TABLE OF CONTENTS

PURPOSE

♦ To provide MA-PDP and Stand-alone PDP organizations with complex operations guidelines necessary to submit accurate and timely PDE data.

TRAINING FORMAT

Application

Concepts

- ♦ Examples
- ♦ Exercises
- ♦ Group Participation
- ♦ Interactive

PARTICIPATION MAKES THE DIFFERENCE

TRAINING TOOLS

- ♦ Workbook
- ♦ Job Aids
- ♦ www.csscoperations.com
- ♦ MMA Help Desk
- ♦ Panel of Experts

AUDIENCE

- ♦ Staff of PDPs

- ♦ Staff of MA-PD plans, including demonstration projects and specialty plans

- ♦ Employer Group Health Plans

- ♦ PBMs

- ♦ Third Party submitters

AGENDA

8:00 – 9:00	Registration
9:00 – 9:30	Introduction
9:30 – 11:00	Plan-to-Plan (P2P)
11:00 – 11:15	Break
11:15 – 12:30	Reconciliation
12:30 – 1:30	Lunch
1:30 – 2:00	Q&A Part 1
2:00 – 3:00	Operations
3:00 – 4:00	Complex Examples
4:00 – 4:15	Break
4:15 – 5:00	Q&A Part 2
5:00	Adjourn

OBJECTIVES

- ♦ Describe the P2P process
- ♦ Explain the process for Part D Payment Reconciliation
- ♦ Review new operations updates
- ♦ Apply calculating and reporting rules to complex examples

INTRODUCING THE TEAM

CMS

Palmetto (CSSC)

Leading Through Change, Inc. (LTC)

Prescription Drug Event Data Advanced

Introduction

LTC, Inc.

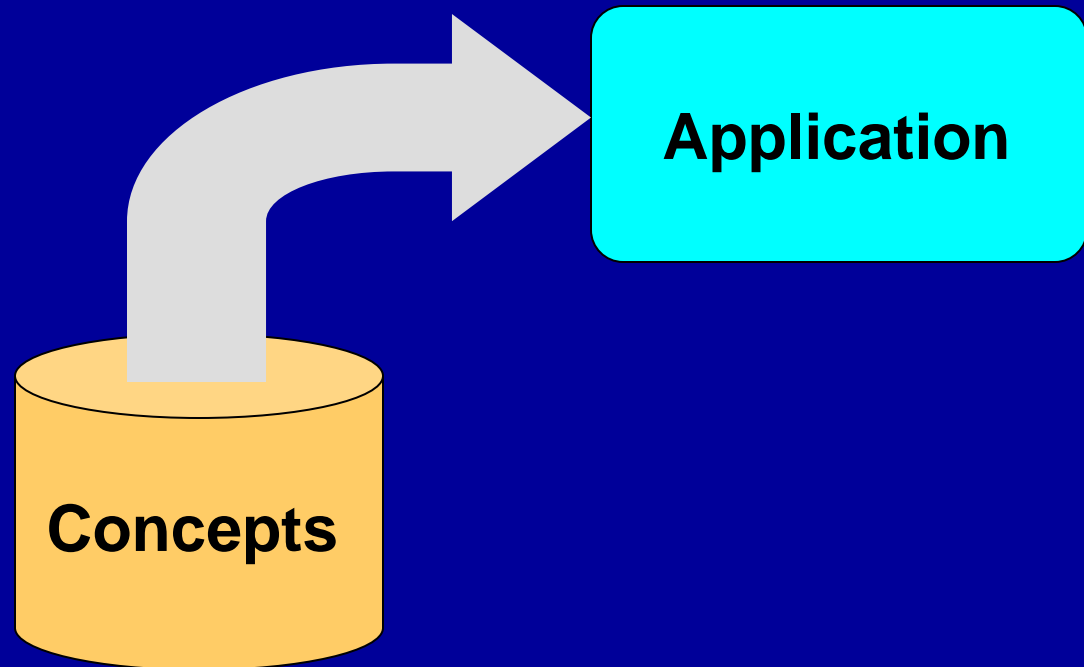# PURPOSE

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♦ Examples
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♦ Group Participation
♦ Interactive

PARTICIPATION MAKES THE DIFFERENCE

2

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Plan-to-Plan (P2P) Reconciliation

LTC, Inc.

PURPOSE

◆ To provide participants with an understanding of the Plan-to-Plan (P2P) process ultimately leading to accurate Part D payment reconciliation

OBJECTIVES

♦ Define P2P Reconciliation and common terms

♦ Describe the P2P process flow

♦ Identify edits related to the P2P process

♦ Apply the P2P process to examples, including reporting financial data

P2P PROCESS OVERVIEW

PDE Submission
- DDPS Return File
- Cumulative Beneficiary Summary Report

P2P Identification and Financial Settlement
- P2P PDE Accounting Report
- P2P Payables Report
- P2P Receivables Report
- P2P Part D Reconciliation Report

Contract/PBP Update
- Special Return File

P2P Identification and Financial Settlement
- Cumulative Beneficiary Summary Report
- P2P PDE Accounting Report
- P2P Payables Report
- P2P Receivables Report
- P2P Part D Reconciliation Report

Part D Reconciliation

Workbook Scenario 1

COMMON TERMS

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

P2P PROCESS

PDE Submission

↓

P2P Identification and Financial Settlement

↓

Contract/PBP Update

↓

P2P Identification and Financial Settlement

↓

Part D Reconciliation

STATUTORY AUTHORITY

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

CMS TRANSITION PERIOD

Begins

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

Ends

♦ The later of…

◊ 30-days after the effective date of coverage, or

◊ 30-days after the date CMS processes the enrollment into the new contract of record

PART D SPONSOR ASSUMED RESPONSIBILITIES

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

P2P ROLES AND RESPONSIBILITIES

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

Workbook Scenario 2

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

Submitting Contract = Contract of Record
- No → DOS > 06/30/07
  - No → Drug Coverage Status Code = C
  - Yes → DOS ≤ (later of Enrollment Effective Date or CMS Process Date) + 30 Days
    - No → Reject Edit 706
    - Yes → Enrollment Source ID Code = D (Rollover)
      - Yes → Reject Edit 706
      - No → Submitting Contract = Prior Contract of Record
        - No → Info Edit 712
        - Yes → Drug Coverage Status Code = C
- Yes → Submitting PBP = PBP of Record
  - No → Reject Edit 707
  - Yes → Resume Editing

Drug Coverage Status Code = C
- No → Info Edit 709 → Resume Editing
- Yes → Info Edit 708 → Resume Editing

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

Submitting Contract = Contract of Record
- No → DOS > 06/30/07
  - No →
  - Yes → DOS ≤ (later of Enrollment Effective Date or CMS Process Date) + 30 Days
    - No → Reject Edit 706
    - Yes → Enrollment Source ID Code = D (Rollover)
      - Yes → Reject Edit 706
      - No → Submitting Contract = Prior Contract of Record
        - No → Info Edit 712
        - Yes → Drug Coverage Status Code = C
- Yes → Submitting PBP = PBP of Record
  - No → Reject Edit 707
  - Yes → Resume Editing

Drug Coverage Status Code = C
- No → Info Edit 709 → Resume Editing
- Yes → Info Edit 708 → Resume Editing

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

Flowchart:

- **Submitting Contract = Contract of Record**
  - No → **DOS > 06/30/07**
    - No → (to Drug Coverage Status Code = C path)
    - Yes → **DOS ≤ (later of Enrollment Effective Date or CMS Process Date) + 30 Days**
      - No → **Reject Edit 706**
      - Yes → **Enrollment Source ID Code = D (Rollover)**
        - Yes → **Reject Edit 706**
        - No → **Submitting Contract = Prior Contract of Record**
          - No → **Info Edit 712**
          - Yes → (to Drug Coverage Status Code = C)
  - Yes → **Submitting PBP = PBP of Record**
    - No → **Reject Edit 707**
    - Yes → **Resume Editing**

- **Drug Coverage Status Code = C**
  - No → **Info Edit 709** → **Resume Editing**
  - Yes → **Info Edit 708** → **Resume Editing**

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

Submitting Contract = Contract of Record
- No → DOS > 06/30/07
  - No → (continues to Drug Coverage Status Code = C)
  - Yes → DOS ≤ (later of Enrollment Effective Date or CMS Process Date) + 30 Days
    - No → Reject Edit 706
    - Yes → Enrollment Source ID Code = D (Rollover)
      - Yes → Reject Edit 706
      - No → Submitting Contract = Prior Contract of Record
        - No → Info Edit 712
        - Yes → (continues)
- Yes → Submitting PBP = PBP of Record
  - No → Reject Edit 707
  - Yes → Resume Editing

Drug Coverage Status Code = C
- No → Info Edit 709 → Resume Editing
- Yes → Info Edit 708 → Resume Editing

CMS COMMUNICATION TO PLANS

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

REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
DDPS Return File	RPT00000.RPT.DDPS_TRANS_VALIDATION
Special Return File	RPT00000.RPT.DDPS_P2P_PHASE3_RTN
Cumulative Beneficiary Summary Report (04 COV/ENH/OTC)	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC
P2P Accounting Report (40COV/ENH/OTC)	RPT00000.RPT.DDPS_P2P_PDE_ACC_C RPT00000.RPT.DDPS_P2P_PDE_ACC_E RPT00000.RPT.DDPS_P2P_PDE_ACC_O
P2P Receivable Report (41COV)	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P Part D Payment Reconciliation Report (42COV)	RPT00000.RPT.DDPS_P2P_PARTD_RCON
P2P Payable Report (43COV)	RPT00000.RPT.DDPS_P2P_PAYABLE

DDPS RETURN FILES FOR SUBMISSION OF PDES FOR JOHN BROWN

PDE	Date of Service	PDE Record Submission Date	Record Type	Edit Code	Contract of Record populated (Y or N)
1	September 5, 2007	September 29, 2007	INF	708	Y
2	September 7, 2007	September 29, 2007	INF	709	N
3	October 2, 2007	October 20, 2007	INF	708	Y
4	October 15, 2007	October 29, 2007	REJ	706	N

Workbook Scenario 2

WINTER HEALTH PLAN'S P2P REPORTS
(SUBMITTING CONTRACT)

Report 40 – Accounting
Report 41 – Receivables

PDE	Date of Service	PDE Record Submission Date	COV	ENH	OTC	Month of Report
1	September 5, 2007	September 29, 2007	X			September
2	September 7, 2007	September 29, 2007			X	September
3	October 2, 2007	October 20, 2007	X			October
4*	October 15, 2007	October 29, 2007				

*PDE 4 was rejected, so it will not appear on these reports.

Report 42 – Part D Payment Reconciliation
Report 43 – Payables

PDE	Date of Service	PDE Record Submission Date	COV	Month of Report
1	September 5, 2007	September 29, 2007	**X**	September
2	September 7, 2007	September 29, 2007		
3	October 2, 2007	October 20, 2007	**X**	October
4*	October 15, 2007	October 29, 2007		

*PDE 4 was rejected, so it will not appear on these reports.

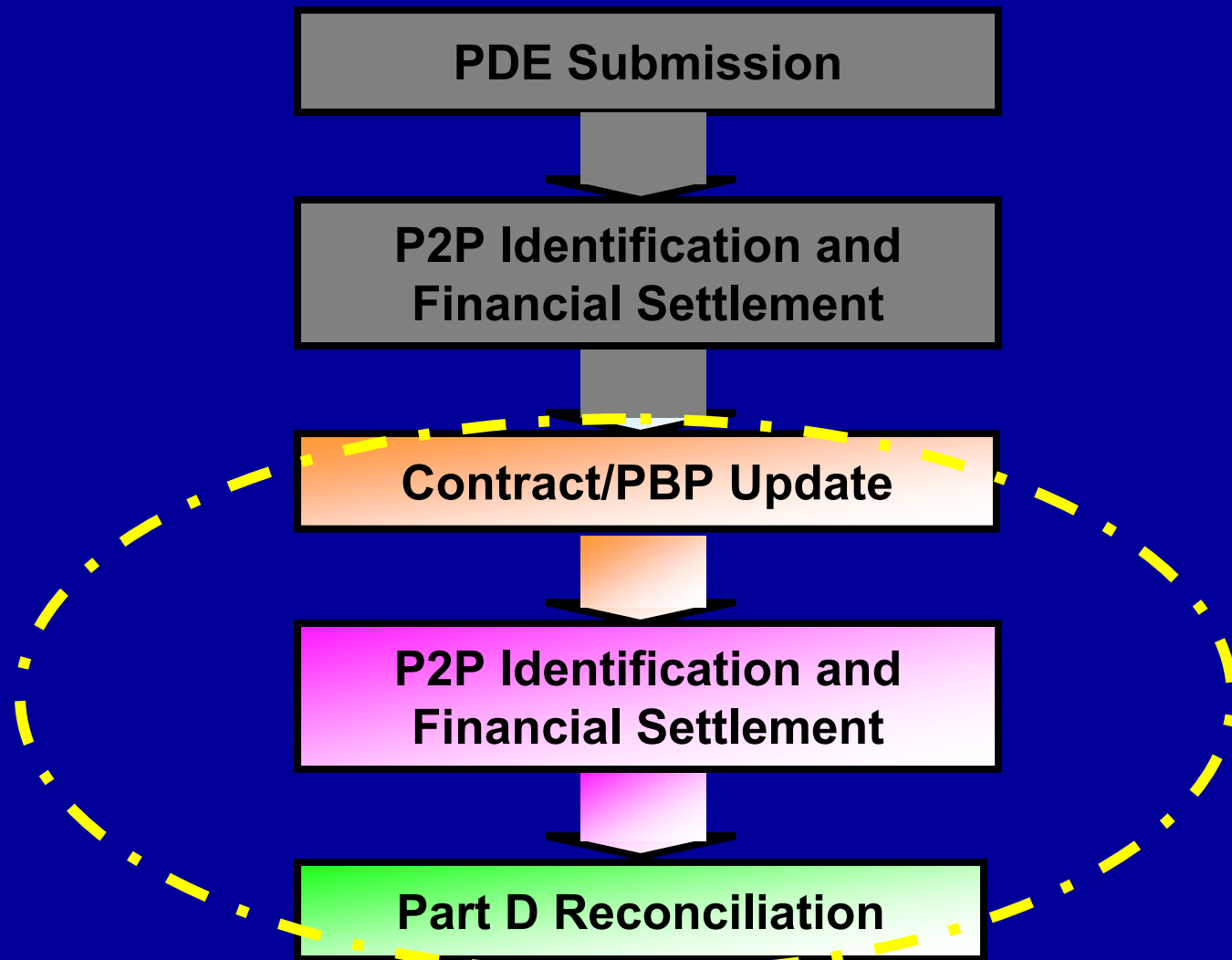# P2P CONTRACT/PBP UPDATE PRIOR TO PART D PAYMENT RECONCILIATION

♦ Prior to running Part D Payment Reconciliation:

◊ PDEs must be attributed to the appropriate Contract of Record

Updates to contract/PBP of record may occur more than once per coverage year, but will always occur prior to Part D Payment Reconciliation.
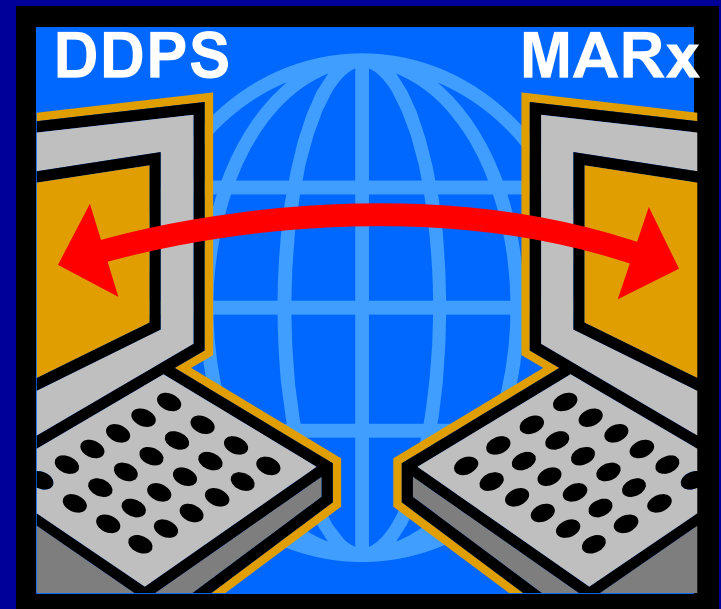
P2P PROCESS

PDE Submission

↓

P2P Identification and Financial Settlement

↓

Contract/PBP Update

↓

P2P Identification and Financial Settlement

↓

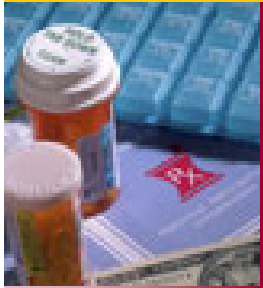Part D Reconciliation

P2P CONTRACT/PBP UPDATE PROCESSING

♦ **DDPS queries MARx for changes to Contract and PBP of Record**

◊ Changes result in DDPS updating affected PDEs

◊ No changes result in no updates to saved PDEs

DDPS   MARx

P2P CONTRACT/PBP UPDATE PROCESSING (CONTINUED)

♦ Updates are for all changes to enrollment information and are not limited to changes affecting P2P.

♦ Update Codes regarding P2P changes resulting from Contract/PBP Update will *only* be sent to the Submitting Contract, not to the Updated or Original Contract of Record.

♦ Changes to HICN will appear on the Special Return file and will generate an edit code 710.

♦ Updated Contract of Record and Original Contract of Record are *only* informed of P2P changes through monthly reports.

P2P CONTRACT/PBP UPDATE INFORMATIONAL EDIT CODES

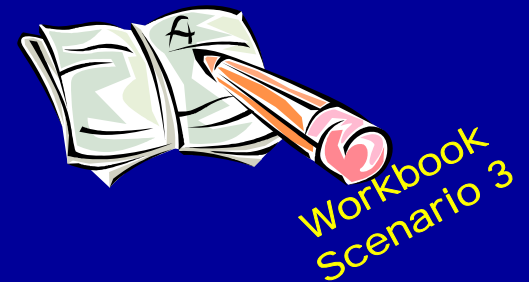| Update Code	Description	P2P Condition
851	Contract of Record has been updated.	Condition now exists.
852	Submitting Contract/PBP is now the Contract/PBP of Record.	Condition no longer exists.
853	PBP of Record has been updated.	Continues to be non-P2P PDE.
854	Contract of Record and PBP of Record have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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 3

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

(S) Contract	(S) PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	B	1	A	1	N	N

(S) = Submitting

Workbook Scenario 4

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

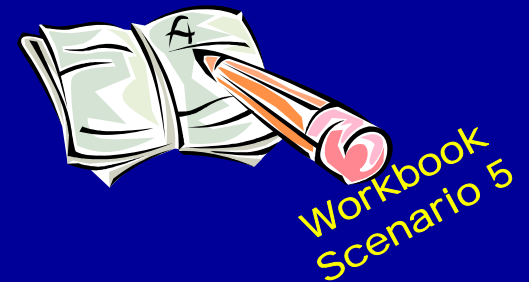| Report	Submission Month	Month after Submission	Update Month
4	$0	$0	$100
40	$100	$100	$0
41	$100	$0	($100)
42	$100	$100	$0
43	$100	$0	($100)

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 5

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

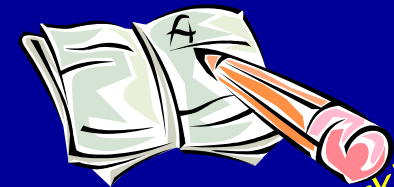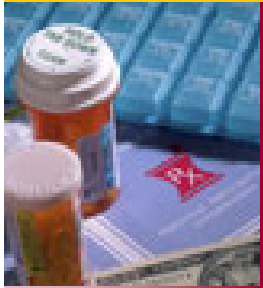| (S) Contract	(S) PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	B	1	C	1	Y	N

(S) = Submitting

Workbook Scenario 6

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

Contract A to Contract B

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

Contract A to Contract C

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 7

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 8

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

P2P PROCESS

PDE Submission

↓

P2P Identification and Financial Settlement

↓

Contract/PBP Update

↓

P2P Identification and Financial Settlement

↓

Part D Reconciliation

P2P RECONCILIATION PROCESS EXAMPLE

John Brown changes from Winter Health Plan to Spring Health Plan in the middle of the coverage year.

ENROLLMENT INFORMATION		
Contract	Start Date	End Date
Winter Health Plan	07/01/07	09/30/07
Spring Health Plan	10/01/07	

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan submits PDEs

PDE ACTIVITY			
Date of Service	CPP	CMS Processed Date	P2P Condition?
09/28/07	$42.50	09/29/07	N
09/28/07	$23.42	09/29/07	N
10/02/07	**$18.36**	**10/03/07**	**Y**
10/02/07	**$12.20**	**10/03/07**	**Y**
10/09/07	$14.72	10/25/07	Y
10/09/07	$23.42	10/25/07	Y
10/15/07	$15.45	10/25/07	Y
11/16/07	$42.50	11/18/07	N

Winter Health Plan - September Monthly Reports

Report 4

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan - October Monthly Reports

Report 4

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

Reports 40 and 41

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Spring Health Plan - October Monthly Reports

Reports 42 and 43

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

Winter Health Plan
For Contract/PBP Update

Special Return File

DOS	CPP	Contract of Record	Update Code
10/02/07	$18.36	Spring Health	851
10/02/07	$12.20	Spring Health	851

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan – July Monthly Reports

Reports 40 and 41

DOS	CPP	Contract of Record
10/02/07	$18.36	Spring Health
10/02/07	$12.20	Spring Health

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Spring Health Plan – July Monthly Reports

Reports 42 and 43

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan and Spring Health Plan for Part D Payment Reconciliation

Winter Health Plan

Reports	Total CPP
Report 4	$65.92
Report 42	$ 0.00

Spring Health Plan

Reports	Total CPP
Report 4	$ 0.00
Report 42	$84.15

PLAN LIABILITY

Enrollment Submissions

As frequency of Enrollment Submissions increases, plan liability decreases
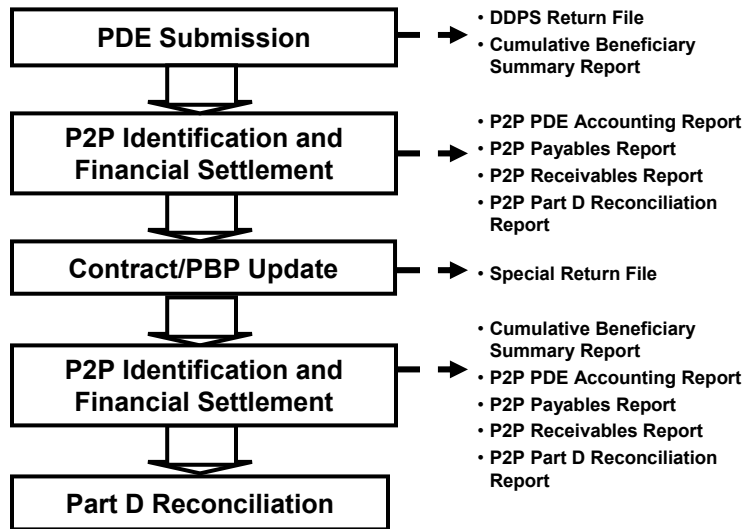
Plan Liability

SUMMARY

- ◆ Defined P2P Reconciliation and common terms

- ◆ Described the P2P process flow

- ◆ Identified edits related to the P2P process

- ◆ Applied the P2P process to examples, including reporting financial data

EVALUATION

Please take a moment to complete the evaluation form for the Plan-to-Plan (P2P) Reconciliation Module.

**Prescription Drug Event Data
Advanced**

Plan-to-Plan (P2P) Reconciliation

LTC, Inc.

PURPOSE

♦ To provide participants with an understanding of the Plan-to-Plan (P2P) process ultimately leading to accurate Part D payment reconciliation

OBJECTIVES

♦ Define P2P Reconciliation and common terms

♦ Describe the P2P process flow

♦ Identify edits related to the P2P process

♦ Apply the P2P process to examples, including reporting financial data
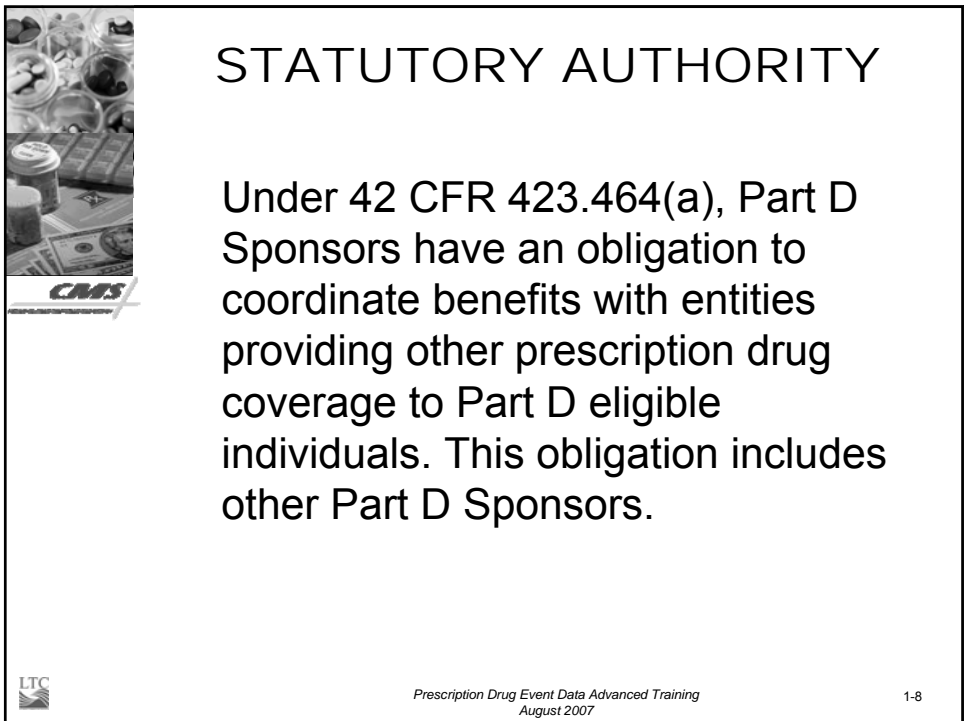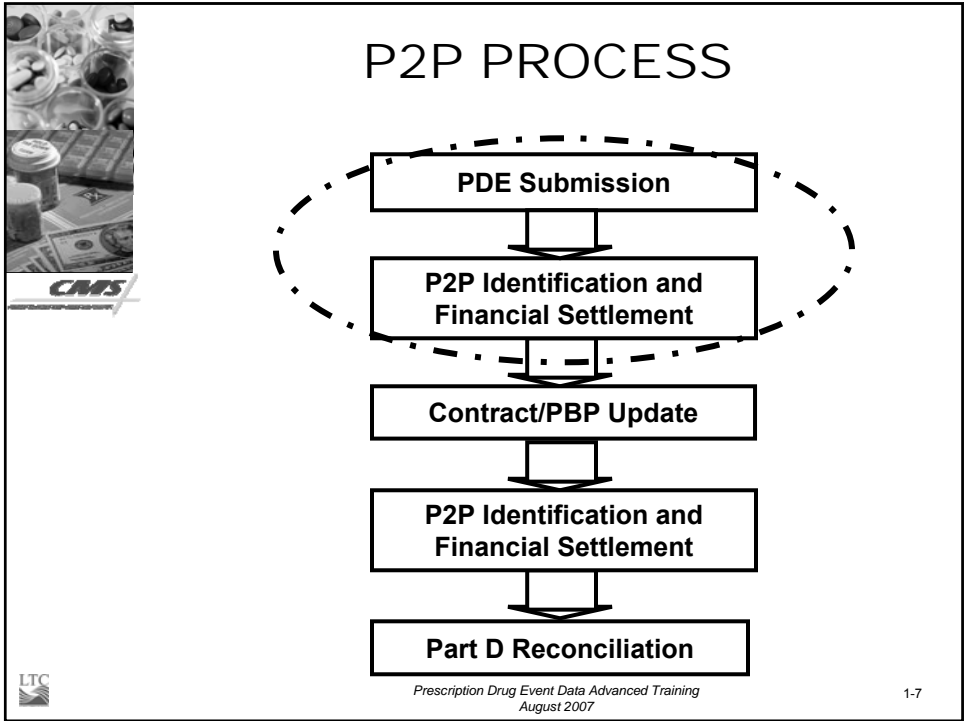

P2P PROCESS OVERVIEW

PDE Submission	• DDPS Return File • Cumulative Beneficiary Summary Report
P2P Identification and Financial Settlement	• P2P PDE Accounting Report • P2P Payables Report • P2P Receivables Report • P2P Part D Reconciliation Report
Contract/PBP Update	• Special Return File
P2P Identification and Financial Settlement	• Cumulative Beneficiary Summary Report • P2P PDE Accounting Report • P2P Payables Report • P2P Receivables Report • P2P Part D Reconciliation Report
Part D Reconciliation	

Workbook Scenario 1

COMMON TERMS

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

P2P PROCESS

```
        ┌─────────────────────────────┐
        │       PDE Submission        │
        └─────────────────────────────┘
                      │
                      ▼
        ┌─────────────────────────────┐
        │    P2P Identification and   │
        │    Financial Settlement     │
        └─────────────────────────────┘
                      │
                      ▼
        ┌─────────────────────────────┐
        │     Contract/PBP Update     │
        └─────────────────────────────┘
                      │
                      ▼
        ┌─────────────────────────────┐
        │    P2P Identification and   │
        │    Financial Settlement     │
        └─────────────────────────────┘
                      │
                      ▼
        ┌─────────────────────────────┐
        │    Part D Reconciliation    │
        └─────────────────────────────┘
```

STATUTORY AUTHORITY

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

CMS TRANSITION PERIOD

Begins

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

Ends

♦ The later of…

◊ 30-days after the effective date of coverage, or

◊ 30-days after the date CMS processes the enrollment into the new contract of record

