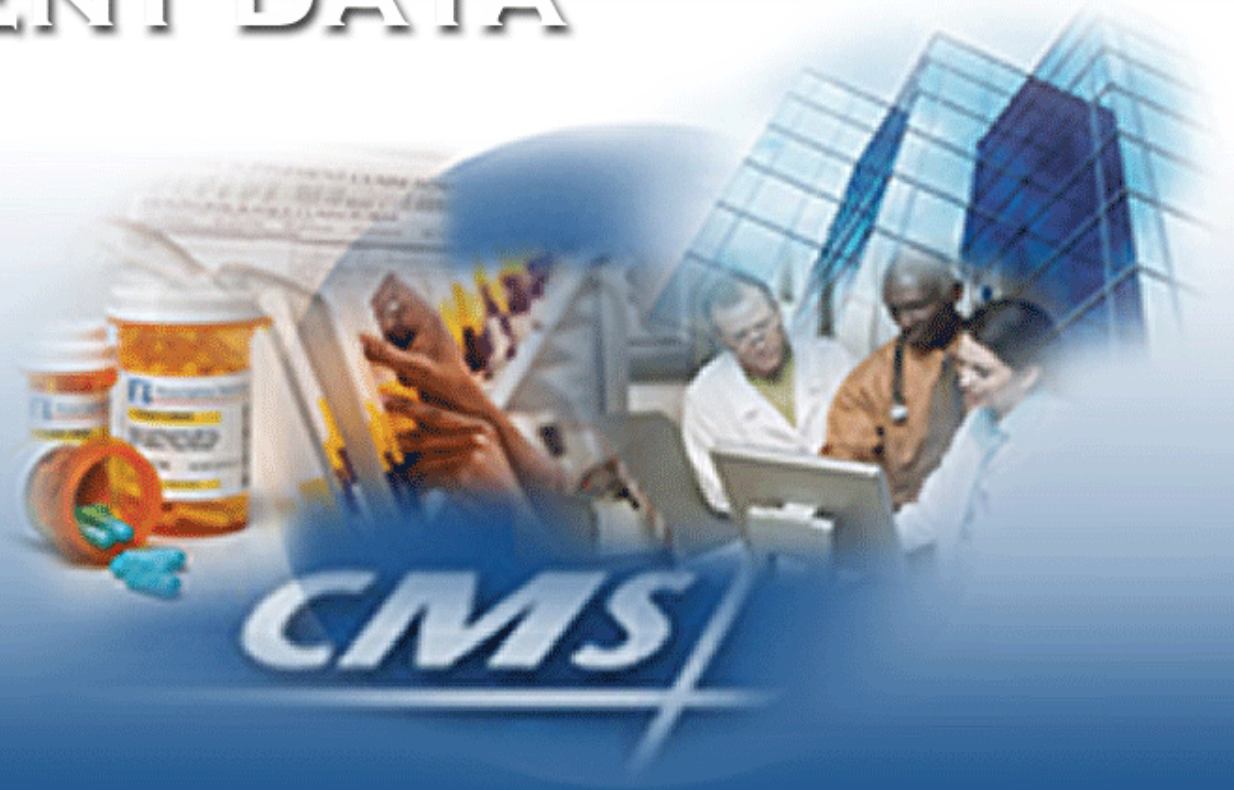
2008 Regional Technical Assistance
Prescription Drug Event Data



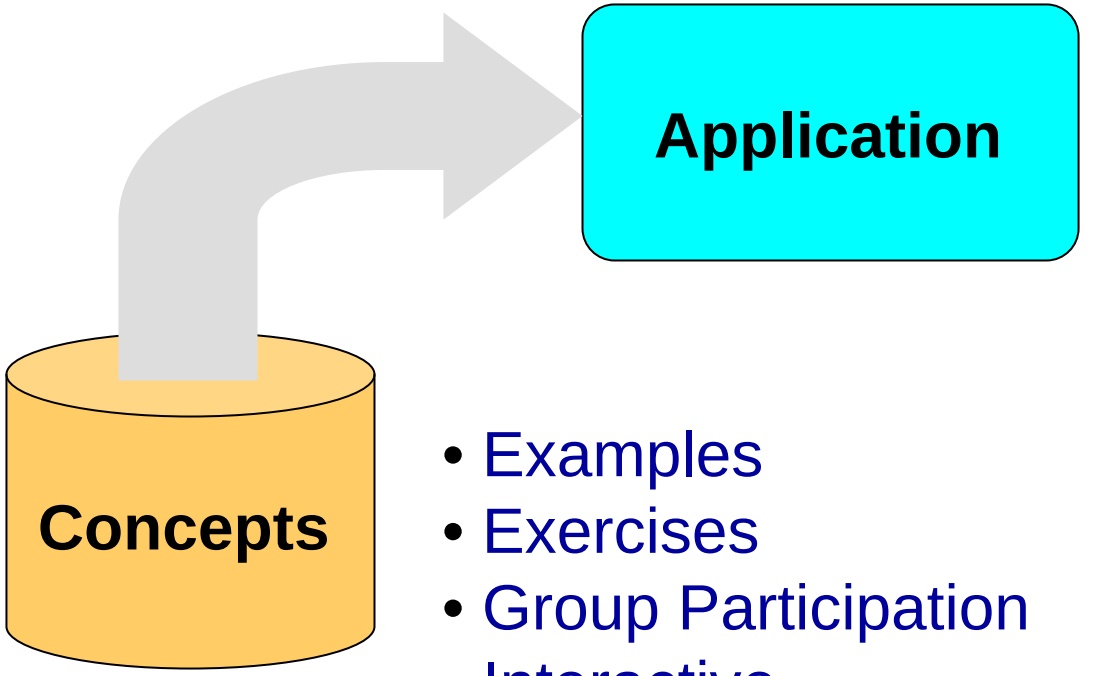
CMS Centers for Medicare & Medicaid Services

Introduction

PURPOSE

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

TECHNICAL ASSISTANCE FORMAT



- Examples
- Exercises
- Group Participation
- Interactive

PARTICIPATION MAKES THE DIFFERENCE

TECHNICAL ASSISTANCE TOOLS

- Participant Guide
- Job Aids
- www.csscoperations.com
- MMA Help Desk
- Panel of Experts

AUDIENCE

- Staff of PDPs
- Staff of MA-PD plans, including demonstration projects and specialty plans
- PBMs
- Third Party Submitters

AGENDA – DAY ONE

8:00 – 9:00	Registration
9:00 – 9:30	Introduction
9:30 – 10:30	Part D Payment Methodology
10:30 – 10:45	Break
10:45 – 11:45	PDE Process Overview
11:45 – 12:45	Data Format
12:45– 1:45	Lunch
1:45 – 2:30	The Basic Benefit
2:30 – 3:15	True Out-of-Pocket Costs (TrOOP)
3:15 – 3:30	Break
3:30 – 4:15	Low Income Cost-Sharing Subsidy
4:15 – 5:00	Question & Answer Session
5:00	Adjourn

AGENDA – DAY TWO

8:00 – 8:30	Registration
8:30 – 9:00	Review of Day One
9:00 – 10:00	Enhanced Alternative Benefit & Payment Demonstration Options
10:00 – 10:15	Break
10:15 – 11:45	Edits
11:45 – 1:00	Lunch
1:00 – 2:30	Reports
2:30 – 2:45	Break
2:45 – 4:15	Reconciliation
4:15 – 5:00	Question & Answer Session
5:00	Adjourn

OBJECTIVES

- Identify the prescription drug payment calculation methodology
- Describe the flow of the data from PDFS to DDPS
- Identify the fields required for completion of the PDE record
- Explain claims processing for the Basic Benefit structure

OBJECTIVES (CONTINUED)

- Distinguish between what does and does not count toward TrOOP
- Identify the fields on the PDE associated with LICS
- Interpret the layout rules for the EA benefit and Payment Demonstration options

OBJECTIVES (CONTINUED)

- Interpret the edit logic and error reports for PDFS and DDPS
- Describe how management reports can ensure accurate quality and quantity of data stored in the system
- Identify the systems and steps for calculating components used in the reconciliation process

INTRODUCING THE TEAM

CMS

Palmetto (CSSC)

Leading Through Change, Inc. (LTC)

Part D Payment Methodology

PURPOSE

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

OBJECTIVES

- Identify the four legislated payment mechanisms for Part D
- Describe payments subject to reconciliation and risk sharing
- Establish context for understanding PDE data reporting and reconciliation processes

FOUR MMA PAYMENT METHODS

- Direct subsidy
- Low income subsidy
- Reinsurance subsidy
- Risk sharing (risk corridors)

WHAT IS COVERED?

- Statutorily-specified Part D drugs also covered under a specific plan benefit package (PBP)
  - Includes coverage under transitions, appeals and other such processes

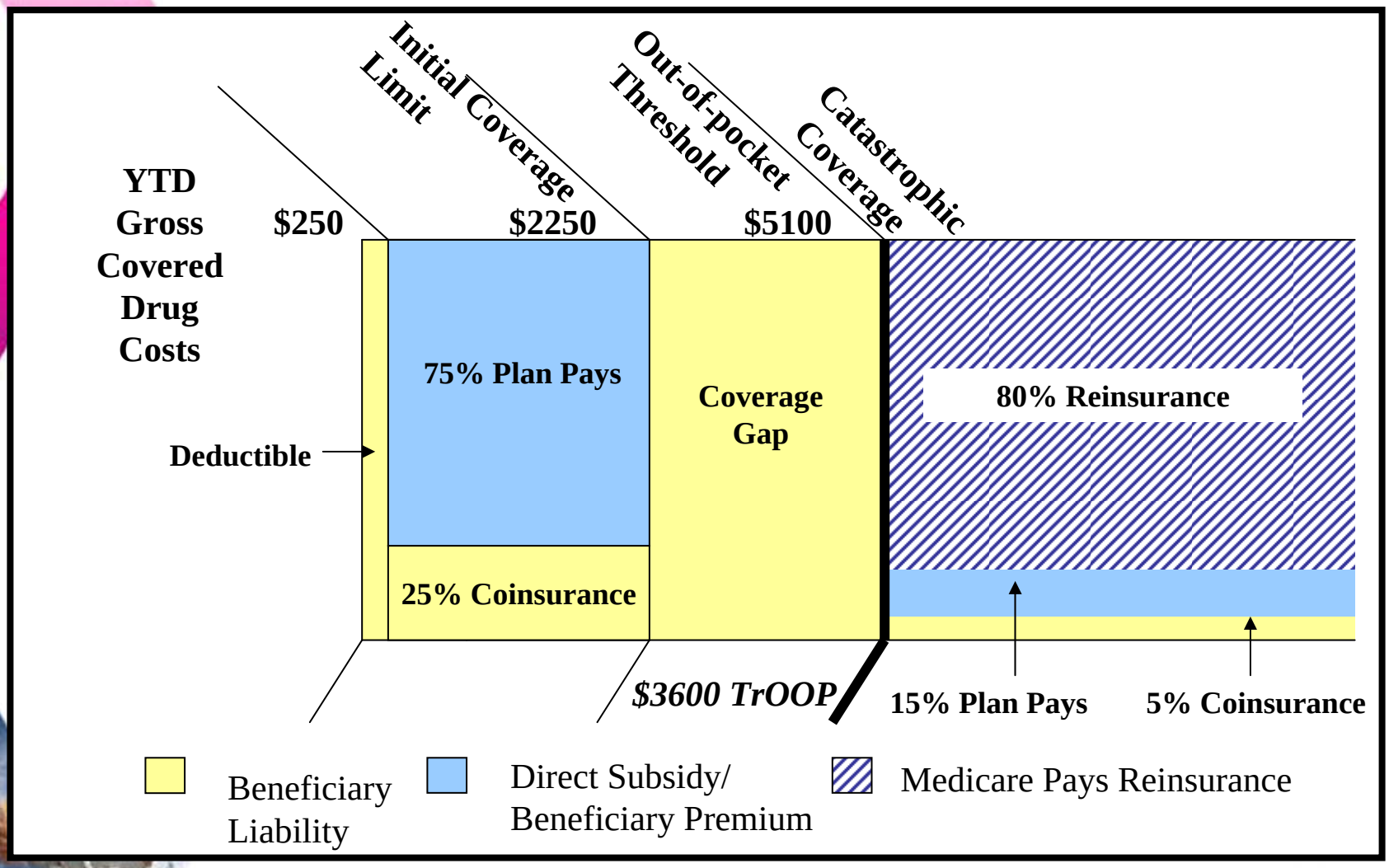
Gross Covered Drug Cost

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

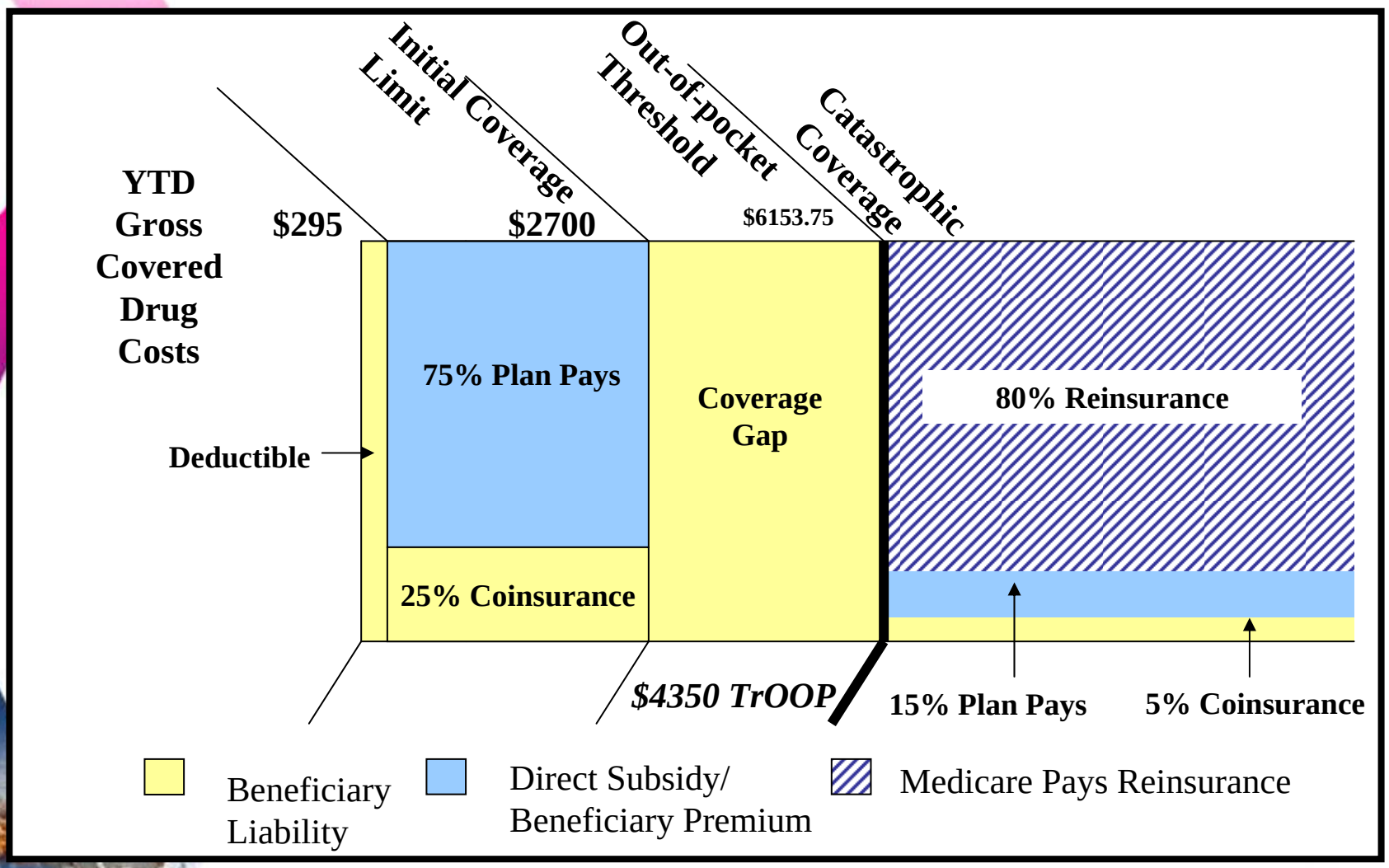
Gross Covered Drug Cost

- Cost incurred by plan for covered Part D drugs including amounts paid by or on behalf of an enrollee and including certain dispensing fees, but not including admin. fees
- PDE fields: Ingredient cost, Dispensing Fee, Sales Tax, Vaccine Administration Fee

2006
DEFINED STANDARD BENEFIT



2009
DEFINED STANDARD BENEFIT



2009
DEFINED STANDARD BENEFIT

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

DIRECT SUBSIDY

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

LOW INCOME SUBSIDY

- Two types: cost-sharing assistance and premium assistance

- PDE data: cost-sharing assistance, referred to as the Low-Income Cost-sharing Subsidy (LICS)
  - Applies throughout all phases of the benefit for qualifying beneficiaries
  - A cost-based component of payment

REINSURANCE SUBSIDY

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

RISK SHARING

- Compares the plan-level risk payments (direct subsidy and premiums) to aggregate allowed plan costs in the initial coverage period and the catastrophic phase

- Federal government and the plan share unexpected plan loss or gain

WHAT IS RECONCILIATION?

- Conducted after the end of the coverage year
- Compares monthly prospective payments CMS makes throughout the year with actual costs incurred by the plan
- Different rules for reconciling each payment mechanism
- Plan-to-plan (P2P) reconciliation
  - Part of normal Part D reconciliation
  - Separate guidance and training

Payment Timetable and Reconciliation

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

PDE DATA ENABLE PAYMENT AND RECONCILIATION

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

DIRECT AND INDIRECT REMUNERATION (DIR)

- Payment and reconciliation must exclude DIR, defined as:

  Discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants of other price concessions or similar benefits offered to some or all purchasers from any source, including manufacturers, pharmacies, enrollees, or any other person, that would serve to decrease the costs incurred by the Part D sponsor for the drug (42 CFR 423.308).

DIR IN PAYMENT/RECONCILIATION

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

Direct Subsidy

- Monthly prospective payment received by plan for every enrollee
- Adjustment to the Direct Subsidy is required to account for the health status of the beneficiary

PART D RISK ADJUSTMENT: THE BASICS

- Risk adjustment is used to standardize bids, establishing a plan bid for a 1.0 (average) beneficiary.
- Allows direct comparison of bids based on populations with different health status and other characteristics.
- On the payment side, risk adjustment appropriately adjusts payment for the costs of each enrollee.

RECONCILIATION: DIRECT SUBSIDY

- Prospective monthly direct subsidy

  Direct subsidy =
  Plan's approved Part D standardized bid amount
  x beneficiary's risk score (RS)
  – monthly beneficiary basic premium

- Re-calculated during the year based on new enrollment and RS; updated and reconciled after year-end

- Note: Also used in risk sharing reconciliation

RECONCILIATION: LICS

Monthly prospective LICS subsidy =

(LICS estimate in approved bid * # LI beneficiaries enrolled/month)

LICS reconciliation amount =

(Sum of plan-reported LICS dollars from PDEs – Beneficiary-plan-level prospective LICS subsidy including adjustments)

Reconciliation payment adjustment (+) or (-)

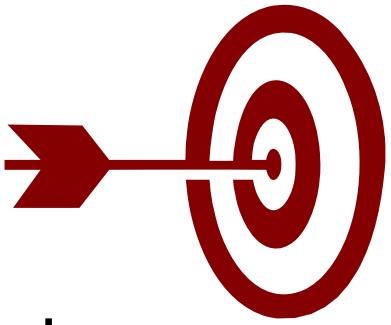
RECONCILIATION: REINSURANCE

- Determine allowable reinsurance costs
  - On PDE, plans identify all gross covered drug costs that are above the out-of-pocket threshold (GDCA)
  - CMS sums GDCA by plan
  - Subtract DIR attributed to reinsurance costs (formula)
  - Multiply by 0.80
- Compare to monthly prospective reinsurance subsidy amounts to obtain reconciliation payment adjustment (+) or (-)

RECONCILIATION: RISK SHARING - OVERVIEW

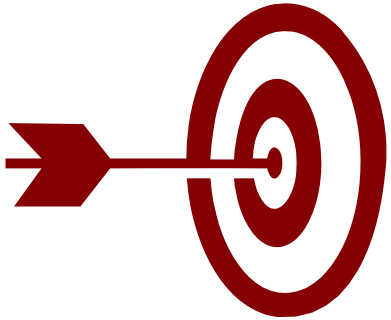
- Calculate the plan's "goal" (target amount) payments
  - Includes direct subsidy
- Determine actual costs from PDEs
- Compare actual to target within specified risk limits -> Payment adjustment if applicable

RECONCILIATION: RISK SHARING



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

CALCULATE TARGET AMOUNT



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

In formula:

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

CALCULATE ADJUSTED ALLOWABLE RISK CORRIDOR COSTS (AARCCs)

