNT OF UNIQUE MEMBERS PER YEAR	271 - 279	9(9)	9	Count of total unique members in a plan within the coverage year, regardless of how many months each member was enrolled in the plan. If the beneficiary enrolls and then re-enrolls in the same plan, the count will only be one.
24	FILLER	280 - 1024		745	SPACES

PRS INPUTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE NO	4 - 10	9(7)	7	Must start with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Must match CHD
4	NON P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	16 - 29	S9(12)V99	14	Total Actual Low Income Cost-Sharing Subsidy Amount (submitted by the Contract of record) that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status for all plans within the contract during the coverage year.
5	P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	30 - 43	S9(12)V99	14	Total Actual Low Income Cost-Sharing Subsidy Amount (submitted by other than the Contract of record) that the plan reduced patient liability due to a beneficiary's low income cost-sharing subsidy (LICS) status for all plans within the contract during the coverage year.
6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	44 - 57	S9(12)V99	14	Total amount that the plan reduced patient liability during a coverage year due to a beneficiary's low income cost-sharing subsidy (LICS) status for all PBPs within the contract. This is a summation of Report 4 COV and Report 42.
7	FILLER	58 - 71	S9(12)V99	14	SPACES
8	NON P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	72 - 85	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by the Contract of record, for all PBPs within the contract during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.

PRS INPUTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
9	P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	86 - 99	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by other than the Contract of record, for all PBPs within the contract during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.
10	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	100 - 113	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters) for all PBPs within the contract during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
11	NON P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	114 - 127	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), submitted by the Contract of record for all PBPs within the contract during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.
12	P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	128 - 141	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters), as submitted by other than the Contract of record for all PBPs within the contract during the coverage year. Applies only to covered drugs. Note: All allowable costs are accounted for by GDCAA and GDCBA.

PRS INPUTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
13	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	142 - 155	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters) for all PBPs within the contract during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
14	NON P2P COVERED PART D PLAN PAID AMOUNT	156 - 169	S9(12)V99	14	Total of Medicare covered amount, submitted by the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit for all PBPs within the contract for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
15	P2P COVERED PART D PLAN PAID AMOUNT	170 - 183	S9(12)V99	14	Total of Medicare covered amount, submitted by other than the Contract of record, which the plan has paid for a Part D covered drug under the Basic benefit for all PBPs within the contract for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field.
16	TOTAL COVERED PART D PLAN PAID AMOUNT	184 - 197	S9(12)V99	14	Total of Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit for all PBPs within the contract for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field. This is a summation of Report 4 COV and Report 42.
17	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	198 - 211	S9(12)V99	14	Total dollar amount of Part D Low Income Prospective Payment for all PBPs within the contract, net of all adjustments for the coverage year.
18	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	212 - 225	S9(12)V99	14	Total dollar amount of Part D Reinsurance Prospective Payment, net of all adjustments for the coverage year, for all PBPs within the contract.

PRS INPUTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
19	PART D BASIC PREMIUM AMOUNT	226 - 239	S9(12)V99	14	Total Part D basic premium dollar amount, net of adjustments, related to standardized bid, based on number of months in the plan for all beneficiaries in the plan benefit package for all PBPs within the contract during the coverage year. This is an annualized amount that corresponds to the premium amount used to calculate the Direct Subsidy. This amount can be negative.
20	DIRECT SUBSIDY AMOUNT	240 - 253	S9(12)V99	14	Total dollar amount of Part D Direct Subsidy, net of adjustments, for all PBPs within the contract during the coverage year. A direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount. This amount can be negative.
21	PACE COST-SHARING ADD-ON AMOUNT	254 - 267	S9(12)V99	14	Total Beneficiary PBP PACE Cost Sharing Add-On Amount for all PBPs within the contract during the coverage year.
22	TOTAL COUNT OF PBPs	268-276	9(9)	9	Total count of PBPs in the contract.
23	FILLER	277-1024		748	SPACES

PRS INPUTS REPORT TO PLANS (CONTINUED)

FTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"FTR"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	TOTAL COUNT OF UNIQUE MEMBERS PER YEAR	11-21	9(11)	11	Count of total unique members in a plan within the coverage year, regardless of how many months each member was enrolled in the plan. If the beneficiariy enrolls and then re-enrolls in the same plan, the count will only be one.
4	TOTAL COUNT OF PBPs	22-32	9(11)	11	Total count of PBPs in the program.
5	TOTAL COUNT OF CONTRACTS	33-43	9(11)	11	Total count of contracts in the program.
6	FILLER	44-1024		981	SPACES

Payment Reconciliation System (PRS) Results Report to Plans

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PRS RESULTS REPORT TO PLANS

RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
FHD	File header	Occurs once per file
CHD	Contract level file header	Occurs once per Contract for each one on file
DET	Plan detail records for the report	Occurs 1 to many times per Contract/Plan record
CTR	Contract level file trailer	Occurs once per each CHD on the file
FTR	File trailer	Occurs once per file

FHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"FHD"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	COVERAGE YEAR DATE	11 - 14	X(4)	4	Year for which a specific Part D payment reconciliation is conducted. The coverage year is always the calendar year.
4	RECONCILIATION NUMBER	15 - 18	9(4)	4	Reconciliation Iteration number.
5	PRS SYSTEM DATE	19 - 26	DATE	8	'CCYYMMDD' = PRS File creation date
6	PRS SYSTEM TIME	27 - 32	TIME	6	'HHMMSS' = PRS File creaton time
7	PRS REPORT ID	33 - 40	X(9)	8	PRS Report Identifier (RECRSCTR)
8	FILLER	41 - 1024		984	SPACES

CHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD-ID	1 - 3	X(3)	3	"CHD"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Unique identifier enabling an entity to provide coverage to eligible Medicare beneficiaries.
4	PRS SYSTEM DATE	16 - 23	DATE	8	'CCYYMMDD' = PRS File creation date
5	PRS SYSTEM TIME	24 - 29	TIME	6	'HHMMSS' = PRS File creaton time
6	PRS REPORT ID	30 - 37	X(9)	8	PRS Report Identifier (RECRSCTR)
7	FILLER	38 - 1024		987	SPACES

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"DET"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Unique identifier enabling an entity to provide coverage to eligible Medicare beneficiaries.
4	PLAN BENEFIT PACKAGE IDENTIFIER	16 - 18	X(3)	3	A unique identifier for the plan benefit package offered under the contract. For Part D this number is a unique identification for an agreement between CMS and a Part D provider enabling the Part D provider to provide drug coverage to eligible beneficiaries.
5	PAYMENT RECONCILIATION PLAN TYPE CODE	19 - 20	X(2)	2	A numeric identifier assigned to a valid payment reconciliation plan type.
6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	21 - 34	S9(12)V99	14	Total amount that the plan reduced patient liability during a coverage year due to a beneficiary's low income cost-sharing subsidy (LICS) status for all beneficiaries enrolled in the plan benefit package. This is a summation of Report 4 COV and Report 42.
7	FILLER	35 - 48	S9(12)V99	14	SPACES
8	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	49 - 62	S9(12)V99	14	Total dollar amount of Part D Low Income Prospective Payment for all beneficiaries enrolled in the plan benefit package, net of all adjustments for coverage year.
9	LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	63 - 76	S9(12)V99	14	Net reconciliation of the Low Income Cost-Sharing Subsidy. Calculated as Total Actual Low Income Cost-Sharing Subsidy Amount minus Prospective Low Income Cost-Sharing Subsidy Amount. This amount can be negative.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
10	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	77 - 90	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters) for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
11	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	91 - 104	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters) for all beneficiaries enrolled in the plan benefit package during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
12	REINSURANCE DIR RATIO	105-109	S9(1)V9999	5	The portion of total direct and indirect remuneration (DIR) that is applicable to catastrophic coverage.
13	PART D COVERED DIR AMOUNT	110-123	S9(12)V99	14	Direct and indirect remuneration received by plan for Part D covered drugs associated with a specific coverage year. Reported annually to CMS. Revenue reported under DIR includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source (including manufacturers, pharmacies, enrollees, or any other person) that would serve to decrease the costs incurred by the Part D sponsor for the drug.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
14	REINSURANCE PORTION OF DIR AMOUNT	124-137	S9(12)V99	14	Amount of covered direct and indirect remuneration (DIR) that is applicable to reinsurance. Calculated as Reinsurance DIR Ratio x Part D Covered DIR Amount.
15	ALLOWABLE REINSURANCE COST AMOUNT	138-151	S9(12)V99	14	Total actual costs eligible for reinsurance subsidy, after removing direct and indirect remuneration (DIR). Calculated as Gross Drug Cost Above Out of Pocket Threshold - Plan Level Reinsurance Portion of DIR Amount.
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	152-165	S9(12)V99	14	The actual reinsurance subsidy amount paid for a coverage year to a plan eligible to receive the reinsurance subsidy, as calculated by PRS. Calculated as: Actual Reinsurance Amount based on computations using GDCA amounts, GDCB amounts and DIR. (Allowable Reinsurance Cost Amount x 0.80)
17	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	166-179	S9(12)V99	14	Total dollar amount of Part D Reinsurance Prospective Payment, net of all adjustments for coverage year for all beneficiaries enrolled in the plan benefit package.
18	REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	180-193	S9(12)V99	14	Net reinsurance reconciliation amount. Calculated as Actual Reinsurance Subsidy Amount minus Prospective Reinsurance Subsidy Amount. This amount can be negative.
19	TOTAL COVERED PART D PLAN PAID AMOUNT	194-207	S9(12)V99	14	Total of Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit for all beneficiaries enrolled in the plan benefit package for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field. This is a summation of Report 4 COV and Report 42.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
20	INDUCED UTILIZATION RATIO	208-212	S9(1)V9999	5	Ratio used to determine induced utilization. Will be equal to 1 except for all EA plans. The factor that would adjust the scripts/1,000 for the expected utilization difference that would apply if the enhanced alternative benefits in the base period were modified to be the defined standard prescription drug plan. (OMB Approved # 0938-NEW, CMS-10142 (03/2005))
21	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	213-226	S9(12)V99	14	Total actual costs allowed in risk sharing reconciliation, after removing direct and indirect remuneration (DIR) for covered drugs and the reinsurance subsidy, and allowing for induced utilization for Enhanced Alternative (EA) plans. Calculated as: (Covered Part D Plan Paid Amount - Actual Reinsurance Subsidy Amount - Part D DIR Amount) / Induced Utilization Ratio
22	DIRECT SUBSIDY AMOUNT	227-240	S9(12)V99	14	Total dollar amount of Part D Direct Subsidy, net of adjustments, for all beneficiaries enrolled in the plan benefit package during the coverage year. A direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount. This amount can be negative.
23	PART D BASIC PREMIUM AMOUNT	241-254	S9(12)V99	14	Total Part D basic premium dollar amount, net of adjustments, related to standardized bid, based on number of months in plan for all beneficiaries in plan benefit package during the coverage year. This is an annualized amount that corresponds to the premium amount used to calculate the Direct Subsidy. This amount can be negative.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
24	ADMINISTRATIVE COST RATIO	255-259	S9(1)V9999	5	A ratio built using components of Plan Bid. Total Plan Bid costs include Administrative Costs and Drug Costs. The ACR represents the ratio of administrative costs to total costs for the Basic Benefit.
25	PACE COST-SHARING ADD-ON AMOUNT	260-273	S9(12)V99	14	Total Beneficiary PBP PACE Cost Sharing Add-On Amount for all beneficiaries enrolled in the plan benefit package during the coverage year.

26	TARGET AMOUNT	274-287	S9(12)V99	14	Total amount paid to plan for Part D bid less administrative costs (with administrative costs deducted based on bid assumptions rather than actual administrative costs). This amount is compared to actual costs in risk sharing reconciliation.
					Calculated as:
					IF PRS plan type = 1, 2, 3, 4, 8, 11, 13 THEN
					TA = (Direct Subsidy Amount + Part D Basic Premium Amount) x (1 - Administrative Cost Ratio).
					IF PRS plan type = 7 THEN
					TA = (Direct Subsidy Amount + Part D Basic Premium Amount) x (1 - Administrative Cost Ratio) + PACE Cost-sharing Add-on Amount.
					IF PRS plan type = 9 or 10 THEN
					TA = (Direct Subsidy Amount + Part D Basic Premium Amount) x (1 - Administrative Cost Ratio) + Actual Reinsurance Subsidy Amount

27	SIXTY SIXTY RULE MET INDICATOR	288	X(1)	1	Indicates whether or not the Part D program, based on a particular coverage year and reconciliaiton, has met the 60/60 rule. Y = Yes, has met the 60/60 rule N = No, has not met the 60/60 rule