PART D SPONSOR ASSUMED RESPONSIBILITIES

♦ Submitting accurate and timely PDEs

♦ Making appropriate adjustments and reversals
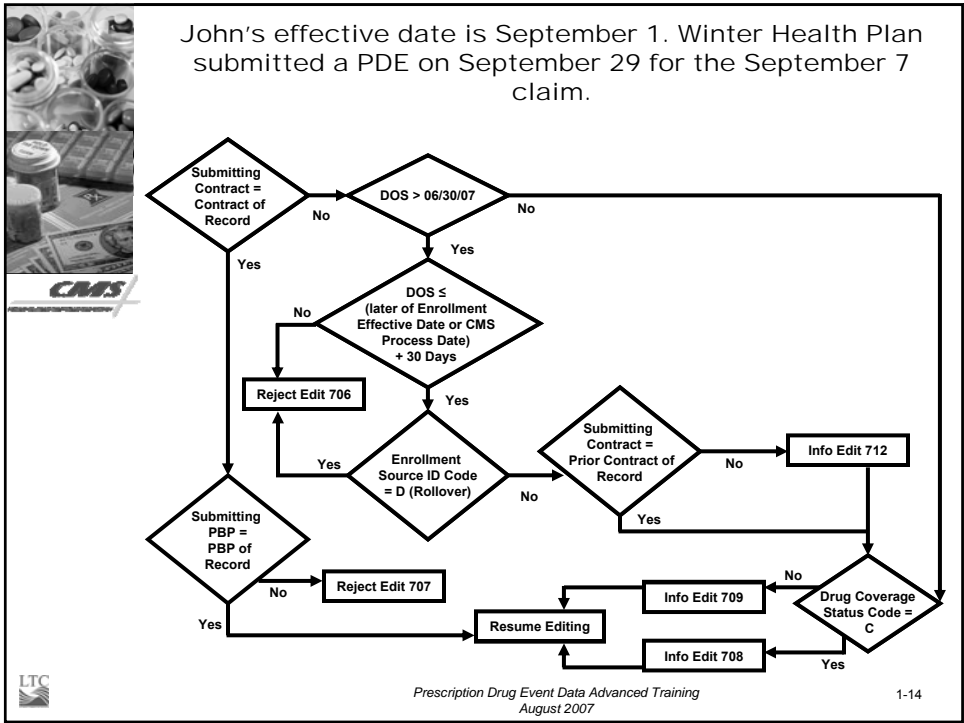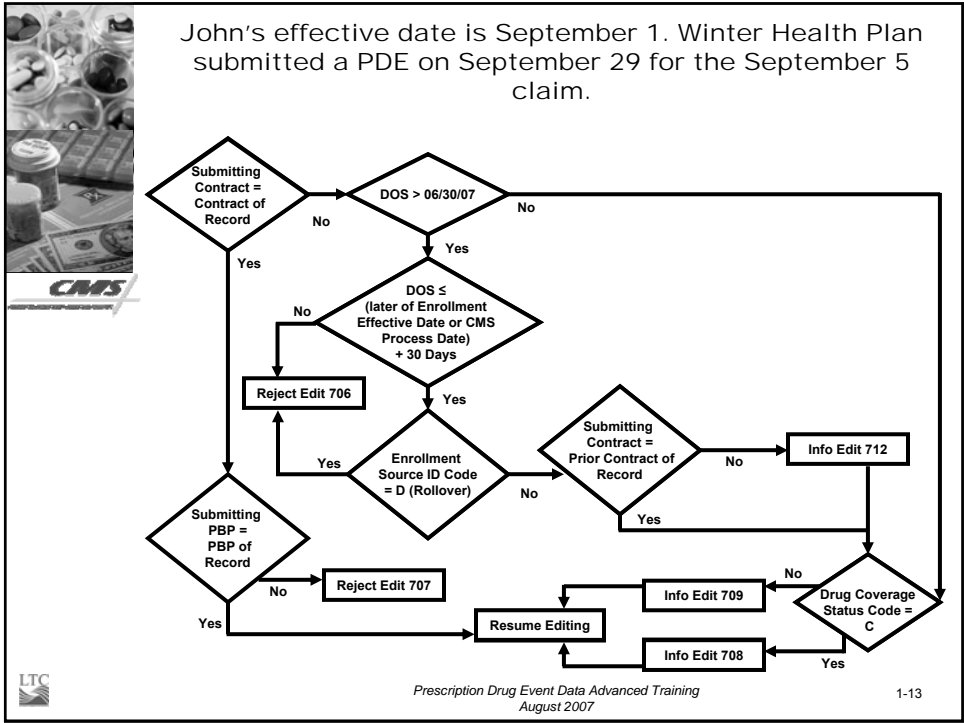
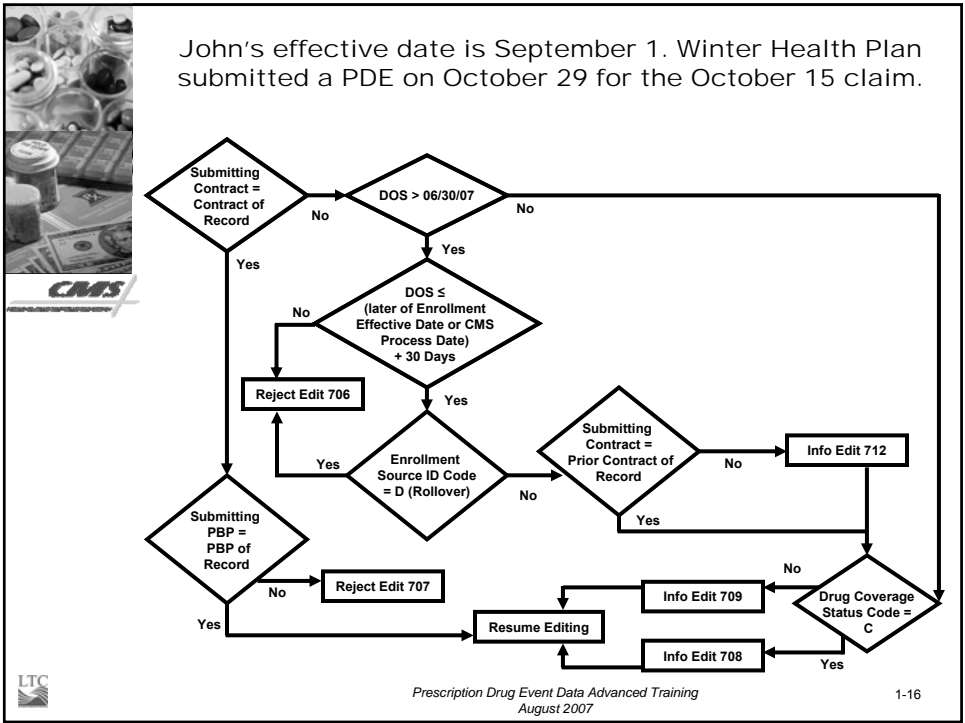♦ Accessing and reviewing monthly reports
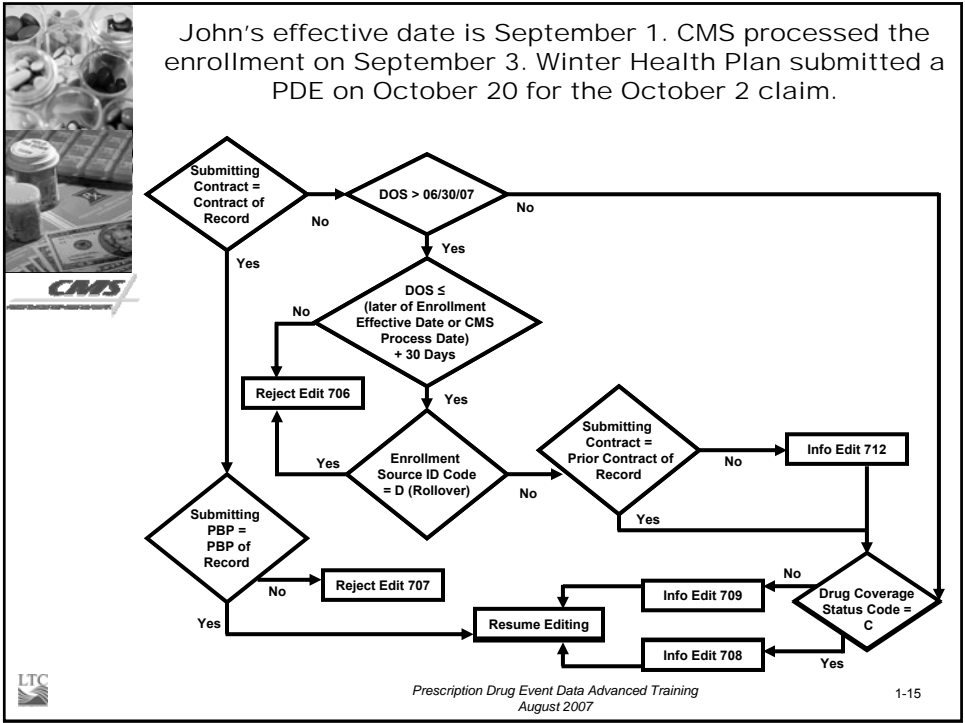
P2P ROLES AND RESPONSIBILITIES

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

Workbook Scenario 2

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

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

7
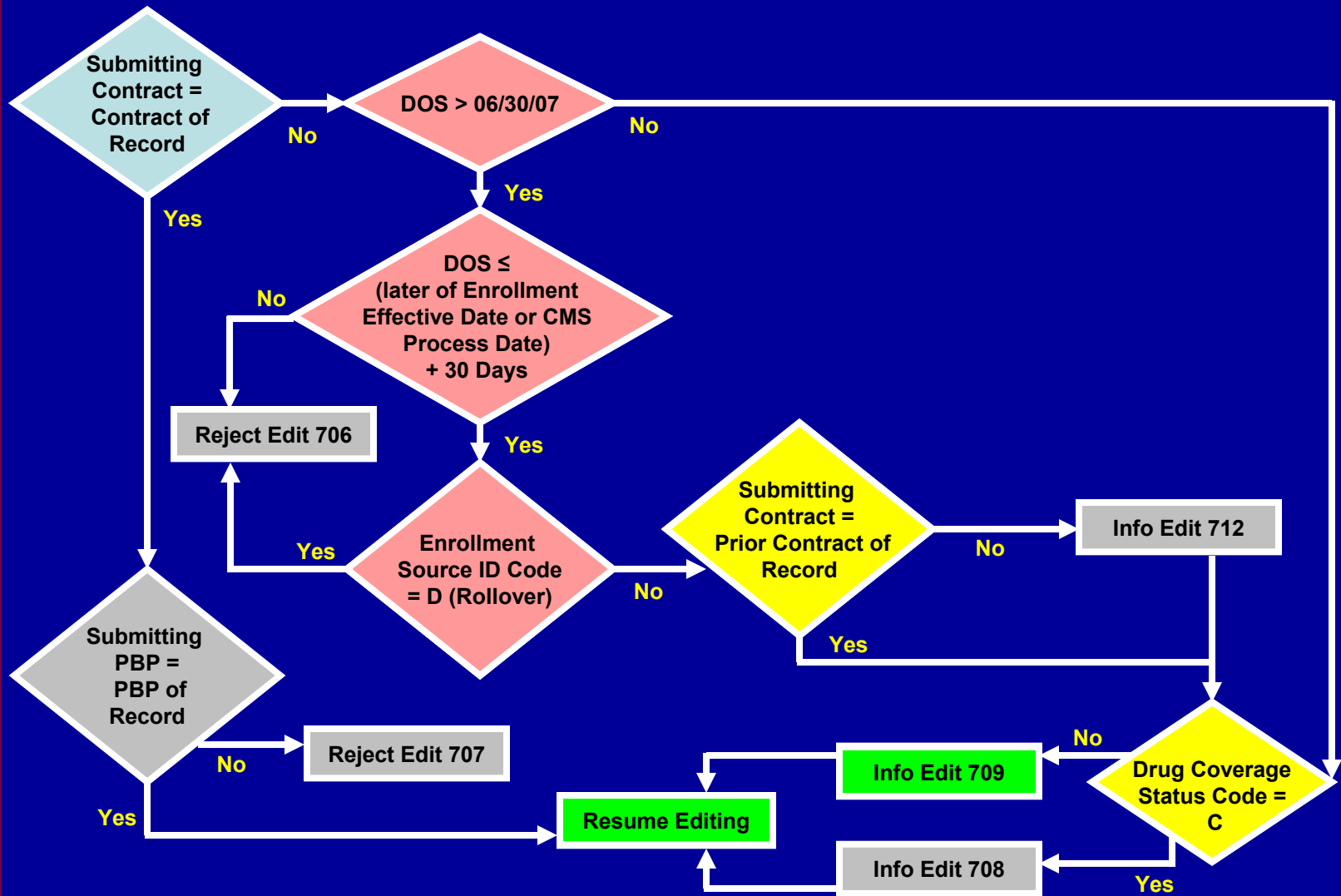
John's effective date is September 1. CMS processed the enrollment on September 3. Winter Health Plan submitted a PDE on October 20 for the October 2 claim.

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

8

CMS COMMUNICATION TO PLANS

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

REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
DDPS Return File	RPT00000.RPT.DDPS_TRANS_VALIDATION
Special Return File	RPT00000.RPT.DDPS_P2P_PHASE3_RTN
Cumulative Beneficiary Summary Report (04 COV/ENH/OTC)	RPT00000.RPT.DDPS_CUM_BENE_ACT_COV RPT00000.RPT.DDPS_CUM_BENE_ACT_ENH RPT00000.RPT.DDPS_CUM_BENE_ACT_OTC
P2P Accounting Report (40COV/ENH/OTC)	RPT00000.RPT.DDPS_P2P_PDE_ACC_C RPT00000.RPT.DDPS_P2P_PDE_ACC_E RPT00000.RPT.DDPS_P2P_PDE_ACC_O
P2P Receivable Report (41COV)	RPT00000.RPT.DDPS_P2P_RECEIVABLE
P2P Part D Payment Reconciliation Report (42COV)	RPT00000.RPT.DDPS_P2P_PARTD_RCON
P2P Payable Report (43COV)	RPT00000.RPT.DDPS_P2P_PAYABLE

DDPS RETURN FILES FOR SUBMISSION OF PDES FOR JOHN BROWN

PDE	Date of Service	PDE Record Submission Date	Record Type	Edit Code	Contract of Record populated (Y or N)
1	September 5, 2007	September 29, 2007	INF	708	Y
2	September 7, 2007	September 29, 2007	INF	709	N
3	October 2, 2007	October 20, 2007	INF	708	Y
4	October 15, 2007	October 29, 2007	REJ	706	N

Workbook Scenario 2

WINTER HEALTH PLAN'S P2P REPORTS
(SUBMITTING CONTRACT)

Report 40 – Accounting
Report 41 – Receivables

PDE	Date of Service	PDE Record Submission Date	COV	ENH	OTC	Month of Report
1	September 5, 2007	September 29, 2007	X			September
2	September 7, 2007	September 29, 2007			X	September
3	October 2, 2007	October 20, 2007	X			October
4*	October 15, 2007	October 29, 2007				

*PDE 4 was rejected, so it will not appear on these reports.

SPRING HEALTH PLAN'S P2P REPORTS
(CONTRACT OF RECORD)

Report 42 – Part D Payment Reconciliation
Report 43 – Payables

PDE	Date of Service	PDE Record Submission Date	COV	Month of Report
1	September 5, 2007	September 29, 2007	X	September
2	September 7, 2007	September 29, 2007		
3	October 2, 2007	October 20, 2007	X	October
4*	October 15, 2007	October 29, 2007		

*PDE 4 was rejected, so it will not appear on these reports.

P2P CONTRACT/PBP UPDATE PRIOR TO PART D PAYMENT RECONCILIATION

♦ Prior to running Part D Payment Reconciliation:

◊ PDEs must be attributed to the appropriate Contract of Record

Updates to contract/PBP of record may occur more than once per coverage year, but will always occur prior to Part D Payment Reconciliation.

P2P PROCESS


```
┌─────────────────────────────┐
│       PDE Submission         │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│   P2P Identification and     │
│    Financial Settlement      │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│     Contract/PBP Update      │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│   P2P Identification and     │
│    Financial Settlement      │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│     Part D Reconciliation    │
└─────────────────────────────┘
```

P2P CONTRACT/PBP UPDATE PROCESSING

♦ DDPS queries MARx for changes to Contract and PBP of Record

   ◊ Changes result in DDPS updating affected PDEs

   ◊ No changes result in no updates to saved PDEs

P2P CONTRACT/PBP UPDATE PROCESSING (CONTINUED)

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

P2P CONTRACT/PBP UPDATE INFORMATIONAL EDIT CODES

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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 3

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

(S) Contract	(S) PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	B	1	A	1	N	N

(S) = Submitting

Workbook Scenario 4

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

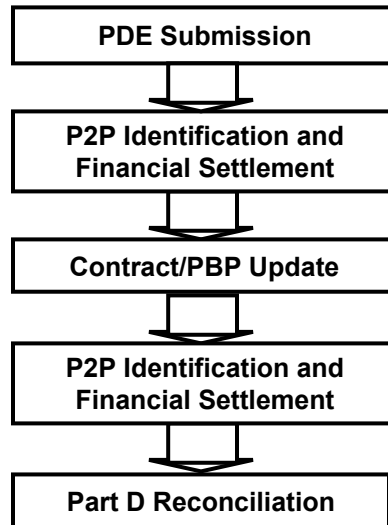| (S) Contract	(S) PBP	Original Contract of Record	Original PBP of Record	Updated Contract of Record	Updated PBP of Record	Contract of Record Update Reported on Return File	PBP of Record Update Reported on Return File
A	1	A	1	A	2	N	Y

(S) = Submitting

Workbook Scenario 5

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

16

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 6

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

Contract A to Contract B   CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

Contract A to Contract C

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 7

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

CONTRACT/PBP UPDATE EXAMPLE

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

(S) = Submitting

Workbook Scenario 8

CONTRACT/PBP UPDATE EXAMPLE (CONTINUED)

CPP = $100

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

P2P PROCESS

PDE Submission

↓

P2P Identification and Financial Settlement

↓

Contract/PBP Update

↓

P2P Identification and Financial Settlement

↓

Part D Reconciliation

P2P RECONCILIATION PROCESS EXAMPLE

John Brown changes from Winter Health Plan to Spring Health Plan in the middle of the coverage year.

ENROLLMENT INFORMATION

Contract	Start Date	End Date
Winter Health Plan	07/01/07	09/30/07
Spring Health Plan	10/01/07	

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan submits PDEs

PDE ACTIVITY

Date of Service	CPP	CMS Processed Date	P2P Condition ?
09/28/07	$42.50	09/29/07	N
09/28/07	$23.42	09/29/07	N
10/02/07	**$18.36**	**10/03/07**	Y
10/02/07	**$12.20**	**10/03/07**	Y
10/09/07	$14.72	10/25/07	Y
10/09/07	$23.42	10/25/07	Y
10/15/07	$15.45	10/25/07	Y
11/16/07	$42.50	11/18/07	N

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan - September Monthly Reports

Report 4

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan - October Monthly Reports

Report 4

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

Reports 40 and 41

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Spring Health Plan - October Monthly Reports

Reports 42 and 43

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan
For Contract/PBP Update

Special Return File

DOS	CPP	Contract of Record	Update Code
10/02/07	$18.36	Spring Health	851
10/02/07	$12.20	Spring Health	851

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan – July Monthly Reports

Reports 40 and 41

DOS	CPP	Contract of Record
10/02/07	$18.36	Spring Health
10/02/07	$12.20	Spring Health

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Spring Health Plan – July Monthly Reports

Reports 42 and 43

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

P2P RECONCILIATION PROCESS EXAMPLE (CONTINUED)

Winter Health Plan and Spring Health Plan for Part D Payment Reconciliation

Winter Health Plan

Reports	Total CPP
Report 4	$65.92
Report 42	$ 0.00

Spring Health Plan

Reports	Total CPP
Report 4	$ 0.00
Report 42	$84.15

PLAN LIABILITY

Enrollment Submissions

As frequency of Enrollment Submissions increases, plan liability decreases

Plan Liability

SUMMARY

♦ Defined P2P Reconciliation and common terms

♦ Described the P2P process flow

♦ Identified edits related to the P2P process

♦ Applied the P2P process to examples, including reporting financial data

EVALUATION

Please take a moment to complete the evaluation form for the Plan-to-Plan (P2P) Reconciliation Module.

PRESCRIPTION DRUG EVENT – ADVANCED TRAINING
Plan-to-Plan (P2P) Reconciliation

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

LTC
LEADING THROUGH CHANGE

Workbook

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Workbook Scenario 1

John Brown has been enrolled in Summer Health Plan under Plan Benefit Package 002 since January 1, 2007. Fall Health Plan submitted an enrollment record to CMS on August 15, 2007. The enrollment effective date is August 1, 2007 for Plan Benefit Package 001. Summer Health Plan submitted a PDE for John Brown with a DOS of September 13, 2007.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		

Workbook Scenario 2

John Brown joined Winter Health Plan in January 2007 as a dual-eligible and completed an enrollment application on August 27, 2007 for Spring Health Plan's PBP 002. Spring Health Plan submitted the enrollment. CMS processed the enrollment on September 3, 2007. John's effective date is September 1, 2007.

John fills a prescription on September 5, 2007 for a covered drug and on September 7, 2007 for an OTC drug using an ID card from Winter Health Plan. He also fills prescriptions on October 2, 2007 and October 15, 2007 for covered drugs. Winter Health Plan PBP 001 submitted two PDEs on September 29, 2007 for the September 5, 2007 and September 7, 2007 claims. They also submitted a PDE on October 20, 2007 for the October 2, 2007 claim and on October 29, 2007 for the October 15, 2007 claim.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		
2		
3		
4		

Workbook Scenario 3

When Winter Health Plan PBP 001, submitted a PDE for a covered drug on November 10, 2007 for John Brown with DOS October 15, 2007 CMS databases indicated that they were the Contract of Record for John.

When CMS conducted the P2P Contract/PBP Update, the Contract and PBP of Record changed to Spring Health Plan PBP 001 with an effective date of October 1, 2007.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		

Workbook Scenario 4

Jane Doe was also enrolled in Winter Health Plan PBP 001. However, when Winter Health submitted a PDE on November 1, 2007 for an October DOS, CMS had Spring Health plan as the Contract of Record in their databases, so this created a P2P condition.

After the PDE was accepted and saved, a retroactive enrollment processed for Winter Health plan on November 3, 2007. The enrollment effective date of this transaction was October 1, 2007.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		

Workbook Scenario 5

Jane Brown, John's wife, changed from Winter Health's PBP 001 to PBP 002, effective September 1, 2007.

This situation does not qualify as a P2P condition. Even after the Contract/PBP Update, this remains a non-P2P condition. However, CMS will send Winter Health a Special Return File because the Contract/PBP Update is meant to update all enrollment changes including PBP-only updates.

Enrollment Effective Date _____

Workbook Scenario 6

Frank Cloud was enrolled in Winter Health Plan effective August 1, 2007. Winter Health submitted a PDE record on September 17, 2007 for DOS September 2, 2007. On August 15, 2007, Spring Health submitted an enrollment transaction for Frank with a September 1, 2007 effective date, which created a P2P condition. Spring Health settled financially with Winter Health.

Summer Health Plan also submitted an enrollment for Frank, but on September 25, 2007, with effective date August 1, 2007. Winter Health was not informed that Summer Health was the Contract of Record until it received the Special Return File following the Contract/PBP Update.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		

Workbook Scenario 7

Sarah Blue was enrolled in Winter Health in August 2007. Spring Health enrolled Sarah in their plan. The enrollment effective date was September 1, 2007. During September Winter Health submitted a PDE. Spring Health paid Winter Health for the claim because of the P2P condition.

The beneficiary re-enrolled into Winter Health for September 2007 under PBP 002. This transaction processed after the Enrollment into Spring Health. During the Contract/PBP Update process, Winter Health was found to be the Contract of Record, but the PBP had changed according to the Special Return File from PBP 001 to PBP 002.

Enrollment Effective Date _____

PDE	Date of Service	PDE Record Submission Date
1		

Workbook Scenario 8

Kelly Yellow enrolls in Spring Health in July, which disenrolled her from Winter Health Plan. Spring Health paid Winter Health for Kelly's P2P PDEs for covered drugs that occurred during the transition period. Kelly switched PBPs in July, not long after her enrollment was effective.

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

110 Plan-to-Plan Reconciliation

110.1 Overview:

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

110.2 Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

110.3 Authority:

Under 42 CFR 423.464(a), Part D Sponsors have an obligation to coordinate benefits with entities providing other prescription drug coverage to Part D eligible individuals. This obligation includes other Part D Sponsors. The P2P process provides a means to coordinate correction of claims payments made by a Sponsor other than the Contract of Record. CMS requires that all Part D Sponsors participate in the P2P process.

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

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

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

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

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

• CMS provides the capacity to accept the data and report back to each affected Sponsor the appropriate information to facilitate P2P reconciliation.

• CMS provides all Sponsors with CPP and LICS on the P2P Monthly Reports. CMS cannot disclose proprietary data so additional data cannot be provided.

• All Sponsors are required to submit accurate and timely PDEs that represent all Part D covered claims paid, making adjustments and reversals where appropriate.

• The Submitting Contract must attest to the accuracy of all submitted PDEs, including those for P2P reconciliation. All submitted PDE data is subject to audit.

• The Submitting Contract must retain (and report as DIR) any rebates earned for P2P claims.

• The Contract of Record is required to make timely payment to the Submitting Contract for all CPP and LICS reported on the monthly reports as outlined below. The Contract of Record has no authorization to require any additional documentation or attestations regarding the accuracy of the Submitting Contract's financial data on the P2P reports. The Contract of Record must pay the full amount displayed on the monthly payables report.

• The Contract of Record is required to certify payment of all P2P amounts due to all Part D Sponsors. CMS will not reconcile P2P amounts that have not been certified as paid.

• The Contract of Record must pay P2P payables to the Submitting Contract within thirty days of the date on which CMS distributes P2P reports.

• Part D Sponsors must promptly open and review monthly reports in order to meet P2P payment timeframes.

• Part D Sponsors make payments without intervention from CMS. CMS does not dictate the manner in which the payment is made.

110.4 P2P Process

110.4.1 P2P PDE Processing

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

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

       Submitting Contract = Contract of Record

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

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

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

a. DOS > 06/30/07

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

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

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

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

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

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

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

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

c. DDPS evaluates the Enrollment Source ID.

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

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

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

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

Submitting Contract = Prior Contract of Record

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

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

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

Plan-to-Plan Reconciliation Eligibility Edits
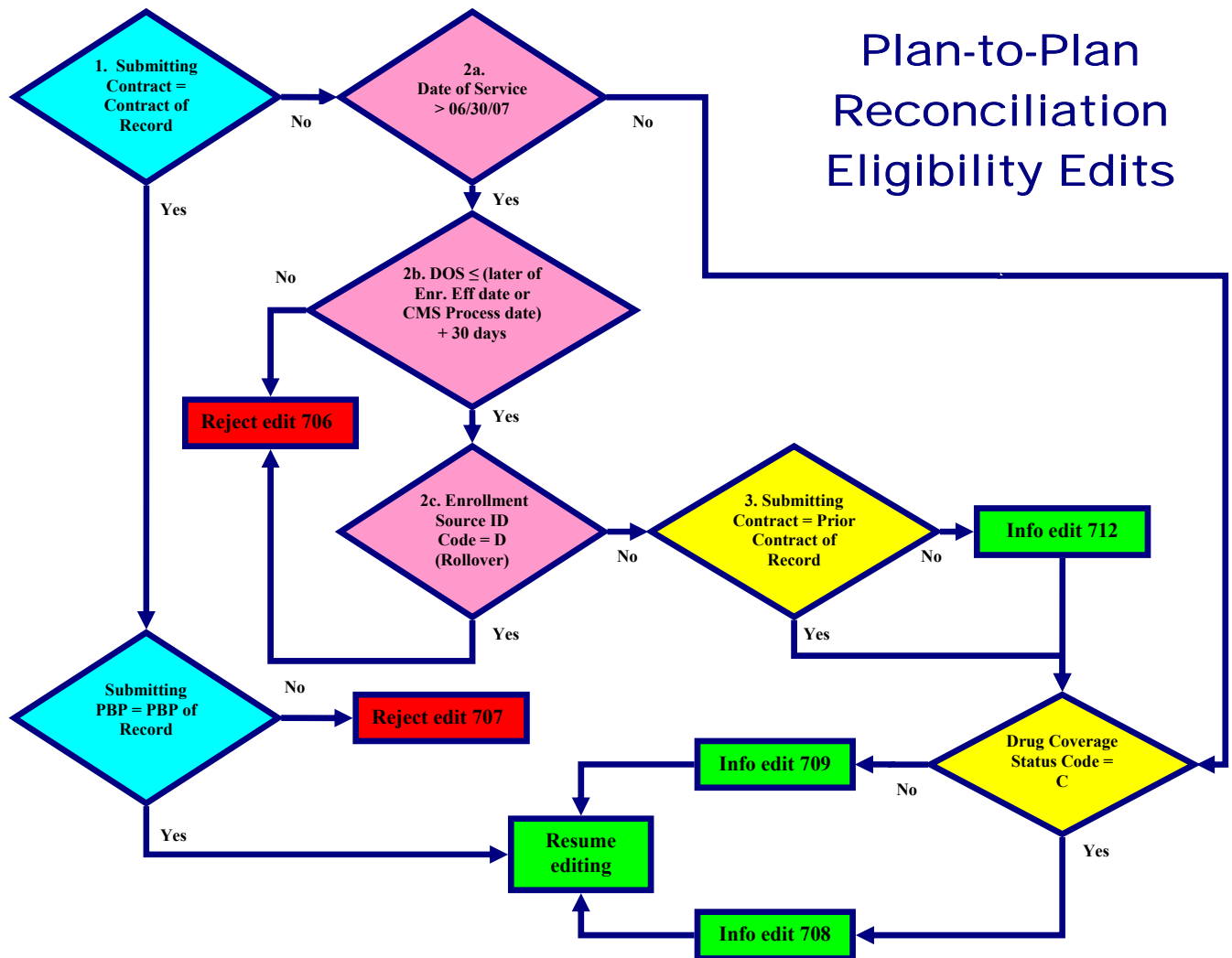
Diagram 1

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

110.4.2 Return File

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

110.4.3 P2P Reporting

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

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

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

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

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

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

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

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

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

General layout is as follows:

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

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

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

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

General layout is as follows:

> Submitting Plan = Contract A
> Contract of Record = Contract of Record B-1, B-2, B-3, etc.
> Report Recipient = Contract A
File Structure:
CHD
Contract A
> **PHD**
> Contract of Record B-1
> > **DET**
> > Bene
> **PTR**
> Summary of monthly amounts due from Contract of Record B-1

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

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

> P2P Part D Payment Reconciliation Report (Report 42COV)-
> Report 42 is the YTD cumulative report of all financial amounts reported by Submitting Contracts that will be used in the Contract of Record's Part D Payment Reconciliation. The detail records in this report have the same data as the detail records in Report 41, with the addition of Submitting Contract's contract number. The report is batched by Contract of Record's PBPs, allowing for incorporation in Contract of Record's Part D Payment Reconciliation (which is always performed at the Contract/PBP level).
>
> To understand the status of Part D Payment Reconciliation, the Contract of Record will sum the totals on Report 4 and the P2P Part D Payment Reconciliation Report (Report 42). These combined totals, in comparison to the Plan's prospective payments reported on the MMR are the basis for Part D Payment Reconciliation.
>
> General layout is as follows:
>
>> Submitting Contract = Contract A-1, A-2, A-3, A-etc.
>> Contract of Record = Contract B

Report Recipient = Contract B

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

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

General layout is as follows:

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

Report Recipient = Contract B

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

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

Overview

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

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

P2P Contract/PBP Update Processing:

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

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

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

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

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

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

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

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

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

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

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

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

Example 1:
Scenario

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

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

Reports – Change in CPP

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

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

Example 2:
Scenario

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

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

Reports – Change in CPP

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

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

Example 3:
Scenario

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

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

Reports – Change in CPP

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

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

Example 4:
Scenario

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

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

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

Reports – Change in CPP between Contracts A and B

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

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

Reports – Change in CPP between Contracts A and Contract C

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

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

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

Example 5:
Scenario

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

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

Reports – Change in CPP

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

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

Example 6:
Scenario

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

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

Reports – Change in CPP

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

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

110.4.5 P2P involvement in Part D Payment Reconciliation

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

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

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

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

110.5 Example of the P2P Reconciliation Process

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

Enrollment Information

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

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

PDE activity for Beneficiary 1

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

Non-P2P PDEs

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

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

P2P PDEs

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

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

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

Monthly Reports

September Monthly Reports
Contract A

Report 4

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

October Monthly Reports
Contract A

Report 4

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

Reports 40 and 41

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

Contract B

Reports 42 and 43

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

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

Contract/PBP Update

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

Contract A will receive a return file that contains affected PDEs.

