



**CMS Responses to Questions from Potential  
Proposers for**

**Request for Proposals**

**Medicare Part D  
Retroactive and Point of Sale Coverage for  
Certain Low Income Beneficiaries**

*Issued March 20, 2009*

*Proposals due 5:00 p.m. EDT May 8, 2009*

- 1) A.3.1, p. 6: Will CMS supply a prospective termination date to the Contractor for all retroactive enrollments into the Contractor?

A: Yes, the Transaction Reply Report (TRR) that includes the enrollment confirmation into the Contractor should be accompanied by the disenrollment effective date. The disenrollment effective date will be generated by CMS' prospective auto/facilitated enrollment into a PDP that qualifies to receive auto/facilitated enrollments.

- 2) A.3.2, p. 7: In the last paragraph on page 7, the RFP states that if low income subsidy (LIS) eligibility is present on CMS' systems, those members are immediately enrolled into the "Contractor's standard plan" retroactively. Please confirm that the "standard plan" is the Contractor's unique contract/PBP as referenced on page 37 B.1.a, and not the standard plan referenced in B.1.b.

A: Page 7 describes the existing POS FE process, where Confirmed Beneficiaries are enrolled in the 2009 contractor's standard LIS plan (for month of service forward). Page 37 refers to the 2010 model of POS FE, where retroactive enrollments will be in unique contract ID X0001; prospective enrollments will be random, and will go to PDPs that qualify to receive auto/facilitated enrollments (including any that may be offered by the Contractor).

- 3) A.3.2, p. 7 This section stipulates that the Contractor work with a CMS contractor on checking state eligibility; on page 17 (A.6.18) it refers to the Contractor working with the states; and then on page 37 (B.1.3) it says CMS will facilitate the request to 50 states. Please clarify the differences among these statements.

A: Again, page 7 describes what happens in 2009, where the POS FE contractor is required to use another CMS contractor (QSSI) to do eligibility verifications. Under the demonstration contract, the Contractor will be responsible for conducting the eligibility verification process with states, either directly or through a subcontracted arrangement. However, CMS will work with the Contractor to ensure a smooth transition with the states to the new eligibility verification arrangement.

- 4) A.6.1.f, p. 9: Will the unique contract/PBP for the retroactive autoenrollments be the same unique contract/PBP for POS FE?

A: Yes. CMS expects that the contract ID will be "X0001" and that there will be a single PBP of "001" for all 34 PDP regions.

- 5) A.6.3, p. 10 In interfacing with CMS' TrOOP Facilitation Contractor (currently RelayHealth) for POS FE eligibility purposes, what is the scope within which CMS permits the TrOOP Facilitation Contractor to use the data the TrOOP Facilitation Contractor receives from CMS to support enhanced E1 queries?

A: The TrOOP Facilitation Contractor is permitted to subcontract with potential proposers for the Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries demonstration to perform front-end claims eligibility edits using the data specified in the data use agreement (DUA) addendum that permits the TrOOP Facilitation Contractor's current re-use of

CMS eligibility data for Anthem, the 2009 CMS POS FE contractor. Re-use of any additional data or performance of additional activities for a potential proposer for the demonstration contract would require CMS approval.

- 6) A.6.5, p. 11: Relative to the Eligibility Verification System, is it CMS' expectation that this be built by the Contractor, or can it be subcontracted?

A: The Contractor may build the eligibility verification function or it may subcontract the function.

- 7) A.6.12 and A.6.16, pp. 12 and 16: Does the Contractor use the current plan year benefit and copayment to adjudicate claims where the date range spans more than one plan year?

A: The Contractor must adjudicate claims using the benefit parameters and LIS level for the year the services were rendered (fill/dispense date) to the beneficiary with the exception of any deductible, as no deductible may be charged under the demonstration contract.

- 8) A.6.14, p. 14: Is it possible that once the members have been prospectively enrolled into a Medicare Part D plan, and disenrolled from the Contractor's unique plan, that a retroactive change could happen to the member's LIS status? In that instance, would the Contractor be required to make the beneficiary whole?

A: Yes, this scenario is possible and, in such instances, the Contractor would be responsible for making the beneficiary whole.

- 9) A.6.15.c.i, p. 15: Does the new Contractor have to process those claims from 36 months ago (i.e. 2007) or just claims that would fall from claims with Date of Service of Jan 1, 2010 on for 36 months?

A: The Contractor must process claims up to 36 months in the past without prior authorization. For example, in May, 2010, the 36 months would extend back to June, 2007, with older claims requiring prior authorization.

