Preliminary Data Requirements for the Medicare Prescription Drug Plan Price Comparison Tool on www.medicare.gov

Draft: March 8, 2005

Objective:

The following pages contain preliminary guidance to prospective Medicare prescription drug plans regarding additional data submission requirements for the Medicare Prescription Drug Plan Comparison tool that will be housed on www.medicare.gov. Both stand alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA-PDs) plans will be required to submit these data to CMS and these data will be posted on www.medicare.gov. The purpose of the data is to enable people with Medicare to compare, learn, select and enroll in a plan that best meets their needs. The database structure provides the flexibility to design and communicate plan design, formulary and pharmacy network information to people with Medicare by displaying program contact and pricing information at the network pharmacy level.

CMS will review these preliminary data requirements and take questions from prospective plans during the User Group call scheduled for March 16, 2005.

CMS welcomes comments to be submitted for consideration from prospective plans regarding the questions associated with the proposed database design that are listed on pages 3 – 18 of this document. Comments must be submitted in writing no later than 4:00 PM Eastern Time on March 18, 2005. Comments can be submitted via email to both tdudley@cms.hhs.gov and koh@cms.hhs.gov or via land mail to the following address:

Thomas Dudley
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop S1-01-26
Baltimore, MD 21244

Timeline for Data Submissions:

The initial public release of the pricing data on www.medicare.gov is tentatively scheduled for October 13, 2005. In order to be properly prepared for this released date, there will be several electronic test data submissions required by all prospective plans. The timeline for these electronic test data submissions is as follows:

- 5/16/2005 - Post data requirements on www.cms.hhs.gov for prospective plans
- 7/15/2005 - Plans submit electronic test pricing data (not thru HPMS)
- 7/16/205 – 8/15/2005 – CMS to analyze test pricing data submitted by prospective plans
- 8/15/2005 – CMS to send data analysis to all prospective plans
- 8/29/2005 – Prospective plans submit corrected electronic pricing data to CMS
- 9/16/2005 – Approved plans submit electronic pricing data to CMS for final testing (Not for public reporting)
- 10/6/2005 – Approved plans submit electronic pricing data files that will be released on 10/13/2005 on www.medicare.gov.

Details regarding the actual file layout and file submission procedure will be posted on www.cms.hhs.gov no later than May 16, 2005.

Table of Contents for Sample Data File Layouts and Questions:

FORMULARY FILE

Field Name	Field Description
CONTRACT_ID	References Organization's Contract Number assigned by CMS
FORMULARY_ID	Unique Identifier
NDC	11 digit
TIER_LEVEL_VALUE	Defines the Cost Share Tier Level Value Associated with the NDC. Assumption is that the NDC is assigned to one tier value. These values are consistent with the selection of value options available to data entry users in the Plan Benefit Package software. If no Tier Level Value applies, enter '1' as the value for this field.

Notes:

- This file will provide the tier information by NDC.
- An organization may submit multiple formulary files.
- A formulary file can be assigned to multiple plans for the organization.
- A formulary must be assigned to each of the organization's plans.

Submission Frequency: Organizations can submit updates to this file on a monthly basis after receiving approval of any formulary changes from CMS. Any changes submitted in this file must be coordinated with the formulary approval process submitted through HPMS each month. If an organization does not have any formulary changes for a given month, they will be required to certify that there are no updates. In the case of no updates, the previous month's formulary data will be used.

Options and Questions for Comment:

The HPMS data model submission uses NDCs as a proxy for the drug name. If the same drug appears on different Tier levels, duplicate entries of the NDC must be made for that drug for each Tier where it appears. Exceptions can be noted in the Formulary Exceptions Word file. The plan compare tool will need more complete submissions when there are exceptions to the standard 1 tier/drug. Examples of exceptions to that standard include: drugs with low doses in one tier and high doses in another tier, or excluded NDCs. To handle >1 tier/drug scenarios, there are two submission options. We are seeking input on preferred solutions.

1. Submit the formulary file as described above for all covered NDCs in the plan's formulary.
2. Submit the formulary file as described above only for NDCs that deviate from the HPMS formulary submission, or where drugs cross tiers.