DOS	CPP	Contract of Record	Update Code
10/02/07	$18.36	Contract B	851
10/02/07	$12.20	Contract B	851

The update code 851 is sent to the Submitting Contract to inform them that the Contract of Record has been updated; a P2P condition now exists.

July Monthly Reports

The amounts that were previously documented on Report 4 will now be documented on the P2P amounts.

Reports 40 and 41 for Contract A

DOS	CPP	Contract of Record
10/02/07	$18.36	Contract B
10/02/07	$12.20	Contract B

Reports 42 and 43 for Contract B

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

Contract B owes Contract A $30.56.

Part D Payment Reconciliation

Amounts from Reports 4 and 42 will be summed.

Contract A

Report Totals	Total CPP
Report 4	$65.92
Report 42	$0.00

Contract B

Report Totals	Total CPP
Report 4	$0.00
Report 42	$84.15

Prescription Drug Event Data Advanced

Reconciliation

CMS

PURPOSE

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

OBJECTIVES

♦ Understand the systems and processes used in payment reconciliation

♦ Describe the reconciliation reports plans will receive from PRS

♦ Determine how the organization can use the PRS reports to understand their Part D reconciliation

RECONCILIATION

♦ Compares actual costs to prospective payments

♦ Calculates risk-sharing

♦ Determines reconciliation amounts for each payment type

THREE PAYMENT METHODOLOGIES RECONCILED BY PRS

♦ Low Income Cost-Sharing Subsidy

♦ Reinsurance Subsidy

♦ Risk Sharing

See Module 1 – Part D Payment Methodology

RECONCILIATION SYSTEMS OVERVIEW

PRE-RECONCILIATION INITIATIVES

♦ For Coverage Year 2006:

◊ Enrollment Reconciliation

◊ Plan-to-Plan Phase III

◊ Premium Withhold Reconciliation

PRS REPORTS TO PLANS

♦ Plans active within the coverage year will receive two reconciliation reports from PRS:

◊ PRS Inputs Report to Plans

◊ PRS Reconciliation Results Report to Plans

PRS INPUTS REPORT TO PLANS

♦ Provides plans with beneficiary-level inputs from MARx and DDPS

♦ Allows plans to validate the beneficiary-level inputs used in the Part D reconciliation

LAYOUT OF THE PRS INPUTS REPORT TO PLANS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Plan-level file trailer	Occurs once per PHD on the file
CTR	Contract-level file trailer	Occurs once per CHD

P2P AND NON-P2P FIELDS

♦ The Inputs Report to Plans contains Plan-to-Plan (P2P) and non-P2P amounts for the following fields:

◊ Actual Low Income Cost-Sharing Subsidy Amount

◊ Gross Drug Cost Below the Out of Pocket Threshold Amount

◊ Gross Drug Cost Above the Out of Pocket Threshold Amount

◊ Covered Part D Plan Paid Amount

P2P AND NON-P2P FIELDS
(CONTINUED)

♦ P2P amounts represent amounts paid when the contract for the plan was not the Submitting Contract.

♦ Since the Contract of Record (COR) for the plan repays the submitting contract in the P2P process, P2P amounts are included in the COR's reconciliation at the plan-level.

P2P AND NON-P2P FIELDS
(CONTINUED)

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

PRS RECONCILIATION RESULTS REPORT TO PLANS

PRS Reconciliation Results Report to Plans

◊ Provides the results of the three Part D payment reconciliations:

❖ Low Income Cost-Sharing Subsidy (LICS)

❖ Reinsurance

❖ Risk sharing

◊ Provides the final reconciliation amount

◊ Provides plan-level inputs from HPMS and program-level inputs from CMS

◊ Allows plans to understand how their Part D reconciliation was calculated

PRS RECONCILIATION RESULTS REPORT TO PLANS FILE LAYOUT

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

FIELDS PASSED FROM INPUTS TO RESULTS REPORT

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
DDPS	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	7	6
	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	11	11
	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	14	10
	TOTAL COVERED PART D PLAN PAID AMOUNT	17	19

FIELDS PASSED FROM INPUTS TO RESULTS REPORT (CONTINUED)

Source System	Field Name	Inputs Report PTR Record Field No.	Results Report DET Record Field No.
MARx	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	18	8
	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	19	17
	PART D BASIC PREMIUM AMOUNT	20	23
	DIRECT SUBSIDY AMOUNT	21	22
	PACE COST-SHARING ADD-ON AMOUNT	22	25

HPMS INPUTS ON THE RESULTS REPORT

♦ Plan-level HPMS inputs include:

  ◊ Part D Covered DIR

  ◊ Administrative Cost Ratio

  ◊ Induced Utilization Ratio (for Enhanced Alternative plans)

CMS PROVIDED INPUTS ON THE RESULTS REPORT

Field No.	Field Name
28	FIRST UPPER THRESHOLD PERCENT
29	SECOND UPPER THRESHOLD PERCENT
30	FIRST LOWER THRESHOLD PERCENT
31	SECOND LOWER THRESHOLD PERCENT
37	FIRST UPPER RISK SHARING RATE
38	SECOND UPPER RISK SHARING RATE
39	FIRST LOWER RISK SHARING RATE
40	SECOND LOWER RISK SHARING RATE

PAYMENT RECONCILIATION PLAN TYPE CODE

♦ The PRPTC determines which reconciliations plans participate in and how they are calculated.

♦ Plans bid one of four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative).

♦ If plans also fall into another category, for reconciliation purposes, that is the designation to which the plan is assigned.

LOW INCOME COST-SHARING RECONCILIATION

♦ Compare actual LICS reported on PDEs to prospective LICS amounts from MARx.

◊ Actual LICS is retained in DDPS.

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

BAYSIDE'S LOW INCOME COST-SHARING RECONCILIATION

LICS Reconciliation Amount

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

LICS Reconciliation Amount = $120,000

Results Report, DET Record

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

REINSURANCE SUBSIDY

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

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

STEP 1 - REINSURANCE DIR RATIO

- ◆ The DIR Ratio is unadjusted reinsurance cost divided by total drug cost.

- ◆ Unadjusted reinsurance cost is the plan-level GDCA amount reported on PDEs.

- ◆ Total drug cost is the sum of GDCA and GDCB.

CALCULATE BAYSIDE'S DIR RATIO

DIR_Ratio

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

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

DIR_Ratio = .1667

Results Report, DET Record

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

STEP 2 – CALCULATE THE REINSURANCE PORTION OF DIR

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

CALCULATE BAYSIDE'S REINSURANCE PORTION OF DIR

Reinsurance Portion of DIR

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

Reinsurance Portion of DIR = $275,055

Results Report, DET Record

Field No.	Field Name	
12	REINSURANCE DIR RATIO	0.1667
13	PART D COVERED DIR AMOUNT	$1,650,000
14	**REINSURANCE PORTION OF DIR AMOUNT**	**$275,055**

STEP 3 - ALLOWABLE REINSURANCE COST

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

CALCULATE BAYSIDE'S ALLOWABLE REINSURANCE COST

Allowable Reinsurance Cost

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

Allowable Reinsurance Cost = $2,474,945

Results Report, DET Record

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

STEP 4 – CALCULATE THE REINSURANCE SUBSIDY

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

CALCULATE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Subsidy

Reinsurance Subsidy = $2,474,945 * 0.8

Reinsurance Subsidy = $1,979,956

Results Report, DET Record

Field No.	Field Name	
15	ALLOWABLE REINSURANCE COST AMOUNT	$2,474,945
16	**ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,979,956**

STEP 5 – RECONCILE THE REINSURANCE SUBSIDY

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

RECONCILE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Reconciliation Amount

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

Reinsurance Reconciliation Amount = -$120,044

Results Report, DET Record

Field No.	Field Name	
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
17	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
18	**REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**($120,044)**

RISK SHARING

♦ Calculate target amount

♦ Calculate risk corridor thresholds

♦ Determine adjusted allowable risk corridor costs

♦ Compare costs to thresholds and determine risk sharing amount

DETERMINE TARGET AMOUNT

♦ Sum the total direct subsidy payments and the Part D basic premiums

♦ Eliminate administrative costs using the administrative cost ratio

CALCULATE BAYSIDE'S TARGET AMOUNT

Target Amount

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

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

Target Amount = $4,222,800

Results Report, DET Record

Field No.	Field Name	
22	DIRECT SUBSIDY AMOUNT	$2,868,000
23	PART D BASIC PREMIUM AMOUNT	$2,100,000
24	ADMINISTRATIVE COST RATIO	0.15
26	**TARGET AMOUNT**	**$4,222,800**

DETERMINE RISK CORRIDORS

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

CALCULATE BAYSIDE'S RISK CORRIDORS

Risk Corridor Thresholds

Second threshold upper limit (STUL) = $4,222,800 * 1.05   = $4,433,940

First threshold upper limit (FTUL)   = $4,222,800 * 1.025 = $4,328,370

First threshold lower limit (FTLL)   = $4,222,800 * 0.975 = $4,117,230

Second threshold lower limit (STLL)   = $4,222,800 * 0.95   = $4,011,660

CALCULATE BAYSIDE'S RISK CORRIDORS (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
26	TARGET AMOUNT	$4,222,800
28	FIRST UPPER THRESHOLD PERCENT	1.025
29	SECOND UPPER THRESHOLD PERCENT	1.05
30	FIRST LOWER THRESHOLD PERCENT	0.975
31	SECOND LOWER THRESHOLD PERCENT	0.95
32	**FIRST UPPER THRESHOLD AMOUNT**	**$4,328,370**
33	**SECOND UPPER THRESHOLD AMOUNT**	**$4,433,940**
34	**FIRST LOWER THRESHOLD AMOUNT**	**$4,117,320**
35	**SECOND LOWER THRESHOLD AMOUNT**	**$4,011,660**

RISK CORRIDORS 2006

80% payment

$4,433,940
and more

2nd Threshold Upper Limit

75% payment*

$4,328,370

1st Threshold Upper Limit

Target Amount

No payment/
repayment

$4,222,800

1st Threshold Lower Limit

$4,117,230

75% repayment

2nd Threshold Lower Limit

$4,011,660
and less

80% repayment

*75% rate will change to 90% if certain circumstances are met

CALCULATE AARCC

♦ **To determine Adjusted Allowable Risk Corridor Costs:**

◊ Determine unadjusted allowable risk corridor costs (plan-level CPP)

◊ Subtract plan-level reinsurance subsidy

◊ Subtract Covered Part D DIR

◊ For Enhanced Alternative (EA) plans only, reduce by the induced utilization factor

CALCULATE BAYSIDE'S AARCC

Adjusted Allowable Risk Corridor Cost (AARCC)

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

AARCC = $4,620,044 / 1.018

AARCC = $4,538,353

Results Report, DET Record

Field No.	Field Name	
13	PART D COVERED DIR AMOUNT	$1,650,000
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
19	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,250,000
20	INDUCED UTILIZATION RATIO	1.018
21	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,538,353**

DETERMINE RISK SHARING

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

DETERMINE BAYSIDE'S RISK SHARING

Cost Subject to Risk Sharing

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

Total Cost Subject to Risk Sharing = $209,983

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

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

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

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

Risk Sharing Payment

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

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

Risk Sharing Payment = $178,543

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

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
21	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,538,353
32	FIRST UPPER THRESHOLD AMOUNT	$4,433,940
33	SECOND UPPER THRESHOLD AMOUNT	$4,328,370
37	FIRST UPPER RISK SHARING RATE	0.9
38	SECOND UPPER RISK-SHARING RATE	0.8
41	**RISK-SHARING AMOUNT**	**$178,543**
42	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$83,530
43	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$95,013

BUDGET NEUTRALITY

♦ The Budget Neutrality Adjustment Amount (BNAA):

◊ Allows demonstration plans to achieve budget neutrality

◊ Is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA)

◊ Is subtracted from the sum of the three Part D reconciliations (LICS, reinsurance, and risk sharing)

CALCULATE BAYSIDE'S BUDGET NEUTRALITY ADJUSTMENT

Budget Neutrality Adjustment

Budget Neutrality Adjustment = $7.57 * 5000

Budget Neutrality Adjustment Amount = $37,850

Results Report, DET Record

Field No.	Field Name	
44	COUNT OF UNIQUE MEMBERS PER YEAR	5000
45	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	$7.57
46	**BUDGET NEUTRALITY ADJUSTMENT AMOUNT** (DEMONSTRATION PLANS ONLY)	**$37,850**

ADJUSTMENT DUE TO PAYMENT RECONCILIATION

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost Sharing Subsidy Amount	Field 9
+	Reinsurance Subsidy Adjustment Amount	Field 18
+	Risk Sharing Amount	Field 41
–	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 46
=	Adjustment Due to Payment Reconciliation Amount	Field 47

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

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

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

Bayside's ARA – Results Report, DET Record

Field No.	Field Name	
9	LOW INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
18	REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$120,044
41	RISK SHARING AMOUNT	$178,543
46	BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	-$37,850
47	**ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**$140,649**

SUMMARY

♦ Understand the systems and processes used in payment reconciliation

♦ Described the reconciliation reports plans will receive from PRS

♦ Determined how the organization can use the PRS reports to understand their Part D reconciliation

EVALUATION

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

Prescription Drug Event Data Advanced

Reconciliation

CMS

PURPOSE

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

1

OBJECTIVES

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

RECONCILIATION

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

THREE PAYMENT METHODOLOGIES RECONCILED BY PRS

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

See Module 1 – Part D Payment Methodology

RECONCILIATION SYSTEMS OVERVIEW

DDPS

MARx → PRS

HPMS

PRE-RECONCILIATION INITIATIVES

♦ For Coverage Year 2006:

◊ Enrollment Reconciliation
◊ Plan-to-Plan Phase III
◊ Premium Withhold Reconciliation

PRS REPORTS TO PLANS

♦ Plans active within the coverage year will receive two reconciliation reports from PRS:

◊ PRS Inputs Report to Plans

◊ PRS Reconciliation Results Report to Plans

PRS INPUTS REPORT TO PLANS

♦ Provides plans with beneficiary-level inputs from MARx and DDPS

♦ Allows plans to validate the beneficiary-level inputs used in the Part D reconciliation

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LAYOUT OF THE PRS INPUTS REPORT TO PLANS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
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PTR	Plan-level file trailer	Occurs once per PHD on the file
CTR	Contract-level file trailer	Occurs once per CHD

P2P AND NON-P2P FIELDS

♦ The Inputs Report to Plans contains Plan-to-Plan (P2P) and non-P2P amounts for the following fields:

◊ Actual Low Income Cost-Sharing Subsidy Amount

◊ Gross Drug Cost Below the Out of Pocket Threshold Amount

◊ Gross Drug Cost Above the Out of Pocket Threshold Amount

◊ Covered Part D Plan Paid Amount

P2P AND NON-P2P FIELDS
(CONTINUED)

♦ P2P amounts represent amounts paid when the contract for the plan was not the Submitting Contract.

♦ Since the Contract of Record (COR) for the plan repays the submitting contract in the P2P process, P2P amounts are included in the COR's reconciliation at the plan-level.

P2P AND NON-P2P FIELDS
(CONTINUED)

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

PRS RECONCILIATION RESULTS REPORT TO PLANS

PRS Reconciliation Results Report to Plans

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

PRS RECONCILIATION RESULTS REPORT TO PLANS FILE LAYOUT

Record Indicator	Record Definition	Notes
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FIELDS PASSED FROM INPUTS TO RESULTS REPORT

Source System	Field Name	Inputs Report PTR Record Field No.		Results Report DET Record Field No.
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	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	11		11
	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	14		10
	TOTAL COVERED PART D PLAN PAID AMOUNT	17		19

8

FIELDS PASSED FROM INPUTS TO RESULTS REPORT (CONTINUED)

Source System	Field Name	Inputs Report PTR Record Field No.		Results Report DET Record Field No.
MARx	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	18		8
	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	19		17
	PART D BASIC PREMIUM AMOUNT	20		23
	DIRECT SUBSIDY AMOUNT	21		22
	PACE COST-SHARING ADD-ON AMOUNT	22		25

HPMS INPUTS ON THE RESULTS REPORT

♦ Plan-level HPMS inputs include:

◊ Part D Covered DIR

◊ Administrative Cost Ratio

◊ Induced Utilization Ratio (for Enhanced Alternative plans)

CMS PROVIDED INPUTS ON THE RESULTS REPORT

Field No.	Field Name
28	FIRST UPPER THRESHOLD PERCENT
29	SECOND UPPER THRESHOLD PERCENT
30	FIRST LOWER THRESHOLD PERCENT
31	SECOND LOWER THRESHOLD PERCENT
37	FIRST UPPER RISK SHARING RATE
38	SECOND UPPER RISK SHARING RATE
39	FIRST LOWER RISK SHARING RATE
40	SECOND LOWER RISK SHARING RATE

PAYMENT RECONCILIATION PLAN TYPE CODE

♦ The PRPTC determines which reconciliations plans participate in and how they are calculated.

♦ Plans bid one of four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative).

♦ If plans also fall into another category, for reconciliation purposes, that is the designation to which the plan is assigned.

LOW INCOME COST-SHARING RECONCILIATION

♦ Compare actual LICS reported on PDEs to prospective LICS amounts from MARx.

◊ Actual LICS is retained in DDPS.

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

BAYSIDE'S LOW INCOME COST-SHARING RECONCILIATION

LICS Reconciliation Amount

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

LICS Reconciliation Amount = $120,000

	Results Report, DET Record	
Field No.	**Field Name**	
6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$3,000,000
8	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	$2,880,000
9	**LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT**	**$120,000**

REINSURANCE SUBSIDY

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

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

STEP 1 - REINSURANCE DIR RATIO

♦ The DIR Ratio is unadjusted reinsurance cost divided by total drug cost.

♦ Unadjusted reinsurance cost is the plan-level GDCA amount reported on PDEs.

♦ Total drug cost is the sum of GDCA and GDCB.

CALCULATE BAYSIDE'S DIR RATIO

DIR_Ratio

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

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

DIR_Ratio = .1667

Results Report, DET Record

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

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STEP 2 – CALCULATE THE REINSURANCE PORTION OF DIR

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

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CALCULATE BAYSIDE'S REINSURANCE PORTION OF DIR

Reinsurance Portion of DIR

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

Reinsurance Portion of DIR = $275,055

Results Report, DET Record

Field No.	Field Name	
12	REINSURANCE DIR RATIO	0.1667
13	PART D COVERED DIR AMOUNT	$1,650,000
14	**REINSURANCE PORTION OF DIR AMOUNT**	**$275,055**

STEP 3 - ALLOWABLE REINSURANCE COST

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

CALCULATE BAYSIDE'S ALLOWABLE REINSURANCE COST

Allowable Reinsurance Cost

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

Allowable Reinsurance Cost = $2,474,945

Results Report, DET Record

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

STEP 4 – CALCULATE THE REINSURANCE SUBSIDY

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

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CALCULATE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Subsidy

Reinsurance Subsidy = $2,474,945 * 0.8

Reinsurance Subsidy = $1,979,956

Results Report, DET Record

Field No.	Field Name	
15	ALLOWABLE REINSURANCE COST AMOUNT	$2,474,945
16	**ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,979,956**

STEP 5 – RECONCILE THE REINSURANCE SUBSIDY

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

RECONCILE BAYSIDE'S REINSURANCE SUBSIDY

Reinsurance Reconciliation Amount

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

Reinsurance Reconciliation Amount = -$120,044

Results Report, DET Record

Field No.	Field Name	
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
17	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
18	**REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**($120,044)**

RISK SHARING

♦ Calculate target amount

♦ Calculate risk corridor thresholds

♦ Determine adjusted allowable risk corridor costs

♦ Compare costs to thresholds and determine risk sharing amount

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DETERMINE TARGET AMOUNT

♦ Sum the total direct subsidy payments and the Part D basic premiums

♦ Eliminate administrative costs using the administrative cost ratio

---

CALCULATE BAYSIDE'S TARGET AMOUNT

Target Amount

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

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

Target Amount = $4,222,800

Results Report, DET Record

Field No.	Field Name	
22	DIRECT SUBSIDY AMOUNT	$2,868,000
23	PART D BASIC PREMIUM AMOUNT	$2,100,000
24	ADMINISTRATIVE COST RATIO	0.15
26	**TARGET AMOUNT**	**$4,222,800**

DETERMINE RISK CORRIDORS

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

CALCULATE BAYSIDE'S RISK CORRIDORS

Risk Corridor Thresholds

Second threshold upper limit (STUL) = $4,222,800 * 1.05 = $4,433,940

First threshold upper limit (FTUL) = $4,222,800 * 1.025 = $4,328,370

First threshold lower limit (FTLL) = $4,222,800 * 0.975 = $4,117,230

Second threshold lower limit (STLL) = $4,222,800 * 0.95 = $4,011,660

CALCULATE BAYSIDE'S
RISK CORRIDORS (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
26	TARGET AMOUNT	$4,222,800
28	FIRST UPPER THRESHOLD PERCENT	1.025
29	SECOND UPPER THRESHOLD PERCENT	1.05
30	FIRST LOWER THRESHOLD PERCENT	0.975
31	SECOND LOWER THRESHOLD PERCENT	0.95
32	**FIRST UPPER THRESHOLD AMOUNT**	**$4,328,370**
33	**SECOND UPPER THRESHOLD AMOUNT**	**$4,433,940**
34	**FIRST LOWER THRESHOLD AMOUNT**	**$4,117,320**
35	**SECOND LOWER THRESHOLD AMOUNT**	**$4,011,660**

RISK CORRIDORS 2006

$4,433,940 and more — 80% payment

2nd Threshold Upper Limit — 75% payment*

$4,328,370

1st Threshold Upper Limit
Target Amount — No payment/repayment
1st Threshold Lower Limit

$4,222,800

$4,117,230

2nd Threshold Lower Limit — 75% repayment

$4,011,660 and less — 80% repayment

*75% rate will change to 90% if certain circumstances are met

CALCULATE AARCC

♦ To determine Adjusted Allowable Risk Corridor Costs:

◊ Determine unadjusted allowable risk corridor costs (plan-level CPP)

◊ Subtract plan-level reinsurance subsidy

◊ Subtract Covered Part D DIR

◊ For Enhanced Alternative (EA) plans only, reduce by the induced utilization factor

---

CALCULATE BAYSIDE'S AARCC

Adjusted Allowable Risk Corridor Cost (AARCC)

AARCC = ($8,250,000 - $1,979,956 - $1,650,000) / 1.018
AARCC = $4,620,044 / 1.018
AARCC = $4,538,353

	Results Report, DET Record	
Field No.	**Field Name**	
13	PART D COVERED DIR AMOUNT	$1,650,000
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
19	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,250,000
20	INDUCED UTILIZATION RATIO	1.018
21	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,538,353**

DETERMINE RISK SHARING

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

DETERMINE BAYSIDE'S RISK SHARING

Cost Subject to Risk Sharing

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

Total Cost Subject to Risk Sharing = $209,983

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

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

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

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

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DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Risk Sharing Payment

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

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

Risk Sharing Payment = $178,543

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

DETERMINE BAYSIDE'S RISK SHARING (CONTINUED)

Results Report, DET Record

Field No.	Field Name	
21	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,538,353
32	FIRST UPPER THRESHOLD AMOUNT	$4,433,940
33	SECOND UPPER THRESHOLD AMOUNT	$4,328,370
37	FIRST UPPER RISK SHARING RATE	0.9
38	SECOND UPPER RISK-SHARING RATE	0.8
41	**RISK-SHARING AMOUNT**	**$178,543**
42	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$83,530
43	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$95,013

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BUDGET NEUTRALITY

♦ The Budget Neutrality Adjustment Amount (BNAA):

◊ Allows demonstration plans to achieve budget neutrality

◊ Is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA)

◊ Is subtracted from the sum of the three Part D reconciliations (LICS, reinsurance, and risk sharing)

CALCULATE BAYSIDE'S BUDGET NEUTRALITY ADJUSTMENT

Budget Neutrality Adjustment

Budget Neutrality Adjustment = $7.57 * 5000

Budget Neutrality Adjustment Amount = $37,850

Results Report, DET Record

Field No.	Field Name	
44	COUNT OF UNIQUE MEMBERS PER YEAR	5000
45	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	$7.57
46	**BUDGET NEUTRALITY ADJUSTMENT AMOUNT** (DEMONSTRATION PLANS ONLY)	$37,850

ADJUSTMENT DUE TO PAYMENT RECONCILIATION

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost Sharing Subsidy Amount	Field 9
+	Reinsurance Subsidy Adjustment Amount	Field 18
+	Risk Sharing Amount	Field 41
–	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 46
=	Adjustment Due to Payment Reconciliation Amount	Field 47

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

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

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

Bayside's ARA – Results Report, DET Record

Field No.	Field Name	
9	LOW INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
18	REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$120,044
41	RISK SHARING AMOUNT	$178,543
46	BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	-$37,850
47	**ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**$140,649**

SUMMARY

♦ Understand the systems and processes used in payment reconciliation

♦ Described the reconciliation reports plans will receive from PRS

♦ Determined how the organization can use the PRS reports to understand their Part D reconciliation

EVALUATION

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

LTC

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MODULE 12 – RECONCILIATION

Purpose

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

Learning Objectives

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

- Understand the systems and processes used in payment reconciliation.
- Understand the relationship of reported data to payment.
- Determine how the organization can monitor reports to ensure appropriate reconciliation.

ICON KEY	
Definition	ᐵ
Example	⊠
Reminder	🔍
Resource	📖

12.1   Overview of Part D Reconciliation

Reconciliation compares actual costs to prospective payments, calculates risk sharing, and determines reconciliation amounts for each payment type. Prior to carrying out the cost based portion which consists of reconciling the Low Income Cost-Sharing Subsidy (LICS) and reinsurance, and the calculation of risk sharing, the reconciliation of the direct subsidy will be completed. The final direct subsidy will be used in the cost-based portion of the Part D reconciliation.

12.2   Direct Subsidy

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

ᐵ   The Part D basic 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. This section refers to the "premium related to the standardized bid amount" with no further detail about who pays the premium.

✍ All plan types submit a Part D standardized bid. Actuarially Equivalent plans, Basic Alternative plans, and Enhanced Alternative plans report additional bid information to describe their benefit. 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 typically increase. Not all beneficiaries will have an increased risk adjustment factor, and there may be plan-by-plan variation from this general rule.

12.2.1   Data Oversight

Data oversight requires accurate maintenance of enrollments in plan and CMS systems and the review of CMS responses to enrollment transactions. Monthly membership reports from the Medicare Advantage and Prescription Drug System (MARx) provide information on enrollment and the component parts of the Part D prospective payments, specifically the direct subsidy. These amounts represent the prospective payments against which actual costs will be reconciled.

12.2.2   Direct Subsidy System Overview

MARx reconciles the direct subsidy. The process for the direct subsidy is described in Figure 12A.

Figure 12A – 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 Minimum Data Set (MDS) data).
  - Month-by-month long-term low-income subsidy status for risk adjustment (originally from the MBD data).
  - MARx reconciles the final direct subsidy and forwards the amount to the APPS for payment.

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

12.2.3   Direct Subsidy Data Oversight

CMS uses the standardized bid amount, the Part D basic 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.

- Part D basic 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 and more complete data become available.

12.2.3.1   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. Adams was enrolled in Happy Health Plan from January 1, 2006 through December 31, 2006. When Happy Health Plan received Mrs. Adams' enrollment during the last week of December 2005, the plan immediately updated its enrollment file to document Mrs. Adams' 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. Adams' risk score was 1.106.

Monthly Prospective Direct Subsidy

$75.60 = $100.00 * 1.106 - $35.00

From January through December of 2006 Happy Health Plan received twelve monthly direct subsidy prospective payments of $75.60 each for a total annual prospective direct subsidy of $907.20.

At reconciliation, Mrs. Adams' risk score increased to 1.221 because an additional diagnosis was reported. The additional diagnosis was 733.00 – osteoporosis, which has an associated risk factor of .115.

Risk Factor

Initial Risk Factor	1.106
Reconciled Risk Factor	1.221[a]

[a]Risk Factor increased .115 because new diagnosis code, 733.00 - Osteoporosis was reported late in the year

Reconciled Monthly Direct Subsidy – Mrs. Adams

Direct Subsidy = $100.00 * 1.221 - $35.00
Direct Subsidy = $87.10

The monthly prospective direct subsidy increased by $11.50 to $87.10 because the final risk factor increased from 1.106 to 1.221; the reconciled direct subsidy is $1,045.20.

