TABLE OF CONTENTS

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more
information regarding sources of updated information.

LIST OF TABLES

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

LIST OF FIGURES

INTRODUCTION

Purpose (Slide 3)

The purpose of this training is to provide participants with the support needed to understand Part D payment and data submission. This information will enable participants to collect and submit Part D data in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

About This Training

This training is organized into 7 modules:

ICON KEY	
Definition	ᵍ
Example	⊠
Reminder	💡
Resource	📖

1. **Part D Payment Methodology**
   Defines the Part D Prescription Drug payment calculation methodology including the PACE special payments.
2. **PACE Payment Calculations**
   Describes the PACE benefit calculation and provides an overview of the Part D payment reconciliation as applied to PACE.
3. **PDE Process Overview**
   Introduces key concepts associated with Prescription Drug Event (PDE) data, including collection, submission, formatting, editing, and processing.
4. **Data Format**
   Identifies the file layout for the PDE record and the formatting requirements for PDE fields.
5. **Edits**
   Interprets the edit logic for the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS).
6. **Reports**
   Provides an understanding of the way management reports can ensure both quality and quantity of data stored in the system.
7. **Reconciliation**
   Explains the systems and steps for calculating components used in the reconciliation process.

Participant Guide (Slide 6)

This Participant Guide is designed as the foundation of the training program. The presentation slides complement the Participant Guide, and both will be used extensively throughout this training. The participant binder includes the Participant Guide, Presentation Slides, a Resource Guide, and Job Aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

TABLE A – TRAINING TOOLS

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant Part D information • Examples
Slides	• Organized by module • Printed two slides per page
Resource Guide	• Official CMS Instructions • List of Acronyms • Website Links

Future Use of This Participant Guide

The Participant Guide, Slides, and Resource Guide are designed for use when participants return to their organizations. Additional copies of the training materials are available at www.cssoperations.com. CMS revised training materials, when required. An appropriate label will appear in the footer of the replacement pages affected by the revisions. Organizations are encouraged to register at www.cssoperations.com to receive notification for these revisions.

Audience (Slide 7)

This training program is designed for individuals charged with responsibility to administer the Part D drug benefit. The primary audiences for this training include:

• Staff of PACE organizations
• Plan Benefit Managers (PBMs) staff.
• Third party submitters, contracted to submit data on behalf of plans.

Learning Objectives (Slides 9 – 11)

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

• Identify the prescription drug payment calculation methodology.
• Describe the flow of the data from the PDFS to the DDPS.
• Identify the fields required for completion of the PACE PDE record.
• Interpret the edit logic for PDFS and DDPS as applied to PACE.
• Describe how reports can ensure accurate quality and quantity of data stored in the system.
• Understand the systems and steps for calculating components used in the reconciliation process.

Roles and Contact Information (Slide 12)

The roles and contact information for important resources are provided in Table B.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE B – PART D PAYMENT PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
CMS Center for Beneficiary Choices (CBC)	Develops and implements the Part D payment methodology. Monitors plans to improve the quality of data.	Jeff Grant jeffrey.grant@cms.hhs.gov Henri Thomas henry.thomas@cms.hhs.gov Sandra Anderson sandra.anderson@cms.hhs.gov Harvey Hull harvey.hull@cms.hhs.gov
Palmetto Government Benefits Administration (Palmetto GBA)	Manages the PDFS and the Customer Service and Support Center (CSSC).	www.csscoperations.com csscoperations@palmettogba.com
Aspen Systems Corporation	Training Contractor responsible for Prescription Drug Event Data training initiatives, including regional training programs and User Group meetings.	cmstraining@aspensys.com Angela Reddix areddix@aspensys.com

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MODULE 1 – PART D PAYMENT METHODOLOGY

Purpose (Slide 2)

Introduce Part D payment mechanisms as applicable to Program of All-Inclusive Care for the Elderly (PACE) organizations. Understanding the statutorily established payment methodologies and the financial data needed to support Part D payments will allow PACE organizations to receive accurate payments.

Learning Objectives (Slide 3)

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

- Identify the four payment mechanisms related to Dual Eligible PACE organizations and Medicare PACE organizations.
- Understand payment methodologies specific to PACE organizations.
- Establish context for understanding PACE PDE data reporting and reconciliation processes.

ICON KEY	
Definition	ᴥ
Example	⊠
Reminder	🔵
Resource	📖

1.1 Overview

In December 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), amending the Social Security Act by adding Part D under Title XVIII. The new benefit allows Medicare payment to plans that contract with CMS to provide qualified Part D prescription drug coverage. The law provides four payment mechanisms and, as a condition of payment, requires that plans submit data and information necessary for CMS to carry out those payment provisions.

Program of All Inclusive Care for the Elderly (PACE) organizations are required by law to offer drugs to enrollees with no co-payments. This provision must be reconciled with the global provisions in MMA that require beneficiary out-of-pocket expenditures. Specifically, sections 1894(b)(1)(A)(i) and 1934(b)(1)(A)(i) of the Act preclude PACE organizations from charging PACE enrollees any form of cost sharing and section 460.186(d) of the PACE regulation precludes PACE organizations from charging a premium to any Medicaid eligible PACE enrollees.

PACE organizations need to have two separate benefit plans and two separate Part D bids. The dual eligible population will be enrolled in a standard benefit plan and the Medicare only population will be enrolled in an enhanced alternative plan.

CMS will revise payment methodologies as appropriate for each plan type.

1.1.1 Payment Methodologies (Slides 4, 7-10)

Part D provides four mechanisms to pay plans for Part D basic benefits. The Prescription Drug Event (PDE) record is structured to report data to make these four payments. The four payment mechanisms are the direct subsidy, the low income cost-sharing subsidy, the reinsurance subsidy and risk sharing. Table 1A summarizes the applicability of each payment methodology to the two PACE organization types.

TABLE 1A-PAYMENT APPLICABILITY TO PACE PLANS

PAYMENT METHODOLOGY	DUAL ELIGIBLE	MEDICARE ONLY
Direct Subsidy	Y	Y
Beneficiary Basic Premium	N	S
Beneficiary Supplemental Premium	N	Y
Low Income Premium Subsidy	Y	S
Additional Capitated Payment for Premium*	Y	N
Low Income Cost Sharing Subsidy	Y	N
Reinsurance Subsidy	Y	N
2% Additional Capitation	Y	N

S (situational) indicates that payment applicability depends on the circumstances of the individual beneficiary
*The additional capitated payment for premium is made in cases where the bid exceeds the low income benchmark.

✍ **Direct Subsidy** – The direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount.

The beneficiary premium related to the standardized bid amount includes premium amounts paid by enrollees or paid on their behalf, including A/B rebates applied to the basic benefit and low income premium subsidies. Unless specifically noted, when CMS refers to basic beneficiary premium in this module, it means the "premium related to the standardized bid amount" without specifying who pays the premium. CMS excludes any premiums for supplemental benefits or A/B benefits. Premiums are discussed further detail in the Target Amount section of Module 2.

✍ **Low Income Subsidies** – Low income subsidies are government payments of behalf of certain beneficiaries based on their income and asset levels that cover part or all of the premium subsidy amount and beneficiary cost sharing.

The premium subsidy provides assistance in paying the monthly premium. Dual eligible PACE enrollees pay no premium. Medicare only PACE enrollees may qualify for limited premium assistance. Section 1.2.3.1 of this Module explains PACE premium assistance.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The cost sharing subsidy is explained in greater detail because it specifically applies to each prescription drug event and is subject to year-end cost-based reconciliation. The low income premium and the Low Income Cost Sharing Subsidy (LICS) apply differently to dual eligible and Medicare only plans.

✍ **Reinsurance subsidy** – The reinsurance subsidy is a federal subsidy for 80 percent of allowable drug costs above the out-of-pocket threshold, net of any other remuneration (e.g., rebates, coupons, etc). It is also subject to cost-based reconciliation. The reinsurance subsidy applies to dual eligible plans only.

✍ **Risk Sharing** – Risk sharing is designed to limit a plan's exposure to unexpected expenses not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits or losses resulting from expenses for the standard benefit within defined symmetrical risk corridors around a target amount. Risk sharing applies uniformly to dual eligible and Medicare only plans.

1.1.2 Covered Drugs

The four payment methodologies apply to covered drugs. The term covered drugs refers to those drugs that a plan covers under its basic benefit. Covered drugs are Part D drugs that are approved for coverage under a specific PBP. Part D drugs are defined as any prescription drug described in §1927(k)(2)(A) of the Act, a vaccine licensed under section 351 of the Public Health Service Act, a biological product described in §1927(k)(2)(B) of the Act, or insulin described in §1927(k)(2)(C) and medical supplies associated with the injection of insulin as allowed under §1860D-2(e)(1)(B). Except for smoking cessation drugs, Part D drugs must be prescribed for the purposes allowed under §1862(a) and §1927(d)(2) (e.g., reasonable and necessary guidelines, exclusion of drug classes used for weight loss or cosmetic surgery). Drugs cannot be billed as Part D drugs if they are already covered under Medicare Parts A or B as prescribed, dispensed, or administered (§1860D-2(e)(2)(B)).

1.1.3 The Four Payment Mechanisms Related to the Defined Standard Benefit

Figure 1A and Table 1B illustrate application of the four payment mechanisms and how those payments apply in the defined standard benefit.

FIGURE 1A - DEFINED STANDARD BENEFIT 2006
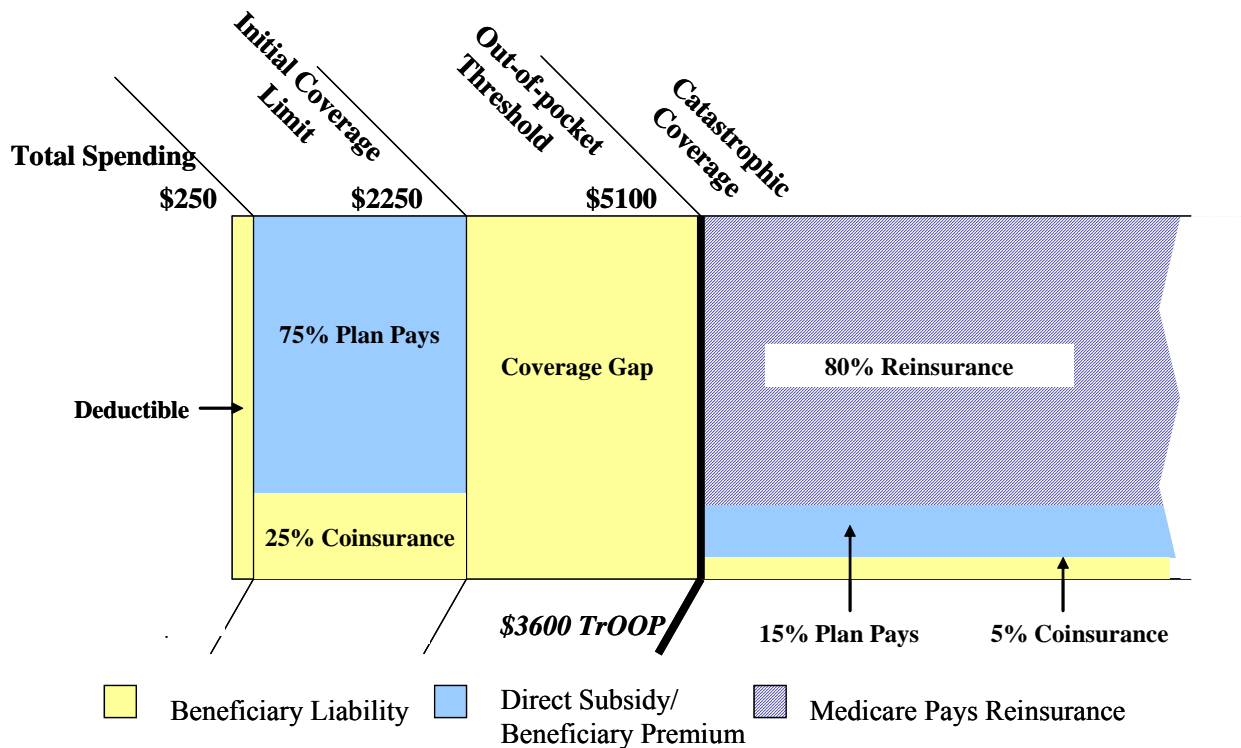
1.1.3.1   The Defined Standard Benefit

The defined standard benefit has four benefit phases: the Deductible Phase, the Initial Coverage Period, the Coverage Gap, and the Catastrophic Coverage Phase. Year-to-Date (YTD) covered drug costs determine when the beneficiary is in the Deductible Phase, the Initial Coverage Period and the Coverage Gap. Accumulated True Out-Of-Pocket (TrOOP) greater than the Out of Pocket (OOP) Threshold determines when the beneficiary enters the Catastrophic Coverage Phase of the benefit. Since PACE enrollees do not have copays in any phase of the benefit, CMS will determine the beneficiary's position in the benefit on behalf of PACE organizations by calculating YTD covered drug costs and TrOOP.

- TrOOP only applies to determining the threshold for catastrophic coverage. The deductible and initial coverage period are not dependent on any specific TrOOP level. The beneficiary liabilities in these phases of the benefit may be paid by the beneficiary or any party on behalf of the beneficiary.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

- YTD covered drug costs determine if the beneficiary is in the Deductible Phase, the Initial Coverage Period, and the Coverage Gap. YTD accumulated TrOOP costs greater than the OOP threshold determine if the beneficiary is in Catastrophic Coverage.

TABLE 1B - THE DEFINED STANDARD BENEFIT PLAN

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	Year-to-Date (YTD) Total Covered Drug Cost	YTD TrOOP Costs		
Deductible	≤ $250	N/A*	100% coinsurance (= $250)	0%
Initial Coverage Period	> $250 and ≤ $2,250	N/A*	25% coinsurance (= $500)	75% (= $1,500)
Coverage Gap	> $2,250 and ≤ $5,100	≤ $3,600	100% coinsurance (= $2,850)	0%
Catastrophic Coverage Phase	> $5,100	> $3,600 (OOP threshold)	Greater of 5% coinsurance or $2/$5 (generic/ brand) co-payment	Lesser of 95%** or Total Covered Drug Cost – $2/$5

* It is not necessary to achieve a minimum TrOOP for transitioning from the Deductible to the Initial Coverage Period or from the Initial Coverage period to the Coverage Gap. These phases are dependent upon total covered drug spending, regardless of who pays for the drug. However, any beneficiary paid amounts will count as TrOOP during these phases of the benefit.

** 80 percent reinsurance subsidy; and 15 percent government/plan shared risk.

- Deductible Phase – In 2006 the Part D defined standard benefit begins with a $250 deductible for covered drug costs for which the beneficiary (or another party on the beneficiary's behalf) is responsible.

> Beneficiary liability   100%
> Plan liability   0%

- Initial Coverage Period – The next $2,000 of covered drug cost (above $250 and up to and including $2,250, the Initial Coverage Limit) falls in the Initial Coverage Period in which the beneficiary pays 25 percent coinsurance and the plan is responsible for 75 percent of the costs.

> Beneficiary liability   25%
> Plan liability   75%

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

- Coverage Gap – The next $2,850 of covered drug cost (above the Initial Coverage limit of $2,250 and up to and including the (OOP) threshold falls in the Coverage Gap in which the beneficiary pays 100 percent coinsurance.

Beneficiary liability	100%
Plan liability	0%

The Coverage Gap is unique to the Part D benefit.

Because plans offering the Defined Standard Benefit cannot alter beneficiary cost-sharing in any phase of the benefit, the point at which the beneficiary reaches the OOP threshold almost always corresponds to $5,100 in total covered drug cost.

The dual eligible plan differs from the defined standard in one important respect. There is a nominal cost-sharing amount in the defined standard benefit that low income beneficiaries pay themselves for each prescription drug event. Because PACE organizations cannot apply cost sharing, the dual eligible PACE plan pays this nominal amount, estimated to be 2 percent and the government in turn reimburses the PACE organizations. In PACE accounting, this 2 percent amount is excluded from TrOOP because it is counted as a plan paid amount, subject to risk sharing, rather than a beneficiary cost sharing amount. Any reduction in cost-sharing extends the point at which a beneficiary reaches the OOP threshold. As a result the covered drug cost corresponding the point at which the beneficiary reaches the OOP always increases $104 from $5,100 in the defined standard benefit to $5,204 in the PACE dual eligible plan.

- Catastrophic Coverage - Catastrophic Coverage begins after the beneficiary reaches the OOP threshold. Costs in catastrophic coverage are split three ways, with the government providing reinsurance equal to 80 percent, the Part D plan covering approximately 15 percent, and the beneficiary paying the greater of a 5 percent coinsurance, or co-payments of $2 for generic drugs and $5 for non-generic drugs.

Beneficiary liability	> of 5% or $2/$5
Plan liability	approximately 15%
Government liability	80% reinsurance subsidy

1.1.3.2 Other Benefit Types: Year-to-Date Covered Drug Cost and the Out-of-Pocket (OOP) Threshold

CMS has pointed out the relationship between YTD covered drug cost and the point at which the beneficiary reaches the OOP threshold. When all beneficiaries pay exactly the same cost-sharing, as in the defined standard benefit, $5,100 of YTD covered drug cost coincides with the point at which the beneficiary reaches the OOP threshold (i.e., in 2006 TrOOP = $3,600), assuming no Other Health Insurance (OHI). Part D allows three other plan types, which have variable cost-sharing. Because of cost-sharing differences in these other plan types, YTD covered drug cost coinciding with the OOP threshold varies.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

- Actuarially Equivalent (AE) and Basic Alternative (BA) plans are actuarially equivalent in value to the defined standard benefit. On average, the relationship between YTD covered drug cost and the OOP threshold will be the same as the defined standard benefit in these plans. However the YTD drug cost coinciding with the OOP threshold will be higher or lower than $5,100 for some beneficiaries. For example, YTD covered drug cost will be higher for a beneficiary who consistently purchases drugs with low cost-sharing. These benefit types do not apply to PACE.

- Enhanced Alternative (EA) plans may offer lower cost-sharing in exchange for higher premiums. Lower cost-sharing extends the point at which the beneficiary reaches the OOP threshold. YTD drug costs coinciding with the OOP threshold will be higher than $5,100. Medicare only plans are enhanced alternative plans.

1.1.3.3   Payment Methodologies in Relation to the Defined Standard Benefit

- Direct subsidy is one of the two risk components of payment. The other is the basic beneficiary premium. The direct subsidy and basic beneficiary premium cover 75 percent plan cost-sharing in the Initial Coverage Period and approximately 15 percent plan cost-sharing in the Catastrophic Coverage phase, as well as administrative costs and profits approved in the bid.

- LICS applies throughout all phases of the benefit for low income eligible beneficiaries.

- Reinsurance Subsidy applies in the Catastrophic Coverage phase of the benefit

- Risk sharing is calculated at the plan level for the basic benefit and compares risk payments (direct subsidy and basic beneficiary premium) with aggregate allowed plan paid drug costs.

1.1.4 Data Collection for Part D

For each dispensing event, the plan must submit a prescription drug event or PDE record. The PDE is a summary record that documents the final adjudication of a dispensing event.

Criteria to Determine Data Requirements - In order to implement the four payment mechanisms, CMS collects a limited subset of data elements on 100 percent of prescription drug events (PDEs). CMS uses the following four criteria to determine data submission requirements:

- Ability to make timely, accurate payment using the four legislated mechanisms (direct subsidy, low income subsidy, reinsurance, and risk corridors)

- Minimal administrative burden on CMS, plans and other entities including pharmacy benefit managers, pharmacies and others

- Legislative authority

- Data validity and reliability

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Part D plans must, as a condition of payment, submit data and information necessary for CMS to carry out these four payment provisions. CMS will use the PDE data to reconcile low income cost-sharing subsidy and reinsurance payments and to implement risk sharing.

1.2   Risk Adjustment Model (Slides 11-13)

1.2.1 Overview

Risk adjustment is a statistical method that predicts cost based on an individual's health status and demographic characteristics. The MMA requires that CMS adjust the direct subsidy for the health status of the beneficiary. Under risk adjustment, a plan receives a relatively higher payment for a beneficiary with one or more diagnoses that predict higher drug costs than for a similar beneficiary without such diagnoses.

In 2006 CMS will use the RxHCC model to calculate Part D risk scores to adjust the Direct Subsidy payment.

  Because Part D is a new program, researchers used alternate data sources to simulate Part D utilization as discussed in the 45 Day Advance Notice of Methodological Change and Final Payment Notice. See http://www.cms.hhs.gov/healthplans/rates/2006

  The RxHCC model is very similar to other models CMS uses to risk adjust payments to Medical Advantage plans. The underlying principles of these medical cost risk adjustment models may be found in the research paper *Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report); December 2000*. See http://www.cms.hhs.gov/healthplans/research/dcg.pdf

The RxHCC model has good predictive power, which is comparable to other models for drugs that have been reported.

1.2.2 RxHCC Model (Slide 14)

The RxHCC model uses an individual's demographic and disease information collected in a base year to predict the drug costs for that individual in the next year.

- The drug risk adjustment model explains approximately 23 percent of the variation in drug costs. That is, the R^2 of the Rx-HHC is 0.23. The R^2 measures of "goodness of fit" and explains how well a model uses data to make predictions.

Demographic data includes age, sex and originally disabled status.

  Individuals under the age of 65 who are entitled to Medicare are defined as being "originally disabled."

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Disease data consists of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes submitted either through Fee-for-Service claims for inpatient and outpatient hospitals settings and physician settings or the Risk Adjustment Processing System (RAPS). (Medicare Advantage plans submit diagnosis encounter records).

1.2.2.1   Condition Codes (Slide 15)

The RxHCC model categorizes diagnosis codes into separate groups of clinically related codes with similar cost implications, e.g., diabetes, cancer, ischemic heart disease, infections, etc. The model groups 3,562 diagnosis codes into 84 categories.

The RxHCC model is hierarchical. The model has multiple categories for several diseases, like diabetes. When beneficiary diagnoses fall into two or more of these categories, the model assigns the risk factor associated with the category for the most severe manifestation of the disease.

⊠   **Example: 1**

Two diabetes codes are on file for a sample beneficiary, Mrs. Taft this year.

> 250.00, Diabetes without mention of complication, unspecified
> 250.70, Diabetes with peripheral circulatory disorders, unspecified
> Code 250.00 is in RxHCC18 which has a relative weight of 0.190
> Code 250.70 is in RxHCC17 which has a relative weight of 0.258
> The higher weight of 0.258 is added to Mrs. Taft's' risk calculation.

1.2.2.2   Base Year Diseases Predict Payment Year Costs

The RxHCC model analyzes the relationships between demographics and condition categories for an individual in the base year and the individual's expected drug costs to the plan for the drug benefit in the next year. Based on these relationships RxHCC assigns factors to each demographic and condition category. Table 1C provides examples of condition codes and relative weights.

TABLE 1C - EXAMPLES OF CONDITION CODES AND RELATIVE WEIGHTS

RxHCC GROUPS	RxHCC LABELS	RELATIVE WEIGHT
RxHCC17	Diabetes with Complications	0.258
RxHCC18	Diabetes without Complications	0.190
RxHCC91	Congestive Heart Failure	0.257
RxHCC102	Cerebral Hemorrhage and Effects of Stroke	0.063
RxHCC106	Vascular Disease	0.035

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

1.2.2.3   Interactions

The RxHCC model also includes interactions, which are combinations of conditions or characteristics that, in combination, predict additional cost. In the RxHCC model there are only three interactions. Those interactions occur between disabled status and certain conditions, including:

- Schizophrenia (RxHCC 65)
- Other Major Psychiatric Disorders (RxHCC 66)
- Cystic Fibrosis (RxHCC 108)

Table 1D provides the relative weights for the RxHCC interactions.

TABLE 1D - RXHCC INTERACTIONS

RxHCC GROUPS	RxHCC LABELS	RELATIVE WEIGHT
RxHCC65	Disabled and Schizophrenia	0.375
RxHCC66	Disabled and Other Major Psychiatric Disorders	0.165
RxHCC108	Disabled and Cystic Fibrosis	0.897

1.2.2.4   Low Income Cost-Sharing and Institutionalized Beneficiaries (Slides 17-18)

The RxHCC model takes Part D's low income cost-sharing subsidy into account by providing higher payments for low income subsidy eligible beneficiaries (LIS).

The model projects higher overall spending for long term institutionalized (LTI) beneficiaries, primarily because CMS expects that the prices for the specific packages of drugs they receive are somewhat higher in the institution than the same drugs in the community.

☞   LTI status is defined as a beneficiary who resides in an institution for more than 90 days as reported by the Minimum Data Set (MDS).

For any beneficiary, either an LIS or LTI factor may be applied. That is, a beneficiary can be either LTI or LIS but the beneficiary cannot be both for purposes of risk adjustment. There is an important distinction between the demographic and disease factors and the LIS and LTI factors. The demographic and disease factors are additive; the LTI and LIS factors are multipliers. The LTI or LIS factor, if applicable, is applied after the demographic and disease factors are summed. Table 1E provides the LTI and LIS factors:

TABLE 1E – LTI AND LIS FACTORS

LONG TERM INSTITUTIONAL		LOW INCOME	
Aged ≥ 65	Disabled < 65	Group 1 – Full subsidy eligible	Group 2 – Partial subsidy eligible (15%)
1.08	1.21	1.08	1.05

1.2.2.5   Systems Reporting LIS and LTI Status

LIS is a concurrent adjustment that is reported monthly in the payment system. When retroactive LIS status changes occur, risk adjusted payments for the impacted months is adjusted to reflect the new status information.

According to payment policy, LTI status can change each month. However, LTI status will not change monthly for purposes of making initial payments during the payment year. For initial monthly payments during the payment year, LTI is applied based on one LTI status that will be used for every month. This initial LTI status is assigned prior to the payment year. CMS may elect to update that status during the year, and the updated status will also be assigned for every month in the year. Month by month variation in LTI is available only upon final reconciliation.

1.2.2.6   Plan Liability Model

Finally, the RxHCC is a Plan liability model that takes into account the plan liability for spending after deductibles and other cost sharing the Standard Part D benefit.

- Researchers also developed a risk model for total drug spending that does not account for cost sharing. The spending model is predictive of total expenditures on prescription drugs covered by Part D. For additional information about both the Plan liability model and the spending model see the Final Payment Notice at http://www.cms.hhs.gov/healthplans/rates/2006

1.2.3   Implementation of the RxHCC Model

In 2006, CMS will use the RxHCC model to calculate risk factors for all Medicare-eligible beneficiaries. CMS will use demographic and diagnosis data from 2005 for beneficiaries with 12 months of either Part A

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

or Part B during the data collection period. For beneficiaries with less than 12 months of either Part A or Part B, CMS will calculate the risk factor using demographic data only.

1.2.3.1 Factor Calculation – Data Collection Periods

CMS calculates risk factors three times: at the beginning of the year, at mid-year and at final reconciliation. For the first factor, there is a built-in six-month lag between the end of the data collection period and the start of the payment year. This lag needs to occur to allow collection, submission, and processing of the data. At mid-year, the data collection period is shifted forward by six months to include the most recent diagnosis data available. This is the final data collection period for the payment year and the one that is used for final reconciliation. The main difference between the mid-year factors and those used for final reconciliation is the additional data. In the final reconciliation, CMS also has more complete information regarding low income and LTI status.

1.2.3.2 Risk Factor Examples

⊠ **Example: 2**

New Enrollee Example

Mrs. Washington enrolled in a Part D plan on March 6, 2006 when she became 65. Mrs. Washington is a new enrollee. Her risk factor is 0.459.

New enrollees do not have 12 months of diagnosis data on file with Medicare. RxHCC assigns a demographic factor only to new enrollees.

⊠   **Example**: 3

Continuing Enrollee

Mrs. Taft is a 76-year old female with diabetes, high cholesterol, congestive heart failure and osteoporosis. RxHCC will calculate her risk factor as follows.

RxHCC FACTOR	RxHCC LABELS	RELATIVE WEIGHT
Female 80-85		0.416
RxHCC21	Other Specified Endocrine/Metabolic/ Nutritional Disorders	0.049
RxHCC31	Chronic Pancreatic Disease	0.048
RxHCC45	Disorders of the Vertebrae and Spinal Discs	0.141
RxHCC47	Osteoporosis and Vertebral Fractures	0.115
RxHCC66	Other Major Psychiatric Disorders	0.158
RxHCC79	Polyneuropathy, except Diabetic	0.077
RxHCC87	Other Neurological Conditions/Injuries	0.031
RxHCC91	Congestive Heart Failure	0.251
RxHCC92	Acute Myocardial Infarction and Unstable Angina	0.140
RxHCC102	Cerebral Hemorrhage and Effects of Stroke	0.063
RxHCC106	Pulmonary Embolism and Deep Vein Thrombosis	0.035
RxHCC109	Asthma and COPD	0.163
RxHCC134	Chronic Renal Failure	0.074
Beneficiary Risk Factor		1.761

⊠   **Example**: 4

LIS

Mrs. Taft, the beneficiary in Example 3, is enrolled for the full year in a PACE dual eligible plan. She qualifies as a Group 1 – full subsidy eligible individual. The LIS factor of 1.08 is included in the risk score calculation.

Beneficiary Risk Factor for Demographic and Disease Conditions	1.761
LIS Multiplier	1.08
Final Beneficiary Risk Factor	1.902

1.2.4 Special Provisions for PACE Payment

1.2.4.1   Premium Methodology Applicable to Dual Eligible Plans (Slide 19)

PACE organizations cannot impose premiums on any Medicaid eligible enrollee. Dual eligible PACE participants are not responsible for Part D premium payments. Like low income eligible enrollees in any Part D plan, dual eligible enrollees in PACE organizations receive 100 percent premium assistance for the portion of the basic premium below the low income benchmark. If a PACE organization's bid exceeds the low income benchmark, premiums that would otherwise be incurred due to the bid are accounted for as an additional capitated payment. This capitated payment will be based on information that the PACE organization reported in its approved bid.

The PACE Medicare plan is an enhanced alternative plan. It has both a basic premium for the basic portion of the benefit and a supplemental premium for the supplemental portion of the benefit. These enrollees receive no assistance for the supplemental portion of the benefit. Since enrollees in the Medicare only plan are not dual eligible they do not automatically receive assistance for the basic portion of their premium. However, they may qualify for sliding scale premium subsidy assistance for the basic premium. This sliding scale premium assistance is available to any qualifying beneficiary in any Part D plan. To qualify, these individuals have:

- Income at or above 135 percent Federal Poverty Level (FPL) but below 150% FPL **and**
- Assets that do not exceed $10,000 for an individual or $20,000 for a couple.)