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
28	FIRST UPPER THRESHOLD PERCENT	289-293	S9(1)V999 99	5	Approved percent which, when applied to the Target Amount, is used to calculate the first upper threshold amount for the risk sharing calculation. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if PRS plan type = 13 then the percent is Limited Risk First Threshold Percent.
29	SECOND UPPER THRESHOLD PERCENT	294-298	S9(1)V999 99	5	Approved percent which, when applied to the Target Amount, is used to calculate the second upper threshold amount for the risk sharing calculation. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if PRS plan type = 13 then is Limited Risk Second Threshold Percent.
30	FIRST LOWER THRESHOLD PERCENT	299-303	S9(1)V999 99	5	Approved percent which, when applied to the Target Amount, is used to calculate the first lower threshold amount for the risk sharing calculation. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if PRS plan type = 13 then the percent is Limited Risk First Threshold Percent.
31	SECOND LOWER THRESHOLD PERCENT	304-308	S9(1)V999 99	5	Approved percent which, when applied to the Target Amount, is used to calculate the second lower threshold amount for the risk sharing calculation. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if PRS plan type = 13 then is Limited Risk Second Threshold Percent.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
32	FIRST UPPER THRESHOLD AMOUNT	309-322	S9(12)V99	14	Dollar amount which defines first upper limit for plan. Government will owe plan if plan Adjusted Allowable Risk Corridor Costs exceed this threshold. Calculated as First Upper Threshold Percent x Target Amount.
33	SECOND UPPER THRESHOLD AMOUNT	323-336	S9(12)V99	14	Dollar amount which defines second upper limit for plan. Government will owe plan if plan Adjusted Allowable Risk Corridor Costs exceed this threshold. Calculated as Second Upper Threshold Percent x Target Amount.
34	FIRST LOWER THRESHOLD AMOUNT	337-350	S9(12)V99	14	Dollar amount which defines first lower limit for plan risk sharing. Plan will owe government if plan Adjusted Allowable Risk Corridor Costs are below this threshold. Calculated as First Lower Threshold Percent x Target Amount.
35	SECOND LOWER THRESHOLD AMOUNT	351-364	S9(12)V99	14	Dollar amount which defines second lower limit for plan. Plan will owe government if plan Adjusted Allowable Risk Corridor Costs are below this threshold. Calculated as Second Lower Threshold Percent x Target Amount.
36	COST OVER FIRST UPPER THRESHOLD INDICATOR	365	X(1)	1	Indicates whether the Adjusted Allowable Risk Corridor Cost Amount is greater than the First Upper Threshold Amount for payment reconciliation plan types 1, 2, 3, 4, 7, 8, 9, 10, 11, 13. Valid values: 1 = over the First Upper Threshold Amount 0 = below the First Upper Threshold Amount
37	FIRST UPPER RISK SHARING RATE	366-370	S9(1)V9999	5	Approved rate at which the government shares risk for adjusted allowable risk corridor costs between the first and second upper threshold limits. NOTE for data being reported: If payment reconciliation plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if payment reconciliation plan type = 13 then is Limited Risk First Risk-sharing Rate.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
38	SECOND UPPER RISK-SHARING RATE	371-375	S9(1)V9999	5	Approved rate at which the government shares risk for adjusted allowable risk corridor costs above the second upper threshold limit. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is default value. Otherwise, if PRS plan type = 13 then is Limited Risk Second Risk-sharing Rate.
39	FIRST LOWER RISK-SHARING RATE	376 - 380	S9(1)V9999	5	Approved rate at which the government shares risk for adjusted allowable risk corridor costs between the first and second lower threshold limits. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is statutory (default) value. Otherwise, if PRS plan type = 13 then the rate is Limited Risk First Risk-sharing Rate.
40	SECOND LOWER RISK-SHARING RATE	381 - 385	S9(1)V9999	5	Approved rate at which the government shares risk for adjusted allowable risk corridor costs below the second lower threshold limit. NOTE for data being reported: If PRS plan type = 1, 2, 3, 4, 7, 8, 9, 10 or 11 then is default value. Otherwise, if PRS plan type = 13 then is Limited Risk Second Risk-sharing Rate.
41	RISK-SHARING AMOUNT	386 - 399	S9(12)V99	14	Net risk-sharing reconciliation amount. This amount can be negative.
42	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	400 - 413	S9(12)V99	14	Contribution to risk-sharing amount caused by plan cost beyond either Second Upper Threshold Amount or Second Lower Threshold Amount.
43	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	414 - 427	S9(12)V99	14	Contribution to risk-sharing amount caused by plan cost between First and Second Threshold Amounts.
44	COUNT OF UNIQUE MEMBERS PER YEAR	428 - 436	9(9)	9	Count of total unique members in a plan within the coverage year, regardless of how many months each member was enrolled in the plan. If the beneficiary enrolls and then re-enrolls in the same plan, the count will only be one.

PRS RESULTS REPORT TO PLANS (CONTINUED)

DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
45	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	437 - 441	S9(3)V99	5	Dollar amount per member per annum required for Payment Demonstration Plans to achieve budget neutrality. This amount represents the input value for the reconciliation budget neutrality computation.
46	BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	442 - 455	S9(12)V99	14	Dollar amount required for payment demonstration plan to achieve budget neutrality.
47	ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	456 - 469	S9(12)V99	14	Net reconciliation amount for plan in a coverage year. Calculated as Low-income Cost-sharing Adjustment Amount + Reinsurance Subsidy Adjustment Amount + Risk-sharing Amount - (Annual Budget Neutrality Dollar Amount (Demonstration Plans) x Unique Member Per Year). This amount can be negative.
48	FILLER	470 - 1024		555	SPACES

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"CTR"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	CONTRACT IDENTIFIER	11 - 15	X(5)	5	Must match CHD
4	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	16 - 29	S9(12)V99	14	Total amount that the plan reduced patient liability during a coverage year due to a beneficiary's low income cost-sharing subsidy (LICS) status for all PBPs within the contract.
5	FILLER	30 - 43	S9(12)V99	14	SPACES
6	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	44 - 57	S9(12)V99	14	Total dollar amount of Part D Low Income Prospective Payment for all PBPs within the contract, net of all adjustments for coverage year.
7	LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	58 - 71	S9(12)V99	14	Total net reconciliation at the contract level of the Low Income Cost-Sharing Subsidy. This amount can be negative.

PRS RESULTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
8	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	72 - 85	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs above the out-of-pocket threshold (as established by plan type/benefit year parameters) for all PBPs within the contract during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
9	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	86 - 99	S9(12)V99	14	Total amount paid (regardless of payer) toward allowable point of sale costs below the out-of-pocket threshold (as established by plan type/benefit year parameters) for all PBPs within the contract during the coverage year. Applies only to covered drugs. This is a summation of Report 4 COV and Report 42. Note: All allowable costs are accounted for by GDCAA and GDCBA.
10	REINSURANCE PORTION OF DIR AMOUNT	100 - 113	S9(12)V99	14	Total amount of covered direct and indirect remuneration (DIR) at the contract level that is applicable to reinsurance.
11	PART D COVERED DIR AMOUNT	114 - 127	S9(12)V99	14	Total direct and indirect remuneration at the contract level received by plans within the contract for Part D covered drugs associated with a specific coverage year. Reported annually to CMS. Revenue reported under DIR includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source (including manufacturers, pharmacies, enrollees, or any other person) that would serve to decrease the costs incurred by the Part D sponsor for the drug.
12	ALLOWABLE REINSURANCE COST AMOUNT	128 - 141	S9(12)V99	14	Total actual costs eligible for reinsurance subsidy at the contract level, after removing direct and indirect remuneration (DIR).

PRS RESULTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
13	ACTUAL REINSURANCE SUBSIDY AMOUNT	142 - 155	S9(12)V99	14	Total actual reinsurance subsidy amount at the contract level paid for a coverage year to plans within the contract that are eligible to receive the reinsurance subsidy, as calculated by PRS.
14	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	156 - 169	S9(12)V99	14	Total dollar amount of Part D Reinsurance Prospective Payment, net of all adjustments for coverage year for all PBPs within the contract.
15	REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	170 - 183	S9(12)V99	14	Total net reinsurance reconciliation amount at the contract level. This amount can be negative.
16	TOTAL COVERED PART D PLAN PAID AMOUNT	184 - 197	S9(12)V99	14	Total of Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit for all PBPs within the contract for the coverage year. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-counter drugs are excluded from this field. This is a summation of Report 4 COV and Report 42.
17	DIRECT SUBSIDY AMOUNT	198 - 211	S9(12)V99	14	Total dollar amount of Part D Direct Subsidy, net of adjustments, for all PBPs within the contract for the coverage year. A direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount. This amount can be negative.
18	PART D BASIC PREMIUM AMOUNT	212 - 225	S9(12)V99	14	Total Part D basic premium dollar amount, net of adjustments, related to standardized bid, based on number of months in plan for all beneficiaries in plan benefit package during the coverage year for all PBPs in the contract. This is an annualized amount that corresponds to the premium amount used to calculate the Direct Subsidy. This amount can be negative.

PRS RESULTS REPORT TO PLANS (CONTINUED)

CTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
19	PACE COST-SHARING ADD-ON AMOUNT	226 - 239	S9(12)V99	14	Total Beneficiary PBP PACE Cost Sharing Add-On Amount for all PBPs within the contract during the coverage year.
20	RISK-SHARING AMOUNT	240 - 253	S9(12)V99	14	Total net risk-sharing reconciliation amount at the contract level. This amount can be negative.
23	BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	254 - 267	S9(12)V99	14	Dollar amount, at the contract level, required for payment demonstration plans to achieve budget neutrality.
24	ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	268 - 281	S9(12)V99	14	Total net reconciliation amount for all plans within the contract in a coverage year. This amount can be negative.
25	COUNT OF PBPs	282 - 290	9(9)	9	Count of PBPs in the contract.
26	FILLER	291 - 1024		734	SPACES

FTR RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	"FTR"
2	SEQUENCE NO	4 - 10	9(7)	7	Starts with 0000001
3	TOTAL COUNT OF UNIQUE MEMBERS PER YEAR	11-21	9(11)	11	Count of total unique members in a plan within the coverage year, regardless of how many months each member was enrolled in the plan. If the beneficiary enrolls and then re-enrolls in the same plan, the count will only be one.
4	TOTAL COUNT OF PBPs	22-32	9(11)	11	Total count of PBPs in the program.
5	TOTAL COUNT OF CONTRACTS	33-43	9(11)	11	Total count of contracts in the program.
6	FILLER	44-1024		981	SPACES

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Monthly Membership Report (MMR)

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MONTHLY MEMBERSHIP REPORT (MMR)

MMR DATA FILE

#	Field Name	Len	Pos	Description
1*	MCO Contract Number	5	1-5	MCO Contract Number
2*	Run Date of the File	8	6-13	YYYYMMDD
3*	Payment Date	6	14-19	YYYYMM
4*	HIC Number	12	20-31	Member's HIC #
5*	Surname	7	32-38	
6*	First Initial	1	39-39	
7*	Sex	1	40-40	M = Male, F = Female
8*	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10*	State & County Code	5	53-57	
11*	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12*	Part A Entitlement	1	59-59	Y = Entitled to Part A
13*	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Working Aged/Medicare Secondary Payer	1	63-63	Y = Working Aged/Medicare Secondary Payer
17	Institutional	1	64-64	Y = Institutional
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
20	FILLER	1	67-67	SPACE
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon

MMR DATA FILE (CONTINUED)

#	Field Name	Len	Pos	Description
22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28*	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29*	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30*	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-99999.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-99999.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-99999.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-99999.99
35	LIS Premium Amount	28	144-171	SPACES

MMR DATA FILE (CONTINUED)

#	Field Name	Len	Pos	Description
36	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
37	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
38	FILLER	2	183-184	SPACES
39*	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
40	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = American Native
41	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD)
42	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
43	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
44	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
45	Segment ID	3	194–196	Identification number of the segment of the PBP. Blank if there are no segments.

MMR DATA FILE (CONTINUED)

#	Field Name	Len	Pos	Description
46*	Enrollment Source	1	197-197	The source of the enrollment. Values are A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover)
47*	EGHP Flag	1	198-198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
48	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
49	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
50	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
51	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
52	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
53	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
54	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99

MMR DATA FILE (CONTINUED)

#	Field Name	Len	Pos	Description
55	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
56	Rebate for Part D Supplemental Benefits – Part A Amount	8	263-270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
57	Rebate for Part D Supplemental Benefits – Part B Amount	8	271-278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
58	Total Part A MA Payment	10	279- 288	The total Part A MA payment. -999999.99
59	Total Part B MA Payment	10	289-298	The total Part B MA payment. -999999.99
60	Total MA Payment Amount	11	299-309	The total MA A/B payment including MARx adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -999999.99
61*	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD
62*	Part D Low-Income Indicator	1	317-317	An indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank.
63*	Part D Low-Income Multiplier	7	318-324	The member's low-income multiplier. NN.DDDD
64*	Part D Long Term Institutional Indicator	1	325-325	An indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank.
65*	Part D Long Term Institutional Multiplier	7	326-332	The member's long term institutional multiplier. NN.DDDD
66	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99
67*	Part D Basic Premium Amount	8	341-348	The plan's Part D premium amount. -9999.99
68*	Part D Direct Subsidy Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. -999999.99

MMR DATA FILE (CONTINUED)

#	Field Name	Len	Pos	Description
69*	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
70*	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
71*	Total Part D Payment	11	379-389	The total Part D payment for the member. -999999.99
72*	Number of payment/adjustment months Part D	2	390-391	Total number of months covered by the payment/adjustment 99
73	PACE Premium Add-On	10	392-401	Total Part D PACE Premium Add-on amount -999999.99
74	PACE Cost Sharing Add-On	10	402-411	Total Part D PACE Cost Sharing Add-on amount -999999.99

* Identifies fields applicable to PDPs.