Prospective Direct Subsidy

Prospective Monthly Direct Subsidy = $100.00 * 1.106 - $35.00
Prospective Monthly Direct Subsidy = $75.60
Month-by-month total of Prospective Direct Subsidy = $75.60 * 12
Total Prospective Direct Subsidy = $907.20

Reconciled Direct Subsidy

Reconciled Monthly Direct Subsidy = $100.00 * 1.221 - $35.00
Reconciled Monthly Direct Subsidy = $87.10
Month-by-month total of Reconciled Direct Subsidy = $87.10 * 12
Total Reconciled Direct Subsidy = $1,045.20

Annual Reconciled Direct Subsidy

Annual Reconciled Direct Subsidy = Total Reconciled Direct Subsidy – Total Prospective Direct Subsidy
Annual Reconciled Direct Subsidy = $1,045.20 - $907.20
Annual Reconciled Direct Subsidy = $138.00

Happy Health Plan will receive $138.00, which is the difference between the total prospective direct subsidy and the total final reconciled direct subsidy.

12.2.3.2   Plan-level Direct Subsidy 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.

12.3   Reconciliation Overview

One of the primary purposes for collecting and reporting Prescription Drug Event (PDE) data is to support reconciliation of the Low Income Cost-Sharing Subsidy (LICS), Reinsurance, and calculation of any risk sharing. While all PDE data elements are important, four data elements are essential for reconciliation and risk sharing.

- Low Income Cost-Sharing Subsidy (LICS) Amount
- Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)
- Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)
- Covered D Plan Paid Amount (CPP)

Other essential PDE fields are used to substantiate these four fields.

The Drug Data Processing System (DDPS) uses Patient Pay Amount, LICS, Other True Out-of-Pocket Costs (TrOOP) Amount, and Patient Liability Reduction due to Other Payers Amount (PLRO), in combination with the Drug Coverage Status Code to first impute TrOOP and then validate GDCB, GDCA, and the Catastrophic Coverage Code. Plans should realize that CMS also uses PDE data for other legislated functions such as quality monitoring, program integrity, and oversight.

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 and saved in DDPS 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 the Plan Benefit Package (PBP) level, referred to as "plan-level" in this module. Within each PBP, individual PDE records roll up to beneficiary summaries and beneficiary summaries roll up to the plan-level summary. Reconciliation uses plan-level summaries.

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.

12.4   System Overview

The Payment Reconciliation System (PRS) uses data from multiple systems for reconciliation and risk sharing. Table 12A provides descriptions of the systems involved in this payment and reconciliation process.

TABLE 12A – SYSTEM OVERVIEW

DDPS **PDE Data**
Plans submit PDEs to the DDPS through the Prescription Drug Front-End System (PDFS). DDPS receives and edits individual PDEs. DDPS forwards accepted PDE records to the Integrated Data Repository (IDR). IDR is a data warehouse. It stores PDE records and accumulates summary data for reporting. Specifically, IDR accumulates LICS, GDCB, GDCA, CPP, and Year-to-Date (YTD) TrOOP. At reconciliation, IDR sends total plan/beneficiary LICS, GDCB, GDCA, and CPP to the PRS.
HPMS **Bid Data**
Health Plan Management System (HPMS) stores approved bid data and sends it to the Medicare Advantage and Prescription Drug System (MARx) for monthly payment calculation and to PRS for final reconciliation. Both MARx and PRS use bid data for payments. HPMS also sends Direct and Indirect Remuneration (DIR), Induced Utilization, and the Administrative Cost Ratio to PRS for final reconciliation.
MARx **Monthly Prospective Payments**
MARx calculates monthly payments using enrollment and LICS eligibility status from Medicare Beneficiary Database (MBD), drug risk adjustment factors from the Risk Adjustment System (RAS), and bid data from HPMS. MARx calculates the final direct subsidy reconciliation. For purposes of LICS reconciliation, reinsurance reconciliation and risk sharing, MARx sends the final direct subsidy, the total Part D basic premium, and the final LICS and reinsurance prospective payment amounts it has calculated to the PRS.
PRS **DDPS Data, MARx Data, HPMS Data**
PRS receives the necessary inputs for reconciliation and risk sharing from DDPS, MARx and HPMS. It calculates final reconciliation amounts and forwards them to the Automated Plan Payment System (APPS).

Figure 12B illustrates the system flow.

Figure 12B – System Flow
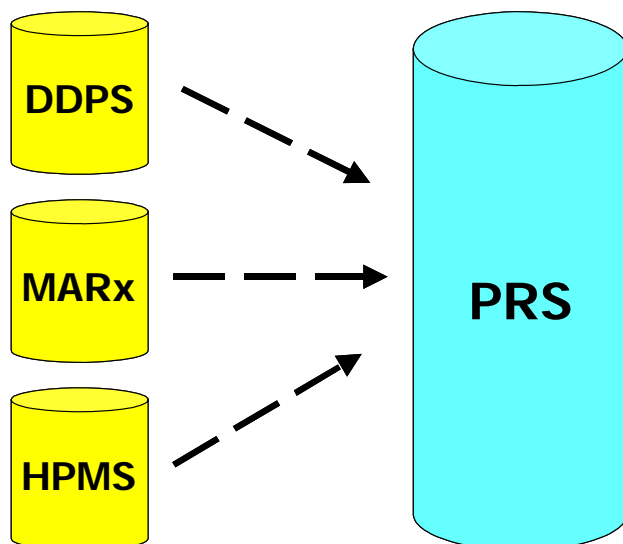
12.5   Data Oversight

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, and analyzing rejected records to either correct and resubmit or to prevent erroneous data from being submitted in the future. Transactional oversight also requires accurate maintenance of enrollments in plan and CMS systems, as well as reviewing CMS responses to enrollment transactions.

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

12.5.1   Beneficiary and Payment Data

Plans must monitor enrollment data, LICS status and monthly payment amounts. The purpose of monitoring is to ensure that enrollment and disenrollment dates, as well as LICS status in the plan's internal systems are consistent with MBD information. The purpose of monitoring monthly payments is to ensure that the plan's payment is correct and that the plan understands how the payment was

calculated. At reconciliation, total monthly prospective payments will be compared to actual payments. Errors in monthly prospective payments will adversely affect reconciliation.

12.5.2   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.

12.5.2.1   Transaction Reports

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

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

- Deletion PDEs – rejected deletion PDEs cause overstated DDPS data. Overstated data leads to overpayment.

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

12.5.2.2   DDPS Management Reports

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

Plans should refer to two reports, the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) and the P2P Part D Payment Reconciliation Report (Report 42COV). The P2P Part D Payment Reconciliation Report reflects plan-level amounts on PDEs, which were not originally submitted by the contract but which will be included in the plan-level reconciliation because of the plan-to-plan (P2P) process. The report entitled Cumulative Beneficiary Summary Report, Covered Drugs, reflects records which have been submitted by the plan and that are accepted and stored in DDPS. The net LICS, GDCB, GDCA and CPP, as well as year-to-date TrOOP dollars, at the beneficiary and the plan-level are communicated on the Cumulative Beneficiary Summary Report, Covered Drugs. Any discrepancies in these reported fields may require plans to perform analysis at the detail record level in the DDPS Return File for the beneficiary in question.

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

1. Does the number of PDE records agree with the plan's accepted PDE count for each beneficiary? Data in the columns labeled Number of Original PDEs, Number of Adjusted PDEs and Number of Deleted PDEs give a general indication of the PDE volume on which the data is based.

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

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

12.6   Certification of Data for Payment

In accordance with the Part D regulation at 42 CFR 423.505(k)(3), the plan sponsor's Chief Executive Officer, Chief Financial Officer, or an individual delegated with the authority to sign on behalf of one of these officers and who reports directly to the officer must certify that the PDE data submitted for payment and reconciliation are accurate, complete, and truthful. The officer or delegate must also certify the same with respect to the underlying claims data. If claims and/or PDE data are generated by a third party on behalf of the plan, the third party must similarly certify.

Certification of PDE and claims data for payment is not the same as the certification required for data submission, which is described in the module Data Format. The two "certification" processes are separate requirements that are both incumbent on the plan sponsor and any third party submitter. CMS expects to conduct certification of PDE and claims data for payment on an annual basis after the end of each coverage year, in preparation for final reconciliation.

📖   42 CFR 423.505(k)(3)

12.7   Appeal

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

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

12.8   PRS Part D Payment Reports

As part of the Part D payment reconciliation, plans active within the coverage year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the reconciliation process for the coverage year.

The PRS Inputs Report to Plans provides plans with the beneficiary-level inputs received from MARx and DDPS. These inputs provide data on the prospective payments and the actual payments made on behalf of a beneficiary. The PRS Inputs Report to Plans allows plans to validate the beneficiary-level inputs received from DDPS and MARx that will be used in their Part D payment reconciliation.

The PRS Reconciliation Results Report to Plans provides plan-level inputs received from HPMS, plan-level inputs passed from the PRS Inputs Report to Plans, and the results of the three Part D payment

reconciliations: LICS, reinsurance, and risk sharing. The PRS Reconciliation Results Report to Plans is meant to provide plans with all of the inputs plans would need to understand how their Part D payment reconciliation is calculated, in addition to the results of the Part D payment reconciliations and the final reconciliation adjustment amount.

12.8.1 PRS Inputs Report to Plans

The PRS Inputs Report to Plans provides plans with the prospective payment and actual payment inputs at the beneficiary/plan-level from MARx and DDPS. Because a beneficiary could be in more than one contract and/or more than one PBP within a contract within a specific coverage year, beneficiary/plan-level data indicates the beneficiary-level data for a specific plan only. Beneficiary-level and beneficiary/plan-level are used interchangeably. Plan-level and contract/PBP-level are also used interchangeably.

12.8.1.1 PRS Inputs Report to Plans File Layout

The layout of the PRS Inputs Report to Plans follows a similar file structure as the DDPS management reports (Report 4, Reports 40-43) that plans are already receiving.

The PRS Inputs Report to Plans file contains a contract header (CHD) record, followed by a plan header (PHD) record which sets up cumulative reporting at both the contract-level and at the plan-level. The CHD and PHD records identify the contract and PBP, respectively. Each has the file name on the record, allowing the distribution of reports at the contract-level, and a contract to treat plan-level reports as unique reports. The CHD record also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first to be run or if the reconciliation has been re-run.

The detail (DET) record provides the beneficiary/plan-level reporting. The DET record establishes the basic format for the rest of the file. It is important to note that on the DET record, beneficiaries are identified by their most current HICN as reported on the DDPS management files.

The plan trailer (PTR) record has the same basic layout as the DET record. However, in place of the beneficiary ID, there is a contract number and a PBP ID. This record will sum all of the amounts in each of the DET records for the contract/PBP. Table 12B provides the record definitions and descriptions for the PRS Inputs Report to Plans.

TABLE 12B – PRS INPUTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

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

12.8.1.2   Data Elements and Report Fields

Beneficiary/plan-level information is present only on the Inputs Report and is rolled up to the plan and contract-level.

12.8.1.2.1   P2P and Non-P2P Fields

The Inputs Report to Plans contains both Plan-to-Plan (P2P) amounts and non-P2P amounts for the following four fields: Actual Low Income Cost-Sharing Subsidy Amount (ALICSA), Gross Drug Cost Below the Out of Pocket Threshold Amount (GDCBA), Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA), and Covered Part D Plan Paid Amount (CPPA). These four fields represent data received from the Drug Data Processing System (DDPS). Table 12C provides the names and field locations on the DET record of the data elements which have both P2P and non-P2P amounts.

TABLE 12C – P2P AND NON-P2P FIELDS ON PRS INPUTS REPORT

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

The P2P amounts represent plan-level amounts paid when the contract was not the Submitting Contract. Since the Contract of Record (COR) has repaid the Submitting Contract during the P2P process, the P2P amounts incurred will be on the COR's reconciliation. Contracts will only be reconciled for plan-level amounts incurred when they are the COR.

PRS sums the P2P and non-P2P amounts for these fields at the beneficiary-level. The beneficiary/plan-level sums of these four fields are on the DET record and are aggregated to the plan and contract levels in the Inputs Report. Plans should also refer to the DDPS Management Report 4 COV and Report 42 for the non-P2P and P2P amounts for these fields. Prior to reconciliation, CMS will release Report 4 COV and Report 42 with the coverage year's cumulative results as they will be used in the Part D reconciliation. These reports are critical for the plan to review and refer to in understanding their Part D payment reconciliation.

12.8.1.2.2   Data Elements and Field Numbers

The beneficiary/plan-level information received from DDPS and MARx present on the Inputs Report is rolled up to the plan-level and the contract-level on the PTR and CTR records. The plan-level summaries of the data elements present on the PTR record are used for the Part D payment reconciliation. Table 12D provides the data elements and field numbers for the Inputs Report.

TABLE 12D – INPUTS REPORT – DATA ELEMENTS AND FIELD NUMBERS

Field No.			Data Elements
DET Record	PTR Record	CTR Record	
4	5	4	NON P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
5	6	5	P2P ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
6	7	6	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT
8	9	8	NON P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
9	10	9	P2P GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
10	11	10	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT
11	12	11	NON P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
12	13	12	P2P GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
13	14	13	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT
14	15	14	NON P2P COVERED PART D PLAN PAID AMOUNT
15	16	15	P2P COVERED PART D PLAN PAID AMOUNT
16	17	16	TOTAL COVERED PART D PLAN PAID AMOUNT
17	18	17	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT
18	19	18	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT
19	20	19	PART D BASIC PREMIUM AMOUNT
20	21	20	DIRECT SUBSIDY AMOUNT
21	22	21	PACE COST-SHARING ADD-ON AMOUNT

12.8.2 PRS Reconciliation Results Report to Plans

The PRS Reconciliation Results Report to Plans provides plans with the results of the three Part D payment reconciliations and the final reconciliation payment adjustment amount. The Results Report also provides the contract/PBP-level inputs received from HPMS and the totaled plan-level inputs from DDPS and MARx that are necessary for plans to understand how their Part D payment reconciliation is calculated.

12.8.2.1 PRS Reconciliation Results Report to Plans File Layout

The PRS Reconciliation Results Report to Plans file layout is similar to that of the PRS Inputs Report, but there are key differences. The Results Report file begins with the CHD record. In the Results Report, there are no beneficiary-level records; the DET record in the Results Report provides the reconciliation results at the contract/PBP-level. As with the Inputs Report, each report also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first run for the coverage year or if the reconciliation has been re-run. Table 12E provides the definitions and descriptions of the records in the PRS Reconciliation Results Report to Plans.

**TABLE 12E – PRS RECONCILIATION RESULTS REPORT TO PLANS - RECORD
DEFINITIONS/DESCRIPTIONS**

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

The CTR record provides reconciliation results summarized to the contract level and represents the activity of all PBPs under one contract number. It is important to note here that the totals in this CTR record are not the totals used for any Part D payment reconciliation. All payment reconciliation is at the contract/PBP-level which is reported in the DET record. The CTR record may provide a useful contract-level summary, but will not directly impact any payment calculation.

12.8.2.1.1   Inputs Report Fields Passed to the Results Report

Certain fields from the Inputs Report are carried through to the Reconciliation Results Report. The elements passed are summed to the contract/PBP-level on the PRS Inputs Report PTR record. The data elements that are passed from the Inputs Report to the Results Report are values that are necessary inputs into the payment reconciliation calculations PRS performs. For example, the plan-level Total Actual Low Income Cost-Sharing Subsidy Amount (ALICSA) and the plan-level Prospective Low Income Cost-Sharing Subsidy Amount (PLICSA) are the only data elements used to calculate the LICS Reconciliation Adjustment Amount (LICSAA) and therefore, are passed to the Results Report from the Inputs Report. Other data elements passed from the Inputs Report to the Results Report also comprise values in the Part D payment reconciliation calculations. These data elements are shown in Table 12F.

**TABLE 12F – DATA ELEMENTS PASSED FROM THE PRS INPUTS REPORT
TO THE PRS RESULTS REPORT**

Source System	Field Name	Inputs Report PTR Record Field No.		Results Report DET Record Field No.
DDPS	TOTAL ACTUAL LOW-INCOME COST-SHARING SUBSIDY AMOUNT	7		6
	TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	11		11
	TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	14		10
	TOTAL COVERED PART D PLAN PAID AMOUNT	17		19
MARx	PROSPECTIVE LOW-INCOME COST-SHARING SUBSIDY AMOUNT	18		8
	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	19		17
	PART D BASIC PREMIUM AMOUNT	20		23
	DIRECT SUBSIDY AMOUNT	21		22
	PACE COST-SHARING ADD-ON AMOUNT	22		25

12.8.2.1.2   Plan-Level HPMS Inputs

Plan-level inputs needed to calculate reconciliation amounts are only found on the PRS Reconciliation Results Report to Plans. These plan-level inputs are HPMS inputs and include: the Part D Covered DIR Amount, the Administrative Cost Ratio, and the Induced Utilization Ratio (for Enhanced Alternative plans only). The Part D Covered DIR Amount is adjusted within HPMS to account for the Part D Covered Incentive Payment Amount prior to being passed to PRS. Table 12G provides the HPMS plan-level inputs found on the PRS Reconciliation Results Report to Plans.

**TABLE 12G – HPMS PLAN-LEVEL INPUTS FOUND ON THE PRS RECONCILIATION
RESULTS REPORT TO PLANS**

Data Element	Short Name
PART D COVERED DIR AMOUNT	DDIRA
ADMINISTRATIVE COST RATIO	ACR
INDUCED UTILIZATION RATIO	IUR

12.8.2.1.3   Program-Level CMS Inputs

The last set of reconciliation inputs that are found in the Results Report are CMS provided, program-wide data elements. These fields are necessary to perform the risk sharing portion of reconciliation. The values for these data elements will be the same for all plans that participate in risk sharing. Table 12H provides the CMS program level inputs on the PRS Results Report to Plans.

**TABLE 12H – CMS PROVIDED PROGRAM LEVEL INPUTS ON THE
PRS RESULTS REPORT TO PLANS**

Data Element	Short Name
FIRST UPPER THRESHOLD PERCENT	FUTP
SECOND UPPER THRESHOLD PERCENT	SUTP
FIRST LOWER THRESHOLD PERCENT	FLTP
SECOND LOWER THRESHOLD PERCENT	SLTP
FIRST UPPER RISK SHARING RATE	FURSR
SECOND UPPER RISK SHARING RATE	SURSR
FIRST LOWER RISK SHARING RATE	FLRSR
SECOND LOWER RISK SHARING RATE	SLRSR

12.8.2.1.4   Payment Reconciliation Plan Type Code

The Payment Reconciliation Plan Type Code (PRPTC) indicates which of the three reconciliations (LICS, reinsurance, and risk sharing) a plan may participate in and how those reconciliations will be calculated. The PRS contains a decision process to determine Payment Reconciliation Plan Type Code which considers the HPMS Plan Benefit Package Type Code (PBPTC), among other plan type flags and indicators to arrive at one of 14 distinct PRS reconciliation plan types. Table 12I provides a list of the PRS plan types and their allowed reconciliations.

TABLE 12I – PART D PLANS AND ALLOWED RECONCILIATION CALCULATIONS

Payment Reconciliation Plan Types	Unique PRS Plan Type Code	LICS Reconciliation	Reinsurance Reconciliation	Risk Corridor Analysis
Defined Standard Benefit Plan*	1	Yes	Yes	Yes
Actuarially Equivalent Plan*	2	Yes	Yes	Yes
Basic Alternative Plan*	3	Yes	Yes	Yes
Enhanced Alternative Plan*	4	Yes	Yes	Yes
Employer Group Waiver Plan (EGWP) Calendar Year	5	Yes	Yes	No
Employer Group Waiver Plan (EGWP) Non-Calendar Year	6	Yes	No	No
Dual-eligible PACE Plan	7	Yes	Yes	Yes
Medicare-only PACE Plan	8	Yes	Yes	Yes
Flexible Capitated Payment Demonstration Option	9	Yes	No	Yes
Fixed Capitated Payment Demonstration Option	10	Yes	No	Yes
MA Rebate Payment Demonstration Option	11	Yes	Yes	Yes
Non-Payment Demonstration Private Fee-for-Service (Non-Demo PFFS)	12	Yes	Yes	No
Limited Risk	13	Yes	Yes	Yes
Fallback	99	TBD	TBD	TBD
* Mutually exclusive of all other plan types.				

Note: All plans are required to bid as one of the four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative), but if the plan also falls into another category in addition to the HPMS PBP Type Code, such as a payment demonstration or an employer group, for PRS and reconciliation purposes, that is the designation to which the plan is assigned.

All PRS plan types participate in LICS reconciliation. Non-Calendar Year Employer Group Waiver Plans and Fixed and Flexible Capitated Payment Demonstration Plans do not receive reinsurance reconciliation. Calendar Year and Non-Calendar Year Employer Group Waiver Plans and Non-Payment Demonstration Private Fee-For-Service Plans do not participate in risk sharing.

12.9 Reconciling Low Income Cost-Sharing Subsidy

LICS reconciliation compares actual LICS to prospective LICS. Each month CMS pays plans prospectively for LICS amounts based on plan projections in the approved bid. The prospective payment for the LICS is based on the low income estimate (p(LI)mpm) calculated from the plan's approved bid and enrollment counts documented in MBD. The plan receives this amount for each low-income subsidy beneficiary enrolled in the plan as of the first day of the payment month. PDE data reports actual LICS.

12.9.1 Low Income Cost-Sharing Subsidy System Overview

MARx calculates prospective LICS payments month-by-month and again after year-end. DDPS provides the actual LICS payments made. The information process for LICS is described in Figure 12C.

Figure 12C – LICS System Process

PRS calculates the LICS reconciliation amount:

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

- Receives actual LICS reported on PDEs from DDPS.

- Calculates the difference between actual and prospective LICS.

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

12.9.2 Low Income Cost-Sharing Subsidy Data Oversight

The following information is used to calculate prospective LICS.

- Plans should review prospective payments for accuracy.

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

- Plans should closely monitor and update LICS status for their enrolled beneficiaries to determine the number of low income subsidy beneficiaries enrolled in the month.

LICS data reported on PDEs: LICS reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) and the P2P Part D Payment Reconciliation Report (Report 42COV) will be used for LICS reconciliation. The plan's understanding of LICS in internal files and LICS reported on the Cumulative Beneficiary Summary Report, Covered Drugs should be the same. Plans should be able to explain any interim differences between the two. At reconciliation, the plan's internal records and LICS reported on PDEs should agree.

Each PDE must reflect accurate data. Retroactive LICS status changes warrant careful follow-up. When LICS status is established retroactively, plans must repay the beneficiary for any overpayments in cost-sharing. To ensure accurate reconciliation amounts, plans must also submit PDE adjustments for every PDE affected by the retroactive status.

12.9.3 Low Income Cost-Sharing Subsidy Reconciliation Calculation

Plans are paid dollar for dollar for the 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.

⊠ **Example: 2**

Bayside Health Plan (refer to Table 12K on page 32) received $120 per low-income member per month of prospective LICS based on their Part D bid. The plan had 24,000 LI member months, meaning that the plan received a total of $2,880,000 of prospective LICS. Based on PDE data, the plan had $3,000,000 of actual LICS.

LICS Reconciliation Amount

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

LICS Reconciliation Amount = $120,000

Bayside's LICS Reconciliation – Results Report, DET Record

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

12.10 Reconciling the Reinsurance Subsidy

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

PDE data reports GDCA, which is the basis for determining allowable reinsurance costs. The Reinsurance Subsidy is 80 percent of GDCA, after Direct and Indirect Remuneration (DIR) has been subtracted.

12.10.1   Reinsurance System Overview

PRS reconciles the Reinsurance Subsidy. The Reinsurance Subsidy process is described in Figure 12D.

Figure 12D – Reinsurance Subsidy System Process

PRS calculates the Reinsurance Subsidy reconciliation:

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

- Receives DIR from HPMS.

- Receives GDCA and GDCB reported on PDEs from DDPS.

- PRS calculates the Reinsurance Subsidy.

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

Remember that Flexible and Fixed Payment Capitated Demonstration plans, and Employer Group Waiver Plans (EGWPs) that operate on a non-calendar year basis are excluded from reinsurance reconciliation. EGWPs that operate on a calendar-year basis are subject to reinsurance reconciliation (they are not paid prospective reinsurance, but they do receive retrospective reinsurance payment based on costs reported on PDEs and in the DIR report for reconciliation). EGWPs that operate on a non-calendar year basis receive no federal reinsurance subsidy.

12.10.2   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 and GDCB reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) and the P2P Part D Payment Reconciliation Report (Report 42COV) will be used for reinsurance reconciliation. The plan's understanding of both GDCA and GDCB in internal files and the GDCA and GDCB reported on the Cumulative Beneficiary Summary Report, Covered Drugs should agree. Plans should be able to explain any interim differences between their internal files and the CMS generated reports. At reconciliation, the plan's internal records and GDCA and GDCB reported on PDEs should agree.

- Before plans are able to report data correctly on PDEs, they must first calculate TrOOP costs correctly in order to appropriately administer catastrophic benefits when the Out of Pocket (OOP) limit is reached. Final PDE data must accurately report GDCA totals at the plan/beneficiary level.

- If the plan incorrectly reported dollars in GDCB instead of GDCA, reinsurance costs will be understated. Similarly, if the plan incorrectly reported dollars in GDCA instead of GDCB, unadjusted reinsurance costs would be overstated.

Report as Administered - When reversal of a prior claim causes one or more subsequent claims to move from catastrophic coverage to non-catastrophic coverage, plans must be careful to report GDCA and GDCB accurately on PDEs affected by the reversal. For additional information, see the Module entitled Calculating and Reporting True Out-of-Pocket Costs (TrOOP).

CMS will evaluate the accuracy of GDCA data. CMS will estimate net TrOOP Amount based on the sum of the Net Patient Pay, Net Other TrOOP, Net LICS, and Net Patient Liability due to Other Payers Amount (PLRO) for all PDEs at or below the attachment point. Because the attachment point PDE may contain Out-of-Pocket (OOP) amounts paid during Catastrophic, this may vary slightly from plan computed TrOOP, which applies only to payments made before Catastrophic Coverage is reached.

12.10.3   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

The DIR ratio is the unadjusted reinsurance cost divided by the total drug cost. Unadjusted reinsurance cost is the plan-level GDCA amount reported on PDEs. Total drug cost is the sum of GDCA and GDCB. The DIR ratio is applied to DIR to allocate the reinsurance portion of DIR. To derive allowable reinsurance cost, the reinsurance portion of DIR is subtracted from unadjusted reinsurance cost. The plan-level reinsurance subsidy is eighty percent (80%) of the plan's allowable reinsurance cost. The reconciliation calculation determines the difference between the actual reinsurance subsidy and the plan's prospective reinsurance payments.

12.10.3.1   Calculate DIR Ratio

Bayside reported GDCA equal to $2,750,000 and GDCB equal to $13,750,000. The sum of GDCA and GDCB, which equals $16,500,000, is Bayside's total gross drug cost. To determine Bayside's DIR ratio, divide GDCA by total gross drug cost. Bayside's DIR ratio is .1667.

DIR_Ratio

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

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

DIR_Ratio = .1667

Bayside's Reinsurance DIR Ratio – Results Report, DET Record

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

12.10.3.2   Calculate Reinsurance Portion of DIR

Bayside reported DIR for total covered drugs equal to $1,650,000. To calculate the reinsurance portion of Bayside's DIR, multiply the DIR for total covered drugs by the DIR Ratio. Bayside's reinsurance portion of DIR is $275,055.

Reinsurance Portion of DIR

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

Reinsurance Portion of DIR = $275,055

Bayside's Reinsurance Portion of DIR – Results Report, DET Record

Field No.	Field Name	
12	REINSURANCE DIR RATIO	0.1667
13	PART D COVERED DIR AMOUNT	$1,650,000
14	**REINSURANCE PORTION OF DIR AMOUNT**	**$275,055**

12.10.3.3   Calculate Allowable Reinsurance Cost

Bayside reported GDCA equal to $2,750,000. To calculate Bayside's allowable reinsurance cost, subtract the reinsurance portion of DIR from GDCA. Bayside's allowable reinsurance cost is $2,474,945.

Allowable Reinsurance Cost

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

Allowable Reinsurance Cost = $2,474,945

Bayside's Allowable Reinsurance Cost Amount – Results Report, DET Record

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

12.10.3.4   Calculate Plan-Level Reinsurance Subsidy

The reinsurance subsidy is 80 percent of allowable reinsurance cost. To calculate Bayside's reinsurance subsidy, multiply allowable reinsurance cost by .8. Bayside's reinsurance subsidy is $1,979,956.

Reinsurance Subsidy

Reinsurance Subsidy = $2,474,945 * 0.8

Reinsurance Subsidy = $1,979,956

Bayside's Actual Reinsurance Subsidy – Results Report, DET Record

Field No.	Field Name	
15	ALLOWABLE REINSURANCE COST AMOUNT	$2,474,945
16	**ACTUAL REINSURANCE SUBSIDY AMOUNT**	**$1,979,956**

12.10.3.5   Reconcile Reinsurance Subsidy

The reinsurance reconciliation amount is the difference between the actual and prospective reinsurance subsidy. Bayside's total prospective reinsurance was $2,100,000. Since Bayside bid a prospective reinsurance amount of $35 pmpm and had 60,000 member months, Bayside's total prospective reinsurance was $2,100,000 ($35*60,000 = $2,100,000). The difference between $1,979,956 and $2,100,000 is -$120,044. The reinsurance reconciliation amount is negative. Bayside over-estimated its reinsurance subsidy. In other words, Bayside's prospective reinsurance, based on its own bid estimates, was greater than the actual reinsurance subsidy, which was based on the plan's own PDE data. Bayside will pay back $120,044.

Reinsurance Reconciliation Amount

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

Reinsurance Reconciliation Amount = -$120,044

Bayside's Reinsurance Reconciliation – Results Report, DET Record

Field No.	Field Name	
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
17	PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	$2,100,000
18	**REINSURANCE SUBSIDY ADJUSTMENT AMOUNT**	**-$120,044**

12.10.3.6   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.

12.11 Risk Sharing

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

Each month, CMS prospectively pays plans the direct subsidy based on plan projections in the approved bid. The direct subsidy is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status adjustment factor, minus the Part D basic premium related to the standardized

bid amount. The plan receives this amount for each beneficiary enrolled in the plan as of the first day of the payment month.

PDE data reports actual CPP, which is the basis for determining adjusted allowable risk corridor costs (AARCC) used in calculating risk sharing.

12.11.1   Risk Sharing System Overview

PRS calculates risk sharing. The risk sharing process is described in Figure 12E.

Figure 12E - Risk Sharing System Process

PRS calculates risk sharing:

- PRS receives the final direct subsidy amount, final Part D basic premium related to the standardized bid and prospective reinsurance payments of the flexible and fixed capitated demonstration plans from MARx.

- PRS receives the administrative cost ratio, total DIR for covered drugs, and induced utilization from HPMS.