There is a full discussion of the PACE premium subsidy in the 45 Day Advance Notice of Methodological Change and Final Payment Notice. See http://www.cms.hhs.gov/healthplans/rates/2006

1.2.4.2   Payment Methodology Applicable to Dual Eligible PACE Enrollees (Slide 20)

By law, dual eligible PACE enrollees have no co-payment responsibility. In recognition of this PACE prohibition on beneficiary co-payments, the government makes a monthly capitated payment to the plan for the nominal low income co-payments that the plan would otherwise receive from the beneficiary. For cost allocation purposes, the government considers this nominal beneficiary liability to be 2 percent of all covered drug costs below the OOP threshold. Plans account for this 2 percent capitated payment in their bids. Like any other non-administrative cost in the basic bid, the 2 percent monthly capitated payment is subject to risk sharing.

1.2.4.3 Payment Methodology Applicable to Medicare Only PACE Enrollees (Slide 21)

Enrollees in Medicare only PACE plans receive no low income cost-sharing (LICS) subsidy. They are also prohibited from paying any cost-sharing. As a result, these beneficiaries never accumulate TrOOP and never enter the Catastrophic Coverage phase of the benefit.

1.2.4.4 Data to Support Payment Calculations

To support payment calculations, PACE plans must report detailed drug costs for their beneficiaries. However, PACE plans do not report payment breakdowns of these costs since the plan is paying 100 percent of the costs. The government arrays each beneficiary's costs into the standard benefit categories (see Module 2).

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MODULE 2 – PACE PAYMENT CALCULATIONS

PURPOSE (Slide 2)

Explain Program of All-Inclusive Care for the Elderly (PACE) calculations and review reconciliation so plans understand the statutorily established payment methodologies and the financial data needed to support Part D payments.

Learning Objectives (Slide 3)

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

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

ICON KEY	
Definition	ᏗᏊ
Example	⊠
Reminder	🔵
Resource	📖

2.1   PACE Cost Allocation

Like all plans, PACE Organizations report actual costs on Prescription Drug Events (PDEs). However, since PACE organizations pay 100 percent of the cost, they report payment as a single amount on each PDE. Amounts for covered Part D drugs and non-covered drugs are reported separately. All other plans break down payments into component amounts generally based on patient liability (differentiating amounts that are included in True Out-of-Pocket (TrOOP) and plan liability based on covered and non-covered amounts. Other plans also report information described as Gross Drug Cost Below the Out-of-Pocket (OOP) Threshold (GDCB) and Gross Drug Cost Above the OOP Threshold (GDCA), which explain the beneficiary's position in the benefit. CMS aggregates the amounts reported on individual PDEs to beneficiary/plan level and plan level totals. The plan total amounts are used in payment calculations.

These payment breakdowns have been waived for PACE PDE reporting. However, some of the detail payment information waived for PACE reporting is essential for payment calculations. To support payment, DDPS will calculate the amounts needed for payment on behalf of the PACE plan. Instead of summing these payment amounts from individual PDEs for covered drugs, Drug Data Processing System (DDPS) will break down the total payment for covered drugs for each beneficiary into detail payment amounts. Finally DDPS will create a plan level total for final payment calculations by summing the beneficiary/plan level amounts. Using the allocation method, CMS arrives at PACE plan totals without requiring detail payment information on PDEs.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The allocation is a two-step process.

1. The allocation will first use year-to-date covered drug cost (called Reported Covered Plan Paid Amount, or Reported CPP) and accumulated TrOOP to determine the beneficiary's position as if the individual been enrolled in the defined standard benefit.

2. Then, using business rules that apply uniquely to PACE, the allocation distributes the beneficiary's total payment amounts within each benefit phase to four financial categories reported on PDEs.

    Low Income Cost Sharing Subsidy Amount (LICS) (applies to dual eligible PACE plans only): LICS is the amount the plan would have paid on behalf of the low income beneficiary at point-of-sale (pos). The LICS is the difference between the cost sharing paid by a non low-income beneficiary in the plan ad the nominal amount of low income cost- sharing. Since dual eligible PACE enrollees do not pay cost-sharing, the allocation method determines the LICS amount that would apply to a low income beneficiary enrolled in the defined standard benefit.

    Covered D Plan Paid Amount (CPP) (applies to both dual eligible PACE plans and Medicare only PACE plans): CPP is the plan paid amount that would be covered in the standard benefit.

    Non-covered Plan Paid Amount (NPP) (applies to Medicare only PACE plans): NPP is the net amount paid by the plan for benefits beyond the standard benefit. The amount recorded in NPP is excluded form risk corridor payments.

    Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA) (applies to dual eligible PACE plans only): GDCA is the gross drug cost (Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax) paid to the pharmacy after the beneficiary has reached the OOP threshold. GDCA is used to calculate allowable reinsurance cost.

*   Reported Covered D Plan Paid Amounts submitted by dual eligible PACE plans are allocated to LICS, GDCB, GDCA and calculated CPP.

*   Reported Covered D Plan Paid Amounts submitted by Medicare only PACE plans are allocated to GDCB, GDCA, calculated CPP and NPP.

Plan level summaries of LICS, CPP and GDCA, in addition to total covered drug cost are used in payment calculations.

2.1.1 Determine Beneficiary's Position in the Benefit

Year- to- date covered drug cost determines if the beneficiary is in the deductible, the initial coverage period or the coverage gap. Year –to- date TrOOP determines if the beneficiary is in the catastrophic phase of the benefit.

Aspen Systems Corporation

2-2

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

In both dual eligible and Medicare only plans:

- The first $250 of covered drug cost will be considered the deductible.
- The next $2,000 of covered drug cost will be considered the initial coverage period.
- The next $2,850 of covered drug cost will be considered the coverage gap.

For Medicare only plans all covered drug cost above $5,100 will be considered defined standard catastrophic coverage. Risk sharing provisions in the catastrophic phase of the defined standard benefit apply. Medicare only PACE plans receive the same risk sharing provisions as any other defined standard plan for all covered drug cost above $5,100.

Reinsurance subsidy does not apply to Medicare only PACE plans.

For dual eligible plans only, the next $104 covered drug cost, when covered drug cost is above $5,100 and at or below $5,204, will be considered defined standard catastrophic coverage. In addition to the defined standard benefit risk sharing provisions, dual eligible PACE plans also risk share on the 2 percent capitation payment.

For dual eligible plans only, covered drug cost above $5,204 will be considered PACE catastrophic coverage in which the reinsurance subsidy applies. DDPS uses GDCA to identify costs eligible for the reinsurance subsidy.

2.1.2 PACE Specific Allocation Percentages

After determining the beneficiary's position in the benefit, the payment amounts are allocated using business rules specific to each PACE plan type. The major differences between the two types of PACE plans are 1.) LICS along with the 2 percent capitation and 2.) the reinsurance subsidy.

LICS and the 2 percent Capitation: Only dual eligible plans are eligible for LICS and the 2 percent capitation. The amounts that would otherwise be allocated to LICS and the 2 percent capitation in the dual eligible plan are allocated to NPP in the Medicare only plan.

Reinsurance Subsidy: The reinsurance subsidy only applies to dual eligible plans because LICS applies in these plans only. Medicare only beneficiaries never receive LICS; in turn they never accumulate TrOOP and never to enter the catastrophic phase of the benefit where reinsurance applies.

2.1.2.1 Dual Eligible PACE Specific Allocation Percentages (Slides 5-6)

Table 2A displays the allocation percentages by benefit phase for Dual Eligible PACE plans.

**TABLE 2A – ALLOCATION RULES: PAYMENT FOR COVERED PART D DRUGS
DUAL ELIGIBLE PLANS**

YTD TOTAL COVERED DRUG COST	LICS	2% CAPITATION	CPP	CPP PORTION ELIGIBLE FOR REINSURANCE (GDCA)	NPP
≤ $250	98%	2%	2%**	0%	0%
> $250 and ≤ $2,250	23%	2%	77%**	0%	0%
> $2,250 and ≤ $5,100	98%	2%	0%	0%	0%
> $5,100 and ≤ $5,204	83%	2%	17%**	0%	0%
> $5,204*	5%	n/a	95%	80%	0%

*   In 2006 $5,204 in Total Covered Drug Cost in PACE dual eligible plans corresponds to the OOP Threshold
** Includes 2% capitation

2.1.2.2   Medicare Only PACE Specific Allocation Percentages (Slide 7)

Table 2B displays the allocation percentages by benefit phase for Medicare Only plans.

**TABLE 2B – ALLOCATION RULES: PAYMENT FOR COVERED PART D DRUGS
MEDICARE ONLY PLANS**

YTD TOTAL COVERED DRUG COST	CPP	CPP PORTION ELIGIBLE FOR REINSURANCE (GDCA)	NPP
≤ $250	0%	0%	100%
> $250 and ≤ $2,250	75%	0%	25%
> $2,250 and ≤ $5,100	0%	0%	100%
> $5,100	15%	0%	85%

* 2006, $5,100 in Total Covered Drug Cost in Medicare only plans corresponds to the OOP Threshold.

⊠   **Example: 1**

Example 1 shows how DDPS use the allocation steps to array cumulative beneficiary costs into the standard benefit for payment reconciliation. The example shows the allocation for a beneficiary with $6,000 year-to-date covered drug cost in both a dual eligible plan and a Medicare only plan.

Table 2C illustrates the calculations CMS will perform to array beneficiary costs into standard benefit categories for payment reconciliation.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PACE PAYMENT CALCULATIONS

TABLE 2C – CALCULATIONS FOR ARRAYING BENEFICIARY COSTS

		Dual Eligible PACE Program The Dual Eligible PACE Program has submitted PDEs for Beneficiary A for Covered Part D drugs that total $6,000				Medicare PACE Program The Medicare PACE Program has submitted PDEs for Beneficiary B for Covered Part D drugs that total $6,000			
Standard Benefit Category	Total Covered Drug Cost	LICS	CPP	Portion of CPP eligible for Reinsurance	NPP	Standard Benefit Category	Total Covered Drug Cost	CPP	NPP
Deductible	The first $250	$245 (.98*250)	$5 (.02 * 250)	$0	$0	Deductible	The first $250	$0	$250
Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$460 (.23*2000)	$1,540 (.02 * 2000) + (.75 * 2000)	$0	$0	Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$1500	$500
Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$2,793 (.98*2850)	$57 (.02*2850)	$0	$0	Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$0	$2,850
Defined Standard Catastrophic Coverage	The next $104 > $5,100 and ≤ $5,204†	$86.32 (.83 * 104)	$17.68 (.15 * 104) + (.02 * 104)	$0	$0	Defined Standard Catastrophic Coverage	The remaining $900 > $5,100	$135	$765
PACE Catastrophic Coverage (Reinsurance)	The remaining $796 > $5,204† and ≤ $6,000	$39.80 (.05*796)	$756.20 (.15 * 796) + (.80 * 796)	$796	$0				
Total	$6,000	$3,624.12	$2,375.88	$796	$0			$1,635	$4,365

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

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.2   General Summary of Reconciliation (Slide 8)

Throughout the benefit year, the government makes prospective payments to plans that cover three subsidies: the direct subsidy, the LICS subsidy and the reinsurance subsidy. These payment amounts are based on information in the approved standard bid and data provided by CMS that update payments throughout the year. For PACE organizations these data include enrollment dates, long-term institutional status and risk adjustment factors. Enrollment dates will change throughout the year, and retroactive changes may even occur after the payment year ends. Those updates will result in monthly adjustments to prior payments. There is a final update of long-term institutional status and risk adjustment factors before reconciliation begins. During reconciliation, CMS sums the finalized prospective payments and the corresponding actual costs reported in PDEs and pay the plan according to the rules for each payment.

2.2.1 Payment Timetable and Reconciliation Status (Slides 9-12)

Table 2D displays the four payment types and shows if the payment is prospective and subject to reconciliation.

TABLE 2D – FOUR PAYMENT MECHANISMS

PAYMENT MECHANISM	APPLIES TO DUAL ELIGIBLE PLANS	APPLIES TO MEDICARE ONLY PLANS	PAYMENT SCHEDULE	RECONCILIATION
Direct Subsidy	Yes	Yes	Monthly Prospective Payments	Yes-recalculate Risk Adjustment Factors
Low Income Cost-sharing Subsidy*	Yes	No	Monthly Prospective Payments	Yes
Reinsurance Subsidy	Yes	No	Monthly Prospective Payments	Yes
Risk sharing	Yes	Yes	Reconciliation Payment	Yes

*Low income eligible beneficiaries also receive premium assistance which is paid and reported separately.

2.3   Direct Subsidy (Slide 13)

The direct subsidy is a capitated payment that, along with the basic beneficiary premium (irregardless of funding source), is an estimate of the revenue requirements needed to provide basic benefits as well as covered administrative expenses and profit levels in the approved bid. The estimate is adjusted for the individual risk characteristics of each beneficiary enrolled in the plan.

The direct subsidy will be used to calculate risk sharing during payment reconciliation. If all assumptions are realized, the plan's bid pricing tool would accurately predict revenue requirements. Neither CMS nor the plan would need risk sharing to mitigate the impact of over-estimates or under-estimates.

Aspen Systems Corporation

2-6
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.3.1 Timing of Payment – Monthly

Plans receive prospective payments each month. After year-end these prospective payments are used in risk sharing calculations based on actual plan paid amounts calculated from PDE data s for the basic benefit.

2.3.2 Calculate Monthly Direct Subsidy

In its most basic form the direct subsidy is the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment factor, minus the monthly beneficiary premium for basic coverage. In its most basic form the calculation is:

DS = STAND_BID * RAF – BENE_PREM

Where
DS = Direct subsidy
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RAF = Beneficiary's health status risk adjustment factor
BENE_PREM = Monthly beneficiary premium for basic coverage

⊠ **Example: 2**

Direct Subsidy for Mrs. Taft

Mrs. Taft enrolls in Happy Health Plan. Happy Health Plan's standardized bid amount is $100.00 and the beneficiary premium is $35.00. CMS uses the risk factor of 1.902 from Example 4 in Module 1 to calculate that the direct subsidy that Happy Health Plan will receive for Mrs. Taft is $155.20. The calculation is:

Direct Subsidy = $100.00 * 1.902 - $35
Direct Subsidy = $155.20

The monthly plan-level direct subsidy is the sum of the direct subsidies for each beneficiary enrolled on the first day of the month for a PBP.

CMS will make some adjustments to direct subsidy payments on an ongoing basis (e.g., enrollment changes).

2.4 Low Income Cost-Sharing Subsidy– Dual Eligible Plans Only (Slide x)

Medicare subsidizes the cost-sharing liability of qualifying low income beneficiaries for covered Part D drugs and pays the plan an additional 2 percent capitated amount for the nominal cost sharing that low income beneficiaries pay themselves. Plans risk share on the 2 percent capitated amount. Plans receive the Low Income Cost-Sharing Subsidy for calculated LICS amount. Each month CMS pays plans

Aspen Systems Corporation

2-7
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

prospectively for LICS amounts based on plan projections in the approved bid. CMS reconciles to the actual amounts as calculated after the payment year-ends.

2.4.1 Timing of Payment

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

2.4.2 Data Reported on Individual PDEs

On each PDE the plan reports the actual payment amount for the event. DDPS allocates the appropriate LICS amount for the dispensing event in the LICS field which is described as actual LICS dollars.

2.4.3 LICS Calculation/Reconciliation

2.4.3.1 Monthly Prospective Low Income Cost-Sharing Subsidy

The prospective payment for the low income cost-sharing subsidy is based on the low income estimate (p(LI)mpm) in the plan's approved bid and enrollment counts documented in the Medicare Beneficiary Database (MBD). The plan receives this amount for each low income beneficiary enrolled in the plan as of the first day of the payment month. The calculation is:

PLICS = BLICS * LI_ENR

Where
PLICS = Monthly prospective low income cost-sharing subsidy
BLICS = Low income estimate in the approved bid (See Plan Bid Pricing Tool)
LI_ENR = Number of low income beneficiaries enrolled in the month

---

2.4.3.2 LICS Reconciliation for PACE

During reconciliation, CMS subtracts the total prospective low income cost-sharing subsidy payments from the actual LICS dollars reported on PDES. The calculation is:

RLICS = ALICS - PLICS

Where
RLICS = LICS reconciliation amount CMS –calculated
ALICS = Sum of low income cost-sharing dollars in the coverage year
PLICS = Sum of all Prospective Low income Cost-sharing Subsidy payments (includes any adjusted payments) in the coverage year

---

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PACE organizations are paid dollar for dollar for the calculated LICS. If the LICS reconciliation amount is positive, plans will receive payment in full for the LICS reconciliation amount. If the LICS reconciliation amount is negative, plans will repay in full the LICS reconciliation amount.

2.5 Reinsurance Subsidy - Dual Eligible Plans Only (Slide x)

Reinsurance reduces the risk of participating in Part D. The federal government subsidizes 80 percent of covered Part D costs actually paid by the plan in the catastrophic phase of the benefit, after DIR has been subtracted. The beneficiary enters the catastrophic phase of the benefit after accumulating $3,600 in TROOP. The $3,600 limit applies to 2006 and is subject to annual increases.

2.5.1 DIR

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

DIR will also include any retroactive payments or re-payments that plans make as part of capitated arrangements with providers.

Within six months of year-end, plans must submit amounts to CMS in the following three categories:

- DIR for Non-Part D Covered drugs
- DIR for Covered Part D drugs
- Total DIR

DIR reporting requirements will be released in separate guidance. The information stream is separate from PDE reporting and from Part D reporting requirements for Pharmaceutical Manufacturer Rebates, Discounts and Other Price Concessions.

2.5.2 Prospective Reinsurance Subsidy

Plans receive prospective payments each month. After year-end, prospective payments are reconciled to reported reinsurance costs.

Prospective Payment – The prospective payment for the reinsurance subsidy is based on the reinsurance per member per month (pmpm) estimate in the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month. The calculation is:

PROSP_REINS = BID_REINS * ENR

Where
PROSP_REINS = Monthly prospective reinsurance subsidy
BID_REINS = Reinsurance pmpm estimate in the approved bid (See Plan Bid Pricing Tool)
ENR = Number of beneficiaries enrolled in the month

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.5.3 Unadjusted Reinsurance Costs

Reinsurance costs are those costs for Covered Part D drugs for beneficiaries in the catastrophic phase of the benefit. Prior to adjustment for DIR, CMS describes these costs as unadjusted reinsurance costs. For any Part D covered drug, DDPS calculates gross drug costs above and below the OOP threshold. Unadjusted reinsurance costs will be the sum of the calculated GDCA, which includes both amounts paid by the plan and amounts paid by the beneficiary.

2.5.4 Reinsurance Subsidy Calculation

There is a five-step process to calculate and reconcile the Reinsurance Subsidy. The reinsurance subsidy is a plan level payment based on aggregated beneficiary level catastrophic coverage data.

2.5.4.1   Calculate DIR Ratio

For all Part D covered drugs, CMS allocates costs into plans report GDCA and GDCB. The DIR ratio is determined by dividing the GDCA by the total GDCB using the following formula:

$$DIR\_RATIO = GDCA / (GDCA + GDCB)$$

Where
GDCA = Gross drug cost above the OOP threshold
GDCB = Gross drug cost below the OOP threshold

2.5.4.2   Calculate Reinsurance Portion of DIR

To calculate Allowable Reinsurance Costs, CMS must exclude the reinsurance portion of DIR. The calculation to determine the reinsurance portion of DIR is:

$$REINS\_DIR = DIR\_RATIO * DDIR$$

Where
REINS_DIR = Reinsurance portion of DIR
DDIR = DIR for Covered Part D drugs

2.5.4.3   Calculate Allowable Reinsurance Costs

To derive Allowable Reinsurance Costs, CMS subtracts the reinsurance portion of DIR. The calculation is:

$$ALLOW\_REINS = GDCA - REINS\_DIR$$

Where
ALLOW_REINS = Allowable Reinsurance Costs
GDCA = Gross Drug Costs Above the Out-of-Pocket Threshold
REINS_DIR = Reinsurance Portion of DIR

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.5.4.4 Calculate Plan-Level Reinsurance Subsidy

The reinsurance subsidy is 80 percent of Allowable Reinsurance Costs. The calculation is:

REINS_SUBS = ALLOW_REINS * .8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

2.5.5 Reconcile Reinsurance Subsidy

The calculation to determine the reconciliation amount is:

REINS_RECON = REINS_SUBS − PROSP_REINS

Where
REINS_RECON = Reinsurance Reconciliation Amount
REINS_SUBS = Reinsurance Subsidy
PROSP_REINS = Sum of Prospective Monthly Reinsurance Subsidy

If the Reinsurance Reconciliation Amount is positive, the actual amount incurred exceeded the amount paid prospectively and the plan is entitled to additional payments. The plan will receive payment in full for the Reinsurance Reconciliation Amount. If the Reinsurance Reconciliation Amount is negative, the actual amount incurred was less than the amount paid prospectively. The Plan will repay in full the Reinsurance Reconciliation Amount.

2.6 Risk Sharing (Slide 16)

2.6.1 Definition

Risk corridors are designed to minimize unexpected gains or losses to the plan not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits and losses resulting from expenses for the standard benefit within defined symmetrical risk corridors around a target amount.

2.6.2 Timing of Payment

Risk Sharing is a single annual payment computed after year-end.

Aspen Systems Corporation

2-11
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.6.3 Calculating Unadjusted Risk Corridor Costs

Unadjusted Risk Corridor Costs are plan paid costs for Covered Part D drugs in all phases of the benefit in which the plan has liability under the standard benefit. DDPS calculates Covered Part D Plan Paid Amounts (CPP). CMS calculates CPP at a plan level to determine Unadjusted Risk Corridor Costs.

2.6.4 Calculate Risk Sharing

There is a four-step process to calculate risk sharing.

- Calculate the Plan's Target Amount
- Calculate Risk Corridor Thresholds
- Calculate adjusted allowable risk corridor costs (AARCC)
- Determine where costs fall with respect to the thresholds and calculate payment adjustment

2.6.5 Calculate the Plan's Target Amount (Slide 17)

In summary, the target amount is the total projected revenue necessary for the basic benefit reduced for administrative costs. Projected revenue has a CMS paid component and a beneficiary paid component. To fully account for this combined total, CMS sums the:

- Direct subsidy which is the CMS paid component

- Beneficiary revenue which is the basic Part D premium (including if paid by government under low income premium subsidy)

- A/B rebate for the basic Part D premium paid to MA plans.

CMS also excludes administrative costs by first calculating an administrative cost ratio. The administrative cost ratio is calculated as follows from bid data:

AC_RATIO = (NON_PHARM + GAIN_LOSS) / BASIC_BID

Where
AC_RATIO = Administrative Cost Ratio
NON_PHARM = Non-Pharmacy Expense *
GAIN_LOSS = Gain/(Loss)*
BASIC_BID = Total Basic Bid*
*See Plan Bid Pricing Tool

Aspen Systems Corporation

2-12
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The direct subsidy, beneficiary premiums and any A/B rebates applied to the basic benefit are added together to develop a preliminary target amount. Then, CMS removes administrative costs to develop a final target amount. The calculations are:

Dual Eligible Plans
PRELIM_TARGET = DS + BENE_PREM_PAY + ADD_CAP_PMT

Where
PRELIM_TARGET = Target amount before administrative cost adjustment
DS = Total direct subsidy
BENE_PREM_PAY = Total basic beneficiary premiums for payment purposes
ADD_CAP_PMT = Additional capitated payment

Medicare Only Plans
PRELIM_TARGET = DS + BENE_PREM_PAY

Where
PRELIM_TARGET = Target amount before administrative cost adjustment
DS = Total direct subsidy
BENE_PREM_PAY = Total basic beneficiary premiums for payment purposes

TARGET= PRELIM_TARGET * (1.00 − AC_RATIO)

Where
TARGET = Target amount
PRELIM_TARGET = Target amount before administrative cost adjustment
AC_RATIO = Administrative cost ratio

Note that risk factors are calculated three times a year: initial calculation, mid-year correction, and final at year-end. The direct subsidy as used in this calculation will reflect all retroactive adjustments made based on changes in enrollment, relevant status (long-term institutionalized), and final risk adjustment factors, for any month during the payment year.

2.6.6 Calculate Risk Corridor Thresholds

CMS uses the threshold risk percentage in combination with the plan's target amount to calculate plan specific risk corridor thresholds. The first and second upper and lower risk corridor thresholds are calculated based on the target amount plus or minus the threshold risk percentages associated with four symmetrical threshold limits.

In 2006 the threshold risk percentages are:

- Second threshold lower limit   95.0%
- First threshold lower limit   97.5%
- First threshold upper limit   102.5%
- Second threshold upper limit   105.0%

Aspen Systems Corporation

2-13

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PACE PAYMENT CALCULATIONS

The thresholds that will be used in the 2006 risk sharing calculations for a plan with a target amount of $1,000,000 appear below.

Second threshold lower limit = $1,000,000 * 0.95 = $950,000
First threshold lower limit   = $1,000,000 * 0.975 = $975,000
First threshold upper limit   = $1,000,000 * 1.025 = $1,025,000
Second threshold upper limit = $1,000,000 * 1.05 = $1,050,000

Different risk sharing percentages are associated with each risk threshold as shown in Figure 2A.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Figure 2A – Risk Sharing Thresholds and Percentages

Risk Threshold Percentages - 2006

Government Pays 80%	Plan Pays 20%

+ 5%

Government Pays 75%*	Plan Pays 25%*

+ 2.5%

Plan Pays 100%

Target Amount

Plan Keeps 100%

- 2.5%

Plan Pays 75%	Plan Keeps 25%

- 5%

Plan Pays 80%	Plan Keeps 20%
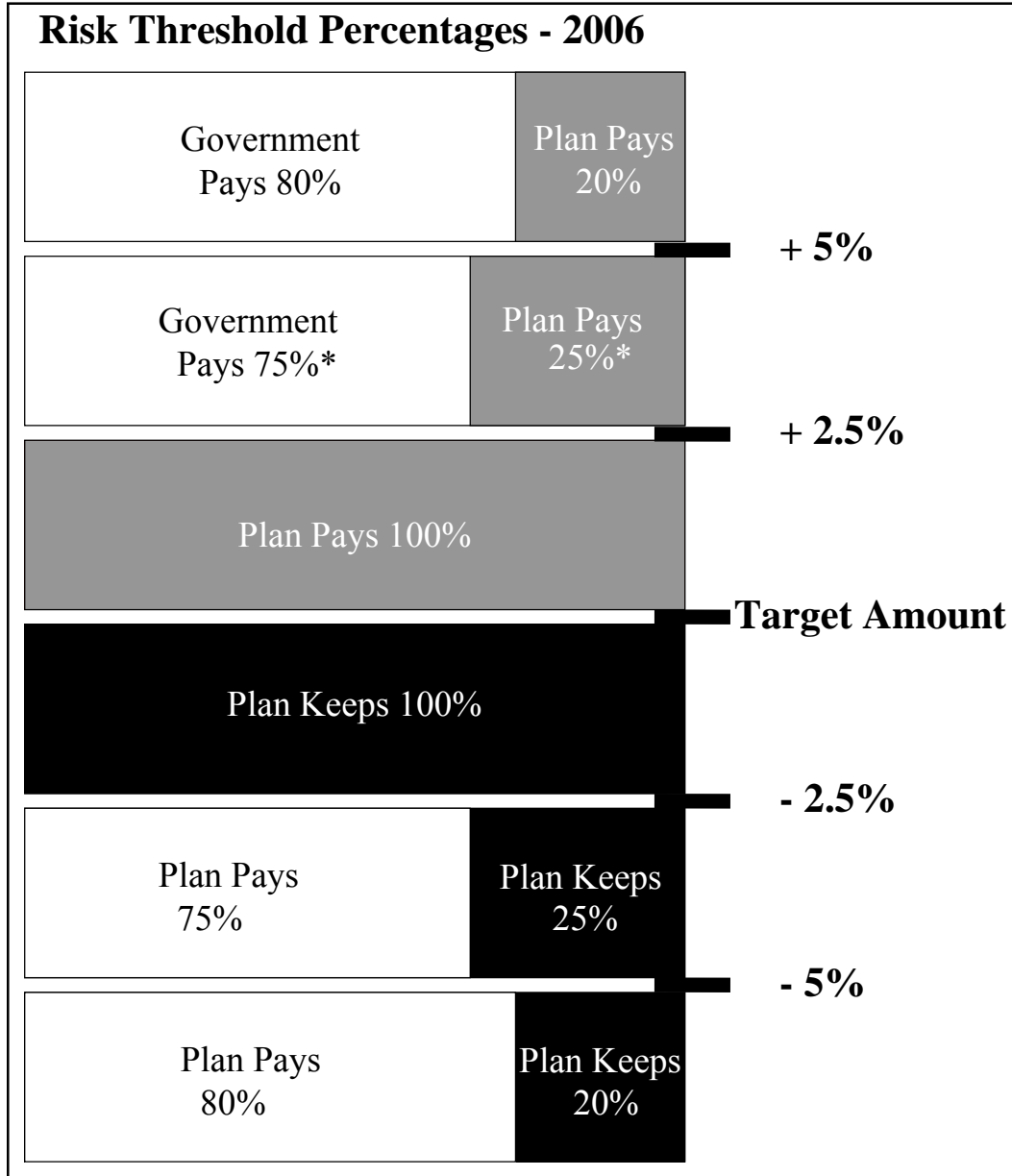
****60/60 Rule** – In 2006 the 75 percent risk sharing for adjusted allowable risk corridor costs between the first and second upper threshold limits will change to 90 percent if the following two conditions have been met:

1. At least 60 percent of Part D plans have adjusted allowable risk corridor costs for the Part D plan for the year that are above 102.5 percent of their target amount

AND

2. Such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA-PD plan

Aspen Systems Corporation

2-15
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

2.6.7 Calculate Adjusted Allowable Risk Corridor Costs (AARCC) (Slide 18)

There are 4 steps to determine adjusted allowable risk corridor costs.

1. Determine unadjusted risk corridor costs. The plan level sum of dollars reported in the calculated CPP field represents the unadjusted allowable risk corridor costs. Remember that the calculated CPP will be less than the PACE reported CPP.

   The costs for risk sharing differ from the costs for reinsurance. Risk sharing costs are CPP costs, both above and below the OOP threshold. Reinsurance costs are total covered drug costs, but only those costs above the OOP threshold (GDCA).

2. For enhanced alternative plans only, reduce unadjusted risk corridor costs by the induced utilization factor plans reported in their bids. This step applies to Medicare only plans.

   Induced Utilization factor: See Plan Bid Pricing Tool

3. Subtract Plan level reinsurance subsidy

4. Subtract Covered Part D DIR

The calculation is:

AARCC = (URCC * (1.00 – IU)) – REINS_SUBS – DDIR

Where
AARCC = Adjusted allowable risk corridor costs
URCC = Unadjusted risk corridor costs
IU = Induced Utilization factor
REINS_SUBS = Reinsurance Subsidy
DDIR = Covered Part D DIR

Induced utilization applies to Medicare only plans; reinsurance subsidy applies to dual eligible plans.