Add

- Plan-paid amounts for covered Part D drugs from PDEs

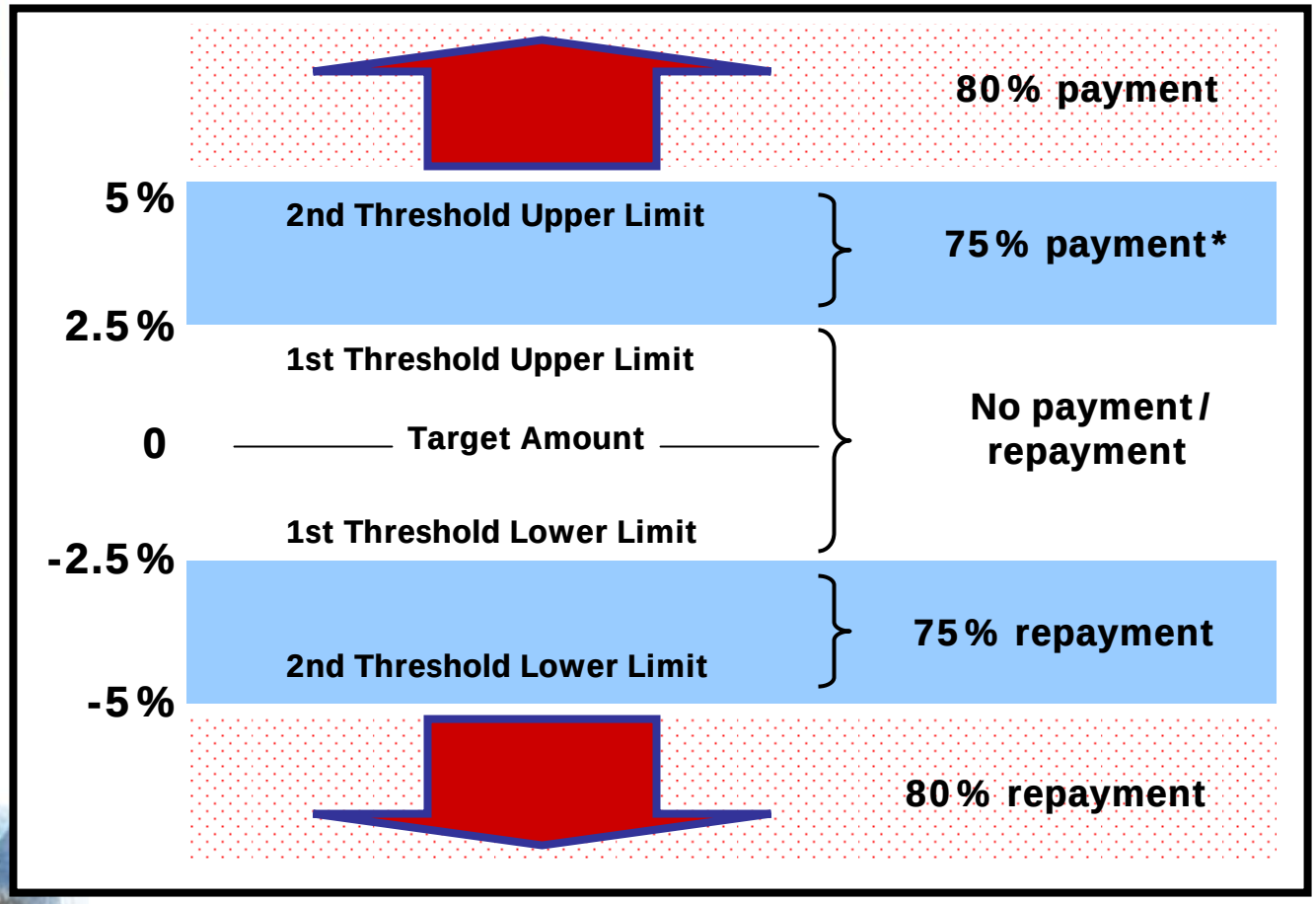
Then subtract

- Reinsurance subsidy
- Net Covered Part D DIR

For Enhanced Alternative plans only, reduce by

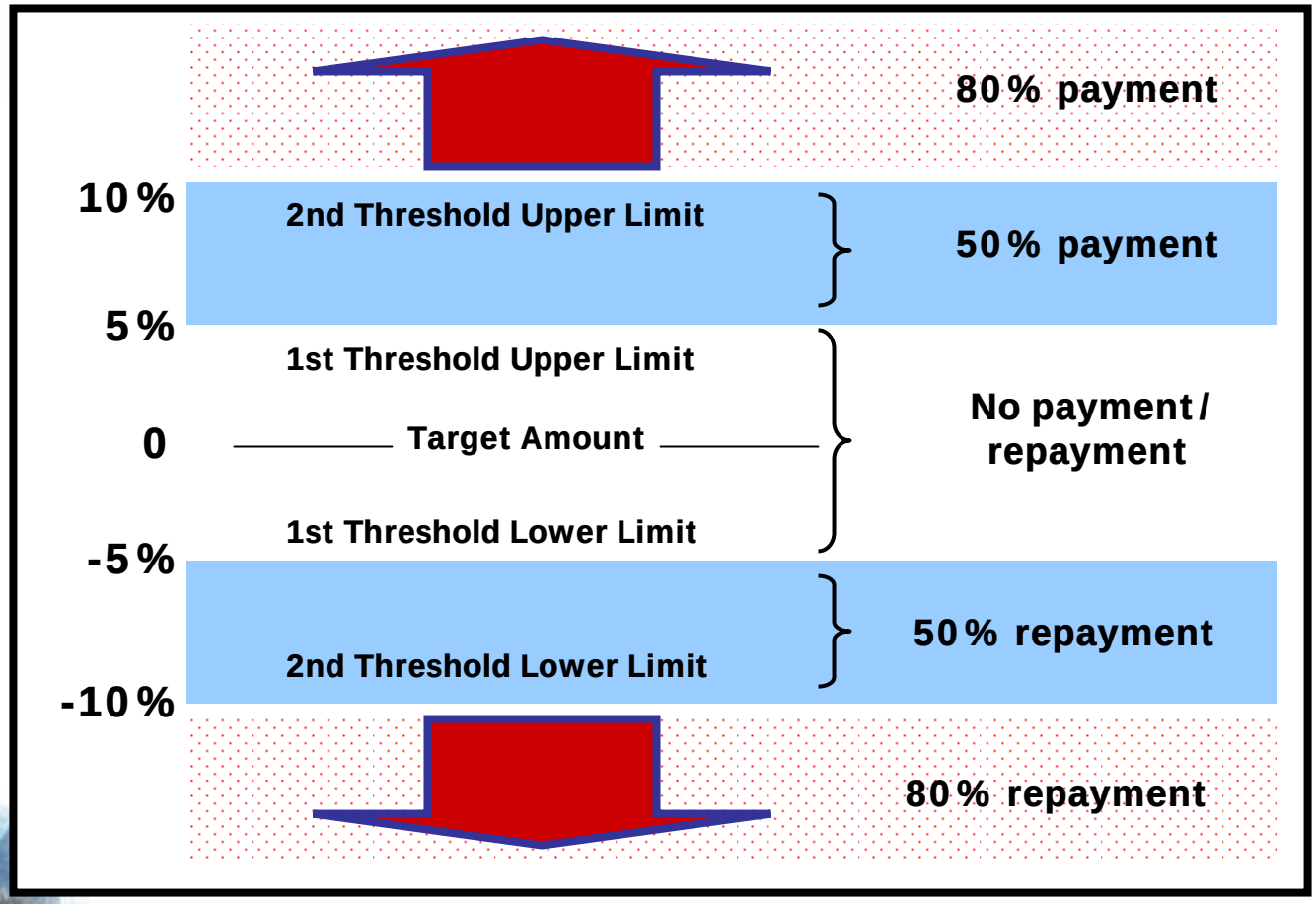
- Induced utilization

RISK CORRIDORS 2006 - 2007



*60/60

RISK CORRIDORS 2008 - 2011



Q&A

EVALUATION

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

THANK YOU!

PDE Process Overview

PURPOSE

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

OBJECTIVES

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

COMMON PDE SYSTEM TERMS

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

PART D BENEFIT OPTIONS

Plans may offer the following benefits:

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

PDE RECORD OVERVIEW

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

PDE RECORD OVERVIEW (CONTINUED)

Includes CMS and NCPDP-defined data elements that track:

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

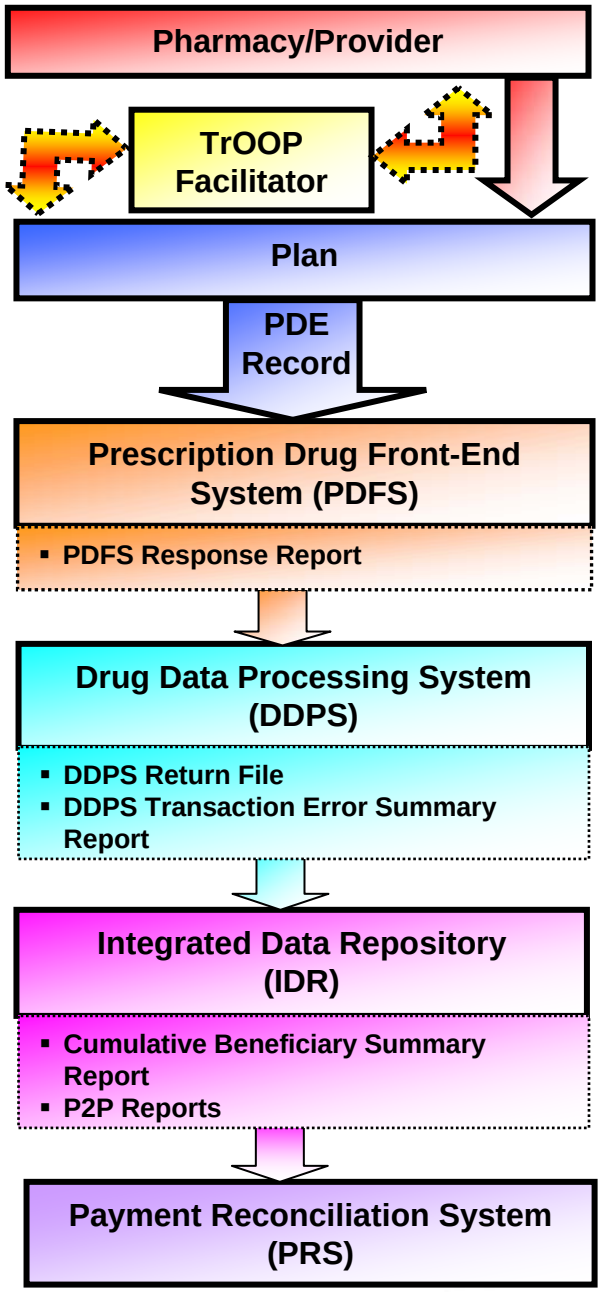
NEW CONTRACT EFFECTIVE JANUARY 1, 2009 PDE DATA SUBMISSION TIMELINE

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

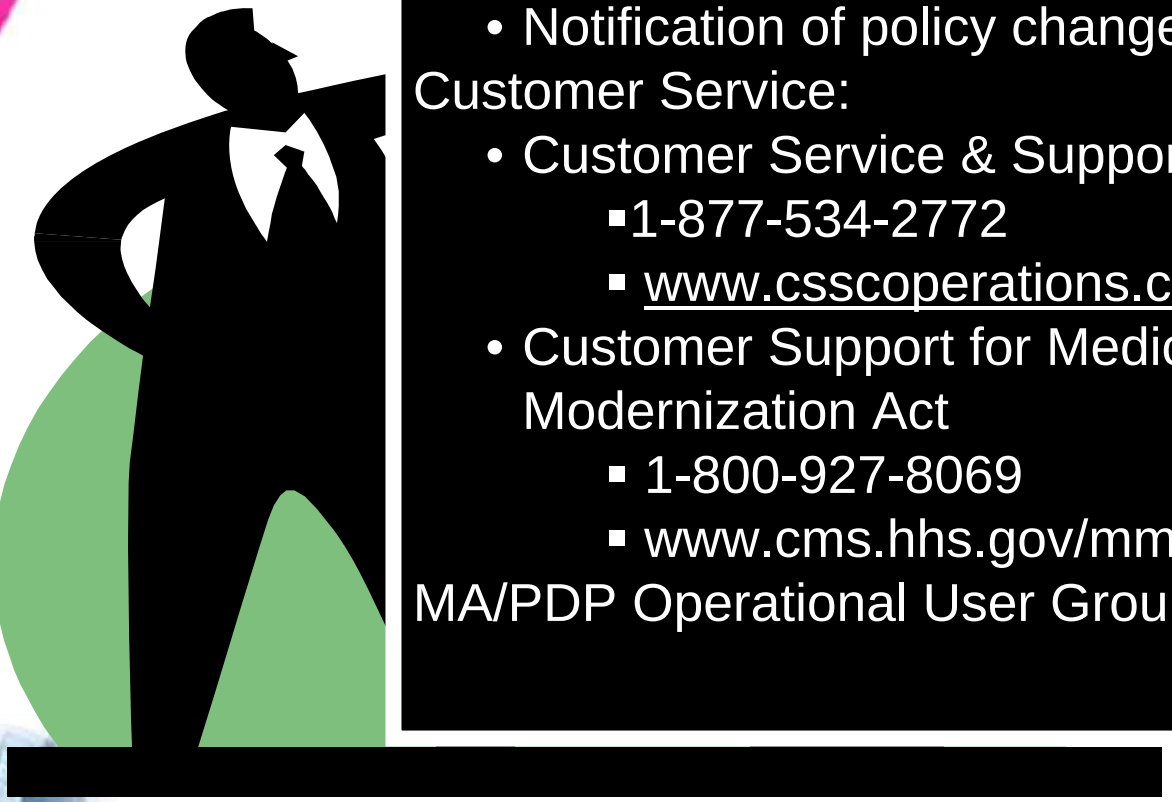
* Only new contracts submitting directly or new third party submitters submitting in CY2009 must complete the testing and certification process.

PDE DATAFLOW

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



TECHNICAL ASSISTANCE AND SUPPORT



HPMS:

- Notification of policy changes.

Customer Service:

- Customer Service & Support Center
  - 1-877-534-2772
  - www.csscoperations.com
- Customer Support for Medicare Modernization Act
  - 1-800-927-8069
  - www.cms.hhs.gov/mmahelp

MA/PDP Operational User Group Calls

SUMMARY

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

EVALUATION

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

THANK YOU!

Data Format

PURPOSE

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

OBJECTIVES

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

PDE ENROLLMENT PACKAGES

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

CONNECTIVITY OPTIONS

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

CERTIFICATION PROCESS

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

≥ 80%
acceptance rate

CERTIFICATION PHASES

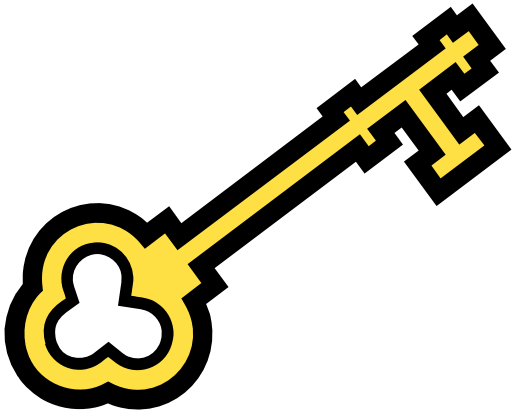
Phase 1

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

Phase 2

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

CERTIFICATION AND SYSTEM CHANGES



KEY POINT

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

2009
DATA SUBMISSION TIMELINE

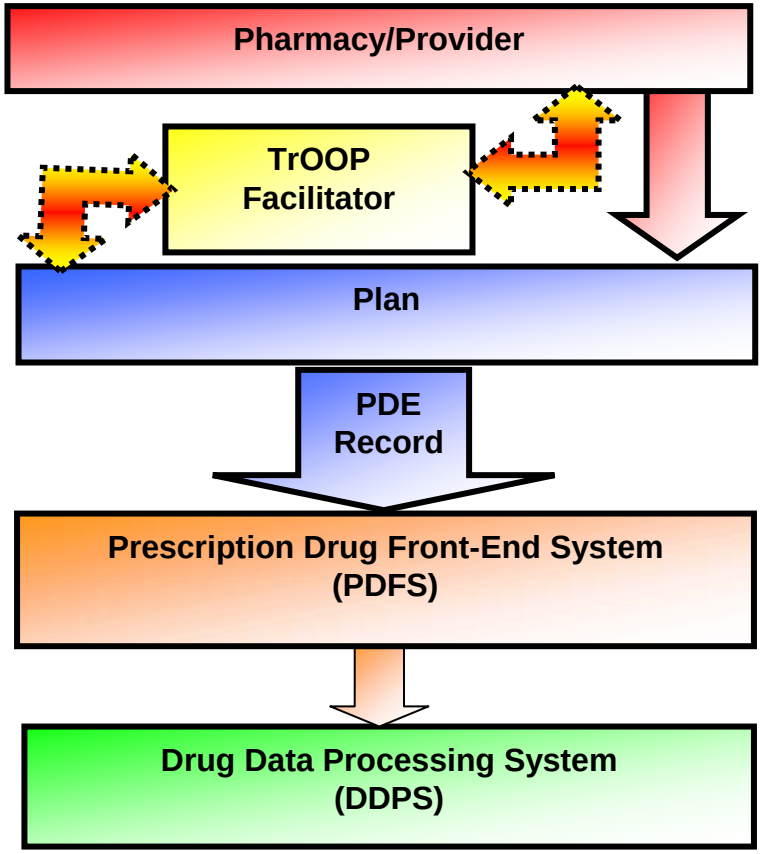
CY	Data Submission Type	Submission Timeline
2009	EDI Agreement and Submitter Application Deadline	October 31, 2008
2009	Certification Complete*	January 31, 2009
2009	First Production File Due	March 31, 2009
2009	Production Submissions	Ongoing Monthly Submissions March 31, 2009 – May 31, 2010
2009	Final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

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

PLAN MONITORING

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

PDE PROCESS DATAFLOW



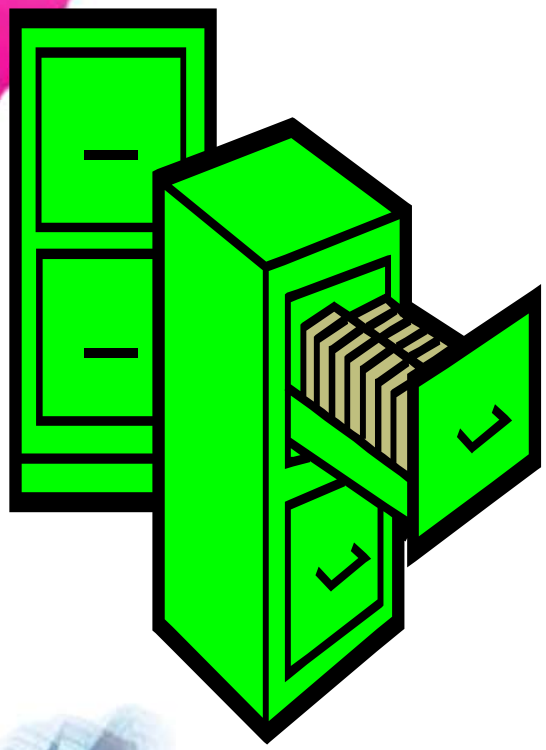
PDE RECORD LAYOUT LOGIC

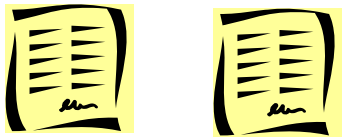
File level information	Identifies the submitter
Batch level information	Identifies the contract/PBP
Detail level information	Identifies the beneficiary

PDE RECORD LAYOUT LOGIC

(CONTINUED)

File level **Batch level** **Detail level**





CONTRACT IDENTIFICATION

Plan Type	First Letter
Local MA-PD Plans	Begins with an “H”
Regional MA-PD Plans	Begins with an “R”
Prescription Drug Plans (PDP)	Begins with an “S”
Employer/Union Direct Contract Plans	Begins with an “E”

PLAN IDENTIFICATION

Plan Benefit Package (PBP) ID

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

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

HICN

CMS Number ⇒ 111223334A

SSN BIC

RRB Pre 1964 ⇒ WA123456

Prefix Random

RRB Post 1964 ⇒ WA123456789

Prefix SSN

DRUG COVERAGE STATUS CODE

Drug Coverage Status Code

C = Covered

E = Enhanced

O = Over-the-Counter

CATASTROPHIC COVERAGE CODE

- When the beneficiary is below the OOP threshold
  - Catastrophic Coverage Code = <blank>
- When beneficiary reaches the OOP threshold
  - Catastrophic Coverage Code = A
- When beneficiary is above the OOP threshold
  - Catastrophic Coverage Code = C

DOLLAR FIELDS

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

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

COST FIELDS

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

Catastrophic Coverage Code = <blank>

Catastrophic Coverage Code = A

Catastrophic Coverage Code = C

PAYMENT FIELDS

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

NON-STANDARD FORMAT

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

NON-STANDARD FORMAT

(CONTINUED)

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

Effective in 2010

Prescription Origin Code

0=Not Specified
1=Written
2=Telephone
3=Electronic
4=Facsimile
<blank>

MODIFYING PDE RECORDS

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

MODIFYING PDE RECORDS

(CONTINUED)

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

MODIFYING PDE RECORDS

(CONTINUED)

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

SUMMARY

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

EVALUATION

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

THANK YOU!

Calculating and Reporting the Basic Benefit

2008 PRESCRIPTION DRUG EVENT DATA

PURPOSE

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

OBJECTIVES

- Explain the characteristics of the “Basic Benefit” and the three types of Basic Benefit plans
- Illustrate how the Defined Standard benefit is the foundation of all other Basic benefit plans
- Define covered and non-covered drugs

OBJECTIVES (CONTINUED)

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

BASIC BENEFIT PLAN TYPES

- There are three Basic benefit plan types.
  - Defined Standard (DS)
  - Actuarially Equivalent (AE)
  - Basic Alternative (BA)

- Basic benefit only pays for drugs that:
  - meet a statutorily defined Part D drug

    and
  - covered under a Part D plan's benefit package (PBP).

COVERED AND NON-COVERED DRUGS

Covered Part D Drugs:

- A Part D drug
- Approved for coverage under a specific PBP

Non-covered Part D Drugs:

- Not a Part D drug
- Covered under Medicare Parts A or B
- Is a Part D drug, but not approved for coverage under a specific PBP

Approved for coverage includes exceptions under transitions, appeals, and other such processes

THE 2006 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$250	100%
Initial Coverage Period	>$250 and ≤ $2,250	25%
Coverage Gap	>$2,250 and ≤ $5,100	100%
Catastrophic Coverage	>$5,100	Greater of 5% coinsurance or $2/$5 co-pay

THE 2008 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$275	100%
Initial Coverage Period	>$275 and ≤ $2,510	25%
Coverage Gap	>$2,510 and ≤ $5,726.25	100%
Catastrophic Coverage	>$5,726.25	Greater of 5% coinsurance or $2.25/$5.60 co-pay

THE 2009 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$295	100%
Initial Coverage Period	>$295 and ≤ $2,700	25%
Coverage Gap	>$2,700 and ≤ $6,153.75	100%
Catastrophic Coverage	>$6,153.75	Greater of 5% coinsurance or $2.40/$6.00 co-pay

BASIC BENEFIT PLAN TYPES

Defined Standard (DS)	• Statutorily mandated cost sharing and benefit parameters that the plan sponsor cannot change (see Tables 4A-B)
* Actuarially Equivalent (AE)	• Must use the same deductible and initial coverage limit that apply in the DS benefit. • Can change cost-sharing in the initial coverage period and/or catastrophic coverage phase from the DS amounts, including use of tiers
* Basic Alternative (BA)	• Can reduce the deductible, lower or raise the initial coverage limit, and/or change the cost-sharing in any phase from the DS provisions, including use of tiers.

*The actuarial value remains equivalent to a DS benefit plan such that no supplemental premium is required.

TIERED COST-SHARING

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

EXAMPLE OF A TIERED BENEFIT

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

DATA ELEMENTS KEY TO BASIC BENEFIT

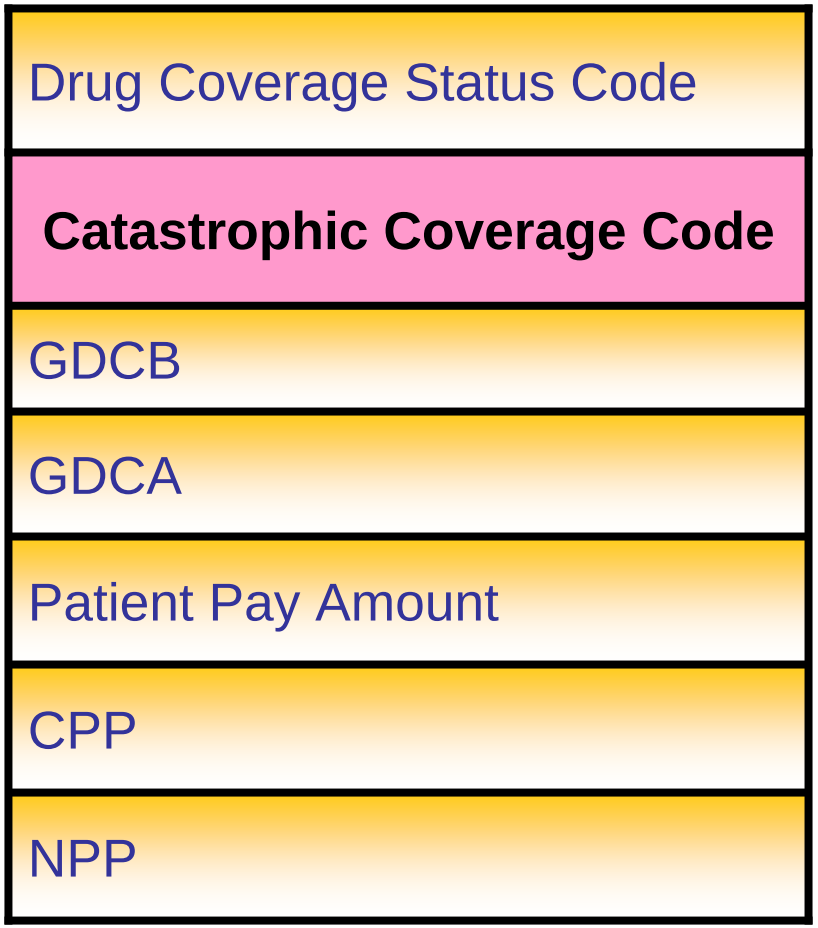
- Drug Coverage Status Code
- Catastrophic Coverage Code
- GDCB
- GDCA
- Patient Pay Amount
- CPP
- NPP

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

Drug Coverage Status Code
Catastrophic Coverage Code
GDCB
GDCA
Patient Pay Amount
CPP
NPP

"C" = Covered Part D Drug

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

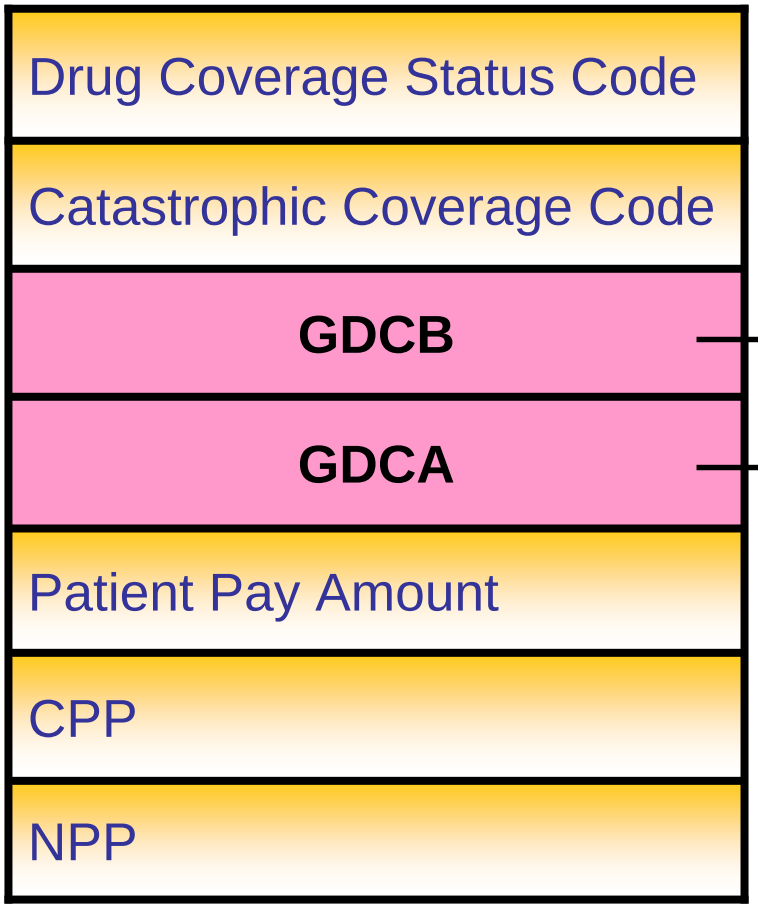


<blank> = OOP threshold has not been reached.