- PRS receives CPP from DDPS.

- PRS calculates AARCC.

- PRS calculates risk sharing.

12.11.2   Risk Sharing Data Oversight

The following information is used for risk sharing.

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

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

    – Part D basic premium is the same information received on the plan's approved bid.

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

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

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

- Induced Utilization: Enhanced Alternative plans should also understand the induced utilization ratio reported on the bid.

- CPP: CPP reported on the Cumulative Beneficiary Summary Report, Covered Drugs will be used for risk sharing calculations. The plan's understanding of CPP in internal files and of the CPP reported on the Cumulative Beneficiary Summary Report, Covered Drugs (Report 04COV) should agree. Plans should be able to explain any interim differences between the two. At reconciliation, the plan's internal records and CPP reported on PDEs should agree. CPP as reported on the P2P Part D Payment Reconciliation Report (Report 42COV) will also be used for risk sharing calculations.

- Drug Coverage Status Code: All plans must report covered drugs accurately. Errors in the Drug Coverage Status Code field directly affect risk sharing. Risk sharing calculations include covered drugs only (i.e., Drug Coverage Status Code = "C"). CPP will be understated when covered drugs are reported as either enhanced alternative drugs or OTC drugs. CPP will be overstated when either enhanced alternative drugs or OTC drugs are reported in error as covered drugs. Any other reasons for over-reporting covered drugs, like including Part A/B drugs, will overstate CPP. Finally, Enhanced Alternative Plans and Payment Demonstration Plans must map costs to CPP correctly for accurate risk sharing.

12.11.3 Risk Sharing Calculations

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

- Calculate the plan's target amount
- Calculate risk corridor thresholds
- Calculate AARCC
- Determine where costs fall with respect to the thresholds and calculate payment adjustment

12.11.3.1 Calculate the Plan's Target Amount

Bayside received $2,868,000 in total direct subsidy payments and $2,100,00 in Part D basic premiums related to the standardized bid. Bayside's administrative cost ratio is 15 percent. To calculate Bayside's target amount, sum the total direct subsidy payments and the Part D basic premiums related to the standardized bid which add up to $4,968,000.

Next, eliminate administrative costs. Bayside's administrative cost ratio is 15 percent; the remaining cost, which should be included in the target amount, is non-administrative cost. Find Bayside's non-administrative cost by first subtracting .15 from 1.00, which is .85. To calculate Bayside's target amount, multiply the sum of the total direct subsidy payments and the Part D basic premium amount by .85.

Target Amount

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

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

Target Amount = $4,222,800

Bayside's Target Amount – Results Report, DET Record

Field No.	Field Name	
22	DIRECT SUBSIDY AMOUNT	$2,868,000
23	PART D BASIC PREMIUM AMOUNT	$2,100,000
24	ADMINISTRATIVE COST RATIO	0.15
26	**TARGET AMOUNT**	**$4,222,800**

12.11.3.2   Calculate Risk Corridor Thresholds

Bayside uses its target amount and Part D threshold risk percentages to calculate the risk corridor thresholds. Bayside's target amount is $4,222,800. 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 Bayside's target amount by each of these percentages. Later, these threshold limits are part of the final risk sharing amount calculation.

Risk Corridor Thresholds

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

Bayside's Risk Corridors – Results Report, DET Record

Field No.	Field Name	
26	TARGET AMOUNT	$4,222,800
28	FIRST UPPER THRESHOLD PERCENT	1.025
29	SECOND UPPER THRESHOLD PERCENT	1.05
30	FIRST LOWER THRESHOLD PERCENT	0.975
31	SECOND LOWER THRESHOLD PERCENT	0.95
32	**FIRST UPPER THRESHOLD AMOUNT**	**$4,328,370**
33	**SECOND UPPER THRESHOLD AMOUNT**	**$4,433,940**
34	**FIRST LOWER THRESHOLD AMOUNT**	**$4,117, 230**
35	**SECOND LOWER THRESHOLD AMOUNT**	**$4,011,660**

Bayside's Adjusted Allowable Risk Corridor Cost – Results Report, DET Record
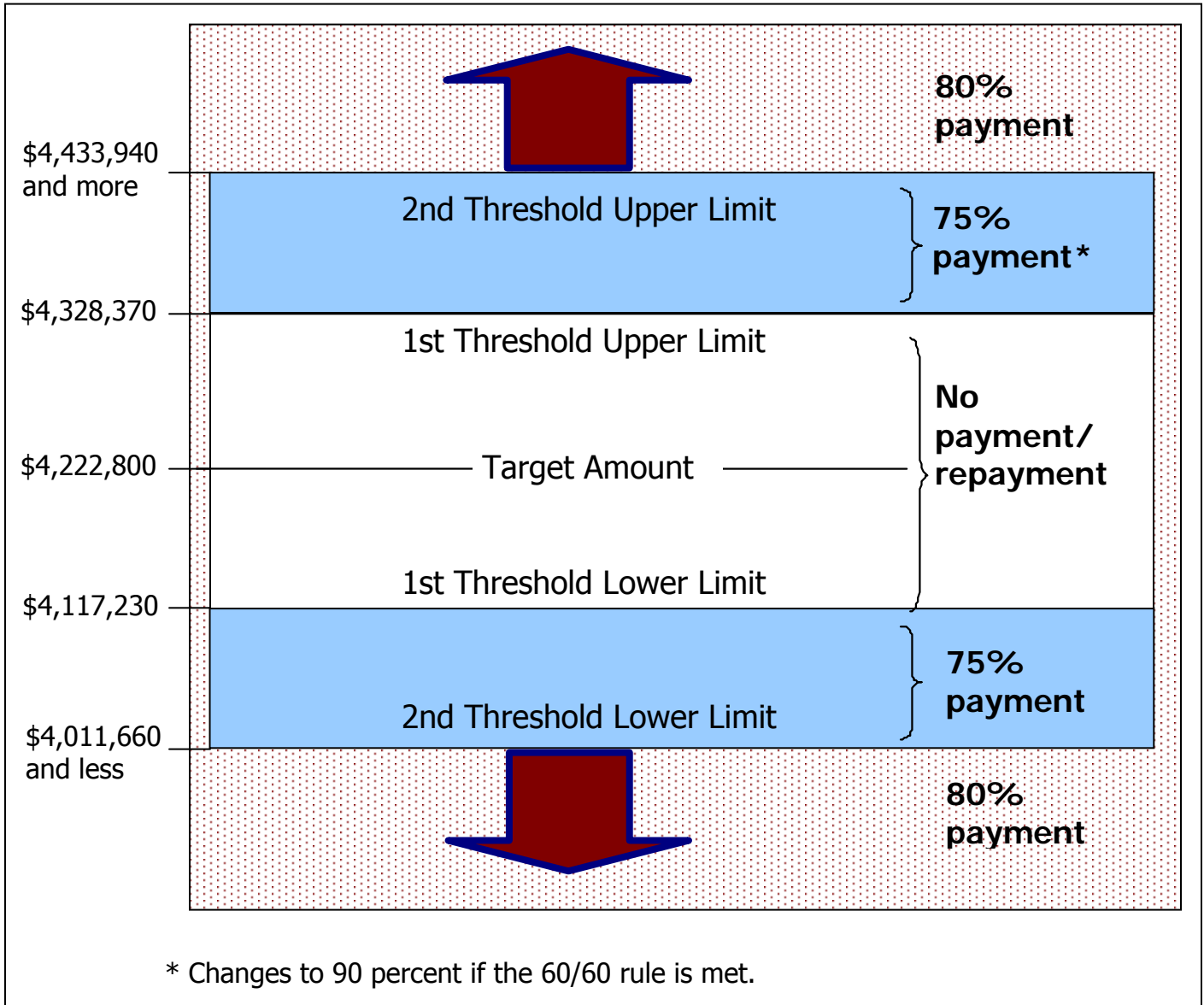
Field No.	Field Name	
13	PART D COVERED DIR AMOUNT	$1,650,000
16	ACTUAL REINSURANCE SUBSIDY AMOUNT	$1,979,956
19	TOTAL COVERED PART D PLAN PAID AMOUNT	$8,250,000
20	INDUCED UTILIZATION RATIO	1.018
21	**ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT**	**$4,538,353**

12.11.3.4 Determine Where Costs Fall With Respect To The Thresholds And Calculate Payment Adjustment

The last step in risk sharing is to determine where AARCC falls with respect to the thresholds and calculate the payment adjustment. To review, Bayside's AARCC is $4,538,353. Figure 12F displays Bayside's risk sharing thresholds and percentages. In this example, assume that the 60/60 rule is met.

The 60/60 rule - In 2006 and 2007, the government has the authority to 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 subject to risk sharing have AARCC above the FTUL, provided that those plans represent at least 60 percent of Part D enrollees.

Figure 12F – Bayside's Risk Sharing Thresholds and Percentages

$4,433,940 and more	80% payment
	2nd Threshold Upper Limit — 75% payment*
$4,328,370	
	1st Threshold Upper Limit
$4,222,800	Target Amount — No payment/ repayment
	1st Threshold Lower Limit
$4,117,230	
	75% payment
	2nd Threshold Lower Limit
$4,011,660 and less	80% payment

* Changes to 90 percent if the 60/60 rule is met.

Since Bayside's AARCC is above the $4,433,930 that marks the Second Threshold Upper Limit (STUL), there are two portions of Bayside's risk sharing.

The first portion lies between $4,328,370 and $4,433,940 (between the First Threshold Upper Limit (FTUL) and the STUL) and has 90 percent risk sharing. The second portion falls above the $4,433,940 that marks the STUL and has 80 percent risk sharing.

Cost Subject to Risk Sharing

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

Total Cost Subject to Risk Sharing = $209,983

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

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

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

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

Finally, calculate the risk sharing percentage for each portion of AARCC. First apply 90 percent risk sharing to the $105,570 between the FTUL and STUL, which is $95,013.

Then, apply 80 percent risk sharing to the $104,413 above the STUL, which is $83,530. Sum these two amounts to calculate Bayside's total risk sharing payment of $178,543.

Risk Sharing Payment

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

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

Risk Sharing Payment = $178,543

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

Bayside's Risk Sharing – Results Report, DET Record

Field No.	Field Name	
21	ADJUSTED ALLOWABLE RISK CORRIDOR COST AMOUNT	$4,538,353
32	FIRST UPPER THRESHOLD AMOUNT	$4,433,940
33	SECOND UPPER THRESHOLD AMOUNT	$4,328,370
37	FIRST UPPER RISK SHARING RATE	0.9
38	SECOND UPPER RISK-SHARING RATE	0.8
41	**RISK-SHARING AMOUNT**	**$178,543**
42	RISK-SHARING PORTION FROM COSTS BEYOND SECOND LIMIT	$83,530
43	RISK-SHARING PORTION FROM COSTS BETWEEN FIRST AND SECOND LIMITS	$95,013

12.12 Final Reconciliation Payment Adjustment

After PRS has completed calculating the LICS, reinsurance, and risk sharing reconciliation values, these values are used to calculate the Adjustment Due to Payment Reconciliation Amount (ARA). The ARA is the total of the three reconciliations (LICS, reinsurance, and risk sharing) minus the Budget Neutrality Adjustment Amount (BNAA).

12.12.1   Determine Budget Neutrality Adjustment Amount

The BNAA applies to demonstration plans only and is the product of unique member per year and the Annual Budget Neutrality Dollar Amount (ABNDA). Bayside is a MA Rebate Payment Demonstration Plan and is therefore subject to the budget neutrality adjustment.

Budget Neutrality Adjustment

Budget Neutrality Adjustment = $7.57 * 5000

Budget Neutrality Adjustment Amount = $37,850

Bayside's Budget Neutrality Adjustment – Results Report, DET Record

Field No.	Field Name	
44	COUNT OF UNIQUE MEMBERS PER YEAR	5000
45	ANNUAL BUDGET NEUTRALITY DOLLAR AMOUNT (DEMONSTRATION PLANS ONLY)	$7.57
46	**BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)**	**$37,850**

12.12.2   Determine Adjustment Due to Payment Reconciliation Amount

The Adjustment Due to Payment Reconciliation Amount (ARA) is the plan level final net reconciliation value. Table 12J illustrates how ARA is calculated.

TABLE 12J – PART D RECONCILIATION ADJUSTMENT AMOUNTS AND FIELD LOCATIONS

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost Sharing Subsidy Amount	Field 9
+	Reinsurance Subsidy Adjustment Amount	Field 18
+	Risk Sharing Amount	Field 41
–	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 46
=	**Adjustment Due to Payment Reconciliation Amount**	**Field 47**

At this point, every step in the reconciliation process has been completed. In addition, to the reconciled direct subsidy that Bayside received from MARx, Bayside receives the net reconciliation amount of $140,649 from PRS.

Total Reconciliation Payment from PRS

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

Bayside's Adjustment Due to Payment Reconciliation – Results Report, DET Record

Field No.	Field Name	
9	LOW-INCOME COST-SHARING SUBSIDY ADJUSTMENT AMOUNT	$120,000
18	REINSURANCE SUBSIDY ADJUSTMENT AMOUNT	-$120,044
41	RISK-SHARING AMOUNT	$178,543
46	BUDGET NEUTRALITY ADJUSTMENT AMOUNT (DEMONSTRATION PLANS ONLY)	$37,850
47	**ADJUSTMENT DUE TO PAYMENT RECONCILIATION AMOUNT**	**$140,649**

Table 12K illustrates the data used to calculate Bayside's Health Plan's total reconciliation payment.

TABLE 12K – BAYSIDE HEALTH PLAN

HPMS Information

Plan Bid Information	
1. Standard Bid	$92
2. Part D Basic Premium Related to the Standardized Bid	$35
3. Prospective Low Income Cost-Sharing	$120
4. Prospective Reinsurance	$35
5. Admin Cost Ratio	0.15
6. Induced Utilization	1.018

DIR Information

7. DDIR	$1,650,000

MARx Information

8. Average Monthly Enrollment	5,000
9. Total Member Months	60,000
10. Average Risk Factor	0.900
11. Risk Adjusted Bid	$4,968,000
12. Total Direct Subsidy	$2,868,000
13. Total Low Income Member Months	24,000
14. Total Prospective Low Income Cost-Sharing	$2,880,000
15. Total Prospective Reinsurance	$2,100,000
16. Total Part D Basic Premium Related to the Standardized Bid	$2,100,000
17. Unique Member Per Year Count	5,000

DDPS Data

18. Low Income Cost-Sharing	$3,000,000
19. Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)	$2,750,000
20. Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)	$13,750,000
21. Covered D Plan Paid Amount	$8,250,000
22. Total GDCA+GDCB	$16,500,000

CMS Provided Data

23. Annual Budget Neutrality Dollar Amount (MA Rebate Payment Demonstrations)	$7.57

PRESCRIPTION DRUG EVENT – ADVANCED TRAINING
Reconciliation

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Workbook

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Scenario 1

Bayside Health Plan received $120 per low-income member per month of prospective LICS based on their Part D bid. The plan had 24,000 LI member months, meaning that the plan received a total of $2,880,000 of prospective LICS. Based on PDE data, the plan had $3,000,000 of actual LICS.

Scenario 2

Bayside reported GDCA equal to $2,750,000 and GDCB equal to $13,750,000. Bayside reported DIR for total covered drugs equal to $1,650,000.   Bayside's total prospective reinsurance was $2,100,000. Since Bayside bid a prospective reinsurance amount of $35 pmpm and had 60,000 member months, Bayside's total prospective reinsurance was $2,100,000 ($35*60,000 = $2,100,000).

Scenario 3

Bayside received $2,868,000 in total direct subsidy payments and $2,100,000 in Part D basic premiums related to the standardized bid. Bayside's administrative cost ratio is 15 percent. Bayside's unadjusted allowable risk corridor cost is $8,250,000 and their induced utilization ratio is 1.018. Part D threshold risk percentages, in descending order are 105 percent, 102.5 percent, 97.5 percent, and 95.0 percent. 60 percent of Part D plans subject to risk sharing representing 60 percent of Part D enrollees have AARCC above the FTUL.

Scenario 4

PRS has completed calculating the LICS, reinsurance, and risk sharing reconciliation values for Bayside Health Plan. Bayside is a MA Rebate Payment Demonstration Plan. Bayside's Unique Member Per Month count is 5,000. The Annual Budget Neutrality Dollar Amount for the MA Rebate Payment Demonstration Plans is $7.57.

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

DATE: June 7, 2007

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

FROM: Thomas Hutchinson
                Director, Medicare Plan Payment Group

SUBJECT: Payment Reconciliation System (PRS) Part D Payment Reconciliation Reports

As part of the yearly Part D payment reconciliation, plans active within the coverage year will receive a
set of management reports from the Payment Reconciliation System (PRS) detailing inputs and results of
the reconciliation process for the coverage year. The PRS reports, the PRS Inputs Report to Plans and the
PRS Reconciliation Results Report to Plans, will provide plans with information regarding the inputs and
values used to calculate the three Part D payment reconciliations: the Low Income Cost-Sharing Subsidy
(LICS) reconciliation, the reinsurance reconciliation, and the risk sharing reconciliation.

Questions regarding the PRS Part D Payment Reconciliation Reports should be directed to either
Tara.Waters@cms.hhs.gov or Jeffrey.Grant@cms.hhs.gov.

Attachment

The Payment Reconciliation System (PRS) Part D Payment Reconciliation Reports

As part of the yearly Part D payment reconciliation, plans active within the coverage year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the reconciliation process for the coverage year. The layout and data elements in the reports, the PRS Inputs Report to Plans and the PRS Reconciliation Results Report to Plans, are explained here. To provide a framework for the PRS reports, an explanation of how the data elements within the reports operate in the Part D payment reconciliation calculations performed by the PRS is also outlined below.

The PRS Inputs Report to Plans provides plans with the beneficiary-level inputs received from the Medicare Advantage and Prescription Drug System (MARx) and the Drug Data Processing System (DDPS). These inputs provide data on the prospective payments and the actual payments made on behalf of a beneficiary. The PRS Inputs Report to Plans allows plans to validate the beneficiary-level inputs received from DDPS and MARx that will be used in their Part D payment reconciliation.

The PRS Reconciliation Results Report to Plans provides plan-level inputs received from the Health Plan Management System (HPMS), totaled plan-level inputs passed from the PRS Inputs Report to Plans, and the results of the three Part D payment reconciliations: the Low Income Cost-Sharing Subsidy (LICS) reconciliation, the reinsurance reconciliation, and the risk-sharing reconciliation. The PRS Reconciliation Results Report to Plans is meant to provide plans with all of the inputs plans would need to understand how their Part D payment reconciliation is calculated, in addition to the results of the Part D payment reconciliations and the final reconciliation adjustment amount.

The PRS Inputs Report To Plans

The PRS Inputs Report to Plans provides plans with the prospective payment and actual payment inputs at the beneficiary/plan-level from MARx and DDPS. Because a beneficiary could be in more than one contract and/or more than one Plan Benefit Package (PBP) within a contract within a specific coverage year, beneficiary/plan-level data indicates the beneficiary-level data for a specific plan only. In this document, beneficiary-level and beneficiary/plan-level are used interchangeably. Plan-level and contract/PBP-level are also used interchangeably.

PRS Inputs Report to Plans File Layout

The layout of the PRS Inputs Report to Plans follows a similar file structure as the DDPS management reports (Report 4, Reports 40-43) that plans are already receiving.

The PRS Inputs Report to Plans file contains a contract header (CHD) record, followed by a plan header (PHD) record which sets up cumulative reporting at both the contract-level and at the plan-level. The CHD and PHD records identify the contract and PBP, respectively. Each has the file name on the record, allowing the distribution of reports at the contract-level, and a contract to treat plan-level reports as unique reports. The CHD record also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first to be run or if the reconciliation has been re-run.
The detail (DET) record provides the beneficiary/plan-level reporting. The DET record establishes the basic format for the rest of the file. It is important to note that on the DET record, beneficiaries are identified by their most current HICN as reported on the DDPS management files.

The plan trailer (PTR) record has the same basic layout as the DET record. However, in place of the beneficiary ID, there is a contract number and a PBP ID. This record will sum all of the amounts in each of the DET records for the contract/PBP. Table 1 provides the definitions and descriptions of the records in the PRS Inputs Report to Plans.

TABLE 1 - PRS INPUTS REPORT TO PLANS - RECORD DEFINITIONS/DESCRIPTIONS

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
PHD	Plan-level file header	Occurs once per Plan on file
DET	Detail records for the report	Occurs 1 to many times per PHD record
PTR	Plan-level file trailer	Occurs once per PHD on the file
CTR	Contract-level file trailer	Occurs once per CHD

PRS Inputs Report to Plans – Data Elements and Report Fields

Only beneficiary/plan-level information is present on the Inputs Report. Plan-level inputs needed to calculate reconciliation amounts are found on the PRS Reconciliation Results Report to Plans discussed in a later section.

P2P and Non-P2P Fields
The Inputs Report to Plans contains both Plan-to-Plan (P2P) amounts and non-P2P amounts for the following four fields: Actual Low Income Cost-Sharing Subsidy Amount (ALICSA), Gross Drug Cost Below the Out of Pocket Threshold Amount (GDCBA), Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA), and Covered Part D Plan Paid Amount (CPPA). These four fields represent data received from the Drug Data Processing System (DDPS). Table 2 provides the names and field locations on the DET record of the data elements which have both P2P and non-P2P amounts.

TABLE 2: P2P AND NON-P2P FIELDS ON PRS INPUTS REPORT

DATA ELEMENT	SHORT NAME	NON P2P	P2P	TOTAL
ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	4	5	6
GROSS DRUG COST BELOW THE OUT OF POCKET THRESHOLD	GDCBA	8	9	10
GROSS DRUG COST ABOVE THE OUT OF POCKET THRESHOLD	GDCAA	11	12	13
COVERED PART D PLAN PAID AMOUNT	CPPA	14	15	16

The P2P amounts represent amounts paid for which the plan was not the submitting plan. Since the Plan of Record (POR) has repaid the submitting plan during the P2P process, the P2P amounts incurred will be on the POR's reconciliation. Plans will only be reconciled for amounts incurred when they are the POR.

PRS sums the P2P and non-P2P amounts for these fields at the beneficiary-level. The beneficiary/plan-level sums of these four fields are on the DET record and are aggregated to the plan and contract levels in the Inputs Report. Plans should also refer to the DDPS Management Report 4 COV and Report 42 for the non-P2P and P2P amounts for these fields. Prior to reconciliation, CMS will release Report 4 COV and Report 42 with the coverage year's cumulative results as they will be used in the Part D reconciliation. These reports are critical for the plan to review and refer to in understanding their Part D payment reconciliation.

PRS Reconciliation Results Report To Plans

The PRS Reconciliation Results Report to Plans provides plans with the results of the three Part D payment reconciliations and the final reconciliation payment adjustment amount. The Results Report also provides the contract/PBP-level inputs received from HPMS and the totaled plan-level inputs from DDPS and MARx that are necessary for plans to understand how their Part D payment reconciliation is calculated.

The PRS Reconciliation Results Reports to Plans File Layout

The PRS Reconciliation Results Report to Plans file layout is similar to that of the PRS Inputs Report, but there are key differences. The Results Report file begins with the CHD record. In the Results Report, there are no beneficiary-level records; the DET record in the Results Report provides the reconciliation results at the contract/PBP-level. As with the Inputs Report, each report also has the coverage year, the calendar year for which a specific Part D payment reconciliation is conducted, and the reconciliation number which indicates whether the reconciliation is the first run for the coverage year or if the reconciliation has been re-run. Table 3 provides the definitions and descriptions of the records in the PRS Reconciliation Results Report to Plans.

**TABLE 3 - PRS RECONCILIATION RESULTS REPORT TO PLANS - RECORD
DEFINITIONS/DESCRIPTIONS**

RECORD INDICATOR	RECORD DEFINITION	NOTES
CHD	Contract-level file header	Occurs once per Contract
DET	Detail records at the plan-level for the report	Occurs 1 to many times per CHD record
CTR	Contract-level file trailer	Occurs once per CHD

The CTR record provides reconciliation results summarized to the contract level and represents the activity of all PBPs under one contract number. It is important to note here that the totals in this CTR record are not the totals used for any Part D payment reconciliation. All payment reconciliation is at the contract/PBP-level which is reported in the DET record. The CTR record may provide a useful contract-level summary, but will not directly impact any payment calculation.

Inputs on the Results Report

Inputs Report Fields Passed to the Results Report

Certain fields from the Inputs Report are carried through to the Reconciliation Results Report. The elements passed are summed to the contract/PBP-level on the PRS Inputs Report PTR record. The data elements that are passed from the Inputs Report to the Results Report are values that are necessary inputs into the payment reconciliation calculations PRS performs. For example, the plan-level Total Actual Low Income Cost-Sharing Subsidy Amount (ALICSA) and the plan-level Prospective Low Income Cost-Sharing Subsidy Amount (PLICSA) are the only data elements used to calculate the LICS Reconciliation Adjustment Amount (LICSAA) and therefore, are passed to the Results Report from the Inputs Report. Other data elements passed from the Inputs Report to the Results Report also comprise values in the Part D payment reconciliation calculations. These data elements are shown in Table 4.

**TABLE 4: DATA ELEMENTS PASSED FROM THE PRS INPUTS REPORT
TO THE PRS RESULTS REPORT**

DATA ELEMENT	SHORT NAME	SOURCE SYSTEM
TOTAL ACTUAL LOW INCOME COST-SHARING SUBSIDY AMOUNT	ALICSA	DDPS
TOTAL GROSS DRUG COST BELOW OUT OF POCKET THRESHOLD AMOUNT	GDCBA	DDPS
TOTAL GROSS DRUG COST ABOVE OUT OF POCKET THRESHOLD AMOUNT	GDCAA	DDPS
TOTAL COVERED PART D PLAN PAID AMOUNT	CPPA	DDPS
PROSPECTIVE LOW INCOME COST-SHARING SUBSIDY AMOUNT	PLICSA	MARx
PROSPECTIVE REINSURANCE SUBSIDY AMOUNT	PRSA	MARx
PART D BASIC PREMIUM AMOUNT	PA	MARx
DIRECT SUBSIDY AMOUNT	DSA	MARx
PACE COST-SHARING ADD-ON AMOUNT	PCAA	MARx

Plan-level HPMS Inputs
Plan-level inputs needed to calculate reconciliation amounts are only found on the PRS Reconciliation Results Report to Plans. These plan-level inputs are HPMS inputs and include: the Part D Covered DIR Amount, the Administrative Cost Ratio, and the Induced Utilization Ratio (for Enhanced Alternative plans only). The Part D Covered DIR Amount is adjusted within HPMS to account for the Part D Covered Incentive Payment Amount prior to being passed to PRS. These data elements are show in Table 5.

**TABLE 5: HPMS PLAN-LEVEL INPUTS FOUND ON THE PRS RECONCILIATION
RESULTS REPORT TO PLANS**

DATA ELEMENT	SHORT NAME
PART D COVERED DIR AMOUNT	DDIRA
ADMINISTRATIVE COST RATIO	ACR
INDUCED UTILIZATION RATIO	IUR

Program Level CMS Inputs

The last set of reconciliation inputs that are found in the Results Report are CMS provided, program-wide data elements. These fields are necessary to perform the risk sharing portion of reconciliation. The values for these data elements will be the same for all plans that participate in risk sharing. CMS provided, program-wide inputs are shown in Table 6.

TABLE 6: CMS PROVIDED PROGRAM LEVEL INPUTS ON THE PRS RESULTS REPORT TO PLANS

DATA ELEMENT	SHORT NAME
FIRST UPPER THRESHOLD PERCENT	FUTP
SECOND UPPER THRESHOLD PERCENT	SUTP
FIRST LOWER THRESHOLD PERCENT	FLTP
SECOND LOWER THRESHOLD PERCENT	SLTP
FIRST UPPER RISK SHARING RATE	FURSR
SECOND UPPER RISK SHARING RATE	SURSR
FIRST LOWER RISK SHARING RATE	FLRSR
SECOND LOWER RISK SHARING RATE	SLRSR

Payment Reconciliation Plan Type Code

The Payment Reconciliation Plan Type Code (PRPTC) indicates which of the three reconciliations (LICS, reinsurance, and risk sharing) a plan may participate in and how those reconciliations will be calculated. The PRS contains a decision process to determine Payment Reconciliation Plan Type Code which considers the HPMS Plan Benefit Package Type Code (PBPTC), among other plan type flags and indicators to arrive at one of 14 distinct PRS reconciliation plan types. See Table 7 for a list of the PRS plan types and their allowed reconciliations.

TABLE 7: PART D PLANS AND ALLOWED RECONCILIATION CALCULATIONS

Payment Reconciliation Plan Types	Unique PRS Plan Type Code	LICS Reconciliation	Reinsurance Reconciliation	Risk Corridor Analysis
Defined Standard Benefit Plan*	1	Yes	Yes	Yes
Actuarially Equivalent Plan*	2	Yes	Yes	Yes
Basic Alternative Plan*	3	Yes	Yes	Yes
Enhanced Alternative Plan*	4	Yes	Yes	Yes
Employer Group Waiver Plan (EGWP) Calendar Year	5	Yes	Yes	No
Employer Group Waiver Plan (EGWP) Non-Calendar Year	6	Yes	No	No
Dual-eligible PACE Plan	7	Yes	Yes	Yes
Medicare-only PACE Plan	8	Yes	Yes	Yes
Flexible Capitated Payment Demonstration Option	9	Yes	No	Yes
Fixed Capitated Payment Demonstration Option	10	Yes	No	Yes
MA Rebate Payment Demonstration Option	11	Yes	Yes	Yes
Non-Payment Demonstration Private Fee-for-Service (Non-Demo PFFS)	12	Yes	Yes	No
Limited Risk	13	Yes	Yes	Yes
Fallback	99	TBD	TBD	TBD
* Mutually exclusive of all other plan types.				

Note: All plans are required to bid as one of the four HPMS Plan Benefit Types (Defined Standard, Actuarially Equivalent, Basic Alternative, or Enhanced Alternative), but if the plan also falls into another category in addition to the HPMS PBP Type Code, such as a payment demonstration or an employer group, for PRS and reconciliation purposes, that is the designation to which the plan is assigned.

