2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

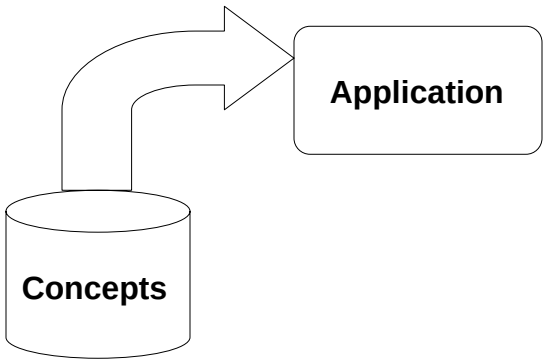
Introduction

LTC, Inc.

PURPOSE

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

TRAINING FORMAT



- Examples
- Exercises
- Group Participation
- Interactive

PARTICIPATION MAKES THE DIFFERENCE

TRAINING TOOLS

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

AUDIENCE

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

AGENDA – DAY ONE

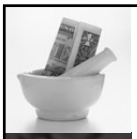
7:30 – 8:00	Registration
8:00 – 8:30	Introduction
8:30 – 9:15	Part D Payment Methodology
9:15 – 10:45	PDE Process Overview
10:45 – 11:00	Break
11:00 – 12:00	Data Format
12:00 – 1:00	Lunch
1:00 – 2:00	The Basic Benefit
2:00 – 3:00	True Out-of-Pocket Costs (TrOOP)
3:00 – 3:15	Break
3:15 – 4:15	TrOOP Facilitation
4:15 – 5:00	Low Income Cost-Sharing Subsidy
5:00 – 5:45	Enhanced Alternative Benefit
5:45 – 6:00	Question & Answer Session
6:00	Adjourn

AGENDA – DAY TWO

11:30 – 12:00	Registration
12:00 – 12:30	Review of Day One
12:30 – 1:30	Payment Demonstrations
1:30 – 2:15	Edits
2:15 – 2:30	Break
2:30 – 3:30	Reports
3:30 – 4:30	Reconciliation
4:30 – 5:00	Question & Answer Session
5:00	Adjourn

OBJECTIVES

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



OBJECTIVES (CONTINUED)

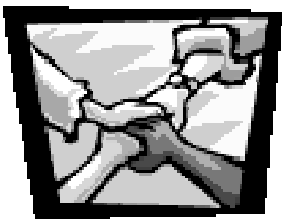
- Distinguish between what does and does not count toward TrOOP
- Describe the TrOOP facilitation process
- Identify the fields on the PDE associated with LICS
- Interpret the layout rules for the EA benefit
- Define the Payment Demonstration options

OBJECTIVES (CONTINUED)

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

INTRODUCING THE TEAM

CMS



Palmetto (CSSC)

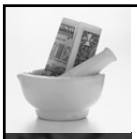
Leading Through Change, Inc. (LTC)

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Part D Payment Methodology

CMS



PURPOSE

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

OBJECTIVES

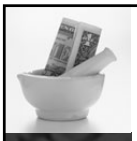
- Identify the four legislated payment mechanisms for Part D
- Describe payments subject to reconciliation and risk sharing
- Establish context for understanding PDE data reporting and reconciliation processes

FOUR MMA PAYMENT METHODS

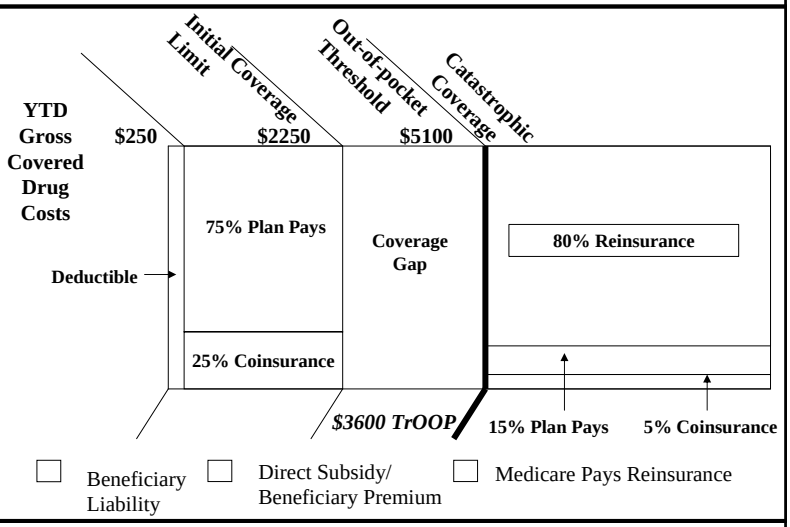
- Direct subsidy
- Low income subsidy
- Reinsurance subsidy
- Risk sharing (risk corridors)

WHAT IS COVERED?

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



2006 DEFINED STANDARD BENEFIT



2007
DEFINED STANDARD BENEFIT

BENEFIT PHASE	PARAMETERS TO DEFINE BENEFIT PHASE		BENEFICIARY COST-SHARING	PLAN LIABILITY
	YTD Gross Covered Drug Costs	YTD TrOOP Costs		
Deductible	≤ $265	N/A	100% coinsurance (= $265)	0%
Initial Coverage Period	> $265 and ≤ $2,400	N/A	25% coinsurance (= $533.75)	75% (= $1,601.25)
Coverage Gap	> $2,400 ≤ $5,451.25	≤ $3,850	100% coinsurance (= $3,051.25)	0%
Catastrophic Coverage Phase	> $5,451.25	> $3,850 (OOP Threshold)	Greater of 5% coinsurance or $2.15/$5.35 generic/brand co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.15/$5.35)

DIRECT SUBSIDY

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

LOW INCOME SUBSIDY

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

REINSURANCE SUBSIDY

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

RISK SHARING

- Compares the plan-level risk payments (direct subsidy and premiums) to aggregate allowed plan costs in the initial coverage period and the catastrophic phase
- Federal government and the plan share unexpected plan loss or gain

WHAT IS RECONCILIATION?

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

PAYMENT TIMETABLE AND RECONCILIATION

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

PDE DATA ENABLE PAYMENT AND RECONCILIATION

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

DIRECT AND INDIRECT REMUNERATION (DIR)

- Payment and reconciliation must exclude DIR, defined as:

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

DIR IN PAYMENT/RECONCILIATION

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

PART D RISK ADJUSTMENT: THE BASICS

- Risk adjustment is used to standardize bids, enabling comparison of Part D bids against a baseline (average) standard.
- Allows direct comparison of bids based on populations with different health status and other characteristics.
- On the payment side, risk adjustment appropriately adjusts payment for the characteristics of the enrolled population.

PART D RISK ADJUSTMENT: OVERVIEW

- Part D payment is risk-adjusted using the Rx-HCC model which shares most of the characteristics of the CMS-HCC model: demographic, prospective, additive, hierarchical, demographic new enrollee model.
- Key differences:
  - ◊ Rx-HCC model designed to predict plan liability for prescription drugs under the Part D benefit rather than Medicare Part A/B costs
  - ◊ Different diseases predict drug costs than Part A/B costs
  - ◊ Incremental costs of Low Income and Long Term Institutional beneficiaries are multipliers to the base Rx-HCC model score

DEMOGRAPHIC FACTORS

- Age
  - ◊ Payment for year based on enrollee age as of February 1st
- Gender
- Disability status
- Originally-disabled and age ≥ 65

DISEASE GROUPS IN THE RX-HCC MODEL

- Diseases included in the model cover most body systems and derive from both inpatient and outpatient settings.
- Model development was an iterative process.
  - ◊ Diseases grouped into smaller subgroups, then regrouped based on cost and clinical considerations

DISEASE HIERARCHIES

- Payment based on most severe manifestation of disease when less severe manifestation also present.
- Purpose:
  - ◊ Diagnoses are clinically related and ranked by cost.
  - ◊ Accounts for the costs of lower cost diseases, reducing need for coding proliferation.
- For example, a beneficiary with Rx-HCC 17 (diabetes w/complications) and Rx-HCC 18 (diabetes w/o complications) receives Rx-HCC 17

MODEL COEFFICIENTS

- Each disease group has an associated coefficient.
- Includes 113 coefficients
  - ◊ 84 disease coefficients
  - ◊ 24 age-gender adjustments
  - ◊ 3 age-disease interactions
  - ◊ 2 gender-age-originally disabled status interactions
- Hierarchies cover 11 conditions.