- 10) A.6.17.a, p. 17: Regarding the time frame in which the Contractor must submit enrollment transactions for Confirmed Beneficiaries, a 2-day timeframe for any enrollment process is very aggressive. Can it be lengthened?

A: Yes, CMS will modify this deadline to be consistent with the standard enrollment transaction submission deadline of 7 calendar days.

- 11) A.6.17.a.ii, p. 17 Regarding special coding instructions for enrollment transactions and PDE under the demonstration contract, will those be supplied?

A: Yes. There will be unique values for enrollment source code and election type on the enrollment transaction. At this time, there are no unique values for data elements on PDE, but CMS will inform the Contractor of any future changes.

- 12) A.6.20.c., p. 19: With respect to the risk of unrecoverable costs from claims paid for Unconfirmed Beneficiaries who subsequently were determined to be

Ineligible Beneficiaries, the RFP stipulates this risk is the Contractor's responsibility. Is this negotiable?

A: This risk should be factored into the estimate of bad debt within the administrative portion of the Contractor's bid (see section C.4, Table 1, row labeled "Bad Debt: Ineligibles' Claims"). However, please note that per section A.7 (p. 27), the administrative portion of the Contractor payment can be renegotiated if it is significantly different than original estimates.

13) A.6.21, p. 19-21: In the treatment of appeals and grievances, is there an expectation that contact with the Social Security Administration will be necessary? If so, is there a facilitated process for working directly with Social Security? Today, Social Security will only respond to inquiries if the beneficiary is on the call.

A: We anticipate few if any appeals under this contract, given that most appeals are tied to formulary restrictions and utilization management, which are not applicable under this demonstration. With respect to verifying if an individual is an LIS applicant (including their correct copayment level), the Contractor would only be required to query CMS' systems, or accept Best Available Evidence, to verify LIS applicant status.

14) A.6.25, p. 22: Can a Medicaid subrogation company (third party) submit claims to the Contractor on behalf of beneficiary?

A: The demonstration Contractor is not required to accept claims submitted by a subrogation company on behalf of a Medicaid beneficiary.

15) A.6.26-28, pages 23-25. What is CMS' expectation for the negotiated rates used to reimburse pharmacy providers that have a contractual relationship with the Contractor?

A: CMS expects the rates used to reimburse contracted pharmacy providers and develop the drug cost estimates for Payment Rate B in section C.4, Table 2, to be reasonable relative to the negotiated prices paid to the contracted pharmacy providers under its other defined standard PDPs.

16) A.6.25.d and A.6.27.c, p. 23: When would the Contractor collect the member copayment?

A: The Contractor would not collect a copayment but rather decrease the reimbursement to the pharmacy or beneficiary by the applicable copayment amount.

17) A.6.25.d and A.6.27.c, p. 23: Does the Contractor reduce payment to pharmacy provider by the applicable member copayment?

A: Yes.

18) A.6.25.d and A.6.27.c, p. 23: Will the Contractor collect member copayments when cost is above the gross drug costs above out of pocket thresholds (GDCA)?

A: The Contractor would not collect copayment but rather decrease the reimbursement by the applicable copayment amount, if any. For example, after the GDCA, those initially eligible for 15% coinsurance who would pay the lesser of copayment level 1 (\$2.50/\$6.20 in 2009) or 5% coinsurance.

19) A.6.26.e, p. 24: Can the Contractor require network pharmacists to collect wrongfully paid claims from beneficiaries?

A: No. Per the RFP, pharmacies will be held harmless for claims from beneficiaries found to be ineligible for the process. The Contractor should seek recovery directly and build potential uncollected amounts into the bad debt estimate (see question 12). The only exceptions are for duplicate payment or fraud, waste, and abuse; in these instances, the Contractor can reverse pharmacy claims after giving ample time for the pharmacy to respond. Additionally, the Contractor must provide the pharmacy with a reason for these reversals.

20) A.6.27.b, p. 25: The RFP requires that "Pharmacy providers that do not have a contractual relationship with the Contractor shall be (i) paid their Usual and Customary (U&C) rate; **and** (ii) provided the means for submitting claims at no greater cost than contractor pharmacy providers would incur for the same transaction." Should this be: (i) **or** (ii), whichever is less?

A: No, in subparagraph (i) of this section, "U&C" is what the Contractor must reimburse for the cost of the claim itself. Separately, subparagraph (ii) requires that costs related to submitting the transaction (transaction fee) may not be in excess of what the Contractor charges network pharmacists.

21) A.6.27.b, p. 25: Can the Contractor encourage a beneficiary using an out-of-network pharmacy to use mail order or an in-network pharmacy?