"A" = The event reaches the OOP threshold.

"C" = The event is in the Catastrophic Coverage phase.

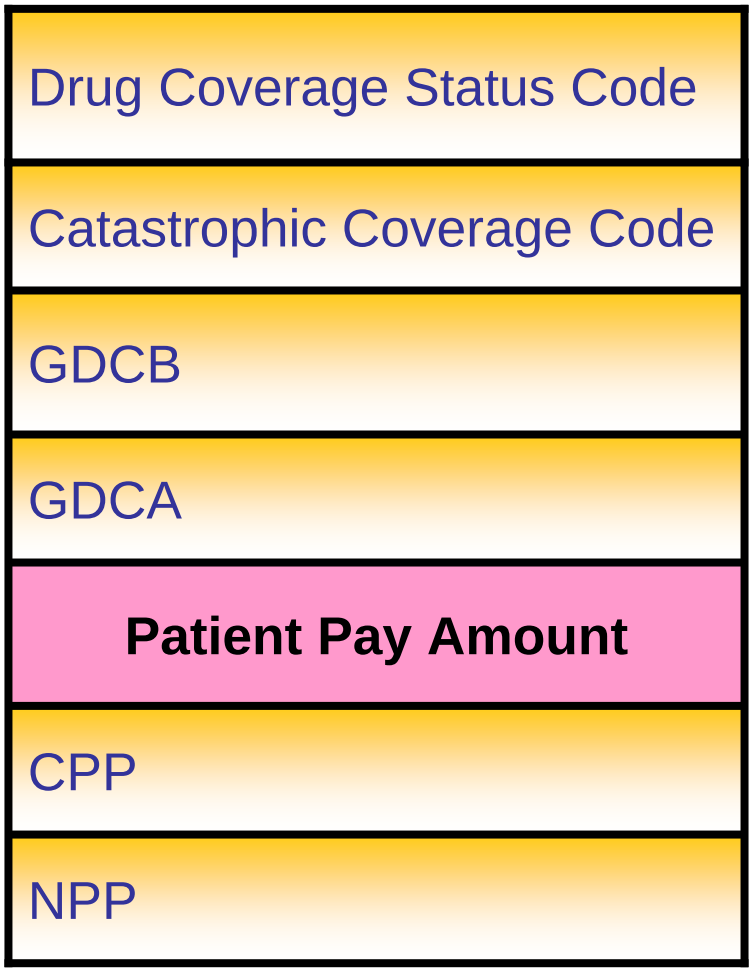
DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)



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

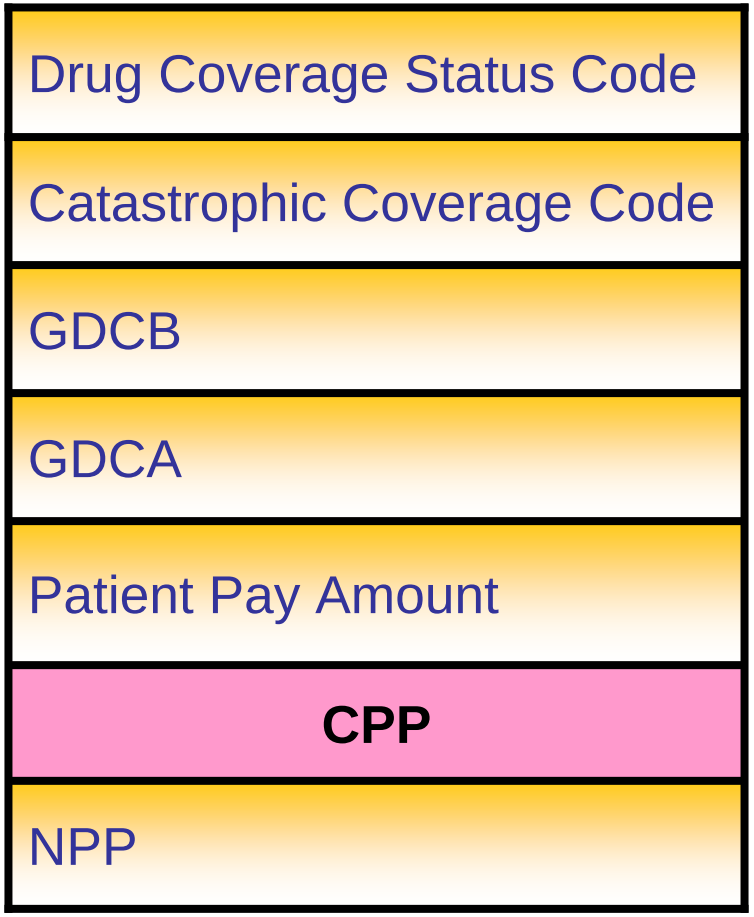
Gross Covered Drug Cost **above** the OOP threshold

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)



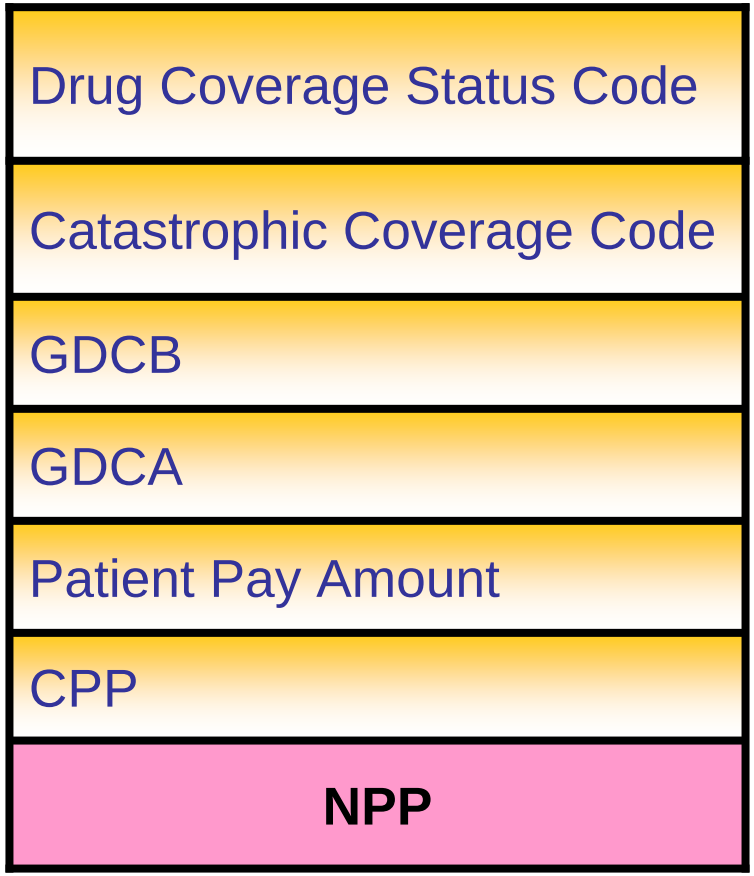
The dollar amount that a beneficiary paid.

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)



The dollar amount the plan paid for the Basic benefit

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)



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

THE 2006 DEFINED STANDARD BENEFIT

Deductible Phase	Initial Coverage Period	Coverage Gap Phase	Catastrophic Coverage Phase
100%	25%	100%	Greater of 5% or $2/$5

THE “SIMPLEST” CASE

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

Characteristics:

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

DS PLAN: DEDUCTIBLE PHASE

Scenario

In 2006, the beneficiary purchased a $100 covered drug in the Deductible phase of the Defined Standard benefit.

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

DS PLAN: CATASTROPHIC PHASE

Scenario

2006 YTD TrOOP = $3,600.

The beneficiary purchased a $75 brand name covered drug.

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

OVER-THE-COUNTER (OTC) DRUGS

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

DS PLAN: OTC DRUG

Scenario

2006 YTD gross covered drug cost = $300. The beneficiary purchased a $15.00 OTC drug used in step therapy.

Result

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

EXAMPLE OF A TIERED BENEFIT

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

AE PLAN: INITIAL COVERAGE PHASE

Scenario

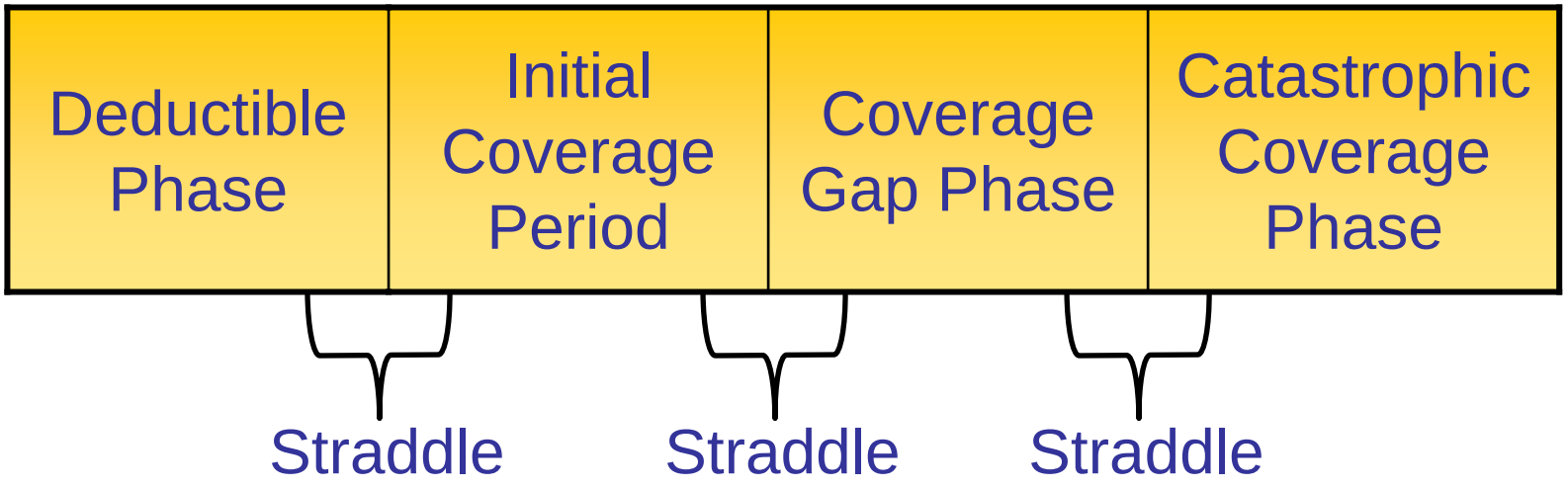
YTD gross covered drug cost = $300 in a AE plan.
The beneficiary purchased a $100 covered drug in Tier 2.

Result

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

STRADDLE CLAIMS

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



DS 2006: COVERAGE GAP TO CATASTROPHIC PHASE

Scenario

2006 YTD TrOOP = $3,550. The beneficiary purchased a $150 covered brand name drug.

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

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

DS 2006: COVERAGE GAP TO CATASTROPHIC PHASE

Results - Calculation

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

TIERED COST-SHARING STRADDLE CLAIMS

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

≤

Patient Pay **Negotiated Drug Cost**

BA PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PERIOD

Scenario

2006 YTD gross covered drug cost = $70 in a BA plan. The beneficiary purchased a $100 negotiated price covered drug in Tier 3 with a deductible of $100.

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

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

BA 2006: PATIENT PAY AMOUNT LESS THAN NEGOTIATED PRICE

Results - Calculation

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

AE PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PERIOD

Scenario

YTD gross covered drug cost = $175. The beneficiary purchased a $100 negotiated price covered drug in Tier 3.

Result

Step 1: Calculate the first phase.

Step 2: Calculate the second phase.

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

AE 2006: TOTAL PATIENT PAY AMOUNT

Results - Calculation

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

Adjustments/Deletions

KEY FIELDS

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

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

ADJUSTMENT/DELETION CODE DEFINITIONS

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

SITUATIONS THAT MAY CAUSE ADJUSTMENTS AND DELETIONS

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

REVERSALS WITH NO BENEFIT PHASE CHANGE

- Reversals with no benefit phase change impact the following:
  - Benefit Administration
    - YTD TrOOP Balance
    - YTD Gross Covered Drug Cost Accumulator
  - PDE Reporting

REVERSALS WITH NO BENEFIT PHASE CHANGE SCENARIO

Beneficiary:

- Enrolled in AE plan ($250 deductible in 2006)
- Purchases three covered drugs
  - January 10 - $100 drug, filled by pharmacy and billed to plan
  - January 15 - $75 drug
  - January 20 - $50 drug
- Reversal – January 21
  - Pharmacy reverses January 10 claim (prescription not picked up) and refunds plan

REVERSALS WITH NO BENEFIT PHASE CHANGE RESULT

Claim Date	Current Claim		Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance effective January 1			$ 0.00	$ 0.00
January 10	$100.00	$100.00	$100.00	$100.00
January 15	$ 75.00	$ 75.00	$175.00	$175.00
January 20	$ 50.00	$ 50.00	$225.00	$225.00
January 10 reversal (effective January 21)	<$100.00>	<$100.00>	$125.00	$125.00

REVERSALS WITH BENEFIT PHASE CHANGE

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

PDE REPORTING
"AS ADMINISTERED"/"AS ADJUSTED"

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

REVERSALS WITH BENEFIT PHASE CHANGE SCENARIO

Beneficiary:

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

ADJUSTMENTS IMPACTING STRADDLE CLAIMS

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

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

SUMMARY

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

SUMMARY (CONTINUED)

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

EVALUATION

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

THANK YOU!

Calculating and Reporting True Out-of-Pocket (TrOOP) Costs

PURPOSE

- To understand the process and requirements related to administering the TrOOP component of the Part D benefit

OBJECTIVES

- Define TrOOP costs
- List why TrOOP accounting is important
- Classify payments
- Describe how to administer the Part D benefit with respect to accumulating and reporting TrOOP
- Illustrate how to populate a PDE with TrOOP
- Identify two methods for administering the benefit and reporting retroactive TrOOP changes in PDEs
- Review Coordination of Benefits (COB) and the TrOOP Facilitation Process

TrOOP

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

TrOOP is set at $3,600 for 2006.

$4,050 for 2008.

$4,350 for 2009.

TrOOP stops at the OOP Threshold

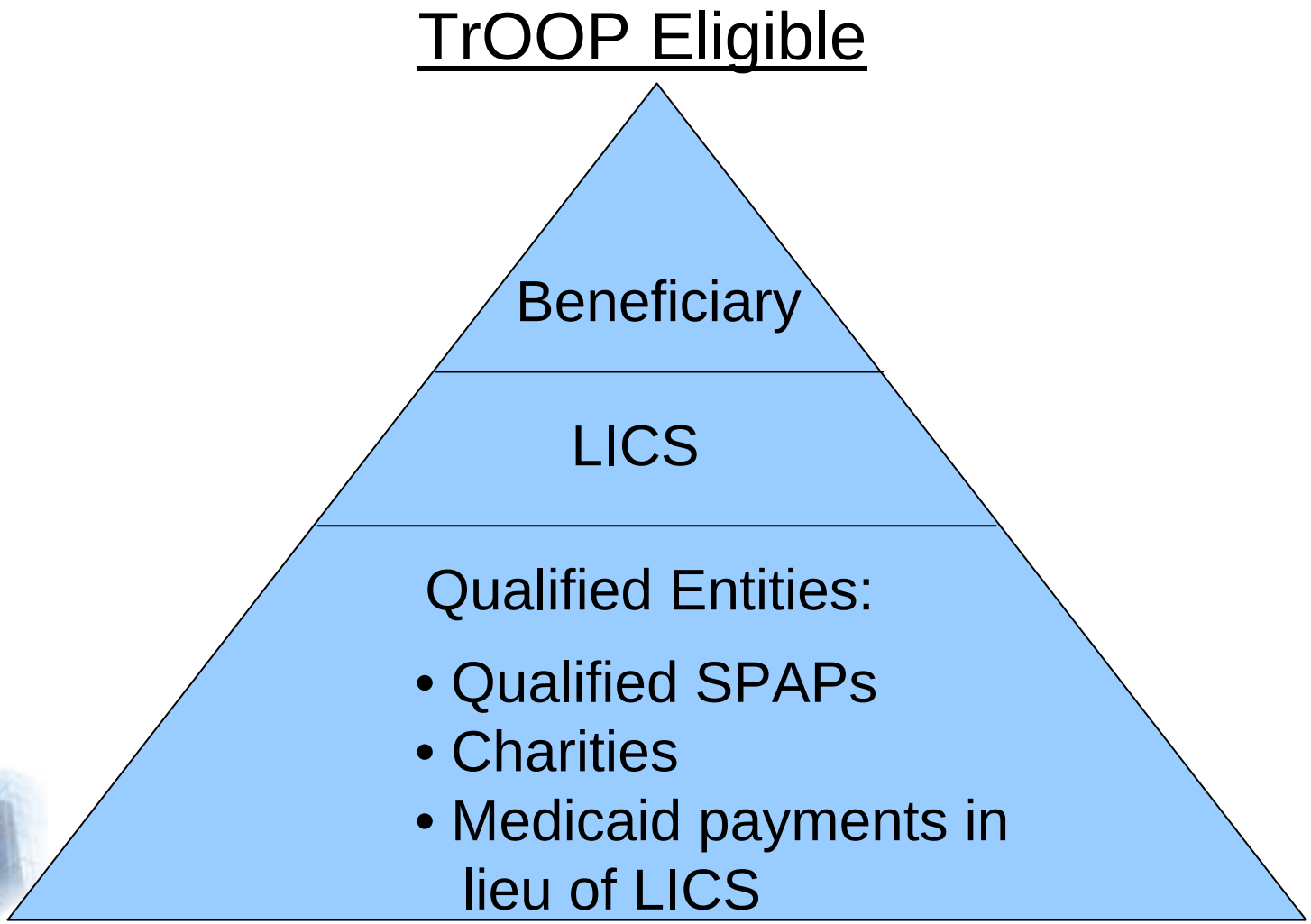
THE IMPORTANCE OF TrOOP

Reasons Why TrOOP is Important

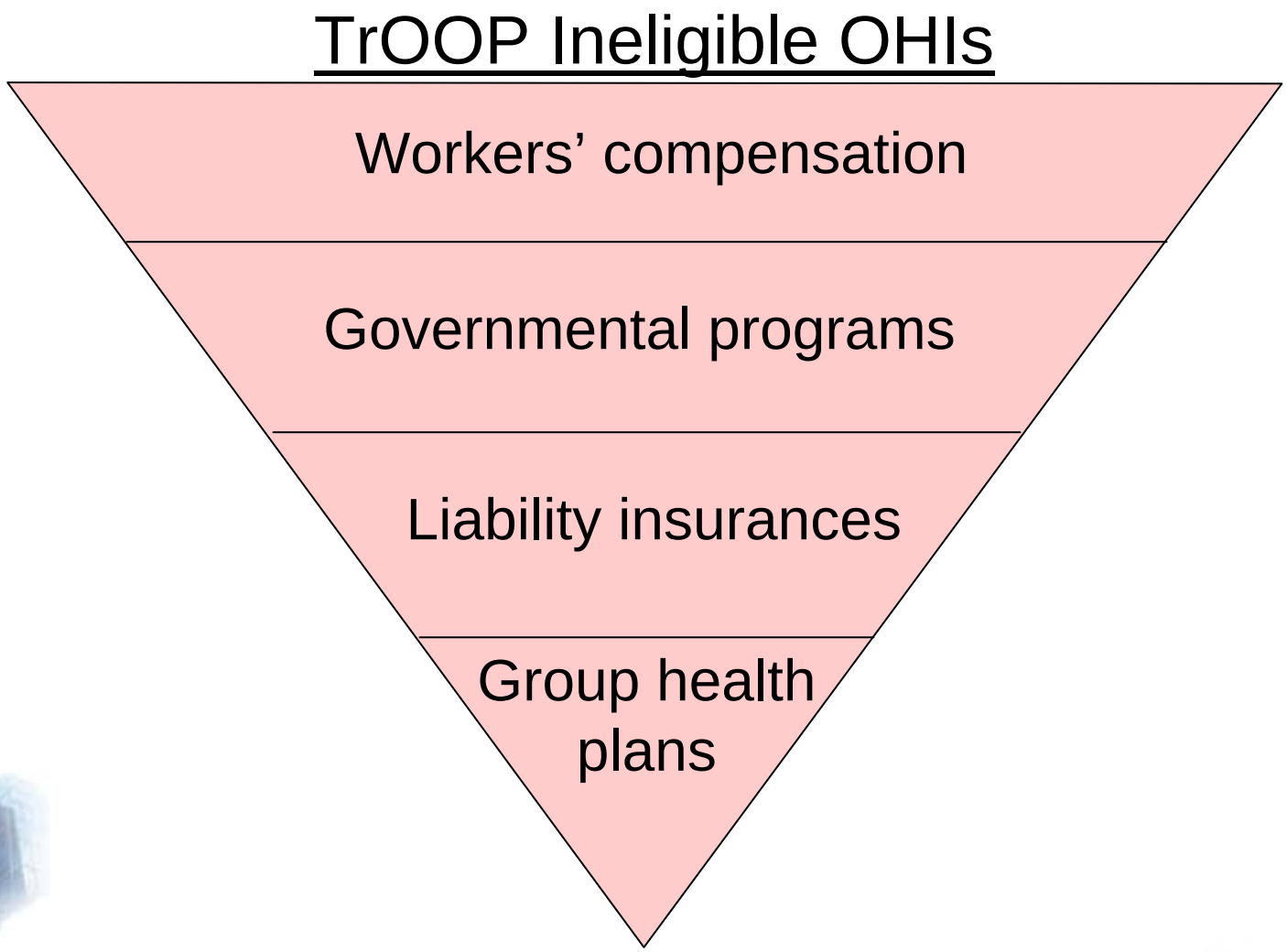
1. The beneficiary is subject to lower cost-sharing.