CSSC WEB RESOURCES

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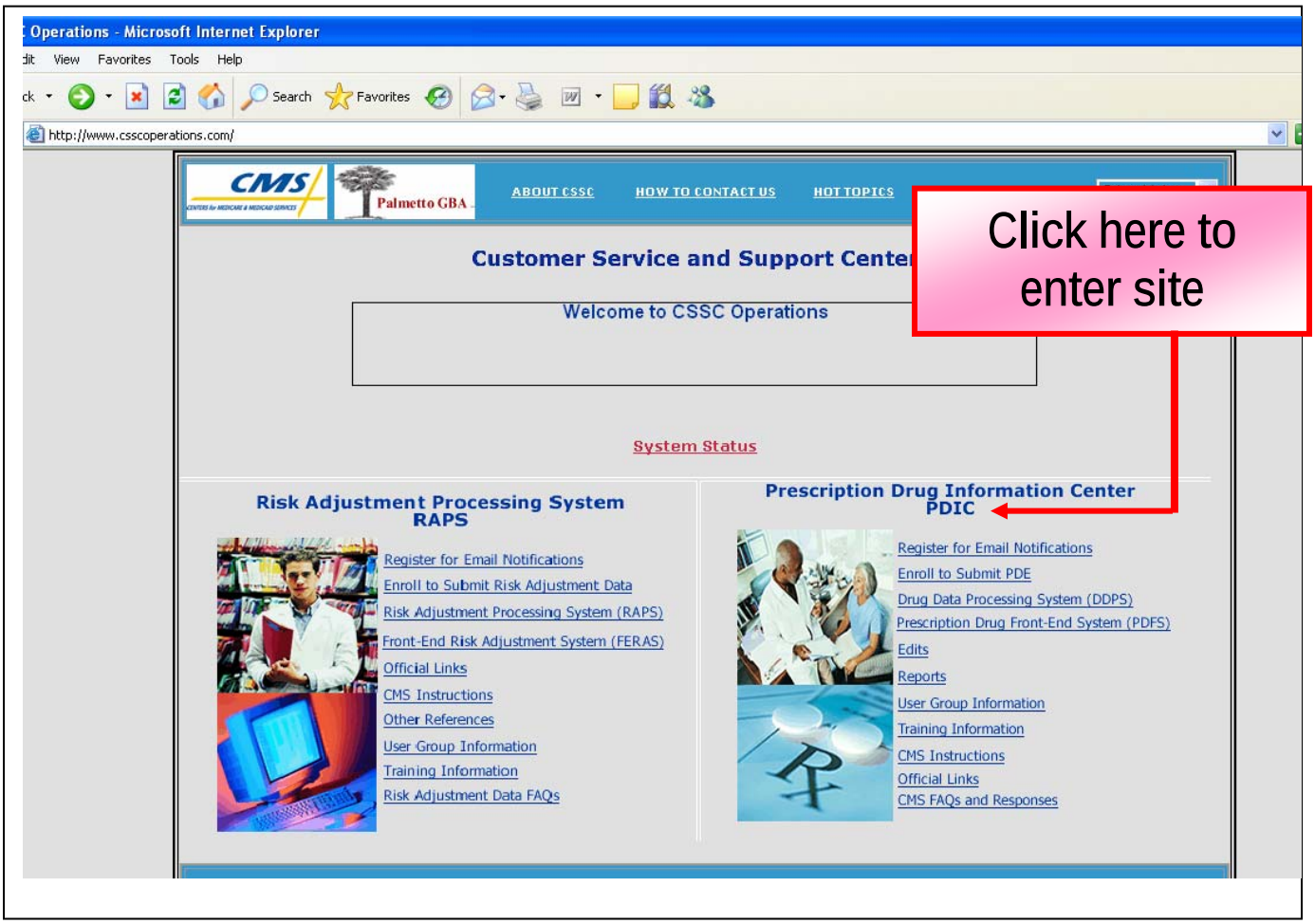
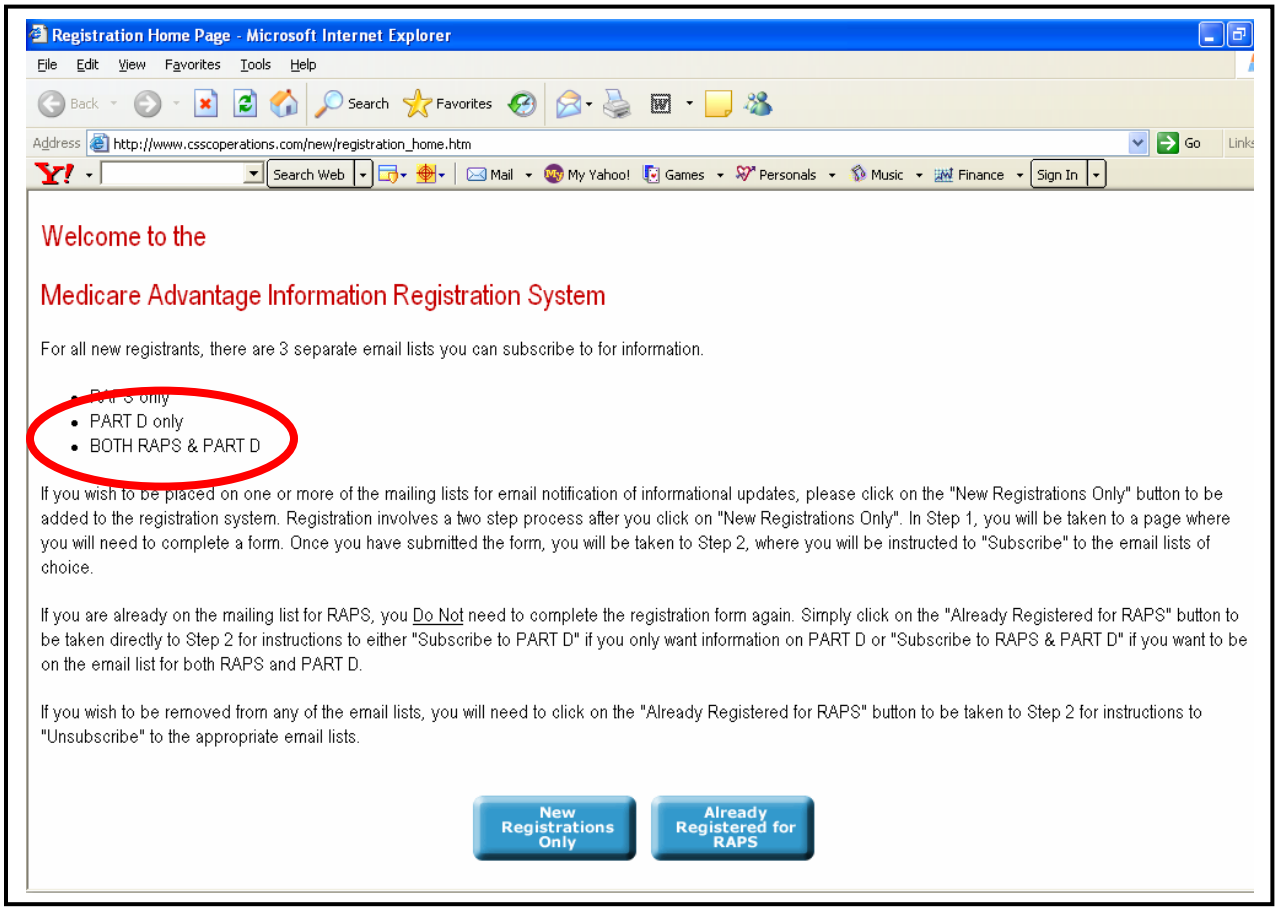
WWW.CSSCOPERATIONS.COM

http://www.csscoperations.com



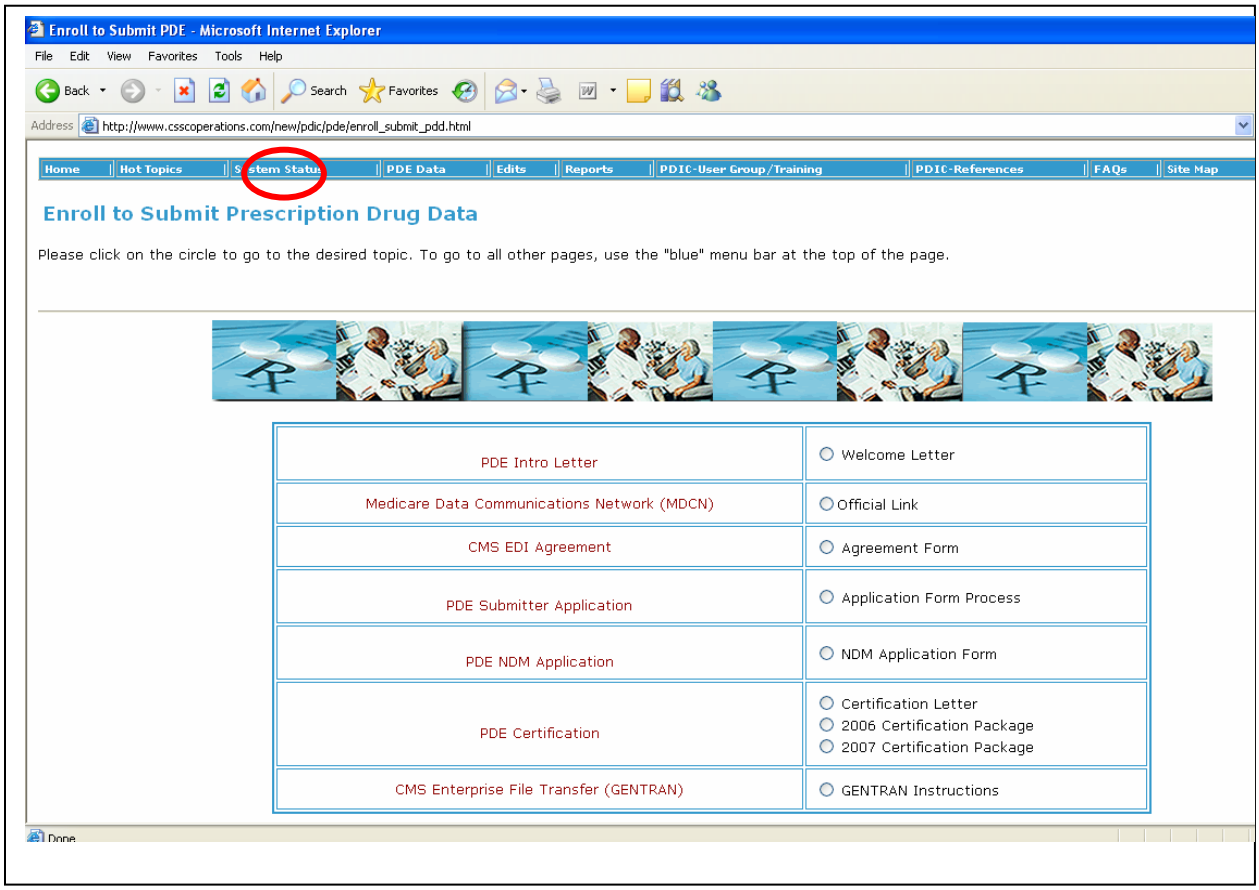
Register for Email Service

http://www.csscoperations.com/new/registration_home.htm



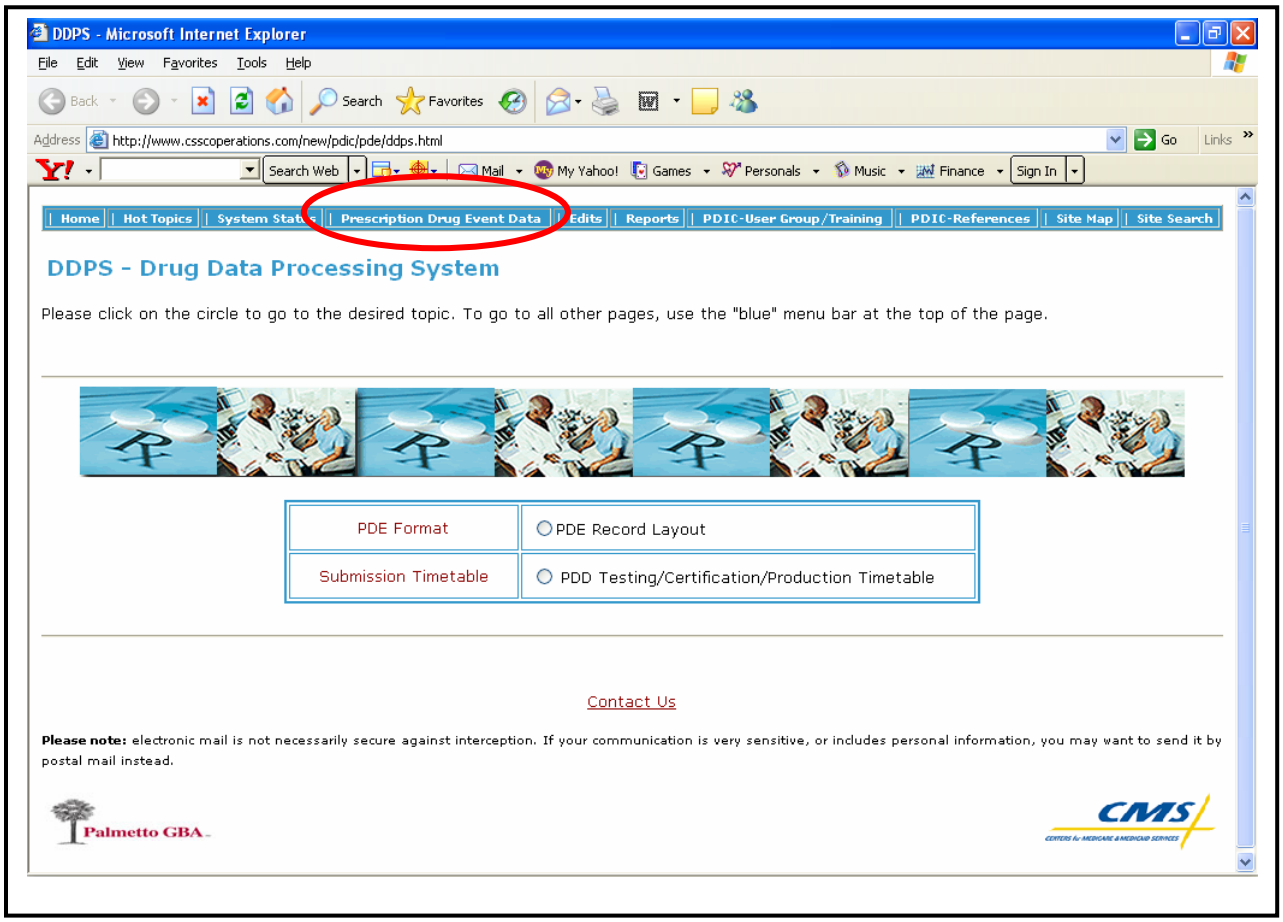
Enroll to Submit Prescription Drug Data (PDD)