A: No, given that a beneficiary will be enrolled in this plan only retroactively or for a very short time, we do not believe the Contractor should encourage a change in pharmacy provider. Such changes could be counterproductive if the future Part D plan receiving the auto-enrollment does not have the same pharmacy in their network.

22) A.6.29, p. 25: Will the two populations use the same formulary?

A: Yes. Please note that that the vendor must cover all Part D drugs subject only to Part B vs. D and safety edits as opposed to their other "formularies."

23) A.6.29.b, p. 25: For a drug that could be either a Part B or Part D drug, does the Contractor need to make the determination whether the drug is Part B or Part D covered?

A: Yes, this is an existing Part D requirement that also applies to the demonstration Contractor. Whenever a Part B vs. Part D edit occurs, that coverage determination needs to be resolved at the point of sale. The Contractor must follow the Part B vs. Part D standards and coverage policy as outlined in Chapter 6 of the Medicare Prescription Drug Manual.

24) A.6.29, p. 25: Are claims under the contract subject to standard Part D requirements on primary versus secondary payor?

A: While we do not anticipate that many of these beneficiaries will have secondary coverage, the Contractor will need to receive Coordination of Benefits (COB) files from CMS and coordinate benefits with secondary payers when necessary.

25) A.6.29.b, p. 25: This section references the requirement for appropriate use of safety edits. Is it expected or prudent to document the safety and abuse edits used in the development of Cap Rates A & B?

A: It is not expected that proposers document the safety and abuse edits used to develop their estimates for Rates A & B.

26) A.7, p. 27: Will CMS provide claims data for the retroactive enrollment population for plans to use as a baseline for this population?

A: CMS does not intend to provide any additional data regarding the retroactive enrollment population beyond what has already been provided in Appendix 2, with the exception of noting the risk score for beneficiaries included in the retroactive coverage data in the first item in Appendix 2 was 1.062.

27) A.7, p. 27: Regarding the calculation of monthly payments, does prospective payment include all months up to auto assignment or just current month?

A: Yes, payment will be made for all months up to the month that auto-assign is effective.

28) A.7, p. 27: Payment Methodology -- Will capitation payment apply to retroactive member months?

A: Yes. The capitation payment described on pages 27 and 28 of the RFP would apply for each month that a beneficiary is enrolled in the Contractor's plan, including retroactive member months.

29) A.7, p. 27: Payment Methodology -- With respect to the example on slide 10 presented at the pre-proposal conference, would capitation payment be made for 21 months?

A: Yes. In the example on slide 10, the beneficiary is enrolled in the Contractor's plan for the retroactive period of 10/1/08 to 6/30/10. The Contractor would receive capitation payments for these 21 months of retroactive coverage.

30) A.7, p. 28: Please advise what "LICS amounts from PDE records" represents in the demonstration allowable risk corridor costs (DARCC) formula.

A: This refers to the low-income cost sharing amounts which Part D sponsors would report on the PDE records. The demonstration Contractor would be required to report the difference between the cost sharing for non-LIS beneficiaries under the defined standard benefit and the cost sharing for LIS beneficiaries under the demonstration contract in the LICS field of the PDE

records. The Contractor would assume the defined standard benefit for purposes of PDE calculations.

31) A.7, p. 28: There is an equation for Demonstration Allowable Risk Corridor Costs, based on Covered Plan Paid (CPP) Amounts from the PDE Records and LICS Amounts from the PDE Records. The use of both fields in the calculation infers that there is an underlying member benefit (CPP), supplemented by governmental cost sharing subsidy (LICS). However, if we understand the rest of the document, the Contractor cannot impose a deductible, cannot impose a coverage gap, cannot charge a premium, and will not receive direct subsidy, low-income subsidy, or reinsurance payments. Taken together, that implies to us that the entire amount between the cost of the drug and the member's low income cost sharing amount is actually the plan payment amount, and subject to the narrow risk corridor calculations, and there will be no LICS amount reported on the PDE record. Please clarify the use of those fields in this calculation, and the benefit that is expected to be administered and reconciled.

A: The prospective capitation payments made to the Contractor will replace the direct subsidy, low-income subsidy, and reinsurance payments typically made under Medicare Part D. The Contractor will be required to report the difference between the cost sharing for non-LIS beneficiaries under the defined standard benefit and the cost sharing for LIS beneficiaries under the demonstration contract in the LICS field of the PDE records. The remaining amount calculated as (Gross Covered Drug Cost – member's low income cost sharing amount – LICS) will be reported in the CPP field of the PDE record. The amounts reported in both the LICS and CPP fields, net of the Contractor's direct and indirect remuneration, will be subject to the narrowed risk corridors described on page 28 of the RFP. Thus, the entire amount between the net cost of the drug and the enrollee's cost sharing will be subject to risk sharing. While the Contractor will not receive separate low-income cost sharing subsidy payments, the Contractor will be required to report LICS amounts on the PDE record to provide CMS with data for the evaluation of this demonstration.