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

CONTRIBUTORS TO TrOOP



NON-CONTRIBUTORS TO TrOOP



PDE DATA ELEMENTS

- PDE fields enable CMS to distinguish costs that must be included or excluded from payment and/or TrOOP.
- The data elements that are most relevant to TrOOP accounting are:
  - Drug Coverage Status Code
  - Catastrophic Coverage Code
  - Six payment fields
  - Two cost fields (GDCA and GDCB)

PDE RECORD – PAYMENT FIELDS

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

- Beneficiary
- Family and Friends

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

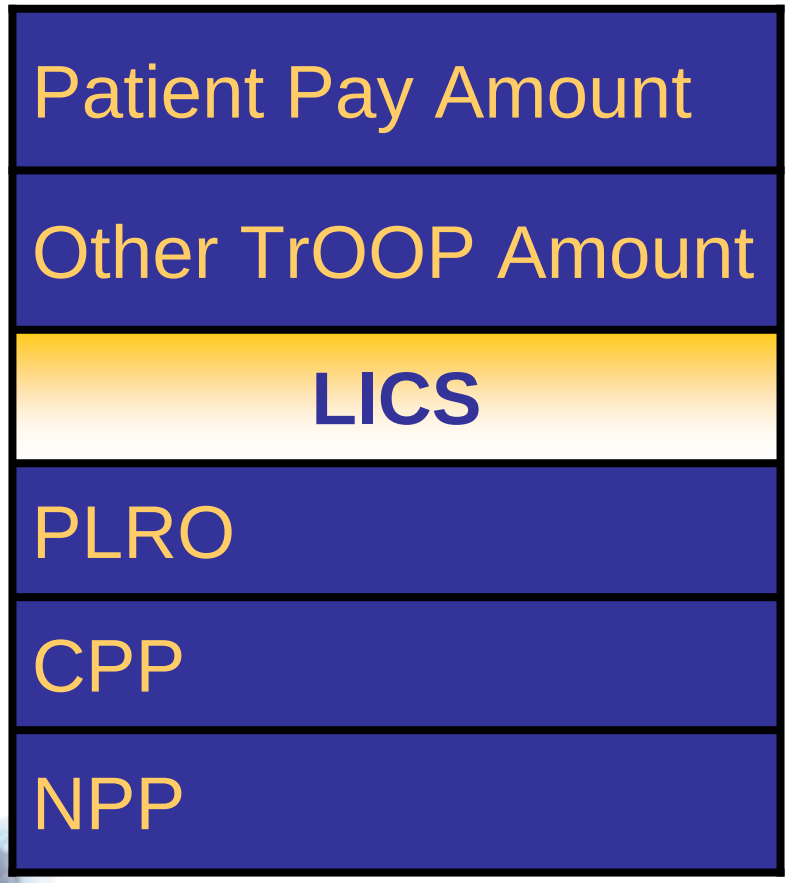
- Patient Pay Amount
- **Other TrOOP Amount**
- LICS
- PLRO
- CPP
- NPP

- Qualified SPAPs
- Charities
- Territories' 1860D-42(a) Payments

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

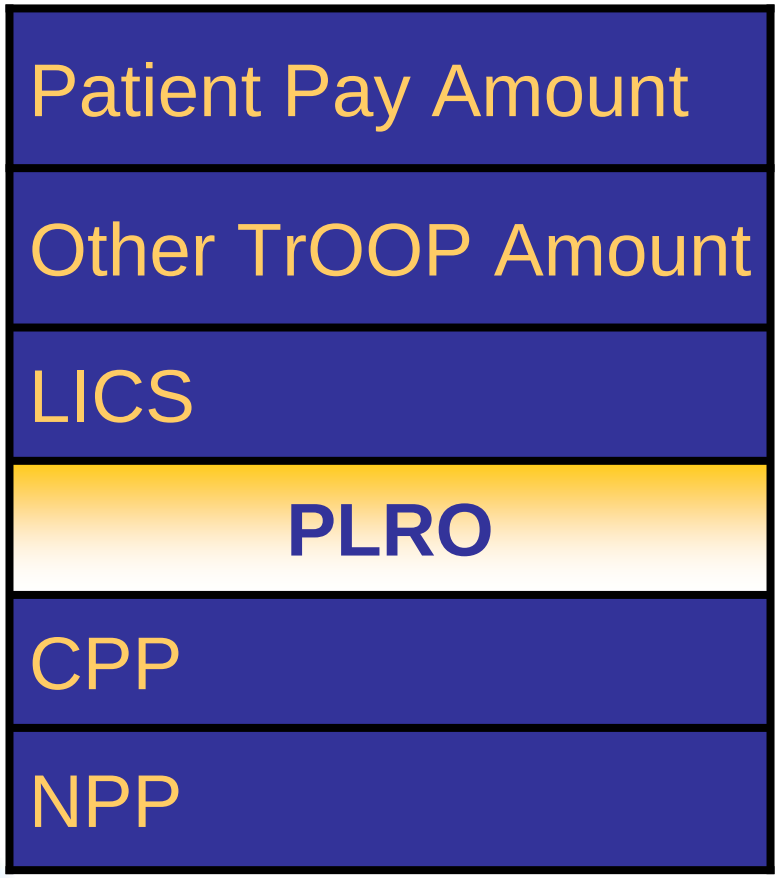


- Low Income Cost-Sharing Subsidy Amounts

Included in TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

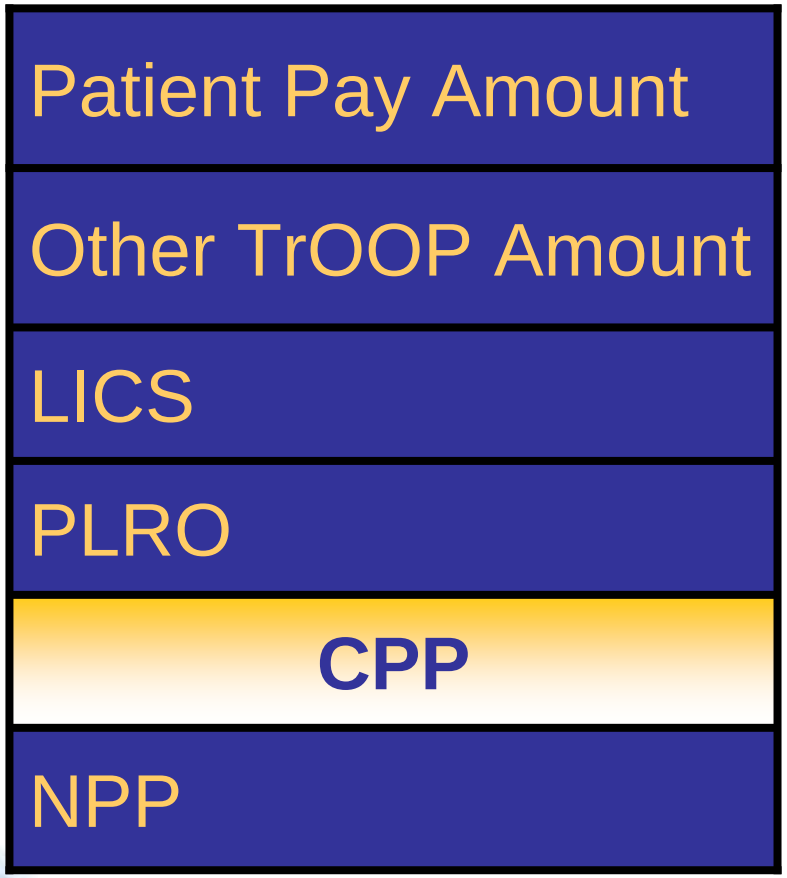


- Non-TrOOP Third Party Payments

Excluded from TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)

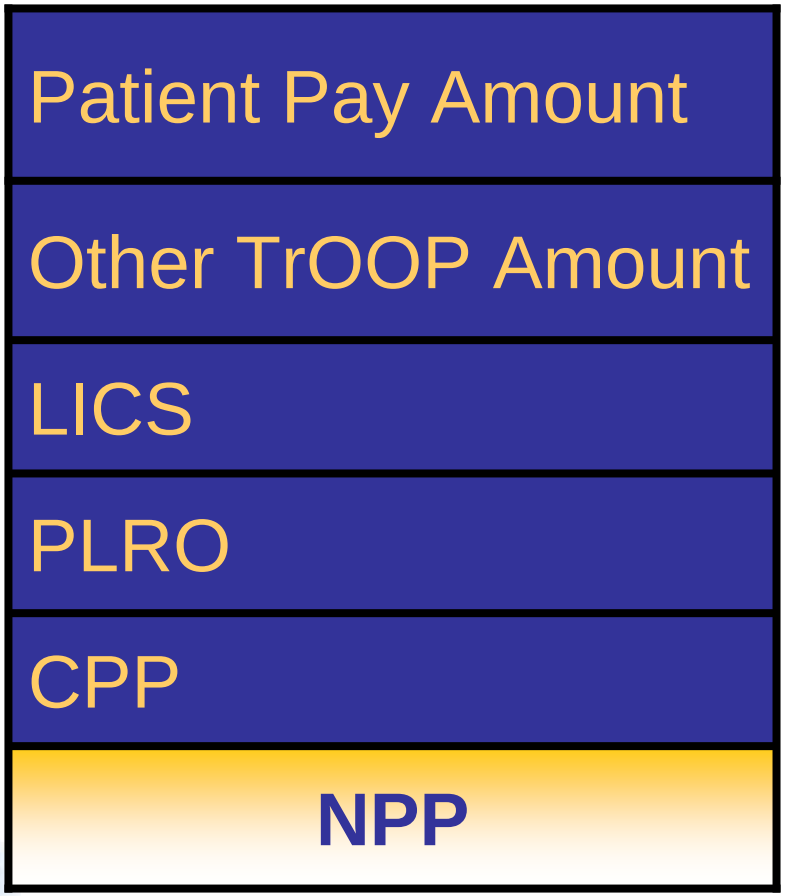


- Plan paid amounts attributed to the Basic benefit (covered drugs)

Excluded from TrOOP

PDE RECORD – PAYMENT FIELDS

(CONTINUED)



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

Excluded from TrOOP

CALCULATING TrOOP COSTS

OHI Payer

Step 4: Update the TrOOP accumulator

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

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

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

STEPS TO CALCULATE TrOOP COSTS

Scenario

Beneficiary is in the Initial Coverage period of the Defined Standard benefit. Before the TrOOP Facilitator, the Patient Pay Amount was $25. The TrOOP Facilitator reported a Patient Pay Amount of $10 with a secondary insurance paying the difference.

Result

Step 1: Identify the net change in Patient Pay Amount

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

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

Step 4: Update the TrOOP accumulator

STEPS TO CALCULATE TrOOP COSTS
(CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

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

STEPS TO CALCULATE TrOOP COSTS
(CONTINUED)

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

Non-TrOOP OHI = **PLRO field**

PLRO	$15

STEPS TO CALCULATE TROOP COSTS
(CONTINUED)

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

Patient Pay Amount	$10

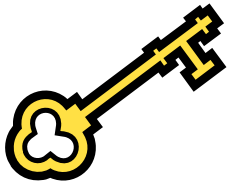
STEPS TO CALCULATE TROOP COSTS
(CONTINUED)

Step 4: Update the TrOOP accumulator

PLRO field amounts are not TrOOP eligible.

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

KEY POINT



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

PDE FIELDS AND TrOOP

- Drug Coverage Status Code
- Catastrophic Coverage Code
- GDCB
- GDCA
- Patient Pay Amount
- Other TrOOP Amount
- LICS
- PLRO
- CPP
- NPP

TrOOP Accumulator

TrOOP ELIGIBLE OHI

Scenario

The beneficiary is in the Initial Coverage period of the Defined Standard Benefit and purchases a covered Part D drug for $100. A qualified SPAP reduced the beneficiary's cost-share to $5.

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

TrOOP Accumulator	$5

TrOOP ELIGIBLE OHI (CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

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

TrOOP ELIGIBLE OHI (CONTINUED)

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

Other TrOOP Amount	$20

TrOOP ELIGIBLE OHI (CONTINUED)

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

Patient Pay Amount	$5

TrOOP ELIGIBLE OHI (CONTINUED)

Step 4: Update the TrOOP accumulator

Other TrOOP amount field is TrOOP eligible.

TrOOP Accumulator	+$25

TrOOP Eligible OHI (continued)

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$100.00
GDCA	$ 0.00
Patient Pay Amount	$ 5.00
Other TrOOP Amount	$ 20.00
CPP	$ 75.00

TrOOP Accumulator	+$25

Adjustments/Deletions

ADJUSTMENT/DELETION PROCESSING AND TrOOP

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

1. Only TrOOP moves the beneficiary into the Catastrophic phase of the benefit
2. Plans do not increment TrOOP balances beyond $3,600
   - TrOOP accumulation is a pre-catastrophic activity to satisfy the pre-requisite to receive catastrophic benefits

REVERSAL WITH NO BENEFIT PHASE CHANGE – CATASTROPHIC BENEFIT PHASE

Beneficiary:

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

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

Claim Date	Current Claim			Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance before the August 10 claim				$5,500.00	$3,600.00
August 10	$100.00	$5.00	$0.00	$5,600.00	$3,600.00
August 15	$ 75.00	$5.00	$0.00	$5,675.00	$3,600.00
August 20	$ 50.00	$5.00	$0.00	$5,725.00	$3,600.00
August 10 reversal (effective August 21)	<$100.00>	<$5.00>	$0.00	$5,625.00	$3,600.00

REVERSALS WITH BENEFIT PHASE CHANGE – CATASTROPHIC AND THE COVERAGE GAP

- Reversals with benefit phase change impact the following:
  - Benefit Administration
    - Update accumulators
    - Pay back benefit
      - Apply cost-sharing difference on future claims

        or
      - Recalculate affected claims/settle with beneficiary
  - PDE Reporting (two options)
    - Report as administered
    - Report as adjusted

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

Beneficiary:

- Enrolled in DS plan and was in Catastrophic Phase
- Purchases three covered drugs
  - August 10 - $100 name drug, filled by pharmacy and billed to plan
  - August 15 - $100 drug
  - August 20 - $100 drug
- Reversal – August 21
  - Pharmacy reverses August 10 claim (prescription not picked up) and refunds plan
- Purchases
  - August 25 - $100 drug
  - August 30 - $100 drug
- Plan applies 100% coinsurance to the next $100 in covered drug cost (Coverage Gap cost-sharing)
  - This restores the TrOOP balance to $3600 and the beneficiary reenters the Catastrophic phase of the benefit when the plan processes the August 30 Claim

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

Claim Date	Current Claim			Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance before the August 10 claim				$5,000.00	$3,500.00
August 10	$100.00	$100.00	$100.00	$5,100.00	$3,600.00
August 15	$100.00	$ 5.00	$ 0.00	$5,200.00	$3,600.00
August 20	$100.00	$ 5.00	$ 0.00	$5,300.00	$3,600.00
August 10 reversal (effective August 21)	<$100.00>	<$100.00>	<$100.00>	$5,200.00	$3,500.00
August 25	$100.00	$100.00	$100.00	$5,300.00	$3,600.00
August 30	$100.00	$ 5.00	$ 0.00	$5,400.00	$3,600.00

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

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

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

Claim Date	Current Claim			Accumulators	
	Gross Covered Drug Cost	Patient Pay Amount	Change in TrOOP	YTD Gross Covered Drug Cost	YTD TrOOP Balance
Balance before the August 10 claim				$5,000.00	$3,500.00
August 10	~~$100.00~~ $0.00	~~$100.00~~ $0.00	~~$100.00~~ $0.00	~~$5,100.00~~ $5,000.00	~~$3,600.00~~ $3,500.00
August 15	$100.00	~~$5.00~~ $100.00	~~$0.00~~ $100.00	~~$5,200.00~~ $5,100.00	$3,600.00
August 20	$100.00	$5.00	$0.00	~~$5,300.00~~ $5,200.00	$3,600.00
August 25	$100.00	$5.00	$0.00	$5,300.00	$3,600.00
August 30	$100.00	$5.00	$0.00	$5,400.00	$3,600.00

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

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

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

Benefit Administration Approach	Future claim (Table 5G)	Recalculated Claim (Table 5I)
August 15 claim	Catastrophic Phase Plan pays $95.00 Beneficiary pays $ 5.00	Coverage Gap Plan pays $ 0.00 Beneficiary pays $100.00
August 25 claim	Coverage Gap Plan pays $ 0.00 Beneficiary pays $100.00	Catastrophic Phase Plan pays $95.00 Beneficiary pays $ 5.00

COMPARISON OF PDE REPORTING: "AS ADMINISTERED" VS "AS ADJUSTED"

	As administered (Table 5G)	As adjusted (Table 5I)
Cost-sharing reported on PDE	Actual cost-sharing at POS	Recalculated cost-sharing
Number of "A" claims	2	1
Required to adjust PDE *(assume previous PDE was saved)*	no	yes

COB AND TrOOP FACILITATOR OVERVIEW AND REQUIREMENTS

- COB Contractor:
  - Gathers other health insurance information (OHI) to support Medicare coordination of benefits and the Medicare Secondary Payer program
  - Conducts data exchanges with employers and insurers/payers
  - Develop leads that identify a beneficiary's other insurance(s) that may pay secondary or primary to Medicare
  - Supports Part D COB at POS and Part C and D at the Plan (Part C relevant to particular plan type)

COB AND TrOOP FACILITATOR OVERVIEW AND REQUIREMENTS
(CONTINUED)

- TrOOP Facilitation Contractor:
  - Works with COB Contractor and secondary/supplemental payers to Medicare to “grab” claims information
  - Creates and routes transactions to plans based on claims secondary to Part D
  - Facilitates calculation of TrOOP at the Part D Plan
  - Services E1 eligibility queries from pharmacies for Part D enrollment and A/B entitlement information

TrOOP FACILITATION 6-STEP PROCESS

Step 1

Pharmacy lacks plan information to fill prescription. Pharmacy executes E1 request transaction. E1 response transaction returns enrollment information including OHI (if any).

Step 2

Pharmacy submits claim to Part D plan.

Step 3

Part D plan/processor adjudicates and returns response to pharmacy with payment information.

TrOOP FACILITATION 6-STEP PROCESS (CONTINUED)

Step 4

If OHI is returned on response from 1st claim or is known from the E1 response, pharmacy generates secondary claim to OHI payers. Pharmacy switches identify claims as secondary to Part D and route claims to TrOOP Facilitator.

Step 5

OHI payer sends responses back to pharmacy routed through the TrOOP Facilitator.

Step 6

TrOOP Facilitator builds NCPDP N1 reporting transaction from the response and sends to the appropriate Part D plan.

TrOOP FACILITATOR AND TrOOP BALANCES

	Responsibilities of TrOOP Facilitator	Responsibilities of Part D Plans
Maintaining TrOOP Balances		X
Storing/Accessing TrOOP Balances		X
Deliver Prescription Drug Claim Information	X	X
Calculate TrOOP		X
Transfer TrOOP Balances to Another Insurer if Necessary		X

TRANSFERRING TrOOP BALANCES

- Necessary when beneficiaries change plans at the contract level mid-year
- Part D plans must:
  - Follow the CMS process for transferring TrOOP balance information to other plans
  - Follow-up with transferring balances for adjustments to claims after the initial transfer of information

SUMMARY

- Defined TrOOP costs.
- Identified why TrOOP accounting is important.
- Classified payments.
- Described how to populate a PDE with TrOOP.
- Learned two methods for reporting retroactive TrOOP changes in PDEs
- Reviewed COB and the TrOOP Facilitation Process

EVALUATION

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

THANK YOU!

Calculating and Reporting Low Income Cost-Sharing Subsidy

PURPOSE

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

OBJECTIVES

- Define LICS
- Determine how to administer the Part D benefit by determining whether or not any LICS applies to a given prescription event and the appropriate amount of cost-sharing due from a low income beneficiary
- Calculate LICS amount using the rules that apply to all plan types
- Identify the PDE data fields required to report LICS payments
- Explain how LICS affects TrOOP

LICS DEFINED

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

LICS RULES

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

LOW INCOME COST-SHARING SUBSIDY

2009 LICS Categories Maximum LI Beneficiary Cost-Sharing				
Copay Category	**Deductible**	**Initial Coverage**	**Coverage Gap**	**Catastrophic**
2	$ 0	$1.10 generic $3.20 brand	$1.10 generic $3.20 brand	$0
1	$ 0	$2.40 generic $6.00 brand	$2.40 generic $6.00 brand	$0
4	$60	15%	15%	$2.40 generic $6.00 brand
3	$ 0	$0	$0	$0

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

LOW INCOME COST-SHARING SUBSIDY (CONTINUED)

2006 LICS Categories Maximum LI Beneficiary Cost-Sharing				
Copay Category	**Deductible**	**Initial Coverage**	**Coverage Gap**	**Catastrophic**
2	$ 0	$1 generic $3 brand	$1 generic $3 brand	$0
1	$ 0	$2 generic $5 brand	$2 generic $5 brand	$0
4	$50	15%	15%	$2 generic $5 brand
3	$ 0	$0	$0	$0

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

LICS AMOUNT FORMULA

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

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

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

LICS CALCULATION STEPS

Scenario

In 2006, NCE Health Plan offers a Defined Standard benefit package to beneficiaries.

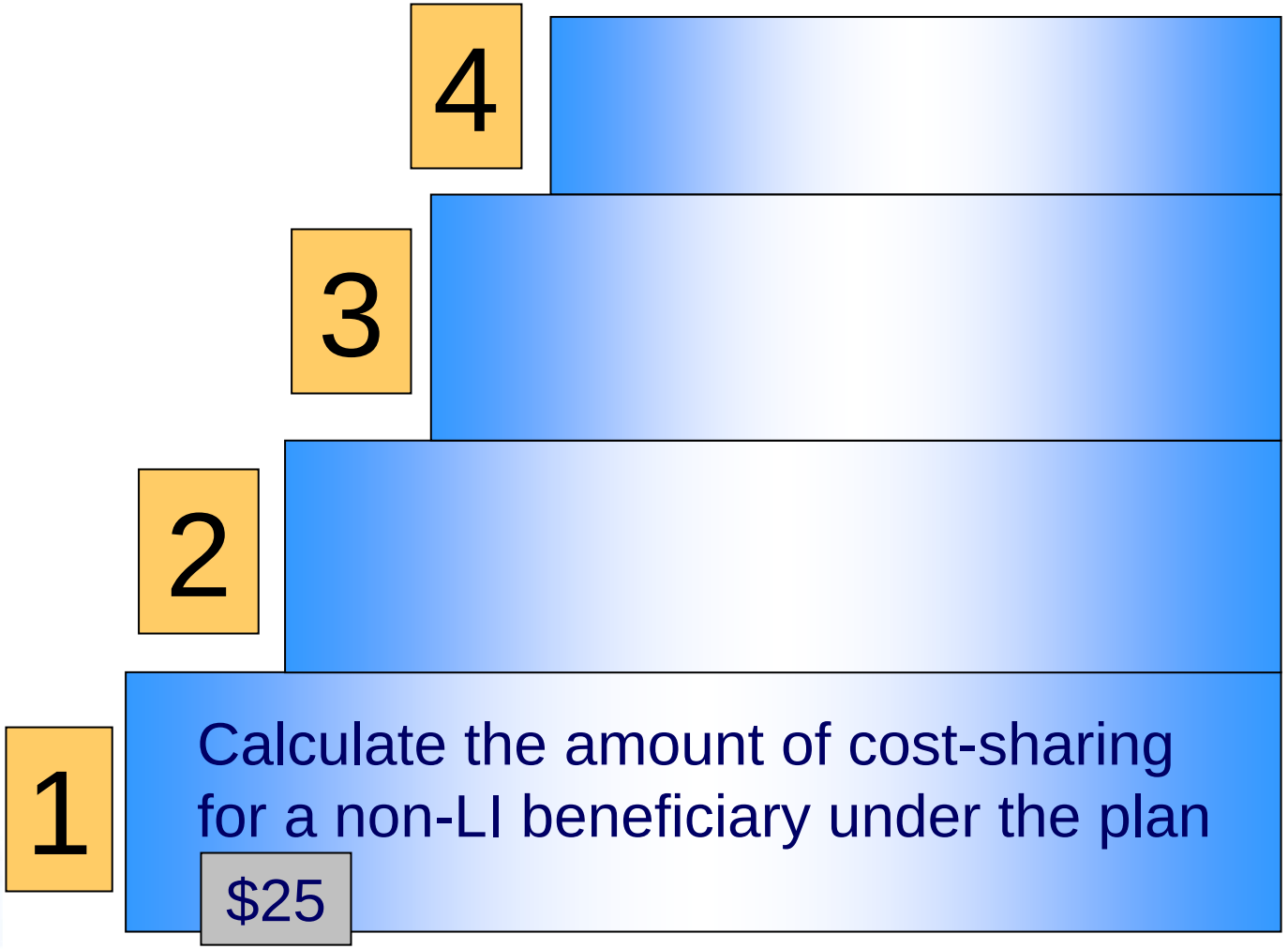
A LI-Category 1 beneficiary enrolled in the plan has YTD gross covered drug costs of $1,500.