http://www.csscoperations.com/new/pdic/pde/enroll_submit_pdd.html



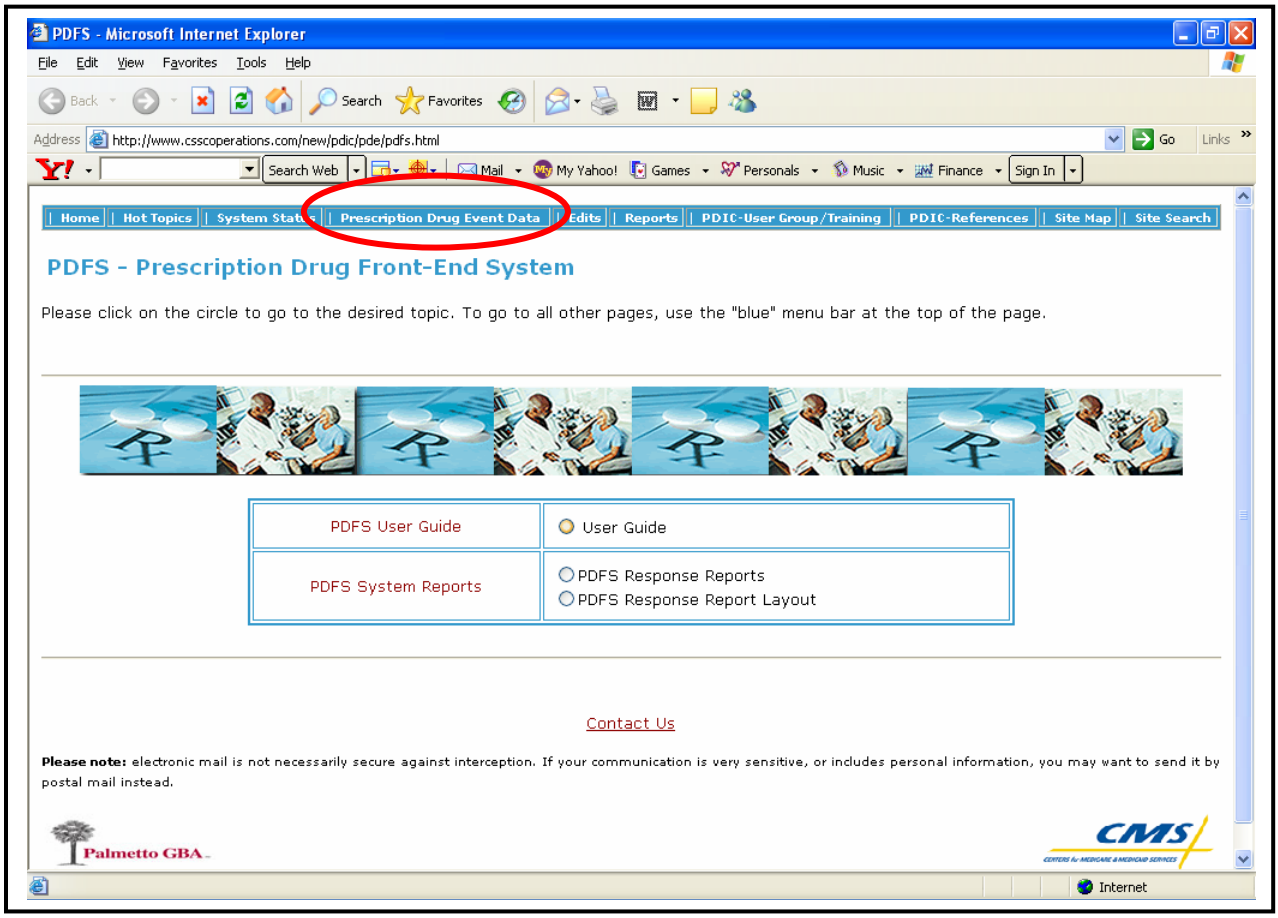
Drug Data Processing System (DDPS) Resources

http://www.csscoperations.com/new/pdic/pde/ddps.html



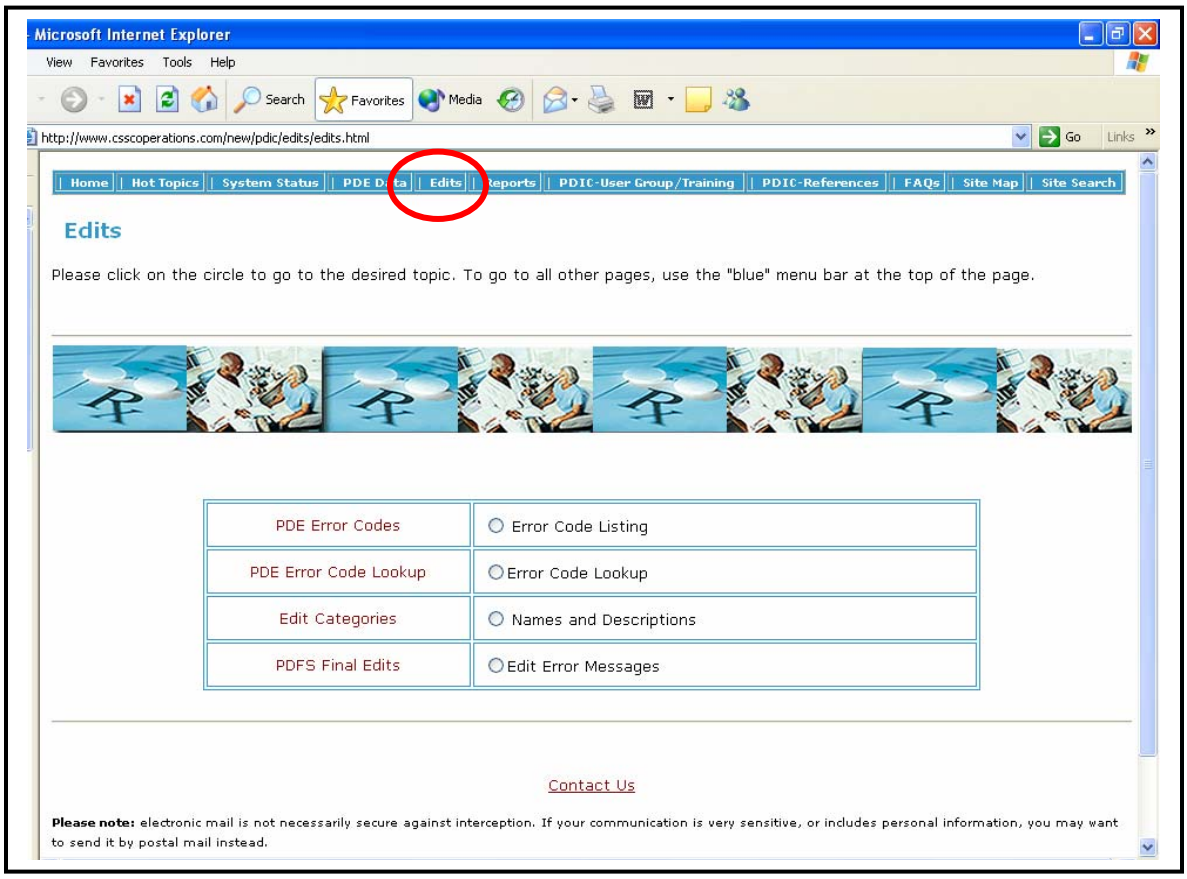
Prescription Drug Front-End System (PDFS) Resources