32) B.1.3, p. 37: States' Eligibility Systems - What assistance does CMS provide in facilitating the Plan's access to States' Medicaid eligibility verification systems (EVS)?

A: CMS will be able to assist the Contractor in requesting an "atypical" provider identification number to access state Medicaid eligibility data. Since all states are now familiar with this process with CMS, and many states provide this to health plans, we do not expect the demonstration contractor to encounter any obstacles to gaining access to state EVS. Please note that each state has its own method for connecting to its EVS and its own procedure for obtaining a dummy provider number and password. Currently, CMS' eligibility verification contractor, QSSI, leverages EDI automation via Emdeon, which performs electronic batch queries of 44 states' EVS; for the rest, QSSI submits queries directly to the state.

33) B.1.4, p. 37: Is enhanced BEQ batch or direct connect?

A: The enhanced BEQ is a batch process, similar to what is currently provided in the regular BEQ process available to Part D plans.

34) B.1.11, p. 38: Does CMS have dedicated Central Office staff to assist the Contractor with ongoing operational/regulatory guidance, or will the Contractor continue to use existing dedicated Regional Office resources?

A: Yes, there will be dedicated CMS Central Office staff for the demonstration contract.

35) C.5, p. 54: Define bad debt categories: Ineligibles' claims, Uncollected cost sharing, and, specifically, where premium bad debt resides.

A: Enrollees in the demonstration contract will not be charged a premium. Therefore, there should be no premium bad debt. The category "Ineligibles' claims" refers to amounts not recouped from Unconfirmed Beneficiaries subsequently determined to be Ineligible Beneficiaries for POS immediate coverage. The "Uncollected cost sharing" category would include any cost sharing not collected from plan enrollees.

36) C.5, p. 58-59: Can we use prospective 2009 data for Version 1 of Table 1 as it most accurately reflects the cost structure in place to provide these services?

A: Proposers must provide 2008 data in Version 1 of Table 1. Proposers may use 2009 data to explain adjustments made to develop their estimates in Version 2 of Table 1.

37) Appendix 2, p. 67: What are the historical claim and beneficiary statistics pertaining to how many transactions come in as paper claims?

A: Currently, paper claims are not accepted in the 2009 POS FE contract.

38) Appendix 2, p. 67: What are the historical claim and beneficiary statistics pertaining to the percentage of collections, based on dollars, pertaining to claims filled where a beneficiary does not ultimately qualify for Medicare?

A: From July – December 2008, approximately 4% of the claims dollar amount was collected out of the total claims dollar amount subject to recovery from beneficiaries who are determined ineligible for POS FE.

39) Appendix 2, p. 67: What are the historical claim and beneficiary statistics pertaining to what percent of claims are state to plan claims?

A: State to plan is not a feature of POS FE, but CMS can provide data on plan-to-plan claims. From July – December 2008, approximately 5% of all accepted claims that were later determined ineligible for POS FE were deemed ineligible due to other Part D enrollment on the date of service and required the POS FE Contractor to conduct Plan-to-Plan reconciliation.

40) Appendix 2, p. 67: What are the historical claim and beneficiary statistics pertaining to the breakdown of beneficiaries by region using this program, further broken down by whether the beneficiary was Medicare eligible or not?

A: These data are not available by region. For February 2009, there were 6,535 POS FE claims that were rejected due to invalid HICN and 191 POS FE claims that were rejected due to not being Part D eligible.

41) Appendix 2, p. 67: What are the historical claim and beneficiary statistics pertaining to any seasonality in this program?

A: POS FE utilization has been highest in January of each year. There has been an approximate 39 percent decline in utilization between January and February, followed by an approximate 13 percent increase in utilization each month from March through May. Beginning in June, utilization begins to decline at an approximate rate of 8 percent each month through December. There is typically a 25 percent increase in utilization at the beginning of each month that declines by approximately 10-25 percent each week during the remaining 3 weeks of the month.

42) Appendix 2, p. 67 Enrollment Populations: Is there any anticipated overlap between the quoted estimates of enrollment between the two populations, Retroactive Coverage (40K) and Point-of-Sale Coverage (28K total, 8K accepted)?

A: No, CMS anticipates little overlap between the estimates.