LOW INCOME AND LONG-TERM INSTITUTIONAL ADD-ONS

- The Part D model includes incremental factors for beneficiaries who are low income subsidy eligible (LIS) or long-term institutionalized (LTI).
- The factors are multipliers that are applied to the basic Part D risk adjustment factor.
- A beneficiary cannot receive both factors; if both apply, LTI is assigned.

LOW INCOME AND LONG-TERM INSTITUTIONAL MULTIPLIERS

Long-Term Institutional		Low Income	
Aged ≥ 65	Disabled < 65	Group 1 – Full subsidy eligible	Group 2 – Partial subsidy eligible (15%)
1.08	1.21	1.08	1.05

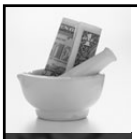
RECONCILIATION: DIRECT SUBSIDY

- Prospective monthly direct subsidy

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

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

- Note: Also used in risk sharing reconciliation



RECONCILIATION: LICS

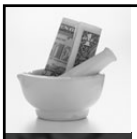
Monthly prospective LICS subsidy =
(LICS estimate in approved bid * # LI beneficiaries enrolled/month)

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

Reconciliation payment adjustment (+) or (-)

RECONCILIATION: REINSURANCE

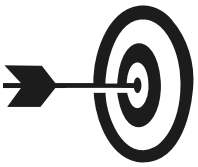
- Determine allowable reinsurance costs
  - ◊ On PDE, plans identify all gross covered drug costs that are above the out-of-pocket threshold (GDCA)
  - ◊ CMS sums GDCA by plan
  - ◊ Subtract DIR attributed to reinsurance costs
  - ◊ Multiply by 0.80
- Compare to monthly prospective reinsurance subsidy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



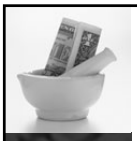
RECONCILIATION: RISK SHARING - OVERVIEW

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

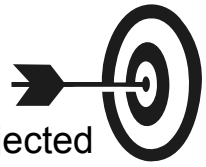
RECONCILIATION: RISK SHARING



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



CALCULATE TARGET AMOUNT



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

In formula:

Total direct subsidy
\+ Total Part D basic premiums related to standardized bid
– Administrative Costs
Target Amount

CALCULATE ADJUSTED ALLOWABLE RISK CORRIDOR COSTS (AARCCs)

Add

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

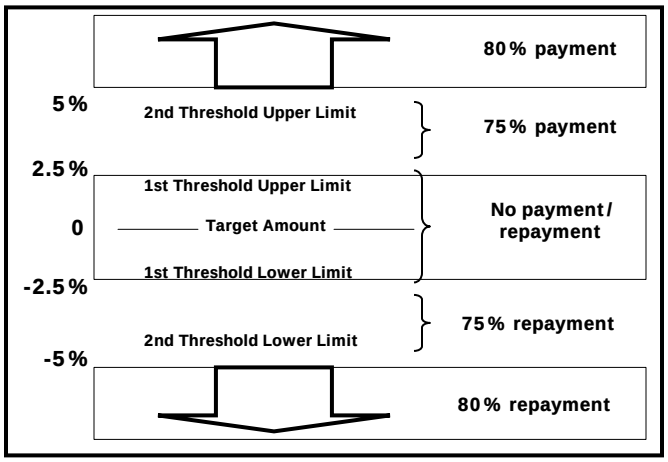
Then subtract

- ◊ Reinsurance subsidy
- ◊ Covered Part D DIR

For Enhanced Alternative plans only, reduce by

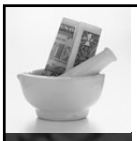
- ◊ Induced utilization

RISK CORRIDORS 2006 - 2007



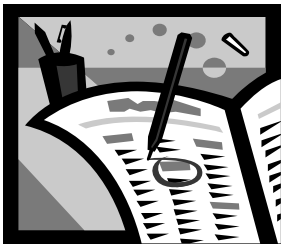
*60/60 Rule - 75% rate will change to 90% if certain circumstances are met

Q & A



EVALUATION

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



THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

PDE Process Overview

LTC, Inc.

PURPOSE

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

OBJECTIVES

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

COMMON PDE SYSTEM TERMS

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

PART D BENEFIT OPTIONS

Plans may offer the following benefits:

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

PDE RECORD OVERVIEW

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

PDE RECORD OVERVIEW
(CONTINUED)

Includes CMS and NCPDP-defined data elements that track:

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

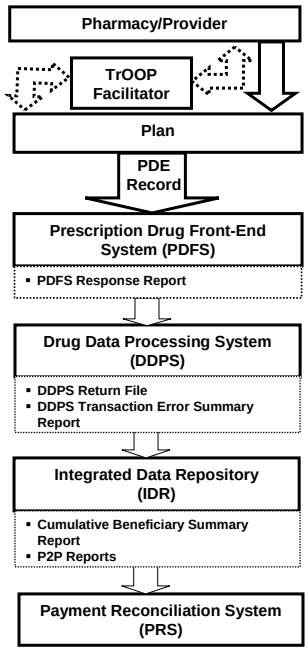
NEW CONTRACT EFFECTIVE JANUARY 1, 2008 PDE DATA SUBMISSION TIMELINE

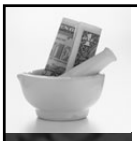
CY	Data Submission Type	Submission Timeline
2008	EDI Agreement and Submitter Application Deadline	October 31, 2007
2008	Certification Complete*	January 31, 2008
2008	First Production File Due	March 31, 2008
2008	Production Submissions	Monthly April 1, 2008 – May 31, 2009
2008	Final Submission Deadline	May 31, 2009
2008	Direct & Indirect Remuneration (DIR) Submission Deadline	June 30, 2009

* Only new contracts submitting directly or new third party submitters submitting in CY2008 must complete the testing and certification process.

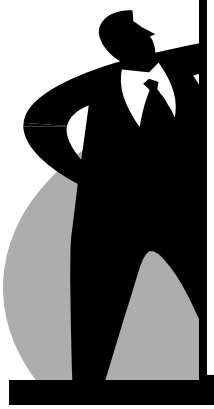
PDE DATAFLOW

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





TRAINING AND SUPPORT



HPMS:
- Notification of policy changes.

Training:
- Regional Training Program

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

MA/PDP Operational User Group Calls

SUMMARY

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

EVALUATION

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

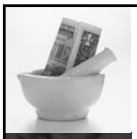
THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Data Format

LTC, Inc.



PURPOSE

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

OBJECTIVES

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

PDE ENROLLMENT PACKAGES

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

CONNECTIVITY OPTIONS

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

CERTIFICATION PROCESS

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

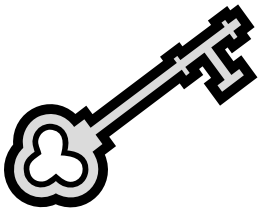
≥ 80%
acceptance rate

CERTIFICATION PHASES

Phase 1	Submitters must establish communication with PDFS, transmit successfully, and clear PDFS edits.
Phase 2	In the DDPS phase, submitters must achieve an 80% acceptance rate (in a file with at least 100 records) and successfully delete at least one saved record.

