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


**CENTER FOR BENEFICIARY CHOICES**

MEMORANDUM

TO: All Part D Plan Sponsors

FROM: Gary Bailey, Deputy Director

RE: Plan-to-Plan EOB Transfer Instructions

DATE: April 7, 2006

In my letter dated April 4, 2006, we outlined a temporary process to facilitate the required coordination of benefits between plans, and the plan-to-plan transfer of true out-of-pocket (TrOOP) and total drug spend balances for beneficiaries affected by the Enrollment Reconciliation process. More details concerning this process to support the transfer of explanation of benefits (EOBs) between Part D plans are provided in these instructions.

**EOB Transfer Contact**

As a required first step in this process, we requested that Part D plans populate the new Health Plan Management System (HPMS) "EOB Transfer Contact" field. We anticipate that all Part D plans will have entered the requisite contact information by midnight Eastern Time Friday, April 7, 2006. To enter this information, please follow this navigation path: HPMS Homepage > Contract Management > Contract Management > Select Contract Number > Contact Data > EOB Transfer Contact.

CMS will publish a list of these contacts as soon as plans have completed the entry of this contact information.

**Transfer EOBs Procedure**

These instructions outline the EOB procedures plans must follow during the Enrollment Reconciliation process. Plans must (1) identify beneficiaries with claims activity who have transferred to another plan, (2) prepare EOB information for those beneficiaries and (3) report that information to the plan of record. These instructions also explain how the plans of record, the recipients of EOBs, will use the information.

Plans must use two different data strategies to identify beneficiaries who have transferred. Strategy One uses the Updated Enrollment Reconciliation File (distributed April 7) and Strategy Two uses the Enrollment Reconciliation Election TRR scheduled for distribution on or about April 22.

Strategy One: Updated Enrollment Reconciliation File (distributed April 7)

CMS distributed the Updated Enrollment Reconciliation File on April 7 for purposes of getting EOB information to plans of record. The file is in the same format as the original Enrollment Reconciliation TRR. This file updates the enrollment file sent previously to plans on either March 14 or March 21. Changes in the Update file are as follows:

- the Update file was sent to Part D plans only,
- the Source File ID field reports the plan of record documented in CMS systems as of April 3, 2006,
- beneficiaries who are no longer actively enrolled have been removed from the file.

To determine which beneficiaries need EOBs sent to their new plans, you should remove the following beneficiaries from the Updated Enrollment Reconciliation File:

- Remove beneficiaries with no claims activity, and
- Remove beneficiaries with claims activity who, by April 30, 2006, elected to remain in your plan. This includes any beneficiary with an enrollment that is documented on the plan's enrollment reconciliation file submitted to CMS by April 15, as well as any other beneficiary who elects to remain in the plan after April 15 with an effective date of May 1.

The plan will create EOBs for the remaining beneficiaries.

Strategy Two: Enrollment Reconciliation Election TRR scheduled for distribution on or about April 22.

The plan will create EOBs for any beneficiary listed on the Enrollment Reconciliation Election TRR for whom the plan has claim activity. The Source File ID field identifies the contract number of the plan of record that will receive the EOB.

**How to Use EOB Information**

The EOB data elements and transmission modes are described below. In order to position a beneficiary in any Part D plan (i.e., contract/plan benefit package), the plan needs two pieces of information in the EOB: year-to-date covered drug cost under the basic benefit ("gross drug spend") and TrOOP balance (see second page of the attached CMS Model EOB Document for these highlighted fields). The Transfer Out plan is responsible for preparing and distributing this EOB information. The plan of record is

responsible for receiving the EOB information, updating its information system, and using the information to position the beneficiary in the correct benefit phase. During this Enrollment Reconciliation process, plans will observe the following EOB information timelines:

- May 15 – Deadline for Transfer Out plans to transmit EOB information to the plan of record covering all costs incurred for affected beneficiaries through April 30, 2006.

- May 31 – Deadline for plans of record to integrate the EOB information into their information systems for all beneficiaries on their enrollment reconciliation file.

Please also note that the difference between the Gross Covered Drug Spend and TrOOP Balance amounts represents the liabilities of the plan of record for reimbursing Transfer-Out plans during the plan-to-plan reconciliation process later this year.

**Format of Transfer EOBs**

As part of the Enrollment Reconciliation process, Transfer Out plans must generate and send to the plan of record information on TrOOP and gross covered drug spend balances for all affected beneficiaries. This information may be in the form of a paper copy EOB if the total number of beneficiary records to be transmitted to any one plan of record is less than 100. Note that only the two relevant fields need be filled in, and there is no need to send a complete EOB that includes proprietary pricing detail.

If 100 or more records must be transmitted to a plan of record, the Transfer Out plan must create an Excel file in the format described below (and attached) on a CD-ROM.

| A | B | C | D | E |
|---|---|---|---|---|
| HICN | Transfer Out Plan Contract Number | Effective Date | TrOOP Balance | Gross Covered Drug Costs |
| | | | | |
| | | | | |

**Transfer EOBs Transmission**

Paper copy EOBs may be faxed to the EOB Transfer Contact specified in HPMS for the plan of record or shipped through a common carrier to the Contact either as paper copy EOBs or scanned copies on a CD-ROM. Excel files must be shipped on a CD-ROM through a common carrier.