http://www.csscoperations.com/new/pdic/pde/pdfs.html



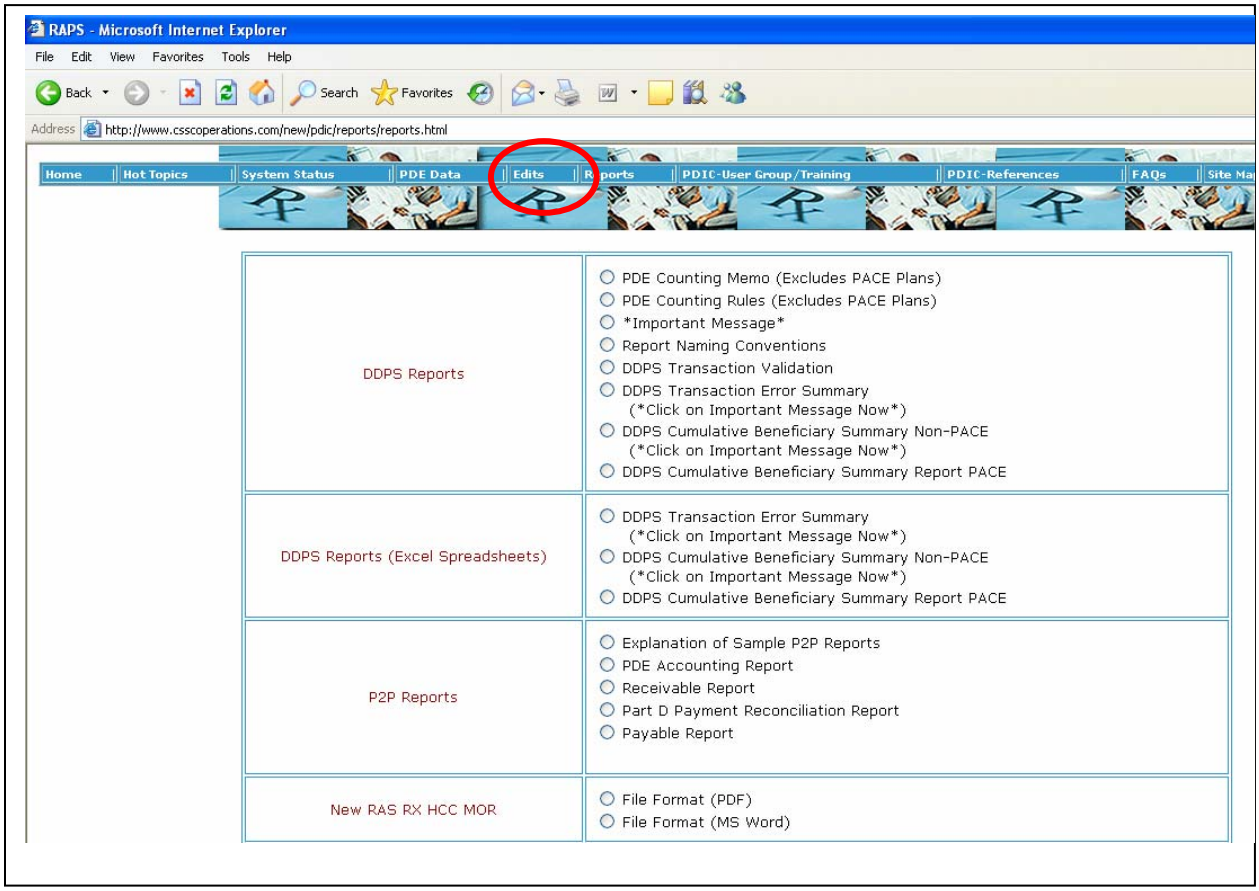
Error Code Resources

http://www.csscoperations.com/new/pdic/edits/edits.html



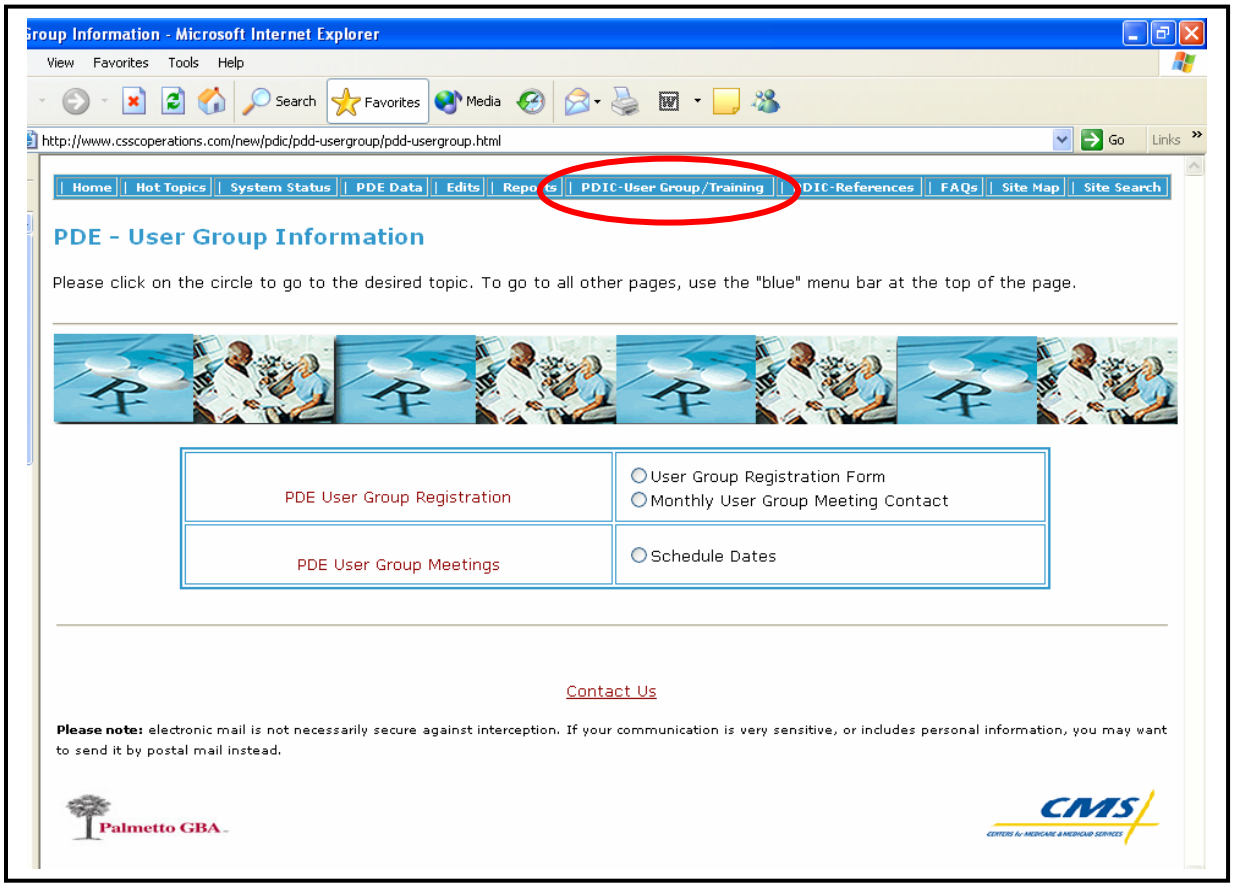
Reports Resources

http://www.csscoperations.com/new/pdic/reports/reports.html



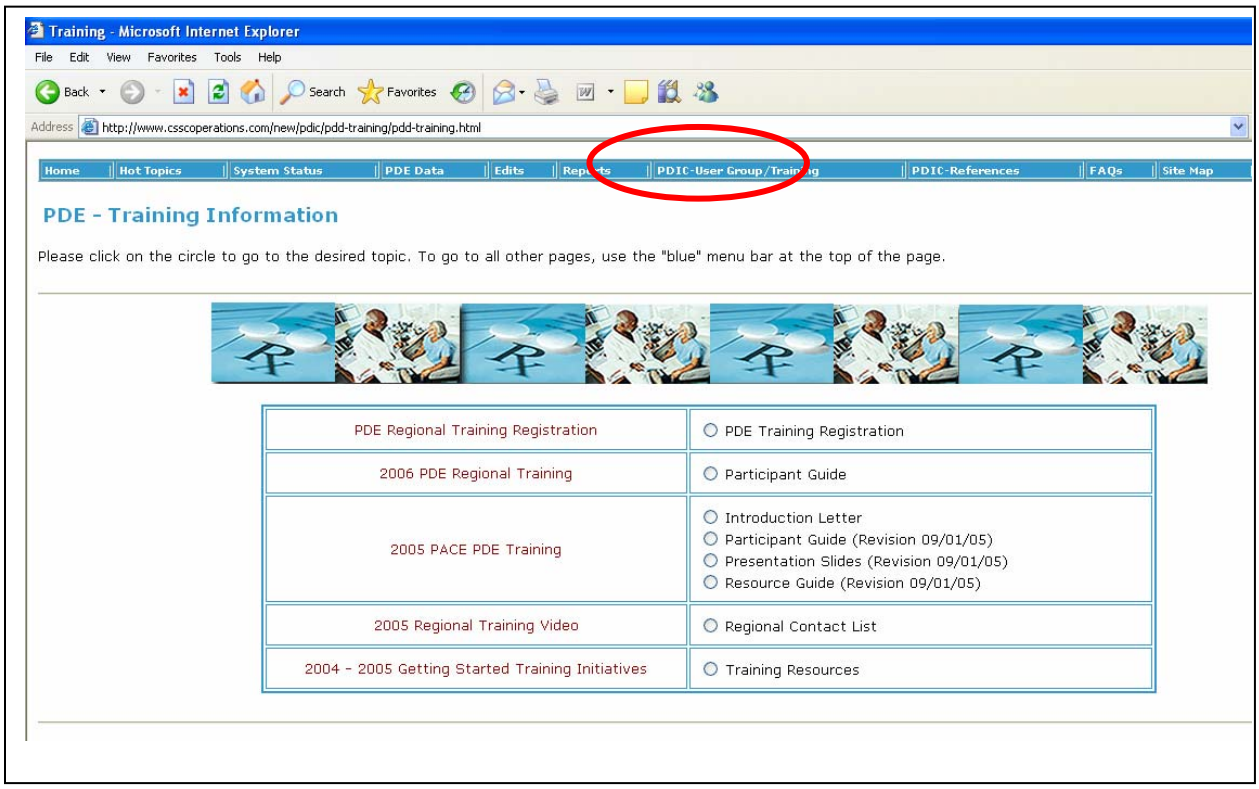
User Group Information

http://www.csscoperations.com/new/pdic/pdd-usergroup/pdd-usergroup.html



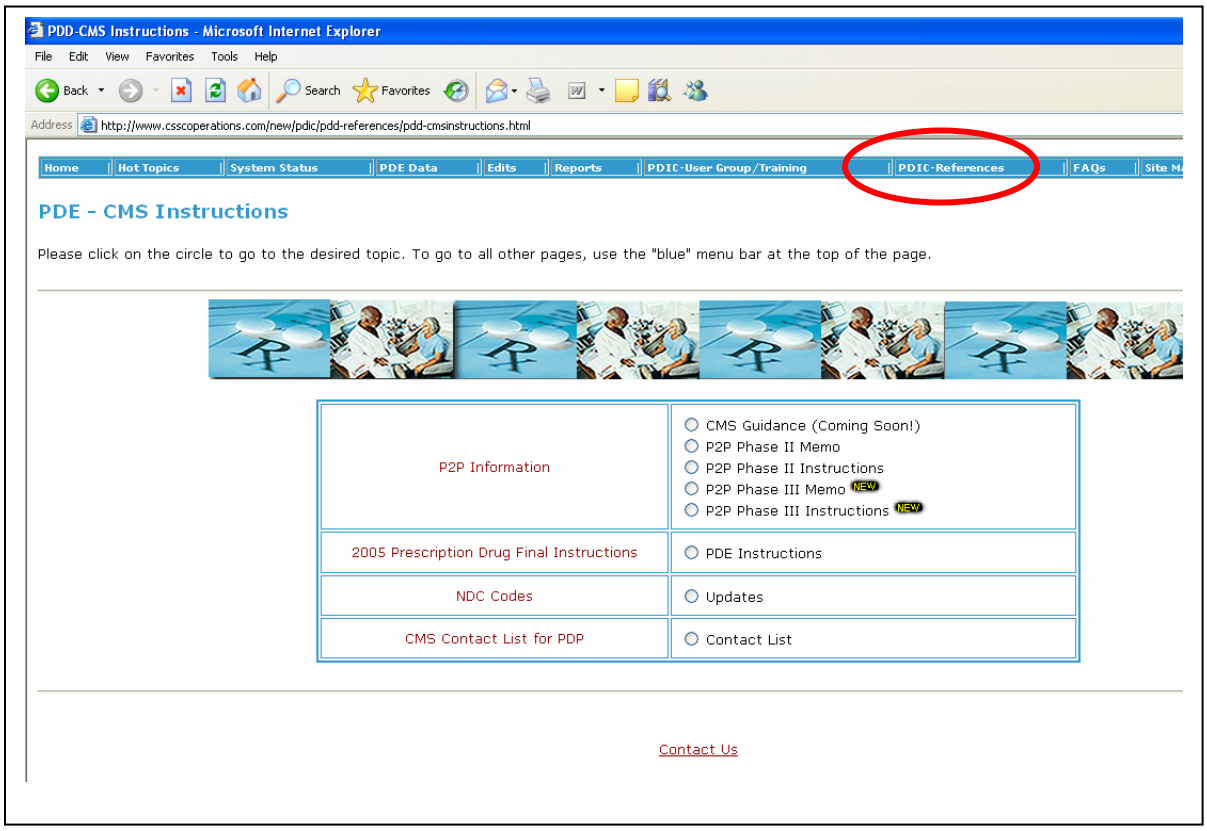
Training Information

http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html



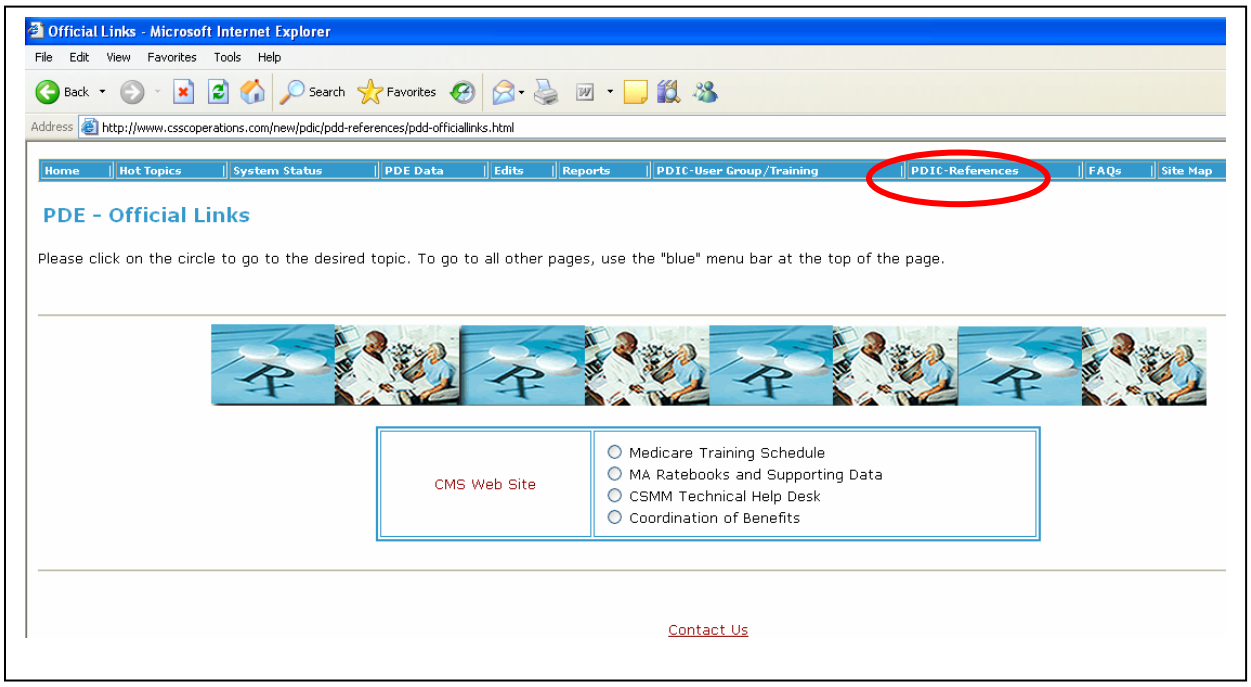
CMS Resources

http://www.csscoperations.com/new/pdic/pdd-references/pdd-cmsinstructions.html



Links to CMS Website

http://www.csscoperations.com/new/pdic/pdd-references/pdd-officiallinks.html



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CSSC REFERENCE DOCUMENTS

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PDE Introduction Letter

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TO: Organizations Submitting Prescription Drug Event (PDE) Data

RE: EDI Enrollment and Submitter Application for PDE Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Prescription Drug Organizations submitting PDE Data. The CSSC and the Prescription Drug Front-End Processing System (PDFS) look forward to working with you in all aspects of the submission of PDE data.

Please note the following requirements for submitting PDE Data:
Each entity submitting PDE data must establish a connection to the PDFS through the Medicare Data Communication Network (MDCN), provided by AT&T Global Network Services. The MDCN is the secure network linking the PDE data processing entities. You may contact the MDCN for assistance at 1-800-905-2069.

If your organization is currently submitting data for Risk Adjustment, there is no requirement to establish another connection to Palmetto GBA.
The following information must be completed and sent to the CSSC for enrollment for the submission of data for Prescription Drug Event (PDE) data:

- CMS / EDI Agreement for PDE Data collection
- PDE Submitter Application
- PDE NDM Specifications (For NDM users only)

Entities submitting through CMS's GENTRAN application need to submit the first two items (EDI agreement and Submitter application) only. Any questions that GENTRAN users have should be directed to the Customer Support for Medicare Modernization (CSMM) technical help desk at 800-927-8069 or through the website at www.mmahelp.cms.hhs.gov or through e-mail at mmahelp@cms.hhs.gov.

- **EDI Agreement:** A CMS EDI Agreement for PDE Data must be completed by each submitter and on file with CSSC, prior to submitting Test or Production PDE Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** If the submitter will be an entity other than a Medicare Drug Plan, the third party submitter must complete the Submitter ID Application form and the EDI Agreement. The Plan must complete the Submitter Application and EDI Agreement. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. A letter from the Plan, authorizing the third party to submit on their behalf, must accompany the EDI Agreement. Regardless who submits the data; CMS holds the MA/PDP/Fallback organization accountable for the content of the submission.

- **Submitter ID Assignment:** A Submitter ID will be assigned to you by the CSSC and will remain effective for ongoing submission of PDE data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application and return it to CSSC Operations with the completed EDI Agreement.

- **NDM Specifications**: Datasets are required to be set up for NDM users. The Prescription Drug Event data (PDE) NDM Specifications should be completed and returned to the CSSC with the Submitter Application and the EDI Agreement. NDM Specifications are available on our web site at: www.csscoperations.com .

- Technical Specifications are available based on the communication medium that your organization intends to use. NDM instructions and the PDFS User Guide are available on the web site. Testing instructions for each medium are included within the document.

- **Testing and Certification for PDE Data:** In order to support an efficient and effective transition to a production environment, each submitter must complete testing and certification of their PDE transactions. Refer to the CMS Certification of Prescription Drug Event (PDE) Data Requirements.

Phase I	PDFS Testing	11/15/05 - 01/31/06
Phase I	DDPS Testing and Certification	11/15/05 - 01/31/06
Phase II	DDPS Large Volume Testing	12/01/05 – 12/23/05
	DDPS Production Submissions	01/01/06

- **Reports:** Reports will be returned on all PDE data submitted. Response reports are available to the Submitter only. Return files, transaction count and control summary reports and transaction error summary reports will be made available to both the Submitter and Contract/PBP. Daily transactional reports will be returned to the submitter with the option of the Contract/PBP's also electing to receive the reports. Monthly management reports will be returned to the Contracts/PBP's only.

All reference material is available on the www.csscoperations.com web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the guidelines provided herein, using the following contact information:

CSSC Operations
1-877-534-CSSC
FAX: 1-803-935-0171
http://www.csscoperations.com

CMS EDI Agreement

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Medicare Plans Offering Part D Prescription Drug Benefit
Electronic Data Interchange (EDI) Agreement
Enrollment Form

The eligible organization agrees to the following provisions for submitting Medicare Prescription Drug Event (PDE) data, electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

The Eligible Organization Agrees:

That it will be responsible for all Medicare PDE data submitted to CMS by itself, its employees, or its agents.

That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, as required by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable State and/or Federal laws. That it will ensure that every electronic entry can be readily associated and identified with an original source document.

That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents related to the eligible organization's submissions, including the beneficiary's authorization and signature. Based on best knowledge, information, and belief; that it will submit prescription drug event data that is accurate, complete, and truthful.

That it will retain all original source documentation pertaining to any such particular Medicare prescription drug event for a period of at least 10 years after the prescription drug event is received and processed.

That it will affix the CMS-assigned unique identifier number (Submitter ID, Contract Number & Plan Benefit Package ID (PBP-ID) of the eligible organization on each PDE file electronically transmitted to the contractor.

That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

That it will use adequate security procedures to ensure that all transmissions of documents are secure, and to protect all beneficiary-specific data from unauthorized access.

That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor.

That it will research and correct PDE discrepancies in the event that a record or file is rejected or found to be in error.

That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

That the Submitter/Plan (PBP) agrees to complete testing and certification of the PDE Data: In order to support an efficient and effective transition from test to a production environment, each submitter must complete testing and certification of their PDE transactions. **Failure to successfully complete the required testing and certification will void this EDI Agreement.**

The testing will include transmission/communications, format and content. There will be a two phased approach to this testing. The Prescription Drug Front-end Processing System (PDFS) will be the preliminary test for transmission and format. The secondary test will fully examine the content of the PDE records to ensure they pass format and logical edits at the detail PDE record level.

PDE Test data must be submitted from the same automated system that will be used to submit production PDE data.

If any major system changes are made to your system of record, the PDE data will have to be re-certified.