All PRS plan types participate in LICS reconciliation. Non-Calendar Year Employer Group Waiver Plans and Fixed and Flexible Capitated Payment Demonstration Plans do not receive reinsurance reconciliation. Calendar Year and Non-Calendar Year Employer Group Waiver Plans and Non-Payment Demonstration Private Fee-For-Service Plans do not participate in risk sharing. During the 2006 reconciliation process, CMS will calculate the reinsurance subsidy for Non-Payment Demonstration Private Fee-for-Service (Non-

Demo PFFS) plans using the same methodology used to determine the reinsurance subsidy for MA-PD plans.[1]

PRS Payment Calculations, Interim Calculated Values, and Reconciliation Results

This section provides an explanation of how the various inputs identified on the Inputs Report and on the Results Report operate within the PRS reconciliation calculations. In addition to values received from source systems, the Reconciliation Results Report to Plans has PRS interim calculated values used in the reinsurance and risk sharing reconciliations. More information on the PRS interim calculated values can be found in the sections below.

More importantly, this section explains how the three Part D payment reconciliation calculations operate within the PRS and how the inputs and interim calculated values operate within the calculations to provide plans with the final reconciliation values for the three Part D payment reconciliations (LICS reconciliation, reinsurance reconciliation, and risk sharing reconciliation) and the final reconciliation payment adjustment value, the Adjustment Due to Payment Reconciliation Amount (ARA). This section explains how PRS arrives at the these final reconciliation values and tells plans where to find specific values on the plan-level DET record of the Results Report.

Low Income Cost-Sharing Subsidy (LICS) Reconciliation:

The LICS reconciliation is the most straightforward of the reconciliations. In the LICS reconciliation, prospective payments are compared to actual payments to determine the Low Income Cost-Sharing Subsidy Adjustment Amount (LICSAA). The values that go into the LICS reconciliation calculations are totaled DDPS and MARx values passed from the Inputs Report to the Results Report. No calculated interim PRS values are used in the LICS reconciliation:

$$LICSAA=ALICSA-PLICSA$$

The Actual Low Income Cost-Sharing Subsidy Amount minus the Prospective Low Income Cost-Sharing Subsidy Amount provides the Low Income Cost-Sharing Subsidy Adjustment Amount.

The Low Income Cost-Sharing Subsidy Adjustment Amount is Field 9 on the PRS Reconciliation Results Report to Plans DET record. This amount can be positive or negative.

Reinsurance Reconciliation:

As with the LICS reconciliation, the reinsurance reconciliation compares the Prospective Reinsurance Subsidy Amount to the Actual Reinsurance Subsidy Amount to determine the Reinsurance Subsidy Adjustment Amount (RSAA). Calculating the reinsurance subsidy reconciliation is a 5 step process. PRS uses GDCAA and GDCBA values from DDPS and the Prospective Reinsurance Subsidy Amount (PRSA) from MARx which are passed to the Results Report from the Inputs Report as totaled plan-level values.

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[1] After initial reconciliation payments have been made, CMS will conduct analysis to determine how closely the reinsurance payments made to PFFS plans approximate the reinsurance payments that they would have received if they were MA-PD plans with populations of similar risk. If appropriate, CMS may adjust the reinsurance subsidies paid PFFS plans to more accurately reflect the reinsurance subsidies they would have received as MA-PD plans with populations of similar risk.

PRS uses these values to determine the interim calculated values, such as the Reinsurance DIR Ratio (RDIRR), the Reinsurance Portion of DIR Amount (RPDIRA), the Allowable Reinsurance Cost Amount (ARCA), and the Actual Reinsurance Subsidy Amount (ARSA), used in the reinsurance reconciliation calculations and which are further explained below:

1. **The first step in determining the reinsurance reconciliation is to calculate the Reinsurance DIR Ratio (RDIRR).** The Total Gross Drug Cost Above the Out of Pocket Threshold Amount (GDCAA) is divided by total drug costs (the sum of GDCAA and the Total Gross Drug Cost Below the Out-of-Pocket Threshold Amount (GDCBA)) to determine RDIRR, the Part D Direct and Indirect Remuneration Ratio. (RDIRR is a PRS interim calculated value and is found on Field 12 of the DET record on the PRS Reconciliation Results Report to Plans).

	RDIRR=GDCAA/(GDCAA+GDCBA)

2. **The second step is to calculate the Reinsurance Portion of DIR Amount (RPDIRA).** The DIR ratio is multiplied by the Part D Covered DIR Amount (DDIRA) which is a contract/PBP-level value received from HPMS, and identified on the Results Report, to produce the Reinsurance Portion of DIR. (RPDIRA is a PRS interim calculated value and is found on Field 14 of the DET record on the PRS Reconciliation Results Report to Plans.)

	RPDIRA=RDIRR x DDIRA

3. **In the third step, PRS calculates the allowable reinsurance cost (ARCA).** The Reinsurance Portion of DIR is subtracted from the Total Gross Drug Cost Above the Out of Pocket Threshold to determine the Allowable Reinsurance Cost Amount. (ARCA is a PRS interim calculated value in Field 15 of the DET record on the PRS Reconciliation Results Report to Plans.)

	ARCA=GDCAA-RPDIRA

4. **In the fourth step, PRS determines the Actual Reinsurance Subsidy Amount (ARSA).** The Allowable Reinsurance Cost Amount is multiplied by .8 to determine the Actual Reinsurance Subsidy Amount. (ARSA is found in Field 16 of the DET record on the PRS Reconciliation Results Report to Plans.)

	ARSA=ARCA x 0.80

5. **In the fifth step, the reinsurance subsidy is reconciled to determine the Reinsurance Subsidy Adjustment Amount (RSAA).** The Reinsurance Subsidy Adjustment Amount is determined by subtracting the Prospective Reinsurance Subsidy Amount received from MARx and identified on the Inputs Report from the Actual Reinsurance Subsidy Amount (ARSA).

	RSAA=ARSA-PRSA

The Reinsurance Subsidy Adjustment Amount is Field 18 on the PRS Reconciliation Results Report to Plans DET Record. This amount can be positive or negative.

Risk Sharing Reconciliation:

Calculating the risk sharing reconciliation is a more involved process than the previous two reconciliations. Most of the risk sharing reconciliation is performed at the plan-level with the exception of the 60/60 rule calculation portion which is conducted at the program level. There are essentially five steps to calculate risk sharing:

1. Calculate the plan's Target Amount (TA).
2. Calculate the risk threshold amounts.
3. Calculate the Adjusted Allowable Risk Corridor Cost Amount (AARCCA).
4. Determine if the 60/60 rule applies (for years 2006 and 2007 only).
5. Determine where costs fall with respect to the thresholds and calculate payment adjustment.

Essentially, the purpose of the risk sharing reconciliation is to perform a comparison of the Target Amount, the total projected revenue necessary for the basic benefit (reduced for administrative costs) and the Adjusted Allowable Risk Corridor Cost Amount which represents actual costs that have been adjusted to determine if there is any risk sharing.

The risk sharing reconciliation uses the Direct Subsidy Amount (DSA), the Part D Basic Premium Amount (PA), the Administrative Cost Ratio (ACR), the Pace Cost Sharing Add-on Amount (PCAA), the Covered Part D Plan Paid Amount (CPPA), the Direct and Indirect Remuneration Amount (DIRRA), and the Induced Utilization Amount (IUR) from DDPS, MARx, and HPMS to calculate the interim values needed for the risk sharing reconciliation.

1. **The first step is to calculate the plan's Target Amount (TA).** The Direct Subsidy Amount and the Part D Basic Premium Amount are summed and then adjusted by the Administrative Cost Ratio to determine the TA, the first PRS calculated value used in the risk sharing calculations. For plan type 7, the Pace Cost-sharing Add-on Amount (PCAA) is added to that amount. For plan types 9 and 10, the Prospective Reinsurance Subsidy Amount (PRSA) is added. Note: The reconciliation calculations are using the Direct Subsidy as it relates to the risk adjusted standardized bid minus the beneficiary premium and the A/B rebates.

   $$TA = (DSA+PA) \times (1-ACR)$$

   For PRS plan type 7 (Dual Eligible PACE plan), then

   $$TA = (DSA+PA) \times (1-ACR) + PCAA$$

   For PRS plan type 9 or 10 (Flexible Capitated Payment Demonstration or Fixed Capitated Payment Demonstration), then

   $$TA = (DSA+PA) \times (1-ACR) + PRSA$$

2. **The second step is to calculate the risk corridor thresholds.** The Target Amount is multiplied by the threshold risk percentages (the First Upper Threshold Percent, Second Upper Threshold Percent, First Lower Threshold Percent, Second Lower Threshold Percent) provided by CMS to determine the First Upper Threshold Amount (FUTA), the Second Upper Threshold

Amount (SUTA), the First Lower Threshold Amount (FLTA), and the Second Lower Threshold Amount (SLTA).

$$FUTA = FUTP \times TA$$

$$SUTA = SUTP \times TA$$

$$FLTA = FLTP \times TA$$

$$SLTA = SLTP \times TA$$

3. **In the third step, the PRS calculates the Adjusted Allowable Risk Corridor Cost Amount (AARCCA).** The Actual Reinsurance Subsidy Amount (ARSA) and the Part D DIR Amount (DDIRA) are subtracted from the Covered Part D Plan Paid Amount (CPPA). This amount is adjusted by the Induced Utilization Ratio (IUR). Note: The Induced Utilization Ratio is set to 1 for all plans except EA plans. For EA plans, including payment demonstrations, the HPMS IUR value will be used which will be equal to or greater than 1.

$$AARCCA = (CPPA – ARSA – DDIRA)/IUR$$

4. **In the fourth step, the PRS determines if the 60/60 rule applies.** When the 60/60 rule is applicable, at least 60 percent of Part D plans subject to risk sharing have AARCCA above the First Upper Threshold Amount and those plans represent at least 60 percent of Part D enrollees. If the 60/60 rule is applicable and if CMS chooses to utilize it, then the government will increase the risk sharing percentage between the First Threshold Upper Limit and the Second Threshold Upper Limit from 75 percent to 90 percent. The 60/60 Rule Met Indicator in Field 27 on the Results Report will report Y for Yes or N for No to indicate whether the 60/60 rule applies.

    The Cost Over First Upper Threshold Indicator, Field 36 on the Results Report, denotes whether an individual plan's AARCCA is over the First Upper Threshold Amount. This field will report either a 0 for No or a 1 for Yes.

5. **In the last step, PRS determines where costs fall with respect to the thresholds and calculates payment adjustment.** The Adjusted Allowable Risk Corridor Costs are matched against the thresholds to determine where costs fall and to calculate the Risk Sharing Adjustment. The risk sharing rates (the First Upper Risk Sharing Rate, Second Upper Risk Sharing Rate, First Lower Risk Sharing Rate, Second Lower Risk Sharing Rate) are applied, as appropriate. The Risk Sharing Adjustment (RA) is the last calculated PRS value in the risk sharing reconciliation.

> If FUTA < AARCCA < or = SUTA then
> $$RA = FURSR \times (AARCCA – FUTA)$$
> If SUTA < AARCCA then
> $$RA = [FURSR \times (SUTA - FUTA)] + [SURSR \times (AARCCA - SUTA)]$$
> If FLTA > AARCCA > or = SLTA then
> $$RA = FLRSR \times (AARCCA - FLTA)$$
> If SLTA > AARCCA then

$$RA = [FLRSR \times (SLTA - FLTA)] + [SLRSR \times (AARCCA - SLTA)]$$
$$\text{If } FUTA > \text{ or } = AARCCA > \text{ or } = FLTA \text{ then}$$
$$RA = 0$$

On the PRS Reconciliation Results Report to Plans, there are two fields that indicate the contributions to the Risk Sharing Amount (RA), the Risk Sharing Portion from Costs Beyond the Second Limit, Field 42, and the Risk Sharing Portion from Costs Between the First and Second Limits, Field 43. The first field indicates the contribution to the Risk Sharing Amount from plan costs beyond either the Second Upper Threshold Amount or the Second Lower Threshold Amount. The second field indicates the contribution to the Risk Sharing Amount from plan costs between the First and Second Threshold Amounts. These fields are signed and will be used to show any positive contributions to risk sharing or negative contributions to risk sharing. Positive values and negative values in these fields are mutually exclusive. In other words, a plan will not have a positive value in one and a negative value in the other.

The Risk Sharing Amount is Field 41 on the PRS Reconciliation Results Report to Plans DET Record. This amount can be positive or negative.

The Final Reconciliation Payment Adjustment

The Adjustment Due to Payment Reconciliation Amount (ARA) is the last field found on the DET record of the PRS Reconciliation Results Report to Plans. This amount is the net reconciliation amount for the plan for the coverage year. The following fields identified in Table 8 are used to calculate the final reconciliation payment adjustment amount:

TABLE 8: PART D RECONCILIATION ADJUSTMENT AMOUNTS AND FIELD LOCATIONS

	Reconciliation Amounts	Results Report DET Record Field
	Low Income Cost-Sharing Subsidy Amount	Field 9
+	Reinsurance Subsidy Adjustment Amount	Field 18
+	Risk Sharing Amount	Field 41
−	Budget Neutrality Adjustment Amount (Demonstration Plans Only)	Field 46
=	Adjustment Due to Payment Reconciliation Amount	Field 47

The first three fields are critical for the plans because they represent the final reconciliation amounts for LICS, reinsurance, and risk sharing. The adjustment due to reconciliation amount is the total of the three reconciliations (LICS, reinsurance, and risk sharing/risk corridor) minus the Budget Neutrality Adjustment Amount (BNAA, Field 46). The BNAA applies only for demonstration plans and is the product of unique member per year (UMPY) and the Annual Budget Neutrality Dollar Amount (ABNDA).

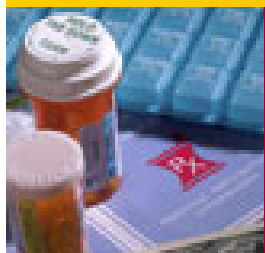$$ARA = LICSAA + RSAA + RA - BNAA$$

The ARA is summed to the contract-level for all plans in a contract. This value can be found in the CTR record in the Results Report. However, since the Part D payment reconciliation is conducted at the plan level, the Adjustment Due to Payment Reconciliation Amount (ARA) is calculated at the contract/PBP-level.

The Adjustment Due to Payment Reconciliation Amount is Field 47, the last field found on the DET record of the PRS Reconciliation Results Report to Plans. This amount can be positive or negative.

Prescription Drug Event Data Advanced

Operations

LTC, Inc.

PURPOSE

♦ To describe the most current Prescription Drug Event Data operations procedures

OBJECTIVES

♦ Review the PDE Submission process

♦ Describe NPI processing in DDPS

♦ Identify changes to DDPS edits

♦ Discuss how to resolve errors

PDE DATA FLOW

- Pharmacy/Provider submits a claim to plan.

- Plan submits PDE record to PDFS.

- PDFS performs front-end checks.

- File is submitted to DDPS.

- DDPS performs detail edits.

- The IDR sums LICS and calculates unadjusted reinsurance and risk corridor costs.

- PRS creates a beneficiary record and calculates reconciliation payment.

Pharmacy/Provider

TrOOP Facilitator

Plan

PDE Record

Prescription Drug Front-End System (PDFS)

- PDFS Response Report

Drug Data Processing System (DDPS)

- DDPS Return File
- DDPS Transaction Error Summary Report

Integrated Data Repository (IDR)

- Cumulative Beneficiary Summary Report
- P2P Reports

Payment Reconciliation System (PRS)

PDE RECORD REQUIRED DATA ELEMENTS

♦ A PDE record has 39 required data elements:

  ◊ 15 data elements from the National Council for Prescription Drug Programs (NCPDP) billing transaction

  ◊ 4 data elements from the NCPDP billing response transaction

  ◊ 20 data elements defined by CMS --- these data elements were added for the purposes of administering Part D

PDE RECORD FIELDS

NEW

FIELD NO	FIELD NAME	POSITIONS	VALUE
39	Estimated Rebate at Point of Sale	291-298	The amount of the rebate passed through to the pharmacy.
40	Vaccine Administration Fee	299-306	Amount the plan paid for administering a vaccination.

WHAT IS NPI?

National Provider Identifier (NPI) is a federally mandated unique 10-digit "intelligence free" number issued to healthcare providers who conduct standard electronic healthcare transactions.

WHY IS NPI IMPORTANT?

♦ NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions by covered entities

♦ Simpler electronic transmission of HIPAA standard transactions

♦ More efficient coordination of benefit transactions

IMPORTANT NPI DATES

♦ January 23, 2004 Final Rule issued for NPI as standard unique identifier

♦ May 23, 2007 NPI Compliance Date

♦ May 23, 2008 Small Plan NPI Compliance Date

12-MONTH GRACE PERIOD

- ♦ Begins May 23, 2007 and ends May 23, 2008.

- ♦ No civil money penalties for Plans with contingency plans.

- ♦ Plans must demonstrate outreach/ testing efforts and continue processing of payments to providers.

- ♦ Plans may end its contingency plan prior to May 23, 2008.

SUBMISSION REQUIREMENTS – SERVICE PROVIDER IDENTIFICATION FIELD

♦ *If* original claim was submitted with NPI, *then* the Plan must submit with NPI.

♦ *If* original claim was submitted with NCPDP ID, but has been reversed, rebilled, or adjusted using the NPI, *then* the Plan can submit all PDEs related to the claim with the NCPDP ID or NPI.

Standard Format PDEs

♦ *If* the plan receives an NPI, *then* the plan must populate the Prescriber ID field with NPI.

♦ *If* the plan does not receive an NPI, *then* the plan must populate the Prescriber ID field with one of the acceptable alternate Prescriber IDs.

Non-Standard Format PDEs

♦ *If* plan receives a Prescriber ID, *then* the plan should populate the Prescriber ID field.

♦ *If* the plan does not receive a Prescriber ID, *then* the plan is not required to populate this field since it remains an optional data element for non-standard submissions.

DDPS IMPLEMENTATION OF NPI

Pharmacy/Provider

TrOOP Facilitator

Plan

PDE Record

Prescription Drug Front-End System (PDFS)
- PDFS Response Report

Drug Data Processing System (DDPS)
- DDPS Return File
- DDPS Transaction Error Summary Report

Integrated Data Repository (IDR)
- Cumulative Beneficiary Summary Report
- P2P Reports

Payment Reconciliation System (PRS)

Processing of NPI include:

♦ Look-up/Translate NPI

♦ Perform validity check

♦ Conduct duplicate checks

♦ Perform edit checks for adjustments/deletions

♦ Provide Alternate Service Provider ID and Alternate Service Provider ID Qualifier to Return File

NPI LOOK-UP/TRANSLATION

	If	Then
Standard	NPI is submitted and successfully translated	DDPS will use NCPDP ID for duplicate checks
Standard	NCPDP ID is submitted and successful	DDPS will use NCPDP ID for duplicate checking
Non-Standard	NPI is submitted and does not crosswalk to NCPDP ID	DDPS will perform duplicate check using NPI
Non-Standard	NCPDP ID is submitted	DDPS will perform duplicate check using NCPDP ID

NPI VALIDATION

When a NPI or NCPDP ID submitted does not crosswalk to NCPDP ID, DDPS performs the validation function.

◊ A check digit algorithm indicates the status of the attempted match and is applied based on the submission method.

❖ Standard PDEs

❖ Non-standard PDEs

STANDARD VERSUS NON-STANDARD

Standard Format Validity Check

Provider Identifier Submitted	On Provider Table	Check Algorithm Status	Edit Returned
NCPDP	No	Pass	781
NPI	No	Pass	781
NCPDP	No	Fail	615
NPI	No	Fail	615

STANDARD VERSUS NON-STANDARD (CONTINUED)

Non-standard Format Validity Check

Provider Identifier Submitted	On Provider Table	Check Algorithm Status	Edit Returned
NCPDP	No	Pass	781
NCPDP	No	Fail	615
NPI	No	Pass	None
NPI	No	Fail	615

DUPLICATE CHECK LOGIC

♦ Once DDPS completes its look up and validation functions the data is then reviewed for duplicate checking.

♦ The duplicate check logic will be modified to perform as follows:

◊ When NCPDP ID is submitted, DDPS will use NCPDP ID for duplicate checking.

◊ When NPI is submitted and is successfully translated to NCPDP ID, DDPS will use the NCPDP ID for duplicate checking.

◊ If PDE is non-standard format, NPI is submitted, and NPI does not crosswalk to NCPDP ID, then DDPS will perform duplicate check using NPIs.

PERFORM ADJUSTMENT/DELETION EDIT CHECK LOGIC

Edit	Edit Description	Modification to Edit to Accommodate NPI
615	"Service Provider ID is missing."	♦ "Service Provider ID is missing or invalid." ♦ Validity checks added.
781	"Service Provider ID is not on master provider file."	♦ Applies to both NCPDP ID and NPI.
661 662 663	Adjustment/Deletion logic	♦ No change in edit message text. ♦ Added cross-reference check on Service Provider ID Qualifier and Service Provider ID on incoming and existing PDEs.

ADD ALTERNATE SERVICE PROVIDER ID AND QUALIFIER TO RETURN FILE

♦ A successful crosswalk of a submitted NPI to NCPDP ID will return the following on the PDE Return File:

◊ "07" in the Alternate Service Provider ID Qualifier field

◊ The associated NCPDP ID in the Alternate Service Provider ID field

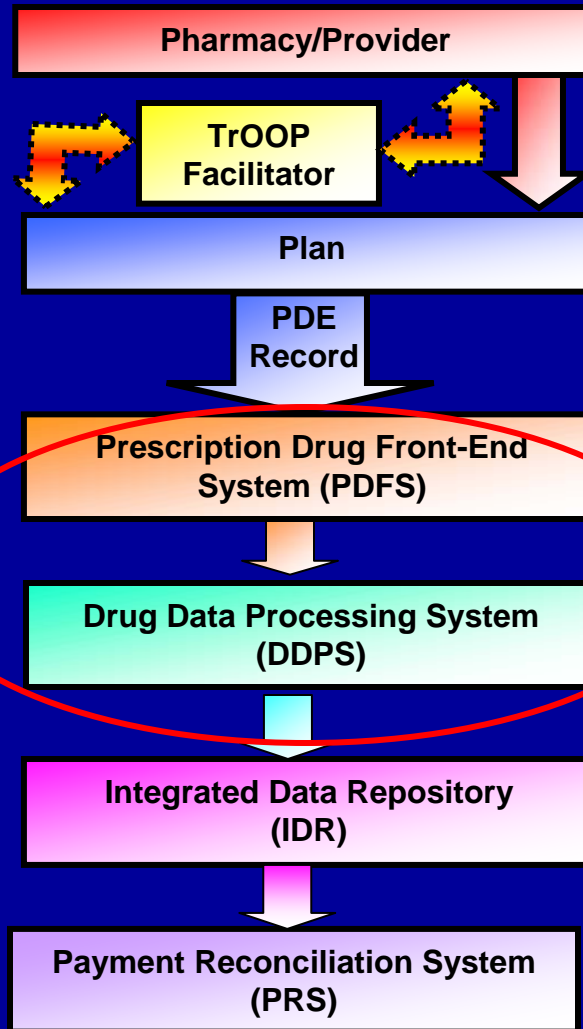♦ A valid NCPDP ID submitted on a PDE will return the following on the PDE Return File, if it successfully maps to an NPI:

◊ "01" is the Alternate Service Provider ID Qualifier field

◊ The associated NPI will be populated in the Alternate Service Provider ID field

Workbook Scenario 1

EDIT PROCESS

Pharmacy/Provider

TrOOP Facilitator

Plan

PDE Record

Prescription Drug Front-End System (PDFS)

Drug Data Processing System (DDPS)

Integrated Data Repository (IDR)

Payment Reconciliation System (PRS)

PDFS EDIT LOGIC AND RANGES

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

DDPS EDITING RULES

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

EDIT RANGES AND CATEGORIES

Range	Edit Category
603-659	Missing/Invalid
660-669	Adjustment or Deletion
670-689	Catastrophic Coverage Code
690-699	Cost
700-714	Eligibility
715-734	LICS
735-754	NDC
755-774	Drug Coverage Status Code
775-799 900-999	Miscellaneous
851-855	Update Codes

BYPASSED EDITS

Edit	Descriptions	Period of Bypass
736	DOS < NDC Effective Date	indefinitely
782	Record had no error, but was submitted as part of a rejected batch with 100 or more records. DDPS rejects batches with error rates exceeding 50%.	indefinitely

CONDITIONAL EDITS

Edit	Descriptions	Condition
704	DOS cannot be greater than the DOD plus 32 days.	Bypassed if DOS is within 32 days of the DOD.
715	Dollars reported in LICS are greater than zero. However, beneficiary is not eligible for LICS.	Bypassed for 2006. Applies to DOS 2007 and beyond.
783	Service Provider ID was not an active pharmacy on DOS.	Bypassed currently for 2006 only.

NEW EDITS

Edit	Descriptions
642	State-to-Plan PDEs are not allowed with DOS after March 31, 2006. (Effective December 2006)
643	State-to-Plan PDEs are not allowed with non-covered drugs. (Effective December 2006)
644	Service Provider ID Qualifier must be '07' for State-to-Plan PDEs. (Effective December 2006)
645	Service Provider ID '5300378' allowed only for State-to-Plan PDEs. (Effective December 2006)
712	Submitting Contract was not prior Contract of Record. (Effective May 2007) [INF]
713	The Submitting Contract/PBP does not offer Part D on DOS. (Effective December 2006)

NEW EDITS (CONTINUED)

Edit	Descriptions
714	The DOS is greater than the Date of Death (DOD), but is within the 32 day allowable margin. (Effective May 2007) [INF]
722	Dollars reported in LICS are greater than zero. However, beneficiary is not eligible for LICS subsidy in CMS systems. (Applies to covered drugs with DOS in 2006) [INF]
762	If Drug Coverage Status Code is "E", the contract type must be Enhanced Alternative. (Effective November 2006)
784	Duplicate PDE record, originally submitted by a different contract. (Effective November 2006)
998	Internal CMS issue regarding Contract/PBP of Record encountered. (Effective December 2006)

ERROR RESOLUTION 600 EDITS

Range	Resolution
603-659	1. Check formatting. Certain fields require specific format. 2. Correct the data issue and resubmit.
660-669	1. Determine if original PDE was saved/active. 2. Confirm all nine fields match the original PDE. 3. Correct inconsistency and resubmit, if necessary.
670-689	1. Determine the cause of the inconsistency. 2. Correct the issue and resubmit.
690-699	1. Determine the cause of the inconsistency. 2. Correct the issue and resubmit.

Workbook Scenario 2-6

RESOLUTION PROCESS
(CONTINUED)

Plans can ask the following questions:

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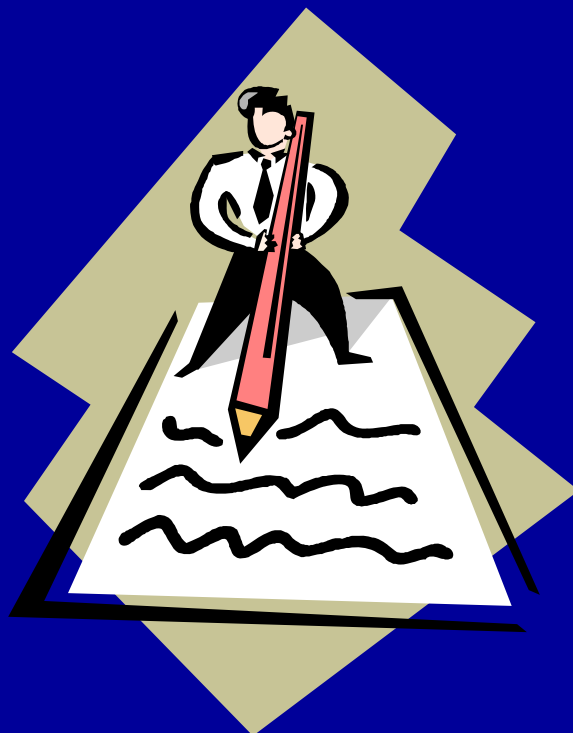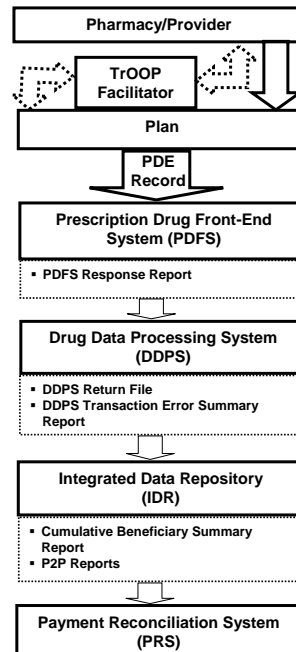- ♦ Could system enhancements, such as better user prompts, minimize high volume recurring errors?

SUMMARY

♦ Reviewed the PDE Submission process

♦ Described NPI processing in DDPS

♦ Identified changes to DDPS edits

♦ Discussed how to resolve errors

EVALUATION

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

**Prescription Drug Event Data
Advanced**

Operations

LTC, Inc.

PURPOSE

♦ To describe the most current
Prescription Drug Event Data
operations procedures

1

OBJECTIVES

♦ Review the PDE Submission process

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Pharmacy/Provider

TrOOP Facilitator

Plan

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LTC

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♦ Simpler electronic transmission of HIPAA standard transactions

♦ More efficient coordination of benefit transactions

LTC

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♦ *If* original claim was submitted with NCPDP ID, but has been reversed, rebilled, or adjusted using the NPI, *then* the Plan can submit all PDEs related to the claim with the NCPDP ID or NPI.

SUBMISSION REQUIREMENTS – PRESCRIBER IDENTIFICATION FIELD

Standard Format PDEs

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SUBMISSION REQUIREMENTS – PRESCRIBER IDENTIFICATION FIELD (CONTINUED)

Non-Standard Format PDEs

♦ *If* plan receives a Prescriber ID, *then* the plan should populate the Prescriber ID field.

♦ *If* the plan does not receive a Prescriber ID, *then* the plan is not required to populate this field since it remains an optional data element for non-standard submissions.

DDPS IMPLEMENTATION OF NPI

Pharmacy/Provider

TrOOP Facilitator

Plan

PDE Record

Prescription Drug Front-End System (PDFS)
- PDFS Response Report

Drug Data Processing System (DDPS)
- DDPS Return File
- DDPS Transaction Error Summary Report

Integrated Data Repository (IDR)
- Cumulative Beneficiary Summary Report
- P2P Reports

Payment Reconciliation System (PRS)

Processing of NPI include:

♦ Look-up/Translate NPI

♦ Perform validity check

♦ Conduct duplicate checks

♦ Perform edit checks for adjustments/deletions

♦ Provide Alternate Service Provider ID and Alternate Service Provider ID Qualifier to Return File

NPI LOOK-UP/TRANSLATION

	If	Then
Standard	NPI is submitted and successfully translated	DDPS will use NCPDP ID for duplicate checks
	NCPDP ID is submitted and successful	DDPS will use NCPDP ID for duplicate checking
Non-Standard	NPI is submitted and does not crosswalk to NCPDP ID	DDPS will perform duplicate check using NPI
	NCPDP ID is submitted	DDPS will perform duplicate check using NCPDP ID

NPI VALIDATION

When a NPI or NCPDP ID submitted does not crosswalk to NCPDP ID, DDPS performs the validation function.