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

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

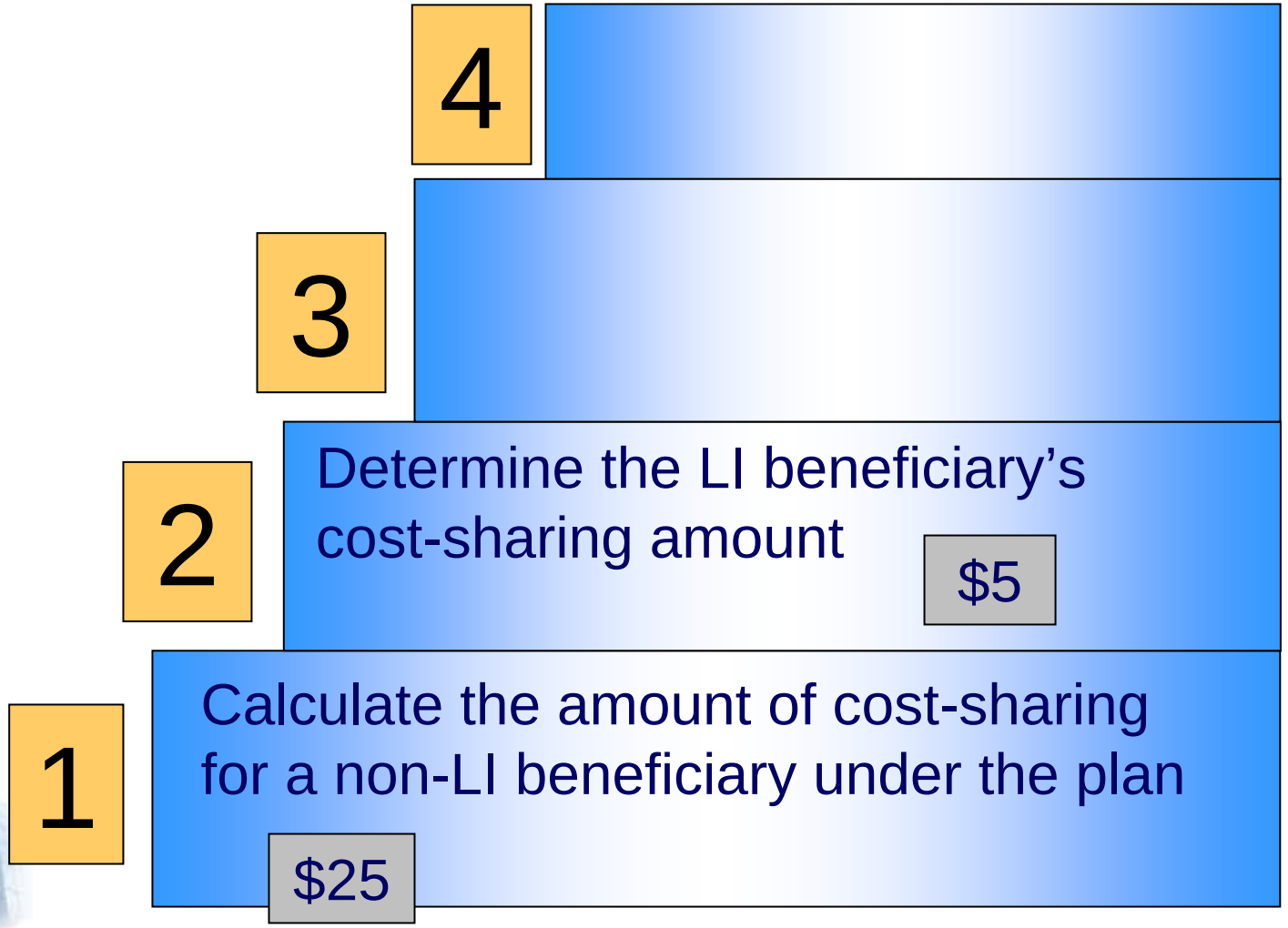
LICS CALCULATION STEPS

(CONTINUED)



LICS CALCULATION STEPS

(CONTINUED)



LICS CALCULATION STEPS

(CONTINUED)

4

3

Compare non-LI and LI cost-sharing and apply "lesser of" test

$25 > $5

2

Determine the LI beneficiary's cost-sharing amount

$5

1

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

$25

LICS CALCULATION STEPS

(CONTINUED)

4 Use the LICS Amount formula

$25- $5= $20

3 Compare non-LI and LI cost-sharing and apply "lesser of" test

$25 > $5

2 Determine the LI beneficiary's cost-sharing amount

$5

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

$25

POPULATING THE PDE RECORD

Drug Coverage Status Code
Catastrophic Coverage Code
GDCA/GDCB
Patient Pay Amount
LICS Amount
CPP
NPP
Other TrOOP Amount
Adjustment/Deletion

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD

Scenario

In 2006, 3J Prescription Benefit offers an actuarially equivalent benefit with 5% tiered cost-sharing for generic drugs.

A LI-Category 1 beneficiary with YTD gross covered drug costs of $500 purchases a generic drug for $5.

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:
$5 x .05 = $0.25

Step 2: Determine the LI cost share:
$2

Step 3: Apply the "Lesser of" Test:
$0.25 < $2

Step 4: Use the LICS Amount formula:
$0.25 – $0.25 = $0.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$ 0.25
CPP	
LICS Amount	$ 0.00

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$5.00
GDCA	$0.00
Patient Pay Amount	$0.25
CPP	$4.75
LICS Amount	$0.00

TrOOP Accumulator	+ $0.25

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER

Scenario

In 2006, Sunny Valley Health Plan offers a Defined Standard benefit.

A LI-Category 4 eligible beneficiary with YTD gross covered drug costs=$2,800 purchases a covered brand drug for $300.

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

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

Result

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

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

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

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

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

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

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

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

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$300.00
GDCA	$ 0.00
Patient Pay Amount	$ 0.00
CPP	$ 0.00
LICS Amount	$255.00
Other TrOOP Amount	$ 45.00

TrOOP Accumulator	+$300.00

LICS AND STRADDLE CLAIMS

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

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

Scenario

A Category 4 beneficiary joined a Defined Standard plan ($250 deductible in 2006). The beneficiary's first two claims of the year have a negotiated price (gross drug cost) of $100 each and both are for covered drugs. In the "lesser of" test, a $50 deductible for the first claim is included in the calculation on the Category 4 side. After the $50 deductible is met, a 15 percent coinsurance provision is applied to the remaining drug cost in Claim 1 and to the gross drug cost in Claim 2.

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

Result – Claim 1

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

Step 2: Determine the LI cost share:
$50.00 + ($50.00 x 0.15) = $57.50

Step 3: Apply the "Lesser of" Test:
$57.50 < $100.00

Step 4: Use the LICS Amount formula:
$100.00 – $57.50 = $42.50

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$57.50
CPP	
LICS Amount	$42.50

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

Result – Claim 2

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

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

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

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

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

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

Populating the PDE Record

	Claim 1	Claim 2
Drug Coverage Status Code	C	C
Catastrophic Coverage Code	<blank>	<blank>
GDCB	$100.00	$100.00
GDCA	$ 0.00	$ 0.00
Patient Pay Amount	$ 57.50	$ 15.00
CPP	$ 0.00	$ 0.00
LICS Amount	$ 42.50	$ 85.00

TrOOP Accumulator

Claim 1	Claim 2
+ $100.00	+ $100.00

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

- When the plan deductible < Statutory Category 4 Amount and > Zero:
  - Cost-sharing is 15% coinsurance “after the annual deductible under the plan”
  - Cost-sharing is whichever is less:
    - Statutory Category 4 deductible ($50 in 2006)
    - Lower deductible amount under the PBP

MODIFYING THE PDE

When modifying a PDE for an LI beneficiary, a plan:

- Must adjust each PDE record for retroactive LI determinations.
- Must refund the beneficiary directly unless it is a “minimal amount.”
- May not establish beneficiary receivable accounts unless the amount is “minimal.”

SUMMARY

- Defined LICS
- Calculated LICS amount using the rules that apply to all plan types
- Determined how to administer the Part D benefit by determining whether or not any LICS applies to a given prescription event and the appropriate amount of cost-sharing due from a low income beneficiary
- Identified the PDE data fields required to report LICS payments
- Explained how LICS affects TrOOP

EVALUATION

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

THANK YOU!

Calculating and Reporting Enhanced Alternative & Payment Demonstration Options

2008 PRESCRIPTION DRUG EVENT DATA

PURPOSE

- To provide a description of the Enhanced Alternative (EA) and Payment Demonstration benefit options and essential calculating and reporting rules related to submitting data for each

OBJECTIVES

- Define the two EA and two Payment Demonstration benefit options
- Administer the EA and Payment Demonstration benefit options
- Apply the principles and business rules in calculating and reporting plan-paid amounts for the EA and Payment Demonstration benefit options

EA BENEFITS

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

DATA FIELDS IN THE PDE RELATED TO EA BENEFITS

Three PDE fields identify EA benefits:

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

DRUG COVERAGE STATUS CODE AND EA

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

PDE Record
Drug Coverage Status Code
E

CPP AND EA

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

PDE Record
CPP
$

NPP AND EA

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

PDE Record
NPP
$

PRINCIPLES FOR EA DRUGS

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

EA DRUG

Scenario

In 2006, Sunhealth PBP1 provides cost-sharing in the Initial Coverage period using tiered flat co-pays of $10/$20/$40. The beneficiary purchased a $65.00 EA drug in Tier 1. The beneficiary is in the Initial Coverage period of the benefit.

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

EA DRUG (CONTINUED)

Results - Calculation

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

EA DRUG (CONTINUED)

Result - PDE Related Fields

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

BUSINESS RULES FOR CALCULATING AND REPORTING EACS

Reporting EACS involves three steps.

Step 1 Report beneficiary cost-sharing in **Patient Pay Amount** field

Step 2 Calculate and report **CPP**

Step 3 Calculate and report **NPP**

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2006

EACS Rule #	YTD Gross 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 (gross covered drug cost - $2/$5)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

Calculating and reporting NPP—Method 1

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

Calculating and reporting NPP—Method 2

EACS = Plan-paid at POS − CPP

EACS – RULE #2

Scenario

In 2006, Sunhealth PBP3 employs a $5/$15/$30 tiered cost-sharing in the Initial Coverage period. The beneficiary has met the deductible and has YTD gross covered drug costs of $400. The beneficiary is now purchasing a Tier 3 brand name covered drug for $200.

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

EACS – RULE #2 (CONTINUED)

Results - Calculation

Drug Coverage Status Code	C
Gross Covered Drug Cost	$200.00
Patient Pay Amount	$ 30.00
Plan POS	$170.00
CPP	$150.00
NPP	$ 20.00

EACS – RULE #2 (CONTINUED)

Result - PDE Related Fields

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

EACS – RULE #4

Scenario

In 2006, Sunhealth PBP5 extends the initial coverage limit to $4,000. The beneficiary pays 100 percent cost-sharing in the EA Coverage Gap. YTD gross covered drug cost = $6,000 and the beneficiary is still in the EA Coverage Gap. The beneficiary purchases a covered drug for $100.

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

EACS – RULE #4 (CONTINUED)

Results - Calculation

Drug Coverage Status Code	C
Gross Covered Drug Cost	$100.00
Patient Pay Amount	$100.00
Plan POS	$ 0.00
CPP	$ 15.00
NPP	- $ 15.00

EACS – RULE #4 (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$100.00
CPP	$ 15.00
NPP	-$ 15.00

EACS – STRADDLE CLAIM

Scenario

In 2006, Sunhealth PBP7 offers tiered cost-sharing in the Initial Coverage period ($10/$15/$20), and extends the initial coverage limit to $4,000. The beneficiary has total YTD gross covered drug costs of $2,240. The beneficiary purchases a covered brand **name** drug in Tier 3 for $125. This event straddles two phases of the Defined Standard benefit, the Initial Coverage Period and the Coverage Gap.

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

EACS – STRADDLE CLAIM

(CONTINUED)

Results - Calculation

	Initial Coverage Period	Coverage Gap	PDE
Drug Coverage Status Code			C
Gross Covered Drug Cost	$10.00	$115.00	
Patient Pay Amount	$10.00	$ 10.00	$ 20.00
Plan POS	$ 0.00	$105.00	
CPP	$ 7.50	$ 0.00	$ 7.50
NPP	-$ 7.50	$105.00	$ 97.50

EACS – STRADDLE CLAIM

(CONTINUED)

Result - PDE Related Fields

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

PLAN PAID AMOUNTS

ALTERNATIVE APPROACH

CPP (per Defined Standard Benefit)	Report in CPP
Plan Paid Amount at POS (per EA Benefit design) minus CPP (per Defined Standard Benefit)	Report in NPP

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES

Scenario

In 2006, Sienna's Enhanced Alternative Plan has a $200 deductible, offers tiered cost-sharing in the Initial Coverage Period ($10/$20/$30) and extends the Initial Coverage Limit to $4,000. The beneficiary has YTD Gross Covered Drug Costs of $190 and purchases a covered brand **name** drug in Tier 2 that costs $100. This event straddles Sienna's deductible and Initial Coverage Period. For mapping purposes, the claim also straddles the Defined Standard benefit.

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

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES (CONTINUED)

Results – Calculation Under EACS

	Deductible Phase	Initial Coverage Period
Drug Coverage Status Code	C	C
Gross Covered Drug Cost	$10.00	$90.00
Patient Pay Amount	$10.00	$20.00
Plan Paid Amount	$ 0.00	$70.00

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES (CONTINUED)

Results – Calculation Under Defined Standard

	Deductible Phase	Initial Coverage Period
Drug Coverage Status Code	C	C
Gross Covered Drug Cost	$60.00	$40.00
Patient Pay Amount	$60.00	$10.00
CPP	$ 0.00	$30.00

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$30.00
CPP	$30.00
NPP	$40.00

RULES FOR EACS AND LICS

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

EACS - LICS

In 2006, a Category 1 LICS beneficiary paid a supplemental premium to enroll in Sunhealth's PBP8. Instead of cost-sharing at 25 percent, the plan has tiered cost-sharing to $10/$15/$30 in the Initial Coverage period. Initial coverage limit is shifted up to $4,500. The beneficiary with YTD gross covered drug costs of $1,500 purchases a generic Tier 1 covered drug for $75.

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

EACS - LICS (CONTINUED)

Results - Calculation

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

Beneficiary Liability	$10.00

EACS - LICS (CONTINUED)

Result

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

Step 2: Identify the LI cost share:
$2

Step 3: Apply the "Lesser of" test:
$2 < $10

Step 4: Utilize the LICS formula:
$10 – $2 = $8

Drug Coverage Status Code	C
Gross Covered Drug Cost	$75.00
Patient Pay Amount	$ 2.00
LICS	$ 8.00
Plan POS	$65.00
CPP	$56.25
NPP	$ 8.75

EACS - LICS (CONTINUED)

Result - PDE Related Fields

Drug Coverage Status Code	C
Patient Pay Amount	$ 2.00
LICS	$ 8.00
CPP	$ 56.25
NPP	$ 8.75

PAYMENT DEMONSTRATIONS

Increased flexibility in designing alternative prescription drug coverage

- Enhanced Alternative benefits funded by supplemental premiums or A/B rebates
- Capitated reinsurance payments
- Special rules for OOP threshold

THE TWO OPTIONS

Flexible Capitated

- Reduces/eliminates cost-sharing (any phase)
- Risk sharing in Catastrophic Coverage phase based on the Defined Standard
- Catastrophic Coverage begins when the OOP threshold is met

Fixed Capitated

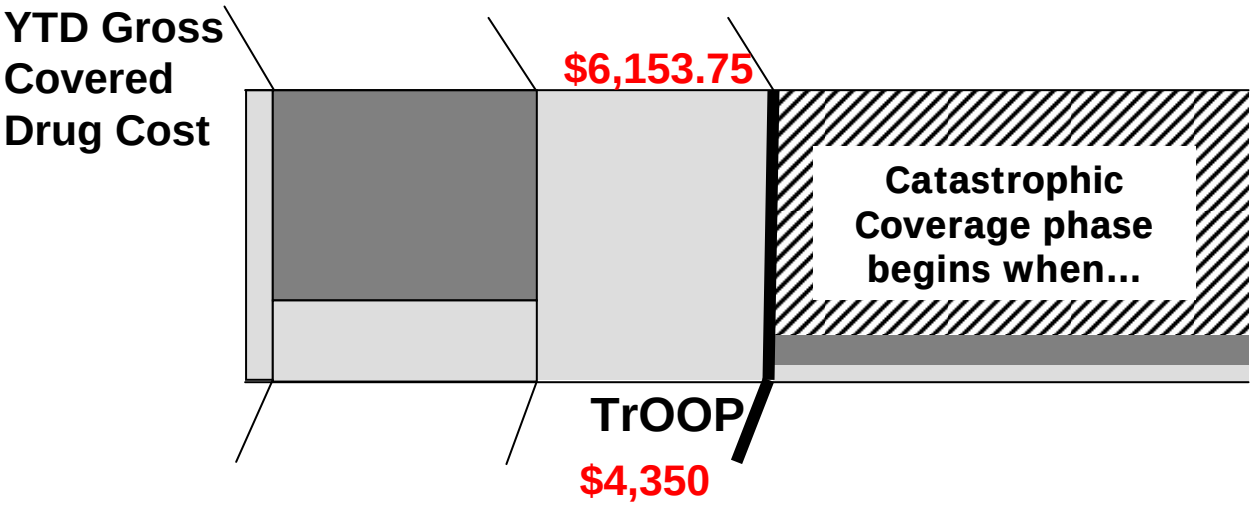
- Reduces/eliminates cost-sharing (any phase)
- Risk sharing in Catastrophic Coverage phase is based on the Defined Standard
- Catastrophic Coverage is fixed at $5,100 (in 2006) in YTD gross **covered** drug cost

FLEXIBLE & FIXED CAPITATED OPTIONS

- Share risk based on amounts plans would have paid under the Defined Standard
- Similar to EA plans except in the amount of risk sharing above $5,100 in gross covered drug costs
- Reinsurance is subject to risk sharing rather than being subsidized at 80% of GDCA

2009 FLEXIBLE & FIXED CAPITATED OPTIONS (CONTINUED)

Fixed Capitated Option



Flexible Capitated Option

PDE FIELDS RELATED TO FLEXIBLE AND FIXED CAPITATED OPTIONS

Catastrophic Coverage Code
GDCB
GDCA
Patient Pay Amount
CPP
NPP

CALCULATING CPP (2006)

Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined 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 ≤ OOP threshold	Lesser of 95% or (Gross covered drug cost - $2/$5)	N/A
5	> OOP threshold	Lesser of 95% or (Gross covered drug cost - $2/$5)	

FLEXIBLE CAPITATED OPTION

Scenario

Plan A offers a $250 deductible then 25% cost-sharing throughout the benefit until the beneficiary reaches the Catastrophic Coverage phase. In this example, the OOP threshold is reached when YTD gross covered drug costs = $13,650. The beneficiary's 2006 YTD gross covered drug cost = $6,000. The beneficiary purchases a covered Part D drug for $100.

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	$
CPP	$
NPP	$

FLEXIBLE CAPITATED OPTION

(CONTINUED)

Results

Calculation

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$ 100.00
GDCA	$ 0.00
Patient Pay Amount	$ 25.00
Plan POS	$ 75.00
CPP	$ 95.00
NPP	$ - 20.00

FIXED CAPITATED OPTION

Scenario

Plan B eliminates both the $250 Deductible and cost-sharing in the Coverage Gap by offering a tiered cost-sharing structure: $5/$20/$40. The plan offers Defined Standard cost-sharing once the beneficiary crosses the OOP threshold. The beneficiary's 2006 YTD gross covered drug cost = $6,000. The beneficiary purchases a covered Part D drug for $100 in Tier 2.

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	$
GDCA	$
Patient Pay Amount	$
Plan POS	
CPP	$
NPP	$

FIXED CAPITATED OPTION

(CONTINUED)

Results

Calculation

Drug Coverage Status Code	C
Catastrophic Coverage Code	C
GDCB	$ 0.00
GDCA	$ 100.00
Patient Pay Amount	$ 5.00
Plan POS	$ 95.00
CPP	$ 95.00
NPP	$ 0.00

SUMMARY

- Defined the two EA and two Payment Demonstration benefit options
- Administered the EA and Payment Demonstration benefit options
- Applied the principles and business rules in calculating and reporting plan-paid amounts for the EA and Payment Demonstration benefit options

EVALUATION

Please take a moment to complete the evaluation form for the Enhanced Alternative and Payment Demonstration Benefit Options Module.

THANK YOU!

Edits

PURPOSE

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

OBJECTIVES

- Describe the edit logic for the PDFS and DDPS
- Identify the nine edit categories in DDPS
- Recognize and apply the resolution process to resolve errors received from PDFS and DDPS
- Review the P2P process and update codes
- Discuss IAPs and contract reports

EDIT PROCESS

Prescription Drug Front-End System (PDFS) → **Drug Data Processing System (DDPS)**

Format **Integrity** **Validity**

PDFS EDITS

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

PDFS EDIT LOGIC AND RANGES

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

PDFS EDIT CODES

Scenario

Blue Sky Health changes to a new PBM in January 2007 and tells the new PBM to begin submitting data immediately; however, the plan did not provide an authorization letter to CMS.

PDFS EDIT CODES (CONTINUED)

Result

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

DDPS EDITING RULES

Stage 1	Individual Field Edits
Stage 2	Enrollment/Eligibility Edits
Stage 3	Duplicate Check Edits
Stage 4	Field-to-Field Edits

DDPS EDITING RULES (CONTINUED)

Adjustments/Deletions

EDIT RANGES AND CATEGORIES

Series	Edit Category
603-659	Missing/Invalid
660-669	Adjustment or Deletion
670-689	Catastrophic Coverage Code
690-699	Cost
700-714	Eligibility
715-734	LICS
735-754	NDC
755-774	Drug Coverage Status Code
775-799 900-999	Miscellaneous

DRUG COVERAGE STATUS CODE EDITS

Scenario

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

DRUG COVERAGE STATUS CODE EDITS (CONTINUED)

Result

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

COMMON EDITS

Edit Code	Description
132	Duplicate file ID
234	PBP does not match Contract ID
716	Patient Liability exceeds the statutorily defined maximum for institutionalized Low income beneficiary
700	The HICN does not match an existing beneficiary
779	Submitter cannot report NPP for covered Part D drug

RESOLUTION PROCESS

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

RESOLUTION PROCESS
(CONTINUED)

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

RESOLUTION PROCESS (CONTINUED)

- Edits requiring specific problem-solving steps:
  - Eligibility (Edits 700-714)
  - LICS

    715-Use best available data policy

    716-722-CMS data is accurate

RESOLUTION PROCESS (CONTINUED)

Plans can ask the following questions:

- Are plan system's field definitions and values consistent with PDE definitions and values?
- Are plan system's edits compatible with DDPS edits?
- Did system deficiencies contribute to the error?
- Could system enhancements, such as better user prompts, minimize high volume recurring errors?