Failure to achieve certification prior to January 31st of the plan contract calendar year, will have to be addressed on a case by case basis.

Once the testing & certification of the PDE transmission is complete, a one-time test in the production region can be requested by the submitter, if desired. This one-time test will only be allowed between 12/1/05 and 12/23/05. After that, test records will only be processed in the Validation Region and there will be no facility for Plans to run production-level volume testing of the DDPS front-end system.

The Centers for Medicare & Medicaid Services Agrees To:

Transmit to the eligible organization an acknowledgment of PDE receipt, if requested. Affix the Submitter ID, Contract Number and PBP-ID, as its electronic signature, on each response/report sent to the eligible organization.

Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose.

Notify the eligible Part D Medicare organization within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare Prescription Drug Event data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Signature:
I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's
Name: _____

Address: _____

_____

City/State/ZIP: _____

By: _____

Title: _____ Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records.
Complete and mail this form with original signature to:

PDE EDI Enrollment
P.O. Box 100275 – AG 570
Columbia, SC 29202-3275

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PDE Submitter Application

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CSSC Operations
1-877-534-CSSC

CSSC Prescription Drug Event (PDE) Data Submitter Application

Welcome to the Submitter Application Form

Instructions

Start a New Application
If you have not previously started or completed a submitter application for your contract, you will want to start here with a new application.

The application form consists of 6 steps -
- Step 1. Complete the general contract information.
- Step 2. Add any additional contracts that you submit for.
- Step 3. Choose your report receipt designations.
- Step 4. Review your application.
- Step 5. Confirm, Print and Submit Your Application.
- Step 6. Print your submission receipt.

Find an Existing Application
If you have previously started or completed a submitter application for your contract, you will want to start here. You will need the main contract you provided in Step 1 and the Application Number you were provided at the start of you application.

Start a New Application

Start

Find an Existing Application

Contract Application ID

Lookup Application

Exit

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PDE NDM Application

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Prescription Drug Front-End System NDM Specifications

☐ **Submitter** ☐ **Contract**

THE NDM NODE CONNECTION INFORMATION THAT YOU (THE SUBMITTER) WILL NEED TO CONNECT TO PALMETTO IS DEFINED AS FOLLOWS:

Palmetto SNA Values		**Palmetto TCP/IP Values**	
NET ID:	SCA	**NAT'd IP Address:**	32.90.254.160
NODE ID:	SCA.A70NDM.MC	**Listener Port:**	1369
APPLID:	A70NDMMC	**NODE ID:**	SCA.A70NDM.MC
AGNS ID:	PGBA	**AGNS ID:**	PGBA

PLEASE LIST BELOW THE INFORMATION PALMETTO NEEDS IN ORDER TO NDM FILES TO YOUR SYSTEM (Required entry):

This is required for Submitters. This section is also required for any Contracts who want reports returned directly to them.

Please indicate whether you wish to connect to Palmetto through SNA or TCP/IP.

☐ **Submitter** ☐ **Contract**

NET ID:	_____	**NAT'd IP Address**	_____
NODE ID:	_____	**Listener Port**	_____
APPLID:	_____	**NODE ID:**	_____
AGNS ID:	_____	**AGNS ID:**	_____

PLEASE LIST BELOW THE USER ID AND PASSWORD THAT PALMETTO NEEDS IN ORDER TO NDM FILES TO YOUR SYSTEM (if your datasets are RACF protected)

User ID: _____

Password: _____

This is required for Submitters. This section is also required for any Contracts who want reports returned directly to them

This Section pertains to Submitters only.

PRESCRIPTION DRUG Transaction Submission (PDE Dataset):

(Listed below are the file parameter values that you as the submitter need to code in your NDM SCL.)

	DSN:	**MAB.PROD.NDM.PDFS.PROD.submitter id(+1)**
7	DISP:	(NEW,CATLG,DELETE)
	UNIT:	SYSDG
	SPACE:	(CYL,(1200,500),RLSE)
	DCB:	(RECFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.PDFS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, HDR record field number 5, must also indicate “TEST” or “PROD”, depending on the type of file being submitted.

PDFS Reports

Response Report Retrieval (Enter DSN name below)
Please enter the name of the dataset (that resides on your system) where you want Palmetto to NDM your report. This dataset needs to be a GDG. This will allow multiple files to be sent to you without your manual intervention or accidental overwriting of your existing files.

(PDFS) Response Report
Frequency: Daily
Report **DSN**:_____
DCB=(DSORG=PS,LRECL=80,RECFM=FB,BLKSIZE=27920)

This page is required for Submitters. For any Contracts who want reports returned directly to them, fill in the appropriate information.

DDPS (Daily) Reports

Report Retrieval (Enter DSN names below)
Please enter the names of the datasets (that reside on your system) where you want Palmetto to NDM your reports. These datasets need to be GDGs. This will allow multiple files to be sent to you without your manual intervention or accidental overwriting of your existing files.

Note - Submitters are to receive all of the Daily reports. Contracts may elect to receive the daily reports. Contracts need to indicate which report they want by filling in the Return DSN name in the spaces provided.

DDPS Return File – Report #1

Frequency: Daily
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS Transaction Error Summary – Report #3

Frequency: Daily
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

This page is required for Contracts or Submitters that have been set up as Designated Submitters.

Only Contracts and Designated Submitters can receive Monthly reports.

If a contract wishes to have Monthly reports returned to their site please provide a return DSN for the monthly report you want in the spaces provided. *Submitters can fill in information in the spaces provided only if a contract has elected that submitter as a Designated Submitter.*

DDPS (Monthly) Reports

Report Retrieval (Enter DSN names below)
Please enter the names of the datasets (that reside on your system) where you want Palmetto to NDM your reports. These datasets need to be GDGs. This will allow multiple files to be sent to you without your manual intervention or accidental overwriting of your existing files.

DDPS 04COV Cumulative Beneficiary Activity For Covered Drugs
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 04ENH Cumulative Beneficiary Activity For Enhanced Alternative Drugs
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 04OTC Cumulative Beneficiary Activity For Over the Counter Drugs
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

This page is required for Contracts or Submitters that have been set up as Designated Submitters.

Only Contracts and Designated Submitters can receive Plan-to-Plan reports.

If a contract wishes to have Plan-to-Plan reports returned to their site please provide a return DSN for the monthly report you want in the spaces provided.
Submitters can fill in information in the spaces provided only if a contract has elected that submitter as a Designated Submitter.

DDPS Plan-to-Plan Reports – These reports will be returned on a Monthly Basis

Report Retrieval (Enter DSN names below)
Please enter the names of the datasets (that reside on your system) where you want Palmetto to NDM your reports. These datasets need to be GDGs. This will allow multiple files to be sent to you without your manual intervention or accidental overwriting of your existing files.

DDPS 40COV PDE Accounting Report (Covered Drugs)
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 40ENH PDE Accounting Report (Enhanced Drugs)
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 40OTC PDE Accounting Report (Over-The-Counter Drugs)
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS Plan-to-Plan Reports – (Continued)

DDPS 41 PDE Receivable Report
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 42 PDE PartD Payment Reconciliation Report
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

DDPS 43 PDE Payable Report
Frequency: Monthly
Flat **DSN**:_____
DCB=(DSORG=PS,LRECL=512,RECFM=FB,BLKSIZE=27648)

PDE Certification Letter

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CERTIFICATION OF PRESCRIPTION DRUG EVENT (PDE) DATA

In order for Prescription Drug Event (PDE) data to be accepted by the production Prescription Drug Front end Processing System (PDFS) and the Drug Data Processing System (DDPS); the Submitter and associated plans must successfully pass the PDE Certification process.

The testing will include transmission/communications, format and content. There will be a two phased approach to this testing. The PDFS will be the preliminary test for transmission and format. The secondary test (DDPS) will fully examine the content of the PDE records to ensure they pass format and logical edits at the detail PDE record level.

PDE Test data must be submitted from the same automated system that will be used to submit production PDE data. If any major system changes are made to your processing or submission system, the PDE data will have to be re-certified. All MA-PD / PDPs must be certified to submit or must be registered with a certified submitter by January 31st of the contract year.

Certification Steps:

1. Complete the EDI Agreement and Submitter Application completely. Return to CMS/Palmetto GBA. A Submitter ID will be assigned to your organization.

2. Each Submitter should assign one or more Contract IDs and Prescription Benefit Package (PBP) IDs to the test file(s). Contact Palmetto GBA to schedule and coordinate your PDE testing and certification.

3 Prepare a PDE test file (with a minimum of 100 PDE records and a maximum of 5000 PDE records) using the automated system that will be used to submit production PDEs. The PDE test file submitted should contain a representative sample of Medicare Part D beneficiaries.

4. Response and Error reports will be returned to the Submitter for review and revision of any errors encountered during PDE testing. Resubmit as necessary until all mandatory field errors are satisfactorily resolved. Informational messages will not prevent the Submitter from completing the required PDE data certification.

5. Delete at least one of the previously accepted records.

6. Once the testing & certification of the PDE transmission is completed successfully, a one-time, volume test in the production region can be requested by the submitter, if desired.

7. As each PBP schedules and completes their testing and certification, CSSC Operations will maintain an automated record of those plans that are ready for PDE production processing.

All reference material is available on the **www.csscoperations.com** web site. We encourage you to visit the site and register for e-mail notification of all updates. Please contact the CSSC Help Line with any questions regarding the guidelines provided herein, using the following contact information.

CSSC Operations AG-570
PO Box 100275
Columbia, SC 29202-3275
1-877-534-CSSC
http://www.csscoperations.com/
FAX: 1-803-935-0171

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DDPS Certification Testing Protocol - 2007

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DDPS Certification Testing Protocol – 2007

SUBMITTER CERTIFICATION PROCESS OVERVIEW

1. CBC will provide a list of all Contract/PBPs who have been selected for participation in Part D to Palmetto GBA and the DDPS Development team. This list will identify the type of plan (DSB, AE, BA, etc.).

2. Palmetto GBA will assign a submitter ID to each Part D submitter.

3. Palmetto GBA will assign test contract IDs to Part D submitters.

4. Palmetto GBA will post a "certification test packet" at www.csscoperations.com.

5. Each submitter will receive a packet containing the following items:

    a. A welcome letter
    b. Submission protocol information
    c. Instructions about how the submitters should build their test and certification files

6. Palmetto GBA will maintain a certification-testing log that will show the results of each file submitted as well as the status of each submitter's test status.

7. Submitters can submit two types of files during the certification testing process:

    a. Preliminary Test Files (a.k.a "TEST" files) – To work through issues prior to submitting files for the record
    b. Certification Files (a.k.a "CERT" files) – To be submitted and scored for the record. These submissions will be used to determine the submitter's certification status.

8. A submitter is considered to have successfully completed the certification process when PDEs submitted per the requirements have been processed with an error rate of no greater than 20%. (A file of original PDEs as well as a file of deletion PDEs has been submitted and each file had an error rate of 20% or less.)

9. Upon successful completion of certification testing, Palmetto GBA will formally notify the submitter and make the appropriate updates in the front-end system to accept production transmissions.

10. Submitters must be enrolled as a submitter with Palmetto GBA prior to submitting test/certification data, but are not required to have finalized contracts with their clients (MA-PDs / PDPs).

Instructions for Building Test Files

Palmetto Responsibilities:

Palmetto GBA will contact each submitter in order to:

1. Obtain a signed EDI Agreement to cover Part D submissions.

2. Assign a Submitter ID (for those submitters who don't already have one).

3. Confirm the submitter's data transmission protocol. (*Connect:Direct, SFTP, etc.*)

4. Assign test contract numbers. (*A unique contract number that CSSC has assigned to a submitter for use during the certification testing process only. This number will be valid only in the certification test region and does not represent a real contract. It should be used on all test and certification files. If the submitter desires, additional test contract numbers can be requested in order to test submissions containing data from multiple contracts.*) Each test contract number will have associated test PBP IDs that can be used for testing PDEs specific to each plan type. The following PBPs will be established for each test contract:

Test PBP ID	Benefit Plan Type Description
T01	Defined Std Benefit Plan
T02	Actuarially Equivalent Std Plan
T03	Basic Alternative Plan
T04	Enhanced Alternative Plan
T05	Employer-only Plan
T06	Dual-eligible PACE Plan
T07	Medicare-only PACE Plan
T08	Flexible Capitated Payment Demonstration Option
T09	Fixed Capitated Payment Demonstration Option
T10	MA Rebate Payment Demonstration Option

Submitters' Responsibilities:

Each submitter will generate test PDEs from their internal systems and batch into files for transmission to Palmetto GBA. It is strongly recommended that the submitters prepare test PDEs that cover the full range of scenarios that could be encountered, in order to establish a high level of confidence that records will not be rejected in production. CMS suggests that PDEs for the various benefit plan types described in the table above be created. In addition, CMS strongly advises that PDEs for various types of beneficiaries be represented in the test PDEs. The two tables below describe the representative PDE conditions that should be included in the test PDEs and the beneficiary characteristics that are built into the certification-testing environment.