◊ A check digit algorithm indicates the status of the attempted match and is applied based on the submission method.

❖ Standard PDEs
❖ Non-standard PDEs

STANDARD VERSUS NON-STANDARD

Standard Format Validity Check

Provider Identifier Submitted	On Provider Table	Check Algorithm Status	Edit Returned
NCPDP	No	Pass	781
NPI	No	Pass	781
NCPDP	No	Fail	615
NPI	No	Fail	615

STANDARD VERSUS NON-STANDARD (CONTINUED)

Non-standard Format Validity Check

Provider Identifier Submitted	On Provider Table	Check Algorithm Status	Edit Returned
NCPDP	No	Pass	781
NCPDP	No	Fail	615
NPI	No	Pass	None
NPI	No	Fail	615

DUPLICATE CHECK LOGIC

♦ Once DDPS completes its look up and validation functions the data is then reviewed for duplicate checking.

♦ The duplicate check logic will be modified to perform as follows:

◊ When NCPDP ID is submitted, DDPS will use NCPDP ID for duplicate checking.

◊ When NPI is submitted and is successfully translated to NCPDP ID, DDPS will use the NCPDP ID for duplicate checking.

◊ If PDE is non-standard format, NPI is submitted, and NPI does not crosswalk to NCPDP ID, then DDPS will perform duplicate check using NPIs.

PERFORM ADJUSTMENT/DELETION EDIT CHECK LOGIC

Edit	Edit Description	Modification to Edit to Accommodate NPI
615	"Service Provider ID is missing."	♦ "Service Provider ID is missing or invalid." ♦ Validity checks added.
781	"Service Provider ID is not on master provider file."	♦ Applies to both NCPDP ID and NPI.
661 662 663	Adjustment/Deletion logic	♦ No change in edit message text. ♦ Added cross-reference check on Service Provider ID Qualifier and Service Provider ID on incoming and existing PDEs.

ADD ALTERNATE SERVICE PROVIDER ID AND QUALIFIER TO RETURN FILE

♦ A successful crosswalk of a submitted NPI to NCPDP ID will return the following on the PDE Return File:

◊ "07" in the Alternate Service Provider ID Qualifier field

◊ The associated NCPDP ID in the Alternate Service Provider ID field

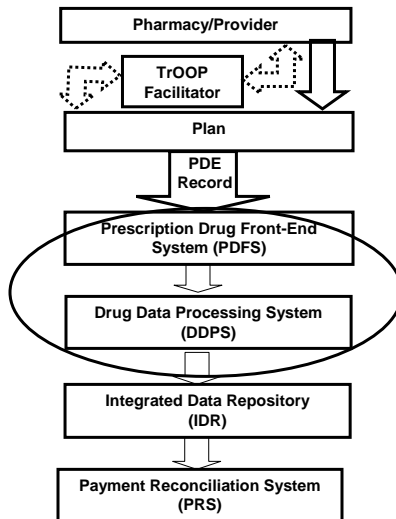## ADD ALTERNATE SERVICE PROVIDER ID AND QUALIFIER TO RETURN FILE (CONTINUED)

♦ A valid NCPDP ID submitted on a PDE will return the following on the PDE Return File, if it successfully maps to an NPI:

◊ "01" is the Alternate Service Provider ID Qualifier field

◊ The associated NPI will be populated in the Alternate Service Provider ID field

Workbook Scenario 1

EDIT PROCESS

```
┌─────────────────────────┐
│    Pharmacy/Provider     │
└─────────────────────────┘
        ┌──────────────┐
        │    TrOOP     │
        │  Facilitator │
        └──────────────┘
┌─────────────────────────┐
│          Plan           │
└─────────────────────────┘
        ┌──────────────┐
        │     PDE      │
        │    Record    │
        └──────────────┘
┌─────────────────────────────────┐
│ Prescription Drug Front-End      │
│       System (PDFS)              │
└─────────────────────────────────┘

┌─────────────────────────────────┐
│  Drug Data Processing System     │
│            (DDPS)                │
└─────────────────────────────────┘

┌─────────────────────────────────┐
│  Integrated Data Repository      │
│            (IDR)                 │
└─────────────────────────────────┘

┌─────────────────────────────────┐
│ Payment Reconciliation System    │
│            (PRS)                 │
└─────────────────────────────────┘
```

PDFS EDIT LOGIC AND RANGES

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

DDPS EDITING RULES

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

EDIT RANGES AND CATEGORIES

Range	Edit Category
603-659	Missing/Invalid
660-669	Adjustment or Deletion
670-689	Catastrophic Coverage Code
690-699	Cost
700-714	Eligibility
715-734	LICS
735-754	NDC
755-774	Drug Coverage Status Code
775-799 900-999	Miscellaneous
851-855	Update Codes

BYPASSED EDITS

Edit	Descriptions	Period of Bypass
736	DOS < NDC Effective Date	indefinitely
782	Record had no error, but was submitted as part of a rejected batch with 100 or more records. DDPS rejects batches with error rates exceeding 50%.	indefinitely

CONDITIONAL EDITS

Edit	Descriptions	Condition
704	DOS cannot be greater than the DOD plus 32 days.	Bypassed if DOS is within 32 days of the DOD.
715	Dollars reported in LICS are greater than zero. However, beneficiary is not eligible for LICS.	Bypassed for 2006. Applies to DOS 2007 and beyond.
783	Service Provider ID was not an active pharmacy on DOS.	Bypassed currently for 2006 only.

NEW EDITS

Edit	Descriptions
642	State-to-Plan PDEs are not allowed with DOS after March 31, 2006. (Effective December 2006)
643	State-to-Plan PDEs are not allowed with non-covered drugs. (Effective December 2006)
644	Service Provider ID Qualifier must be '07' for State-to-Plan PDEs. (Effective December 2006)
645	Service Provider ID '5300378' allowed only for State-to-Plan PDEs. (Effective December 2006)
712	Submitting Contract was not prior Contract of Record. (Effective May 2007) [INF]
713	The Submitting Contract/PBP does not offer Part D on DOS. (Effective December 2006)

NEW EDITS (CONTINUED)

Edit	Descriptions
714	The DOS is greater than the Date of Death (DOD), but is within the 32 day allowable margin. (Effective May 2007) [INF]
722	Dollars reported in LICS are greater than zero. However, beneficiary is not eligible for LICS subsidy in CMS systems. (Applies to covered drugs with DOS in 2006) [INF]
762	If Drug Coverage Status Code is "E", the contract type must be Enhanced Alternative. (Effective November 2006)
784	Duplicate PDE record, originally submitted by a different contract. (Effective November 2006)
998	Internal CMS issue regarding Contract/PBP of Record encountered. (Effective December 2006)

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ERROR RESOLUTION
600 EDITS

Range	Resolution
603-659	1. Check formatting. Certain fields require specific format. 2. Correct the data issue and resubmit.
660-669	1. Determine if original PDE was saved/active. 2. Confirm all nine fields match the original PDE. 3. Correct inconsistency and resubmit, if necessary.
670-689	1. Determine the cause of the inconsistency. 2. Correct the issue and resubmit.
690-699	1. Determine the cause of the inconsistency. 2. Correct the issue and resubmit.

Workbook Scenario 2-6

RESOLUTION PROCESS
(CONTINUED)

Plans can ask the following questions:

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

SUMMARY

♦ Reviewed the PDE Submission process

♦ Described NPI processing in DDPS

♦ Identified changes to DDPS edits

♦ Discussed how to resolve errors

EVALUATION

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

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

LTC

LEADING THROUGH CHANGE

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Scenario 1

Pleasant Pharmacy notified May Health Plan that Sue Brown failed to pick up her prescription. According to the plan's reports the PDE was successfully submitted using the standard format with Pleasant Pharmacy's NCPDP ID number. Pleasant Pharmacy has now been assigned an NPI. May Health Plan submits a deletion PDE to reverse the claim, again using the standard format.

Scenario 2

May Health Plan submitted a file with 35 PDE records. On record 27, the sum of the GDCA and GDCB equaled $75 and the sum of the Ingredient Cost, Dispensing Fee, and Sales Tax equaled $70. This caused a 600-level error.

Scenario 3

Avery Health Plan submitted a file with 47 PDE records. On record 7, the plan received an error because the date of service was 38 days after date of death. This caused a 700-level error.

Scenario 4

Park Health Plan submitted a file and received an error on record 13 of 20 that were submitted. The error indicated the beneficiary was not enrolled in the PBP for this contract on the date of service. This caused a 700-level error.

Scenario 5

Blue-sky Health Plan received a 700-level error on record 43 of 67 in a submitted file. The error was because the beneficiary liability exceeded the statutorily defined maximum for Category 4 LICS beneficiary, as defined by MBD.

Scenario 6

Vertical Health Plan submitted a file and received a 700-level error on record 5 of 20 that were submitted. The error indicated the drug is always excluded from Part D because it is always covered by Part B.

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

DATE: April 16, 2007

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

FROM: Thomas Hutchinson
              Director, Medicare Plan Payment Group

SUBJECT: National Provider Identifier (NPI) Implementation for Prescription Drug Events
              (PDEs)

The attached instructions detail the operational implementation of NPI in the Drug Data
Processing System (DDPS), as well as Part D sponsor requirements for NPI submission of NPI
on PDEs. CMS anticipates that the new NPI process will go live in DDPS by May 15. The
implementation will be announced through the Customer Service and Support Center email
distribution when the precise date is known.
If you have any questions regarding this process please contact sandra.anderson@cms.hhs.gov.

National Provider Identifier (NPI) Implementation and Drug Data Processing System (DDPS)

CMS has recently issued contingency guidance for National Provider Identifier implementation. This contingency guidance provides that, for a period of 12 months after the NPI Rule compliance date of May 23, 2007, CMS will not impose civil money penalties on covered entities that deploy contingency plans, including (in order to ensure the smooth flow of payments) continuing to use and accept legacy identifiers on HIPAA transactions, if they have made reasonable and diligent efforts to become compliant and, in the case of health plans (that are not small health plans), in order to facilitate the compliance of their trading partners.

CMS remains committed to implement NPI processing in DDPS to support plans as they work with trading partners to achieve compliance during the contingency period. These instructions lay out the processing that CMS will utilize and the plan requirements for submission of NPI.

Submission requirements

Service Provider ID

CMS requires that plans submit the NPI when it is received on an original claim. Plans may submit NPI on a claim that was originally submitted under NCPDP but has since been reversed/rebilled or adjusted using NPI. However, CMS is leaving this decision to the plan. If a pharmacy reverses/rebills or adjusts in any way a claim that was originally submitted with NCPDP as the service provider identifier, NCPDP may be submitted on all PDEs related to that claim, even if any reversals/rebills or adjustments to that claim are done using NPI. CMS also allows plans to submit NCPDP IDs when that is the only ID that the pharmacy submitted for claims after May 23.

Prescriber ID

CMS again requires that plans submit the NPI as prescriber ID when NPI is submitted. Even if NPI is not on the original claim, prescriber ID remains a required field on standard format PDEs, and one of the acceptable alternate prescriber IDs must be submitted. For non-standard format PDEs, prescriber ID should be submitted when received but remains an optional data element.

DDPS processing of NPIs

DDPS will provide new functionality on or around May 1 in order to handle the NPI for all core system processes. The objective of the DDPS implementation of NPI is to apply consistent rules across all PDE transactions regardless of whether NPI or NCPDP ID is submitted. Current DDPS processing treats NPIs and NCPDP IDs as distinct identifiers, and does not crosswalk between the two identification systems. When the new process is implemented, CMS will use the NCPDP to NPI crosswalk from the NCPDP version 2.1 file to map NPIs to NCPDP numbers. The new process will work as follows:

o DDPS will translate all NPI numbers to NCPDP numbers prior to performing duplicate checking and adjustment/deletion logic. Note that for non-standard format claims, the NPI may not relate to a specific NCPDP ID. Until DDPS has a full NPI roster (including NPIs that have no associated NCPDP ID), special processing rules (outlined below) will apply to NPIs on non-standard format PDEs that do not successfully crosswalk to NCPDP.

o The duplicate check logic will be modified to perform as follows:
  - When NCPDP is submitted, always use NCPDP ID for duplicate checking.
  - When NPI is submitted and is successfully translated to NCPDP ID, again use the NCPDP ID for duplicate checks.
  - If PDE is non-standard format, NPI is submitted, and NPI does not crosswalk to NCPDP ID, then perform duplicate check using NPIs.
o Modify Edit 615: Modify the Edit message from "The Service Provider ID is missing" to "The Service Provider ID is missing or invalid". Validity checks will be added for both NPIs and NCPDP IDs that do not match our reference table.
o Modify Adjustment/Deletion logic for existing Edits 661, 662, and 663: add cross-reference check on Service Provider ID Qualifier and Service Provider Identifier between the incoming and existing PDE using '07' for qualifier and NCPDP number for all checks where possible. As with duplicate checking, the only time NPI shall be used for adjustment/deletion logic is on a non-standard format PDE with NPI as the service provider ID, when that NPI does not translate successfully to an NCPDP ID.
o When performing the service provider ID look-up function and associated editing, DDPS will modify program logic to include look-up for NPI and add Check Digit algorithms to PDE Edit programs for both, NCPDP Provider Number and NPI validation.
  o **The following will occur for Standard PDES:**
    o When the NCPDP or NPI number is not on the Provider table and the provider number provided on the PDE passes the Check Digit algorithm, edit 781 will be returned.
    o When the NCPDP or NPI number is not on the Provider table and the provider number provided on the PDE fails the Check Digit algorithm, edit 615 will be returned.
  o **The following will occur for Non-Standard PDES:**
    o If NCPDP number is provided, edit the same as for standard format PDEs. The number must be on the NCPDP table; if it is not present, generate the 615 or 781 as appropriate.
    o When the NPI number is not on the Provider table and the provider number provided on the PDE passes the Check Digit algorithm, the PDE will be accepted.
    o When the NPI number is not on the Provider table and the provider number provided on the PDE fails the Check Digit algorithm, edit 615 will be returned.
o Add Alternate Service Provider ID and Alternate Service Provider ID Qualifier to the PDE Return file. When NPI is submitted and successfully crosswalks to an NCPDP ID, 07 will be the alternate service provider ID qualifier and the associated NCPDP ID will be the alternate service provider ID. When a valid NCPDP ID is submitted, 01 will be returned as the alternate service provider ID qualifier and the associated NPI will be in the alternate service provider ID. These numbers are being provided to assist plans in understanding our duplicate check and adjustment/deletion logic as applied to each PDE.

DDPS Error Resolution

Error Code	Error Message	Description	Resolution
603-659	Various Messages identifying missing or invalid values	Identifies invalid or missing values. If blank is an allowed value, the missing edit does not apply.	Check formatting – certain fields require specific format. Rule out illegal values - for example, legal values for gender are 1 or 2 (not 0, M or F). Omit Optional fields – 605 (DOB) is optional for all Plans; 610 (Paid Date) is optional for all plans except Fallback plans. Correct the data issue and resubmit.
660-669	Various Messages for adjustment/deletion issues	Adjustment/deletion code inconsistent with stored data. Edits in a hierarchy using nine fields (Contract number, PBP ID, HICN, Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status)	General Resolution - Correct inconsistency and resubmit if necessary. All nine fields must match the existing PDE record. Also, determine if an original has already been accepted and confirm that the Adjustment/Deletion Code on the submitted PDE is correct.
			662 - Data is already deleted and no further action is required. 663 – Confirm that Dispensing Status is reported correctly. Dispensing Status is the only field that edit 663 questions.
670-689	Various messages with errors for PDEs with Catastrophic Coverage Code	Edits that test the relationship between Catastrophic Coverage Code and the summary cost fields for GDCB and GDCA, so that allowable reinsurance costs are summed correctly. (Applies only to PDEs for Part D Covered Drugs)	Confirm that the drug is correctly reported as a Part D Covered Drug. Determine the cause of the inconsistency, correct, and resubmit.
690-699	Various messages with errors between cost and payment fields	Cost edits perform basic accounting functions to confirm that 1.) the summary cost fields and the detail cost fields balance and that 2.) the detail cost fields and payment fields balance. The summary cost field for GDCA is used to sum allowable reinsurance cost fields. Note that cost edits allow a $.05 rounding error.	Confirm that Dispensing Status is reported correctly. 690 excludes Dispensing Status = 'C' (i.e. completion of partial fill) 692 applies exclusively to Dispensing Status = ' ' (i.e. regular fill) 693 applies exclusively to Dispensing Status = 'P' (i.e. Partial Fills.) 691 – Confirm that the drug is correctly reported as a Part D Covered Drug. Determine the cause of the inconsistency, correct, and resubmit.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
700-714	Various messages related to Eligibility Edits	Eligibility Edits verify the HICN and the beneficiary's eligibility for Part D.	General Resolution – compare submitted Eligibility data to Eligibility data within CMS database. Correct discrepancy and resubmit.
			700 - Determine if HICN is correct for the beneficiary with the claim (husband and wife often have same claim account number with different beneficiary identification code at the end). If the plan's processor administers Medicare and Commercial products confirm that Part D eligibility files are used for Part D claims administration and PDE reporting. 701 – DOB discrepancy. 1. Do not submit DOB. DOB is an optional field. 2. If submitting DOB, update DOB on PDE to the DOB on the CMS files.
			702 – Gender discrepancy. Determine if HICN is correct for the beneficiary with the claim (husband and wife often have same claim account number with different beneficiary identification code at the end). If correct, update gender to match CMS files; if incorrect, correct the HICN.
			704 - DOS > DOD by more than 32 days. This error cannot generally be corrected. If DOD is incorrect on CMS files, beneficiary will need to work with Social Security Administration to update their Master Beneficiary Record.
			705 – Beneficiary must be enrolled in Part D on DOS. Research TRRs and determine if enrollment transaction failed to process successfully at CMS, or if a disenrollment TRC was missed, and take appropriate action.
			706 – DOS does not fall in valid P2P Period. Beneficiary must be enrolled in this Contract on DOS. As with 705, research TRRs and determine if enrollment transaction failed to process successfully at CMS and take appropriate action.
			707 – Beneficiary must be enrolled in this Part D Plan Benefit Package on the DOS. Compare the PBP reported on the PDE and PBP reported in enrollment and resubmit with correct PBP. If PBP is correct on PDE and incorrect on CMS databases, submit 71 transaction to correct the PBP. 713 – Confirm that contract and PBP number were active on the DOS.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
715-734	Various messages related to Low Income Cost-Sharing Subsidy (LICS)	LICS edit 715 confirms that CMS documents the beneficiary's LICS status. LICS edits 716-718 and 720-721 are excessive cost-sharing edits. They validate that beneficiary cost-sharing never exceeds statutorily defined maximum amounts. Edits 717 and 718 test pre-catastrophic LI cost-sharing. Edits 720 and 721 test catastrophic LI cost-sharing. Edit 716 applies to both pre-catastrophic and catastrophic cost-sharing. LICS edits apply to Part D Covered Drugs only. Dollars reported in LICS are used to reconcile LICS.	715 – Dollars reported in LICS are greater than 0; beneficiary is not eligible for LICS. If plan has used best available information policy and updated beneficiary status, work with CMS to correct CMS status. If plan has not followed the proper policy, LICS must be converted to patient pay, and payment recovery policies at plan must be implemented.
			716-718, 720-721 – Plan cost-sharing was less generous than the level set by CMS. Plan should correct LICS levels in their system, refund the beneficiary for excessive cost-sharing, and resubmit PDE with correct LICS cost-sharing amount.
735-754	Various messages related to NDC	NDC edits confirm that an NDC exists. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered drugs are excluded from TrOOP, LICS, and payment calculations.	735 – The NDC code is invalid. The NDC code does not match a valid code on the NDC database. If plan believes this edit was generated in error, report NDC to CSSC.
			737 – Inappropriate Drug Coverage. Drug Coverage Status Code is not "O" although the drug is on the OTC list. If plan believes this edit was generated in error, report the NDC to CSSC. Edit 737 excludes supplies used for insulin administration; they must be submitted with Drug Coverage Status Code = 'C'.
			738 – Inappropriate Drug Coverage. Drug Coverage Status Code is 'C' although the drug is on the exclusion list. If plan believes this edit was generated in error, report the NDC to CSSC.
			740 - NDC is DESI drug. If plan believes this edit was generated in error, report the NDC to CSSC.
			741 - The drug is always excluded from Part D; the drug is always covered by Part B. If plan believes this edit was generated in error, report the NDC to CSSC.

DDPS Error Resolution (continued)

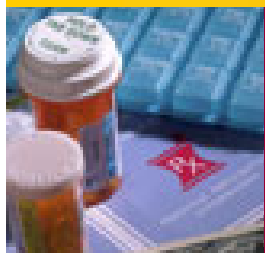| Error Code	Error Message	Description	Resolution
755-774	Various edit messages related to Drug Coverage Status Code	Edits that test the relationship between non-covered drugs, the Catastrophic Coverage Code field, and dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, and payment calculations.	Plans should evaluate the PDE. Confirm that Drug Coverage Status Code is reported correctly. Certain fields should not be populated when the drug coverage status code is "E" or "O". Correct the discrepancy and resubmit data.
775-799, 900-999	Various messages on miscellaneous data elements	Edits on Miscellaneous data elements.	777 – Duplicate PDE records have the same values in the following seven fields: HICN, Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status. Edit 777 identifies two types of dupes. When duplicates are submitted within the same file, all duplicate records are rejected. If this occurs, the plan must resubmit a single PDE; if that PDE passes all other editing it will be accepted. In the second case, a newly submitted PDE that is being edited duplicates a saved PDE. If this occurs, the new PDE fails editing and is rejected. There is no further action if the plan sent the duplicate in error. However, if the plan intended to modify the saved PDE it should change the Adjustment/Deletion Code on the rejected PDE and resubmit.
			779 - Submitting Plan cannot report NPP for Covered Part D Drug. Plan should confirm plan type; plans shall only map CPP/NPP for Enhanced Alternative plans or plans that were told to submit as Enhanced Alternative (e.g., employer plans, payment demonstrations).
			781 – Service Provider ID is not on master provider file. If plan believes this edit was generated in error, report the provider ID number to CSSC.
			783 – Service Provider ID was not an active pharmacy on DOS. CMS is preparing to bypass this edit for 2006, while refining it for 2007 to eliminate circumstances where the edit triggers inappropriately.
			784 – Duplicate PDE Record, originally submitted by a different Contract. CMS has created this edit to provide information on the original submitting contract. The contract that receives this edit must contact the original submitting contract to determine how to resolve. If pharmacy billed multiple contracts, one of the plans must reverse the claim. If the original submitting contract reversed the claim to the pharmacy previously and failed to submit a deletion PDE, the original submitting contract must submit a deletion PDE; then the contract that received the 784 reject can resubmit.

DDPS Error Resolution (continued)

Error Code	Error Message	Description	Resolution
775-799, 900-999 (continued)			999 – Internal CMS system issue encountered. This edit code triggers when the enrollment databases have inconsistent information, preventing PDEs from processing. Most cases have been resolved. If this code was triggered, allow several weeks for data to be updated and resubmit PDEs.

Prescription Drug Event Data Advanced

Calculating and Reporting Complex Examples

LTC, Inc.

PURPOSE

♦ Provide participants with a review of more complex calculations for reporting data on PDE records

OBJECTIVES

♦ Review the rules and guidelines for calculating and reporting Part D data on PDE records

♦ Apply the calculating and reporting rules and guidelines to advanced calculation examples

WHAT ARE ESTIMATED REBATES AT POINT OF SALE?

♦ Discounts in the negotiated prices of covered Part D drugs made available to beneficiaries at the point of sale at network pharmacies.

♦ The rebates serve to reduce the negotiated price and, thus the gross drug cost reported to CMS.

Reporting Rebates Applies to the Point-of-Sale Price

Guidance Released May 2007

APPLYING ESTIMATED REBATES AT POINT OF SALE (POS)

The reduced negotiated price and gross drug cost must be used consistently to:

1. Calculate beneficiary cost-sharing
2. Accumulate gross covered drug costs and advance the beneficiary through the benefit
3. Calculate true out-of-pocket costs (TrOOP)
4. Report drug costs on the PDE record
5. Determine the low-income cost sharing subsidy amounts reported to CMS
6. Develop the Part D bid

APPLYING ESTIMATED REBATES AT POINT OF SALE (POS) (CONTINUED)

28	INGREDIENT COST PAID	506-F6	203 – 210	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
29	DISPENSING FEE PAID	507-F7	211 – 218	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
30	AMOUNT ATTRIBUTED TO SALES TAX		219 – 226	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
31	GDCB		227 – 234	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
32	GDCA		235 – 242	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
33	PATIENT PAY AMOUNT	505-F5	243 – 250	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
34	OTHER TrOOP AMOUNT		251 – 258	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
35	LICS AMOUNT		259 – 266	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
36	PLRO		267 – 274	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
37	CPP		275 – 282	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
38	NPP		283 – 290	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
39	ESTIMATED REBATE AT POS		291 – 298	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
40	VACCINE ADMINISTRATION FEE		299 – 306	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS

REPORTING ESTIMATED REBATE AT POS

♦ **Plan PDE reporting of estimated rebates and drug cost to CMS depends upon benefit year**

  ◊ 2006 through 2007, Part D sponsors report the amount of the estimated rebates in the CPP (covered Part D drugs) or NPP (non-Part D covered drugs) fields

  ◊ 2008, Part D sponsors report the amount of any estimated rebates in the "Estimated Rebate at POS" field

ESTIMATED REBATE AT POS PDE REPORTING – 2007

- ♦ Plans report the full ingredient cost paid (prior to the application of the estimated rebate)
- ♦ Sum of reported ingredient cost, dispensing fee, and sales tax are used for GDCB/GDCA
- ♦ Plans report the estimated rebate in CPP
- ♦ Plans use the rebate-reduced cost for progression through the benefit
- ♦ EA Plans use the rebate-reduced cost for mapping to Defined Standard benefit

ESTIMATED REBATE AT POS
PDE REPORTING – 2008 AND BEYOND

♦ Plans reduce PDE ingredient cost by the amount of the estimated rebate

♦ Sum of reported ingredient cost, dispensing fee, and sales tax are used for GDCB/GDCA, resulting in a reduced GDCB/GDCA

♦ Plans report the estimated rebate in new PDE field "Estimated Rebate at POS"

♦ Plans use the rebate-reduced cost for progression through the benefit

♦ EA Plans use the rebate-reduced cost for mapping to defined standard

ESTIMATED REBATE AT POS EXAMPLE 1 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in a Defined Standard plan and has YTD gross covered drug costs of $1,000. The beneficiary is not eligible for the low-income subsidy and does not have additional prescription drug coverage through a third-party.

The beneficiary purchases a covered Part D drug with a drug cost of $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 to the POS price.

The actual rebate amount received by the Part D sponsor at the end of the coverage year is $60 for this claim.

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$25	$25
CPP	$125	$75
NPP	$0	$0
Estimated Rebate at POS		$50

ESTIMATED REBATE AT POS EXAMPLE 2 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in a Defined Standard plan, is not eligible for the low-income subsidy, and has YTD gross covered drug costs of $2,600, which places this beneficiary in the Coverage Gap. The beneficiary does not have prescription drug coverage through a third-party.

The beneficiary purchases a covered Part D drug with a drug cost of $35 ($20 ingredient cost, $10 dispensing fee, and $5 sales tax). The Part D sponsor chooses to apply an estimated rebate of $25 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $20 for this claim.

ESTIMATED REBATE AT POS EXAMPLE 2 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$20	$0
Dispensing Fee Paid	$10	$5
Amount Attributed to Sales Tax	$5	$5
GDCB	$35	$10
GDCA	$0	$0
Patient Pay Amount	$10	$10
CPP	$25	$0
NPP	$0	$0
Estimated Rebate at POS		$25

ESTIMATED REBATE AT POS EXAMPLE 3 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in an Enhanced Alternative plan that fills in the coverage gap and has tiered cost-sharing ($10/$20/$30). The beneficiary is not eligible for the low-income subsidy and does not have prescription drug coverage through a third-party. In this example the beneficiary's YTD gross covered drug cost is $3,000.

The beneficiary purchases a covered Part D drug in Tier 3 that costs $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim.

ESTIMATED REBATE AT POS EXAMPLE 3 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$30	$30
CPP	$50	$0
NPP	$70	$70
Estimated Rebate at POS		$50

ESTIMATED REBATE AT POS EXAMPLE 4 - PDE FIELD VALUES

Scenario

A beneficiary who is enrolled in an Enhanced Alternative plan purchases a supplemental drug that costs $150 ($140 ingredient cost and $10 dispensing fee) and pays a $20 co-payment.

The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim.

ESTIMATED REBATE AT POS EXAMPLE 4 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$0	$0
GDCA	$0	$0
Patient Pay Amount	$20	$20
CPP	$0	$0
NPP	$130	$80
Estimated Rebate at POS		**$50**

BUSINESS RULES FOR CALCULATING AND REPORTING EACS

Reporting EACS involves three steps.

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

Step 2 | Calculate and report **CPP**.

Step 3 | Calculate and report **NPP**.

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2008

EACS Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit
1	≤ $275	0%
2	>$275 and ≤ $2,510	75%
3	>$2,510 and ≤ $5,726.25	0%
4	> $5,726.25 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (gross covered drug cost -$2.25/$5.60)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2006

EACS Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit
1	≤ $250	0%
2	>$250 and ≤ $2,250	75%
3	>$2,250 and ≤ $5,100	0%
4	> $5,100 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (gross covered drug cost -$2/$5)

PLAN PAID AMOUNTS

NEW APPROACH

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

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES

Scenario

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

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

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

Results – Calculation Under EACS

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

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

Results – Calculation Under Defined Standard

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

Result - PDE Related Fields

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

LOW INCOME COST-SHARING SUBSIDY

2008 LICS Categories				
Maximum LI Beneficiary Cost-Sharing				
Copay Category	Deductible	Initial Coverage	Coverage Gap	Catastrophic
2	$ 0	$1.05 generic $3.10 brand	$1.05 generic $3.10 brand	$0
1	$ 0	$2.25 generic $5.60 brand	$2.25 generic $5.60 brand	$0
4	$56	15%	15%	$2.25 generic $5.60 brand
3	$ 0	$0	$0	$0

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

LOW INCOME COST-SHARING SUBSIDY (CONTINUED)

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

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

LICS AMOUNT FORMULA

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

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

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

ACTUARIALLY EQUIVALENT STRADDLE CLAIM

Scenario

In 2006, Bonneville Benefits offers an actuarially equivalent plan with a tiered co-pay structure ($5 generic; $20 preferred brand drugs; and $50 brand drugs) that applies only during the initial coverage period. The beneficiary's YTD gross covered drug costs are $2,225; she is LI-Category 1 eligible and purchases a covered drug in Tier 2 for $80.

