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

CENTER FOR BENEFICIARY CHOICES

Date: October 6, 2006

To: Part D Plan Sponsors

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

Subject: State-to-Plan Reconciliation --Updated Part D Plan Instructions

This letter is intended to provide Part D plans with updated information and instructions on State-to-Plan Reconciliation. As you are aware, the Centers for Medicare and Medicaid Services (CMS), as part of a demonstration project, has been reimbursing many states for certain costs associated with additional assistance they provided to full benefit dual eligible and low-income subsidy entitled beneficiaries early in the year. Since our last communication to Part D plan sponsors in June, we have been working with our contractor, the Public Consulting Group (PCG), to refine the instructions in line with industry comments for submitting claims to Part D plans through their claims processors.

Please find attached CMS guidance prepared by PCG that summarizes the State-to-Plan Reconciliation Medicaid claim plan adjudication and payment recovery phase. Specifically, the document entitled ***Medicare Part D State-to-Plan Reconciliation Claims Layout - NCPDP 5.1 Process Specs*** addresses procedures for claims that were paid in full by state Medicaid agencies during the period covered by the demonstration. We are still considering the need for further instructions on reimbursement of excess cost sharing paid by states or state pharmaceutical assistance programs (SPAPs) as secondary payers.

We expect Part D plan sponsors and their pharmacy benefit managers (PBMs) or other processors to carefully read through these instructions and to participate in a very important call on October 20, 2006 (details referenced in the attachment). It is important to note that PCG is seeking to test the process outlined in the attachment with each PBM/processor, not each Part D plan sponsor, so we will need Part D plan sponsors to (1) require their PBMs/processors to cooperate fully and respond timely to all contacts from CMS contractors and (2) update their PBM contact information in HPMS by October 20, 2006. PBM contact information can be updated at HPMS Homepage > Contract Management > Contract Management > Select a Contract Number > Contact Data .

We remind Part D plan sponsors that under the regulations at 42 CFR § 423.464, Part D sponsors are required to coordinate benefits when a payer other than the correct Part D plan of record pays

for covered Part D drug costs as a primary payer, and to comply with CMS established processes for coordination of benefits. The attached instructions on the claims reimbursement process are consistent with our Part D coordination of benefit requirements. If the procedures and timelines outlined in the attached ***Medicare Part D State-to-Plan Reconciliation Claims Layout - NCPDP 5.1 Process Specs*** are not adhered to by plan sponsors and any applicable plan contractors, we have the authority to consider your plan sponsor out of compliance with the Part D requirements and take appropriate action.

We appreciate your attention to this very important matter and look forward to the October 20th call in which we can address issues or questions you may have. As noted in the attachment, CMS requests that all questions and issues needing to be addressed be sent in advance to nlisk@pcgus.com by October 16, 2006, in order to allow ample time to prepare a complete response. If you have general questions regarding the demonstration, you may direct them to Christine Hinds Christine.hinds@cms.hhs.gov or (410)786-4578. Technical questions should be referred to our contractor. Contact information for PCG is in included at the end of the attachment.

Thank you in advance for your efforts on this important project.

Medicare Part D Claims Reimbursement Process

The Centers for Medicare & Medicaid Services (CMS) has taken numerous actions to ensure that full benefit dual eligible individuals and other low-income subsidy entitled beneficiaries continued to receive needed medications during the transition to drug coverage under the new Medicare Part D drug benefit, including working directly with states to reimburse them for the costs incurred during the transition period. CMS is in the process of making payments to the states participating in the demonstration. Most States have received an initial payment from CMS for claims costs, and an initial payment for administrative costs.

To accurately account for each claim, States created a claims report using the NCPDP 1.1 standard batch format in accordance with instructions provided by Public Consulting Group (PCG), the CMS contractor for this engagement. Based on the information submitted by the state to PCG, CMS made an initial payment equivalent to 95% of the total amount initially claimed. For full benefit dual eligible beneficiaries, this payment covers 95% of eligible costs the state paid on behalf of Part D beneficiaries, except for an adjustment to reflect estimated Part D cost sharing. The second payment for claims costs will account for the remaining 5% payment previously withheld, and any adjustments due to the reconciliation with the plans.