2.6.8 Determine Where Costs Fall With Respect to the Thresholds and Calculate Payment Adjustment (Slide 19)

Risk sharing reduces the impacts of unexpected gains or losses. To the extent that the variation between risk corridor costs and the target amount exceeds certain thresholds, plans receive payments from the government to cover a portion of unexpected losses. To the extent that the variation between risk corridor costs and the target amount falls below certain thresholds, plans share with the government a portion of unexpected gains.

Assume a plan with $1 million target amount. Five scenarios are illustrated.
- AARCC falls within +/- 2.5% of the target amount (i.e., the plan estimate is basically accurate)
- AARCC > 2.5% of the target amount and ≤ 5.0% of the target amount

- AARCC > 5.0% of the target amount
- AARCC < 97.5% of the target amount and ≥ 95% of the target amount
- AARCC < 95% of the target amount

In the following examples assume that the plan's target amount is $1,000,000. See 1.4.5.2 for Threshold limit calculations.

Second threshold lower limit = $1,000,000 * 0.95 = $950,000
First threshold lower limit = $1,000,000 * 0.975 = $975,000
First threshold upper limit = $1,000,000 * 1.025 = $1,025,000
Second threshold upper limit = $1,000,000 * 1.05 = $1,050,000

Example: 3

AARCC > 5.0% of the target amount

AARCC = $1,063,000

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

Example: 4

AARCC > 2.5% of the target amount and ≤ 5.0% of the target amount

AARCC = $1,035,000

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

Example: 5

AARCC falls within +/- 2.5 % of the target amount

In the following examples the plan made accurate predictions in the bid pricing tool.

Example: 6a

AARCC = $978,000

$978,000 falls between the plans 1st lower limit threshold and the target amount.
No payment adjustment is made

Aspen Systems Corporation

2-17
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Example: 6b

AARCC = $1,005,000

$1,005,000 falls between the plan's target amount and the 1st upper limit threshold
No payment adjustment is made

⊠ **Example: 7**

AARCC < 97.5% of the target amount and ≥ 95% of the target amount

AARCC = $973,000

Payment adjustment = 0.75*($975,000-$973,000) = $1,500 (plan pays back to government)

⊠ **Example: 8**

AARCC < 95% of the target amount

AARCC = $945,000

Payment adjustment = [0.75*($975,000-$950,000) + 0.80*($950,000-$945,000)] = $22,750 (plan pays back to government)

Aspen Systems Corporation

2-18
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more
information regarding sources of updated information.

PART D PACE PAYMENT CALCULATIONS

Monthly Direct Subsidy

DS = STAND_BID * RAF – BENE_PREM

Where
DS = Direct subsidy
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RAF = Beneficiary's health status risk adjustment factor
BENE_PREM = Monthly beneficiary premium for basic coverage

Monthly Prospective Low Income Cost-Sharing Subsidy

PLICS = BLICS * LI_ENR

Where
PLICS = Monthly prospective low income cost-sharing subsidy
BLICS = Low income estimate in the approved bid (See Plan Bid Pricing Tool)
LI_ENR = Number of low income beneficiaries enrolled in the month

LICS Reconciliation

RLICS = ALICS - PLICS

Where
RLICS = LICS reconciliation amount
ALICS = Sum of plan-reported actual low income cost-sharing dollars in the coverage year
PLICS = Sum of all Prospective Low income Cost-sharing Subsidy payments (includes any adjusted payments) in the coverage year

Prospective Reinsurance Subsidy

PROSP_REINS = BID_REINS * ENR

Where
PROSP_REINS = Monthly prospective reinsurance subsidy
BID_REINS = Reinsurance pmpm estimate in the approved bid (See Plan Bid Pricing Tool)
ENR = Number of beneficiaries enrolled in the month

Aspen Systems Corporation

1
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

DIR Ratio

DIR_RATIO = GDCA / (GDCA + GDCB)

Where
GDCA = Gross drug cost above the OOP threshold
GDCB = Gross drug cost below the OOP threshold

Reinsurance Portion of DIR

REINS_DIR = DIR_RATIO * DDIR

Where
REINS_DIR = Reinsurance portion of DIR
DDIR = DIR for Covered Part D drugs

Allowable Reinsurance Costs

ALLOW_REINS = GDCA – REINS_DIR

Where
ALLOW_REINS = Allowable Reinsurance Costs
GDCA = Gross Drug Costs Above the Out-of-Pocket Threshold
REINS_DIR = Reinsurance Portion of DIR

Plan-Level Reinsurance Subsidy

REINS_SUBS = ALLOW_REINS * .8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

Aspen Systems Corporation

2
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more
information regarding sources of updated information.

Reconcile Reinsurance Subsidy

REINS_RECON = REINS_SUBS − PROSP_REINS

Where
REINS_RECON = Reinsurance Reconciliation Amount
REINS_SUBS = Reinsurance Subsidy
PROSP_REINS = Sum of Prospective Monthly Reinsurance Subsidy

Plan's Target Amount

Dual Eligible Plans
PRELIM_TARGET = DS + BENE_PREM_PAY + ADD_CAP_PMT

Where
PRELIM_TARGET = Target amount before administrative cost adjustment
DS = Total direct subsidy
BENE_PREM_PAY = Total basic beneficiary premiums for payment purposes
ADD_CAP_PMT = Additional capitated payment

Medicare-Only Plans
PRELIM_TARGET = DS + BENE_PREM_PAY

Where
PRELIM_TARGET = Target amount before administrative cost adjustment
DS = Total direct subsidy
BENE_PREM_PAY = Total basic beneficiary premiums for payment purposes

TARGET= PRELIM_TARGET * (1.00 − AC_RATIO)
Where
TARGET = Target amount
PRELIM_TARGET = Target amount before administrative cost adjustment
AC_RATIO = Administrative cost ratio

Risk Corridor Thresholds

Second threshold lower limit	=	Target Amount * 0.95
First threshold lower limit	=	Target Amount * 0.975
First threshold upper limit	=	Target Amount * 1.025
Second threshold upper limit	=	Target Amount * 1.05

Aspen Systems Corporation

3
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more
information regarding sources of updated information.

Adjusted Allowable Risk Corridor Costs (AARCC)

AARCC = (URCC * (1.00-IU)) – REINS_SUBS – DDIR

Where
AARCC = Adjusted allowable risk corridor costs
URCC = Unadjusted risk corridor costs
IU = Induced Utilization factor
REINS_SUBS = Reinsurance Subsidy
DDIR = Covered Part D DIR

Induced utilization applies to Medicare-only plans; reinsurance subsidy applies to dual-eligible plans.

Aspen Systems Corporation

4
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more
information regarding sources of updated information.

CALCULATIONS FOR ARRAYING BENEFICIARY COSTS

		Dual Eligible PACE Program The Dual Eligible PACE Program has submitted PDEs for Beneficiary A for Covered Part D drugs that total $6,000				Medicare PACE Program The Medicare PACE Program has submitted PDEs for Beneficiary B for Covered Part D drugs that total $6,000			
Standard Benefit Category	Total Covered Drug Cost	LICS	CPP	Portion of CPP eligible for Reinsurance	NPP	Standard Benefit Category	Total Covered Drug Cost	CPP	NPP
Deductible	The first $250	$245 (.98*250)	$5 (.02 * 250)	$0	$0	Deductible	The first $250	$0	$250
Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$460 (.23*2000)	$1,540 (.02 * 2000) + (.75 * 2000)	$0	$0	Initial Cost sharing	The next $2,000 > $250 and ≤ $2,250	$1500	$500
Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$2,793 (.98*2850)	$57 (.02*2850)	$0	$0	Coverage Gap	The next $2,850 > $2,250 and ≤ $5,100	$0	$2,850
Defined Standard Catastrophic Coverage	The next $104 > $5,100 and ≤ $5,204†	$86.32 (.83 * 104)	$17.68 (.15 * 104) + (.02 * 104)	$0	$0	Defined Standard Catastrophic Coverage	The remaining $900 > $5,100	$135	$765
PACE Catastrophic Coverage (Reinsurance)	The remaining $796 > $5,204† and ≤ $6,000	$39.80 (.05*796)	$756.20 (.15 * 796) + (.80 * 796)	$796	$0				
Total	$6,000	$3,624.12	$2,375.88	$796	$0			$1,635	$4,365

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

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MODULE 3 – PDE PROCESS OVERVIEW

Purpose (Slide 2)

The success of Prescription Drug Event data submission is dependent on plans understanding the process of collecting and submitting accurate Prescription Drug Event (PDE) data. The purpose of this module is to present participants with the important terms, key resources, and schedule information that provide a foundation for the Prescription Drug Event Data training.

Learning Objectives (Slide 3)

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

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

ICON KEY	
Definition	ᚙ
Example	⊠
Reminder	🔵
Resource	📖

3.1 Common Prescription Drug Event Data System Terms (Slide 4)

Table 3A provides descriptions for common Prescription Drug Event (PDE) system terminology.

TABLE 3A - PRESCRIPTION DRUG EVENT DATA COMMON SYSTEM TERMS

TERMS	DESCRIPTION
PDFS	Prescription Drug Event data submitters send data to Palmetto through the **Prescription Drug Front-End System**.
DDPS	Prescription Drug Event data are processed by the **Drug Data Processing System**.
HPMS	The **Health Plan Management System** is a CMS information system that contains health plan-level data.
MARx	**Medicare Advantage Prescription Drug System** supports the enrollment and payment functions for MA, capitated payment, and prescription drug plans.
MBD	The **Medicare Beneficiary Database** maintains Medicare beneficiary eligibility and low income cost-sharing subsidy (LICS) data.
DBC	The **Drug Benefit Calculator** calculates beneficiary/plan-level and plan-level LICS, Unadjusted Reinsurance Costs and Unadjusted Risk Corridor costs.
PRS	The **Payment Reconciliation System** calculates final reconciliation payment.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

3.2 PACE Plan Types (Slide 5)

Program of All–Inclusive Care for the Elderly (PACE) organizations may have enrollees that fall into one of two categories for the Part D benefit.

Dual Eligible
Dual eligible enrollees are eligible for both the Medicare and Medicaid benefits and will be enrolled in a plan benefit package that generally maps to the defined standard benefit.

Medicare Only Enrollees
Medicare only enrollees are enrolled in an enhanced alternative (EA) plan in which the purchase order covers all enrollee cost sharing as enhanced alternative cost sharing (EACS).

3.3 Prescription Drug Event Data Process Overview (Slide 6)

The PDE record contains prescription drug cost and payment data that will enable CMS to make payment to plans and otherwise administer the Part D benefit. PDE data is processed through DDPS.

3.3.1 Prescription Drug Event Data (Slide 7)

Plans must submit a PDE record for each dispensing event. CMS expects that the plan will be able to directly link any PDE to the individual claim transaction from which the PDE was extracted and duplicate the summarization.

The 37 data elements required for all PDE records include:
- 15 data elements from the National Council for Prescription Drug Programs (NCPDP) billing transaction.
- 5 data elements from the NCPDP billing response transaction.
- 17 data elements defined by CMS for purposes of administering Part D.

3.3.2 Prescription Drug Event Data Submission (Slide 8)

The DDPS is the information system that collects, validates, and stores PDE data received from plans or their submitters.

PDE records enter DDPS through the PDFS. The PDFS initially performs format and face validity checks. Once the file has passed the front-end checks, it moves through the DDPS where detail level edits are performed and the data are stored.

Plans or third party submitters must submit PDE records electronically to CMS according to the schedule illustrated in Table 3B.

TABLE 3B - TIMELINE FOR 2006 DATA SUBMISSION

DATA TYPE	SUBMISSION TIMELINE
Testing and Certification	November 15, 2005 – January 31, 2006
DDPS Large Volume Testing	December 1, 2005 – December 23, 2005
PDE Production Submissions	January 1, 2006
Subsequent PDE production files for calendar year 2006	Monthly after March 31, 2006 – May 31, 2007

Plans can delay submission until they have finalized the data necessary to populate a PDE, but must submit within the submission deadlines detailed in Table 3B.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

3.3.3 Prescription Drug Event Dataflow (Slide 9)

Figure 3A provides an overview of the PDE dataflow.

- The pharmacy, physician, or other provider submits a claim to the Part D Plan.
  - In some cases, the PACE organization may operate the pharmacy and may not receive a claim. The PDE will be generated based on the data in the pharmacy system.

- The Part D Plan submits data to CMS via the PDE record.

- The Part D Plan successfully submits data at least once a month to PDFS/DDPS.

- The data are sent to PDFS where front-end edits are applied.

- The PDFS response report indicates file acceptance or rejection. If any data fail front-end edits, PDFS will report the failure on the PDFS Response Report.

- After passing the PDFS checks, the file is submitted to DDPS where detail editing is performed.

- The DDPS Return File is returned daily and shows the disposition of all DET records and where errors occurred.

- The DDPS Transaction Error Summary displays the count and rate for each error code found in the submitted data.

- The DBC sums LICS and calculates unadjusted reinsurance and risk corridor payments.

- Management reports are generated in the DBC and provide a summary of net accumulated totals for all dollar fields.

- PRS creates a beneficiary/plan record for each beneficiary enrolled in a plan during the payment year and calculates reconciliation payments at the beneficiary and plan level.

Figure 3A – Prescription Drug Event Dataflow

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.
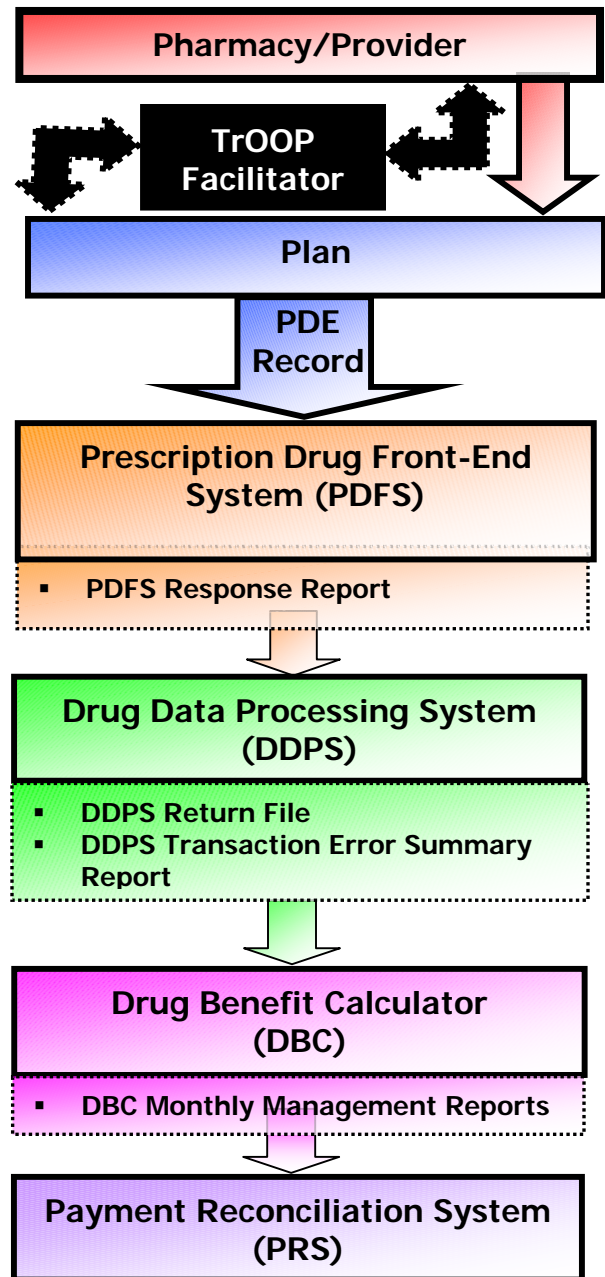
3.3.4 Important Information About Prescription Drug Event Data

- Part D Plans initially transmit PDE data to PDFS at Palmetto GBA.

- PDFS performs format and face validity checks on the file- and batch-level as well as sequencing verification on the detail records.

- The PDFS Response Report identifies whether the file is accepted or rejected.

- Once the file has passed front-end checks, it moves to DDPS. All validity edits on detail-level data are performed in this system.

- After the file has processed through DDPS, the plan will receive a daily transaction report identifying any errors.

- CMS expects that the plan will be able to directly link any PDE to the event from which the PDE was extracted and duplicate the summarization.

- Plans are responsible for the accuracy of data independent of who submits the data (e.g., third party submitter).

- Over-the-counter (OTC) and supplemental drugs will be excluded from Part D payment calculations based on PDE records.

3.4 Training and Support (Slide 10)

In an effort to ensure that participating plans have the necessary tools and information to be successful with the Prescription Drug Event data process, CMS has planned the following outreach efforts, as described in Table 3C.

TABLE 3C – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday 9:00 a.m. to 7:00 p.m. ET (with the exception of observed corporate holidays) to provide assistance. The support center provides ongoing assistance. The PDFS system is available for submission of PDE data 24 hours a day, 7 days a week regardless of holidays. The only exception would be from midnight Saturday through noon Sunday when systems and equipment are routinely maintained.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to the PDE Data Processing System. Visitors to the site can access information about DDPS/PDFS, including opportunities to register for service, enroll to submit data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. User Group and other training information is regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions. To register for email updates, go to www.csscoperations.com and click on Prescription Drug Information Center.
Regional Training Program	The program provides practical training for plans.
Regional Training Video	A video version of the 2005 training. Expected availability is October 2005.

MODULE 4 – DATA FORMAT

Purpose (Slide 2)

Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary record called the prescription drug event (PDE) record to the Centers for Medicare & Medicaid Services (CMS). This module provides the processes required to collect and submit PDE data to CMS, enabling plans to receive accurate and timely payment.

Learning Objectives (Slide 3)

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

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

ICON KEY	
Definition	�£
Example	⊠
Reminder	🔦

4.1   Requirements for Submitting a Prescription Drug Event Record

The Prescription Drug Event (PDE) record contains prescription drug cost and payment data that enable CMS to make payment to plans and otherwise administer the Part D benefit.

Many electronic transactions take place between plans, pharmacies, and intermediaries when an enrollee fills a prescription. This process allows determination of patient cost sharing at the point of sale (POS) by plan adjudication of the claim, and drives eventual plan payment to the pharmacy. The PDE record contains information that is vital for payment, quality oversight, and program integrity.

PACE Organizations operate a pharmacy within their organization and may not receive electronic claims, but will instead account for drug costs in their pharmacy system.

Prior to submitting production data, plans must understand the components of the submission enrollment package, connectivity options, testing, and the submission timeline.

Aspen Systems Corporation

4-1
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

4.1.1 Submission Enrollment Package (Slide 4)

There are two forms that plans must complete prior to submitting data: The Electronic Data Interchange (EDI) Agreement and the Submitter ID Application. In addition, plans must submit an Authorization Letter when they delegate responsibility for data submission to another entity. Table 4A describes the submission documentation requirements.

TABLE 4A - DATA SUBMISSION DOCUMENTATION REQUIREMENTS

FORM	ENTITY	DESCRIPTION
Electronic Data Interchange (EDI)	• Plans	• Agreement that specifies the terms under which plans collect and submit PDE data. • Must be signed by an officer of the plan. • Requires an audit trail or maintenance of source documentation related to PDE claims. • Serves as an attestation that data submitted to CMS are accurate and that plans will abide by HIPAA rules. • An EDI agreement is required for each plan number submitting data.
Submitter ID Application	• Plans • Third Party Submitters	• Upon processing of the form, submitters are issued a Submitter ID Number.
Authorization Letter	• Plan	• A letter from the plan authorizing the third party to submit on their behalf.

Use of the submitter and plan identifying information constitutes the organization's legal electronic signature for the data submitted. Plans are responsible for researching and correcting discrepant data, and completing the testing and certifying the processes used to submit the data.

The PDE record summarizes multiple transactions. The plan must maintain audit trails to PDE source data. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted, and intends to conduct audits of PDE data to ensure the accuracy of payment.

Plans are responsible for the accuracy of data submitted independent of who submits the data.

4.1.2 Connectivity (Slide 5)

Each entity submitting PDE data must establish a connection to the Prescription Drug Front-End System (PDFS) through the Medicare Data Communication Network (MDCN), provided by AT&T Global Network Services (AGNS). The MDCN is the secure network linking the PDE data processing entities.

Connectivity refers to the electronic connection used to submit PDE records and receive reports from CMS. Technical specifications are available based on the communication medium that the organization intends to use. Connect Direct instructions and the PDFS User Guide are available on

Aspen Systems Corporation

4-2
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

www.csscoperations.com. The three connectivity options, and the response time associated with each, are described in Table 4B.

TABLE 4B- CONNECTIVITY OPTIONS

Connect:Direct	• Mainframe-to-mainframe connection • Next day receipt of front-end response • Formerly known as Network Data Mover (NDM)
File Transfer Protocol (FTP)	• Modem-to-modem connection • Requires password and phone line • Same day receipt of front-end response
Secure Website	• Point and click features • Same day receipt of front-end response

Note: Datasets are required to be set up for Connect Direct users. The Prescription Drug Data (PDD) specifications should be completed and returned to the Customer Service and Support Center (CSSC) with the Submitter Application and the EDI Agreement. Connect Direct specifications are available at www.csscoperations.com.

4.1.3 Prescription Drug Event Certification Process (Slides 6-8)

Prior to submitting production files to the Drug Data Processing System (DDPS), plans must submit a test file to DDPS through PDFS.

In order to support an efficient transition to the production environment, each submitter must complete testing and certification of their PDE transactions. There is a two-phased approach to the testing. The Submitter receives Certification only after successful completion of both phases.

1. The PDFS preliminary test for transmission/communications, format, and content.
2. The secondary test in DDPS fully examines the content of the PDE records to ensure they pass format and logical edits at the detail PDE record level.

PDE test data must be submitted from the same automated system that will be used to submit production PDE data. If any major system changes are made to the system of record after initial certification, the plan must re-certify. Table 4C illustrates the steps necessary for certification.

TABLE 4C – CERTIFICATION STEPS

STEP	ACTION
1	Complete the EDI Agreement and Submitter Application in full. Return to CMS/Palmetto GBA. A Submitter ID will be assigned to your organization.
2	Each Submitter should assign one or more Contract Ids and Plan Benefit Package (PBP) IDs to the test file. Contact CSSC operations to schedule and coordinate your PDE testing and certification.

Once certified, a Production File may be submitted. **Note:** In order to receive and maintain certification, error rate(s) cannot exceed 20 percent.

Aspen Systems Corporation

4-3
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

4.1.4 Data Submission Timeline (Slide 9)

In the first year of the benefit (2006), plans or a plan's designee must submit PDE records electronically to DDPS according to the schedule in Table 4D.

TABLE 4D- TIMELINE FOR 2006 DATA SUBMISSION

DATA TYPE	SUBMISSION TIMELINE
Testing and Certification	November 15, 2005 – January 31, 2006
DDPS Large Volume Testing*	December 1, 2005 – December 23, 2005
PDE Production Submissions	January 1, 2006
Subsequent PDE production files for calendar year 2006	Monthly after March 31, 2006 – May 31, 2007

*Plans that complete testing early have the option to submit a large volume test in the production environment. This option expires on December 23, 2005.

The plan's first production file is due by the end of the first quarter of 2006 (March 31, 2006). Thereafter plans must submit monthly. PDE records, adjustments, or deletions that are received after the end of the fifth month of the subsequent coverage year are not considered in reconciliation. This means that prescription drug claims including adjustments for all dates of service within calendar year 2006 must be submitted by May 31, 2007 in order to be processed for payment reconciliation. If necessary, CMS may assign submission schedules to high volume submitters in order to balance DDPS workloads.

4.1.5 Plan Monitoring (Slide 10)

Throughout the coverage year, CMS monitors plan data submission levels to detect plans with submission volumes lower than expected. Low submission patterns often indicate technical or system problems. CMS works with plans in an attempt to correct submission problems before the end of the year so they can meet reconciliation submission deadlines. However, it is the responsibility of the plan to submit adequate data for payment.

Late submission or submission of insufficient data to conduct reconciliation may result in payment recovery through a lump-sum recovery; by adjusting or ceasing monthly payments throughout the remainder of a coverage year; or by adjusting monthly payments in a subsequent year.

4.2   Data Collection (Slide 11)

For each dispensing event, the plan must submit a PDE record. Most organizations use a pharmacy benefit manager (PBM) or other third party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates a claim for payment. The PDE is a summary record that documents the final adjudication of a dispensing event.

Plans have additional reporting requirements to submit Direct and Indirect Remuneration (DIR) data for year-end reconciliation. PDE reporting and DIR reporting are separate information streams. CMS will publish reporting requirements for DIR in separate guidance.

Figure 4A illustrates the PDE Dataflow.

Aspen Systems Corporation

4-4
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Figure 4A – Prescription Drug Event Dataflow

- The pharmacy, physician, or other provider submits a claim to the Part D Plan.
  - In some cases, the PACE organization may operate the pharmacy and may not receive a claim. The PDE will be generated based on the data in the pharmacy system.

- The Part D Plan submits data to CMS via the PDE record.

- The Part D Plan successfully submits data at least once a month to PDFS/DDPS.

- The data are sent to PDFS where front-end edits are applied.

- The PDFS response report indicates file acceptance or rejection. If any data fail front-end edits, PDFS will report the failure on the PDFS Response Report.

- After passing the PDFS checks, the file is submitted to DDPS where detail editing is performed.

- The DDPS Return File is returned daily and shows the disposition of all DET records and where errors occurred.

- The DDPS Transaction Error Summary displays the count and rate for each error code found in the submitted data.

- The DBC sums LICS and calculates unadjusted reinsurance and risk corridor payments.

- Management reports are generated in the DBC and provide a summary of net accumulated totals for all dollar fields.

- PRS creates a beneficiary/plan record for each beneficiary enrolled in a plan during the payment year and calculates reconciliation payments at the beneficiary and plan level.

Aspen Systems Corporation

4-5

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

4.3   Prescription Drug Event Record Layout Logic (Slides 12-13)

The PDE Record is organized into three levels:

- File-level information, which identifies the submitter.
- Batch-level information, which identifies the plan.
- Detail-level information, which identifies the beneficiary and describes the prescription drug event.

A summary of the PDE record layout is illustrated in Figure 4B. A detailed description of each field, including formatting requirements, is found in Table 4N.

Aspen Systems Corporation

4-6
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Figure 4B – PDE Record File Structure Summary   **DATA FORMAT**

RT HDR – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BHD.
- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

> **RT BHD – BATCH HEADER (Plan Info)**
> Must follow RT HDR or RT BTR and must be followed by RT DET.
> - Record ID
> - Sequence Number
> - Contract Number
> - PBP ID
> - Filler
>
>> **RT DET – DETAIL RECORD (Drug Event Information)**
>> Must follow RT BHD or RT DET and may be followed by another RT DET or an RT BTR.
>> - For the detail record, the plan populates 37 fields with data in order to provide DDPS with the information required for identifying each unique PDE and calculating payment. Three fields are filler, and DDPS populates the remaining 12 fields as applicable in the return file.
>
> **RT BTR – BATCH TRAILER**
> Must follow RT DET and may be followed by a RT BHD or RT TLR.
> - Record ID
> - Sequence Number
> - Contract No
> - PBP ID
> - DET Record Total
> - DET Accepted Record Total
> - DET Informational Record Total
> - DET Rejected Record Total
> - Filler

DETAIL LEVEL | **BATCH LEVEL** | **FILE LEVEL**

RT TLR – FILE TRAILER
Must follow RT BTR, and must be the last record on the file.
- Record ID
- Submitter ID
- File ID
- TLR BHD Record Total
- TLR DET Record Total
- TLR DET Accepted Record Total
- TLR DET Informational record total
- TLR DET Rejected Record Total
- Filler
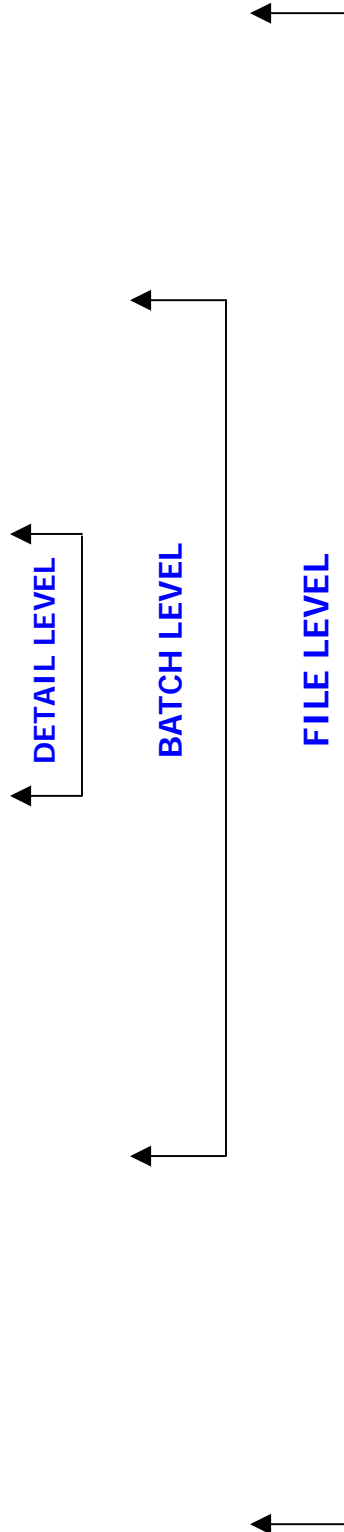
4.3.1 File Level Fields

The file level of the PDE record consists of a file header (HDR) and a file trailer (TLR). These are the first and last records in the PDE record, each representing 512 bytes. The naming conventions HDR and TLR are used to populate the record ID fields at the file level.

The file header contains four fields that are used for processing and tracking submissions. Table 4E provides an overview of those fields.

TABLE 4E – FILE LEVEL INFORMATION

FIELD NAME	CHARACTERISTICS
SUBMITTER ID	• Assigned by CMS (CSSC). • Identifies the entity that is submitting the data. • Must be accurate for appropriate routing of reports and return files.
FILE ID	• Assigned by submitter for file identification purposes. • The same number can only be used once in a 12-month period. • Ten-character alphanumeric field.
TRANS DATE	• The date on which the file is transmitted to PDFS/DDPS. • CCYYMMDD format.

PROD TEST IND	• Indicates if the file is being submitted as a test to ensure the system is functioning or as a production file.
	• Data are only stored for files that are submitted as production files.
	  - PROD indicates that the file is a production file.
	  - TEST indicates that the file is a test file.

The first test file must be submitted by January 31, 2006. The first production file must be received by March 31, 2006.

The TLR matches information contained in the HDR, such as the Submitter ID and File ID, and is populated with counts for the number of batches and detail records in the file. On submission, the TLR also contains spaces that DDPS populates with information about the disposition of the PDE record in the return file.