ACTUARIALLY EQUIVALENT STRADDLE CLAIM (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:
$20.00 + $55.00 = $75.00

Step 2: Determine the LI cost share:
$2.00

Step 3: Apply the "Lesser of" Test:
$2.00 < $75.00

Step 4: Use the LICS Amount formula:
$75.00 – $2.00 = $73.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$ 2.00
CPP	
LICS Amount	$73.00

ACTUARIALLY EQUIVALENT STRADDLE CLAIM (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$80.00
GDCA	$ 0.00
Patient Pay Amount	$ 2.00
CPP	$ 5.00
LICS Amount	$73.00

TrOOP Accumulator	+ $75.00

Scenario

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

Result – Claim 1

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

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

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

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

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

Result – Claim 2

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

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

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

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

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

Populating the PDE Record

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

TrOOP Accumulator

Claim 1	Claim 2
+ $100.00	+ $100.00

CATEGORY 4 LICS BENEFICIARY, PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO

Scenario

Assume that in 2006 a Category 4 beneficiary enrolls in a basic PBP with a $30 deductible, followed by 25 percent coinsurance in the Initial Coverage period. The first two claims of the year for the beneficiary are shown, applying the "lesser of" test by including the plan's $30 deductible (not $50) in the calculation on the Category 4 side. The negotiated prices are $25 for a generic drug in the first claim and $200 for the second claim; both are covered drugs.

Result – Claim 1

Step 1: Calculate the non-LI cost share:
$25.00

Step 2: Determine the LI cost share:
$25.00

Step 3: Apply the "Lesser of" Test:
$25.00 < $25.00

Step 4: Use the LICS Amount formula:
$25.00 – $25.00 = $0.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$25.00
CPP	
LICS Amount	$ 0.00

Result – Claim 2

Step 1: Calculate the non-LI cost share:
$5.00 + ($195.00 x 0.25) = $53.75

Step 2: Determine the LI cost share:
$5.00 + ($195.00 x 0.15) = $34.25

Step 3: Apply the "Lesser of" Test:
$34.25 < $53.75

Step 4: Use the LICS Amount formula:
$53.75 – $34.25 = $19.50

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$34.25
CPP	
LICS Amount	$19.50

Populating the PDE Record

	Claim 1	Claim 2
Drug Coverage Status Code	C	C
Catastrophic Coverage Code	<blank>	<blank>
GDCB	$25.00	$200.00
GDCA	$ 0.00	$ 0.00
Patient Pay Amount	$25.00	$ 34.25
CPP	$ 0.00	$146.25
LICS Amount	$ 0.00	$ 19.50

TrOOP Accumulator

Claim 1	Claim 2
+ $25.00	+ $53.75

CATEGORY 4 LICS BENEFICIARY, ZERO DEDUCTIBLE PLAN

Scenario

A Category 4 beneficiary joins a basic PBP in 2006 with no deductible and 25 percent cost-sharing in the Initial Coverage period. This is the beneficiary's first claim of the year and the negotiated price (gross drug cost) is $100; it is a covered drug. In the "lesser of" test, the deductible is excluded from the calculation on the Category 4 side and only uses 15 percent coinsurance. The Category 4 beneficiary receives the 15 percent coinsurance provision beginning with the first covered drug of the year.

CATEGORY 4 LICS BENEFICIARY, ZERO DEDUCTIBLE PLAN (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:
$100.00 x 0.25 = $25.00

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

Step 3: Apply the "Lesser of" Test:
$15.00 < $25.00

Step 4: Use the LICS Amount formula:
$25.00 – $15.00 = $10.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$15.00
CPP	
LICS Amount	$10.00

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$100.00
GDCA	$ 0.00
Patient Pay Amount	$ 15.00
CPP	$ 75.00
LICS Amount	$ 10.00

TrOOP Accumulator	+ $25.00

SUMMARY

♦ Reviewed the rules and guidelines for calculating and reporting Part D data on PDE records

♦ Applied the calculating and reporting rules and guidelines to advanced calculation examples

EVALUATION

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

Prescription Drug Event Data Advanced

Calculating and Reporting Complex Examples

LTC, Inc.

PURPOSE

♦ Provide participants with a review of more complex calculations for reporting data on PDE records

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OBJECTIVES

♦ Review the rules and guidelines for calculating and reporting Part D data on PDE records

♦ Apply the calculating and reporting rules and guidelines to advanced calculation examples

WHAT ARE ESTIMATED REBATES AT POINT OF SALE?

♦ Discounts in the negotiated prices of covered Part D drugs made available to beneficiaries at the point of sale at network pharmacies.

♦ The rebates serve to reduce the negotiated price and, thus the gross drug cost reported to CMS.

Reporting Rebates Applies to the Point-of-Sale Price
Guidance Released May 2007

APPLYING ESTIMATED REBATES AT POINT OF SALE (POS)

The reduced negotiated price and gross drug cost must be used consistently to:

1. Calculate beneficiary cost-sharing
2. Accumulate gross covered drug costs and advance the beneficiary through the benefit
3. Calculate true out-of-pocket costs (TrOOP)
4. Report drug costs on the PDE record
5. Determine the low-income cost sharing subsidy amounts reported to CMS
6. Develop the Part D bid

APPLYING ESTIMATED REBATES AT POINT OF SALE (POS) (CONTINUED)

28	INGREDIENT COST PAID	506-F6	203 – 210	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
29	DISPENSING FEE PAID	507-F7	211 – 218	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
30	AMOUNT ATTRIBUTED TO SALES TAX		219 – 226	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
31	GDCB		227 – 234	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
32	GDCA		235 – 242	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
33	PATIENT PAY AMOUNT	505-F5	243 – 250	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
34	OTHER TrOOP AMOUNT		251 – 258	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
35	LICS AMOUNT		259 – 266	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
36	PLRO		267 – 274	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
37	CPP		275 – 282	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
38	NPP		283 – 290	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
39	ESTIMATED REBATE AT POS		291 – 298	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
40	VACCINE ADMINISTRATION FEE		299 – 306	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS

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REPORTING ESTIMATED REBATE AT POS

♦ Plan PDE reporting of estimated rebates and drug cost to CMS depends upon benefit year

◊ 2006 through 2007, Part D sponsors report the amount of the estimated rebates in the CPP (covered Part D drugs) or NPP (non-Part D covered drugs) fields

◊ 2008, Part D sponsors report the amount of any estimated rebates in the "Estimated Rebate at POS" field

ESTIMATED REBATE AT POS PDE REPORTING – 2007

♦ Plans report the full ingredient cost paid (prior to the application of the estimated rebate)

♦ Sum of reported ingredient cost, dispensing fee, and sales tax are used for GDCB/GDCA

♦ Plans report the estimated rebate in CPP

♦ Plans use the rebate-reduced cost for progression through the benefit

♦ EA Plans use the rebate-reduced cost for mapping to Defined Standard benefit

ESTIMATED REBATE AT POS
PDE REPORTING – 2008 AND BEYOND

♦ Plans reduce PDE ingredient cost by the amount of the estimated rebate

♦ Sum of reported ingredient cost, dispensing fee, and sales tax are used for GDCB/GDCA, resulting in a reduced GDCB/GDCA

♦ Plans report the estimated rebate in new PDE field "Estimated Rebate at POS"

♦ Plans use the rebate-reduced cost for progression through the benefit

♦ EA Plans use the rebate-reduced cost for mapping to defined standard

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ESTIMATED REBATE AT POS
EXAMPLE 1 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in a Defined Standard plan and has YTD gross covered drug costs of $1,000. The beneficiary is not eligible for the low-income subsidy and does not have additional prescription drug coverage through a third-party.

The beneficiary purchases a covered Part D drug with a drug cost of $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 to the POS price.

The actual rebate amount received by the Part D sponsor at the end of the coverage year is $60 for this claim.

ESTIMATED REBATE AT POS EXAMPLE 1 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$25	$25
CPP	$125	$75
NPP	$0	$0
Estimated Rebate at POS		$50

ESTIMATED REBATE AT POS EXAMPLE 2 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in a Defined Standard plan, is not eligible for the low-income subsidy, and has YTD gross covered drug costs of $2,600, which places this beneficiary in the Coverage Gap. The beneficiary does not have prescription drug coverage through a third-party.

The beneficiary purchases a covered Part D drug with a drug cost of $35 ($20 ingredient cost, $10 dispensing fee, and $5 sales tax). The Part D sponsor chooses to apply an estimated rebate of $25 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $20 for this claim.

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ESTIMATED REBATE AT POS EXAMPLE 2 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$20	$0
Dispensing Fee Paid	$10	$5
Amount Attributed to Sales Tax	$5	$5
GDCB	$35	$10
GDCA	$0	$0
Patient Pay Amount	$10	$10
CPP	$25	$0
NPP	$0	$0
Estimated Rebate at POS		$25

ESTIMATED REBATE AT POS EXAMPLE 3 - PDE FIELD VALUES

Scenario

A Part D beneficiary is enrolled in an Enhanced Alternative plan that fills in the coverage gap and has tiered cost-sharing ($10/$20/$30). The beneficiary is not eligible for the low-income subsidy and does not have prescription drug coverage through a third-party. In this example the beneficiary's YTD gross covered drug cost is $3,000.

The beneficiary purchases a covered Part D drug in Tier 3 that costs $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim.

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ESTIMATED REBATE AT POS EXAMPLE 3 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$30	$30
CPP	$50	$0
NPP	$70	$70
Estimated Rebate at POS		($50)

ESTIMATED REBATE AT POS EXAMPLE 4 - PDE FIELD VALUES

Scenario

A beneficiary who is enrolled in an Enhanced Alternative plan purchases a supplemental drug that costs $150 ($140 ingredient cost and $10 dispensing fee) and pays a $20 co-payment.

The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale.

The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim.

ESTIMATED REBATE AT POS EXAMPLE 4 - PDE FIELD VALUES (CONTINUED)

PDE Field	Amount Reported 2007	Amount Reported 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$0	$0
GDCA	$0	$0
Patient Pay Amount	$20	$20
CPP	$0	$0
NPP	$130	$80
Estimated Rebate at POS		($50)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS

Reporting EACS involves three steps.

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

Step 2 | Calculate and report **CPP**.

Step 3 | Calculate and report **NPP**.

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2008

EACS Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit
1	$\leq$ $275	0%
2	>$275 and $\leq$ $2,510	75%
3	>$2,510 and $\leq$ $5,726.25	0%
4	> $5,726.25 and $\leq$ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (gross covered drug cost -$2.25/$5.60)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2006

EACS Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit
1	$\leq$ $250	0%
2	>$250 and $\leq$ $2,250	75%
3	>$2,250 and $\leq$ $5,100	0%
4	> $5,100 and $\leq$ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (gross covered drug cost -$2/$5)

PLAN PAID AMOUNTS

NEW APPROACH

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

CLAIMS STRADDLING ENHANCED ALTERNATIVE AND DEFINED STANDARD BENEFIT PHASES

Scenario

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

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

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

Results – Calculation Under EACS

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

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

Results – Calculation Under Defined Standard

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

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

Result - PDE Related Fields

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

LOW INCOME COST-SHARING SUBSIDY

2008 LICS Categories Maximum LI Beneficiary Cost-Sharing				
Copay Category	Deductible	Initial Coverage	Coverage Gap	Catastrophic
2	$ 0	$1.05 generic $3.10 brand	$1.05 generic $3.10 brand	$0
1	$ 0	$2.25 generic $5.60 brand	$2.25 generic $5.60 brand	$0
4	$56	15%	15%	$2.25 generic $5.60 brand
3	$ 0	$0	$0	$0

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

LOW INCOME COST-SHARING SUBSIDY (CONTINUED)

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

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

LICS AMOUNT FORMULA

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

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

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

ACTUARIALLY EQUIVALENT STRADDLE CLAIM

Scenario

In 2006, Bonneville Benefits offers an actuarially equivalent plan with a tiered co-pay structure ($5 generic; $20 preferred brand drugs; and $50 brand drugs) that applies only during the initial coverage period. The beneficiary's YTD gross covered drug costs are $2,225; she is LI-Category 1 eligible and purchases a covered drug in Tier 2 for $80.

ACTUARIALLY EQUIVALENT STRADDLE CLAIM (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:
$20.00 + $55.00 = $75.00

Step 2: Determine the LI cost share:
$2.00

Step 3: Apply the "Lesser of" Test:
$2.00 < $75.00

Step 4: Use the LICS Amount formula:
$75.00 – $2.00 = $73.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$ 2.00
CPP	
LICS Amount	$73.00

ACTUARIALLY EQUIVALENT STRADDLE CLAIM (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$80.00
GDCA	$ 0.00
Patient Pay Amount	$ 2.00
CPP	$ 5.00
LICS Amount	$73.00

TrOOP Accumulator	+ $75.00

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

Scenario

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

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

Result – Claim 1

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

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

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

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

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

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

Result – Claim 2

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

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

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

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

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

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

Populating the PDE Record

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

TrOOP Accumulator

Claim 1	Claim 2
+ $100.00	+ $100.00

CATEGORY 4 LICS BENEFICIARY, PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO

Scenario

Assume that in 2006 a Category 4 beneficiary enrolls in a basic PBP with a $30 deductible, followed by 25 percent coinsurance in the Initial Coverage period. The first two claims of the year for the beneficiary are shown, applying the "lesser of" test by including the plan's $30 deductible (not $50) in the calculation on the Category 4 side. The negotiated prices are $25 for a generic drug in the first claim and $200 for the second claim; both are covered drugs.

CATEGORY 4 LICS BENEFICIARY, PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO (CONTINUED)

Result – Claim 1

Step 1: Calculate the non-LI cost share:
$25.00

Step 2: Determine the LI cost share:
$25.00

Step 3: Apply the "Lesser of" Test:
$25.00 < $25.00

Step 4: Use the LICS Amount formula:
$25.00 – $25.00 = $0.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$25.00
CPP	
LICS Amount	$ 0.00

CATEGORY 4 LICS BENEFICIARY, PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO (CONTINUED)

Result – Claim 2

Step 1: Calculate the non-LI cost share:
$5.00 + ($195.00 x 0.25) = $53.75

Step 2: Determine the LI cost share:
$5.00 + ($195.00 x 0.15) = $34.25

Step 3: Apply the "Lesser of" Test:
$34.25 < $53.75

Step 4: Use the LICS Amount formula:
$53.75 – $34.25 = $19.50

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$34.25
CPP	
LICS Amount	$19.50

CATEGORY 4 LICS BENEFICIARY, PLAN DEDUCTIBLE LESS THAN STATUTORY CATEGORY 4 AMOUNT AND GREATER THAN ZERO (CONTINUED)

Populating the PDE Record

	Claim 1	Claim 2
Drug Coverage Status Code	C	C
Catastrophic Coverage Code	<blank>	<blank>
GDCB	$25.00	$200.00
GDCA	$ 0.00	$ 0.00
Patient Pay Amount	$25.00	$ 34.25
CPP	$ 0.00	$146.25
LICS Amount	$ 0.00	$ 19.50

TrOOP Accumulator

Claim 1	Claim 2
+ $25.00	+ $53.75

CATEGORY 4 LICS BENEFICIARY, ZERO DEDUCTIBLE PLAN

Scenario

A Category 4 beneficiary joins a basic PBP in 2006 with no deductible and 25 percent cost-sharing in the Initial Coverage period. This is the beneficiary's first claim of the year and the negotiated price (gross drug cost) is $100; it is a covered drug. In the "lesser of" test, the deductible is excluded from the calculation on the Category 4 side and only uses 15 percent coinsurance. The Category 4 beneficiary receives the 15 percent coinsurance provision beginning with the first covered drug of the year.

CATEGORY 4 LICS BENEFICIARY, ZERO DEDUCTIBLE PLAN (CONTINUED)

Result

Step 1: Calculate the non-LI cost share:
$100.00 x 0.25 = $25.00

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

Step 3: Apply the "Lesser of" Test:
$15.00 < $25.00

Step 4: Use the LICS Amount formula:
$25.00 – $15.00 = $10.00

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$15.00
CPP	
LICS Amount	$10.00

CATEGORY 4 LICS BENEFICIARY, ZERO DEDUCTIBLE PLAN (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$100.00
GDCA	$ 0.00
Patient Pay Amount	$ 15.00
CPP	$ 75.00
LICS Amount	$ 10.00

TrOOP Accumulator	+ $25.00

SUMMARY

♦ Reviewed the rules and guidelines for calculating and reporting Part D data on PDE records

♦ Applied the calculating and reporting rules and guidelines to advanced calculation examples

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EVALUATION

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

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

Center for Beneficiary Choices
Medicare Plan Payment Group

Date: June 1, 2007

To: All Part D Plan Sponsors

From: Tom Hutchinson, Director
                 Medicare Plan Payment Group

Subject: Reporting Estimated Rebates Applied to the Point-of-Sale Price

Per section 1860D-2(d)(1)(B) of the Medicare Modernization Act and 42 CFR 423.100, the negotiated prices made available to Part D beneficiaries at the point of sale shall take into account negotiated price concessions for covered Part D drugs such as discounts and rebates which the Part D sponsor has elected to pass through to their enrollees at the point of sale, as well as any applicable dispensing fees. While several Part D sponsors include discounts in the negotiated prices made available to their enrollees in order to reduce beneficiary cost sharing, they are often unable to pass actual rebates through to their enrollees at the point of sale because rebates from drug manufacturers are typically awarded retrospectively based on market share or utilization. For this reason, Part D sponsors, who choose to make rebates available to their beneficiaries at the point of sale, may elect to apply a reasonable estimate of expected rebates, referred to as estimated rebates, to the negotiated price at the point of sale. Please note that Part D sponsors are not required to apply rebates or an estimate of expected rebates to the negotiated price at the point of sale. This guidance is only applicable for those Part D sponsors who elect to pass rebates through to their Part D enrollees at the point of sale.

As defined in 42 CFR 423.100, negotiated prices are "prices for covered Part D drugs" that "[a]re available to beneficiaries at the point of sale at network pharmacies" and that "[a]re reduced by those discounts,... rebates, ...and direct or indirect remunerations that the Part D sponsor has elected to pass through to Part D enrollees at the point of sale" and "[i]nclude[] any dispensing fees." Rebates which Part D sponsors elect to pass through to beneficiaries at the point of sale serve to reduce the negotiated price and, thus, the gross drug cost reported to CMS. Part D sponsors must use the reduced negotiated price to administer their plan(s). Specifically, the reduced negotiated price and gross drug cost must be used consistently to (i) calculate beneficiary cost-sharing, (ii) accumulate gross covered drug costs and advance the beneficiary through the benefit, (iii) calculate true out-of-pocket costs (TrOOP), (iv) report drug costs on the PDE record, (v) determine the low-income cost sharing subsidy amounts reported to CMS, and (vi) develop the Part D bid. Thus, any rebates applied at the point of sale reduce both plan liability and beneficiary cost sharing by reducing the negotiated price used to administer the prescription drug benefit.

To ensure that the Prescription Drug Event (PDE) record accurately reflects the gross drug costs used to administer the prescription drug benefit, CMS is adding a new field to the PDE record for contract year

2008. Beginning in contract year 2008, Part D sponsors, who elect to pass estimated rebates through to their Part D enrollees at the point of sale, will be required to report these estimated rebates in a new field, "Estimated Rebate at POS". The addition of this field to the PDE record will help to ensure that the estimated rebates applied to the point of sale price are used appropriately to reduce the negotiated price, plan liability, and beneficiary cost sharing. Provided below is additional guidance regarding the reporting of these estimated rebates.

Coverage Year 2008 and Forward

Starting in contract year 2008, Part D sponsors must report the amount of any estimated rebates, which they have elected to apply at the point of sale to CMS in the Estimated Rebate at POS field. In addition, the gross drug cost reported to CMS on the PDE record must be net of the estimated rebates applied to the point-of-sale price. Specifically, these estimated rebates must be used to reduce all five cost fields: "Ingredient Cost", "Dispensing Fee Paid", "Amount Attributed to Sales Tax", "Gross Drug Cost Below the Out-of-Pocket Threshold"(GDCB) and Gross Drug Cost Above the Out-of-Pocket Threshold"(GDCA). The Part D sponsor must first use the estimated rebates applied at the point of sale to reduce the ingredient cost reported to CMS. If the estimated rebates applied to the point-of-sale price are greater than the total ingredient cost, any remaining estimated rebates must then be used to reduce the dispensing fee next and then finally the sales tax. The payments made by or on behalf of the beneficiary and plan paid amounts reported to CMS on the PDE record must be based on the reduced negotiated price and reflect the cost sharing established in the Plan Benefit Package (PBP). The examples provided below demonstrate how estimated rebates applied to the point-of-sale price should be reported to CMS on the PDE records.

For payment reconciliation, Part D sponsors will be required to report all applicable rebates for covered Part D drugs on the DIR Report for Payment Reconciliation, including the actual rebate amounts for the rebates which were estimated and applied at the point of sale. When determining the appropriate DIR amount for the calculation of allowable reinsurance costs and adjusted allowable risk corridor costs, CMS will subtract the amounts reported in the Estimated Rebate at POS field for covered Part D drugs from the total DIR amount (for covered Part D drugs) reported on the DIR Report For Payment Reconciliation. This will capture any difference between the estimated rebates and the actual rebates and ensure that only price concessions which were not already included in the gross covered drug costs reported to CMS are included in the DIR amount used to calculate allowable reinsurance costs and adjusted allowable risk corridor costs.

Coverage years 2006 and 2007

As stated previously, Part D sponsors who elect to apply estimated rebates to the point-of-sale price must use the negotiated price net of the estimated rebates to administer the Part D benefit and calculate beneficiary cost sharing. However, for coverage years 2006 and 2007, Part D sponsors are required to report the gross drug cost prior to the application of these estimated rebate amounts on the PDE record instead of the gross drug cost net of these estimated rebates. Specifically, the gross drugs costs reported in the "Ingredient Cost Paid, Dispensing Fee Paid," "Amount Attributed to Sales Tax," "Gross Drug Cost Above the Out-of-Pocket Threshold (GDCA)," and "Gross Drug Cost Below the Out-of-Pocket Threshold (GDCB)" fields must be based on the gross drug costs prior to the application of any estimated rebates. Since there is no separate field on the PDE record for estimated rebates in contract years 2006 and 2007, Part D sponsors are required to report any estimated rebates applied to the negotiated price at the point of sale in either the Covered D Plan Paid Amount (CPP) field for covered Part D drugs or the Non-covered Plan Paid Amount (NPP) field for non-Part D covered drugs. For payment reconciliation, Part D sponsors will be required to report all applicable rebates for covered Part D drugs on the DIR Report for Payment

Reconciliation including the actual rebate amounts for the rebates which were estimated and applied at the point of sale. The examples provided below demonstrate how estimated rebates applied at point of sale should be reported to CMS on PDE records for contract years 2006 and 2007.

Example 1:
A Part D beneficiary is enrolled in a defined standard plan and has year-to-date gross covered drug costs of $1,000. The beneficiary is not eligible for the low-income subsidy and does not have additional prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 to the point-of-sale price. The actual rebate amount received by the Part D sponsor at the end of the coverage year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE record for coverage years 2007 and 2008.

PDE Field Values for Example 1

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	0	0
Patient Pay Amount	$25	$25
Covered D Plan Paid Amount	$125	$75
Non-Covered Plan Paid Amount	0	0
Estimated Rebate at POS	N/A	$50

For both coverage years 2007 and 2008, the Part D sponsor uses a reduced negotiated price of $100 ($150- $50 estimated rebate amount) to determine beneficiary cost sharing. However, the gross drug costs reported for coverage year 2007 are the drug costs prior to the application of the estimated rebates ($150) and the gross drug costs reported for coverage year 2008 will be net of the estimated rebates ($100). Since this beneficiary is in the initial coverage period, the beneficiary pays 25% of the negotiated price ($25) and the plan is responsible for 75% of the negotiated price ($75) in both coverage years. For coverage year 2007, the Covered D Plan Paid Amount field includes both the $75 plan liability and the estimated rebate amount ($50) applied at the point-of-sale. However, for coverage year 2008, only the $75 plan liability is included in the Covered D Plan Paid Amount field. The $50 estimated rebate amount is reported in the Estimated Rebate at POS field instead. In both coverage years, the Part D sponsor reports the actual rebate amount of $60 on the DIR Report for Payment Reconciliation.

Example 2:
A Part D beneficiary is enrolled in a defined standard plan, is not eligible for the low-income subsidy, and has year-to-date gross covered drug costs of $2,600. The beneficiary does not have prescription drug coverage through a third-party. The beneficiary purchases a covered Part D drug with a drug cost of $35

($20 ingredient cost, $10 dispensing fee, and $5 sales tax). The Part D sponsor chooses to apply an estimated rebate of $25 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of the year is $20 for this claim. The table below illustrates how the Part D sponsor would populate the following nine data elements on the PDE for coverage years 2007 and 2008.

PDE Field Values for Example 2

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$20	$0
Dispensing Fee Paid	$10	$5
Amount Attributed to Sales Tax	$5	$5
GDCB	$35	$10
GDCA	$0	$0
Patient Pay Amount	$10	$10
Covered D Plan Paid Amount	$25	$0
Non-Covered Plan Paid Amount	$0	$0
Estimated Rebate at POS	N/A	$25

For both coverage years 2007 and 2008, the Part D sponsor uses the reduced negotiated price of $10 ($35- $25 estimated rebate amount) to determine beneficiary cost sharing and administer the prescription drug benefit. However, the gross drug costs reported for coverage 2007 are the drug costs prior to the application of the estimated rebates and the gross drug costs reported for coverage year 2008 are net of the estimated rebates. For coverage year 2008, the estimated rebates are used to reduce the ingredient cost reported to $0.00 before the remaining estimated rebates are applied to reduce the dispensing fee to $5.00. Since this beneficiary is in the coverage gap phase of the prescription drug benefit, the beneficiary pays 100% of the negotiated price ($10) and the plan is responsible for 0% of the negotiated price ($0) in both coverage years. For coverage year 2007, the Covered D Plan Paid Amount field includes both the $0 plan liability and the estimated rebate amount ($25) applied at the point-of-sale. For coverage year 2008, only the $0 plan liability is reported in the Covered D Plan Paid Amount field. The $25 estimated rebate amount is reported in the Estimated Rebate at POS field. In both coverage years, the Part D sponsor would report the actual rebate amount of $20 on the DIR Report for Payment Reconciliation.

Example 3:
A Part D beneficiary is enrolled in an enhanced alternative (EA) plan that fills in the coverage gap and has tiered cost-sharing ($10/$20/$30). The beneficiary is not eligible for the low-income subsidy and does not have prescription drug coverage through a third-party. In this example the beneficiary's year-to-date gross covered drug cost is $3,000. The beneficiary purchases a covered Part D drug in Tier 3 that costs $150 ($140 ingredient cost and $10 dispensing fee). The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of

the year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE for coverage years 2007 and 2008.

PDE Field Values for Example 3

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$150	$100
GDCA	$0	$0
Patient Pay Amount	$30	$30
Covered D Plan Paid Amount	$50	$0
Non-Covered Plan Paid Amount	$70	$70
Estimated Rebate at POS	N/A	$50

First, the Part D sponsor determines cost-sharing based on its own enhanced benefit design; the beneficiary pays $30. For EA plans, the sponsor must map to the defined standard benefit in order to determine the covered D plan paid amount (CPP) and the non-covered plan paid amount (NPP). For both 2007 and 2008, Part D sponsors must use the gross drug cost net of the estimated rebate amount ($100) when doing this mapping to determine the CPP and NPP. This claim would fall in the defined standard coverage gap so the mapped amount for CPP is $0 and the Non-Covered Plan Paid Amount (NPP) is $70. (For additional information about mapping see the CMS PDE Training Participant Guide located at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.) For coverage year 2007 plans also report Estimated Rebate at POS in the CPP field. In 2007 the mapped amount is $0 and the Estimated Rebate is $50 so the plan reports $50 in CPP. For coverage year 2008, the Covered D Plan Paid Amount field reports only the mapped amount which is $0. The $70 NPP amount is the same in both years. In 2008, the $50 estimated rebate amount is reported in the Estimated Rebate at POS field. In both coverage years, the Part D sponsor would report the actual rebate amount of $60 on the DIR Report for Payment Reconciliation.

Example 4:
A beneficiary who is enrolled in an enhanced alternative plan purchases a supplemental drug that costs $150 ($140 ingredient cost and $10 dispensing fee) and pays a $20 co-payment. The Part D sponsor chooses to apply an estimated rebate of $50 at the point of sale. The actual rebate amount received by the Part D sponsor at the end of the year is $60 for this claim. The table below illustrates how the Part D sponsor would populate the following eight data elements on the PDE for coverage years 2007 and 2008. (Please note that the Drug Coverage Status Code is 'E'.)

**REPORTING ESTIMATED REBATES
APPLIED TO THE POINT OF SALE (POS) PRICE**

PDE Field Values for Example 4

PDE Field	Amount Reported for Coverage Year 2007	Amount Reported for Coverage Year 2008
Ingredient Cost Paid	$140	$90
Dispensing Fee Paid	$10	$10
GDCB	$0	$0
GDCA	$0	$0
Patient Pay Amount	$20	$20
Covered D Plan Paid Amount	$0	$0
Non-Covered Plan Paid Amount	$130	$80
Estimated Rebate at POS	N/A	$50

First, the Part D sponsor determines cost-sharing based on its own enhanced benefit design; the beneficiary co-payment which is $20 for this drug, is reported in Patient Pay Amount. Since this claim is for a non-Part D covered drug, the entire plan paid amount is reported in the NPP field and $0 is reported in the CPP field for both 2007 and 2008. For 2007, however, the estimated rebate amount of $50 is also reported in the NPP field because the drug is a non-Part D covered drug. Thus, in 2007 the Part D sponsor would report a total of $130 in the NPP field for this claim. For coverage year 2008, the NPP field would only include the plan paid amount ($80). The $50 estimated rebate amount is reported in the Estimated Rebate at POS field instead for coverage year 2008. In both coverage years, the actual rebate amount of $60 is excluded from the DIR Report for Payment Reconciliation. The EA plan includes rebates for non-covered drugs in its accounting for the supplemental premium.

Further Information
If you have questions about this guidance, please contact Meghan Elrington at (410) 786-8675.