CERTIFICATION AND SYSTEM CHANGES

KEY POINT



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

2008
DATA SUBMISSION TIMELINE

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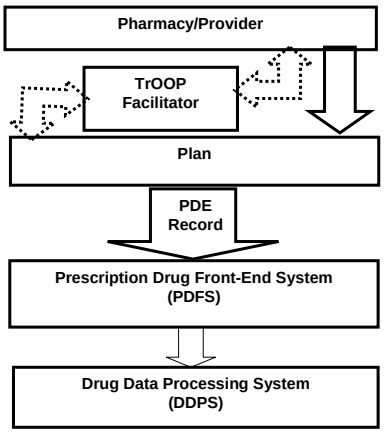
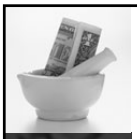
PLAN MONITORING

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

PDE PROCESS DATAFLOW

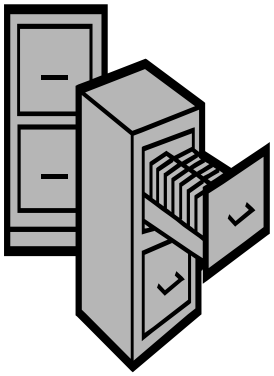




PDE RECORD LAYOUT LOGIC

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

PDE RECORD LAYOUT LOGIC
(CONTINUED)



CONTRACT IDENTIFICATION

Contract Number Enumeration

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

PLAN IDENTIFICATION

Plan Benefit Package (PBP) ID

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

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

HICN

CMS Number → 111223334A

SSN **BIC**

RRB Pre 1964 → WA123456

Prefix **Random**

RRB Post 1964 → WA123456789

Prefix **SSN**

DRUG COVERAGE STATUS CODE

Drug Coverage Status Code

C = Covered

E = Enhanced

O = Over-the-Counter

CATASTROPHIC COVERAGE CODE

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

DOLLAR FIELDS

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

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

COST FIELDS

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

Catastrophic Coverage Code = <blank>

Catastrophic Coverage Code = A

Catastrophic Coverage Code = C

PAYMENT FIELDS

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

NON-STANDARD FORMAT

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

NON-STANDARD FORMAT
(CONTINUED)

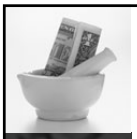
- Prescription Service Reference Number
- Service Provider ID
- Fill Number
- Compound Code
- DAW
- Days Supply
- Ingredient Cost Paid
- Dispensing Fee
- Amount Attributed to Sales Tax

MODIFYING PDE RECORDS

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

MODIFYING PDE RECORDS
(CONTINUED)

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



MODIFYING PDE RECORDS
(CONTINUED)

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

SUMMARY

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

EVALUATION

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

THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Calculating and Reporting the Basic Benefit

LTC, Inc.

PURPOSE

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

OBJECTIVES

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

OBJECTIVES (CONTINUED)

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

BASIC BENEFIT PLAN TYPES

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

- Basic benefit only pays for drugs that:
  - ◊ meet a statutorily definition of Part D drug
    and
  - ◊ covered under a Part D plan's benefit package (PBP).

COVERED AND NON-COVERED DRUGS

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

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

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

THE 2006 DEFINED STANDARD BENEFIT

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

THE 2007 DEFINED STANDARD BENEFIT

PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
Deductible	≤$265	100%
Initial Coverage Period	>$265 and ≤ $2,400	25%
Coverage Gap	>$2,400 and ≤ $5,451.25	100%
Catastrophic Coverage	>$5,451.25	Greater of 5% coinsurance or $2.15/$5.35 co-pay

THE 2008 DEFINED STANDARD BENEFIT

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

BASIC BENEFIT PLAN TYPES

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

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

TIERED COST-SHARING

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

EXAMPLE OF A TIERED BENEFIT

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

DATA ELEMENTS KEY TO BASIC BENEFIT

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

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

"C" = Covered Part D Drug

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

<blank> = OOP threshold has not been reached.

"A" = The event reaches the OOP threshold.

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

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

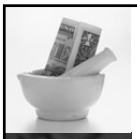
Gross Covered Drug Cost **below** the OOP threshold

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

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

The dollar amount that a beneficiary paid.



DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

The dollar amount the plan paid for the Basic benefit.

DATA ELEMENTS KEY TO BASIC BENEFIT (CONTINUED)

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

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

THE 2006 DEFINED STANDARD BENEFIT

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

THE "SIMPLEST" CASE

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

Characteristics:

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

DS PLAN: DEDUCTIBLE PHASE

Scenario

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

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

DS PLAN: CATASTROPHIC PHASE

Scenario

2006 YTD TrOOP = $3,600

The beneficiary purchased a $75 brand name covered drug.

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

OVER-THE-COUNTER (OTC) DRUGS

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

DS PLAN: OTC DRUG

Scenario

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

Result

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

EXAMPLE OF A TIERED BENEFIT

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

AE PLAN: INITIAL COVERAGE PHASE

Scenario

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

Result

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

STRADDLE CLAIMS

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

Deductible Phase	Initial Coverage Period	Coverage Gap Phase	Catastrophic Coverage Phase

Straddle Straddle Straddle

DS 2006: COVERAGE GAP TO CATASTROPHIC PHASE

Scenario

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

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

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

DS 2006: COVERAGE GAP TO CATASTROPHIC PHASE

Results - Calculation

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

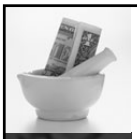
TIERED COST-SHARING STRADDLE CLAIMS

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

Patient Pay

≤

Negotiated Drug Cost



BA PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PERIOD

Scenario

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

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

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

BA 2006: PATIENT PAY AMOUNT LESS THAN NEGOTIATED PRICE

Results - Calculation

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

AE PLAN: STRADDLE OF DEDUCTIBLE PHASE TO INITIAL COVERAGE PERIOD

Scenario

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

Result

Step 1: Calculate the first phase

Step 2: Calculate the second phase

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

AE 2006: TOTAL PATIENT PAY AMOUNT

Results - Calculation

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

Adjustments/Deletions

KEY FIELDS

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

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

ADJUSTMENT/DELETION CODE DEFINITIONS

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

SITUATIONS THAT MAY CAUSE ADJUSTMENTS AND DELETIONS

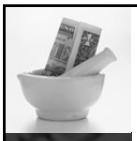
- Reversal
  - Deletes the billing transaction it reverses
- Re-adjudication
  - Changes the total amount paid to the pharmacy
- Re-calculation
  - Corrects beneficiary cost-sharing

REVERSALS WITH NO BENEFIT PHASE CHANGE

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

REVERSALS WITH NO BENEFIT PHASE CHANGE SCENARIO

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



REVERSALS WITH NO BENEFIT PHASE CHANGE RESULT

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

REVERSALS WITH BENEFIT PHASE CHANGE

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

PDE REPORTING "AS ADMINISTERED"/"AS ADJUSTED"

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

REVERSALS WITH BENEFIT PHASE CHANGE SCENARIO

Beneficiary:

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

ADJUSTMENTS IMPACTING STRADDLE CLAIMS

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

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

SUMMARY

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

SUMMARY (CONTINUED)

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

EVALUATION

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

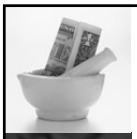
THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

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

LTC, Inc.



PURPOSE

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

OBJECTIVES

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

TrOOP

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

TrOOP is set at $3,600 for 2006.

$3,850 for 2007.

$4,050 for 2008.