Now that PCG has received the initial set of claims data from the states and states have received their initial payments from CMS, PCG is now prepared to submit claims to the Part D plans through their claims processors. (For purposes of this document, the terms “pharmacy claims processors” and “Pharmacy Benefit Managers (PBMs)” are used synonymously, and CMS considers all requirements on processors or PBMs to be requirements on the applicable Part D plan sponsor.) To coincide with the Part D standard claims submission process, CMS and PCG will use the NCPDP 5.1 billing transaction and a standard process of claims submission utilizing the services of two PCG contractors, the Switch vendor, Per-Se and Daytech. PCG will aggregate all the state claims into plan-specific claim files. The claims submitted through this process have already been verified by CMS and PCG as eligible claims, including being screened by CMS Office of Information Services staff for eligibility during the month of service and the CMS Drug Data Processing System (DDPS) excluded drug file filter. Plans are permitted to leave intact their eligibility edits. However, Part D plans should suspend all edits for formulary drugs, prior authorization, and safety and supply limits since these claims cover the initial Part D transition period (January 1, 2006 through March 31, 2006) and are deemed to be covered Part D drugs under the CMS initial program transition policy. The plans’ PBMs will adjudicate these claims and send a response back in the same manner in which the PBM would respond typically for a 5.1 transaction. The response will be intercepted by Per-Se and Daytech and be routed back to PCG.

CMS and PCG are making every effort to submit the original provider’s NCPDP number, thus plans should adjudicate claims as if they were the primary payer. For any claim for which PCG is unable to identify the original provider’s NCPDP number, PCG will submit a PCG-assigned NCPDP number. In such cases, Field 202-B2 Service Provider ID Qualifier will be populated with an 07 and Field 201-B1 Service Provider ID will be populated with 5300378. When this occurs, or when the provider is not in the plan’s network, plans should adjudicate the claim using their average (network) plan allowable amounts so that the response will indicate the

amount the plan would have been responsible for had it been the primary payer. "Payments" on the adjudicated claims will not be made to PCG, but should be accounted for as liabilities. PCG will work with CMS, the plan, and the state to resolve any rejected claims. CMS and PCG are still working through the logistics of the rejected claims resolution processes. The PBMs will be notified as soon as these details are resolved. The "payments" attributable to adjudicated claims will be recouped from future plan payments from CMS as payment adjustments via the Automated Plan Payment System (APPS). Plans will also be responsible for submitting Prescription Drug Event (PDEs) for each claim paid under the demonstration. CMS will update the Drug Data Processing System (DDPS) and publish PDE guidance explaining data submission specific to the State to Plan Reconciliation project. Plans should not submit State to Plan Reconciliation PDEs until they are advised that DDPS changes have been completed.

The process CMS, PCG and the plans must complete is as follows:

Step 1: Participate in Conference Call with CMS. CMS and PCG will conduct a single conference call for all participating PDPs and PBMs to attend and ask questions. The conference call is currently scheduled for 3:00 Eastern Time on October 20, 2006. PBMs are encouraged to participate in the call. CMS requests that all questions and issues needing to be addressed be sent to nlisk@pcgus.com by October 16, 2006 allowing ample time to prepare a proper response. The call-in information is as follows:

Call-In Number:	1-866-804-3241
Conference ID Number:	Programs

Step 2: Modify PBM Claims Processing Systems. PBMs will modify their own claims processing system to appropriately adjudicate the claims submitted through this process. The claims will be sent electronically through CE2000 (i.e., Daytech) and Per-Se in the standard NCPDP 5.1 format. The claims must be adjudicated according to the specifications in this memorandum. PCG will include an indicator of "MEDDSTTOPY" in field 110-AK Software Vendor/Certification ID to indicate to the PBMs to handle these claims differently than their normal pharmacy submission processing. The plans will need to program their systems to ensure these claims are adjudicated separately, thereby ensuring the pharmacies are not reimbursed a second time for the same claim. The system will need to adjudicate the claims according to the guidelines set forth herein and route the payment response back through the normal 5.1 process with the exception that the pharmacy must not receive the actual payment through PBM accounting systems. Once the system is deemed ready, the PBM will contact PCG via *nlisk@pcgus.com* and request submission of a test file. All PBMs must have their systems ready by December 31, 2006 and make contact with PCG by this time to schedule a test.

Step 3: Test PBM Modified Claims Processing Systems. PCG will conduct a test with each individual PBM to confirm accuracy of the claims adjudication process. Once a test date is finalized, PCG will prepare and forward to the PBM a test claim file in an NCPDP 5.1 format. CMS and PCG are working extensively with Daytech and Per-Se to establish a link that most closely resembles the current claims submission process already established to the PBMs. PCG will populate a superset inclusive of all fields required by all participating PBMs and will

submit these claims through CE2000 and onto Per-Se for subsequent routing. Per-Se has established a separate portal for submission of these claims to prevent inappropriate transaction charges to the pharmacies. The claims will be adjudicated accordingly with a proper response prepared in the standard 5.1 format. Once the test is complete and the PBM declares system readiness, the PBM will receive an *Attestation of System Readiness* document verifying the plan's (i.e., the PBM/processor's) system's ability to adjudicate these claims properly. Once this is signed by the PBM, it is to be forwarded to:

Public Consulting Group
c/o Nicole Lisk
200 South Tryon Street, Suite 600
Charlotte, NC 28117

The document can also be scanned and e-mailed to *nlisk@pcgus.com*. Once the Attestation of System Readiness document is received, PCG will then contact the PBM and schedule a date and time for the production cycle run. All tests must be completed and all Attestation of System Readiness documents must be returned by February 15, 2007.