Test Condition Descriptions

Test Condition Number	Test Condition Description
25 & 51	Beneficiary is not classified as Low Income status and PDEs with Drug Coverage Status Code "C"
26 & 52	Beneficiary with a Low Income I status and PDEs with Drug Coverage Status Code "C"
27 & 53	Beneficiary with a Low Income II status and PDEs with Drug Coverage Status Code "C"
28 & 54	Beneficiary with a Low Income III status and PDEs with Drug Coverage Status Code "C"
29 & 55	Beneficiary who is classified as Low Income Institutional status and PDEs with Drug Coverage Status Code "C"
30 & 56	Beneficiary is not classified as Low Income status and PDEs with Drug Coverage Status Code "E"
31 & 57	Beneficiary with a Low Income I status and PDEs with Drug Coverage Status Code "E"
32 & 58	Beneficiary with a Low Income II status and PDEs with Drug Coverage Status Code "E"
33 & 59	Beneficiary with a Low Income III status and PDEs with Drug Coverage Status Code "E"
34 & 60	Beneficiary who is classified as Low Income Institutional status and PDEs with Drug Coverage Status Code "E"
35 & 61	Beneficiary is not classified as Low Income status and PDEs with Drug Coverage Status Code "O"
36 & 62	Beneficiary with a Low Income I status and PDEs with Drug Coverage Status Code "O"
37 & 63	Beneficiary with a Low Income II status and PDEs with Drug Coverage Status Code "O"
38 & 64	Beneficiary with a Low Income III status and PDEs with Drug Coverage Status Code "O"
39 & 65	Beneficiary who is classified as Low Income Institutional status and PDEs with Drug Coverage Status Code "O"
40 & 66	PDEs with a subsequent adjustment and/or deletion that causes the accumulated OOP to drop below the attachment point
41 & 67	PDEs with subsequent adjustments that cause the accumulated OOP to rise above the attachment point
42 & 68	PDEs from multiple years that have the same beneficiary, same Contract and the same PBP
SUBMITTER-DEFINED CONDITIONS	
43 & 69	Submitter-defined – for conditions other than those defined above, beneficiary gender = female
44 & 70	Submitter-defined – for conditions other than those defined above, beneficiary gender = male
OPTIONAL FAILURE CONDITIONS	
45 & 71	Beneficiary is not enrolled in Part D on date of service
46 & 72	Beneficiary is not enrolled in Contract/PBP on date of service
47 & 73	Gender mismatch
48 & 74	DOS after DOD
PLAN-TO-PLAN CONDITIONS [1]	
49 & 75	Contract of Record is different from Submitting Contract
50 & 76	Contract of Record is the same as Submitting Contract; PBP of Record is different from Submitting PBP

[1] Note that for Plan-to-Plan (P2P), only PDEs with dates of service on or before 4/30/2006 will be accepted for processing; all other P2P PDEs will be rejected.

There are two sets of test conditions provided:

- Test conditions 25 through 50 are provided for submitters whose TEST/CERT files will contain PDEs with dates of service in calendar year 2006.
- Test conditions 51 through 76 are provided for submitters whose TEST/CERT files will contain PDEs with dates of service in calendar year 2007.

Test conditions 45-50 and 71-76 are provided for submitters who wish to trigger error conditions in their batches and test their error handling processes. These test conditions should not be included in batches submitted for certification, since these errors would be included in the overall error rate. [Note that test condition 49, if submitted on a PDE with Date of Service on or before 4/30/06 and with Drug Coverage Status Code of "C" will return an informational edit, and will not count as a rejected record.]

Beneficiary Characteristics Associated with Each Test Condition

TEST CONDITION NUMBER	PBP START DATE	PBP END DATE	BENE SEX	BENE BIRTH DATE	BENE DEATH DATE	Low Income Status (LIS) Level[2]	LIS Effective Date	LIS End Date
For use with PDEs with Dates of Service in Calendar Year 2006:								
25	01/01/06		Female	06/12/35				
26	01/01/06		Male	06/18/40		I	02/01/06	10/31/06
27	01/01/06		Female	09/12/36		II	02/01/06	10/31/06
28	01/01/06		Male	07/26/40		III	03/01/06	
29	01/01/06		Female	07/20/40		Institutional	02/01/06	10/31/06
30	01/01/06		Female	03/18/31				
31	01/01/06		Female	09/13/09		I	03/01/06	11/30/06
32	01/01/06		Male	07/27/40		II	03/01/06	11/30/06
33	01/01/06		Male	07/18/39		III	03/01/06	
34	01/01/06		Male	08/31/35		Institutional	03/01/06	11/30/06
35	02/01/06		Male	09/04/28				
36	02/01/06		Male	11/09/32		I	02/01/06	10/31/06
37	02/01/06		Male	08/06/28		II	02/01/06	10/31/06
38	02/01/06		Male	06/13/40		III	02/01/06	
39	02/01/06		Female	02/21/27		Institutional	02/01/06	10/31/06
40	02/01/06		Female	03/18/16				
41	02/01/06		Female	09/09/10		III	02/01/06	
42	02/01/06		Female	08/31/37		III	02/01/06	
43	02/01/06		Female	10/01/34				
44	02/01/06		Male	04/12/31				
45	02/01/06		Female	11/15/33		II	02/01/06	10/31/06
46	02/01/06	8/1/2006	Male	11/02/34		I	02/01/06	10/31/06
47	02/01/06		Female	04/13/39		I	02/01/06	10/31/06

TEST CONDITION NUMBER	PBP START DATE	PBP END DATE	BENE SEX	BENE BIRTH DATE	BENE DEATH DATE	Low Income Status (LIS) Level[2]	LIS Effective Date	LIS End Date
48	02/01/06		Female	01/23/28	08/01/06	II	02/01/06	10/31/06
49	01/01/06		Male	04/12/31				
50	01/01/06		Female	11/15/33				
For use with PDEs with Dates of Service in Calendar Year 2007:								
51	01/01/06		Female	06/12/35				
52	01/01/06		Male	06/18/40		I	02/01/07	10/31/07
53	01/01/06		Female	09/12/36		II	02/01/07	10/31/07
54	01/01/06		Male	07/26/40		III	03/01/07	
55	01/01/06		Female	07/20/40		Institutional	02/01/07	10/31/07
56	01/01/07		Female	03/18/31				
57	01/01/07		Female	09/13/09		I	03/01/07	11/30/07
58	01/01/07		Male	07/27/40		II	03/01/07	11/30/07
59	01/01/07		Male	07/18/39		III	03/01/07	
60	01/01/07		Male	08/31/35		Institutional	03/01/07	11/30/07
61	01/01/07		Male	09/04/28				
62	01/01/07		Male	11/09/32		I	02/01/07	10/31/07
63	01/01/07		Male	08/06/28		II	02/01/07	10/31/07
64	01/01/07		Male	06/13/40		III	02/01/07	
65	01/01/07		Female	02/21/27		Institutional	02/01/07	10/31/07
66	01/01/07		Female	03/18/16				
67	01/01/07		Female	09/09/10		III	02/01/07	
68	01/01/07		Female	08/31/37		III	02/01/07	
69	01/01/07		Female	10/01/34				
70	01/01/07		Male	04/12/31				
71	08/01/06		Female	11/15/33		II	02/01/07	10/31/07
72	07/01/06	8/1/2007	Male	11/02/34		I	02/01/07	10/31/07
73	07/01/06		Female	04/13/39		I	02/01/07	10/31/07
74	07/01/06		Female	01/23/28	08/01/06	II	02/01/07	10/31/07
75	09/01/06		Male	04/12/31				
76	09/01/06		Female	11/15/33				

In order for the PDEs to be processed, CMS-recognized beneficiary IDs (a.k.a. HICNs) must be included on the PDEs. Because no live HICNs are stored in the DDPS testing region, submitters will need to use contrived HICNs on test PDE records. The process to create test HICNs is described in the paragraphs below.

[2] See next page for explanation of Low Income Status (LIS) Categories:

2006 Low Income (LI) Levels and Medicare Beneficiary Database (MBD) Codes

LI Level	*DEDUCTIBLE*	Initial Coverage Period	Coverage Gap	Catastrophic	MBD Code
I	$ 0	$1-generic $3-brand	$1-generic $3-brand	$0	2
II	$ 0	$2-generic $5-brand	$2-generic $5-brand	$0	1
III	$50	15%	15%	$2-generic $5-brand	4
Inst	$ 0	$0	$0	$0	3

2007 Low Income (LI) Levels and Medicare Beneficiary Database (MBD) Codes

LI Level	*DEDUCTIBLE*	Initial Coverage Period	Coverage Gap	Catastrophic	MBD Code
I	$ 0	$1.00-generic $3.10-brand	$1.00-generic $3.10-brand	$0	2
II	$ 0	$2.15-generic $5.35-brand	$2.15-generic $5.35-brand	$0	1
III	$53	15%	15%	$2.15-generic $5.35-brand	4
Inst	$ 0	$0	$0	$0	3

Note: An MBD code of 0 (zero) means no LI eligibility

LI levels and MBD codes: The charts above cross-walk the LI Levels put forth in guidance to the LI level codes as reported in MBD. The LI Levels reported in the PDE as I, II, III and Institutional should correspond to the co-pays in ascending order. The codes in MBD which did not exist when we issued our guidance are just that, codes that represent the levels of cost sharing in the MBD.

Test HICN Description

The composition of the 11-character test HICN is:

Positions	1 – 5	***Test Contract Number***
Positions	6 – 8	***Test PBP ID***
Position	9	***Beneficiary Sequence Number***
Positions	10 – 11	***Test Condition***

Test HICNs are built by concatenating the Test Contract Number, Test PBP-ID, Beneficiary Sequence Number and Test Condition Number into an 11-character string.

The use of separate test HICNs for each test condition provides a simple way to distinguish the various test conditions. A separate HICN should be created for each plan type/test condition being tested and the appropriate HICN should be assigned to the applicable PDEs. The submitter can create up to ten test HICNs (0 through 9) for each test condition by varying the Beneficiary Sequence Number. There is no requirement to use all ten, but they can be created if the submitter wants to vary scenarios within each test condition when submitting PDEs.

It is important to match test HICNs to the appropriate PDEs with care so that inadvertent enrollment errors will not occur when the PDEs are processed, triggering unnecessary investigation and problem resolution.

Please note that, when submitting P2P test conditions (conditions 25, 26, 51, and 52), the Test Contract Number and Test PBP ID must be the submitter's assigned Contract Number and PBP ID.

EXAMPLE: The HICN for test condition 14 should be assigned to the PDEs for that test condition as follows:

Test HICN # T0073T01514 is comprised of the following:

T0073	=	Test Contract Number
T01	=	Test PBP ID
5	=	Beneficiary Sequence Number – Each test Contract/PBP will be allocated 10 distinct beneficiaries for each Contract/PBP/Test Condition. This HICN represents the test condition assigned to the beneficiary designated as # 5 for test condition # 14 for this Contract/PBP. This position may contain a single digit from 0 to 9 and must not be left blank.
14	=	Test Condition – There are currently 26 different test conditions that comprise the certification test suite. This HICN should be used on PDEs testing condition # 14.

File Characteristics

General Characteristics

1. ***Types of Files*** – Submitters have the option of submitting two types of files as part of the certification testing process:

    a. ***Preliminary test files*** that will not impact the submitter's certification status.

    The submission of preliminary test files is optional, but CMS suggests they be used to work through initial tests prior to submitting files for the record. During the "TEST" phase, plans are encouraged to submit a PDE which will fail during the edit process and be returned to the contract/submitter for error resolution. Examples are missing or invalid values in required fields, reversal/deletions and adjustments prior to the submission of an original PDE and duplicate PDEs in the

same submission. Testing of financial fields is also recommended. Some examples include individuals who are non-LI but have a LIS copay amount or a PDE in which the ingredient cost, dispensing fee and sales tax are calculated incorrectly. **Note: testing error conditions should not be performed during the certification ("CERT") process**. If submitted, preliminary test files will be scored, but will not affect the submitter's certification status. If submitters choose to test further after they have achieved certification status (for example to test internal edits), they should submit files designated as preliminary test so that they do not reverse certification status.

To identify a preliminary test file, place "TEST" in the PROD-TEST-IND field on the HDR record.

Maximum file size = 5,000 PDE records.

b. ***Certification files*** that will be evaluated and scored.

Every submitter must successfully submit certification files before being authorized to submit live production data. Only certification files will result in an update to the submitter's certification status.

To identify a certification file, place "CERT" in the PROD-TEST-IND field on the HDR record.

Maximum file size = 5,000 PDE records.

2. ***Original/Adjustment/Deletion PDEs*** – The submitter must submit a file with original PDEs. In addition, a separate file containing deletions must also be submitted. The submitter may also submit adjustment PDEs. If the Submitter's system requires the submission of deletion records followed by the submission of revised "originals," the deletions should be submitted in one batch and the revised originals in a subsequent batch. If the Submitter's system allows the creation of "adjustment" records in lieu of the deletion/revised-original approach, the adjustment records can be included in the same batch as the deletion test records. The contents of the three files should be as follows:

   a. ***File 1*** – A set of PDEs with Adjustment Deletion Code = Blank (original PDEs).

   Minimum File Size: 100 PDE records
   Suggested Test Conditions: 1 – 20

   b. ***File 2*** – A set of PDEs with Adjustment Deletion Code = 'D' and/or 'A'.

   Minimum File Size: 1 PDE record
   Suggested Test Conditions: 1 – 20

If the submitter system does not accommodate the submission of adjustment records (i.e. "deletion/revised original" methodology is used instead), this set of PDEs will contain 'D' records only.

Note: These files can only be submitted after a file of "original PDEs" has been successfully processed and the original PDEs are stored in the database.

c. ***File 3*** – A set of PDEs with Adjustment Deletion Code = Blank (original PDEs). This file is only applicable to those submitters who use the "deletion/revised original" methodology and are transmitting "resubmitted" originals. Prior to submitting this file, a file of "original PDEs" and a file of "deletion PDEs" must both have been successfully processed.

Minimum File Size:	1 PDE record
Suggested Test Conditions:	1 – 20

3. ***Plan Types*** – The submitter should submit files for each plan type in order to fully exercise the various scenarios that are possible.

4. ***General Submission Ground Rules*** – The following ground rules apply to all submissions:

   a. All existing instructions to the Plans regarding the processing and submission of PDE data apply. (NOTE: Edit # 609, "Date of Service must be on or before today's date", will be deactivated for test/certification processing. All other edits will be in force.)

   b. This process is not intended to test beneficiary eligibility, only PDE preparation and submission.

   c. A signed EDI Agreement must be on file for the submitter before the transmission of any files.

   d. Because every file and every accepted record will be logged in the DDPS/DBC system, it is important that each submitter's test data adheres to the production processing practices – i.e., resubmitting the same records will cause duplicates.

Transmission of Test Files to Palmetto and Follow-up Communications

Transmission of the TEST/CERT PDE files should utilize the communications links established between the Prescription Drug Front-end System (PDFS) and the submitter. Submitters should allow for a 2-day turnaround on submissions before being notified of processing results. If a greater than two-day delay occurs, please contact Palmetto at 1-877-534-2772.

Response Files

Submitters will receive Report # 01 (Daily Transaction Validation Detail Report), that documents the status of each submitted record, and Report # 03 (Transaction Edit Summary Report) that will inform them of the edit errors encountered. The submitter should investigate and correct any unexpected errors before processing follow-up files and attempting certification. The ratio of TLR-DET-REJECTED-RECORD-TOTAL to TLR-DET-RECORD-TOTAL will be the basis of determining whether a submitter's file passes or fails the certification process. If this ratio exceeds twenty percent (20%), the submitter's file will have failed the certification criteria. (The TLR-DET-REJECTED-RECORD-TOTAL and TLR-DET-RECORD-TOTAL fields are found on the TLR record of Report # 01.)