TrOOP stops at the OOP Threshold

THE IMPORTANCE OF TrOOP

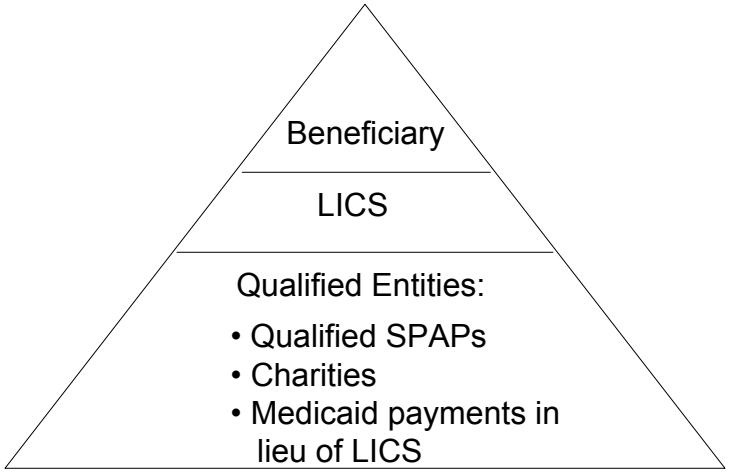
Reasons Why TrOOP is Important

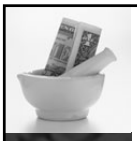
1. The beneficiary is subject to lower cost-sharing.

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

CONTRIBUTORS TO TrOOP

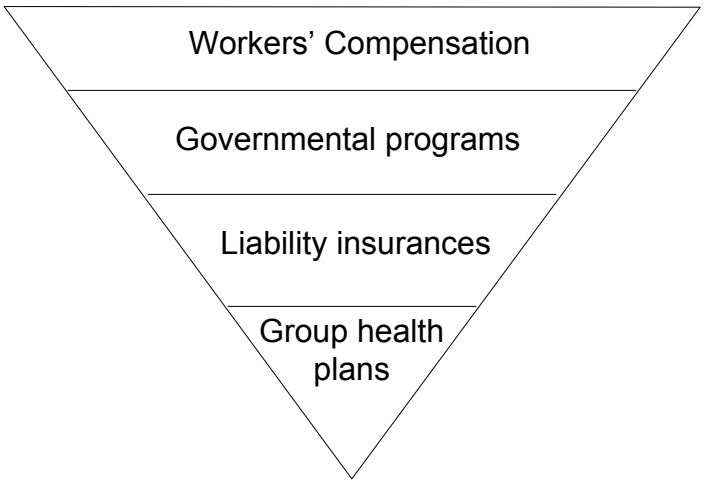
<u>TrOOP Eligible</u>





NON-CONTRIBUTORS TO TrOOP

<u>TrOOP Ineligible OHIs</u>



PDE DATA ELEMENTS

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

PDE RECORD – PAYMENT FIELDS

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

- Beneficiary
- Family and Friends

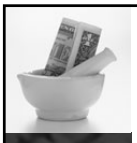
Included in TrOOP

PDE RECORD – PAYMENT FIELDS
(CONTINUED)

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

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

Included in TrOOP



PDE RECORD – PAYMENT FIELDS
(CONTINUED)

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

- Low Income Cost-sharing Subsidy Amounts

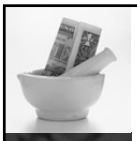
Included in TrOOP

PDE RECORD – PAYMENT FIELDS
(CONTINUED)

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

- Non-TrOOP Third Party payments

Excluded from TrOOP



PDE RECORD – PAYMENT FIELDS
(CONTINUED)

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

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

Excluded from TrOOP

PDE RECORD – PAYMENT FIELDS (CONTINUED)

Patient Pay Amount
Other TrOOP Amount
LICS
PLRO
CPP
NPP

Excluded from TrOOP

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

CALCULATING TrOOP COSTS

OHI Payer

Step 4: Update the TrOOP accumulator

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

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

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

STEPS TO CALCULATE TrOOP COSTS

Scenario

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

Result

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

STEPS TO CALCULATE TrOOP COSTS (CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

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

STEPS TO CALCULATE TrOOP COSTS (CONTINUED)

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

Non-TrOOP OHI = **PLRO field**

PLRO	$ 15

STEPS TO CALCULATE TROOP COSTS (CONTINUED)

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

Patient Pay Amount	$10

STEPS TO CALCULATE TROOP COSTS (CONTINUED)

Step 4: Update the TrOOP accumulator

PLRO field amounts are not TrOOP eligible.

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

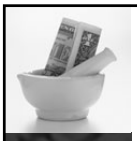
KEY POINT

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

PDE FIELDS AND TrOOP

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

TrOOP Accumulator



TrOOP ELIGIBLE OHI

Scenario

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

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

TrOOP Accumulator	

TrOOP ELIGIBLE OHI (CONTINUED)

Step 1: Identify the net change in Patient Pay Amount

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

TrOOP ELIGIBLE OHI (CONTINUED)

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

Other TrOOP Amount	$ 20

TrOOP ELIGIBLE OHI (CONTINUED)

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

Patient Pay Amount	$ 5

TrOOP ELIGIBLE OHI (CONTINUED)

Step 4: Update the TrOOP accumulator

Other TrOOP amount field is TrOOP eligible.

TrOOP Accumulator	+$25

TrOOP Eligible OHI (continued)

Result

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

TrOOP Accumulator	+$25

Adjustments/Deletions

ADJUSTMENT/DELETION PROCESSING AND TrOOP

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

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

REVERSAL WITH NO BENEFIT PHASE CHANGE – CATASTROPHIC BENEFIT PHASE

Beneficiary:

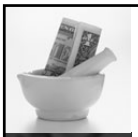
- ♦ Enrolled in DS plan and was in Catastrophic Phase
- ♦ Purchases three covered drugs
  - ◊ August 10 - $100 brand name drug, filled by pharmacy and billed to plan
  - ◊ August 15 - $75 brand drug
  - ◊ August 20 - $50 brand drug
- ♦ Reversal – August 21
  - ◊ Pharmacy reverses August 10 claim (prescription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

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

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

REVERSALS WITH BENEFIT PHASE CHANGE – CATASTROPHIC AND THE COVERAGE GAP

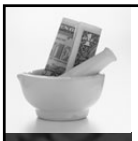
- Reversals with benefit phase change impact the following:
  - Benefit Administration
    - Update accumulators
    - Pay back benefit
      - Apply cost-sharing difference on future claims
      - or
      - Recalculate affected claims/settle with beneficiary
  - PDE Reporting (two options)
    - Report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



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

Beneficiary:

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



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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY

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

EVALUATION

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

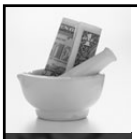
THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

TrOOP Facilitation

CMS



PURPOSE

- To learn how prescription drug claims work within the TrOOP Facilitation Process and how to accurately report TrOOP costs

OBJECTIVES

- Identify the requirements and processes for TrOOP Facilitation and COB at POS and plan
- Describe the six* steps in the TrOOP Facilitation process
- Explain the role of the COB Contractor and its services
- Apply the TrOOP Facilitation process

* Depending on the situation, it could be less than six.

COB AND TrOOP FACILITATOR OVERVIEW AND REQUIREMENTS

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

COB AND TrOOP FACILITATOR OVERVIEW AND REQUIREMENTS (CONTINUED)

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

BIN/PCN COMBINATIONS

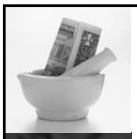
- BIN/PCN combinations allows the TrOOP Facilitation process to recognize (flag) claims that are secondary to Medicare Part D
- To support COB, CMS recommends payers that pay secondary/supplemental to Part D, establish BIN/PCN combinations that are unique/different than the BIN/PCN combination(s) for their other lines of business

TrOOP FACILITATION 6-STEP PROCESS

Step 1
Pharmacy attempts to fill prescription without plan information. Pharmacy executes E1 request transaction. E1 response transaction returns enrollment information including OHI (if any).