Step 4: Receive a Production File from CMS/PCG. Shortly thereafter, PCG will submit production claims to each contracted PBM using Daytech's CE2000 software package and the Switch vendor Per-Se. The production claims will be sent to the PBMs in a standard NCPDP 5.1 format through Daytech and Per-Se. The claims will include all claims paid by State Medicaid agencies on behalf of dual-eligible (i.e., covered by both Medicare Part D and Medicaid) beneficiaries for which the PDPs affiliated with the specific PBMs are liable. Since the claim volume is so high, the production claims may take some time to submit. It is imperative the PBM handle these claims differently than their standard production process to ensure successful adjudication according to the guidelines set forth in this memorandum.

Step 5 : Adjudicate Claims and Return Response. PBMs will adjudicate the claims and send an NCPDP 5.1 response through Per-Se back to PCG providing claim level status for each claim submitted by PCG to the PBM. The 5.1 response will include the standard information required of PBMs for all other claims processing in the NCPDP 5.1 format. The difference is the fact that the claims must not trigger a payment to the pharmacies. The PBMs will instead adjudicate the claim and create a response without creating a payment transaction. PCG will create summary reports for CMS totaling the claims volume and payments owed by the PDPs, and will utilize the patient pay amounts on the claims to adjust state reimbursements for required Medicare cost sharing. A copy of each summary report along with the transaction detail will be sent to each PBM for review. Contact information will be provided to the PBM at that time for claim rejection/acceptance dispute resolution discussions to occur. Once these disputes are resolved, CMS will then retract payments from future PBM payments until the debt is paid in full.

The following are a list of anticipated questions from the PDPs and the PBMs:

1. What is the purpose of this claims submission? This claims submission is intended to report to the Medicare Part D Plans (PDPs) amounts PAID IN ACTUAL by state agencies over the waiver period for Part D covered drugs for dual eligibles.

2. In what format will PCG transmit the claims to the PBMs? PCG will submit NCPDP 5.1 formatted claims through Per-Se, the switch vendor working with PCG on this transaction.

3. Which fields will be submitted? All fields required by the plans through the Switch vendor will be populated in the standard NCPDP 5.1 format.

4. How will the PBMs differentiate these claims from the other claims submitted through the Switch vendor? PCG will populate the Software/Vendor Certification ID field with the expression "MEDDSTTOPY" for all claims included in the demonstration. The plans and their processors will need to program their systems to ensure these claims are adjudicated in such a way that ensures the pharmacies are not reimbursed.

5. Will the PBMs be allowed a testing period prior to the production process? Daytech, Per-Se and PCG will allow a test cycle for each PBM. The PBM may or may not represent a single PDP, thus multiple PDP files may be tested at one time. The PBMs are asked to contact PCG as soon as possible after October 20, 2006 to schedule a test cycle starting anytime after November 15, 2006. PCG will have a PBM-specific file ready for processing and will submit sample records so the PBM can ensure the claims are adjudicated properly and, most importantly, verify that the payment is not routed to the pharmacy. Once the test is complete, PCG and the PBM will agree to a date at which the production cycle will run. In addition, PCG will forward to the PBM an attestation request to provide for formal confirmation that the testing is complete and the system is ready for the production cycle (i.e., the claims paid at the appropriate rate and the pharmacy will not receive reimbursement directly).

6. How will dispensing fees be handled since states did not report dispensing fees to PCG? Since dispensing fees were not reported separately, PCG will use a default dispensing fee of $2.50. PCG will populate field 412-DC Dispensing Fee Submitted with the default dispensing fee of $2.50.

7. Where did PCG obtain the eligibility information used to adjudicate the initial claims file back to the States? CMS prepared the MMA eligibility file for the 402 Waiver by matching state finder files to the CMS eligibility files. PCG used this information to adjudicate the claims paid to the States.