4.3.2 Batch Level Fields (Slides 14-15)

Like the HDR and TLR, each batch record within the PDE record equals 512 bytes. There can be multiple batches within a file, but each must have a batch header and trailer. The batch header is a BHD record and the trailer is a BTR record; these naming conventions are used to populate the Record ID fields at the batch level.

Aspen Systems Corporation

4-8
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Batch level information that identifies the plan is reported in two fields: Contract ID and PBP ID. CMS assigns the Contract ID, while the organization proposes Plan Benefit Package (PBP) IDs when bidding, each of which must be approved by CMS during the negotiation and contracting process. The Contract ID consists of a letter followed by four numbers. The initial letter will vary by plan type as outlined in Table 4F.

TABLE 4F – CONTRACT NUMBER ENUMERATION BY PLAN TYPE

PLAN TYPE	FIRST LETTER ENUMERATION

Local Medicare Advantage-Prescription Drug (MA-PD) Plans	• Begins with an "H"
	  - Includes PACE organizations
	    ▪ e.g., H1234

Regional MA-PD Plans	• Begins with an "R"
Prescription Drug Plans (PDP)	• Begins with an "S"
Fallback Plans	• Begins with an "F"

The Contract ID is used in conjunction with the PBP ID to describe the organization and the plan for which the data are being submitted. This requires that all DET records included between a set of batch level records (i.e., a BHD and BTR record) are for beneficiaries enrolled in both the plan and the PBP identified at the batch level by the Contract ID and PBP ID fields. Plans with multiple PBPs must separate data at the batch level.

Batch level data also provides information necessary for tracking. The Batch Sequence Number is input by the plan and identifies the order in which batches were submitted within the file. Instructions for populating this field are outlined in Table 4G.

TABLE 4G – SEQUENCE NUMBER CHARACTERISTICS

FIELD NAME	CHARACTERISTICS
SEQUENCE NO	• Assigned by submitter • Must begin with 0000001

The BTR matches information contained in the BHD and includes a count of the DET records contained in the batch. On submission, the BTR also reserves spaces that DDPS populates with information about the disposition of the PDE record in the return file.

4.3.3 Detail Record Fields

The Detail Record (DET) record contains 52 fields. Included in these fields are 37 data elements that plans must populate for CMS to reconcile payment and provide program oversight. Plans must sort by the Health Insurance Claim Number (HICN) in the DET record when submitting data. This section reviews data elements within the DET record, with emphasis on data used for payment reconciliation.

There are eight fields within the PDE detail level that PACE plans should populate with spaces or zero dollars.

Aspen Systems Corporation

4-9
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Table 4H provides a description of these fields.

TABLE 4H – PACE RULES

FIELD NUMBER	FIELD NAME	PACE RULES
9	**Paid Date**	Populate with space
27	**Catastrophic Coverage Code**	Populate with space
31	**GDCB**	Populate with space
32	**GDCA**	Populate with zero dollars
33	**Patient Pay Amount**	Populate with zero dollars
34	**Other TrOOP Amount**	Populate with zero dollars
35	**LICS**	Populate with zero dollars
36	**PLRO**	Populate with zero dollars

4.3.3.1 Beneficiary Identifiers (Slide 16)

The following data elements identify the beneficiary:

- HICN
- Cardholder ID
- Patient Date of Birth (DOB)
- Patient Gender

The HICN is the only data element used to identify a beneficiary that is not available in standard format. The HICN is a Medicare beneficiary's identification number. Both CMS and the Railroad Retirement Board (RRB) issue Medicare HICNs. The format of a HICN issued by CMS is a Social Security number followed by an alpha or alpha-numeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers preceded with an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 4I illustrates HICN structure.

TABLE 4I – HICN STRUCTURE

HICN TYPE	CHARACTERISTICS
CMS	9-digit Social Security number - alpha suffix - "A" beneficiary - "B" spouse - "C" children - "D" divorced spouse, widow, widower - alpha-numeric suffix - indicates type of dependent
RRB pre-1964	- alpha prefix 6-digit random numbers
RRB post-1964	- alpha prefix 9-digit Social Security number

Aspen Systems Corporation

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The cardholder ID number is assigned to the beneficiary by the plan. This number is necessary for linking the beneficiary to the appropriate HICN in plan databases, as well as program oversight functions carried out by the plan.

Date of Birth (DOB) is an optional field. If reported, DOB must be valid. When plans submit data for this field the beneficiary's DOB is checked against Medicare records allowing plans to identify potential errors in their records. DOB and patient gender are compared against the Medicare Beneficiary Database (MBD) to validate identifying information.

All data in the DET record must be for beneficiaries enrolled in the plan and PBP indicated at the batch level.

Data in the DET record must be sorted by HICN.

4.3.3.2 Prescription Drug Event Identifiers (Slides 17-18)
Thirteen data elements, which are standard throughout the industry, describe both the drug and the way the drug was dispensed.

- Date of Service (DOS)
- Prescription Service Reference Number
- Product Service ID
- Service Provider ID Qualifier
- Service Provider ID
- Fill Number
- Compound Code
- Dispense as Written (DAW) Product Selection Code
- Quantity Dispensed
- Days Supply
- Prescriber ID Qualifier
- Prescriber ID
- Out-of-Network (OON) Code

Table 4J describes in additional detail the data elements used to identify the prescriber who wrote the prescription and the provider who filled the prescription. The qualifier fields associated with these two data elements (i.e., Service Provider ID Qualifier, and Prescriber ID Qualifier) indicate the type of ID being entered into the corresponding fields.

Aspen Systems Corporation

4-11
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4J – SERVICE PROVIDER AND PRESCRIBER IDENTIFIERS

FIELD NAME	DESCRIPTION	NOTES

SERVICE PROVIDER ID	• Identifies the provider (i.e., pharmacy, physician, or home infusion).
	• May be populated with any of the following:
	  - National Provider Identifier (NPI)
	  - Unique Physician Identification Number (UPIN)
	  - National Council for Prescription Drug Program (NCPDP) number
	  - State License number
	  - Federal tax number
	  - 'Other'
		• UPIN, State license number, and 'other' are valid only for PDE records complied from data collected in non-standard format.

PRESCRIBER ID	• Identifies the individual who prescribed the medication.
	• May be populated with any of the following:
	  - NPI
	  - UPIN
	  - State License Number
	  - Drug Enforcement Agency (DEA) Number
		• Plans should report the DEA number whenever available.
		• Optional for PDE records compiled from data collected in non-standard format.

HIPAA administrative simplification standards for electronic data interchange (EDI) mandate future use of National Provider Identifier (NPI) numbers for health care providers, such as physicians and pharmacists, as well as health care organizations. NPI numbers can be used to populate both the Service Provider ID field and the Prescriber ID field. CMS began accepting applications for NPIs on May 23, 2005 and expects to transition to full use of the NPI number for this field after the NPI is fully implemented. Plans should note that covered entities must submit data using this format by May 24, 2007; small plans must comply by May 24, 2008.

The drug coverage status code is an essential data element that will impact payment. The code identified in this field will impact how dollar fields are populated. The codes that are applicable to this field are discussed in Table 4K.

Aspen Systems Corporation

4-12
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4K – DRUG COVERAGE STATUS CODE RESPONSE CATEGORIES

FIELD NAME	DESCRIPTION	RESPONSE CATEGORIES
Drug Coverage Status Code	Indicates the status of a dispensed drug as one of the following: • **Covered** - Part D drug - Approved for coverage under a specific PBP • **Enhanced** - Not a Part D drug - Approved for coverage under a specific PBP • **Over the counter** - Over the counter drug included in step therapy - Approved for coverage under a specific PBP	• C = Covered • E = Enhanced • O = Over-the-counter

4.3.3.3 Dollar Fields (Slides 19-21)

The PDE Record layout includes eleven fields that must be populated with dollar amounts. These eleven fields can be categorized as detail cost fields, summary cost fields, patient liability payment fields, and plan payment fields. Each of these fields impacts Part D payment. Specific information on populating these fields, based on the benefit structure, is provided in the following modules. Table 4L identifies each of the dollar fields by name and type, and their purpose in the PDE record.

TABLE 4L – PURPOSE OF DOLLAR FIELDS

FIELD #	FIELD NAME	FIELD TYPE	PURPOSE
28	Ingredient Cost Paid	Enter Cost	The sum of these three fields equals the Gross Drug Cost.
29	Dispensing Fee Paid	Enter Cost	
30	Amount Attributed to Sales Tax	Enter Cost	
37	Covered D Plan Paid Amount (CPP)	Enter Cost	Sums the dollar amount paid by plans, differentiating between covered amounts paid for Part D drugs and non-covered amounts paid for enhanced benefits (non-Part D drugs or supplemental plan cost-sharing) or over-the-counter drugs
38	Non-Covered Plan Paid Amount (NPP)	Enter Cost	

Note: The field numbers listed correspond to those included in Table 4M, which lists all fields in the PDE record.

Aspen Systems Corporation

4-13
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

4.3.3.4 Additional DET Fields

Table 4M identifies additional DET fields and provides a description of the fields.

TABLE 4M – ADDITIONAL DET FIELDS

FIELD #	FIELD NAME	FIELD TYPE	DESCRIPTION
1	Record ID	Record Type	Identifies record as a detail record
2	Sequence No	Identifier	Identifies the detail record submitted
3	Claim Control Number	Optional	
40	Corrected HICN	Informational error	Plans submit with spaces. DDPS will populate as applicable based on editing.
41-52	Error fields	Error codes/count	
24	Adjustment Deletion Code	Code	Identifies Adjustment/Deletion
25	Non-Standard Format Code	Code	Identifies type of source date plan used to compile PDE
26	Out-of-Network code	Code	Filled when the prescription was filled out of network

Aspen Systems Corporation

4-14
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

4.3 Prescription Drug Event Record Layout

Each field of the PDE Record, including the file-, batch-, and detail-levels is described in Table 4N. The table references the field number and provides the field name, position, submission status, and an explanation of the data element. Formatting information, including the NCPDP field names (where applicable) that map to PDE fields, is also included.

TABLE 4N – PDE RECORD LAYOUT

PDE RECORD HDR – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory	Record-ID	This field should always be populated with "HDR".
2	4 – 9	Mandatory	Submitter-ID	Identifies the submitter and should be populated with the six-character alphanumeric SH# assigned by the CSSC.
3	10 – 19	Mandatory	File-ID	Created by submitter using an alphanumeric 10-character ID that identifies the specific file submitted. This file name may not be repeated within a 12-month period.
4	20 – 27	Mandatory	Transaction Date	Specifies the date that the file was submitted to PDFS; formatted as CCYYMMDD.
5	28 – 31	Mandatory	Production/Test Indicator	Must be populated with "PROD" or "TEST". Submission test data will proceed through the entire process.
6	32 - 512	Spaces	Filler	Must be populated with 481 spaces. The "Filler" field allows for additional fields in the future.

PDE RECORD BHD – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1 – 3	Mandatory	Record-ID	This field should always be populated with "BHD".
2	4 – 10	Mandatory	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one.
3	11 – 15	Mandatory	Contract Number	Identifies the Plan and should be populated with the five-character alphanumeric H#, R#, S#, or F# assigned by CMS.
4	16 – 18	Mandatory	Plan Benefit Package (PBP) ID	Identifies the specific PBP within a Contract. This field should be populated with A three-characters alphanumeric code. All beneficiaries with detail records within this batch must be enrolled in the PBP coded here.
5	19 – 512	Mandatory	Filler	Must be populated with 494 spaces. The "Filler" field allows for additional fields in the future.

Aspen Systems Corporation

4-15
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	NCPDP FIELD	FIELD NAME	EXPLANATION
			PDE RECORD DET – DETAIL LEVEL		
1	1 – 3	Mandatory		Record-ID	This field should always be populated with "DET".
2	4 – 10	Mandatory		Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one.
3	11 – 50	Optional		Claim Control Number	This optional field may be used by the plan to identify the DET record submitted. The field allows up to 40 alphanumeric characters. Left justify and enter spaces, not zeros, in unused spaces.
4	51 – 70	Mandatory		HICN	The Health Insurance Claim Number for the beneficiary. This is a 20-character alphanumeric field.
5	71 – 90	Mandatory	302-C2	Cardholder ID	Plan-assigned beneficiary identification number that maps to the HICN in field #4. This is a 20-character character alphanumeric field. Left justify and enter spaces, not zeros, in unused spaces.
6	91 – 98	Optional	304-C4	Patient DOB	This optional field may be populated with the patient's date of birth and used to verify that the correct beneficiary was submitted. If the field is populated, it must be formatted as CCYYMMDD. If this field is populated, DDPS will edit this field against the information on file at the MBD. If no DOB is submitted, fill with spaces.
7	99 – 99	Mandatory	305-C5	Patient Gender	This field codes the gender of the beneficiary. It will be used to confirm beneficiary identity. Must be populated with either a "1" or a "2", no zeros.
8	100 – 107	Mandatory	401-D1	Date of Service	This field identifies the date the prescription was filled and must be submitted in CCYYMMDD format. This field should **not** contain dates associated with plan payment or transaction adjustments.
9	108 – 115	Mandatory for Fallback plans; PACE plans should populate with spaces.		Paid Date	This field identifies the date on which the plan originally paid the pharmacy for the prescription drug and must be submitted in CCYYMMDD format. This field will be used to reconcile costs against draw down accounts for Fallback Plans only.

Aspen Systems Corporation

4-16
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4N– PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	NCPDP FIELD	FIELD NAME	EXPLANATION
**PDE RECORD DET – DETAIL LEVEL**				
10	116 – 124	Mandatory	402-D2	Prescription Service Reference NO	A Pharmacy-issued 7-character alphanumeric code that identifies a dispensed prescription is used to populate this field. Plans should right justify the number and follow with two spaces. Planned NCPDP formatting changes will require a 9-character code in the future. In cases where this field is not submitted by the pharmacy the plan must assign a number that is unique for any DOS and Service Provider ID combination.
11	125 – 126	Mandatory		Filler	Must be populated with 2 spaces. The "Filler" field allows for additional fields in the future.
12	127 – 145	Mandatory	407-D7	Product Service ID	National Drug Code (NDC) 11 format. Identifies the dispensed drug. Submit the most expensive NDC drug for compound drugs.
13	146 – 147	Mandatory	202-B2	Service Provider ID Qualifier	Indicates the source of the code used in field 14.
14	148 – 162	Mandatory	201-B1	Service Provider ID	This field identifies the pharmacy or physicians office where the prescription was filled. Populate the field with the NCPDP number or NPI for pharmacies; use the UPIN, State License Number, or Federal Tax Identification Number for all other providers.
15	163 – 164	Mandatory	403-D3	Fill Number	Indicates the number of the current fill for prescriptions with refills.
16	165 – 165	Situational	343-HD	Dispensing Status	<blank>=not specified P=Partial fill C=Completion of partial fill
17	166 – 166	Mandatory	406-D6	Compound Code	Indicates if the dispensed drug was compounded or not.
18	167 – 167	Mandatory	408-D8	Dispense as Written (DAW)	This field reports the instructions provided by the Prescriber regarding substitution of generic equivalents.
19	168 – 177	Mandatory	442-E7	Quantity Dispensed	This field lists the number of units (e.g., pills, milliliters) that were dispensed.
20	178 – 180	Mandatory	405-D5	Days Supply	Indicates the number of days the current prescription provides medication for.
21	181 – 182	Mandatory; Optional for data submitted in Non-standard format.	466-EZ	Prescriber ID Qualifier	Describes the data source of the code used in field 22.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	NCPDP FIELD	FIELD NAME	EXPLANATION
for header		PDE RECORD DET – DETAIL LEVEL			
22	183 – 197	Mandatory; Optional for data collected in Non-Standard format; Mandatory for all other data	411-DB	Prescriber ID Number	Populate this field with either the Drug Enforcement Agency (DEA) Number or the NPI, UPIN or State License number that identifies the prescriber in cases where the DEA is not available.
23	198 – 198	Mandatory		Drug Coverage Status Code	Indicates if the dispensed drug is a Covered Part D drug or not.
24	199 – 199	Situational		Adjustment /Deletion Code	This field is used to identify records for either deletion or adjustment. If neither action is required the field is left blank.
25	200 – 200	Situational		Non-Standard Format Code	This field is coded only when data are collected in non-standard format.
26	201 – 201	Situational		Out-of-Network Code	This field is coded when the prescription was filled at an out-of-network pharmacy.
27	202 – 202	PACE plans should populate with spaces.		Catastrophic Coverage Code	This field identifies the beneficiary's status in the benefit. It is populated when the beneficiary either reaches the TrOOP attachment point (code=A), or is above attachment (code=C). This field is left blank for beneficiaries below the attachment point. For any beneficiary with a "C" code in this field, there must be one previous record coded "A" to indicate the drug event associated with crossing the OOP threshold.
28	203 – 210	Mandatory	506-F6	Ingredient Cost Paid	Populate this field with the dollar amount paid to the pharmacy for the drug itself; do not include costs such as dispensing fees or sales tax. When costs are not disaggregated, enter the total cost of the drug in this field.
29	211 – 218	Mandatory	507-F7	Dispensing Fee Paid	Populate this field with the dollar amount paid to the pharmacy for activities related to the transfer of the drug from the pharmacy to the beneficiary. Include charges for mixing drugs, delivery, and overhead. Do not include administrative or other costs in this field.
30	219 – 226	Situational	523-FN	Amount Attributed to sales tax	This field represents the dollar amount of sales tax, if any, associated with the prescription drug event.
31	227 – 234	PACE plans should populate with zero dollars		Gross Drug Costs Below Out-of-Pocket Threshold (GDCB)	Sum fields 28-30 to calculate gross drug costs. This field is populated by an actual dollar amount when the beneficiary is at or **below** the OOP threshold and the drug is a covered Part D Drug. Otherwise enter a zero dollar amount.

Aspen Systems Corporation

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

					PDE RECORD DET – DETAIL LEVEL
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**NCPDP FIELD**	**FIELD NAME**	**EXPLANATION**
32	235 – 242	PACE plans should populate with zero dollars		Gross Drug Costs Above Out-of-Pocket Threshold (GDCA)	Sum fields 28-30 to calculate gross drug costs. This field is populated by an actual dollar amount when the beneficiary is at or **above** the OOP threshold and the drug is a covered Part D Drug. Otherwise enter a zero dollar amount.
33	243 – 250	PACE plans should populate with zero dollars	505-F5	Patient Pay Amount	Populate this field with the dollar amount paid by the beneficiary.
34	251 – 258	PACE plans should populate with zero dollars		Other TrOOP Amount	This field indicates the dollar amount paid on behalf of the beneficiary by third party TrOOP eligible payers **except** those payments accounted for in fields 33 (patient pay), and 35 (LICS).
35	259 – 266	PACE plans should populate with zero dollars		Low Income Cost-Sharing Subsidy (LICS)	Plans populate this field with the dollar amount attributed to LICS.
36	267 – 274	PACE plans should populate with zero dollars		Patient Liability Reduction Due to Other Payer Amount (PLRO)	This field is populated with the dollar amount paid by entities that reduce patient liability/cost, but do **not** count as TrOOP.
37	275 – 282	Mandatory for Covered Part D Drugs		Covered D Plan Paid Amount (CPP)	For POs this field reports the total amount paid for a Covered Part D Drug. If Drug Coverage Status Code is coded "E" or "O", then this field must be populated with a zero amount.
38	283 – 290	Mandatory for non-Part D Drugs		Non-Covered Plan Paid Amount (NPP)	For POs this field reports the total amount paid for a non-Part D Drug. If Drug Coverage Status Code is coded "C", then this field must be populated with a zero amount.
39	291 – 445	Mandatory		FILLER	Must be populated with 155 spaces. The "Filler" field allows for additional fields in the future.
40	446 – 465	Mandatory		Corrected HICN*	This field should be submitted with spaces.
41	466 – 467	Mandatory		Error Count*	This field should be submitted with spaces.
42	468 – 470	Mandatory		Error 1*	This field should be submitted with spaces.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	NCPDP FIELD	FIELD NAME	EXPLANATION
					PDE RECORD DET – DETAIL LEVEL
43	471 – 473	Mandatory		Error 2*	This field should be submitted with spaces.
44	474 – 476	Mandatory		Error 3*	This field should be submitted with spaces.
45	477 – 479	Mandatory		Error 4*	This field should be submitted with spaces.
46	480 – 482	Mandatory		Error 5*	This field should be submitted with spaces.
47	483 – 485	Mandatory		Error 6*	This field should be submitted with spaces.
48	486 – 488	Mandatory		Error 7*	This field should be submitted with spaces.
49	489 – 491	Mandatory		Error 8*	This field should be submitted with spaces.
50	492 – 494	Mandatory		Error 9*	This field should be submitted with spaces.
51	495 – 497	Mandatory		Error 10*	This field should be submitted with spaces.
52	498 – 512	Mandatory		Filler	Must be populated with 15 spaces. The "Filler" field allows for additional fields in the future.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
				PDE RECORD BTR – BATCH TRAILER
1	1 – 3	Mandatory	Record-ID	Batch trailer information should be populated with "BTR".
2	4 – 10	Mandatory	Sequence NO	7-digit numeric character identifying the batch submitted. Must match the "BHD" record.
3	11 – 15	Mandatory	Contract NO	H# assigned by CMS to identify the Plan. Must match the H# in the corresponding "BHD" record (i.e., the "BHD" record with the same sequence number).
4	16 – 18	Mandatory	PBP ID	Three-digit code identifying the PBP the beneficiaries in the detail record are enrolled in. Must match RT BHD.
5	19 – 25	Mandatory	DET Record Total	This field should total the number of DET records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001).
6	26 – 32	Mandatory	DET Accepted Record Total*	This field should be submitted with spaces.
7	33 – 39	Mandatory	DET Informational Record Total*	This field should be submitted with spaces.
8	40 – 46	Mandatory	DET Rejected Record Total*	This field should be submitted with spaces.
9	47 – 512	Mandatory	FILLER	Must be populated with 466 spaces. The filler field allows for additional fields in the future.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4N – PDE RECORD LAYOUT (CONTINUED)

FIELD NO	POSITION	SUBMISSION STATUS	FIELD NAME	EXPLANATION
**PDE RECORD TLR – FILE TRAILER**
1	1 – 3	Mandatory	Record-ID	This field should always be populated with "TLR".
2	4 – 9	Mandatory	Submitter-ID	Identifies the submitter and must match the 6-character alphanumeric SH# in the HDR record.
3	10 – 19	Mandatory	File-ID	10-character alphanumeric character identifying the specific file submitted. Must match the File ID in the "HDR" record.
4	20 – 28	Mandatory	TLR BHD Record Total	This field should total the number of batches in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001).
5	29 – 37	Mandatory	TLR DET Record Total	This field should total the number of detail records in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001).
6	38 – 46	Mandatory	TLR DET Accepted Record Total*	This field should be submitted with spaces.
7	47 – 55	Mandatory	TLR DET Informational Record Total*	This field should be submitted with spaces.
8	56 – 64	Mandatory	TLR DET Rejected Record Total*	This field should be submitted with spaces.
9	65 – 512	Mandatory	Filler	Must be populated with 448 spaces. The "Filler" field allows for additional fields in the future.

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

4.5   Non-Standard Format (Slides 22-23)

It is expected that the majority of data that plans collect from providers will be in standard (i.e., NCPDP) format. However, plans may receive data in other formats. For example, a physician may submit in X12 format or a beneficiary may submit an out-of-network claim using a paper form. Independent of the type of source data from which the PDE is compiled, plans must submit PDEs for all events. Specific instructions for submitting data collected in non-standard format follows.

The non-standard format code reports the type of source data from which the PDE was compiled. When PDEs are compiled from standard format, the non-standard format field is left blank. Non-standard format code values of "B","X", or "P" indicate that the PDE record was derived from a non-standard format. For non-standard formats, DDPS overrides the requirement to populate two DET fields: Prescriber ID Qualifier and Prescriber ID. However, plans should supply this data if it is available. Table 4O lists the values for the non-standard format field. Note that these codes are mutually exclusive.

Aspen Systems Corporation

4-21
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4O - NON-STANDARD FORMAT FIELD CODES

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

> Only the Prescriber ID and Prescriber ID Qualifier fields are optional for non-standard format submissions, all other fields in the PDE record must be populated.

Non-standard formats may not report the following fields:
- Prescription Service Reference Number
- Service Provider ID
- Fill Number
- Compound Code
- DAW
- Days Supply
- Ingredient Cost Paid
- Dispensing Fee
- Amount Attributed to Sales Tax

For these fields, plans may report default codes when data are unavailable. For example, the prescription service reference number is typically assigned by a pharmacy at the time a prescription is filled. However, if the drug is dispensed in a physician's office, this number may not be included on the claim so the plan will have to assign a number that is unique for the date of service and the service provider. Table 4P provides the field name and the default code or instructions directing plans to populate these fields when source data are not available.

Aspen Systems Corporation

4-22
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 4P – INSTRUCTIONS FOR POPULATING THE PDE RECORD
WITH DATA COLLECTED IN NON-STANDARD FORMAT

FIELD NUMBER	FIELD NAME	INSTRUCTIONS
10	Prescription Service Reference Number	Assign a number that will be unique for the date of service and the service provided
14	Service Provider ID	Utilize the UPIN, State License Number, Tax ID# or the TrOOP Facilitator Default value of "PAPERCLAIM" if a NCPDP ID is not available.
15	Fill Number	Populate with: '00'
17	Compound Code	Populate with: '0=not a compound'
18	DAW	Populate with: '0=no product selection indicated'
20	Days Supply	Populate with: '000'
28-30	Ingredient Cost Paid; Dispensing Fee; and Amount Attributed to Sales Tax	In cases where these three fields are not disaggregated, plans should report the total cost in the "Ingredient Cost Paid" field, and report zero dollar amounts for the other two fields.

Note: The field numbers listed correspond to those included in Table 4M, which lists all fields in the PDE record.

Plans are under the same obligation to maintain an audit trail and submit accurate data independent of the data source.

4.6 Modifying Prescription Drug Event Records (Slides 24-26)

To change a PDE after submission, plans will submit an adjustment or deletion PDE. Examples of when an adjustment or deletion might be required include:

- A beneficiary does not to pick up a prescription, and the plan is not notified until after the PDE record has been submitted.
- The original payment to the pharmacy is adjusted after the PDE has been submitted.

When the adjustment/deletion code is populated, DDPS recognizes that a record is being either adjusted or deleted. In order for one of these actions to take place, the record submitted with the adjustment/deletion field populated must match the file to be adjusted or deleted in the following eight fields.

- HICN
- Service Provider
- Prescription/Service Reference Number
- DOS
- Fill Number
- Dispensing Status
- Contract Number
- PBP ID

Aspen Systems Corporation

4-23
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

The first six fields are located in the DET record. These are referred to as "key fields" because they allow DDPS to identify a unique drug event.

The last two fields, located in the BHD, identify the contract number of the plan that originally submitted the PDE Record and the Plan Benefit Package to which the beneficiary belongs. Requiring a match between these data elements reserves adjustment and deletion authority to the plan that originally submitted the data.

After ensuring field matches between a new record and the record being either adjusted or deleted, and populating the appropriate code in the adjustment/deletion field, the plan submits the new record. Table 4Q provides an overview of the impact of each code.

TABLE 4Q– IMPACT OF THE ADJUSTMENT/DELETION CODE ON PDE RECORDS

CODE	CODE DEFINITION	IMPACT
A	Adjustment	If a current (active) record, matching the eight fields is found in the DDPS database the system will inactivate the old record and save the adjusted record.
D	Deletion	If a current (active) record, matching the eight fields, is found in the DDPS database, the system will inactivate the old record without saving the new record.
<blank>	Original PDE	Indicates original PDE

If a current (active) record is not found in the DDPS database an error message will be returned; the new record is not saved.

There are several things to keep in mind when undertaking this process:

- Internally, DDPS uses the file submission date to identify a PDE, therefore only one original record, adjustment, or deletion for an event can be submitted per day.
- Inactive records (i.e., adjusted or deleted records) are excluded from any calculations for the beneficiary, PBP, or Contract.
- Inactive records cannot be adjusted. If a plan wants to adjust a record that has previously been deleted, a new record must be submitted. Records that have previously been adjusted but not deleted retain an active record (the most recent adjustment) and can be adjusted multiple times.

Plans can minimize adjustment/deletion volume by waiting to submit PDEs until data have been finalized, **however** plans must submit data according to the timeline specified by CMS.

All PDE records with CY 2006 dates of service must be submitted by May 31, 2007.

Aspen Systems Corporation

4-24

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MODULE 5 – EDITS

Purpose (Slide 2)

Centers for Medicare & Medicaid Services (CMS) designed edits to ensure the accuracy of Prescription Drug Event (PDE) data. In this module, participants will learn about the errors that are generated by the Prescription Drug Front-End System (PDFS) and the Drug Data Processing System (DDPS) through descriptions of the types of edits and checks performed and how they are applied to the submitted data. In addition, participants are introduced to a resolution process for correcting errors.

Learning Objectives (Slide 3)

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

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

ICON KEY	
Definition	᠘
Example	⊠
Reminder	🔦
Resource	📖

5.1   Edit Process (Slide 4)

Plans submit Prescription Drug Event (PDE) data to the Prescription Drug Front-End System (PDFS). PDFS performs format, integrity, and validity checks on the file- and batch-level records. PDFS performs limited edits on detail-level records. Once the file passes the PDFS front-end edits, PDFS forwards the file to the Drug Data Processing System (DDPS) at CMS. DDPS edits the detail-level records for format, integrity, and validity before storing the data for future payment calculation.

Understanding the edits and edit logic allows plans to ensure the timely and accurate processing of PDE data. When programming internal systems for submitting PDEs, plans and submitters should incorporate PDFS and DDPS edits. Submitter's error rates must be below 20 percent to receive and maintain PDE Certification. **Refer to the Data Format module, Section 3.1.3** for more information on PDE Certification requirements.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

5.2   PDFS Edits (Slide 5)

PDFS performs format, integrity, and validity checks on the data submitted. Examples of edits include checking for:

- Missing data in header and batch records (e.g., Record ID, Submitter ID, Production/Test Indicator).

- Appropriate sequencing of records:
  - A batch header (BHD) record follows each file header (HDR) record.
  - A detail (DET) record follows each BHD record.
  - A DET record or a batch trailer (BTR) record follows each DET record.
  - A BHD record or a file trailer (TLR) follows each BTR record.

- File IDs that do not duplicate a File ID previously accepted within the last 12 months in test or production.

- Balance:
  - File ID and Submitter ID are the same in the HDR and TLR.
  - Sequence Number, Contract ID, and Plan Benefit Package (PBP) ID are the same on the BHD and BTR.

- Batch and detail Sequence Numbers always begin with 0000001 and are assigned by incrementing the previous sequence number by 1.

- Valid DET and BHD record totals.

If the file passes all the PDFS front-end edits, PDFS will forward the file to the DDPS for processing. If any of the data fails the PDFS front-end editing, PDFS will reject the complete file.