Step 2
Pharmacy submits claim to Part D plan.

Step 3
Part D plan/processor adjudicates and returns response to pharmacy with payment information.



TrOOP FACILITATION 6-STEP PROCESS (CONTINUED)

Step 4
If OHI is returned on response from 1st claim, pharmacy generates secondary claim to OHI payers, if necessary. Pharmacy switches identify claims as secondary to Part D and route claims to TrOOP Facilitator.

Step 5
OHI payer sends responses back to pharmacy routed through the TrOOP Facilitator.

Step 6
TrOOP Facilitator builds NCPDP N1 reporting transaction from the response and sends to the appropriate Part D plan.

ELIGIBILITY TRANSACTIONS

Real-Time Transaction from Pharmacy to Facilitator

Pharmacy

E1 Request Transaction

E1 Response Transaction

TrOOP Facilitator

ELIGIBILITY TRANSACTIONS
(CONTINUED)

Real-Time Transaction from Pharmacy to Facilitator Using a Switch

Pharmacy

E1 Request Transaction

E1 Response Transaction

Switch

E1 Request Transaction

E1 Response Transaction

TrOOP Facilitator

PAYER TRANSACTIONS

Real-Time and Batch Transaction from Facilitator to Part D Plans

Pharmacy

B Transaction

Switch

B Transaction

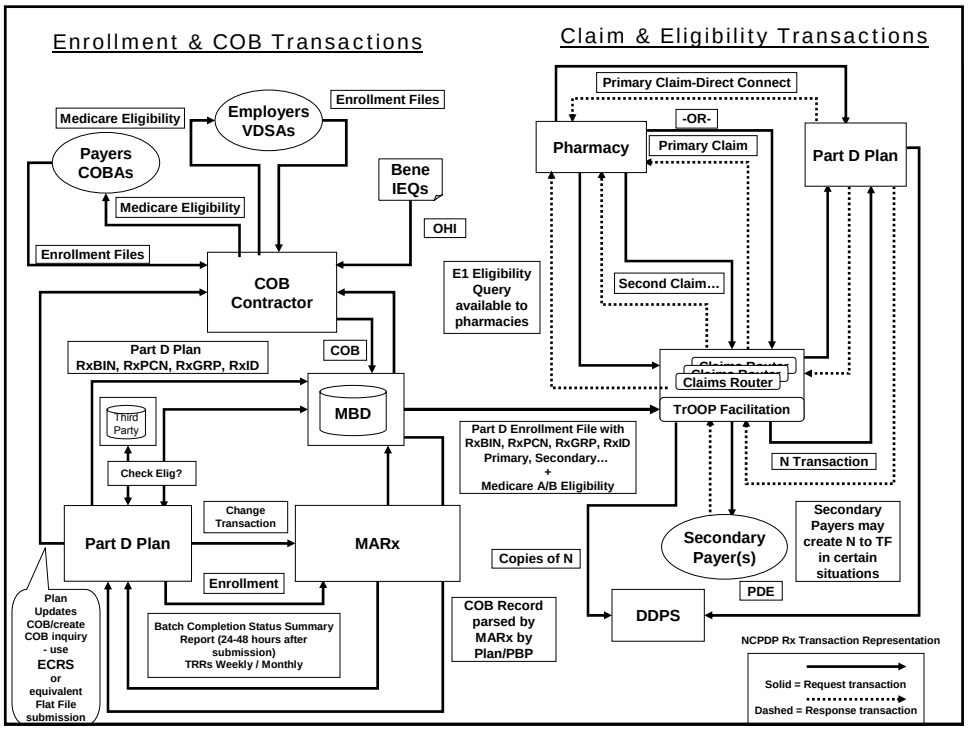
Supplemental Payer

B Transaction

TrOOP Facilitator

N Transaction

Part D Plan



TESTING PROCESS

- Real-time testing for N transactions:
  - ◊ From TrOOP Facilitator to Part D Plans
  - ◊ From supplemental payers to TrOOP Facilitator
- Details available under Payers and Testing Process at http://medifacd.ndchealth.com

TrOOP FACILITATOR AND TrOOP BALANCES

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

TRANSFERRING TrOOP BALANCES

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

SCENARIOS

A beneficiary enters a pharmacy with the following coverage:

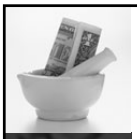
Scenario 1
Primary GHP coverage due to active employment, secondary Part D plan coverage, and SPAP coverage as payer of last resort (tertiary).

Scenario 2
Primary Part D plan coverage and secondary retiree GHP coverage.

Scenario 3
Primary Part D plan coverage and supplemental SPAP coverage.

SUMMARY

- Identified the requirements for COB and TrOOP Facilitation
- Described the six steps in the TrOOP Facilitation process
- Explained the COB Contractor and its services
- Applied the TrOOP Facilitation process



EVALUATION

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

THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Calculating and Reporting Low Income Cost-Sharing Subsidy

LTC, Inc.

PURPOSE

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

OBJECTIVES

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

LICS DEFINED

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

LICS RULES

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

LOW INCOME COST-SHARING SUBSIDY

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

LICS CALCULATION STEPS

Scenario

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

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

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

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

LICS CALCULATION STEPS
(CONTINUED)

4

3

2

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

$25

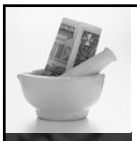
LICS CALCULATION STEPS
(CONTINUED)

4

3

2 Determine the LI beneficiary's maximum cost-sharing amount $5

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



LICS CALCULATION STEPS
(CONTINUED)

4

3 Compare non-LI and LI cost-sharing and apply "lesser of" test $25 > $5

2 Determine the LI beneficiary's cost-sharing amount $5

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

LICS CALCULATION STEPS
(CONTINUED)

4 Use the LICS Amount formula
$25- $5= $20

3 Compare non-LI and LI cost-sharing and apply "lesser of" test
$25 > $5

2 Determine the LI beneficiary's cost-sharing amount
$5

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

POPULATING THE PDE RECORD

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

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD

Scenario

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

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

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD (CONTINUED)

Result

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

Step 2: Determine the LI cost share:
$2

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

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

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

ACTUARIALLY EQUIVALENT INITIAL COVERAGE PERIOD (CONTINUED)

Populating the PDE Record

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

TrOOP Accumulator	+ $0.25

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER

Scenario

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

A LI-Category 4 eligible beneficiary with YTD gross covered drug costs=$2,800 purchases a covered brand drug for $45.

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

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

Result

Step1: Calculate the non-LI cost share:

100% coinsurance = $45

Step 2: Determine the LI cost share:

$45 x .15 = $6.75

Step 3: Apply the "Lesser of " Test:

$6.75 < $45

Step 4: Use the LICS Amount formula:

$45 - $6.75 = $38.25

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$ 6.75
CPP	
LICS Amount	$38.25
Other TrOOP Amount	

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

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

Drug Coverage Status Code	
Catastrophic Coverage Code	
GDCB	
GDCA	
Patient Pay Amount	$ 0.00
CPP	
LICS Amount	$38.25
Other TrOOP Amount	$ 6.75

DEFINED STANDARD COVERAGE GAP WITH TrOOP OTHER PAYER (CONTINUED)

Populating the PDE Record

Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
GDCB	$45.00
GDCA	$ 0.00
Patient Pay Amount	$ 0.00
CPP	$ 0.00
LICS Amount	$ 38.25
Other TrOOP Amount	$ 6.75

TrOOP Accumulator	+ $45.00

LICS AND STRADDLE CLAIMS

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

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

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

MODIFYING THE PDE

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

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

SUMMARY

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

EVALUATION

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

THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Calculating and Reporting Enhanced Alternative Benefit

LTC, Inc.