**Exceptions Process**

In the process of EOB transfer, should you receive EOB information for a beneficiary who is not in your plan, contact the EOB Transfer Contact at the plan that sent the EOB

information and determine if the problem can be resolved. If not, refer the problem to the CMS Regional Office pharmacy contact.

Should you receive EOB information for a beneficiary who has disenrolled from your plan, refer to the updated Enrollment Reconciliation file (dated April 7) and the Enrollment Reconciliation Election TRRs to identify the beneficiary's current plan of record and forward the EOB information to that plan's EOB Transfer Contact.

**Ongoing Applicability to Plan Transfers**

CMS continues to explore the possibility of automating the exchange of these balances in association with the re-enrollment/disenrollment transactions sometime in the future. In the meantime, this process can continue to serve this function for other plan transfers. When a plan receives a disenrollment transaction with a transaction reply code of [014] indicating that the member disenrolled due to enrollment in another plan, you can look in the Source ID field on the transaction reply to find the Contract Number of the plan of record to which the EOB information should be sent.

Attachments: Model EOB (pp. 1-2)
EOB Information Excel File Format

## ATTACHMENT—First Two Pages of CMS Model EOB Document

***Instructions:***

- *Plans do not need to adhere to the format of this model document. Plans may utilize their own format as long as the EOB contains all model language exactly as provided below.*
- *Notes to plans in the squiggle brackets must not be included in the document.*
- *Plans that offer an enhanced alternative plan must include all the bracketed notes to members discussing non-Medicare Part D drugs.*

## Part D Model Explanation of Benefits (EOB)

<Member Name>
<Street Address>
<City, State Zip Code>

<Date>
Member ID Number: <Member ID>

**Your Medicare Prescription Drug Coverage**

This document includes a summary of claims processed from <mm/dd/yyyy> through <mm/dd/yyyy>. It also includes a cumulative statement of the benefits you have been provided this year.

**Drug Expenses**
[***Note***: We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount paid for these drugs is not included in any of the amounts listed below.]

- **Annual Deductible**
  [You have met <insert amount> of your <$xx> deductible for <year>.
  [There is no deductible for this plan this year.]
  [If you are getting extra help paying for your prescription drugs, you have met <insert amount> of your $50 deductible.]
  [If you are getting extra help for your prescription drugs, you do not have a deductible this year.]
- **Amount Paid For Prescriptions [Between the Deductible and the Initial Coverage Limit]**
  You and/or others who have paid for your prescriptions have spent <insert amount> in co-payments and/or co-insurance this year. [In addition, this amount also includes any extra help you get for paying for your drugs.] This amount may also include payments made by your current or former employer/union, other insurance plan or policy. This amount counts toward your initial coverage limit.

  <Plan Name> has paid <insert amount>. These payments count towards your initial coverage limit.

Together, <insert amount> has been paid by <Plan Name>, you and/or others. This is the total that counts towards your initial coverage limit of <insert plan's initial coverage limit>.

- **Out-Of-Pocket Payments After You Reach the Initial Coverage Limit**
  You have spent <insert amount> since reaching your initial coverage limit. You still have to spend <insert amount> before you qualify for Catastrophic Coverage. *{Plans may remove this bullet for members receiving the subsidy.}*

- **Total Out-Of-Pocket Expenditures That Count Towards the Catastrophic Coverage Threshold** *{Plans: This is the TrOOP balance.}*
  You and/or others on your behalf have spent a total of <insert amount> on prescription drugs covered by <Plan Name> for <year>. This total includes the amounts spent for your deductible, co-payments and co-insurance, and coverage gap payments. [This amount also includes any extra help you get for paying for your drugs. However,] This amount does not include payments made by your current or former employer/union, another insurance plan or policy, or other excluded parties.

- **Total Amount Paid For Your Drugs This Year** {*Plans: This is Gross Drug Spend}*
  <Insert Amount>. This is the total amount that has been spent on your drugs this year. It includes the amount paid by you and/or others on your behalf towards the initial coverage limit, coverage gap payments and catastrophic coverage. It also includes the amount <Plan Name> paid for drugs during your initial coverage limit and catastrophic coverage.

**For More Information**
For more detailed information about your <Plan Name> prescription drug coverage, please review your Evidence of Coverage and other Plan materials.

If <Plan Name> ever denies coverage for your prescription drugs, we will explain our decision to you. You always have the right to appeal and ask us to review the claim that was denied. In addition, if your physician prescribes a drug that is not on our formulary, is not a preferred drug, or is subject to additional utilization requirements you may ask us to make a coverage exception.

If you have any questions about <Plan Name>, please contact customer service at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. Or, visit <Web site> on the Web. If you suspect fraud, please contact your plan or 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048.
<CMS Approval Date>
<Material ID Number>