PLAN MASTER

Please Note: grayed out records will be collected from HPMS database

Field Name	Field Description
CONTRACT_ID	References Organization's Contract Number assigned by CMS
PLAN_ID	Unique Plan Identifier assigned by CMS
SEGMENT_ID	Plan Segment ID only for local MA-PD plans assigned by CMS (if applicable)
FORMULARY_ID	References Formulary For the Plan
PLAN_PREMIUM	Monthly premium
PLAN_DEDUCTIBLE_NO_SUBSIDY	Deductible to be met
PLAN_DEDUCTIBLE_PARTIAL_SUBSIDY	Deductible to be met.

Notes:

- This file will provide general information about each plan, such as which of the organization's formulary files to reference,
- There can be multiple plan master files per organization.
- There should be one record per plan.

Submission Frequency: This file will only be submitted one time per plan year. Resubmissions within the plan year will only be allowed on an exception basis with prior approval from CMS Plan Staff.

BENEFICIARY COST

Field Name	Field Description
CONTRACT_ID	References Organization's Contract Number assigned by CMS
PLAN_ID	References Plan Identifier assigned by CMS
SEGMENT_ID	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
COVERAGE_LEVEL	Identifies what level (1 = No Subsidy Copay/Coinsurance, 2 = No Subsidy Coverage Gap, 3 = No Subsidy Catastrophic, 4 = Partial Subsidy Copay/Coinsurance)
TIER_LEVEL_VALUE	References Tier_Level_Value from Formulary File
DAYS_SUPPLY	Identifies for which days supply this cost structure applies (1 = 30 days, 2 = 90 days, 3 = other)
COST_TYPE_PREFERRED	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_PREFERRED	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_PREFERRED	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost.

Field Name	Field Description
	• Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_PREFERRED	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** • Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_PREFERRED	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). • Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_PREFERRED	Member cost share for threshold overage amount. This is the amount a member will be charged in

Field Name	Field Description
	addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_NONPREFERRED	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_NONPREFERRED	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_NONPREFERRED	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_NONPREFERRED	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.

Field Name	Field Description
COST_THRESHOLD_NONPREFERRED	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_NONPREFERRED	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_MAILORDER	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_MAILORDER	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_MAILORDER	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If

Field Name	Field Description
	the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_MAILORDER	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_MAILORDER	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20:

Field Name	Field Description
	$10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_MAILORDER	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_MAILORDER_NONPREFERRED	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_MAILORDER_NONPREFERRED	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_MAILORDER_NONPREFERRED	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_MAILORDER_NONPREFERRED	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the

Field Name	Field Description
	COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_MAILORDER_NONPREFERRED	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_MAILORDER_NONPREFERRED	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.

Notes:

- This file will be used to determine beneficiary cost for each plan. Each record will be a calculation applied to specific pricing data identified by the plan's pharmacy cost file.
- There should be at least 4 records per tier/per plan, each corresponding to the beneficiary costs for each level of coverage.
- There should be at least 1 and at most 4 records per tier/per plan/per coverage level to account for days supply.
- The 24 columns for COST (6 per given location) reflect the basic ways to determine beneficiary cost share.

Submission Frequency: This file will only be submitted one time per plan year. Resubmissions within the plan year will only be allowed on an exception basis with prior approval from CMS Plan Staff.

Options and Questions for Comment:
There are six fields which are used to determine beneficiary cost share responsibility. Are there any beneficiary cost calculations that are not covered by this cost calculation?

We are seeking comment from prospective plans regarding which of the following two options is preferred:

- Option 1: For the Beneficiary Cost table, plans will only submit data that is not already captured in HPMS. This would include all fields in the table above except the following that are already collected in HPMS: Tier_Level_Value, COST_TYPE, and MAIL_COST_TYPE. When the Coverage_Level field indicates "partial subsidy," all fields in the table must be submitted since the partial subsidy data will not be captured in HPMS.
- Option 2: Plans will submit all of the data indicated in the table above.

PHARMACY COST

Field Name	Field Description
CONTRACT_ID	References Organization's Contract Number assigned by CMS
PLAN_ID	References PLAN_ID that this pharmacy cost file serves assigned by CMS
SEGMENT_ID	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
PHARMACY_NUMBER	12-digit Pharmacy Number (7 digit NABP pharmacy number with five preceding zeroes).
PRICE_ID	References the Pricing File to be used at this pharmacy.
BRAND_DISPENSING_FEE	In addition to the ingredient cost (product cost) at the point of sale.
GENERIC_DISPENSING_FEE	In addition to the ingredient cost (product cost) at the point of sale.
PREFERRED_STATUS	Yes/No defines whether pharmacy is preferred or non-preferred pharmacy.