⊠   **Example: 1**

Scenario

Sunrise Health Plan submitted a file with two batches and no detail records in the second batch.

Result

PDFS rejects the file with error message 276 The BTR record is out of sequence or the BTR does not follow a DET record. A DET record must always follow a BHD record; similarly a DET record must always precede a BHD record.

5.2.1 PDFS Edit Logic and Ranges (Slide 6)

When PDFS determines that there is an error, a code and associated message are generated for that error. Table 5A describes the error code logic. The series and ranges indicate whether errors occur on the file-, batch-, or detail-level and more specifically in the header or trailer for the file and batch.

If any errors occur in PDFS, the complete file is rejected and returned to the submitter after all the PDFS checks are completed.

TABLE 5A – PDFS ERROR CODE LOGIC AND RANGES

SERIES	RANGES	EXPLANATION
100	126-150	File-level errors on the HDR.
	176-199	File-level errors TLR records.
200	226-250	Batch-level errors on the BHD.
	276-299	Batch-level errors on the BTR records
600	601-602	Detail-level errors on DET records.

5.2.2 PDFS Error Codes

PDFS checks the format, integrity, and validity of individual fields before cross-checking field to field. For example, PDFS first checks that there is a Submitter ID in the HDR and one in the TLR before cross-checking the Submitter ID between the HDR and TLR. PDFS file-level, batch-level, and detail-level error codes are described in Table 5B.

TABLE 5B – PDFS ERROR CODES

FILE-LEVEL ERROR CODES

ERROR CODE	ERROR DESCRIPTION	
126	RECORD ID IS MISSING OR INVALID.	**HDR**
127	HDR RECORD IS OUT OF SEQUENCE. HDR RECORD IS NOT FIRST RECORD IN FILE OR DOES NOT FOLLOW A TLR RECORD.	
128	SUBMITTER ID IS MISSING.	
129	SUBMITTER ID IS NOT ON FILE.	
130	SUBMITTER ID IS NOT CERTIFIED TO SEND PRODUCTION DATA.	
131	FILE ID IS MISSING. FILE ID IS BLANK.	
132	FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.	
133	TRANS-DATE IS MISSING OR INVALID. MUST BE A VALID DATE IN CCYYMMDD FORMAT AND CANNOT BE A FUTURE DATE.	
134	PROD-TEST-IND IS MISSING OR INVALID. PROD-TEST-IND IS BLANK OR NOT EQUAL TO 'PROD' OR 'TEST'.	
176	TLR RECORD IS OUT OF SEQUENCE. TLR RECORD DOES NOT FOLLOW A BTR RECORD.	**TLR**
177	SUBMITTER ID IS MISSING.	
178	SUBMITTER ID IS NOT EQUAL TO THE SUBMITTER ID IN THE HDR RECORD.	
179	FILE ID IS MISSING.	
180	FILE ID IS NOT EQUAL TO THE FILE ID IN THE HDR RECORD.	
181	TLR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF BATCHES IN THE FILE.	
182	DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.	

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 5B – PDFS ERROR CODES (CONTINUED)

BATCH-LEVEL ERROR CODES

ERROR CODE	ERROR DESCRIPTION	
226	BHD RECORD IS OUT OF SEQUENCE. BHD RECORD DOES NOT FOLLOW EITHER A HDR OR BTR RECORD.	**BHD**
227	SEQUENCE NUMBER IS MISISNG OR INVALID. SEQUENCE NUMBER CANNOT BE BLANK OR ZERO. SEQUENCE NUMBER MUST START WITH A 0000001.	
228	SEQUENCE NUMBER IS INVALID. SEQUENCE NUMBER IS OUT OF ORDER.	
229	CONTRACT NUMBER IS MISSING.	
230	CONTRACT NUMBER DOES NOT MATCH NUMBER ASSIGNED BY CMS.	
231	CONTRACT NUMBER IS NOT ACTIVE.	
232	SUBMITTER NOT AUTHORIZED TO SUBMIT FOR THIS CONTRACT.	
233	PBP ID IS MISSING.	
234	PBP IS NOT VALID FOR THE CONTRACT ID.	
235	PBP ID IS NOT ACTIVE. NOT AUTHROIZED TO SUMBMIT PRODUCTION DATA.	
276	BTR RECORD IS OUT OF SEQUENCE. BTR RECORD DOES NOT FOLLOW A DET REOCRD.	**BTR**
277	SEQUENCE NUMBER IS MISSING OR INVLAID. SEQUENCE NUMBER IS NOT NUMERIC.	
278	SEQUENCE NUMBER IS NOT EQUAL TO THE BHD SEQUENCE NUMBER.	
279	CONTRACT NUMBER IS MISSING OR INVALID.	
280	CONTRACT NUMBER DOES NOT MATCH THE CONTRACT NUMBER IN THE BHD RECORD.	
281	PBP ID IS MISSING.	
282	PBP ID DOES NOT MATCH THE PBP ID IN THE BHD RECORD.	
283	DET RECORD TOTAL ON THE BTR RECORD IS MISSING.	
284	BTR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF DETAIL RECORDS.	

DETAIL-LEVEL ERROR CODES

ERROR CODE	ERROR DESCRIPTION	
601	DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT FOLLOW A BHD OR ANOTHER DET RECORD.	**DET**
602	SEQUENCE NUMBER IS INVALID. DET SEQUENCE NUMBER IS NOT NUMERIC OR NOT EQUAL TO THE COMPUTED SEQUENCE NUMBER.	

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

☒   **Example: 2 (Slides 7-8)**

Scenario

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

Result

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

5.3   DDPS System

After the file passes PDFS front end edits, PDFS sends the file via Connect:Direct to the CMS data center for DDPS processing. DDPS performs edits on all the detail-level records.

5.3.1   DDPS Editing Rules (Slide 9)

The DDPS editing process takes place in stages.

Stage 1 – Individual Field Edits

The DDPS performs format, integrity, and validity checks on all DET fields as a first level of editing. Examples include:

- Dates in CCYYMMDD format.
- Health Insurance Claim Number (HICN) field not filled with spaces.
- Fields contain legal values.

Stage 2 – Duplicate Check Edits

In this stage of editing, DDPS searches for duplicate records associated with a beneficiary using the HICN and briefly checking the Medicare Beneficiary Database (MBD) for the beneficiary's history. DDPS then checks the eight active record identifier fields for a duplicate record.

Stage 3 – Field-to-Field Edits

Following the edits on the individual fields and the edits to determine if a record is not a duplicate, DDPS begins logical edits which compare fields against each other. Examples include:

- Edits based on "If Then" statements (e.g., if Catastrophic Coverage is blank, then Gross Drug Costs Below the Out-of-Pocket Threshold (GDCB) must be greater than zero.

- The sum of detail cost fields are compared with those summing payment.

Stage 4 - Medicare Beneficiary Database Edits

The next stage of editing cross-checks the appropriate fields against the MBD. MBD is the authoritative source of beneficiary information, supporting enrollment and eligibility. Eligibility and Low Income Cost-Sharing Subsidy (LICS) data from the PDE are validated against the MBD.

In this stage DDPS looks up the HICN reported on the PDE and validates that there is a matching HICN on MBD with the same gender and date of birth (DOB) (if present on the PDE).

MBD is updated nightly with the Medicare Advantage Prescription Drug System (MARx) files. DDPS bases eligibility verification on the data stored in MBD. Since MARx is the source system for the plan enrollment data in MBD, both databases should reflect the same data.

5.3.1.1 Adjustments/Deletions (Slide 10)

In the event that the PDE is submitted as an adjustment to or deletion of an original PDE, there is another stage of editing. When the Adjustment/Deletion code reports "A" or "D", DDPS searches the system for a matching current active record. If the current active record is not found, then an error message is reported on the DDPS Return File. DDPS will not assume that the plan submitted an original PDE with an Adjustment/Deletion field incorrectly populated.

Only one original, adjustment, or deletion PDE can be submitted per day. An error is generated if there is more than one action on a specific PDE on a given day. The submission date differentiates the original PDE from subsequent submissions.

5.3.2 DDPS Edit Categories (Slide 11)

Table 5C describes the categories into which the DDPS edits are organized.

TABLE 5C –CATEGORIES AND DESCRIPTIONS

SERIES	EDIT CATEGORIES	DESCRIPTION
603-659	Missing or Invalid	Straightforward edits identifying invalid or missing values. If blank is a legal value, the missing edit does not apply.
660-669	Adjustment or Deletion	Edits in a hierarchy using eight fields (Contract Number, PBP ID, HICN, Service Provider ID, Prescription/Service Reference Number, Date of Service (DOS), Fill Number, and Dispensing Status).
700-714	Eligibility	Eligibility edits verify the HICN, the beneficiary's eligibility for Part D, and enrollment in the Part D plan. Plan enrollment must be accurate because payment calculations are summarized at the plan level.
735-754	National Drug Code (NDC)	NDC edits confirm that an NDC exists and that the NDC existed on the date of service. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered Part D drugs are excluded from True Out-of-Pocket Costs (TrOOP), LICS, and payment calculations.
755-774	Drug Coverage Status Code	Edits that test the relationship between non-covered Part D drugs and the Covered D Plan Paid Amount, so that non-covered Part D drugs are not inadvertently included in payment calculations.
775-799	Miscellaneous	Edits on miscellaneous data elements.
800-809	Program of All-Inclusive Care for the Elderly (PACE)	Edits specifically for PACE plans.

5.3.3 DDPS Error Codes

Tables 5D – 5J provide the DDPS edits by category.

TABLE 5D – DDPS DET ERROR CODES – MISSING/INVALID

ERROR CODE	ERROR DESCRIPTION
603	HICN IS MISSING. MUST NOT BE BLANK.
604	CARDHOLDER ID IS MISSING.
605	DOB IS AN INVALID DATE. DATES MUST BE IN CCYYMMDD FORMAT.
606	GENDER IS MISSING OR INVALID. GENDER MUST BE EITHER '1' OR '2'.
607	DOS IS MISSING OR INVALID. DOS MUST BE IN CCYYMMDD FORMAT AND BE A VALID DATE.
608	DOS MUST BE ON/AFTER 1/1/2006.
609	DOS MUST BE ON OR BEFORE TODAY'S DATE.
611	PAID DATE IS AN INVALID DATE IN CCYYMMDD FORMAT.
612	PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER IS MISSING OR INVALID. PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER MUST BE NUMERIC.
613	NDC CODE IS MISSING.
614	SERVICE PROVIDER ID QUALIFIER IS MISSING OR INVALID. SERVICE PROVIDER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '07' – NCPDP OR '08' – STATE LICENSE OR '11' – TIN OR '99' – OTHER.
615	SERVICE PROVIDER ID IS MISSING.
616	FILL NUMBER IS MISSING OR INVALID. FILL NUMBER MUST BE EQUAL TO A VALUE BETWEEN 0 AND 99.
617	DISPENSING STATUS IS INVALID. DISPENSING STATUS MUST BE EITHER A 'BLANK' OR 'P' OR 'C'.
618	COMPOUND CODE IS MISSING OR INVALID. COMPOUND CODE MUST BE EQUAL TO '0', '1', OR '2'.
619	DAW/PRODUCT SELECTION CODE IS MISSING OR INVLAID. DAW/PRODUCT SELECTION CODE MUST BE EQUAL TO VAUE BETWEEN 0 AND 9.
620	QUANTITIY DISPENSED IS MISSING OR INVALID. QUANTITY DISPENSED MUST BE ≥ 0.001.
621	DAYS SUPPLY IS MISSING OR INVLAID. VALUE MUST BE A VALUE BETWEEN 0 AND 999 DAYS.
622	PRESCRIBER ID QUALIFIER IS MISSING.
623	PRESCRIBER ID QUALIFIER IS INVALID. PRESCRIBER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '08' – STATE LICENSE OR '12' – DEA.
624	PRESCRIBER ID IS MISSING. MUST NOT BE BLANK.
625	DRUG COVERAGE STATUS CODE IS MISSING OR INVALID. VALID VALUES ARE 'C', 'E', AND 'O'.
626	ADJUSTEMENT CODE IS INVALID. VALID VALUES ARE 'A' FOR ADJUSTMENT AND 'D' FOR DELETION, OR 'BLANK'.
627	NON-STANDARD FORMAT CODE IS INVALID. VALID VALUES ARE 'BLANK,' 'B', 'X', OR 'P'.
628	OON IS INVALID. VALID VALUES ARE 'BLANK' OR 'O'.
629	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE 'BLANK', 'A', OR 'C'.
630	INGREDIENT COST PAID IS MISSING OR INVLAID. INGREDIENT COST PAID MUST BE > ZERO.
631	DISPENSING FEE PAID IS MISISNG OR INVALID. MUST BE ≥ ZERO.
632	SALES TAX IS MISSING OR INVALID. MUST BE ≥ ZERO.
633	GDCB IS MISSING OR INVALID. MUST BE ≥ ZERO.
634	GDCA IS MISSING OR INVALID. MUST BE ≥ ZERO.
635	PATIENT PAY AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 5D – DDPS DET ERROR CODES – MISSING/INVALID (CONTINUED)

ERROR CODE	ERROR DESCRIPTION
636	OTHER TrOOP AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
637	LICS VALUE IS MISSING OR INVALID. MUST BE ≥ ZERO.
638	PLRO IS MISSING OR INVALID. MUST BE NUMERIC.
639	CPP IS MISSING OR INVALID. MUST BE ≥ ZERO.
640	NPP IS MISSING OR INVALID. MUST BE NUMERIC.

If plans choose to report the DOB, which is an optional field, then the correct CCYYMMDD format must be used. DDPS rejects any record with invalid format in date fields, even though the field is optional.

If plans choose to report Paid Date, which is an optional field for non-Fallback Plans, date format must be valid. DDPS rejects any record with invalid format in date fields, even though the field is optional.

The error message for missing Prescriber ID Qualifier only applies to PDE records populated from data compiled from standard formats. If the submitter populates the Prescriber ID Qualifier field, then the value must be valid.

The error message for missing Prescriber ID applies on all PDEs populated from data collected from standard and non-standard formats when the Prescriber ID Qualifier is present and valid.

Dollar fields – In general, values in dollar fields must be zero or greater. There are three exceptions.

1. Ingredient Cost Paid – Based on the assumption that there is cost for any drug, values must be greater than zero. "Any drug" includes over-the-counter (OTC) drugs, which are funded by administrative costs.

2. Patient Liability Reduction due to Other Payer Amount (PLRO) and Non-covered Plan Paid Amount (NPP) – negative values are also valid.

3. PLRO and NPP must be numeric.

TABLE 5E – DDPS DET ERROR CODES – ADJUSTMENT/DELETION

ERROR CODE	ERROR DESCRIPTION
660	ADJUSTMENT/DELETION PDE DOES NOT MATCH THE EXISTING PDE RECORD (7 FIELD MATCH).
661	CANNOT ADJUST RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
662	CANNOT DELETE RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
663	VALUE OF DISPENSING STATUS ON ADJUSTMENT RECORD AND THE RECORD TO BE ADJUSTED MUST BE THE SAME.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PDEs with an Adjustment/Deletion code are always checked against five key fields (HICN, Service Provider ID, Prescription/Service Reference Number, DOS, and Fill Number). All five fields, as well as Contract No and PBP ID, must match the active PDE record or an error message 660 is generated. If the first five key fields match, a sixth key field, Dispensing Status, is checked. If dispensing status does not agree with the original PDE, edit 663 is generated. Remember that dispensing status is part of the key to the PDE record and cannot be adjusted. If you need to change dispensing status or any other key field, the original record must be deleted and a new record with the correct key information submitted.

TABLE 5F – DDPS DET ERROR CODES – ELIGIBILITY

ERROR CODE	ERROR DESCRIPTION
700	HICN DOES NOT MATCH AN EXISTING BENEFICIARY.
701	DOB PROVIDED DOES NOT MATCH THE DOB ON MBD.
702	GENDER DOES NOT MATCH THE VALUE ON MBD.
703	DOS CANNOT BE LESS THAN THE DOB.
704	DOS CANNOT BE GREATER THAN THE DATE OF DEATH (DOD).
705	BENEFICIARY MUST BE ENROLLED IN PART D ON THE DOS.
706	BENEFICIARY MUST BE ENROLLED IN THIS CONTRACT ON THE DOS.
707	BENEFICIARY MUST BE ENROLLED IN THIS PART D PLAN BENEFIT PACKAGE ON THE DOS.

DDPS applies edits hierarchically in the order listed above. DDPS discontinues eligibility edits as soon as a PDE fails an eligibility edit.

DDPS applies Edit 701 only when DOB is present.

When MBD documents an updated HICN for the beneficiary, DDPS reports the updated HICN back to the plan for informational purposes. The updated HICN is reported on the DDPS Return File in field 40. DDPS does not reject PDEs for updated HICNs.

TABLE 5G – DDPS DET ERROR CODES – NDC

ERROR CODE	ERROR DESCRIPTION
735	NDC CODE IS INVALID. NDC CODE DOES NOT MATCH A VALID CODE ON THE NDC DATABASE.
736	DOS < NDC EFFECTIVE DATE.
737	INAPPROPRIATE DRUG COVERAGE STATUS CODE. DRUG COVERAGE IS NOT 'O' ALTHOUGH THE DRUG IS ON THE OTC LIST.
738	INAPPROPRIATE DRUG COVERAGE. DRUG COVERAGE IS 'C' ALTHOUGH THE DRUG IS ON THE EXCLUSION LIST.
739	THIS NDC IS FOR A DRUG THAT IS USUALLY COVERED UNDER PART B. IF PLAN DETERMINES THAT THIS DRUG IS PART B COVERED, SUBMIT DELETION RECORD.
740	NDC IS DESI DRUG.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

DDPS validates that NDCs reported as covered drugs are Part D drugs. The definition of Part D drugs excludes Benzodiazepines, Barbiturates, and OTC drugs. CMS plans to develop additional informational edits for drugs that are typically covered under Part B.

TABLE 5H – DDPS DET ERROR CODES – DRUG COVERAGE STATUS CODE

ERROR CODE	ERROR DESCRIPTION
756	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE COVERED D PLAN PAID AMOUNT MUST BE ZERO.

DDPS confirms that PDEs for non-covered drugs do not report data in fields reserved for covered drugs.

DDPS also confirms that plans do not charge beneficiaries for OTC drugs. Plans must fund OTCs from administrative costs.

TABLE 5I – DDPS DET ERROR CODES – MISCELLANEOUS

ERROR CODE	ERROR DESCRIPTION
775	INCOMPATIBLE DISPENSING STATUS ('BLANK' CANNOT FOLLOW 'C' OR 'P'). RECORD FOR A PARITAL OR COMPLETE FILL IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH DISPENSING STATUS = BLANK FOR THE SAME DISPENSING EVENT.
776	INCOMPATIBLE DISPENSING STATUS ('C' OR 'P' CANNOT FOLLOW 'BLANK'). RECORD WITH UNSPECIFIED FILL STATUS IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH PARTIAL OR COMPLETE FILL FOR THE SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C').
777	DUPLICATE PDE RECORD.
778	PAID DATE < DOS.
779	SUBMITTING PLAN CANNOT REPORT NPP FOR COVERED PART D DRUG.
780	SERVICE PROVIDER ID QUALIFIER MUST BE '01' – NPI OR '07' – NCPDP ON STANDARD CLAIM.
781	SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE.
782	RECORD HAD NO ERROR, BUT WAS SUBMITTED AS PART OF A REJECTED FILE. DDPS REJECTS FILES WITH ERROR RATES EXCEEDING 50%.

If a record was previously submitted and the Adjustment/Deletion field is 'blank,' a duplicate PDE record error message is generated.

If the Paid Date field is completed, then the date must equal the date of service.

Only Enhanced Alternative (EA) plans, Flexible Capitated Payment Demonstrations, and Fixed Capitated Payment Demonstrations can report NPP for covered Part D drugs.

Service Provider ID Qualifier does not apply to X12, paper, or beneficiary submitted claims.

Service Provider ID is not on master provider file currently applies only to National Council for Prescription Drug Programs (NCPDP) numbers.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Edit 782 identifies an error-free record that was submitted on a file with many rejected records. DDPS rejects files with error rates greater than 50 percent. Plans should contact Customer Service and Support Center (CSSC).

TABLE 5J – DDPS DET ERROR CODES – PACE

ERROR CODE	ERROR DESCRIPTION
800	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE BLANK IN PDES SUBMITTED BY PACE PROGRAMS.
801	PATIENT PAY AMOUNT IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
802	OTHER TROOP AMOUNT IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS
803	LICS VALUE IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
804	PLRO IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
805	WHEN DRUG COVERAGE STATUS CODE EQUALS 'C', THE NON-COVERED PLAN PAID AMOUNT MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
806	GDCB IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
807	GDCA IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
808	FOR A COVERED DRUG, SUM OF INGREDIENT COST PAID, DISPENSING FEE PAID, AND TOTAL AMOUT ATTRIBUTED TO SALES TAX MUST EQUAL COVERD D PLAN PAID AMOUNT IN PDE SUBMITTED BY A PACE PROGRAM.
809	FOR A NON-COVERED DRUG, SUM OF INGREDIENT COST PAID, DISPENSING FEE PAID AND TOTAL AMOUNT ATTRIBUTED TO SALES TAX MUST EQUAL NON-COVERED PLAN PAID MAOUNT IN PDE SUBMITTED BY A PACE PROGRAM.

5.3.4 Informational Edits

DDPS has a small number of informational edits. Although informational edits identify conditions that are usually errors, the edits are defined as informational because, infrequently, there are documented circumstances in which the condition is not an error. Plans must research informational edits thoroughly and submit adjustments to correct the data whenever necessary.

⊠ **Example: 3 (Slides 12-13)**

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

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

5.4   Resolving Errors (Slides 14-17)

Error resolution has two parallel paths. At the same time plans correct individual errors, they must assess the factors that caused the error. When system deficiencies cause errors, plans should correct the system problem. Plans should also measure and improve their own performance in reducing errors over time.

CMS provides tools to plan for managing and reducing errors. Error codes are specific and the messages clearly identify error conditions. Tools for managing and reducing errors include:

- The DDPS Return File uniquely identifies a maximum of ten errors and reports the total number of known errors. This detail information gives the plan sufficient information to correct the majority of errors in a record and submit clean data.

- Management reports give error rates and identify trends. Error rates decline over time when plans manage the error process successfully.

- DDPS maintains an ongoing test environment for use at the plan's discretion. When any major changes are made to the plan's system of record, plans must repeat the certification process.

Plans should identify the field or fields that triggered the error and why the error occurred including:

- Determining if the error occurred because the format is invalid.

⊠   **Example: 4**

Scenario
Park Health Plan submitted a PDE record with the Prescription/Service Reference Number populated using an alphanumeric format instead of numeric.
Result
Park Health Plan receives edit 612, which indicates that a Prescription Number/Service Reference Number is missing or invalid. The Prescription Number/Service Reference Numbers must be numeric.

Determining if the data value is an invalid value.

⊠   **Example: 5**

Scenario
Lighthouse Health submitted a PDE record with "D" in the Drug Coverage Status Code.
Result
Lighthouse Health received edit 625, which indicates the Drug Coverage Status Code is missing or invalid. The only valid values for this field are 'C', 'E', and 'O'.

Note: Edits 603 through 639 are single field edits and generate single field error codes and messages.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Resolving errors associated with field-to-field edits is similar, but involves several additional steps.

1. Identify the relationships between the multiple fields that triggered the error.
2. Determine which fields had incorrect values that caused the error.

Note: NDC Edits, Drug Coverage Status Code Edits, and some PACE Edits are examples of field-to-field edits.

Eligibility and LICS edits are field-to-field edits with specific problem-solving steps.

- Eligibility Edits (Edits 700 – 707)

⊠   **Example: 6**

Scenario

Yellow Ridge Health Plan submitted a PDE record for a beneficiary on 05/13/05.

Result

Yellow Ridge Health Plan received edit 707 indicating that the beneficiary was not enrolled in the Part D plan benefit package on the DOS. The beneficiary must be enrolled in this Part D plan benefit package on the DOS to receive coverage. Yellow Ridge Health Plan should:
- Determine if the DOS is accurate.
- Determine if the plan's enrollment file shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS. There may be enrollment date discrepancies when a beneficiary transfers from one plan to another.
- Determine if MBD shows that the beneficiary was enrolled in the plan and if the enrollment date is on or before the DOS and if disenrollment date (if applicable) is after DOS.
- If the plan cannot resolve enrollment discrepancies, the last step is to call CSSC. If CSSC determines that MBD needs to have the plan enrollment data updated, the plan will resubmit following MBD correction.

When resolving errors and implementing prevention mechanisms in internal systems, plans can ask the following questions:

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

MODULE 6 – REPORTS

Purpose (Slide 2)

The Centers for Medicare & Medicaid Services (CMS) communicates the status of submitted Prescription Drug Event (PDE) records to submitters on reports. The reports focus on both PDE record processing, including errors generated during processing, and accumulation of dollar amounts. It is essential that plan management staff understand how to read reports and resolve any issues the reports may identify. This module provides insights on the appropriate use of reports to manage data collection, data submission; error resolution processes, and helps prepare plans for the reconciliation process.

Learning Objectives (Slide 3)

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

- Identify the purpose of Prescription Drug Front-End System (PDFS), Drug Data Processing System (DDPS) and Drug Benefit Calculator (DBC) reports.
- Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- Accurately read the DDPS reports to identify and submit corrections.
- Understand the relationship between values in the financial management reports and reconciliation.

ICON KEY	
Definition	ᕦᕤ
Example	⊠
Reminder	🔍
Resource	📖

6.1   Accessing Part D Reports (Slide 4)

Plans can access reports designed to support the prescription drug event data process through the following methods:

- Secure Website
- File Transfer Protocol
- Connect:Direct

Secure Website and FTP users receive reports generated by the Prescription Drug Front-End System (PDFS) typically within 30 minutes of submission. Connect:Direct users should receive PDFS reports the following business day if the file transfer is complete by 5:00 p.m. Eastern Time (ET). If the submission is received after 5:00 p.m. ET, the Connect:Direct user will receive the report 2 business days after submission.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

All submitters receive Drug Data Processing System (DDPS) processing reports the next business day; monthly DDPS reports are available for download the third business day of the month. For FTP and secure website submitters, reports are sent to the submitter's mailbox where they remain for 15 days. The system automatically deletes reports from the mailbox after 15 days, but plans can access reports through the Customer Service and Support Center (CSSC) for 7 years. Connect:Direct users will access reports through a database and should contact CSSC for more information.

Plans may request reports in .zip format. To avoid difficulties opening .zip reports, users should:
- Rename the file with the ".zip" extension.
- Change the command to binary when using the FTP command line.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

6.2   Report Format

With the exception of the PDFS Response Report, all reports will arrive in flat file format. The flat files may be downloaded into databases and converted to display the necessary fields.

TABLE 6A – REPORTS OVERVIEW

PDFS REPORT	
PDFS RESPONSE REPORT	• Indicates if file is accepted or rejected • Identifies 100-, 200-, and 600-level error codes • Report layout • Secured Website and FTP users receive reports the same business day; Connect:Direct users access reports the next business day
DDPS TRANSACTION REPORTS	
DDPS RETURN FILE	• Contains a truncated submitted transaction for accepted detail records • Contains the entire submitted transaction for rejected or informational detail records • Identifies error codes • Flat file layout • Received the next business day after processing
DDPS TRANSACTION ERROR SUMMARY REPORT	• Provides counts and rates for each error in the file • Flat file layout • Received the next business day after processing
DBC MANAGEMENT REPORTS	

DBC CUMULATIVE BENEFICIARY SUMMARY REPORT	• Three reports, each with same format
	  - 04PCC for covered drugs
	  - 04PEN for enhanced alternative drugs
	  - 04POT for over the counter drugs
	• Provides summary of accumulated totals per beneficiary for dollar amount fields
	• Provides CMS calculated values for GDCB, GDCA, LICS, CPP, and NPP
	• Totals apply to one benefit year, with each benefit year having a separate cumulative report
	• Financial amounts are reported as "net"
	• Report will break by submitter, contract, and PBP
	• Available for download the third business day of the month

Table 6B provides the naming conventions for management reports placed in the submitter's mailbox.

TABLE 6B – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
PDFS RESPONSE REPORT	RPT00000.RSP.PDFS_RESP
DDPS RETURN FILE	RPT00000.RPT.DDPS_TRANS_VALIDATION
DDPS TRANSACTION COUNT & CONTROL SUMMARY REPORT	RPT00000.RPT.DDPS_TRANS_CNT_CNTRL_SUM
DDPS TRANSACTION ERROR SUMMARY REPORT	RPT00000.RPT.DDPS_ERROR_SUMMARY
DBC CUMULATIVE BENEFICIARY SUMMARY REPORT	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC

6.3   Prescription Drug Front-End System (PDFS) Report (Slide 9)

The PDFS Response Report identifies errors generated by the PDFS and checks for format, integrity, and validity that occurred in the file-, and batch-level records as well as the checks for sequencing errors on all detail-level records. The report provides the status of the file and whether it was accepted or rejected by the PDFS. If the file is accepted, the report specifies that the file is completely accepted. If the file is rejected, the report identifies the errors or reasons the file was rejected. Figure 6A illustrates the fields on the PDFS Response Report and describes the report's fields.

Figure 6A – Rejected PDFS Response Report

```
[1]REPORT: PDFS-RESP          [2]PRESCRIPTION DRUG FRONT END SYSTEM
[3]RUN DATE: 20060513               PDFS RESPONSE REPORT

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


[7]        [8]        [9]
RECORD    SEQ        ERROR    [10]
TYPE      NO         CODE      ERROR DESCRIPTION
HDR                  132       FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE
                               THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.

END OF REPORT
*****END OF TRANSMISSION*****
```

FIELD NO.	FIELD NAME	FIELD DESCRIPTION
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Report Date	Date the report was generated by Palmetto (CCYYMMDD format).
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one plan. A different report is generated for each plan.
5	File ID	The 10-digit file identification number.
6	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST or PRODUCTION.
7	Record Type	Identifies the level of the error (File, Batch, or Detail record level).
8	Sequence Number	Identifies the batch or detail-level record where the error occurred.
9	Error Code	Identifies the 3-digit error code that caused the file to reject.
10	Error Code Description	Explains the error code.

NOTE: There are three reasons why users would not receive the PDFS Response Report:

- The HDR record is not included on the file. Submitters receive an "INVALID_FILE_HDR" message.
- No Submitter ID on the HDR record.
- The login ID used to submit data to PDFS does not match the Submitter ID. Submitters receive a "SUBMITTER ID IN FILE DOES NOT MATCH THE LOGIN ID" message (FTP and Secure website users only).

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

⊠   **Example: 1**

SureHealth submitted a file, but did not change the file ID. The second batch did not include a valid PBP number for the Contract ID. The first detail record was out of sequence, the fourth batch trailer's PBP did not match the PBP number in the batch header, and the record total in the TLR was missing. Figure 6B illustrates this example.