8. What NCPDP Number will appear on the claim? PCG will include the NCPDP number of the original pharmacy that submitted the claim to the Medicaid agency for all pharmacies for which these numbers can be identified. PCG will attempt to map all Medicaid IDs to the pharmacies' NCPDP number. When this is not possible, PCG will default the NCPDP number to 5300378, a generic NCPDP number assigned to PCG for this purpose only. When this occurs, the PBM is asked to adjudicate the claim at the network average plan allowable reimbursement amount.

9. Will NCPDP include this number on their pharmacy file? Yes NCPDP has added this number with the following data TEMPORARY MEDICAID PHCY ID, 9240 E RAINTREE DR,SCOTTSDALE, AZ 85260 (480) 477-1000().

10. What edits should PBMs apply to these claims? PBMs should suspend edits for formulary drugs, prior authorization, step therapy, and safety and supply limits since these claims cover the initial Part D transition period (January 1, 2006 through March 31, 2006) and are deemed to be covered Part D drugs under the CMS transition policy. PBMs may apply beneficiary coverage edits (i.e., eligibility) against these claims, however, PCG has already completed pre-screening of this information against CMS-supplied eligibility files, thus eligibility should not be an issue in the vast majority of cases. In addition, PBMs should remove any timely filing edits as the claims may exceed the standard timely filing periods with pharmacies.

11. What eligibility information will be passed from PCG to the PBMs? PCG received 4Rx data from CMS in its eligibility filter and will populate all fields required of each PBM through Per-Se including, but not limited to, cardholder ID, group ID, first name, last name and date of birth.

12. At what rate should the PBMs reimburse the claims? The PBMs should adjudicate the claims as if the pharmacies originally submitted the claim. If the pharmacy is identified through the submitted NCPDP number as a Medicare Part D network pharmacy, the PBM should price the claim as it would for an in-network pharmacy and indicate that on the PDE. If the pharmacy is identified as an out-of-network pharmacy, or the claim includes the default NCPDP number as discussed in QA #8 above, the PBM should price the claim at the network average plan allowable reimbursement amount and indicate on the PDE that it was an out-of-network claim.

    We have provided an example of submitted dollars below. In this situation we are reporting an Ingredient cost of $30.00 a dispensing fee of $2.50 (default fee as indicated in number 6 above), a U&C of $34.00 and a gross amount due of $32.50 which will be the sum of the submitted Ingredient cost and dispensing fee. PCG will populate the submitted pricing fields as follows:

SUBMITTED PRICING FIELDS				
FIELD	**FIELD NAME**	**VALUE**	**COMMENTS**	**EXAMPLE SUBMITTED AMOUNT**
5Ø6-F6	INGREDIENT COST SUBMITTED	*300{*	Ingredient cost submitted by Provider on original claim. If not available then submit the amount Medicaid was billed by provider on original claim. Field Format is s9(6)v99	$30.00
426-DQ	DISPENSING FEE SUBMITTED	*25{*	Dispensing fee submitted by Provider on original claim. Field Format is s9(6)v99	$2.50
505-F5	USUAL AND CUSTOMARY CHARGE	*340{*	Usual and Customary charge submitted by provider on original claim. Field Format is s9(6)v99	$34.00
423-DN	GROSS AMOUNT DUE	*352{*	REQUEST FIELD: It contains the net amount Plan Sponsor should have paid to provider - Field Format is s9(6)v99	$32.50

13. <u>What transmission process and software will PCG use to complete these transactions?</u> PCG is working with Daytech as the software vendor and Per-Se as the primary switch vendor to transmit the claims. PCG will use Daytech's CE2000, Per-Se's eClaims and a separate IP portal as the mechanism to transmit these claims back and forth. This separate portal will prevent adding the transaction cost to the pharmacies. PCG will populate the Software/Vendor Certification field with the expression "MEDDSTTOPY" distinguishing these claims from other claims submitted to the plans.

14. <u>How will compound drugs be handled?</u> PCG will submit the highest ingredient cost compound through this transmission process. The PBMs should adjudicate the compound drug claims using their contracted process for submission of highest-cost NDC submitted.

15. <u>Does PCG know how many claims will not have the NCPDP ID number?</u> PCG is conducting a test using actual claims data from the initial claims adjudication process. This test will be completed by October 20th and the results will be reported during our scheduled conference call as referenced earlier in this document.

16. What changes are required for the PDE? These claims should be reported as non-standard claims by populating an “S” in the Non-Data format code field.

For additional clarification or information, please directly contact the PCG claims reconciliation team for this CMS project as follows:

CMS Claims Coordinator

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Suite 600
Charlotte, NC 28202
(704) 372-9384
nlisk@pcgus.com