CENTER FOR BENEFICIARY CHOICES

Date: January 4, 2007

To: Part D Plan Sponsors and Processors

From: Cynthia Tudor, Director, Medicare Drug Benefit Group

Subject: State-to-Plan Reconciliation: Part D Processor Contact Information and Q & A Document

As the Centers for Medicare & Medicaid Services (CMS) nears the final stages of the State-to-Plan Reconciliation Project, every Part D plan, if it has not already done so, ***must*** instruct its processor to contact our contractor, PCG, and provide it with certain information, ***no later than January 22, 2007.*** As of December 13, 2006, only 18 PBMs have contacted PCG, which only cover 398 of the 670 participating plans.

All communications and collaboration with PCG will be facilitated through the Part D plan sponsor's processor/PBM, as the volume of requests from individual PDPs would further delay the process of adjudicating these claims in a timely manner. Accordingly, all plan sponsors should contact their processor/PDP immediately to ensure that they have provided PCG with the following information:

1. Contact person and contact information.
2. Preference for claims submission: NCPDP 1.1 (batch) or 5.1 (real-time) format.
3. Earliest date of availability to receive a test file for claims submission.

PCG's contact is Nicole Lisk who may be reached at nlisk@pcgus.com.

In addition to providing contact information and submission preferences, plan sponsors should instruct their PBMs/Processors to modify their claims processing system. In particular, processors will need to configure their systems to identify the value "MEDDSTTOPY" in the NCPDP field 110-AK: *Software Vendor/Certification ID,* which indicates the special Medicare Part D reconciliation process to avoid duplicate reimbursement to the pharmacy.

Additionally, in response to follow-up questions we received regarding the State-to-Plan Reconciliation Project, we have attached a Q&A document. If you have further technical questions, please contact Nicole Lisk at nlisk@pcgus.com. Any policy questions regarding the State-to-Plan Reconciliation Project should be forwarded to Christine Hinds at christine.hinds@cms.hhs.gov.

The Medicare Part D State-to-Plan header

Medicare Part D State-to-Plan Questions

Estimated Claim Volume and Liability

1. Do you have an estimated claim volume that will be submitted to our plan?

   The total volume is more than 3 million claims and nearly $300 million for the 30 states participating in the State-to-Plan reconciliation process. PCG is currently preparing a detailed report for each PDP following the first of two passes of claims from the States. PCG has provided the initial report to the PDPs in mid-November (November 22, 2006), and approximates that the final report will be available some time in February .

5.1 Format vs. 1.1 Format

2. Can PBMs elect to process claims using the NCPDP Batch v1.1 HIPAA standard? Is this an option?

   Yes. CMS and PCG will make the 1.1 batch an option per pharmacy claim processor/PBM. Each processor/PBM will need to have the same format for all PDPs.

3. Please confirm there will be no deviation from 5.1 record format length and format.

   The claims will be submitted in the NCPDP 5.1 format including all available data fields and record length. As indicated in the instructions, some data may not be available from the states. In those cases the fields will be formatted correctly, yet the data will be left blank except for the few fields populated with State-to-Plan specific data as indicated in the instructions.

4. Are there known differences other than the Pharmacy ID default, the Software Vendor/Certification ID population and other fields noted in the PCG document?

   No.

5. To whom should the PBM submit customer-specific claim submission field requirements?

   PCG is using the Daytech software package. The Daytech software will filter through the required data and select those elements required by the PDP for submission and processing.

NCPDP Software Vendor/Certification ID Field

6. Is the proposed use of the NCPDP Software Vendor/Certification ID within the current NCPDP definition, or is it non-compliant with this HIPAA-named standard?

   It is compliant with the current NCPDP format. The use of the software/certification ID in the manner prescribed in the instructions is a method by which CMS and PCG are assisting the PDPs and their contracted PBMs/claims processors to identify these State-to-Plan claims separately from the claims submitted for reimbursement from providers.

7. What happens if a pharmacy happens to submit a claim online and uses this specified Software Vendor/Certification ID value and it happens to trigger all of these special downstream affects, instead of those under normal claims submission?

This situation is highly unlikely as the information included in the software vendor/certification ID field is specific to this project. However, if it does happen in the NCPDP 5.1 claims submission process, Per Se will reject the claims submitted by any other submitter other than PCG.

8. Could you provide a complete sample claim in NCPDP format?

   PCG will provide this during testing.

Testing Phase

9. When will testing rules/scenarios be made available to PBMs?

   PBMs should execute the following steps right away:

   1. Decide to use the NCPDP 1.1 vs. 5.1 format.

   2. Begin programming system to accept the 5.1 if chosen.

   3. Contact nlisk@pcgus.com to relay decision and begin the testing process.

   4. Schedule test with PCG once system is ready.

   PCG will work with each individual processor/PBM to execute the test. In general, the processor will assign PCG a BIN/PCN which will indicate to the PDP that these claims are associated with the S2P test process. The claims will be routed through Per-Se to the test environment using the BIN/PCN combination. The processor will adjudicate the claims in the test environment, create a response file and return the responses back through Per-Se to PCG. PCG will review the responses and determine if the claims adjudicated as expected. Once the test is complete and the response deemed acceptable, CMS will forward to each PDP an Attestation of System Readiness confirming to both the PDP and processor/PBM that the system is ready to accept production level claims. Once signed, PCG will assign an acceptable date and time to submit the production file to the processor/PBM.