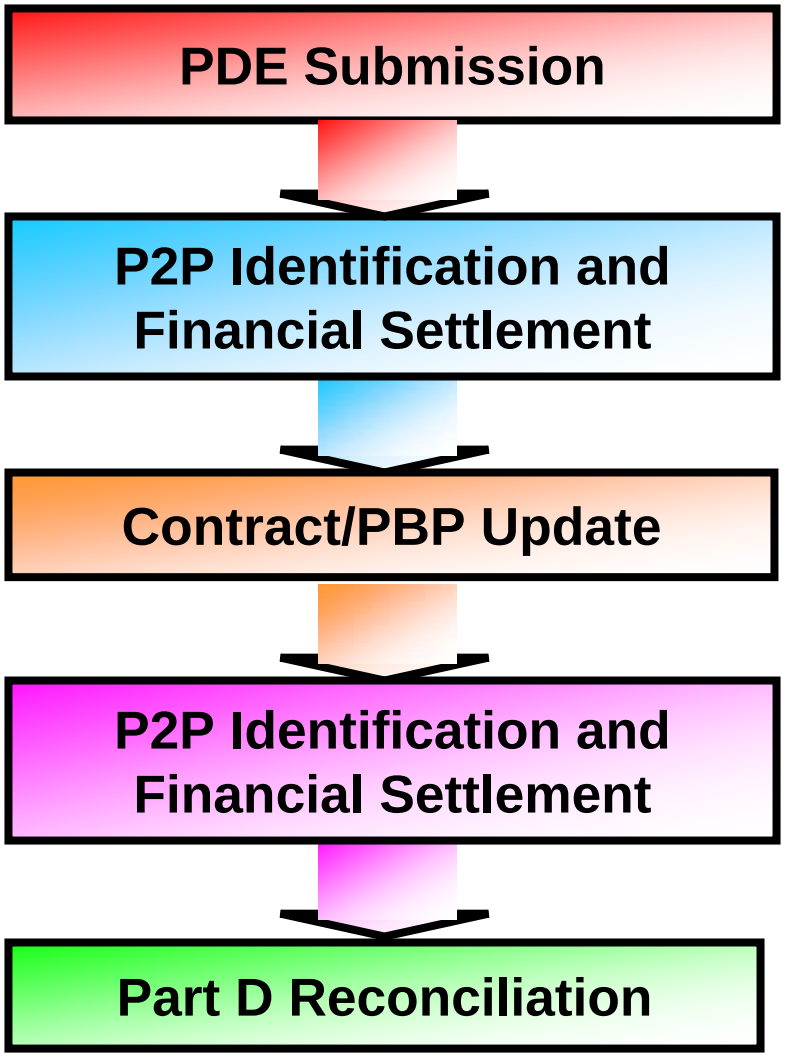
NEW EDITS

Edit	Descriptions
646	Estimated Rebate at Point of Sale is missing or invalid. For service dates effective January 1, 2008 forward, must be ≥ zero. For service dates prior to 2008, must be zero or spaces.
647	Vaccine Administration Fee amount is missing or invalid. For service dates effective January 1, 2008 forward, must be ≥ zero. For service dates prior to 2008, must be zero or spaces.
648	Prescription Origin Code is invalid. Valid values are 'blank', '0', '1', '2', '3', and '4'.
694	Sum of Ingredient Cost, Dispensing Fee, and Vaccine Administration Fee must be > zero.

NEW EDITS (CONTINUED)

Edit	Descriptions
742	If the amount of the vaccine administration fee field is > zero, then the NDC code must qualify as a valid part d vaccine drug.
763	If drug coverage status code is ‘E’ or ‘O’ then the vaccine administration fee must be zero.
785	Duplicate PDE record exists on this file. This PDE is not saved.

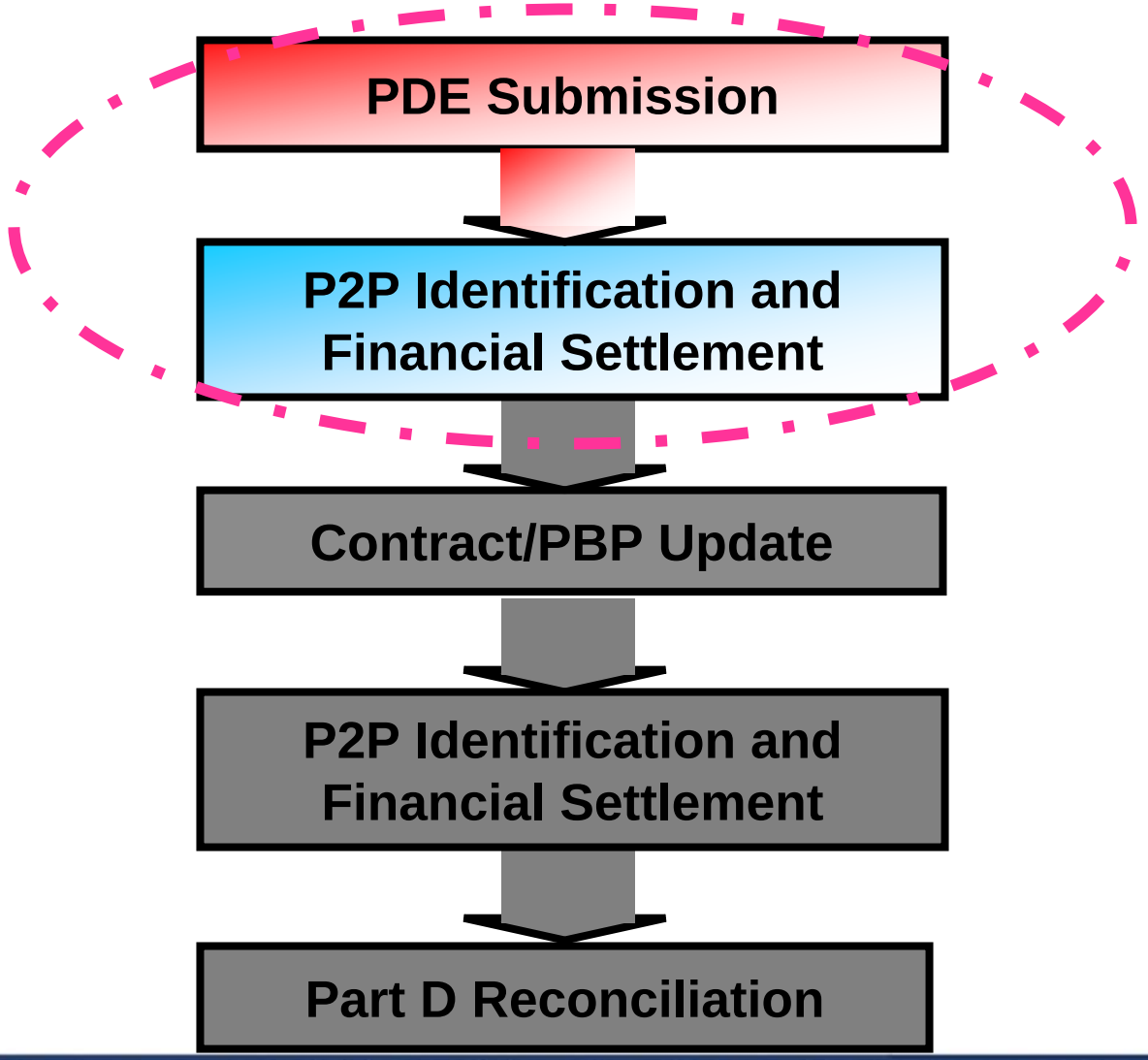
P2P PROCESS OVERVIEW



COMMON TERMS

Term	Definition
Submitting Contract	Contract submitting PDE data.
Submitting PBP	Plan Benefit Package submitting PDE data under the submitting contract.
Original Contract of Record	Beneficiary enrollment as documented in CMS databases when PDE is saved and accepted by CMS.
Original PBP of Record	Plan Benefit Package under the Original Contract of Record as documented in CMS databases.

P2P PROCESS


PDE Submission
P2P Identification and Financial Settlement
Contract/PBP Update
P2P Identification and Financial Settlement
Part D Reconciliation

STATUTORY AUTHORITY

Under 42 CFR 423.464(a), Part D Sponsors have an obligation to coordinate benefits with entities providing other prescription drug coverage to Part D eligible individuals. This obligation includes other Part D Sponsors.

CMS TRANSITION PERIOD

Begins

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

Ends

- The later of…
  - 30-days after the effective date of coverage, or
  - 30-days after the date CMS processes the enrollment into the new contract of record

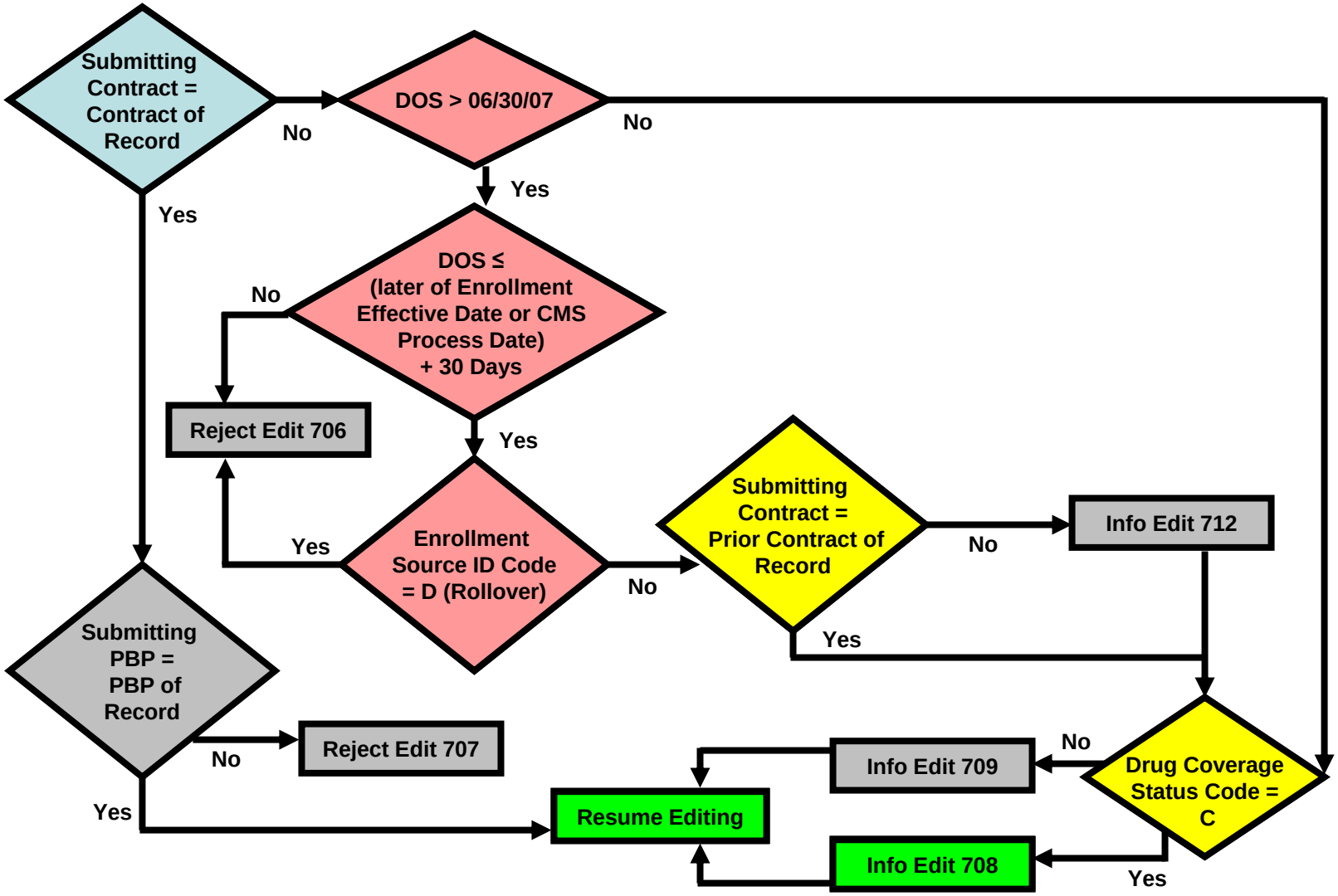
PART D SPONSOR ASSUMED RESPONSIBILITIES

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

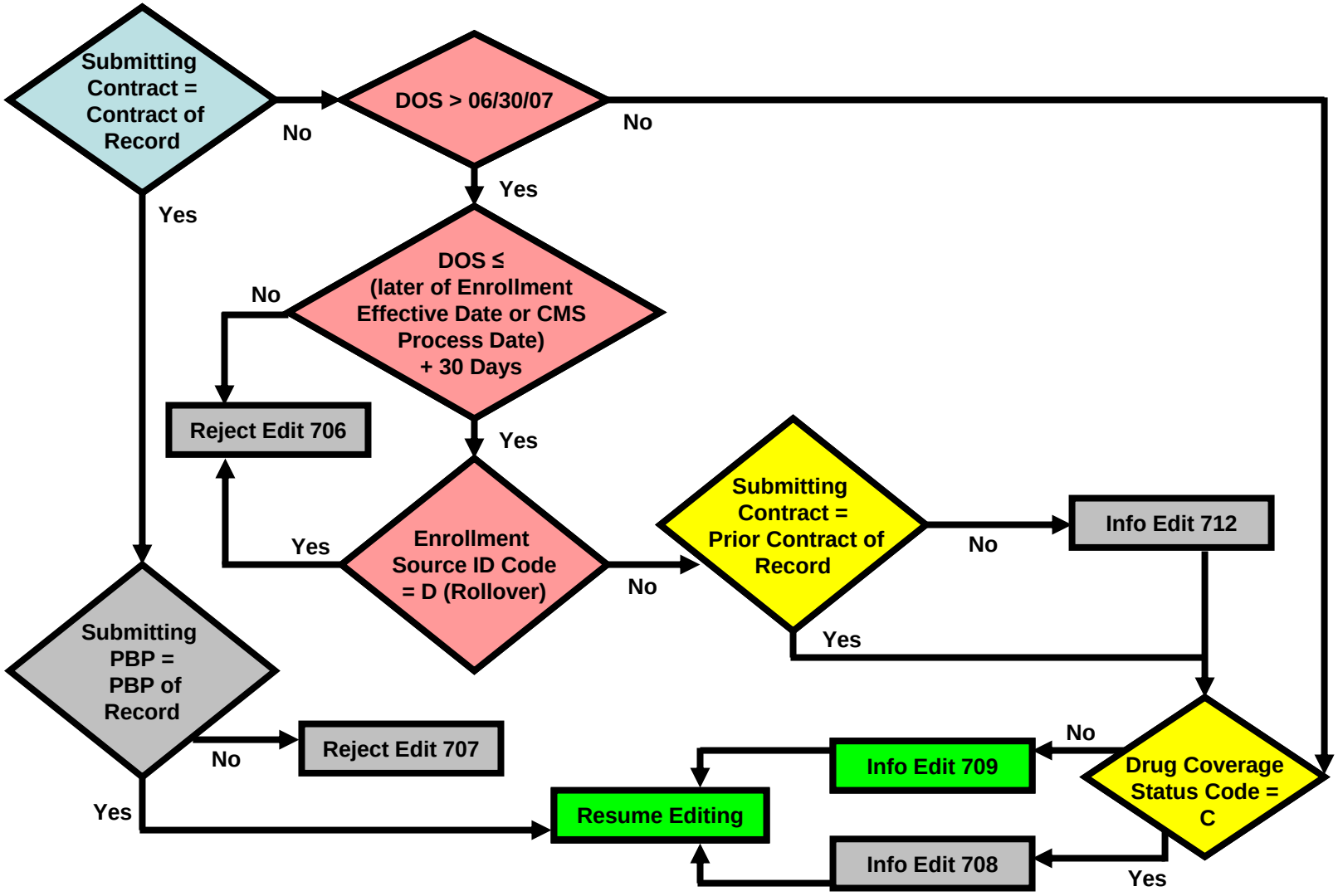
P2P ROLES AND RESPONSIBILITIES

Submitting Contract	• Submits PDEs • Attests to accuracy of submitted PDEs • Reports any DIR earned for P2P PDEs
Contract of Record	• Makes timely payments (LICS and CPP) to the submitting contract • Certifies payments
CMS	• Identifies Contract of Record • Provides CPP and LICS amounts

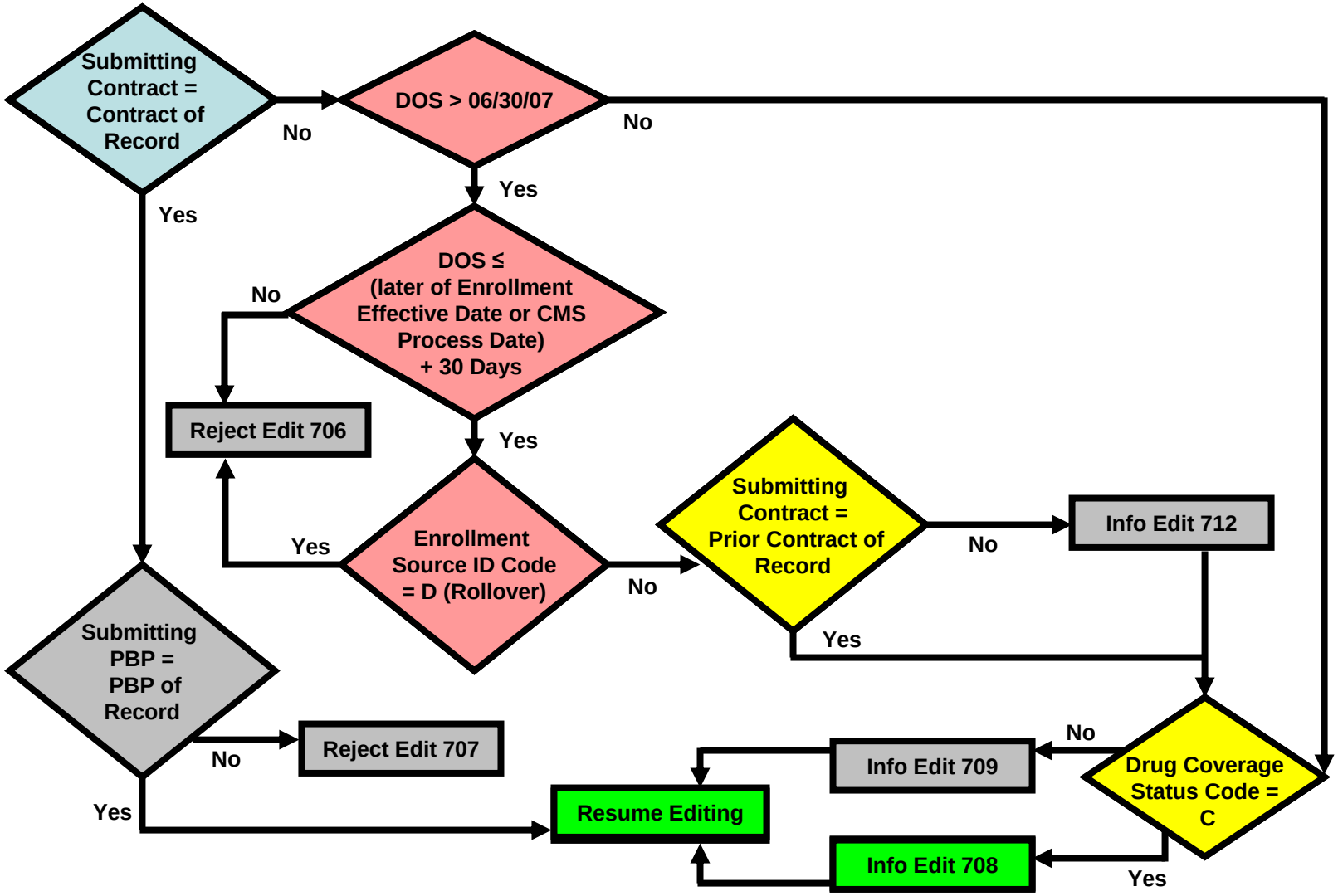
John's effective date is September 1. Winter Health Plan submitted a PDE on September 29 for the September 5 claim.



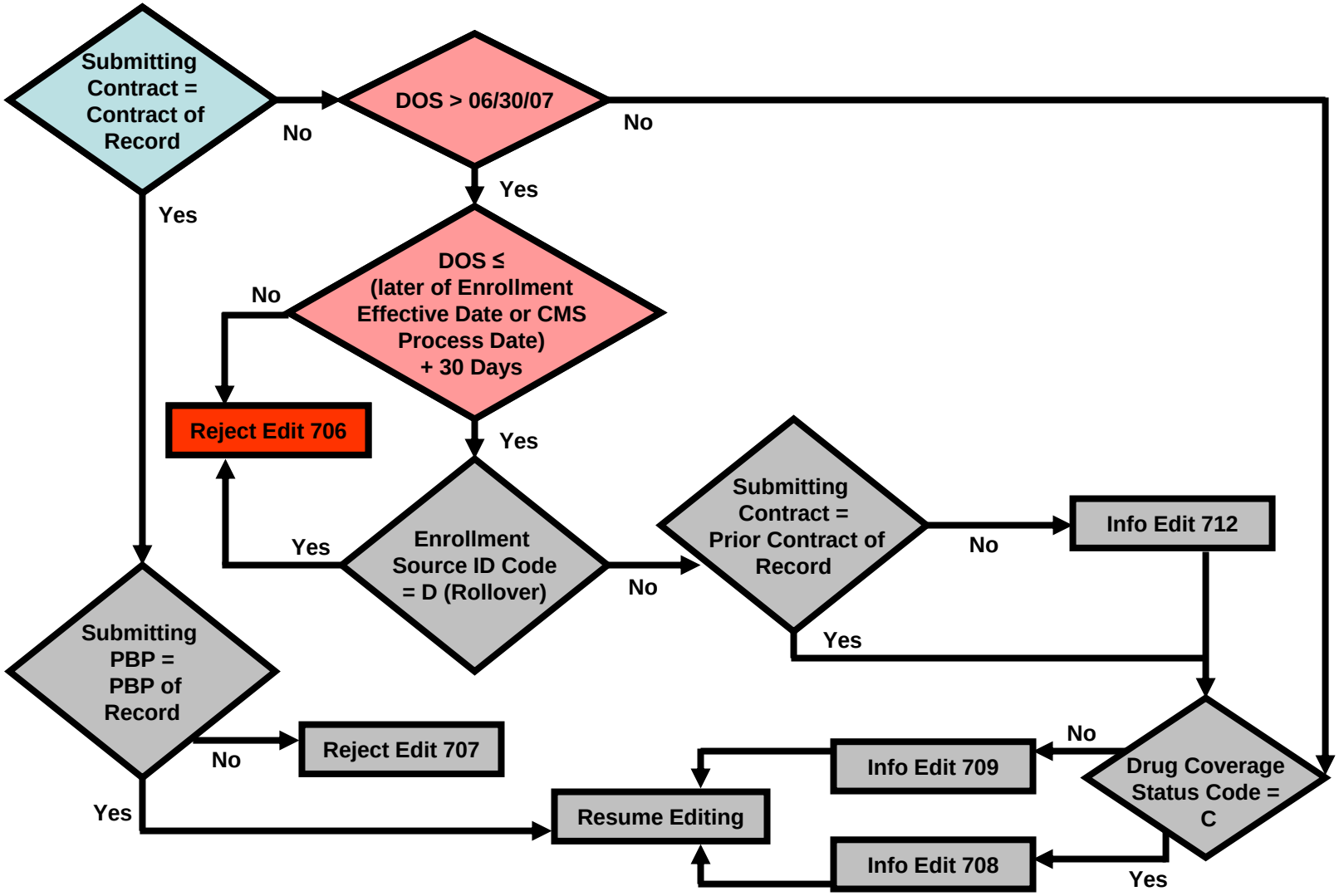
John's effective date is September 1. Winter Health Plan submitted a PDE on September 29 for the September 7 claim.



John's effective date is September 1. CMS processed the enrollment on September 3. Winter Health Plan submitted a PDE on October 20 for the October 2 claim.