PURPOSE

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

OBJECTIVES

- Define the EA benefit, including two types of supplemental benefits that may be present in an EA benefit plan
- Administer an EA benefit, using business rules to identify basic versus enhanced components and report these to the CMS
- Utilize the principles for submitting a PDE for an EA drug
- Apply the business rules in calculating and reporting plan-paid amounts for EACS

EA BENEFITS

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

DATA FIELDS IN THE PDE RELATED TO EA BENEFITS

Three PDE fields identify EA benefits:

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

DRUG COVERAGE STATUS CODE AND EA

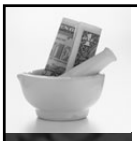
- Enhanced Alternative Drug = “E” for a supplemental drug
- Only EA plans can report a value of “E”

PDE Record
Drug Coverage Status Code
E

CPP AND EA

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

PDE Record
CPP
$



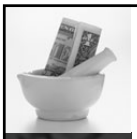
NPP AND EA

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

PDE Record
NPP
$

PRINCIPLES FOR EA DRUGS

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



EA DRUG

Scenario

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

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

EA DRUG (CONTINUED)

Results - Calculation

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

EA DRUG (CONTINUED)

Result - PDE Related Fields

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

BUSINESS RULES FOR CALCULATING AND REPORTING EACS

Reporting EACS involves three steps.

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

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

2006

EACS Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit
1	≤ $250	0%
2	>$250 and ≤ $2,250	75%
3	>$2,250 and ≤ $5,100	0%
4	> $5,100 and ≤ OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (gross covered drug cost -$2/$5)

BUSINESS RULES FOR CALCULATING AND REPORTING EACS (CONTINUED)

Calculating and reporting NPP—Method 1

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

Calculating and reporting NPP—Method 2

EACS = Plan-paid at POS − CPP

EACS – Rule #2

Scenario

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

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

EACS – RULE #2 (CONTINUED)

Results - Calculation

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

EACS – Rule #2 (CONTINUED)

Result - PDE Related Fields

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

EACS – RULE #4

Scenario

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

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

EACS – RULE #4 (CONTINUED)

Results - Calculation

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

EACS – RULE #4 (CONTINUED)

Result - PDE Related Fields

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

EACS – STRADDLE CLAIM

Scenario

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

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

EACS – STRADDLE CLAIM
(CONTINUED)

Results - Calculation

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

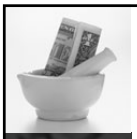
EACS – STRADDLE CLAIM
(CONTINUED)

Result - PDE Related Fields

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

RULES FOR EACS AND LICS

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



EACS - LICS

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

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

EACS - LICS (CONTINUED)

Results - Calculation

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

Beneficiary Liability	$10.00

EACS - LICS (CONTINUED)

Result

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

Step 2: Identify the LI cost share:
$2

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

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

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

EACS - LICS (CONTINUED)

Result - PDE Related Fields

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

SUMMARY

- Defined the EA benefit, including two types of supplemental benefits that may be present in an EA benefit plan
- Administered an EA benefit, using business rules to identify basic versus enhanced components and report these to CMS
- Utilized the principles for submitting a PDE for an EA drug
- Applied the business rules in calculating and reporting plan-paid amounts for EACS

EVALUATION

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

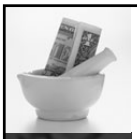
THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Calculating and Reporting Payment Demonstrations

LTC, Inc.



PURPOSE

- Provide the descriptions of the payment demonstration options and essential reporting rules related to submitting data

OBJECTIVES

- Define the three payment demonstration options
- Explain how the Flexible and Fixed capitated options are similar
- Recognize how the Flexible and Fixed Capitated options differ
- Understand how to administer benefits under the capitated options using the policy of mapping to the Defined Standard benefit

OBJECTIVES (CONTINUED)

- Describe how the Medicare Advantage (MA) rebate option is unique
- Administer benefits under a MA Rebate plan by allocating dollars to a beneficiary's True-Out-of-Pocket costs (TrOOP) that would normally constitute enhanced alternative cost-sharing
- Utilize the correct business rules to calculate and report Prescription Drug Events (PDE) for the Flexible Capitated, Fixed Capitated, and MA Rebate options

PAYMENT DEMONSTRATIONS

Increased flexibility in designing alternative prescription drug coverage

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

THE THREE OPTIONS

Flexible Capitated	• Reduces/eliminates cost-sharing (any phase) • Risk sharing in Catastrophic Coverage phase based on the Defined Standard • Catastrophic Coverage begins when the OOP threshold is met
Fixed Capitated	• Reduces/eliminates cost-sharing (any phase) • Risk sharing in Catastrophic Coverage phase is based on the Defined Standard • Catastrophic Coverage is fixed at $5,100 (in 2006) in YTD gross drug cost
MA Rebate	• Reduces/eliminates cost-sharing (coverage gap required) • Supplemental benefits funded with A/B rebate dollars and counts towards TrOOP • Catastrophic Coverage begins when the OOP threshold is met

FLEXIBLE & FIXED CAPITATED OPTIONS

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

FLEXIBLE & FIXED CAPITATED OPTIONS (CONTINUED)

Catastrophic Coverage phase begins…

Flexible Capitated Option:

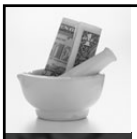
TrOOP = $3,600 (in 2006)
= $3,850 (in 2007)
= $4,050 (in 2008)

Fixed Capitated Option:

YTD gross drug cost = $5,100.00 (in 2006)
= $5,451.25 (in 2007)
= $5,726.25 (in 2008)

PDE FIELDS RELATED TO FLEXIBLE AND FIXED CAPITATED OPTIONS

Catastrophic Coverage Code
GDCB
GDCA
Patient Pay Amount
CPP
NPP



BUSINESS RULES FOR CALCULATING AND REPORTING CAPITATED OPTIONS

Reporting Capitated options involves three steps.

Step 1	Report beneficiary amount paid at POS in **Patient Pay Amount** field
Step 2	Calculate and report **CPP**
Step 3	Calculate and report **NPP**

CALCULATING CPP (2006)

Rule #	YTD Gross Covered Drug Cost	Percentage to Calculate Defined Standard Benefit	
		Flexible Capitated Option	Fixed Capitated Option
1	≤ $250	0%	
2	> $250 and ≤ $2,250	75%	
3	> $2,250 and ≤ $5,100	0%	
4	> $5,100 and ≤ OOP threshold	Lesser of 95% or (Gross covered drug cost -$2/$5)	N/A
5	> OOP threshold	Lesser of 95% or (Gross covered drug cost -$2/$5)	

FLEXIBLE CAPITATED OPTION

Scenario

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

Results

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

FLEXIBLE CAPITATED OPTION
(CONTINUED)

Results

Calculation

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

FIXED CAPITATED OPTION

Scenario

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

Results

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

FIXED CAPITATED OPTION
(CONTINUED)

Results

Calculation

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

MA REBATE OPTION

Supplemental benefit filling in all or part of the Defined Standard's Coverage Gap

- MA Rebate dollars fund the entire supplemental benefit and may not charge a supplemental premium.
- Counts toward TrOOP
- May change cost-sharing in the Initial Coverage period or in Catastrophic
- Standard OOP threshold rules

REPORTING MA REBATE OPTION

Initial Coverage Period

- Same as non-demonstration Basic benefits

Coverage Gap Phase

- Plan spending at POS is attributed to **Other TrOOP** amount.