43) Appendix 2, Table 1, p. 69: What are the drug costs associated with the retroactive auto/facilitated enrollments for a given month in 2008?

A: CMS is unable to provide this specific information at this time. However, please see the general information provided in Appendix 2 on page 67 of the RFP.

44) Appendix 2, Tables 2-3, pp. 70-71: Which fields from the tables on pages 70-71 should be used to calculate the ratio of ineligibles' unpaid claims to total claims?

A: In tables 2 and 3 of Appendix 2, we provided only the beneficiary-level data (number of 1st attempt letters) and dollar amounts of uncollected claims costs for ineligibles, as opposed to claim counts. Approximately 4% of the total processed claims represent the volume of unpaid claims for ineligibles. As a result of the front-end edit created in December 2008 for blocking repeat ineligibles, the percent of unpaid claims for ineligibles has decreased to 3% of the total processed claims (based on Jan.-Feb. 2009 claims data).

45) Appendix 2, Table 2, p. 70. What percent of the rejected claims were rejected at the point of sale?

A: 73% of the total rejected claims were rejected at the point of sale.

46) Appendix 2, Tables 2-3, p. 70-71: Please advise if the dates represented are "incurred" or "paid."

A: The dates represent paid dates.

47) Appendix 2, pp. 67-70: The Contractor will be taking risk for high utilization for a sicker and more vulnerable population for consumption that has already occurred. Will that non-identifiable data be available to help aid in pricing?

A: Currently, CMS does not intend to provide any additional data regarding the retroactive enrollment population beyond what has already been provided. Please see the information provided in Appendix 2 on page 67.

48) Appendix 3: Is the 4Rx data the Contractor will send back for claims rejected in the same format as Sponsors currently send for Part C plans (for COB)?

The 4Rx data sent back by the TrOOP facilitation contractor in the secondary message for code 41 is in the format of the E1 query response. It provides the BIN, PCN, Group ID, and Member ID of the Part D plan in which the beneficiary is enrolled as of the Date of Service of the claim. In addition, it provides that Part D plan's contract number and telephone number.

49) Presumptive Enrollment - What mechanism is in place to reimburse (if any) the Plan for presumptive enrollments that end up non-qualified?

A: If by presumptive enrollment, the inquirer means POS FE coverage prior to temporary enrollment, then the Contractor must attempt to recover any amounts paid to Unconfirmed Beneficiaries subsequently determined to be Ineligible Beneficiaries. If the beneficiary does not pay, there is no reimbursement per se, but the costs should be built into the bad debt estimate. Please see question 11 for more information.

50) Can the Plan retain any discounts negotiated with pharmaceutical manufacturers for these individuals?

A: Any discounts received by the Contractor must be applied to the negotiated price or reported to CMS as Direct or Indirect Remuneration (DIR).

51) Monthly Attestations - What are the consequences of attesting for beneficiaries who may eventually not be qualified, or are these to be excluded?

A: The Contractor should not submit enrollments for Unconfirmed Beneficiaries until after the individuals have been determined to be Confirmed Beneficiaries and thus qualified for enrollment.

52) Is CMS willing to share some of the challenges encountered by previous contractors or CMS in the program's administration prior to the appointment of a new contractor?

A: We believe that the majority of challenges were basically start-up issues, and this RFP reflects how they were successfully resolved. Please see [www.cms.hhs.gov/reports/downloads/Bagchi.pdf](http://www.cms.hhs.gov/reports/downloads/Bagchi.pdf) for a CMS-contracted evaluation of the POS FE process as it operated in 2006 and 2007.

53) How does the Contractor work PDE rejects for eligibility items?

A: The Contractor will research, and if correction is warranted, correct the PDE and resubmit.

54) Is the Contractor held to the same performance metric for PDE rejection rates as a typical submitter ID under Part D?

A: Yes.

55) If the Contractor has an LIS PDP that receives auto/facilitated enrollees that had been previously enrolled under the demonstration contractor, may the Sponsor use the data received during the period of demonstration enrollment to assist with step management etc., in future?

A: Generally we believe there should be a firewall between the two lines of business but we would be open to considering specific proposed uses of such data.

56) For PDE submission, will the Contractor be given unique submitter ID, or will they use the same submitter ID as for PDE under their standard Part D contract?

A: Yes, the Contractor will be given a unique submitter ID for the demonstration contract.

57) Will the Contractor be responsible for the COB user fee, as standard PDPs are?

A: Yes. Proposers should estimate this cost in "COB User Fees" row in Table 1 of section C.5.

58) Will the Contractor be responsible for the National Medicare Education Campaign fee?

A: Yes.