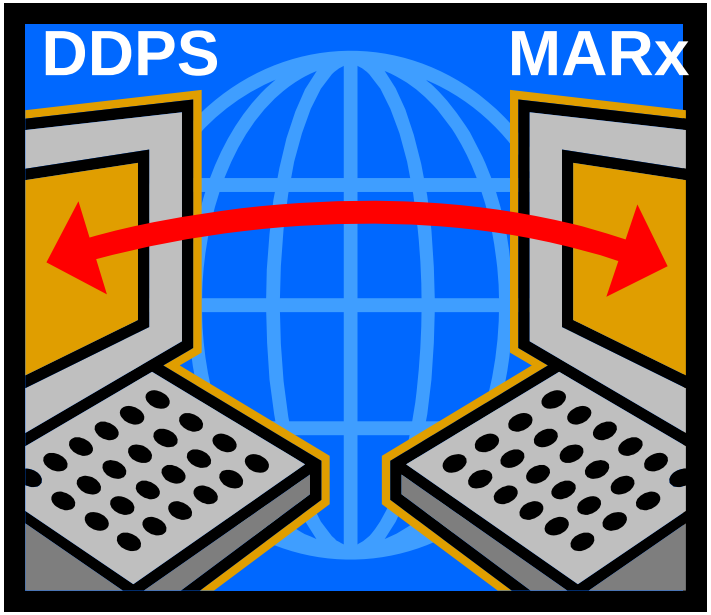


John's effective date is September 1. Winter Health Plan submitted a PDE on October 29 for the October 15 claim.



P2P CONTRACT/PBP UPDATE PROCESSING

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



P2P CONTRACT/PBP UPDATE PROCESSING (CONTINUED)

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

P2P CONTRACT/PBP UPDATE INFORMATIONAL EDIT CODES

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

Immediately Actionable PDE Errors (IAPs) Reports

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

IAP Contract Reports

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

SUMMARY

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

EVALUATION

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

THANK YOU!

Reports

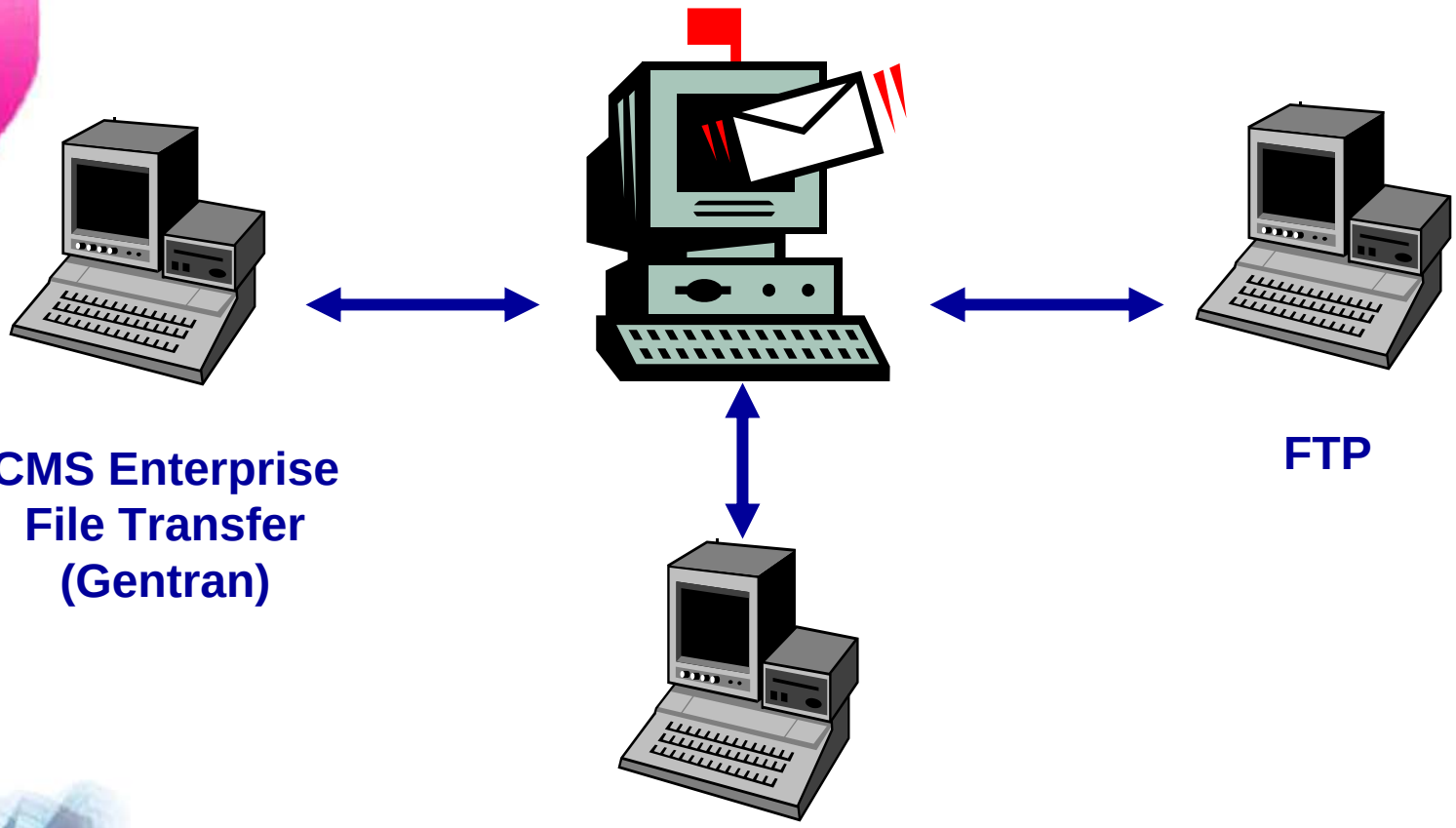
PURPOSE

- To provide insights on the appropriate use of reports to manage data collection, data submission, error resolution, and Plan-to-Plan (P2P) processes

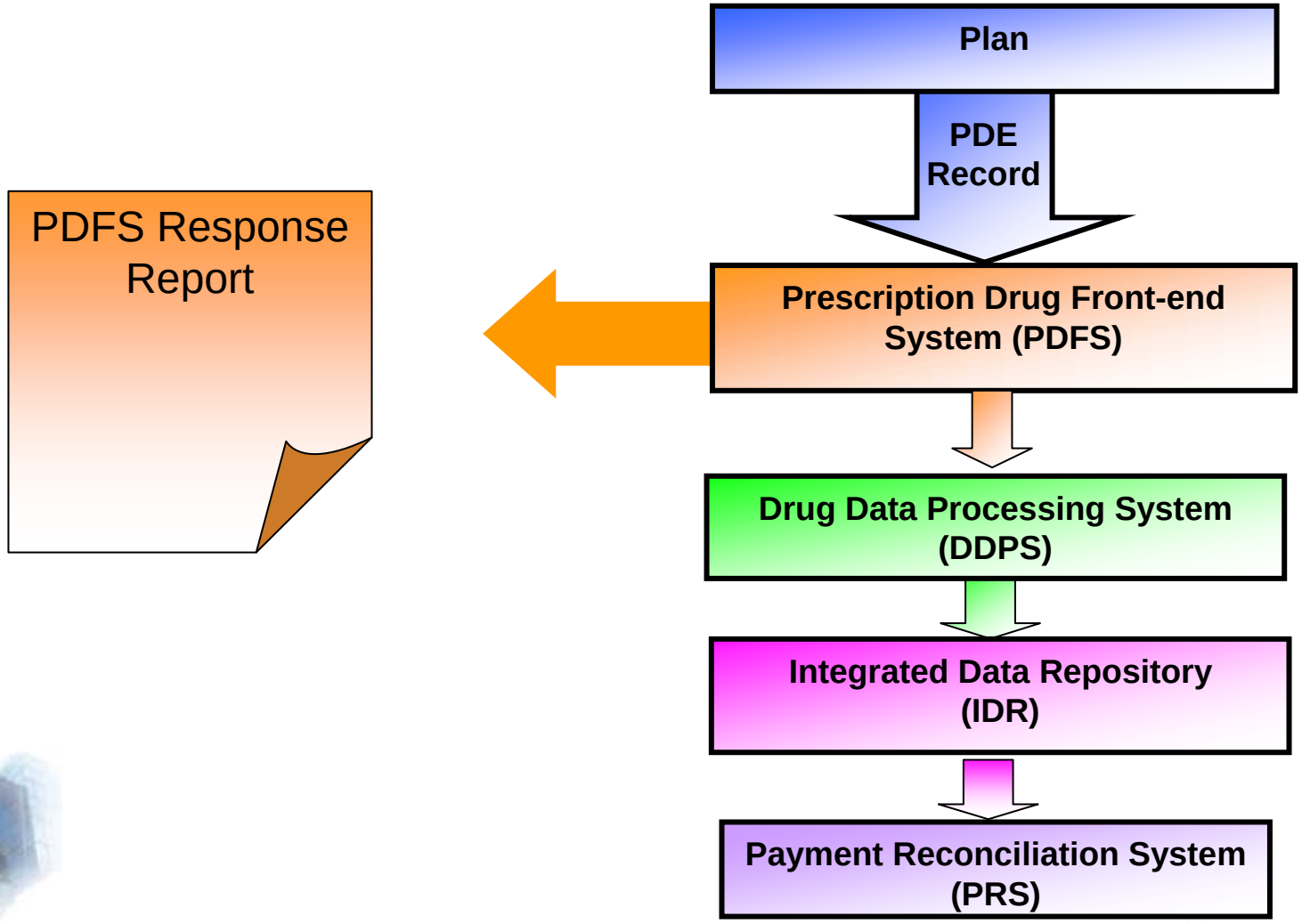
OBJECTIVES

- Identify the purpose of PDFS, DDPS, and IDR reports
- Determine the best use of the reports to monitor data processes and resolve errors
- Read the reports to identify and submit corrections
- Recognize the relationship between values in the management reports and reconciliation
- Determine existence of P2P conditions and associated financial settlements

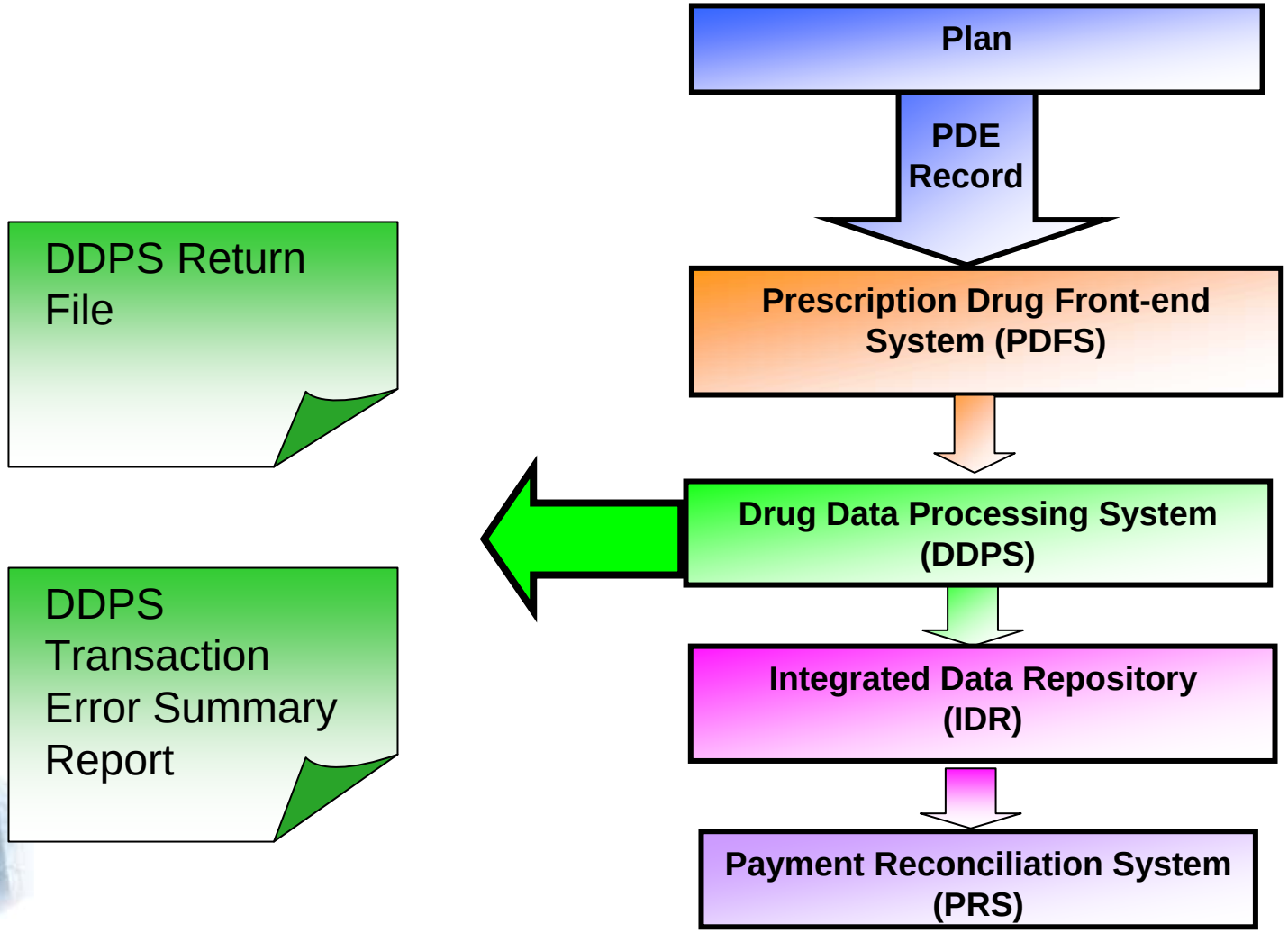
ACCESSING REPORTS



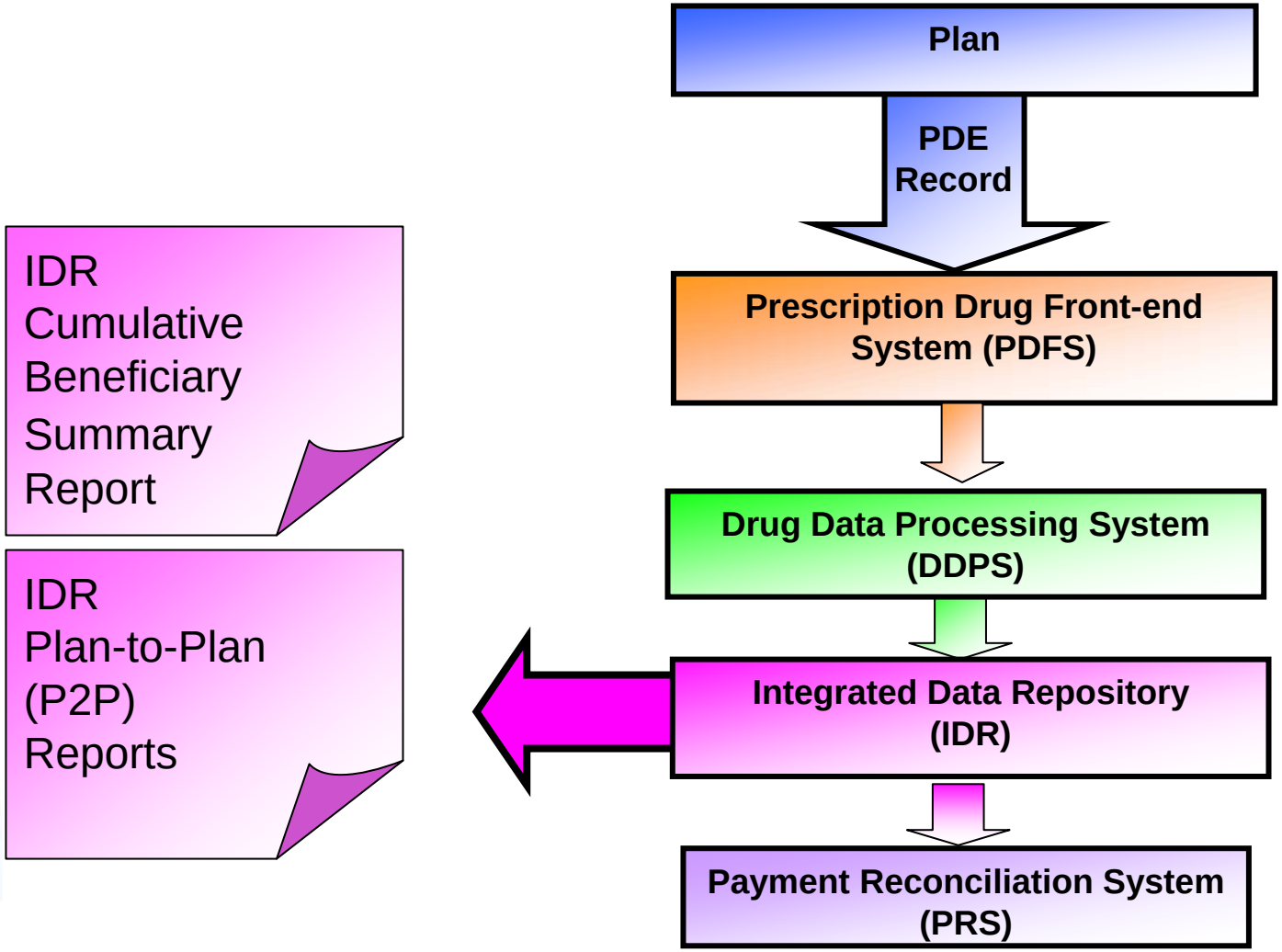
REPORTS OVERVIEW



REPORTS OVERVIEW (CONTINUED)



REPORTS OVERVIEW (CONTINUED)



NAMING CONVENTIONS

Report Name	Mailbox Identification
PDFS Response Report	RPT00000.RSP.PDFS_RESP
DDPS Return File	RPT00000.RPT.DDPS_TRANS_VALIDATION
DDPS Transaction Error Summary Report	RPT00000.RPT.DDPS_ERROR_SUMMARY
Cumulative Beneficiary Summary Report (04COV/ENH/ OTC)	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC

PDFS RESPONSE REPORT

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

TRANSACTION REPORTS

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

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

DDPS RETURN FILE

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

DDPS TRANSACTION ERROR SUMMARY REPORT

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

CUMULATIVE BENEFICIARY SUMMARY REPORTS

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

CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

- Totals apply to dates of service for one benefit year
- Each benefit year has separate cumulative reports
- Financial amounts are reported as “net”.
- Reports will break by submitter, contract, and PBP
- Available in flat file layout early in the month for data submitted the previous month

CMS COMMUNICATION TO PLANS

Report	Information Communicated
DDPS Return File	Provides the disposition of all DET records and where errors occurred. Distributed following processing of PDEs.
Special Return File	Provides Contract/PBP update impact on P2P conditions for PDEs. Will provide 800-level Update Codes. Distributed after contract/PBP update.
Cumulative Beneficiary Summary Report 04COV	Serves as a YTD cumulative report for the Submitting Contract that provides beneficiary-level PDE financial information necessary to perform the YTD Part D Payment reconciliation. Distributed monthly. Displays non-P2P amounts.
P2P Accounting Report 40COV/ENH/OTC	Provides the Submitting Contract with a YTD cumulative report of financial amounts reported by the Submitting Contract for P2P PDEs. This report can be used for accounting purposes but is not used for Part D Payment Reconciliation. Distributed monthly.
P2P Receivable Report 41COV	Provides Submitting Contracts with the net change in P2P reconciliation receivable amounts. Distributed monthly.
P2P Part D Payment Reconciliation Report 42COV	Serves as a YTD cumulative report for the Contract of Record of all financial amounts reported by Submitting Contracts for use in the Contract of Record's Part D Payment Reconciliation. Distributed monthly.
P2P Payable Report 43COV	Serves as the Contract of Record's invoice for P2P reconciliation. Distributed monthly.

P2P REPORT NAMING CONVENTIONS

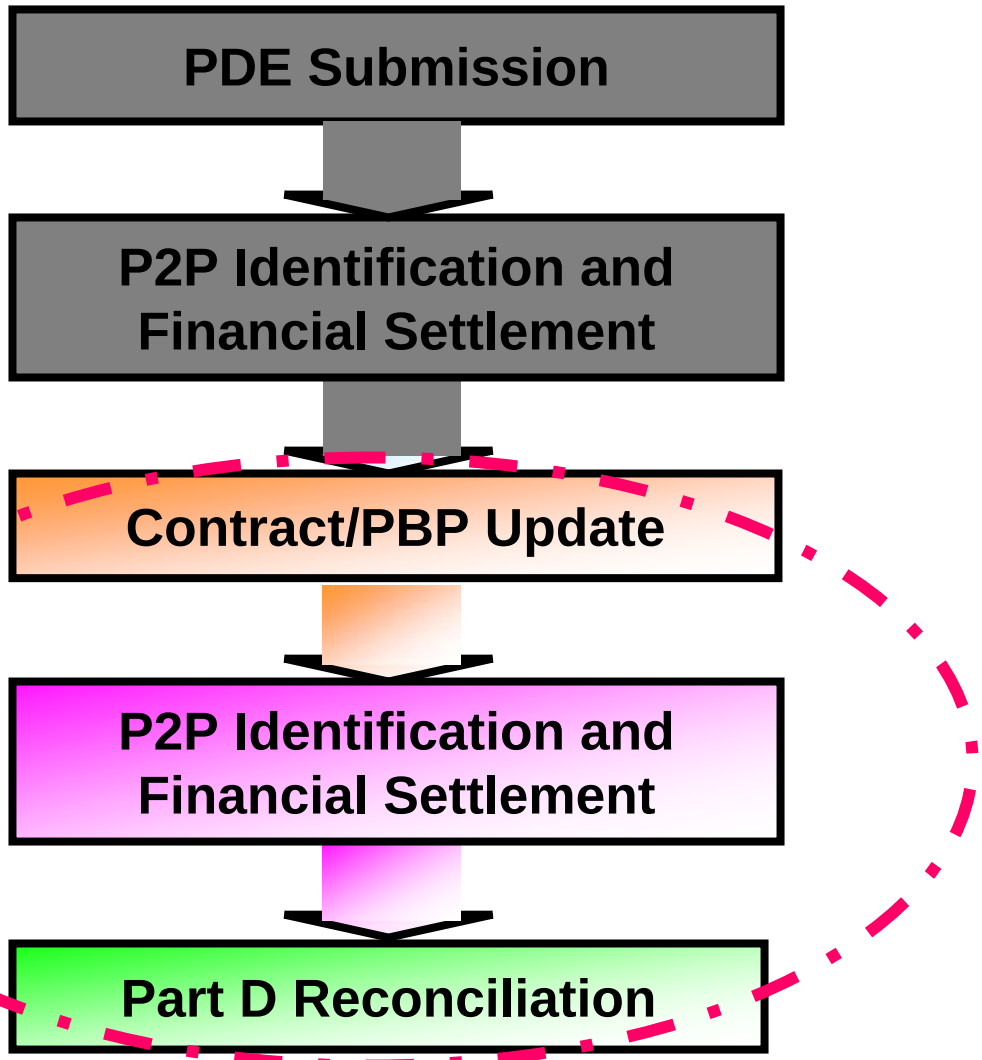
Report Name	Mailbox Identification
Special Return File	RPT00000.RPT.DDPS_P2P_PHASE3_RTN
P2P Accounting Report (40COV/ENH/OTC)	RPT00000.RPT.DDPS_P2P_PDE_ACC_C RPT00000.RPT.DDPS_P2P_PDE_ACC_E RPT00000.RPT.DDPS_P2P_PDE_ACC_O
P2P Receivable Report (41COV)	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P Part D Payment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

P2P CONTRACT/PBP UPDATE PRIOR TO PART D PAYMENT RECONCILIATION

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

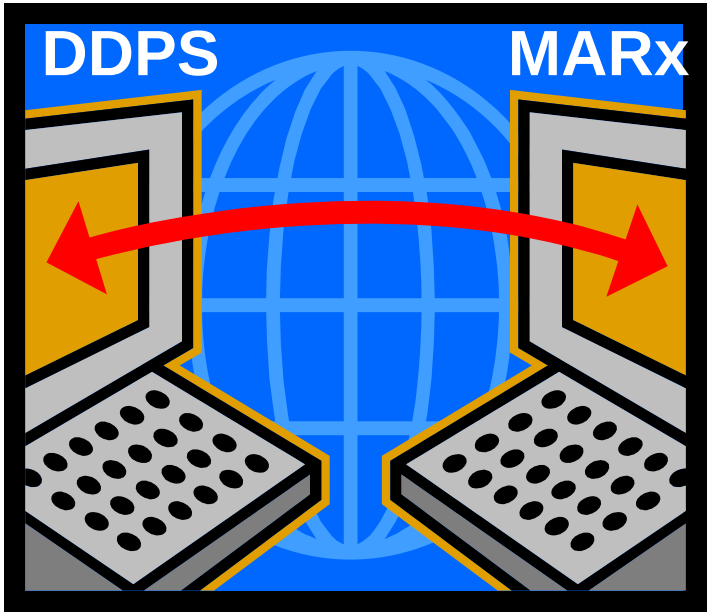
Updates to contract/PBP of record will always occur prior to Part D Payment Reconciliation.