Catastrophic Coverage Phase

- Same as non-demonstration Basic benefits

The MA Rebate option will not report NPP amounts for covered drugs in any phase of the benefit.

MA REBATE OPTION

Scenario

Plan C retains the Deductible and eliminates the Coverage Gap. The plan offers tiered cost-sharing of $5/$20/$40 between the Deductible and Catastrophic up until Catastrophic Coverage. The beneficiary has a 2006 YTD gross covered drug costs of $3,000 and purchases a $100 covered Tier 1 Part D drug.

Results

Drug Coverage Status Code	
Catastrophic Coverage Code	
Gross Covered Drug Cost	$
Patient Pay Amount	$
CPP	$
Other TrOOP Amount	$

MA REBATE OPTION
(CONTINUED)

Scenario

Plan C retains the Deductible and eliminates the Coverage Gap. The plan offers tiered cost-sharing of $5/$20/$40 between the Deductible and Catastrophic up until Catastrophic Coverage. The beneficiary has a YTD gross covered drug costs of $3,000 and purchases a $100 covered Tier 1 Part D drug.

Results

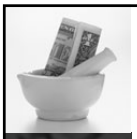
Drug Coverage Status Code	C
Catastrophic Coverage Code	<blank>
Gross Covered Drug Cost	$ 100.00
Patient Pay Amount	$ 5.00
CPP	$ 0.00
Other TrOOP Amount	$ 95.00

SUMMARY

- Defined the three payment demonstration options
- Explained how the Flexible and Fixed capitated options are similar
- Recognized how the Flexible and Fixed Capitated options differ
- Now understand how to administer benefits under the capitated options using the policy of mapping to the Defined Standard benefit


SUMMARY (CONTINUED)

- Described how the Medicare Advantage (MA) rebate option is unique
- How to administer benefits under a MA Rebate plan by allocating dollars to a beneficiary's True-Out-of-Pocket costs (TrOOP) that would normally constitute enhanced alternative cost-sharing
- Utilized the correct business rules to calculate and report Prescription Drug Events (PDE) for the Flexible Capitated, Fixed Capitated, and MA Rebate options




EVALUATION

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

THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Edits

LTC, Inc.

PURPOSE

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

OBJECTIVES

- Describe the edit logic for the PDFS and DDPS
- Identify the nine edit categories in DDPS
- Recognize the resolution process for resolving errors received from the PDFS and DDPS

EDIT PROCESS

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

Format **Integrity** **Validity**

PDFS EDITS

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

PDFS EDIT LOGIC AND RANGES

Series	Range	Explanation
100	126-150	File level errors on HDR
	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

PDFS EDIT CODES

Scenario

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

PDFS EDIT CODES (CONTINUED)

Result

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

DDPS EDITING RULES

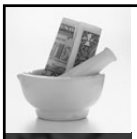
Stage 1	**Individual Field Edits**
Stage 2	**Enrollment/Eligibility Edits**
Stage 3	**Duplicate Check Edits**
Stage 4	**Field-to-Field Edits**

DDPS EDITING RULES
(CONTINUED)

Adjustments/Deletions

EDIT RANGES AND CATEGORIES

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



DRUG COVERAGE STATUS CODE EDITS

Scenario

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

DRUG COVERAGE STATUS CODE EDITS (CONTINUED)

Result

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

COMMON EDITS

Edit Code	Description
132	Duplicate file ID
234	PBP does not match Contract ID
737	Inappropriate Drug Coverage Status Code of “O”, although drug is on OTC list
777	Duplicate PDE record
779	Submitter cannot report NPP for covered Part D drug

RESOLUTION PROCESS

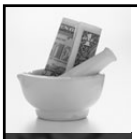
- Paths for resolving errors:
  - ◊ Correct individual errors
  - ◊ Assess factors causing errors and correct system problems if there are deficiencies
  - ◊ Measure and improve performance to reduce future errors
- Tools to manage and reduce errors:
  - ◊ DDPS Return File
  - ◊ Management reports
 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

RESOLUTION PROCESS
(CONTINUED)

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

RESOLUTION PROCESS
(CONTINUED)

- Edits requiring specific problem-solving steps:
  - ◊ Eligibility (Edits 700-710)
  - ◊ LICS
    - 715-Use best available data policy
    - 716-721-CMS data is accurate



RESOLUTION PROCESS
(CONTINUED)

Plans can ask the following questions:

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

SUMMARY

- Described the edit logic for the PDFS and DDPS
- Identified the nine edit categories in DDPS
- Recognized the resolution process for resolving errors received from the PDFS and DDPS

EVALUATION

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

THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Reports

LTC, Inc.

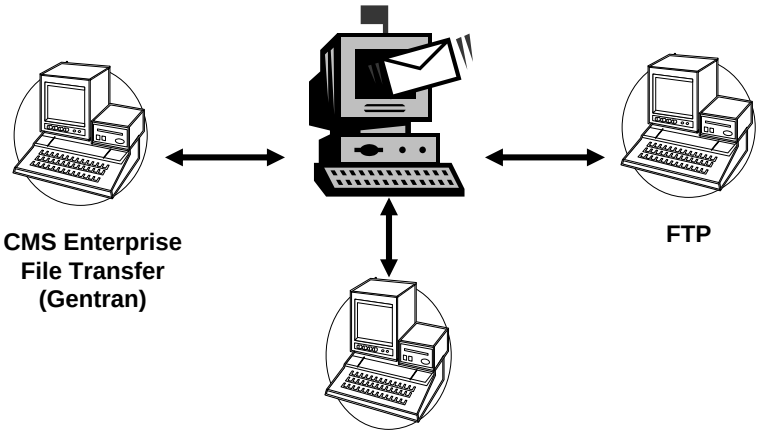
PURPOSE

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

OBJECTIVES

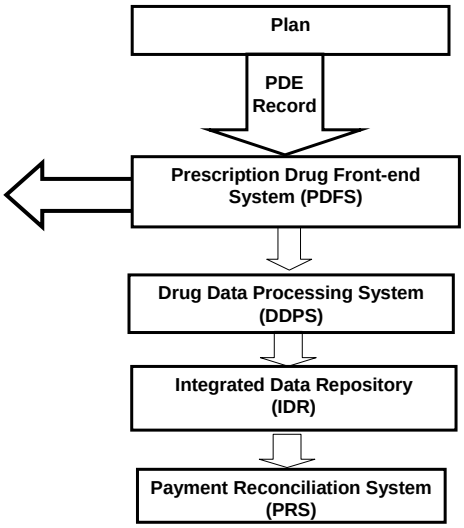
- Identify the purpose of PDFS, DDPS, and IDR reports
- Determine the best use of the reports to monitor data processes and resolve errors
- Read the reports to identify and submit corrections
- Recognize th relationship between values in the management reports and reconciliation