Figure 6B – PDFS Response Report

```
REPORT:  PDFS-RESP      PRESCRIPTION DRUG FRONT END SYSTEM
RUN DATE: 20060315            PDFS RESPONSE REPORT


SUBMITTER ID:  SH9999
FILE-ID: 0000000001          REJECTED    PROD


RECORD       SEQ      ERROR
TYPE         NO       CODE     ERROR CODE DESCRIPTION

HDR                   132      FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE
                               THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.

BHD          0000002  234      PBP IS NOT VALID FOR THE CONTRACT ID.

DET          0000001  601       DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT
                                FOLLOW A BHD OR ANOTHER DET RECORD.

BTR          0000004  282      PBP ID DOES NOT MATCH PBP ID IN THE BHD RECORD.

TLR                   182      DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT
                               MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.
END OF REPORT
*****END OF TRANSMISSION*****
```

6.4   Drug Data Processing System (DDPS) Transaction Reports (Slide 10)

DDPS produces Transaction reports after processing a PDE. These reports give the precise status of each of the submitted PDE records, as well as summary information about the submitted file.

Each of the DDPS Reports will be delivered in flat file format. Report files contain up to seven record types, each containing 512 bytes. The record types are presented in the same order for each report file. Table 6C provides the indicator and definition for each record type included in the report flat file.

Transaction Reports document the result of DDPS processing. They are specific to each file. Plans, or submitters on behalf of plans, must promptly review transaction reports to identify any problems to be

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

resolved. Plans should trend summary data from transaction reports to measure and improve the plan's performance.

6.4.1   DDPS Return File (Slide 11)

The layout of the DDPS return file closely mirrors that of the submitted PDE record. One key element of the report is a change in the DET indicator field. Upon completion of DDPS processing the Record ID field within the DET record is changed from DET to one of three values: ACC indicates that the record had no errors and was accepted and stored, INF indicates that the record contains an informational error, however the data were stored. REJ indicates the record was rejected and the data were not stored. Table 6C shows all of the record values for the DDPS Return File.

TABLE 6C - DDPS RETURN FILE - RECORD DEFINITION/DESCRIPTION

RECORD ID	RECORD DEFINITION	NOTES
HDR	File header created by submitter	Occurs once per file.
BHD	PBP level file header created by submitter	Occurs once per PBP for each plan on file.
ACC*	Accepted PDE records written by DDPS	First 16 fields from accepted DET record.
INF*	Informational PDE records written by DDPS	All fields from DET records with information edit codes appended in fields 42-51 (positions 468-497).
REJ*	Reject PDE records written by DDPS	All fields from DET records with error codes appended in fields 42-51 (positions 468-497).
BTR	PBP level file trailer created by submitter (modified by DDPS)	Occurs once per each BHD on the file. Contains all fields from submitted BTR (including counts of original number of DET records) plus ACC, INF, and REJ record counts.
TLR	File trailer created by submitter (modified by DDPS)	Occurs once per file. Contains all fields from submitted TLR (including counts of original number of DET records) plus ACC, INF, and REJ record counts.

* ACC, INF and REJ records will be sorted by sequence number and appear in the same sequence as on the submitted file.

The DDPS Return File makes no change in the HDR or BHD records originally submitted by the plan.

The DDPS return file will return the detail records in the same basic format as the submission file. The records will be in the same sequence as when they were submitted. However, the records will no longer be labeled "DET;" they will be "ACC," "INF," or "REJ."

Detail records: When the plan submits detail records, the first field on every detail record is "DET". In the DDPS return file, DDPS changes this field to one of the following values:

ACC DDPS accepted the record. DDPS changes the record type from DET to ACC and returns the first 16 fields in the original file. These 16 fields include the six key fields as well as

additional identifiers so the plan can link to its internal databases. DDPS returns spaces in the remaining fields to minimize file size and speed up file transfer time.

INF DDPS accepted the record and is reporting informational errors. Plan should research informational edits thoroughly because they usually report an error condition. These error conditions are considered informational because a small number of exceptions exist in which the data would be correct. DDPS changes the record type from DET to INF. DPPS returns every field the plan submitted and populates the error count field and up to ten error codes.

REJ DDPS rejected the record because it triggered at least one error with a reject outcome. (The rejected record may also have triggered one or more informational edits.) DDPS changes the record type from DET to REJ. DPPS returns every field the plan submitted, populates the error count field and up to ten error codes.

Information about the error codes, including the informational error codes can be found in the Edits Module.

In addition to changes in the Record ID field, DDPS provides a count of all errors in the file, error codes associated with those errors and a corrected HICN, where applicable. Details about the error count and corrected HICN are included below.

Error count defined: The error count counts total errors that DDPS encountered. The DDPS return file gives details for up to 10 error codes, which should be sufficient feedback to correct the record. Very few records will contain more than 10 errors. If the error count is 11, plans can conclude that the record contained additional error conditions for which no error detail could be reported. Records will require more research.

Corrected HICN: MBD is the authoritative source for HIC numbers. If the HICN reported on the PDE does not match the current existing HICN on MBD, DDPS accepts the record and also returns the corrected HICN in field 40. The presence of data in the corrected HICN field is the only indication a plan has that the MBD and the plan's information differ. No informational edit is triggered and the error count is not incremented when a corrected HICN is detected. Corrected HICNs may be reported on any detail record type (ACC, INF, or REJ). Plans should automatically check the Corrected HICN filed on every detail record in the DDPS return file. Anytime Corrected HICN is reported, plans should align their internal data systems with MBD.

The DDPS return file will provide the same BTR record as appeared on the submitted PDE file, including the original count of detail records in the DET field. DDPS also populates batch level record counts in the three fields, reflecting the resolution of the detail records in the batch:

- ACC Total count of DET Accepted records
- INF Total count of DET Informational records
- REJ Total count of DET Rejected records

This data provides a snapshot of the batch-level error rate. By taking the ratio of REJ records to DET records, the plan immediately knows what percentage of records was rejected. Since ACC and INF records are both accepted and stored in DDPS, the percentage of accepted records is calculated by summing those two counts and taking the ratio of that sum to the total DET record count. Table 6D provides the BTR record layout.

TABLE 6D – DDPS RETURN FILE BTR RECORD

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION/VALUES
1	RECORD ID	BTR
2	SEQUENCE NO	Starts with 0000001
3	CONTRACT NO	X(5)
4	PBP ID	X(3)
5	DET RECORD TOTAL	Original count of DET records in the submitted batch
6	DET ACCEPTED RECORD TOTAL	Total count of DET Accepted records
7	DET INFORMATIONAL RECORD TOTAL	Total count of DET Informational records
8	DET REJECTED RECORD TOTAL	Total count of DET Rejected records
9	FILLER	

As with the BTR record, DDPS updates the TLR record with the ACC, INF and REJ counts for the entire file. The DDPS return file populates file-level record counts in the three fields illustrated in Table 6E.

TABLE 6E – DDPS RETURN FILE TLR RECORD – FIELDS UPDATED BY DDPS

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION/VALUES
6	TLR DET Accepted Record Total	Total count of DET Accepted records
7	TLR DET Informational Record Total	Total count of DET Informational records
8	TLR Rejected Record Total	Total count of DET Rejected records

These detail record breakouts can be used to calculate file-level error and acceptance rates in the same manner as shown for the BTR record.

6.4.2 Report 3: DDPS Transaction Error Summary (Slide 13)

The DDPS Transaction Error Summary provides a count of each type of error code generated on a specific transaction. The report provides this data for each submitted batch. This report provides an instant snapshot of the rate at which specific error codes occur. Submitters can use this report to identify the most frequent errors, allowing them to target their resources appropriately to prevent these errors from occurring on future transactions.

This file has HDR, BHD, DET, BTR, and TLR records, similar to a PDE file. The DET records on this report are used to display each error code received on a file and information about that code. Table 6F provides

the record definitions and descriptions for the basic record layout for the DDPS Transaction Error Summary.

TABLE 6F - RECORD DEFINITION/DESCRIPTION

RECORD INDICATOR	RECORD DEFINITION	NOTES
HDR	Submitter file header	Occurs once per file
BHD	Contract/PBP level file header	Occurs once per Contract/PBP on file
DET	Detail records for the report	Occurs 1 to many times per BHD record
BTR	Contract/PBP level file trailer	Occurs once per each BHD on the file
TLR	Submitter file trailer	Occurs once per file

The HDR record defines the submitter. The File ID has the value "03" followed by the File ID from the original PDE submission. The HDR also has a date/time stamp from DDPS indicating when it was produced.

The BHD identifies the Contract and Benefit Plan Package ID and should be the same as what was provided in the PDE.

The DDPS Transaction Error Summary will contain one DET record for every error code received in a submitted batch. Each DET record will list the error code, its associated description, a frequency of occurrence in the batch, and the rate of occurrence as a percentage of all errors received in that batch. Table 6G provides the flat file layout for the DDPS Transaction Error Summary DET record.

TABLE 6G – DDPS TRANSACTION ERROR SUMMARY DET RECORD

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION
1	RECORD ID	DET
2	SEQUENCE NO	Starts with 0000001
3	ERROR CODE	Identification Number of the Error Code
4	ERROR CODE DESCRIPTION	Description of Error Code
5	FREQUENCY OF OCCURRENCE	Count of each Error Code
6	PERCENTAGE OF ALL EDITS	Percentage of each Error Code's frequency to the frequency of all Error Codes. In formula: Frequency Count of the specific error code divided by Frequency Count of all error codes.
7	FILLER	SPACES

The BTR and TLR records provide balancing totals and information that identifies the batch and file, respectively. These records do not provide any additional data for purposes of summary reporting.

6.5 Management Reports (Slides 14 – 15)

Management reports summarize data monthly on a year-to-date basis for any given benefit year. These reports are produced by the Drug Benefit Calculator, the data warehouse established for the PDE data. In particular, management reports show the way that DBC understands the beneficiary's status at the plan in terms of selected financial data that are relevant to one specific benefit year. For each benefit year, DBC will generate separate management reports. There are three management reports scheduled for initial implementation:

Management Report 04PCC – Cumulative Beneficiary Summary, Covered Drug
Management Report 04PEN – Cumulative Beneficiary Summary, Enhanced Alternative Drugs
Management Report 04POT – Cumulative Beneficiary Summary, Over-the-Counter Drugs

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

6.5.1 Report 04PCC – Cumulative Beneficiary Summary Report, Covered Drugs

The Cumulative Beneficiary Summary Report for Covered Drugs provides all of the beneficiary-level PDE financial information necessary to reconcile the cost-based portion of the Part D payment. This report sums a beneficiary's PDE activity and provides net financial information relevant to a specific Part D plan. Table 6H illustrates the specific types of information in this report.

TABLE 6H- KEY INFORMATION IN THE CUMULATIVE BENEFICIARY SUMMARY REPORT

COST	PAYMENT	PDE SUBMISSIONS	BENEFICIARY UTILIZATION
- Net Ingredient Cost Paid - Net Dispensing Fee Paid - Net Total Amount Attributed to Sales Tax	**Reported** - Net CPP **Calculated** - Net GDCB - Net GDCA - Net LICS - Net CPP - Net NPP	- Number of Original PDEs - Number of Adjusted PDEs - Number of Deletion PDEs	- Net Number of Non-Standard Format PDEs - Net Number of Out-of-Network PDEs

6.5.1.1   Basic Record Layout

This file has a different set of records than all of the other files we have examined today. The Beneficiary Summary Report has file HDR and TLR records that package the entire report. Immediately following the HDR record will be a contract header record (CHD), followed by a PBP header (PHD). These records set up cumulative reporting at either the contract or PBP level. The three header records are followed by DET records, which provide the beneficiary level reporting. The report then has three trailer records to mirror the three header records. The PBP trailer (PTR) sums all of the beneficiary level data for each PBP in the file. The contract trailer (CTR) sums all of the PBPs for a contract. The TLR record works like all previous TLR records. Table 6I provides the definitions and descriptions of the records in the Cumulative Beneficiary Summary.

**TABLE 6I - CUMULATIVE BENEFICIARY SUMMARY REPORT - RECORD
DEFINITION/DESCRIPTION**

RECORD INDICATOR	RECORD DEFINITION	NOTES
HDR	Submitter file header	Occurs once per file
CHD	Contract level file header	Occurs once per Contract on file
PHD	Contract/PBP level file header	Occurs once per Contract/PBP on file
DET	Detail records for the report	Occurs 1 to many times per BHD record
PTR	Contract/PBP level file trailer	Occurs once per PHD PBP on the file
CTR	Contract level file trailer	Occurs once per CHD Contract on the file
TLR	Submitter file trailer	Occurs once per file

6.5.1.2   Header Records

The HDR, CHD, and PHD records identify the submitter, contract, and plan, respectively. Each has a file name on the record level, allowing a submitter to distribute reports at the contract level, and a contract to treat plan-level reports as unique reports.

Embedded in the file name is the benefit year on which data is being reported. In addition to the benefit year, the report references an As-of Year and As-of Month. Those dates refer to the latest submission month upon which the data are being reported.

For example, on or about April 1, 2006, DBC will produce a report with the following attributes:
- File Name: DDPS04PCC2006003
- As-of Year: 2006
- As-of Month: 03
- DDPS Date: 20060401

The identifying information shows that this report has data for the 2006 benefit year, submitted to DDPS by March 31, 2006.

On or about April 1, 2007, DBC will need to produce two of these reports, one for benefit year 2006 and one for 2007. The attributes for each will be:

April 2007 Cumulative Beneficiary Summary Report (Benefit Year 2006)
- File Name: DDPS04PCC2006015
- As-of Year: 2007
- As-of Month: 03
- DDPS Date: 20070401

April 2007 Cumulative Beneficiary Summary Report (Benefit Year 2007)
- File Name: DDPS04PCC2007003
- As-of Year: 2007
- As-of Month: 03
- DDPS Date: 20070401

The file name for the first report shows that it is the 15th report produced for benefit year 2006. The file name for the second report shows that it is the third report produced for benefit year 2007. Both reports have the same as of date, indicating that each report represents data submitted through March 31, 2007.

6.5.1.3   DET Record

The DET record establishes the basic format for the rest of the file. The layout for the DET record appears in Table 6M.

DET records have some important basic characteristics:

- Beneficiaries are identified by their most current HICN on file, rather than reported HICNs. Plans will be receiving updated HICNs when a beneficiary's HICN changes. Plans are expected to maintain the most current HICN and cross-walk any previous activity under older HICNs to the most current HICN. Medicare Advantage Prescription Drug System (MARx) will report out payment information using the current HICN, and CMS reconciliation reports will carry the most recent HICN. Therefore, it is essential that plans track HICN changes and retain the current HICN on file.

- Cardholder ID will be the beneficiary's most current cardholder ID for that plan in the benefit year being reported based on PDE data on file. Since CMS will not always know about cardholder ID changes, the plan must maintain a cardholder ID history for each enrolled beneficiary to ensure accurate tracking.

- The Rx Count in field 7 will be net of adjustment and deletion PDEs, as well as partial fill transactions.

- All dollars reported in fields 8-20 will be net of adjustment and deletion PDEs.

- The report reflects the PACE-reported value of CPP (equal to total drug cost), followed by the CMS calculated values for GDCB, GDCA, LICS, CPP, and NPP. These calculated values are used for reconciliation of PACE payments.

- Fields 21-23 are gross counts of each type of PDE. Net values do not apply to these fields.

- Fields 24-28 represent PDE counts net of adjustments and deletions.

The information on this file should be reconciled with plan records. However, it is important that plans track PDE submissions and the results of PDE processing. While plans will need to track the benefit in their claims files, the PDE tracking will reflect which of the plans claims have been submitted and accepted into DDPS as PDEs (and which have not). The reports generated from DBC will correspond only to data that have been submitted and accepted. If a plan compares the summary report to claims data rather than PDE data, outstanding claims (claims that have not been submitted or that were rejected from DDPS) will cause a discrepancy between the DBC financial summary and the plan financial summary. Once plans have compared the DBC report to PDE data and confirmed the report's accuracy, the same comparison can be performed against claims files to determine the impact of outstanding claims.

CMS holds plans responsible for verifying the Cumulative Beneficiary Summary Report for Covered Drugs every month. This report will be the vehicle through which plans receive advance notification of their potential payments or liabilities upon final reconciliation.

Table 6J provides the fields for the DET record to the Cumulative Beneficiary Summary Report.

TABLE 6J - CUMULATIVE BENEFICIARY SUMMARY REPORT - DET RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DESCRIPTION/VALUES
1	RECORD ID	1 - 3	X(3)	3	DET
2	SEQUENCE NO	4 – 10	9(7)	7	Must start with 0000001
3	DRUG COVERAGE STATUS CODE	11 – 11	X(1)	1	Aways "C" on report 04PCC
4	CURRENT CMS HICN	12 - 31	X(20)	20	Medicare HIC or RRB number. If the beneficiary has more than one HICN on file, this is current HICN.
5	SUBMITTED HICN FROM MOST RECENT PDE	32 – 51	X(20)	20	The HICN from the most recent accepted PDE in the DDPS database.
6	MOST RECENT PLAN-SUBMITTED CARDHOLDER ID	52 - 71	X(20)	20	Plan identification of the enrollee, as reported on the most accepted recent PDE for the benefit year.
7	RX COUNT	72 – 82	9(11)	11	Number of Prescriptions net of deleted and adjusted PDEs, as well as partial fill transactions
8	NET INGRED COST	83 – 96	S9(12)V99	14	Net Ingredient Cost paid amount as reported on the PDEs.
9	NET DISPENS FEE	97 – 110	S9(12)V99	14	Net Dispensing Fee paid amount as reported on the PDEs.
10	NET SALES TAX	111 - 124	S9(12)V99	14	Net Sales Tax paid amount as reported on the PDEs.
11	REPORTED NET CPP AMOUNT	125 - 138	S9(12)V99	14	Net Covered D Plan Paid Amount as reported on the PDEs.
12	CALCULATED NET GDCB	139 – 152	S9(12)V99	14	Net Gross Drug Cost Below the attachment point as calculated based on the rules for PACE organizations
13	CALCULATED NET GDCA	153 – 166	S9(12)V99	14	Net Gross Drug Cost Above the attachment point as calculated based on the rules for PACE organizations
14	CALCULATED NET LICS AMOUNT	167 – 180	S9(12)V99	14	Net Low Income Cost Sharing Amount as calculated based on the rules for PACE organizations
15	CALCULATED NET CPP AMOUNT	181 – 194	S9(12)V99	14	Net Covered D Plan Paid Amount as calculated based on the rules for PACE organizations
16	CALCULATED NET NPP AMOUNT	195 – 208	S9(12)V99	14	Net Non-covered Plan Paid Amount as calculated based on the rules for PACE organizations
17	NET NUMBER OF NON-STANDARD FORMAT PDEs	209 – 220	9(12)	12	Count of PDEs with Non-standard Format Code other then blank
18	NET NUMBER OF OON PDES	221 – 232	9(12)	12	Count of PDEs with out-of-network code equal "O"
19	FILLER	233 – 512	X(280)	280	SPACES

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

6.5.1.4   PTR Record

The PTR record has the same basic layout as the DET record. However, in place of the beneficiary ID there is a contract number and PBP ID. This record will sum all of the amounts in each of the DET records for this PBP.

This is the most important record for understanding reconciliation at a plan level. The connection between the totals in this report and the final payment reconciliation is explained in detail in the Reconciliation Module.   For now, it is sufficient to say that all plan financial totals may impact the plan's reconciliation. It is essential that plans verify these totals monthly to ensure there are no year-end discrepancies when CMS reconciles payment. Failure to review these reports and correct data is not a basis for appealing reconciliation payments.

6.5.1.5   CTR Record

The CTR record has the same layout as the PTR record with one exception; the CTR record has no PBP ID because it represents the activity of all PBPs under one contract number. It is important to note here that the totals in this report are not the totals used for any payment reconciliation. All payment reconciliation is at the plan, not contract, level. This report may provide a useful contract level summary, but will not directly impact any payment calculation.

6.5.2   Report 04PEN and 04POT – YTD Beneficiary Summary Reports for Enhanced Alternative and Over the Counter Drugs

The EA and OTC drugs summary reports are laid out exactly like the covered drugs report. There will be less data on these reports, because many of the financial values cannot exist for EA or OTC drugs. Specifically, plans should not see greater than zero dollars reported in the following fields:

- Net GDCA
- Net GDCB
- Net LICS
- Net NPP
- Net CPP

Aspen Systems Corporation

6-16

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MODULE 7 – RECONCILIATION

Purpose (Slide 2)

Reconciliation of Low Income Cost-Sharing Subsidy (LICS), reinsurance subsidy, and risk corridors are based on Prescription Drug Event (PDE) data as well as data captured from other Centers for Medicare & Medicaid Services (CMS) systems. In order to ensure that reconciliation is accurate, plans should continually monitor their submitted data throughout the year. This module is designed to explain the systems and steps for calculating final payment amounts to be used in the reconciliation process.

Learning Objectives (Slide 3)

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

- Understand the systems and processes used in Program of All-Inclusive Care for the Elderly (PACE) payment reconciliation.
- Understand the relationship of reported data and calculated data to PACE payment.
- Determine how the organization can monitor reports to ensure appropriate reconciliation.

ICON KEY	
Definition	ᖆ
Example	⊠
Reminder	💡
Resource	📖

7.1   Overview of Reconciliation (Slides 4, 6-8)

Reconciliation compares prospective payments to actual payments, calculates risk sharing, and determines reconciliation amounts for each payment type. One of the primary purposes for collecting and reporting Prescription Drug Event (PDE) data is to support reconciliation of Low Income Cost-Sharing (LICS), reinsurance, and risk sharing payments.

💡 Please remember that LICS and the reinsurance subsidy do not apply to PACE Medicare Only plans.

While all PACE PDE data elements are important, five data elements are essential for reconciliation and risk sharing.

- Reported Covered D Plan Paid Amount (CPP)
- Calculated CPP
- Calculated LICS
- Calculated Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
- Calculated Gross Drug Above Out-of-Pocket Threshold (GDCA)

One of these elements is reported on PACE PDEs, the other four are calculated by CMS.

Plans should also realize that CMS also uses PDE data for other legislated functions such as quality monitoring, program integrity, and oversight.

Although reconciliation and risk sharing occur after year end, plans must submit PDEs on a timely basis and perform careful data oversight throughout the year. Effective data oversight is continuous, timely and thorough. Data oversight also must be informed by a complete understanding of the individual payment calculations.

PDE data received by May 31 following year-end will be included in reconciliation. Payment will not include data submitted after reconciliation begins. Plans cannot appeal reconciliation results based on the failure to submit data in a timely manner.

Reconciliation is conducted at a plan-level. Within each plan, individual PDE records roll up to beneficiary summaries and beneficiary summaries roll up to the plan summary. Reconciliation uses plan summaries. Data oversight has four aspects.

- Monitor prospective payments.

- Maintain enrollment and LICS eligibility data.

- Ensure that submitted PDE data are accurate and are consistent with plan data at the beneficiary and plan summary level.

- Ensure that CMS summary reports are consistent with the plan's understanding of the data.

7.2   System Overview (Slide 9)

The Payment Reconciliation System (PRS) uses data from multiple systems for reconciliation and risk sharing. Table 7A provides descriptions of the systems involved in this payment and reconciliation process.

TABLE 7A – SYSTEM OVERVIEW

DDPS/DBC
PDE Data
Plans submit PDEs to the Drug Data Processing System (DDPS) through the Prescription Data Front End System (PDFS). DDPS receives and edits individual PDEs. DDPS forwards accepted PDE records to the Drug Benefit Calculator (DBC). DBC is a data warehouse. It stores PDE records and accumulates summary data for reporting. Specifically DBC accumulates reported CCP, calculated CPP, calculated LICS, calculated GDCB, and calculated GDCA. At reconciliation, DBC sends total plan/beneficiary calculated values for LICS, GDCB, GDCA and CPP to the Payment Reconciliation System (PRS).
HPMS
Bid Data
HPMS stores approved bid data and sends it to MARx for monthly payment calculation and to the PRS for final reconciliation. Both MARx and PRS use Bid data for payments.
MARx
Monthly Payments
MARx calculates monthly payments using enrollment and low income cost-sharing eligible status from MBD, drug risk adjustment factors from RAS, and bid data from HPMS. MARx calculates the final direct subsidy reconciliation. For purposes of LICS reconciliation, reinsurance reconciliation and risk sharing MARx sends the final direct subsidy and final payment amounts it has calculated to the Payment Reconciliation System (PRS).
PRS
LICS, GDCB, GDCA, CPP, MARx Data, HPMS Data
PRS receives calculated LICS, GDCB, GDCA, CPP from the DBC and data necessary for payment from MARx and HPMS. It calculates final reconciliation amounts and forwards them to the Automated Plan Payment System (APPS).

Figure 7A illustrates the system flow.

Figure 7A – System Flow
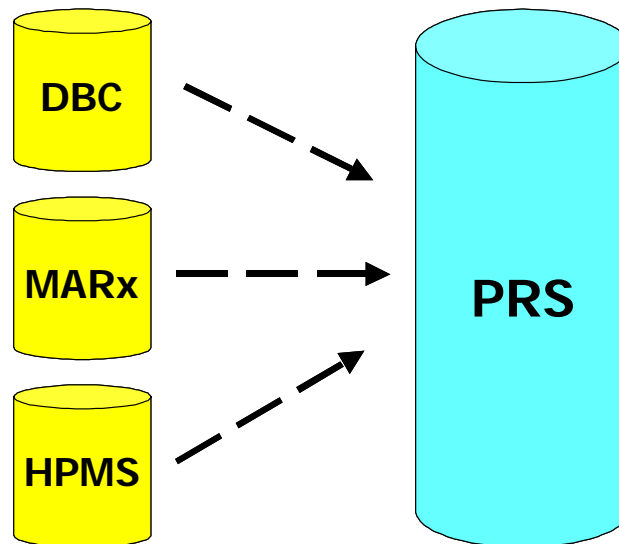
7.3   Data Oversight (Slide 10)

Plans must monitor data on two levels. First, plans must ensure that day-to-day transactions reflect an accurate accounting of their administration of the Part D benefit. This includes reviewing the PDE return files to understand which records were accepted and which were rejected, analyzing rejected records either to correct and resubmit or to prevent erroneous data from being submitted in the future. Transactional oversight also requires accurate maintenance of enrollments in plan and CMS systems, as well as reviewing CMS responses to enrollment transactions.

In addition to monitoring the PDE detail record submission and accuracy, plans should also balance summary data in their systems with the CMS monthly reports. The monthly management reports provide detail beneficiary summaries as well as plan summaries and will permit plans to ensure that their systems agree with CMS. These reports provide all relevant information regarding the cost elements of Part D payment reconciliation. Monthly membership reports from MARx provide information on enrollment and the component parts of the Part D prospective payments, specifically the direct subsidy, prospective LICS, and prospective reinsurance. These amounts represent the prospective payments against which actual costs will be reconciled.

7.3.1   Beneficiary and Payment Data

Plans must monitor enrollment data, low income cost sharing status and monthly payment amounts. The purpose of monitoring is to ensure that enrollment and disenrollment dates, as well as low income cost-sharing status in the plan's internal systems are consistent with MBD information.

The purpose of monitoring monthly payments is to ensure that the plan's payment is correct and that the plan understands how the payment was calculated. At reconciliation, total monthly prospective payments will be compared to actual payments. Errors in monthly prospective payments will adversely affect reconciliation.

7.3.2   PDE Data

Plans should incorporate the use of two levels of reports into data oversight. The PDE data are reported on Transaction and Management reports.

7.3.2.1   Transaction reports

The DDPS Response File documents rejected records. When plans fail to resolve and resubmit rejected records, they introduce payment errors. Rejected records may be original PDEs, adjustments or deletions. The type of payment error depends on the type of record that is rejected.

- Original PDEs – rejected original PDEs cause incomplete DDPS data. Missing data leads to underpayment.

- Deletion PDEs – PDEs submitted for deletion, which were rejected, cause overstated DDPS data. Overstated data leads to overpayment.

- Adjustment PDEs – Adjustment PDEs may change fields essential for payment. Therefore, PDEs submitted for adjustment, which are rejected, may overstate or understate payment.

7.3.2.2   Drug Benefit Calculator Management Reports

DBC data is the basis for reconciliation. Upon receipt, plans should carefully review DBC management reports to confirm that there is a common understanding between DBC and the plan. This common understanding is essential for accurate reconciliation.

The report entitled Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs, reflects records that are accepted and stored in DDPS. The net calculated LICS, GDCB, GDCA and CPP, as well as year-to-date TrOOP dollars, at the beneficiary and the plan-level are communicated on the Cumulative Beneficiary Summary Report-PACE plan, Covered Drugs. Any discrepancies in these fields may require plans to perform analysis at the detail record level in the DDPS response file for the beneficiary in question.

Sample questions to resolve differences between the Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs, and the plan's internal data include:

1. Does the number of PDE records agree with the plan's accepted PDE count for each beneficiary?

    Data in the columns labeled Number of Original PDEs, Number of Adjusted PDEs and Number of Deleted PDEs give a general indication of the PDE volume on which the data is based. Depending on the plan's internal data, the plan may need more specific data. To calculate actual PDE records

Aspen Systems Corporation

7-5

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

included in the Cumulative Beneficiary Summary Report-PACE Plans, Covered Drugs, subtract Number of Deleted PDEs from the Number of Original PDEs.

2. Do net dollars on the Cumulative Beneficiary Summary match the plan's view of aggregate financial data? Does the plan's internal data consistently show higher counts and dollars than the Cumulative Beneficiary Summary Report?

   First, remember to compare these reports to databases that reflect the accepted PDE data, rather than claims databases. The claims data will reflect more information than has been accepted in DDPS, either because data has not yet been submitted or some of the submitted data has been rejected.

7.4   Appeal

Data submission final deadline is 5 months following year-end. Failure to meet the deadlines is not the basis for an appeal. Additionally, plans cannot appeal reconciliation decisions because they submitted incomplete or inaccurate data.

Plans should follow up promptly on any discrepancies between Transaction and Management Reports to ensure that DDPS has complete, correct data before the data submission deadline.

7.5   Reconciliation Example – PACE Dual Eligible and Medicare Only Plans

7.5.1 Direct Subsidy (Slide 11)

The direct subsidy is a capitated per member per month payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status adjustment factor, minus the monthly beneficiary premium related to the standardized bid amount.

✐ The beneficiary premium related to the standardized bid amount includes premium amounts paid by enrollees or paid on their behalf, including any low-income premium subsidies. This section refers to the "premium related to the standardized bid amount" with no further detail about who pays the premium. The Target Amount section describes the premium in further detail.

✐ All plan types submit a Part D standardized bid. The bids that Medicare only PACE plans submit include both a standard component and an enhanced alternative component. The direct subsidy is based on the Part D standardized bid.