P2P PROCESS


PDE Submission
P2P Identification and Financial Settlement
Contract/PBP Update
P2P Identification and Financial Settlement
Part D Reconciliation

P2P CONTRACT/PBP UPDATE PROCESSING

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



REPORTING P2P IN RETURN FILES

- Fields impacted by P2P Processing
  - Submitting Contract
  - Submitting PBP
  - 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

SUMMARY

- Identified the purpose of PDFS, DDPS, and IDR reports
- Determined the best use of the reports to monitor data processes and resolve errors
- Reviewed the reports to identify and submit corrections
- Recognized the relationship between values in the management reports and reconciliation
- Determined existence of P2P conditions and associated financial settlements

EVALUATION

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

THANK YOU!

Reconciliation

PURPOSE

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

OBJECTIVES

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

RECONCILIATION

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

FOUR PAYMENT METHODOLOGIES

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

DIRECT SUBSIDY

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

PROSPECTIVE PAYMENTS

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

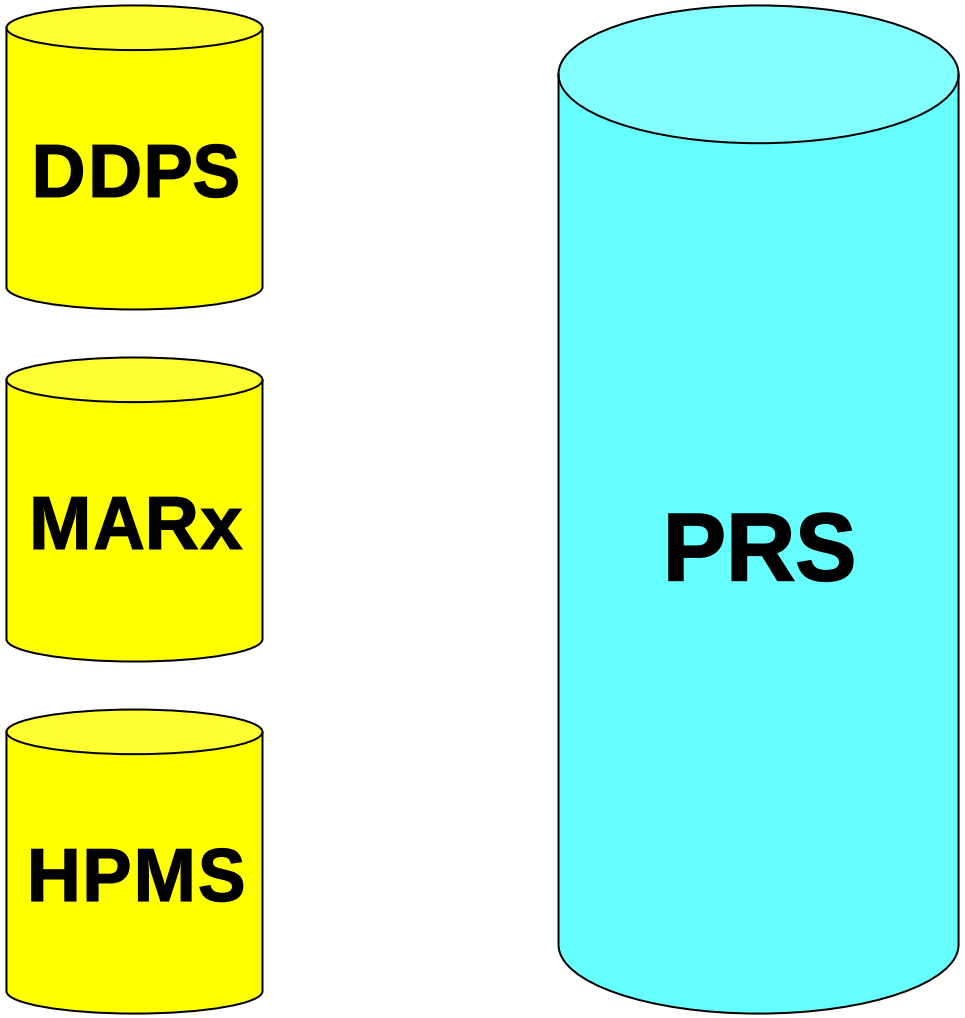
ACTUAL COSTS

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

ACCURATE AND TIMELY PDEs

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

RECONCILIATION SYSTEMS OVERVIEW



PRS REPORTS TO PLANS

- Plans active within the coverage year will receive two reconciliation reports from PRS:
  - PRS Inputs Report to Plans
  - PRS Reconciliation Results Report to Plans
- PRS reports were updated in April 2008.

PRS INPUTS REPORT TO PLANS

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

LAYOUT OF THE PRS INPUTS REPORT TO PLANS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
DET	Detail records for the report	Occurs 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

P2P AND NON-P2P FIELDS

- The Inputs Report to Plans contains Plan-to-Plan (P2P) and non-P2P amounts for the following fields:
  - Actual Low Income Cost-Sharing Subsidy Amount
  - Gross Drug Cost Below the Out of Pocket Threshold Amount
  - Gross Drug Cost Above the Out of Pocket Threshold Amount
  - Covered Part D Plan Paid Amount
  - Estimated POS Rebate Amount

P2P AND NON-P2P FIELDS

- P2P amounts represent amounts paid when the contract was not the Submitting Contract.
- P2P amounts are included in the COR's reconciliation at the plan-level.
- P2P Estimated POS Rebate Amount is the exception.

ESTIMATED POS REBATE

- Beginning in 2008, Estimated Point of Sale (POS) Rebate will be used to calculate DIR used in:
  - Reinsurance reconciliation
  - Risk sharing
- Received from DDPS as non-P2P and P2P amounts.
- P2P Estimated POS Rebate Amount represents amounts from the Submitting Contract.
- The Submitting Contract must retain (and report as DIR) any rebates earned for P2P claims.

P2P AND NON-P2P FIELDS (CONTINUED)

Data Element	Short Name	Field Number		
		Non-P2P	P2P	Total
ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	4	5	6
GROSS DRUG COST BELOW THE OUT OF POCKET THRESHOLD	GDCBA	8	9	10
GROSS DRUG COST ABOVE THE OUT OF POCKET THRESHOLD	GDCAA	11	12	13
COVERED PART D PLAN PAID AMOUNT	CPPA	14	15	16
ESTIMATED POS REBATE AMOUNT	ERPOSA	22	23	24

PRS RECONCILIATION RESULTS REPORT TO PLANS

PRS Reconciliation Results Report to Plans

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

PRS RECONCILIATION RESULTS REPORT TO PLANS FILE LAYOUT

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

RECONCILIATION NUMBER

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

FIELDS PASSED FROM INPUTS TO RESULTS REPORT

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
DDPS	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	7	8
	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	11	18
	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	14	17
	TOTAL COVERED PART D PLAN PAID AMOUNT	17	34
	TOTAL ESTIMATED POS REBATE AMOUNT	26	21

FIELDS PASSED FROM INPUTS TO RESULTS REPORT (CONTINUED)

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
MARx	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	18	11
	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	19	28
	PART D BASIC PREMIUM AMOUNT	20	38
	DIRECT SUBSIDY AMOUNT	21	37
	PACE COST-SHARING ADD-ON AMOUNT	22	40

HPMS INPUTS ON THE RESULTS REPORT

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

CMS PROVIDED INPUTS ON THE RESULTS REPORT

Field No.	Field Name
43	FIRST UPPER THRESHOLD PERCENT
44	SECOND UPPER THRESHOLD PERCENT
45	FIRST LOWER THRESHOLD PERCENT
46	SECOND LOWER THRESHOLD PERCENT
52	FIRST UPPER RISK SHARING RATE
53	SECOND UPPER RISK SHARING RATE
54	FIRST LOWER RISK SHARING RATE
55	SECOND LOWER RISK SHARING RATE

PAYMENT RECONCILIATION PLAN TYPE CODE

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

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES

- PRS Reconciliation Results Report was modified in April 2008 to accommodate both initial and re-opened reconciliations
- To calculate the payment adjustment in a re-opened reconciliation, certain key data elements on the Results Report will have multiple values
- Plans would have to code to only one set of reports

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES
(CONTINUED)

- Previous values are from the last reconciliation or re-opening in which there was a payment adjustment (as identified by the Previous Reconciliation Number)
- Current values are the values used to calculate the reconciliation in progress
- Delta values:
  - Represent the difference between the Current values and Previous values
  - Are the values by which the final payment determination would be adjusted
  - Can be positive or negative

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES (CONTINUED)

Category	Data Element				
	Current		Previous		Delta
DDPS INPUTS	CURRENT TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	-	PREVIOUS TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	=	DELTA TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
MARx INPUTS	CURRENT PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	-	PREVIOUS PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	=	DELTA PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT
	CURRENT PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	-	PREVIOUS PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	=	DELTA PROSPECTIVE REINSURANCE SUBSIDY AMOUNT

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES (CONTINUED)

Category	Data Element				
	Current		Previous		Delta
PRS CALCULATED RECONCILIATION RESULTS	CURRENT LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	-	PREVIOUS LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	=	DELTA LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT
	CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-	PREVIOUS REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	=	DELTA REINSURANCE SUBSIDY ADJUSTMENT AMOUNT
	CURRENT RISK-SHARING AMOUNT	-	PREVIOUS RISK-SHARING AMOUNT	=	DELTA RISK-SHARING AMOUNT

DATA ELEMENTS WITH CURRENT, PREVIOUS, AND DELTA VALUES (CONTINUED)

Category	Data Element				
	Current		Previous		Delta
PRS CALCULATED RECONCILIATION RESULTS	CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMO PLANS ONLY)	-	PREVIOUS BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMO PLANS ONLY)	=	DELTA BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMO PLANS ONLY)
	CURRENT ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	-	PREVIOUS ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT	=	DELTA ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT

LOW INCOME COST-SHARING RECONCILIATION

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

BAYSIDE'S LOW INCOME COST-SHARING RECONCILIATION

LICS Reconciliation Amount

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

LICS Reconciliation Amount = $120,000

Results Report, DET Record

Field No.	Field Name	
8	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$3,000,000
11	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$2,880,000
14	**LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT**	**$120,000**

DIRECT AND INDIRECT REMUNERATION

- Direct and Indirect Remuneration will be adjusted by Estimated POS Rebate amounts beginning in 2008.
- Part D Covered DIR Amount is now Reported Part D Covered DIR amount.
- Net Part D Covered DIR Amount is the difference between Reported Part D Covered DIR Amount and Total Estimated POS Rebate Amount.

DIRECT AND INDIRECT REMUNERATION

- Net Part D Covered DIR Amount:
  - Equals the difference between Reported Part D Covered DIR Amount and Total Estimated POS Rebate Amount.
  - Will be used in the reinsurance reconciliation and risk sharing.
  - For 2007, will equal Reported Part D Covered DIR Amount
  - Beginning in 2008, will reflect estimated POS rebate amounts for contracts that choose to report rebates at the point of sale

DIRECT AND INDIRECT REMUNERATION

Net Part D Covered DIR Amount

Net Part D Covered DIR Amount = $2,000,000 - $350,000

Net Part D Covered DIR Amount = $1,650,000

Results Report, DET Record

Field No.	Field Name	
20	REPORTED PART D COVERED DIR AMOUNT	$2,000,000
21	TOTAL ESTIMATED POS REBATE AMOUNT	$350,000
23	**NET PART D COVERED DIR AMOUNT**	**$1,650,000**

REINSURANCE SUBSIDY

There is a five-step process to calculate and reconcile the Reinsurance Subsidy:

1. Calculate DIR Ratio
2. Calculate Reinsurance Portion of DIR
3. Calculate Allowable Reinsurance Cost
4. Calculate Plan-Level Reinsurance Subsidy
5. Reconcile Reinsurance Subsidy

STEP 1 - REINSURANCE DIR RATIO

- The DIR Ratio is unadjusted reinsurance cost divided by total drug cost.
- Unadjusted reinsurance cost is the plan-level GDCA amount reported on PDEs.
- Total drug cost is the sum of GDCA and GDCB.

CALCULATE BAYSIDE'S DIR RATIO

DIR_Ratio

DIR_Ratio = $2,750,000/($2,750,000 + $13,750,000)

DIR_Ratio = $2,750,000/$16,500,000

DIR_Ratio = .1667

Results Report, DET Record

Field No.	Field Name	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$2,750,000
18	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	$13,750,000
19	**REINSURANCE DIR RATIO**	**0.1667**

STEP 2 – CALCULATE THE REINSURANCE PORTION OF DIR

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

CALCULATE BAYSIDE'S REINSURANCE PORTION OF DIR

Reinsurance Portion of DIR

Reinsurance Portion of DIR = $1,650,000 * .1667

Reinsurance Portion of DIR = $275,055

Results Report, DET Record

Field No.	Field Name	
19	REINSURANCE DIR RATIO	0.1667
22	NET PART D COVERED DIR AMOUNT	$1,650,000
23	**REINSURANCE PORTION OF DIR AMOUNT**	**$275,055**

STEP 3 - ALLOWABLE REINSURANCE COST

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

CALCULATE BAYSIDE'S ALLOWABLE REINSURANCE COST

Allowable Reinsurance Cost

Allowable Reinsurance Cost = $2,750,000 - $275,055

Allowable Reinsurance Cost = $2,474,945

Results Report, DET Record

Field No.	Field Name	
17	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	$2,750,000
23	REINSURANCE PORTION OF DIR AMOUNT	$275,055
24	**ALLOWABLE REINSURANCE COST AMOUNT**	**$2,474,945**

STEP 4 – CALCULATE THE REINSURANCE SUBSIDY

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

CALCULATE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Subsidy

Reinsurance Subsidy = $2,474,945 * 0.8

Reinsurance Subsidy = $1,979,956

Results Report, DET Record

Field No.	Field Name	
24	ALLOWABLE REINSURANCE COST AMOUNT	$2,474,945
25	**CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,979,956**

STEP 5 – RECONCILE THE REINSURANCE SUBSIDY

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

RECONCILE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Reconciliation Amount

Reinsurance Reconciliation Amount = $1,979,956 – $2,100,000

Reinsurance Reconciliation Amount = -$120,044

Results Report, DET Record

Field No.	Field Name	
25	CURRENT ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
28	CURRENT PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
31	**CURENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**($120,044)**

RISK SHARING

- Calculate target amount
- Calculate risk corridor thresholds
- Determine adjusted allowable risk corridor costs
- Compare costs to thresholds and determine risk sharing amount

DETERMINE TARGET AMOUNT

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

CALCULATE BAYSIDE'S TARGET AMOUNT

Target Amount

Target Amount = ($2,868,000 + $2,100,000) * (1.00 - 0.15)

Target Amount = $4,968,000*.85

Target Amount = $4,222,800

Results Report, DET Record

Field No.	Field Name	
37	DIRECT SUBSIDY AMOUNT	$2,868,000
38	PART D BASIC PREMIUM AMOUNT	$2,100,000
39	ADMINISTRATIVE COST RATIO	0.15
41	**TARGET AMOUNT**	**$4,222,800**

DETERMINE RISK CORRIDORS

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

CALCULATE BAYSIDE'S RISK CORRIDORS

Risk Corridor Thresholds

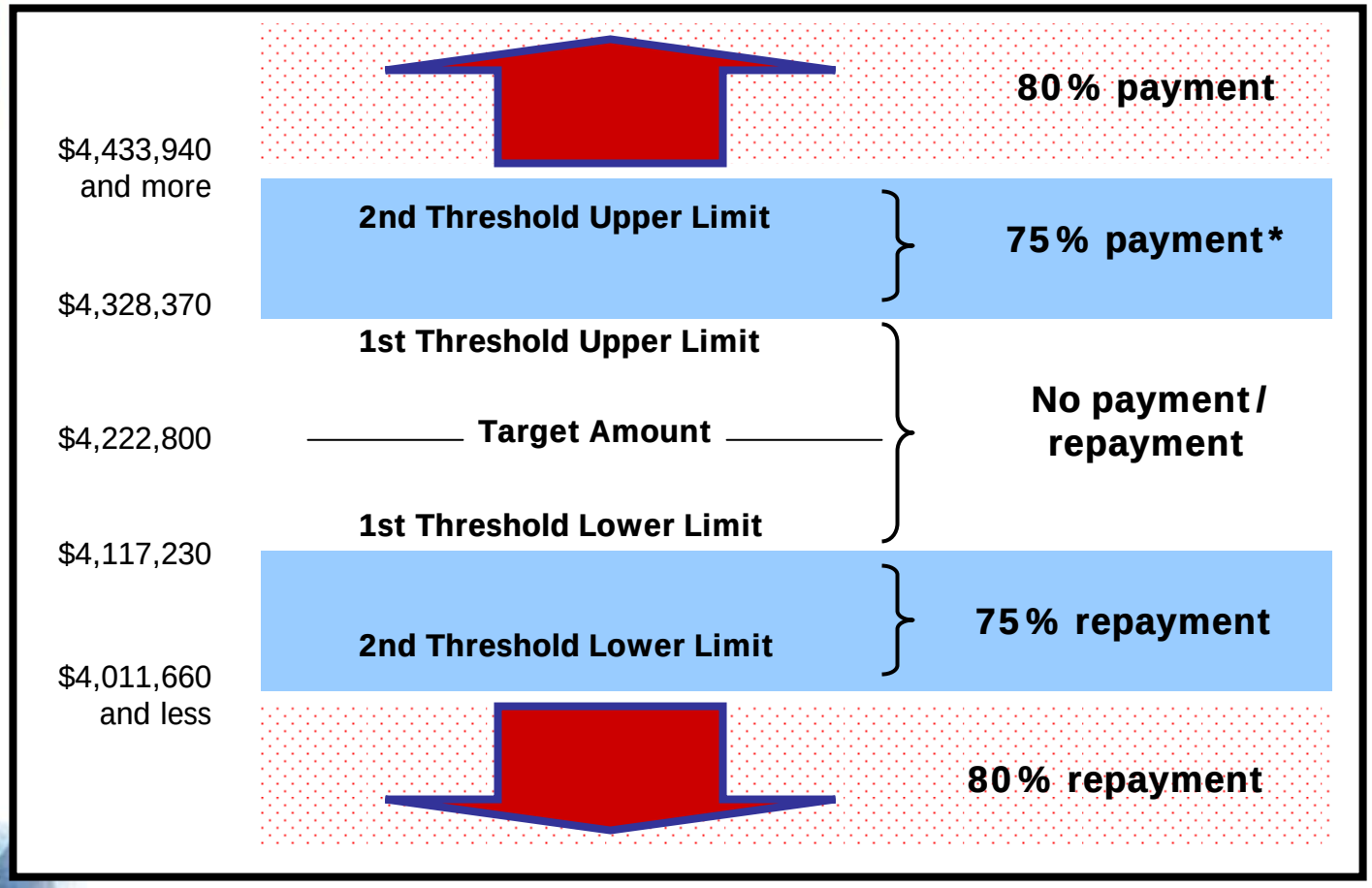
Second threshold upper limit (STUL)	= $4,222,800 *	1.05	=	$4,433,940
First threshold upper limit (FTUL)	= $4,222,800 *	1.025	=	$4,328,370
First threshold lower limit (FTLL)	= $4,222,800 *	0.975	=	$4,117,230
Second threshold lower limit (STLL)	= $4,222,800 *	0.95	=	$4,011,660

CALCULATE BAYSIDE'S RISK CORRIDORS (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
41	TARGET AMOUNT	$4,222,800
43	FIRST UPPER THRESHOLD PERCENT	1.025
44	SECOND UPPER THRESHOLD PERCENT	1.05
45	FIRST LOWER THRESHOLD PERCENT	0.975
46	SECOND LOWER THRESHOLD PERCENT	0.95
47	**FIRST UPPER THRESHOLD AMOUNT**	**$4,328,370**
48	**SECOND UPPER THRESHOLD AMOUNT**	**$4,433,940**
49	**FIRST LOWER THRESHOLD AMOUNT**	**$4,117,230**
50	**SECOND LOWER THRESHOLD AMOUNT**	**$4,011,660**

RISK CORRIDORS 2006



*75%

CALCULATE AARCC

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

CALCULATE BAYSIDE'S AARCC

Adjusted Allowable Risk Corridor Cost (AARCC)

AARCC = ($8,250,000 - $1,979,956 - $1,650,000) / 1.018

AARCC = $4,620,044 / 1.018

AARCC = $4,538,353

Results Report, DET Record

Field No.	Field Name	
22	PART D COVERED DIR AMOUNT	$1,650,000
25	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
34	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,250,000
35	INDUCED UTILIZATION RATIO	1.018
36	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,538,353**

DETERMINE RISK SHARING

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

DETERMINE BAYSIDE'S RISK SHARING

Cost Subject to Risk Sharing

Total Cost Subject to Risk Sharing = $4,538,353 - $4,328,370

Total Cost Subject to Risk Sharing = $209,983

Cost Subject to Risk Sharing > FTUL and ≤ STUL = $4,433,940 - $4,328,370

Cost Subject to Risk Sharing > FTUL and ≤ STUL = $105,570

Cost Subject to Risk Sharing > STUL = $4,538,353 - $4,433,940

Cost Subject to Risk Sharing > STUL = $104,413

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Risk Sharing Payment

Risk Sharing Payment = (.90 * $105,570) + (.80 * $104,413)

Risk Sharing Payment = $95,013 + $83,530

Risk Sharing Payment = $178,543

The risk sharing payment between the FTUL and STUL assumes that the 60/60 rule was met.

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
36	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,538,353
47	FIRST UPPER THRESHOLD AMOUNT	$4,328,370
48	SECOND UPPER THRESHOLD AMOUNT	$4,433,940
52	FIRST UPPER RISK SHARING RATE	0.9
53	SECOND UPPER RISK-SHARING RATE	0.8
56	**CURRENT RISK-SHARING AMOUNT**	**$178,543**
59	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$83,530
60	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$95,013

BUDGET NEUTRALITY

- The Budget Neutrality Adjustment Amount (BNAA):
  - Allows demonstration plans to achieve budget neutrality
  - Is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA)
  - Is subtracted from the sum of the three Part D reconciliations (LICS, reinsurance, and risk sharing)

CALCULATE BAYSIDE'S BUDGET NEUTRALITY ADJUSTMENT

Budget Neutrality Adjustment

Budget Neutrality Adjustment = $7.57 * 5000

Budget Neutrality Adjustment Amount = $37,850

Results Report, DET Record

Field No.	Field Name	
61	COUNT OF UNIQUE MEMBERS PER YEAR	5000
62	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	$7.57
63	**CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT** (DEMO PLANS ONLY)	**$37,850**

ADJUSTMENT DUE TO PAYMENT RECONCILIATION

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

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

LICS Reconciliation	$120,000
Reinsurance Subsidy Reconciliation	+($120,044)
Risk Sharing	+ $178,543
Budget Neutrality Adjustment Amount	- $37,850
Adjustment Due to Payment Reconciliation Amount	**$140,649**

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

Bayside's ARA – Results Report, DET Record

Field No.	Field Name	
14	CURRENT LOW INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
31	CURRENT REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$120,044
56	CURRENT RISK SHARING AMOUNT	$178,543
63	CURRENT BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	-$37,850
66	**CURRENT ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**$140,649**

INTERPRETING RESULTS REPORT IN AN INITIAL RECONCILIATION

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

INTERPRETING RESULTS REPORT IN A RE-OPENED RECONCILIATION

- Previous values of **input** data elements (e.g. Previous Prospective Reinsurance Subsidy Amount) help show the net change between the inputs of the initial reconciliation or prior re-opening and the current re-opening.

- Previous values of **results** data elements (e.g. Previous Risk Sharing Amount) help plans understand how CMS calculates the adjustment to the final payment determination.

SUMMARY

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

EVALUATION

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