The submission process will continue until both original PDE and deletion PDE "CERT" files have been processed and each has been scored with a rejected PDE rate of 20% or less. It is recommended that every test condition be tested and that all follow-up files be transmitted and processed with acceptable results. When certification is attained, Palmetto will notify the submitter and system updates will be applied to allow production transmissions.

After certification, submitters can submit additional runs, if scheduling permits. (If additional files are submitted, they should be designated as TEST so as not to affect certification status.)

Gentran Instructions

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Date: May 2006

To: Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PD) Contracts

Regarding: Submitting and / or Retrieving, Risk Adjustment (RA) and / or Prescription Drug Event (PDE) Data Directly to CMS Enterprise File Transfer (GENTRAN)

Plans / Contracts submitting directly to the GENTRAN application need to submit an EDI agreement and Submitter application to the Customer Service and Support Center (CSSC), 877-534-2772, www.csscoperations.com.

- **EDI Agreement:** A CMS EDI Agreement must be completed for the specific data type, RA / PDE, by each contract and on file with CSSC, prior to submitting Test or Production Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations.

- **Submitter ID Assignment:** A Submitter ID will be assigned to you by the CSSC and will remain effective for ongoing submission of RA and/or PDE data. This is the unique ID assigned to the contract that will allow data submission and report retrieval. Complete the Submitter Application and return it to CSSC Operations with the completed EDI Agreement.

The GENTRAN mailbox(s) for any PDE or RA data must be established and access granted by contacting the Customer Support for Medicare Modernization (CSMM) technical help desk at 800-927-8069 or through the website at www.mmahelp.cms.hhs.gov or e-mail at mmahelp@cms.hhs.gov.

- Contracts using GENTRAN may not have more than 100,000 enrollees.

- The files submitted may not be over 1.5 g in size for any one submission.

- A mailbox must be established for each Plan / Contract number and type of data, i.e. RA and PDE that will be submitted through GENTRAN. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Third Party Submitters submitting RA and / or PDE data through GENTRAN would have to have mailboxes created for each of the contracts for which they are submitting. Multiple Plan / Contract numbers cannot be submitted in the same file through GENTRAN.

- Contracts / Plans using Third Party Submitters should request through the CSMM, that a GENTRAN mailbox be established for the Plan to receive reports / files.

Contracts / Plans considering using the GENTRAN application at CMS will work closely with the CSSC and the CSMM to complete the appropriate paperwork and establish the necessary connectivity.

GENTRAN File and Report Naming Conventions

PDE Production

Plan to CMS GENTRAN Name

guid.racf.PDE.freq.ccccc.FUTURE.P

GENTRAN Report Name

RSP.PDFS_RESP_ssssss
RPT.DDPS_TRANS_VALIDATION_ssssss
RPT.DDPS_ERROR_SUMMARY_ssssss
RPT.DDPS_CUM_BENE_ACT_COV_ssssss
RPT.DDPS_CUM_BENE_ACT_ENH_ssssss
RPT.DDPS_CUM_BENE_ACT_OTC_ssssss

PDE Test

Plan to CMS GENTRAN Name

guid.racf.PDE.freq.ccccc.FUTURE.T

GENTRAN Report Name

TEST.RSP.PDFS_RESP_ssssss
TEST.RPT.DDPS_TRANS_VALIDATION_ssssss
TEST.RPT.DDPS_ERROR_SUMMARY_ssssss
TEST.RPT.DDPS_CUM_BENE_ACT_COV_ssssss
TEST.RPT.DDPS_CUM_BENE_ACT_ENH_ssssss
TEST.RPT.DDPS_CUM_BENE_ACT_OTC_ssssss

APPLICATION FOR ACCESS

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APPLICATION FOR ACCESS TO CMS COMPUTER SYSTEMS

(Read and complete both sides of this form in ink)

1. **Type of Request** (Check only one) ☐ NEW ☐ CHANGE ☐ RECERTIFY ☐ DELETE

Last Name | First Name | MI

Current UserID

CAPITAL LETTERS
(Ø 1 2 3 4 5 6 7 8 9)

2. **User Information**

☐ CMS Employee
☐ Social Security Admin.
☐ FMC
☐ Contractor (non-Medicare)
☐ State Agency
☐ Office of the Inspector General
☐ Fraud Investigation
☐ End-Stage Renal Disease Network
☐ Federal (other than CMS)
☐ Mgd Care Org/Group Health Plan
☐ Vendor
☐ Railroad Retirement Board
☐ Medicare Contr/Intermediary/Carrier
☐ Peer Review Organization
☐ Researcher
☐ Other *(specify):* _____

a. SSN (*see Privacy Act Advisory Statement on back*)

e. Email Address *(non-CMS only)*

b. Mailing Address/Mail Stop

f. CMS Organization or Company Name

c. Central Office Desk Location

g. Company Telephone Number
( )

d. Daytime Telephone Number
( )

h. Contract Number(s) (*non-CMS only)*

3. **Type of Access Required (P**= Production, **D**=Development, **V**=Validation, **R**=Remote/Dialup Access**)**

a. **Application(s):**

	P	D	V	R		P	D	V	R
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )
_____	( )	( )	( )	( )	_____	( )	( )	( )	( )

b. **Subsystems:**

	P	D	V	R		P	D	V	R
CICS	( )	( )	( )	( )	OMVS	( )	( )	( )	( )
DB2	( )	( )	( )	( )	TSO	( )	( )	( )	( )
IDMS	( )	( )	( )	( )	WYLBUR	( )	( )	( )	( )
M204	( )	( )	( )	( )	OTHER _____	( )	( )	( )	( )
NDM	( )	( )	( )	( )	_____	( )	( )	( )	( )

d. **CMS Standard Desktop Software/LAN:**

	Email	No Email	Remote
Central Office	☐	☐	☐
DC1	☐	☐	☐
FMC	☐	☐	☐
ATL1	☐	☐	☐
BOS1	☐	☐	☐
CHI1	☐	☐	☐
DAL1	☐	☐	☐
DEN1	☐	☐	☐
KCM1	☐	☐	☐
NYC1	☐	☐	☐
PHI1	☐	☐	☐
SEA1	☐	☐	☐
SF01	☐	☐	☐
Other _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

c. **Expected Frequency of Use:** (*non-CMS only)* ☐ Daily ☐ Monthly ☐ Quarterly ☐ Annually

4. **Reason for Request**

5. **Authorization:** We acknowledge that our Organization is responsible for all resources to be used by the person identified above and that requested accesses are required to perform their duties. We understand that any change in employment status or access needs are to be reported immediately via submittal of this form.

Requesting Official

Print Name

Signature Date

Telephone Number CMS Userid

Contract Number Contract Exp. Date or 'Not-to-Exceed' Date

Approving Official
(*for non-CMS user only*)

Print Name

Signature Date

Title Organization

Telephone Number CMS Userid

CMS RACF Group Administrator

Print Name

Signature Date

Telephone Number

Desk Location Organization or Region

(July 2001)

PRIVACY ACT ADVISORY STATEMENT
Privacy Act of 1974, P. L. 93-579

The information on side 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's (formerly HCFA's) computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on this form will be maintained in the Individuals Authorized Access to the Centers for Medicare & Medicaid (CMS) Data Center Systems of Records and may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED. REG. 41329 (08-11-94) and as CMS may establish in the future by publication in the *Federal Register*.

Collection of the Social Security Number (SSN) is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in delaying the processing of this request.

SECURITY REQUIREMENTS FOR USERS OF CMS's COMPUTER SYSTEMS

CMS (formerly HCFA) uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of Federal programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in Federal computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. CMS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. CMS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to CMS Computer Systems containing sensitive information must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the con sequences of unauthorized or illegal transactions.
- Do not browse or use CMS data files for unauthorized or illegal purposes.
- Do not use CMS data files for private gain or to misrepresent yourself or CMS.
- Do not make any disclosure of CMS data that is not specifically authorized.
- Do not duplicate CMS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter CMS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of CMS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from Federal Service, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

_____ _____

Signature of User Date

Instructions for Completing the Application for Access to CMS Computer Systems

This form is to be completed and submitted whenever the following situations occur:
– A user **requires access** to a CMS computer system to perform their job duties. (Submit NEW Request)
– A user **changes names**, has a **change in access needs, job duties,** or **moves to another component.** (Submit CHANGE Request)
– A user receives notice that they must **recertify** their access needs. (Submit RECERTIFY Request)
– A user **retires, resigns,** is **removed from a contract with CMS,** or for any reason **no longer requires access**. (Submit DELETE Request)

Section 1: Type of Request COMPLETE FOR ALL REQUESTS. Check one box indicating type of request, enter name and current CMS UserID in blocks indicated, if using one. A separate form must be submitted for each action desired.

Section 2: User Information COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS. Check employee type, and complete blocks a. through h.

CMS Employees – Blocks e., g. and h. may be left blank. If not stationed at CMS Central Office, provide a complete mailing address in block b. and leave block c. blank.

Non-CMS Employees – Block c. may be left blank if not stationed at CMS Central Office. For block h., if your contract number is unknown, obtain it from your Project Officer or your CMS contact person.

Section 3: Type of Access Required COMPLETE FOR NEW, CHANGE AND RECERTIFY REQUESTS.

For NEW Requests – Check each type of access required. List the names of all CMS applications you require access to (i.e., OSCAR, CROWD, CAFM, CLIA) in block a., Application(s). For each application, check the appropriate columns to indicate the environment(s) access is needed in, and if remote access is required. DO NOT USE THIS BLOCK TO ENTER SOFTWARE THAT IS PART OF THE STANDARD CMS WORKSTATION CONFIGURATION; SEE BLOCK D. Use block b., Subsystems, to request access not specific to particular applications. This block is used to note accesses such as native TSO commands, usually required by system developers. If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. Non-CMS employees should complete block c., Expected Frequency of Use. If access to a CMS desktop or LAN is required, check your location in block d., CMS Standard Desktop Software/LAN. Checking this box will ensure you have access to all software available on the standard CMS workstation (i.e., Word, Excel, GroupWise, etc.).

For CHANGE Requests – If access needs have changed, enter an 'A' to add, or a 'D' to delete, for each type of access requiring a change. (Most changes in job duties or organizational placement require a change in access needs.) If 'Other' is checked, be sure to specify here and in Section 4, Reason for Request. For name changes only, leave this block blank and go to Section 4.

For RECERTIFY Requests – Check each type of access required to perform your job duties. If additional accesses are required, submit a separate change request. **(Those accesses currently held but not checked will be lost.)** If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, be sure to specify here and in Section 4, Reason for Request.

Section 4: Reason for Request COMPLETE AS REQUIRED.

For NEW Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For CHANGE Requests – Note the nature of the action requiring a change. For name changes, include previous and new names. For organizational changes, include old and new organization names. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For RECERTIFY Requests *(non-CMS only)* – Provide an explanation of what job duties require you to access a CMS computer system. Include applicable project accounting numbers. If 'Other' is checked in block 3.b., Subsystems, or block 3.d., CMS Standard Desktop Software/LAN, specify here.

For DELETE Requests – Note the nature of the action requiring the removal of accesses.

Read, sign and date the back of the form. Then obtain signatures for Section 5.

Section 5: Authorization COMPLETE FOR ALL REQUESTS. All requested information must be supplied or noted 'N/A'.

CMS Employees – **Requesting Official:** The immediate supervisor must sign and complete the Requesting Official block. The **RACF Group Administrator** must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Non-CMS Employees – **Requesting Official:** The Project Officer, if designated, must sign and complete the Requesting Official block. For Medicare Contractors/Intermediaries/Carriers, a designated company contact must sign and complete the Requesting Official block. For others, the CMS Liaison/Contact or ADP Coordinator must sign and complete the Requesting Official block. (IT IS IMPORTANT THAT CONTRACT NUMBER AND EXPIRATION DATE ARE INCLUDED WHERE APPLICABLE. IF ACCESS IS REQUIRED FOR MULTIPLE CONTRACTS, THE NUMBER AND EXPIRATION DATE FOR THE CONTRACT WITH THE LONGEST PERIOD OF PERFORMANCE SHOULD BE USED. IF NO CONTRACTS APPLY, AN APPROPRIATE 'NOT-TO-EXCEED' DATE SHOULD BE NOTED, OR 'N/A' IF INDEFINITE ACCESS IS REQUIRED.) **Approving Official:** The immediate supervisor of the Requesting Official must sign and complete the Approving Official block. For Medicare Contractors/Intermediaries/Carriers, the Consortium Contractor Management Staff member assigned as Contractor Manager for the company must sign and complete the Approving Official block. The **RACF Group Administrator** should note the preferred group for UserID assignment in Section 1. They must also sign and complete the signature block where noted. These responsibilities cannot be delegated.

Required Signatures for Applications for Access to CMS Computer Systems

Type of CMS User	Requesting Official	Approving Official	RACF Administrator
CMS Employee	Immediate Supervisor	N/A	HQ or Regional GA
State User	RO Coordinator (OSCAR, MDS, OASIS or ASPEN Coordinator) or Project Officer	Division Director*	Regional GA
Medicare Contractor/ Intermediary/Carrier	Company Contact	Consortium Contractor Management Staff Member	Regional GA
Managed Care Organization/ Group Health Plan	Project Officer	Division Director*	HQ GA
Researcher	Project Officer	Division Director*	HQ or Regional GA
Office of Inspector General	OIG Supervisor	OIG Regional GA	HQ GA
Other Federal Agency (Inter/Intra Agency)	System of Records Owner or CMS Liaison or Project Officer or Contact Person	Division Director*	HQ or Regional GA
Contractor (non-Medicare)	Project Officer	Division Director*	HQ or Regional GA
Vendor	Project Officer	Division Director*	HQ or Regional GA
Peer Review Organization Member	Project Officer	Division Director*	HQ or Regional GA
ESRD Network Member	Project Officer	Division Director*	HQ GA

*When Division Director signature would be redundant or not applicable, first-line supervisor of Requesting Official may sign as Approving Official.

(July 2001)