Notes

- There should be one pharmacy cost submission per plan.
- There should be one record per network pharmacy.

Submission Frequency: Organizations will be required to submit pricing on a weekly basis. If no updates are required, Organizations will be required to certify that there are no updates. In the case of no updates, the previous week's pricing data will be used.

PRICING FILE

Field Name	Field Description
CONTRACT_ID	References Organization's Contract Number assigned by CMS
PRICE_ID	Price File Grouping Number
NDC	11 Digit
UNIT_COST	Unit cost for given NDC less dispensing fee.

Notes:

- This file determines the base unit cost of an NDC in a given pricing regime.
- There can be multiple price master files per organization.
- The pricing file is applied to the plan through the Pharmacy Cost file.
- Pricing data must be submitted for all drugs covered on a plan's formulary.

Submission Frequency: Organizations will be required to submit pricing on a weekly basis. If no updates are required, Organizations will be required to certify that there are no updates. In the case of no updates, the previous week's pricing data will be used.

Options and Questions for Comment:

We will be using common dosage pricing instead of the highest pricing we use for Price Compare. In order to accomplish this, a list of exemplar NDCs will be created for the common dosages. We are considering the following options for data submission; they are described below for your consideration and comment.

1. Formulary Drugs:
    a. Option 1: CMS will provide a list (monthly) of exemplar NDCs for each drug and dose combination. These NDCs will be used to project beneficiary cost of a specific drug and dose, for display in the price comparison application irrespective of NDC. Organizations will submit unit cost pricing for all NDCs on the exemplar list that are covered in the formulary. Exemplar NDCs will be determined on a most common unit cost price basis.
    b. Option 2: Organizations will submit unit cost pricing for all covered NDCs. CMS will display pricing for exemplar NDCs for normalized pricing purposes. Exemplar NDCs will be determined on a most common unit cost price basis.

2. Non-Formulary Drugs: Organizations would choose one of the two options below for handling non-formulary drugs for their plans:
    a. Option 1: If an organization opts NOT to submit any prices for Non-formulary drugs, CMS will display pricing for all non-formulary drugs based on a standard calculation based on AWP pricing plus some standardized dispensing fee. This calculation will be determined to derive average estimated costs, and will be between 10% and 13% off AWP.

    or

    b. Option 2: If an organization opts to submit prices for Non-formulary drugs based on the same criteria as formulary drugs, CMS would then display pricing for these drugs based on the pricing submitted by the organization.

PLAN FORMULARY OVERRIDES

Please Note: All of the data on this file will be collected from HPMS database.

Field Name	Field Description
CONTRACT_ID	References organization's Contract Number assigned by CMS
PLAN_ID	References plan assigned by CMS
SEGMENT_ID	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
NDC	11 digit
QUANTITY_LIMIT_AMOUNT_YN	Does the NDC have a quantity limit other than a 30-day or 34-day limit?
QUANTITY_LIMIT_AMOUNT	If Yes to Quantity_Limit_Amount_YN, enter the quantity limit unit amount. The units for this amount may be defined as number of pills, number of injections, etc. If a limit other than 30 or 34 days does not apply, leave this field blank.
QUANTITY_LIMIT_DAYS	Enter the days associated with the quantity limit. If a limit other than 30 or 34 days does not apply, leave this field blank.
PRIOR_AUTHORIZATION_YN	Is prior authorization required for the NDC?
STEP_THERAPY_TYPE_GROUP_NUM	Number of step therapy drug treatment groups, in which the NDC is included. If Step Therapy does not apply to this drug, then leave this field blank.
STEP_THERAPY_TYPE_GROUP_DESC_X	Description of step therapy drug treatment group. Field should be

Field Name	Field Description
	repeated in the record based upon number of groups declared in Step_Therapy_Type_Group_Num If Step Therapy does not apply to this drug, then leave this field blank.
STEP_THERAPY_TYPE_GROUP_STEP_X	

These rules will be derived from the HPMS database.