At reconciliation the direct subsidy is recalculated using updated monthly risk factors. If the updated risk factors lead to any change in the annual total of month-by-month direct subsidy payments, the plan will be paid (or will repay) the difference. Generally, risk scores increase at reconciliation due to the availability of additional data. As a result, direct subsidy payments also increase. Not all beneficiaries will have an increased risk adjustment factor, and there may be plan-by-plan variation from this general rule.

7.5.1.1   Direct Subsidy System Overview

MARx reconciles the direct subsidy. The process for the direct subsidy is described in Table 7B.

TABLE 7B – DIRECT SUBSIDY SYSTEM PROCESS

MARx calculates the prospective and final monthly direct subsidy:

- MARx receives the following information for direct subsidy calculations
  - Reconciled risk factor (from RAS).
  - Month-by-month long-term institutional status for risk adjustment (originally from the MDS data).
  - Month-by-month long-term low-income status for risk adjustment (originally from the MBD data).
  - MARx reconciles the final direct subsidy and forwards the amount to the Automatic Plan Payment System (APPS) for payment.

- MARx also forwards the final direct subsidy to PRS for purposes of calculating the Target amount in risk sharing.

7.5.1.2   Direct Subsidy Data Oversight

CMS uses the standardized bid amount, the beneficiary premium, the beneficiary-specific risk factor, and enrollment data when calculating the direct subsidy. Throughout the year, plans receive ongoing updates about enrollments. Plans should be aware of the data used in these calculations so they can replicate the direct subsidy calculation.

- Standardized bid amount is the same information received on the plan's approved bid and does not change during the year.

- Beneficiary premium is the same information received on the plan's approved bid and does not change during the year.

- Risk Factor is reported at the beginning of the year, is updated at mid-year and again at reconciliation as more recent data and more complete data become available.

7.5.1.3   Beneficiary Level Reconciliation

Example 1 illustrates the data used to calculate the prospective direct subsidy and how that data can change at reconciliation. The example also emphasizes the plan's role in understanding the individual payment calculations and data oversight.

☒   **Example: 1**

Mrs. Taft was enrolled in Happy Health Plan from January 1, 2006 through December 31, 2006. When Happy Health Plan received Mrs. Taft's enrollment during the last week of December 2005, the plan immediately updated its enrollment file to document Mrs. Taft's enrollment effective January 1. Happy Health Plan's standardized bid amount is $100.00 and the beneficiary premium is $35.00. In January 2006 Mrs. Taft's risk score was 1.778.

Monthly Prospective Direct Subsidy

$142.80 = $100.00 * 1.778 - $35.00

From January through December of 2006 Happy Health Plan received 12 monthly direct subsidy payments of $142.80 each for a total annual prospective direct subsidy of $1,713.60.

At reconciliation Mrs. Taft's risk score increased to 1.902 because an additional diagnosis was reported. The additional diagnosis was 733.00 – osteoporosis.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Risk Factor

Initial Risk Factor   1.778
Reconciled Risk Factor   1.902[a]

[a]Risk Factor increased because new diagnosis code, 733.00 - Osteoporosis was reported late in the year

Prospective Direct Subsidy – Mrs. Taft

Direct Subsidy = $100.00 * 1.902 - $35.00
Direct Subsidy = $155.20

The monthly prospective direct subsidy increased by $12.40 to $155.20 because the final risk factor increased from 1.778 to 1.902; the reconciled direct subsidy is $1,862.40.

Prospective Direct Subsidy

Prospective Monthly Direct Subsidy = $100.00 * 1.778 - $35.00
Prospective Monthly Direct Subsidy = $142.80
Month-by-month total of Prospective Direct Subsidy = $142.80 * 12
Month-by=month total of Prospective Direct Subsidy = $1,716.60

Reconciled Direct Subsidy

Reconciled Monthly Direct Subsidy = $100.00 * 1.902 - $35.00
Reconciled Monthly Direct Subsidy = $155.20
Month-by-month total of Reconciled Direct Subsidy = $155.20 * 12
Month-by=month total of Reconciled Direct Subsidy = $1,862.40

Annual Reconciled Direct Subsidy

Annual Reconciled Direct Subsidy = Total Reconciled Direct Subsidy – Total Prospective Direct Subsidy
Annual Reconciled Direct Subsidy = $1,862.40 - $1,716.60
Annual Reconciled Direct Subsidy = $148.80

Happy Health Plan will receive $148.80, which is the difference between the total prospective direct subsidy and the total final reconciled direct subsidy.

7.5.1.4   Plan-level Reconciliation

The plan-level reconciliation is the sum of the reconciliation amounts for each beneficiary enrolled in the plan for all or part of the year. Because risk factors tend to increase during the year, the reconciled direct subsidy will generally be greater than the prospectively paid direct subsidy.

7.5.2 Reconciling Low Income Cost-Sharing Subsidy (Slide 12)

LICS reconciliation compares prospective and actual LICS. Each month CMS pays plans prospectively for LICS amounts based on plan projections in the approved bid. The prospective payment for the low income cost-sharing subsidy is based on the low income estimate (p(LI)mpm) in the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each low-income beneficiary enrolled in the plan as of the first day of the payment month. Calculated LICS, which is based on reported CPP in PDE records, documents actual LICS.

7.5.2.1 Low Income Cost-Sharing Subsidy System Overview

MARx calculates prospective LICS payments month-by-month and again after year-end. The information process for LICS is described in Table 7C.

> Remember that only the dual eligible PACE plan will have an LICS calculation. Medicare only PACE plan enrollees do not receive LICS.

TABLE 7C – LICS SYSTEM PROCESS

PRS calculates the LICS reconciliation amount:

- Receives final prospective LICS payments from MARx.

    - MARx uses the following information to calculate the prospective LICS subsidy.
    - Low income estimate in the approved bid (from HPMS).
    - Number of low income beneficiaries enrolled in the month (from MBD).

- Receives actual (i.e., calculated) LICS reported on PDEs from DDPS/DBC.

- Calculates the difference between prospective and actual LICS.

Note: LICS reconciliation is performed at the plan-level based on the sum of all beneficiary LICS amounts for that plan.

7.5.2.2 Low Income Cost-Sharing Subsidy Data Oversight

The following information is used to calculate prospective LICS.

- Plans should review prospective payments for accuracy.

- Plans should understand the low-income estimate in the approved bid in order to replicate the prospective LICS calculation.

Calculated LICS data is based on reported CPP from PDEs. CMS reports the Calculated LICS on the Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs. This reported value will be used for

LICS reconciliation. The plan can verify the CMS calculation by running an independent calculation of LICS using the CMS formula applied to the reported CPP on records that CMS has accepted in DDPS. The CMS calculated LICS reported on the Cumulative Beneficiary Summary Report-PACE Plans, Covered Drugs should be the same as the plan's calculation.

7.5.2.3   Low Income Cost-Sharing Subsidy Reconciliation Calculation

Plans are paid dollar for dollar for the low income cost-sharing subsidy. If the LICS reconciliation amount is positive, plans will receive payment in full for the LICS reconciliation amount. If the LICS reconciliation amount is negative, plans will repay in full the LICS reconciliation amount.

⊠   **Example: 2**

Daybreak Health Plan (refer to Table 7F on page 7-23) received $140 per low-income member per month of prospective LICS based on their Part D bid for their dual eligible plan. The plan had 6,000 LI member months, meaning that the plan received a total of $840,000 of prospective LICS. Based on the reported CPP on accepted PDE data, the plan's calculated LICS was $800,000.

LICS Reconciliation Amount

LICS Reconciliation Amount = $800,000 - $840,000

LICS Reconciliation Amount = -$40,000

7.5.3   Reconciling Reinsurance Subsidy (Slide 13)

The Reinsurance Subsidy reconciliation compares actual to prospective reinsurance and pays the difference between the two. Each month, CMS pays plans prospectively for the Reinsurance Subsidy based on plan projections in the approved bid. The prospective payment for the Reinsurance Subsidy is based on the estimate (pmpm) in the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month.

Calculated GDCA, based on reported CPP in the PDE, is the basis for determining allowed reinsurance cost. The Reinsurance Subsidy is 80 percent of GDCA, after the reinsurance portion of DIR has been subtracted.

Remember that only the dual eligible PACE plan will have a GDCA amount calculated and only these plans are eligible for the reinsurance subsidy. Medicare only PACE plans do not receive reinsurance because their enrollees accrue no TrOOP.

7.5.3.1   Reinsurance System Overview

PRS reconciles the Reinsurance Subsidy. The Reinsurance Subsidy process is described in Table 7D.

TABLE 7D – REINSURANCE SUBSIDY SYSTEM PROCESS

PRS calculates the Reinsurance Subsidy reconciliation:

- Receives final prospective Reinsurance Subsidy payments from MARx.

    - MARx uses the following information to calculate the prospective Reinsurance subsidy.
    - Reinsurance pmpm estimate in the plan's approved bid (from HPMS).
    - Monthly enrollment.

- Receives DIR and plan type from HPMS.

- Receives calculated GDCA and calculated GDCB based on PACE-reported PDEs from DDPS/DBC.

- PRS calculates the Reinsurance Subsidy.

- PRS calculates the difference between prospective Reinsurance and the actual Reinsurance Subsidy.

7.5.3.2   Reinsurance Data Oversight

The following information is used to calculate prospective Reinsurance payments.

- Plans should understand the prospective reinsurance estimate in the approved bid in order to replicate the reinsurance calculation.
- Plans should closely monitor and update enrollment dates for their enrollees in order to determine the number of beneficiaries enrolled in the month.
- GDCA reported on the Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs will be used for reinsurance reconciliation. The plan's understanding of both calculated GDCA and calculated GDCB based on data in internal files and the calculated GDCA and calculated GDCB reported on the Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs should agree. Plans must explain any interim differences between the two. At reconciliation the plan's internal records and calculated GDCA reported from PDEs should agree.

7.5.3.3   Reinsurance Subsidy Calculations

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

- Calculate DIR Ratio
- Calculate Reinsurance Portion of DIR
- Calculate Allowable Reinsurance Cost
- Calculate Plan-Level Reinsurance Subsidy
- Reconcile Reinsurance Subsidy

To derive allowable reinsurance cost, first use two calculations to allocate the reinsurance portion of DIR. Then subtract the reinsurance portion of DIR from unadjusted reinsurance cost. Unadjusted reinsurance cost are the plan-level GDCA amounts reported on PDEs.

The Plan-level Reinsurance Subsidy is eighty percent (80%) of the plan's allowable reinsurance cost.

The reconciliation calculation determines the difference between the plans prospective reinsurance payments and the reinsurance subsidy.

The following example continues with Daybreak's reconciliation. Again, the reinsurance numbers apply only to Daybreak's dual eligible plan, since the Medicare only plan will not receive the reinsurance subsidy.

7.5.3.3.1   Calculate DIR Ratio

Based on reported CPP submitted by Daybreak, calculated GDCA equals $600,000 and calculated GDCB equals $1,700,000. The sum of calculated GDCA and calculated GDCB, which equals $2,300,000, is Daybreak's total gross drug cost. To determine Daybreak's DIR ratio, divide calculated GDCA by total gross drug cost. Daybreak's DIR ratio is .2609.

DIR_Ratio

DIR_Ratio = $600,000/($600,000 + $1,700,000)

DIR_Ratio = $600,000/$2,300,000

DIR_Ratio = .2609

7.5.3.3.2   Calculate Reinsurance Portion of DIR

Daybreak PBP 001's reported DIR for total covered drug equal to $200,000. To calculate the reinsurance portion of Daybreak's DIR, multiply the DIR for total covered drugs by the DIR Ratio. PBP 001's reinsurance portion of DIR is $52,174.

Reinsurance Portion of DIR

Reinsurance Portion of DIR = $200,000 * .2609

Reinsurance Portion of DIR = $52,174

7.5.3.3.3   Calculate Allowable Reinsurance Costs

Based on reported CPP submitted by Daybreak, the calculated GDCA equals $600,000. To calculate Daybreak's allowable reinsurance cost, subtract the reinsurance portion of DIR from the calculated GDCA. Daybreak's allowable reinsurance cost is $547,826.

Allowable Reinsurance Cost

Allowable Reinsurance Cost = $600,000 - $52,174

Allowable Reinsurance Cost = $547,826

7.5.3.3.4   Calculate Plan-Level Reinsurance Subsidy

The reinsurance subsidy is 80 percent of allowable reinsurance cost. To calculate Daybreak's reinsurance subsidy, multiply allowable reinsurance cost by .8. Daybreak's reinsurance subsidy is $438,261.

Reinsurance Subsidy

Reinsurance Subsidy = $547,826* 0.8

Reinsurance Subsidy = $438,261

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

7.5.3.3.5   Reconcile Reinsurance Subsidy

The reinsurance reconciliation amount is the difference between the actual and prospective reinsurance subsidy. Since Daybreak bid a prospective reinsurance amount of $65 pmpm and had 6,000 member months, Daybreak's total prospective reinsurance was $390,000 ($65*6,000 = $390,000). The difference between $438,261 and $390,000 is $48,261. The reinsurance reconciliation amount is positive.

Reinsurance Reconciliation Amount

Reinsurance Reconciliation Amount = $438,261 − $390,000

Reinsurance Reconciliation Amount = $48,261

7.5.3.3.6   Reinsurance Subsidy Reconciliation

If the reinsurance reconciliation amount is positive, the actual amount incurred exceeded the amount paid prospectively and the plan is entitled to additional payments. The plan will receive payment in full for the reinsurance reconciliation amount. If the reinsurance reconciliation amount is negative, the actual amount incurred was less than the amount paid prospectively. The plan will repay in full the reinsurance reconciliation amount.

7.5.4   Risk Sharing (Slide 14)

Risk sharing includes both prospective and actual costs. Costs subject to risk sharing are plan paid costs attributed to the standard benefit. The government and the plan share risk when prospective and actual costs differ in excess of certain thresholds.

Each month, CMS prospectively pays plans the direct subsidy based on plan projections in the approved bid. The direct subsidy is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status adjustment factor, minus the beneficiary premium related to the standardized bid amount. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month.

PACE plans submit reported CPP on PDE records. The reported CPP serves as the basis for calculated CPP. Calculated CPP is used to determine adjusted allowable risk corridor costs (AARCC).

7.5.4.1   Risk Sharing System Overview

PRS calculates risk sharing. The risk sharing process is described below.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

TABLE 7E - RISK SHARING SYSTEM PROCESS

PRS calculates risk sharing:

- PRS receives final direct subsidy amount, final beneficiary premium, and final additional capitated payment amount from MARx

- PRS receives administrative cost ratio, plan type, total DIR for covered drugs, and induced utilization (for Medicare only PACE plans) from HPMS.

- PRS receives calculated CPP from DBC

- PRS calculates the adjusted allowable risk corridor costs

- PRS calculates risk sharing

7.5.4.2   Risk Sharing Data Oversight

The following information is used for risk sharing.

- Plans should review month-by-month direct subsidy payments and the reconciled direct subsidy for accuracy. The following information is used to calculate the direct subsidy.

- Standardized bid amount is the same information received on the plan's approved bid.

- Beneficiary premium, regardless of payment source (beneficiary or low-income premium subsidy) is the same information received on the plan's approved bid.

- The risk factor reported at the beginning of the year is updated at mid-year and again at reconciliation as more recent data and more complete data become available.

- Plans should update enrollment and disenrollment dates throughout the year.

- Administrative cost data includes non-pharmacy expense, gain/loss and total basic bid in the approved bid

Enhanced Alternative plans should also understand the induced utilization percentage reported on the bid.

- Calculated CPP reported on the Cumulative Beneficiary Summary Report-PACE Plan, Covered Drugs will be used for risk sharing calculations.

The accuracy of the calculated CPP depends upon PACE reporting of covered drugs. All plans must report covered drugs accurately. Errors in the Drug Coverage Status Code field directly affect risk sharing. Risk sharing calculations include covered drugs only (i.e., Drug Coverage Status Code = "C"). CPP will be

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

understated when covered drugs are reported as either enhanced alternative drugs or OTC drugs. CPP will be overstated when either enhanced alternative drugs or OTC drugs are reported in error as covered drugs. Any other reasons for over-reporting covered drugs, like including Part A/B drugs, will over-state CPP.

7.5.4.3   Risk Sharing Calculations

There is a four-step process to calculate risk sharing:
- Calculate the plan's target amount
- Calculate risk corridor thresholds
- Calculate Adjusted Allowable Risk Corridor Costs (AARCC)
- Determine where costs fall with respect to the thresholds and calculate payment adjustment

Since both dual eligible and Medicare only plans receive risk sharing, the reconciliation example will have two risk sharing calculations. Each plan benefit package must be reconciled independently.

7.5.4.3.1   Calculate the Plan's Target Amount

Daybreak's dual eligible plan, PBP 001, received $691,200 in total direct subsidy payments, $192,000 in beneficiary premiums for payment purposes and $39,000 in additional capitated payments. PBP 001's administrative cost ratio is 15 percent. First, determine PBP 001's preliminary target amount. To calculate PBP 001's preliminary target amount, sum the total direct subsidy payments, the beneficiary premiums for payment purposes, and the additional capitated payments, which add up to $922,200.

The same calculation must be performed for Daybreak's Medicare only plan, PBP 002. PBP 002 does not receive additional capitated payments, so the preliminary target amount calculation is simply the direct subsidy plus the beneficiary premium for the basic benefit. PBP 002 received $23,232 in direct subsidy payments and $7,680 in beneficiary premiums, for a total of $30,912.

The second step is to eliminate administrative costs. Daybreak's administrative cost ratio for both PBPs is 15 percent; the remaining cost, which should be included in the target amount, is non-administrative cost. Find Daybreak's non-administrative cost by first subtracting .15 from 1.00, which is .85. To calculate Daybreak's target amount, multiply the preliminary target amount by .85.

Preliminary Target Amount

PBP 001 Preliminary Target Amount = $691,200 + $192,000 + $39,000

PBP 001 Preliminary Target Amount = $922,200

PBP 002 Preliminary Target Amount = $23,232 + $7,680

PBP 002 Preliminary Target Amount = $30,912

Target Amount

PBP 001 Target Amount = $922,200 * (1.00 - 0.15)

PBP 001 Target Amount = $922,200 *.85

PBP 001 Target Amount = $783,870

PBP 002 Target Amount = $30,912 * (1.00 - 0.15)

PBP 002 Target Amount = $30,912 *.85

PBP 002 Target Amount = $26,275

7.5.4.3.2   Calculate Risk Corridor Thresholds

Daybreak uses its target amount and Part D threshold risk percentages to calculate the risk corridor thresholds. Part D threshold risk percentages, in descending order are 105 percent, 102.5 percent, 97.5 percent, and 95.0 percent. To calculate the four threshold limits, multiply Daybreak's target amount by each of these percentages. PBP 001's target amount is $783,870, with thresholds ranging from $823,063.50 down to $744,676.50. PBP 002's target amount is $26,275, with thresholds ranging from $27,588.96 down to $24,961.44. These threshold limits represent the final component of the prospective payment portion of the final risk sharing amount calculation.

Risk Corridor Thresholds

Daybreak PBP 001
Second threshold upper limit (SCUL)   = \$783,870 * 1.05   = \$823,064
First threshold upper limit (FTUL)   = \$783,870 * 1.025 = \$803,467
First threshold lower limit (FTLL)   = \$783,870 * 0.975 = \$764,273
Second threshold lower limit (STLL)   = \$783,870 * 0.95   = \$744,676

Daybreak PBP 002
Second threshold upper limit (SCUL)   = \$26,275 * 1.05   = \$27,589
First threshold upper limit (FTUL)   = \$26,275 * 1.025 = \$26,932
First threshold lower limit (FTLL)   = \$26,275 * 0.975 = \$25,618
Second threshold lower limit (STLL)   = \$26,275 * 0.95   = \$24,961

7.5.4.3.3   Calculate Adjusted Allowable Risk Corridor Costs (AARCC)

There are 4 steps to determine adjusted allowable risk corridor costs.

1. Determine unadjusted risk corridor costs. The plan-level total of dollars in calculated CPP represents the unadjusted allowable risk corridor costs.

2. For Enhanced Alternative (EA) plans only, reduce unadjusted risk corridor costs by the induced utilization factor plans reported in their bids. Since the PACE Medicare only plan is an EA plan, induced utilization will apply to those plans.

3. Subtract plan-level reinsurance subsidy.

4. Subtract Covered Part D DIR.

To summarize, the calculation for Adjusted Allowable Risk Corridor Cost (AARCC) includes four numbers: unadjusted risk corridor cost (URCC), the induced utilization factor (Medicare only plans), the reinsurance subsidy (as calculated above for dual eligible plans) and DIR for total covered drug cost.

The AARCC for all plans excludes the reinsurance subsidy and DIR. PBP 001's unadjusted risk corridor cost is \$1,500,000, while PBP 002's URCC is \$32,000. The reinsurance subsidy for PBP 001 is \$438,261 and the Covered Part D DIR is \$200,000. PBP 002 has 2% induced utilization and \$8,000 in Covered Part D DIR.

Adjusted Allowable Risk Corridor Cost (AARCC)

Daybreak PBP 001
AARCC = $1,500,000 - $438,261 - $200,000
AARCC = $861,739.13

Daybreak PBP 002
AARCC = ($32,000 * (1.00 − 0.02)) - $8,000
AARCC = $31,360 - $8,000
AARCC = $23,360

7.5.4.3.4   Determine Where Costs Fall With Respect To The Thresholds And Calculate Payment Adjustment (Slides 15-16)

The last step in risk sharing is to determine where AARCC falls with respect to the threshold and calculate the payment adjustment. To review Daybreak PBP 001's AARCC is $861,739. Figure 7B displays PBP 001's risk sharing thresholds and percentages.

Figure 7B – Daybreak PBP 001's Risk Sharing Thresholds and Percentages
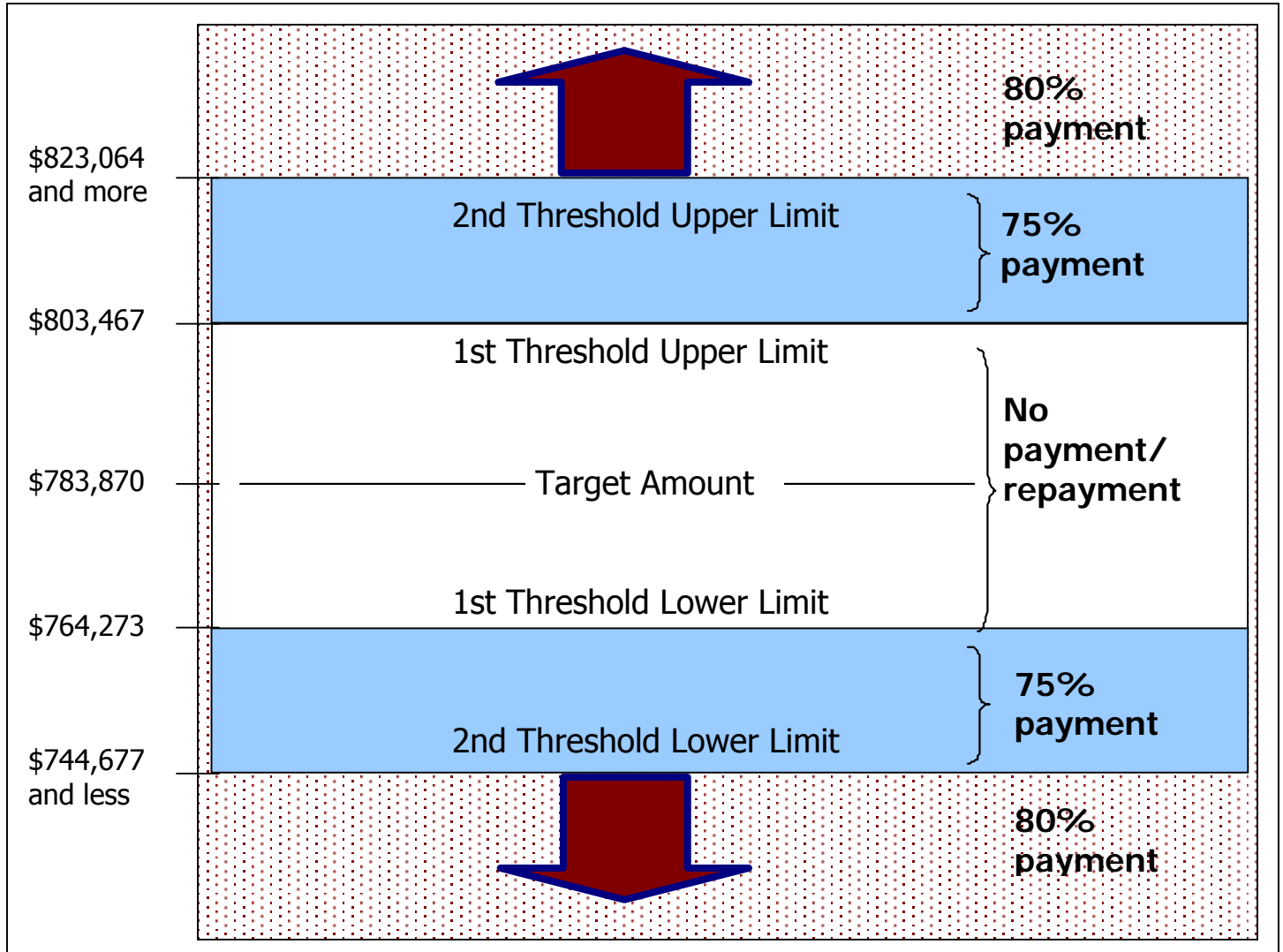
Since PBP 001's AARCC is above the $823,064 that marks the STUL, there are two portions of its risk sharing. The first portion lies between $823,064 and $803,467 (between the FTUL and the STUL) and has 90 percent risk sharing. The second portion is the difference between the AARCC of $861,739 and the $823,064 that marks the STUL. This portion has 80 percent risk sharing.

Figure 7C displays PBP 002's risk sharing thresholds and percentages.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Figure 7C – Daybreak PBP 002's Risk Sharing Thresholds and Percentages
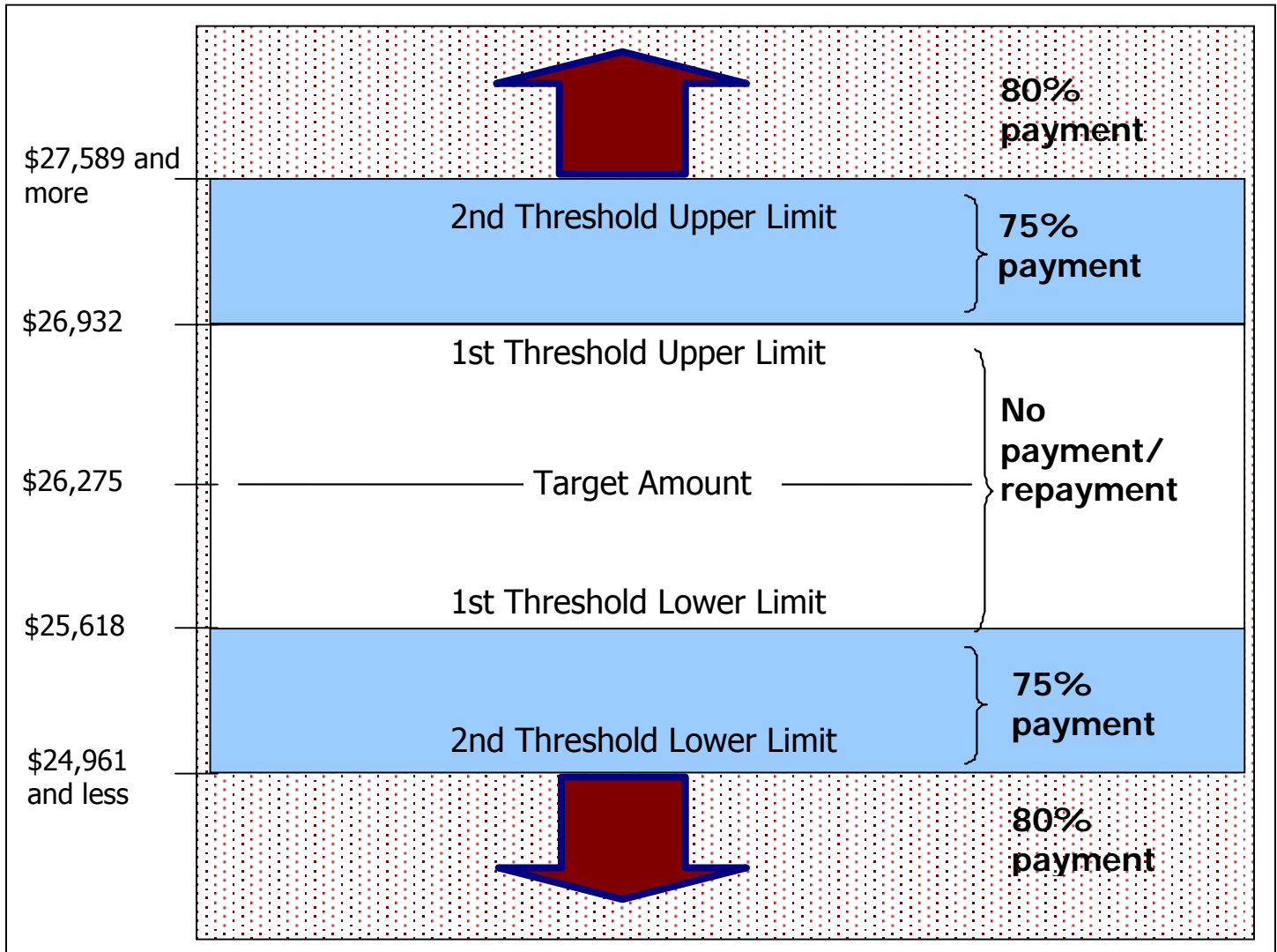
Since PBP 002's AARCC is below the $24,961 that marks the STLL, there are also two portions of this plan's risk sharing. The risk sharing in this case will be negative, meaning the plan will be liable for repayment to CMS. The first portion lies between $24,961 and $25,618 (between the FTLL and the STLL) and has 75 percent risk sharing. The second portion falls between the AARCC of $23,360 and the $24,961 that marks the STLL and has 80 percent risk sharing.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Cost Subject to Risk Sharing

Daybreak PBP 001
Total Cost Subject to Risk Sharing = $861,739 - $803,467

Total Cost Subject to Risk Sharing = $58,272

Cost Subject to Risk Sharing $>$ FTUL and $\leq$ STUL = $823,064 - $803,467

Cost Subject to Risk Sharing > FTUL and $\lessgtr$ STUL = $19,597

Cost Subject to Risk Sharing > STUL = $861,739 - $823,064

Cost Subject to Risk Sharing > STUL = $38,675

Daybreak PBP 002
Total Cost Subject to Risk Sharing = $23,360 - $25,618

Total Cost Subject to Risk Sharing = -$2,258

Cost Subject to Risk Sharing $>$ FTLL and $\leq$ STLL = $24,961 - $25,618

Cost Subject to Risk Sharing > FTLL and $\lessgtr$ STLL = $657

Cost Subject to Risk Sharing > STLL = $23,360 - $24,961

Cost Subject to Risk Sharing > STLL = $1,601

In the final step, CMS calculates the risk sharing percentage for each portion of AARCC for each plan. First, for PBP 001 apply 90 percent risk sharing to the $19,597 between the FTUL and STUL, which is $17,637.