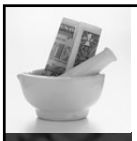
ACCESSING REPORTS



REPORTS OVERVIEW

PDFS Response Report

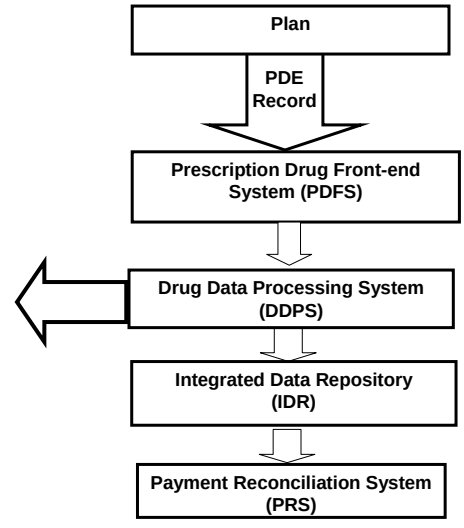




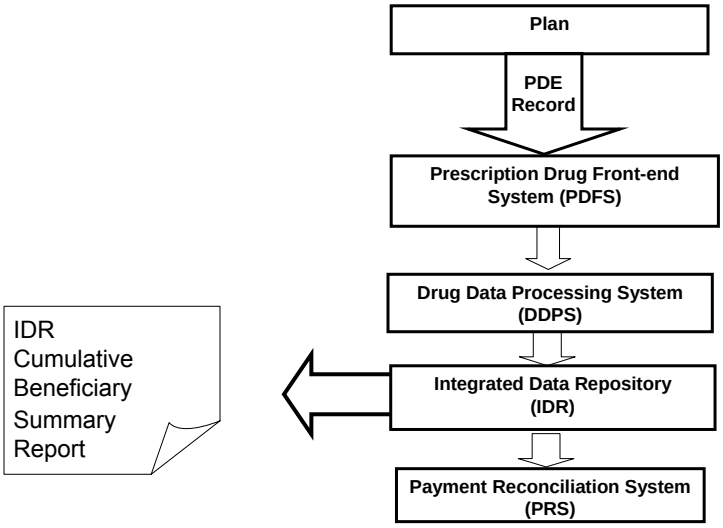
REPORTS OVERVIEW
(CONTINUED)

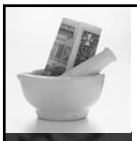
DDPS Return File

DDPS Transaction Error Summary Report



REPORTS OVERVIEW
(CONTINUED)





NAMING CONVENTIONS

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

NAMING CONVENTIONS
(CONTINUED)

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

PDFS RESPONSE REPORT

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

TRANSACTION REPORTS

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

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

DDPS RETURN FILE

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

DDPS TRANSACTION ERROR SUMMARY REPORT

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

CUMULATIVE BENEFICIARY SUMMARY REPORTS

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

CUMULATIVE BENEFICIARY SUMMARY REPORTS (CONTINUED)

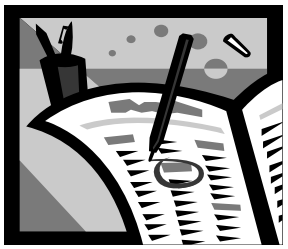
- Totals apply to dates of service for one benefit year
- Each benefit year has separate cumulative reports
- Financial amounts are reported as “net”.
- Reports will break by submitter, contract, and PBP
- Available in flat file layout early in the month for data submitted the previous month

SUMMARY

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

EVALUATION

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



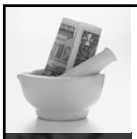
THANK YOU!

2007 REGIONAL TRAINING

Prescription Drug Event Data Foundations

Reconciliation

CMS



PURPOSE

- Explain systems and steps used in the reconciliation process to calculate reconciliation payment amounts.

OBJECTIVES

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

RECONCILIATION

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

FOUR PAYMENT METHODOLOGIES

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

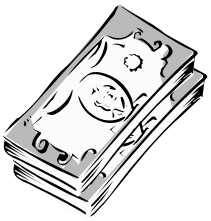
See Module 1 – Part D Payment Methodology

DIRECT SUBSIDY

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

PROSPECTIVE PAYMENTS

- Medicare Advantage Prescription Drug System (MARx) calculates and reports monthly prospective payments.
- Plans monitor monthly prospective payments for accuracy.



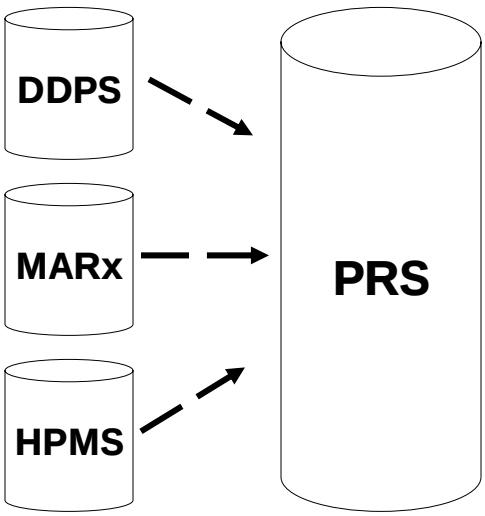
ACTUAL COSTS

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

ACCURATE, TIMELY PDES

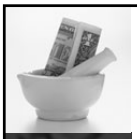
- PDE data must be accurate and timely.
- For purposes of reconciliation, PDE data must be submitted by May 31 following the end of the benefit year.

RECONCILIATION SYSTEMS OVERVIEW



DATA OVERSIGHT

- Effective data oversight is continuous, timely, and thorough.
- Data oversight has four aspects:
  - Monitor prospective payments.
  - Track enrollment and LICS eligibility data.
  - Ensure that submitted PDE data are accurate and 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.



LOW INCOME COST-SHARING

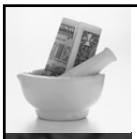
- Compare actual LICS reported on PDEs to prospective LICS amounts from MARx.
  - Actual LICS is retained in DDPS.
  - LICS reconciliation is performed at the plan level based on the sum of all beneficiary LICS amounts for that plan.

BAYSIDE'S LOW INCOME COST-SHARING RECONCILIATION

LICS Reconciliation Amount

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

LICS Reconciliation Amount = $120,000



REINSURANCE SUBSIDY

- Sum all GDCA for the plan.
- Calculate the DIR Ratio.
- Calculate the reinsurance portion of DIR and subtract from GDCA.
- Multiply by 0.8 to determine the reinsurance subsidy.
- Subtract the prospective reinsurance amounts paid in MARx from the actual reinsurance subsidy to determine the reinsurance reconciliation amount.

CALCULATE THE 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

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

DETERMINE THE ALLOWABLE REINSURANCE COST

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

DETERMINE BAYSIDE'S ALLOWABLE REINSURANCE COST

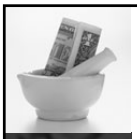
Allowable Reinsurance Cost

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

Allowable Reinsurance Cost = $2,474,945

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

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 Adjustment Amount

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

Reinsurance Reconciliation 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

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

RISK CORRIDORS 2006

		80% payment
$4,433,940 and more	**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		
$4,011,660 and less	**2nd Threshold Lower Limit**	**75% repayment**
		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

DETERMINE RISK SHARING

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

DETERMINE BAYSIDE'S RISK SHARING

Cost Subject to Risk Sharing

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

Total Cost Subject to Risk Sharing = $209,983

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

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

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

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

DETERMINE BAYSIDE'S RISK SHARING

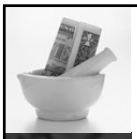
Risk Sharing Payment

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.



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

ADJUSTMENT DUE TO PAYMENT RECONCILIATION

	Reconciliation Amounts
	Low Income Cost Sharing Subsidy Amount
+	**Reinsurance Subsidy Adjustment Amount**
+	**Risk Sharing Amount**
–	**Budget Neutrality Adjustment Amount (Demonstration Plans Only)**
=	**Adjustment Due to Payment Reconciliation Amount**

BAYSIDE'S ADJUSTMENT DUE TO PAYMENT RECONCILIATION

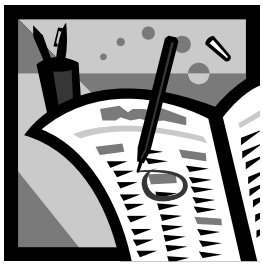
LICS Reconciliation	$120,000
Reinsurance Subsidy Reconciliation	+($120,044)
Risk Sharing	+ $178,543
Budget Neutrality Adjustment Amount	- $37,850
Adjustment Due to Payment Reconciliation Amount	**$140,649**

SUMMARY

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

EVALUATION

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



THANK YOU!