✎ In 2006, the government will increase the risk sharing percentage between the FTUL and STUL from 75 percent to 90 percent if at least 60 percent of Part D plans have AARCC above the FTUL, provided that those plans represent at least 60 percent of Part D enrollees.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

Then, apply 80 percent risk sharing to the $38,675 above the STUL, which is $30,940. Sum these two amounts to calculate PBP 001's total risk sharing payment of $48,577.

Daybreak PBP 001 Risk Sharing Payment

Risk Sharing Payment = (.90 * $19,597) + (.80 * $38,675)

Risk Sharing Payment = $17,637 + $30,940

Risk Sharing Payment = $48,577

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

Finally, CMS calculates the risk sharing percentage for PBP 002. First, apply75 percent risk sharing to the -$657 between the FTLL and STLL, which is -$493. Then, apply 80 percent risk sharing to the -$1,601 below the STLL, which is -$1,281. Sum these two amounts to calculate PBP 002's total risk sharing payment of -$1,774.

Daybreak PBP 001 Risk Sharing Payment

Risk Sharing Payment = (.75 * -$657) + (.80 * -$1,601)

Risk Sharing Payment = -$493 + -$1,281

Risk Sharing Payment = -$1,774

At this point, every step in the reconciliation process has been completed. In addition, to the reconciled direct subsidy that Daybreak received from MARx, Daybreak receives the net reconciliation amount of $55,064 from PRS.

- LICS reconciliation
- Reinsurance subsidy
- Risk sharing for each plan

Total Reconciliation Payment from PRS

LICS Reconciliation	-$40,000
Reinsurance Subsidy Reconciliation	$48,261
Risk Sharing for PBP 001	$48,577
Risk Sharing for PBP 002	-$1,774
Total Reconciliation Payment from PRS	$55,064

TABLE 7F – DAYBREAK

	PACE Dual Eligible Plan PBP 001	PACE Medicare Only Plan PBP 002
HPMS Information		
Plan Bid Information		
1. Standard Bid	$92	$92
2. Beneficiary Premium	$32	$32
3. Prospective Low Income Cost-Sharing	$140	N/A
4. Prospective Reinsurance	$65	N/A
5. Admin Cost Ratio	0.15	0.15
6. Induced Utilization	N/A	0.02
7. Additional Capitated Payment	$6.50	N/A
DIR Information		
8. DDIR	$200,000	$8,000
MARx Information		
9. Average Monthly Enrollment	500	20
10. Total Member Months	6000	240
11. Average Risk Factor	1.6	1.4
12. Risk Adjusted Bid	$883,200	$30,912
13. Total Direct Subsidy	$691,200	$23,232
14. Total Low Income Member Months	6000	0
15. Total Prospective Low Income Cost-Sharing	$840,000	$0
16. Total Prospective Reinsurance	$390,000	$0
17. Total Beneficiary Premium Related to the Standard Bid	$192,000	$7,680
18. Total Additional Capitated Payment	$39,000	$0
DBC Data		
19. Reported CPP	$2,300,000	$100,000
20. Low Income Cost-Sharing	$800,000	$0
21. Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)	$600,000	$0
22. Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)	$1,700,000	$100,000
23. Covered D Plan Paid Amount	$1,500,000	$32,000
24. Total GDCA+GDCB	$2,300,000	$100,000

Defined Standard Benefit 2006

CMS — CENTERS for MEDICARE & MEDICAID SERVICES

Total Spending

Initial Coverage Limit

Out-of-Pocket Threshold

Catastrophic Coverage

$250 $2,250 $5,100

75% Plan Pays

Coverage Gap

80% Reinsurance

Deductible

25% Coinsurance

$3,600 TrOOP

15% Plan Pays

5% Coinsurance

Beneficiary Liability

Direct Subsidy/ Beneficiary Premium

Medicare Pays Reinsurance

August 2005

Aspen Systems Corporation™ — Culture of Commitment

2006 Data Submission Timeline

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

August 2005

PDE Process Dataflow

Pharmacy/Provider

TrOOP Facilitator

Plan

PDE Record

Prescription Drug Front-end System (PDFS)

PDFS Response Report

Drug Data Processing System (DDPS)

DDPS Return File
Transaction Counts & Control Summary

Drug Benefit Calculator (DBC)

Monthly Management Reports

Payment Reconciliation System (PRS)
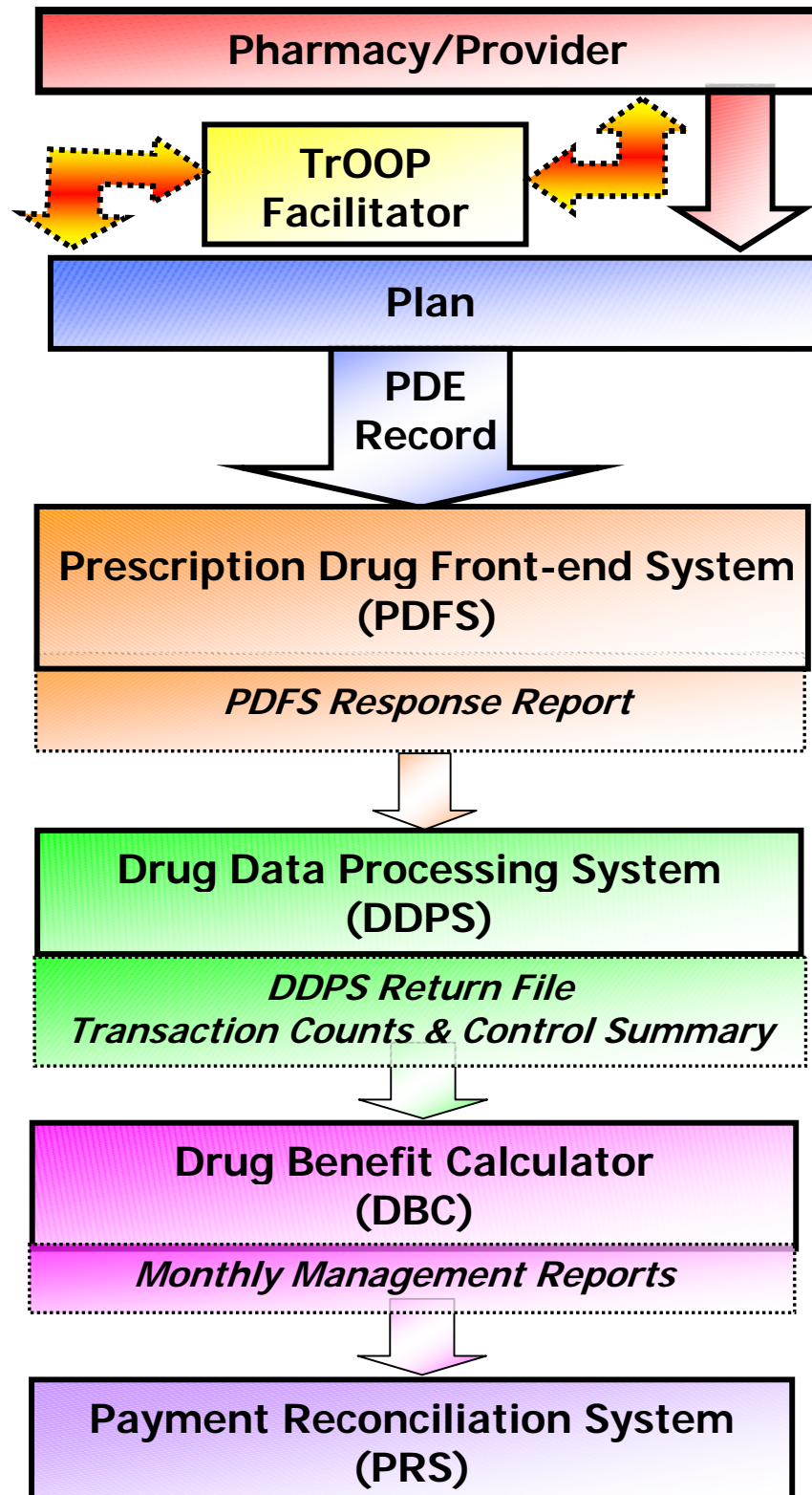
PDE Record File Structure Summary

RT HDR – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BHD.
- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

    RT BHD – BATCH HEADER (Plan Info)
    Must follow RT HDR or RT BTR and must be followed by RT DET.
- Record ID
- Sequence Number
- Contract Number
- PBP ID
- Filler

        RT DET – DETAIL RECORD (Drug Event Information)
        Must follow RT BHD or RT DET and may be followed by another RT DET or RT BTR. The detail record contains 37 data elements that must be populated with data in order to provide CMS with the information required for identifying each unique prescription drug event and calculating payment.

    RT BTR – BATCH TRAILER
    Must follow RT DET and may be followed by a RT BHD or RT TLR.
- Record ID
- Sequence Number
- Contract No
- PBP ID
- DET Record Total
- DET Accepted Record Total
- DET Informational Record Total
- DET Rejected Record Total
- Filler

RT TLR – FILE TRAILER
Must follow RT BTR, and must be the last record on the file.
- Record ID
- Submitter ID
- File ID
- TLR BHD Record Total
- TLR DET Record Total
- TLR DET Accepted Record Total
- TLR DET Informational record total
- TLR DET Rejected Record Total
- Filler

DETAIL LEVEL • *BATCH LEVEL* • *FILE LEVEL*

PACE PDE Record Layout

HDR RECORD

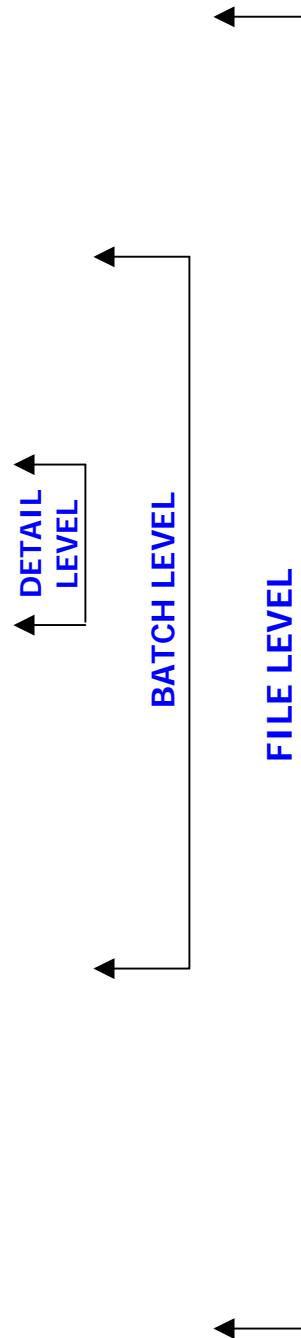| FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'HDR'
2	SUBMITTER-ID	4 – 9	X(6)	'Shnnnn'
3	FILE-ID	10 – 19	X(10)	
4	TRANSACTION-DATE	20 – 27	9(8)	'CCYYMMDD'
5	PROD-TEST-IND	28 – 31	X(4)	'PROD' Or 'TEST'
6	FILLER	32 - 512	X(481)	SPACES

BHD RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BHD'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	CONTRACT NO	11 – 15	X(5)	Assigned by CMS
4	PBP ID	16 – 18	X(3)	Assigned by CMS
5	FILLER	19 – 512	X(494)	SPACES

DET RECORD

DET records follow BHD records and are followed by additional DET records or BTR records.

BTR RECORD

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

TLR RECORD

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

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

PACE PDE Record Layout   August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PACE PDE Record Layout   August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information..

DET RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
1	RECORD-ID		1 – 3	X(3)	'DET'
2	SEQUENCE NO		4 – 10	9(7)	Must begin with '0000001'
3	CLAIM CONTROL NO		11 – 50	X(40)	OPTIONAL
4	HICN		51 – 70	X(20)	MEDICARE HEALTH INSURANCE CLAIM # OR RRB#
5	CARDHOLDER ID	302-C2	71 – 90	X(20)	PLAN IDENTIFICATION OF BENEFICIARY
6	PATIENT DOB	304-C4	91 – 98	9(8)	'CCYYMMDD'
7	PATIENT GENDER	305-C5	99 – 99	9(1)	'1'=MALE '2'=FEMALE
8	DATE OF SERVICE	401-D1	100 – 107	9(8)	'CCYYMMDD'
9	PAID DATE		108 – 115	9(8)	'CCYYMMDD'
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 – 124	9(9)	'00nnnnnnn'
11	FILLER		125 – 126	X(2)	SPACES
12	PRODUCT SERVICE ID	407-D7	127 – 145	X(19)	'MMMMMDDDDPP'
13	SERVICE PROVIDER ID QUALIFIER	202-B2	146 – 147	X(2)	'01'=NPI '06'=UPIN '07'=NCPDP # '08'=STATE LICENSE '11'=FEDERAL TAX ID '99'=OTHER
14	SERVICE PROVIDER NO	201-B1	148 – 162	X(15)	
15	FILL NO	403-D3	163 – 164	9(2)	'0'=NOT AVAILIABLE 1-99=NUMBER OF FILLS
16	DISPENSING STATUS	343-HD	165 – 165	X(1)	<blank>=not specified 'P'=Partial fill 'C'=Completion of partial fill
17	COMPOUND CODE	406-D6	166 – 166	9(1)	'0'=Not Specified '1'=Not a Compound '2'=Compound (multiple)
18	DAW	408-D8	167 – 167	X(1)	'0'=No product selection indicated '1'=Sub not allowed by prescriber '2'=Sub allowed; patient requested product dispensed '3'=Sub allowed – pharmacist selected product dispensed '4'=Sub allowed – generic drug not in stock '5'=Sub allowed – brand drug dispensed as generic '6'=Override '7'=Sub not allowed – brand drug mandated by law '8'=Sub allowed generic drug not available in marketplace '9'=Other
19	QUANTITY DISPENSED	442-E7	168 – 177	9(7)V999	# OF UNITS, GRAMS, MILILITER, OTHER.
20	DAYS SUPPLY	405-D5	178 – 180	9(3)	0-999
21	PRESCRIBER ID QUALIFIER	466-EZ	181 – 182	X(2)	'01'=NPI '06'=UPIN '08'=STATE LICENCE NO '12'=DEA #
22	PRESCRIBER ID	411-DB	183 – 197	X(15)	
23	DRUG COVERAGE STATUS		198 – 198	X(1)	'C'=Covered 'E'=Supplemental 'O'=OTC Drugs

DET RECORD (continued)

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
24	ADJUSTMENT/DELETION		199 – 199	X(1)	'A'=Adjustment 'D'=Deletion <BLANK>=Original PDE Record
25	NON-STANDARD FORMAT CODE		200 – 200	X(1)	'X'=X12 837 'B'=Beneficiary submitted claim 'P'=Paper claim from provider <BLANK>=NCPDP Format
26	OUT OF NETWORK CODE		201 – 201	X(1)	'O'=Out of Network pharmacy <BLANK>=In network pharmacy
27	CATASTROPHIC COVERAGE CODE		202 – 202	X(1)	'A'=Attachment point met on this event 'C'=Above attachment point <BLANK>=Attachment point not met
28	INGREDIENT COST PAID	506-F6	203 – 210	S9(6)V99	Actual or zero dollar amount; no decimals
29	DISPENSING FEE PAID	507-F7	211 – 218	S9(6)V99	Actual or zero dollar amount; no decimals
30	TOTAL AMOUNT ATTRIBUTED TO SALES TAX		219 – 226	S9(6)V99	Actual or zero dollar amount; no decimals
31	GDCB		227 – 234	S9(6)V99	Actual or zero dollar amount; no decimals
32	GDCA		235 – 242	S9(6)V99	Actual or zero dollar amount; no decimals
33	PATIENT PAY AMOUNT	505-F5	243 – 250	S9(6)V99	Actual or zero dollar amount; no decimals
34	OTHER TrOOP AMOUNT		251 – 258	S9(6)V99	Actual or zero dollar amount; no decimals
35	LICS		259 – 266	S9(6)V99	Actual or zero dollar amount; no decimals
36	PLRO		267 – 274	S9(6)V99	Actual or zero dollar amount; no decimals
37	CPP		275 – 282	S9(6)V99	Actual or zero dollar amount; no decimals
38	NPP		283 – 290	S9(6)V99	Actual or zero dollar amount; no decimals
39	FILLER		291 – 445	X(155)	SPACES
40	CORRECTED HICN*		446 – 465	X(20)	SPACES
41	ERROR COUNT*		466 – 467	9(2)	SPACES
42-51	ERROR CODE FIELDS*		468 – 497		SPACES
52	FILLER		498 – 512	X(15)	SPACES

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

PACE PDE Record Layout   August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

PACE PDE Record Layout   August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information..

PDFS Error Codes

ERROR CODE LOGIC AND RANGES

SERIES	RANGES	EXPLANATION
100	126-150	File-level errors on the HDR.
	176-199	File-level errors TLR records.
200	226-250	Batch-level errors on the BHD.
	276-299	Batch-level errors on the BTR records
600	601-602	Detail-level errors on DET records.

FILE-LEVEL ERROR CODES

ERROR CODE	ERROR DESCRIPTION
126	RECORD ID IS MISSING OR INVALID.
127	HDR RECORD IS OUT OF SEQUENCE. HDR RECORD IS NOT FIRST RECORD IN FILE OR DOES NOT FOLLOW A TLR RECORD.
128	SUBMITTER ID IS MISSING.
129	SUBMITTER ID IS NOT ON FILE.
130	SUBMITTER ID IS NOT CERTIFIED TO SEND PRODUCTION DATA.
131	FILE ID IS MISSING. FILE ID IS BLANK.
132	FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.
133	TRANS-DATE IS MISSING OR INVALID. MUST BE A VALID DATE IN CCYYMMDD FORMAT AND CANNOT BE A FUTURE DATE.
134	PROD-TEST-IND IS MISSING OR INVALID. PROD-TEST-IND IS BLANK OR NOT EQUAL TO 'PROD' OR 'TEST'.
176	TLR RECORD IS OUT OF SEQUENCE. TLR RECORD DOES NOT FOLLOW A BTR RECORD.
177	SUBMITTER ID IS MISSING.
178	SUBMITTER ID IS NOT EQUAL TO THE SUBMITTER ID IN THE HDR RECORD.
179	FILE ID IS MISSING.
180	FILE ID IS NOT EQUAL TO THE FILE ID IN THE HDR RECORD.
181	TLR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF BATCHES IN THE FILE.
182	DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.

PDFS Error Codes

BATCH-LEVEL ERROR CODES

ERROR CODE	ERROR DESCRIPTION
226	BHD RECORD IS OUT OF SEQUENCE. BHD RECORD DOES NOT FOLLOW EITHER A HDR OR BTR RECORD.
227	SEQUENCE NUMBER IS MISISNG OR INVALID. SEQUENCE NUMBER CANNOT BE BLANK OR ZERO. SEQUENCE NUMBER MUST START WITH A 0000001.
228	SEQUENCE NUMBER IS INVALID. SEQUENCE NUMBER IS OUT OF ORDER.
229	CONTRACT NUMBER IS MISSING.
230	CONTRACT NUMBER DOES NOT MATCH NUMBER ASSIGNED BY CMS.
231	CONTRACT NUMBER IS NOT ACTIVE.
232	SUBMITTER NOT AUTHORIZED TO SUBMIT FOR THIS CONTRACT.
233	PBP ID IS MISSING.
234	PBP IS NOT VALID FOR THE CONTRACT ID.
235	PBP ID IS NOT ACTIVE. NOT AUTHROIZED TO SUMBMIT PRODUCTION DATA.
276	BTR RECORD IS OUT OF SEQUENCE. BTR RECORD DOES NOT FOLLOW A DET REOCRD.
277	SEQUENCE NUMBER IS MISSING OR INVLAID. SEQUENCE NUMBER IS NOT NUMERIC.
278	SEQUENCE NUMBER IS NOT EQUAL TO THE BHD SEQUENCE NUMBER.
279	CONTRACT NUMBER IS MISSING OR INVALID.
280	CONTRACT NUMBER DOES NOT MATCH THE CONTRACT NUMBER IN THE BHD RECORD.
281	PBP ID IS MISSING.
282	PBP ID DOES NOT MATCH THE PBP ID IN THE BHD RECORD.
283	DET RECORD TOTAL ON THE BTR RECORD IS MISSING.
284	BTR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF DETAIL RECORDS.

DETAIL-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
601	DET	DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT FOLLOW A BHD OR ANOTHER DET RECORD.
602	DET	SEQUENCE NUMBER IS INVALID. DET SEQUENCE NUMBER IS NOT NUMERIC OR NOT EQUAL TO THE COMPUTED SEQUENCE NUMBER.

The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

MISCELLANEOUS

ERROR CODE	ERROR DESCRIPTION
775	INCOMPATIBLE DISPENSING STATUS ('BLANK' CANNOT FOLLOW 'C' OR 'P'). RECORD FOR A PARITAL OR COMPLETE FILL IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH DISPENSING STATUS = BLANK FOR THE SAME DISPENSING EVENT.
776	INCOMPATIBLE DISPENSING STATUS ('C' OR 'P' CANNOT FOLLOW 'BLANK'). RECORD WITH UNSPECIFIED FILL STATUS IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH PARTIAL OR COMPLETE FILL FOR THE SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C').
777	DUPLICATE PDE RECORD.
778	PAID DATE < DOS.
779	SUBMITTING PLAN CANNOT REPORT NPP FOR COVERED PART D DRUG.
780	SERVICE PROVIDER ID QUALIFIER MUST BE '01' – NPI OR '07' – NCPDP ON STANDARD CLAIM.
781	SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE.
782	RECORD HAD NO ERROR, BUT WAS SUBMITTED AS PART OF A REJECTED FILE. DDPS REJECTS FILES WITH ERROR RATES EXCEEDING 50%.

PACE

ERROR CODE	ERROR DESCRIPTION
800	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE BLANK IN PDES SUBMITTED BY PACE PROGRAMS.
801	PATIENT PAY AMOUNT IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
802	OTHER TROOP AMOUNT IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS
803	LICS VALUE IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
804	PLRO IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
805	WHEN DRUG COVERAGE STATUS CODE EQUALS 'C', THE NON-COVERED PLAN PAID AMOUNT MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
806	GDCB IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
807	GDCA IS INVALID. MUST EQUAL ZERO IN PDES SUBMITTED BY PACE PROGRAMS.
808	FOR A COVERED DRUG, SUM OF INGREDIENT COST PAID, DISPENSING FEE PAID, AND TOTAL AMOUT ATTRIBUTED TO SALES TAX MUST EQUAL COVERD D PLAN PAID AMOUNT IN PDE SUBMITTED BY A PACE PROGRAM.
809	FOR A NON-COVERED DRUG, SUM OF INGREDIENT COST PAID, DISPENSING FEE PAID AND TOTAL AMOUNT ATTRIBUTED TO SALES TAX MUST EQUAL NON-COVERED PLAN PAID MAOUNT IN PDE SUBMITTED BY A PACE PROGRAM.

ERROR CATEGORIES AND DESCRIPTIONS

SERIES	EDIT CATEGORIES	DESCRIPTION
603-659	Missing or Invalid	Straightforward edits identifying invalid or missing values. If blank is a legal value, the missing edit does not apply.
660-669	Adjustment or Deletion	Edits in a hierarchy using eight fields (Contract Number, PBP ID, HICN, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status).
700-714	Eligibility	Eligibility edits verify the HICN, the beneficiary's eligibility for Part D, and enrollment in the Part D plan. Plan enrollment must be accurate because payment calculations are summarized at the plan level.
735-754	National Drug Code (NDC)	NDC edits confirm that an NDC exists and that the NDC existed on the date of service. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered Part D drugs are excluded from TrOOP, LICS, and payment calculations.
755-774	Drug Coverage Status Code	Edits that test the relationship between non-covered Part D drugs and the Covered D Plan Paid Amount, so that non-covered Part D drugs are not inadvertently included in payment calculations.
775-799	Miscellaneous	Edits on miscellaneous data elements.
800-809	PACE	Edits specifically for PACE plans.

PACE
DDPS Error Codes

MISSING/INVALID

ERROR CODE	ERROR DESCRIPTION
603	HICN IS MISSING. MUST NOT BE BLANK.
604	CARDHOLDER ID IS MISSING.
605	DOB IS AN INVALID DATE. DATES MUST BE IN CCYYMMDD FORMAT.
606	GENDER IS MISSING OR INVALID. GENDER MUST BE EITHER '1' OR '2'.
607	DOS IS MISSING OR INVALID. DOS MUST BE IN CCYYMMDD FORMAT AND BE A VALID DATE.
608	DOS MUST BE ON/AFTER 1/1/2006.
609	DOS MUST BE ON OR BEFORE TODAY'S DATE.
611	PAID DATE IS AN INVALID DATE IN CCYYMMDD FORMAT.
612	PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER IS MISSING OR INVALID. PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER MUST BE NUMERIC.
613	NDC CODE IS MISSING.
614	SERVICE PROVIDER ID QUALIFIER IS MISSING OR INVALID. SERVICE PROVIDER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '07' – NCPDP OR '08' – STATE LICENSE OR '11' – TIN OR '99' – OTHER.
615	SERVICE PROVIDER ID IS MISSING.
616	FILL NUMBER IS MISSING OR INVALID. FILL NUMBER MUST BE EQUAL TO A VALUE BETWEEN 0 AND 99.
617	DISPENSING STATUS IS INVALID. DISPENSING STATUS MUST BE EITHER A 'BLANK' OR 'P' OR 'C'.
618	COMPOUND CODE IS MISSING OR INVALID. COMPOUND CODE MUST BE EQUAL TO '0', '1', OR '2'.
619	DAW/PRODUCT SELECTION CODE IS MISSING OR INVLAID. DAW/PRODUCT SELECTION CODE MUST BE EQUAL TO VAUE BETWEEN 0 AND 9.
620	QUANTITIY DISPENSED IS MISSING OR INVALID. QUANTITY DISPENSED MUST BE ≥ 0.001.
621	DAYS SUPPLY IS MISSING OR INVLAID. VALUE MUST BE A VALUE BETWEEN 0 AND 999 DAYS.
622	PRESCRIBER ID QUALIFIER IS MISSING.
623	PRESCRIBER ID QUALIFIER IS INVALID. PRESCRIBER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '08' – STATE LICENSE OR '12' – DEA.
624	PRESCRIBER ID IS MISSING. MUST NOT BE BLANK.
625	DRUG COVERAGE STATUS CODE IS MISSING OR INVALID. VALID VALUES ARE 'C', 'E', AND 'O'.
626	ADJUSTEMENT CODE IS INVALID. VALID VALUES ARE 'A' FOR ADJUSTMENT AND 'D' FOR DELETION, OR 'BLANK'.
627	NON-STANDARD FORMAT CODE IS INVALID. VALID VALUES ARE 'BLANK', 'B', 'X', OR 'P'.
628	OON IS INVALID. VALID VALUES ARE 'BLANK' OR 'O'.
629	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE 'BLANK', 'A', OR 'C'.
630	INGREDIENT COST PAID IS MISSING OR INVLAID. INGREDIENT COST PAID MUST BE > ZERO.
631	DISPENSING FEE PAID IS MISISNG OR INVALID. MUST BE ≥ ZERO.
632	SALES TAX IS MISSING OR INVALID. MUST BE ≥ ZERO.
633	GDCB IS MISSING OR INVALID. MUST BE ≥ ZERO.
634	GDCA IS MISSING OR INVALID. MUST BE ≥ ZERO.
635	PATIENT PAY AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
636	OTHER TrOOP AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
637	LICS VALUE IS MISSING OR INVALID. MUST BE ≥ ZERO.
638	PLRO IS MISSING OR INVALID. MUST BE NUMERIC.
639	CPP IS MISSING OR INVALID. MUST BE ≥ ZERO.
640	NPP IS MISSING OR INVALID. MUST BE NUMERIC.

PACE
DDPS Error Codes

ADJUSTMENT/DELETION

ERROR CODE	ERROR DESCRIPTION
660	ADJUSTMENT/DELETION PDE DOES NOT MATCH THE EXISTING PDE RECORD (7 FIELD MATCH).
661	CANNOT ADJUST RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
662	CANNOT DELETE RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
663	VALUE OF DISPENSING STATUS ON ADJUSTMENT RECORD AND THE RECORD TO BE ADJUSTED MUST BE THE SAME.

ELIGIBILITY

ERROR CODE	ERROR DESCRIPTION
700	HICN DOES NOT MATCH AN EXISTING BENEFICIARY.
701	DOB PROVIDED DOES NOT MATCH THE DOB ON MBD.
702	GENDER DOES NOT MATCH THE VALUE ON MBD.
703	DOS CANNOT BE LESS THAN THE DOB.
704	DOS CANNOT BE GREATER THAN THE DATE OF DEATH (DOD).
705	BENEFICIARY MUST BE ENROLLED IN PART D ON THE DOS.
706	BENEFICIARY MUST BE ENROLLED IN THIS CONTRACT ON THE DOS.
707	BENEFICIARY MUST BE ENROLLED IN THIS PART D PLAN BENEFIT PACKAGE ON THE DOS.

NATIONAL DRUG CODE (NDC)

ERROR CODE	ERROR DESCRIPTION
735	NDC CODE IS INVALID. NDC CODE DOES NOT MATCH A VALID CODE ON THE NDC DATABASE.
736	DOS < NDC EFFECTIVE DATE.
737	INAPPROPRIATE DRUG COVERAGE STATUS CODE. DRUG COVERAGE IS NOT 'O' ALTHOUGH THE DRUG IS ON THE OTC LIST.
738	INAPPROPRIATE DRUG COVERAGE. DRUG COVERAGE IS 'C' ALTHOUGH THE DRUG IS ON THE EXCLUSION LIST.
739	THIS NDC IS FOR A DRUG THAT IS USUALLY COVERED UNDER PART B. IF PLAN DETERMINES THAT THIS DRUG IS PART B COVERED, SUBMIT DELETION RECORD.
740	NDC IS DESI DRUG.

DRUG COVERAGE STATUS CODE

ERROR CODE	ERROR DESCRIPTION
756	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE COVERED D PLAN PAID AMOUNT MUST BE ZERO.

August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.

August 2005
The PACE PDE information in this module is accurate as of August 17, 2005. See front cover letter for more information regarding sources of updated information.