10. Please explain the scope of the testing phase.

    As indicated on the call, when the claims processors are ready to test the claims submission process, they are asked to contact PCG to establish a test cycle and schedule. The data will be test data formatted in the NCPDP 5.1 for those plans and processors who choose this route. A test will be performed with each processor with at least one test claim per PDP submitted for the test.

BIN/PCN

11. The draft document defines the process as 'processor' specific. Is this defined by unique BIN? BIN/PCN?

    The claims submission test and production is per BIN.

Fill Dates, Fees and Partial Fill Claims

12. Could you provide confirmation for the two statements below: The default dispensing fee of $2.50 will be used for all claims whether or not the provided NCPDP number is actual or the PCG default value. There will be no reversals submitted, only B1 transactions.

    These statements are correct.

13. If the fill fee on the NABP provided is not $2.50, should $2.50 be used or the appropriate contracted rate.

    The processors should always use the appropriate contracted dispensing fee to adjudicate the claim as opposed to the default $2.50 as indicated in the instructions.

14. Will PBMs receive partial fill claims?

    Yes. Further instructions will be relayed to the processors as to the expected adjudication process for the partial fills.

15. Please confirm that the pharmacy numbers will not be NPI.

    National Pharmacy Identifiers will not be used.

Certification Process
16. Please describe the actual certification process and schedule.

    PCG will report to CMS the amount that should be recouped from the plans after all claims have adjudicated. Instructions regarding the Automated Plan Payment System withhold process and plan certification process will be forthcoming from CMS.

Special Field Handling Requirements
17. a)Will the compound code (field 406-D6) be flagged as "2" for highest ingredient compounds? b)What are the PDE reporting requirements for multi-ingredient compounds? c)Will there be price validity edits when the claim is flagged as compound but the price exceeds the normal for the reported NDC?

    a) A "2" in 406-D6 does not mean Highest Ingredient method. All compounds (both most expensive legend drug and multi-ingredient) are flagged with a "2" in 406-D6. What really triggers the difference is the use of the NDC# of the most expensive legend drug in 407-D7 as opposed to using a zero (0) in the multi-ingredient method. As such, we will be using the NDC to flag and submit the most expensive compound drug.

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    b) Report a value of 2 in Compound code and report the NDC for the most expensive Part D covered drug in the compound. See PDE Instructions and format at: www.csscoperations.com under prescription drug information, CMS instructions.

    c)Plans should not reject claims due to price validity edits, but should adjudicate the claims at their allowable rate.

18. Would it be possible for Payers to obtain a file of beneficiaries for which they will be receiving claims, prior to receiving the actual Claims files in order to reduce the # of potential Membership denials that could occur during the 5.1 transaction processing?

    At this time, the eligibility list requested will not be produced at a plan level.

19. Will Patient Location Field 307-C7 contain the indicators that will allow us to know the patient setting? If this field is not populated, there is a risk that we could deny Part B drugs that actually should be paid under Part D.

    This field will be populated with the appropriate location code.

20. Do you have estimates of how many 'dummy' NCPDP numbers we will receive as a result from a mismatch when PCG attempts to match the state license number to obtain a valid NCPDP number?

    Not yet, but estimates will be published with the detail claim report.

21. Can we define alternate "group" numbers that can be used to submit these claims? Based on our system requirements, we need an additional identifier in order to suspend edits for formulary drugs, prior auths, step therapy etc.

    PCG is willing to discuss this idea during the testing phase.

22. Per the 5.1 Specifications document, a claim or service billing can be Captured, Paid or Rejected with Duplicates for Captured and Paid available. Could you provide what the preferred response would be - Paid/Duplicate of Paid or Captured/Duplicate of Captured?

    We would need the Paid response.

Patient Co-Pay

23. Is patient co-pay included in total ingredient cost?

    Yes. Patient co-pay is included in the total ingredient cost.

24. If a Plan does not have the beneficiary flagged to a low income category, is the Plan expected to override the co-pay category? Is there a default co-pay category to use in this scenario? If there is a process for verifying eligibility prior to the actual pushing of claims, this type of issue could be resolved prior to adjudicating the claim?

    The PDP is expected to calculate the actual co-pay for the individual according to the information available in its systems on the date of the processing. There is not a process established to verify eligibility prior to the claims submission process, as all eligibility records have been processed by CMS. CMS is developing an additional process to "rescreen" all state submitted beneficiaries for eligibility and plan enrollment using CMS records as of mid to late January to further improve eligibility consistency with plan data.

25. Is the assumption the beneficiary has already paid so there is no need to account for copays?

    Yes. For the State-to-Plan reconciliation project, the SPAP, State Medicaid agency or beneficiary has paid the entire claim, or the pharmacy has waived any co-pay. The processors, and thus the plans, will receive ingredient cost and dispensing fee fields, not copays, and adjudicate the claim as it would have as the primary payer without regard for what may have been provided originally by the state or beneficiary.

Edits

26. The specs indicate that all "timely filing edits" should be turned off. Please tell us how we will be able to screen out double-billed claims.

    Processors are asked to reject any claims already paid to the providers. Processors can match on DOS, provider ID, NDC, etc. in order to determine duplicate claims. CMS will determine later if an additional process is needed.

27. Are refill too soon edits allowed? Will PCG do any editing on duplicate claim submissions prior to sending claims to the Plans?

    No, "refill too soon edits" are not allowed. In addition, PCG has screened for duplicate claims within the claims submitted by the State. However, PCG does not have the necessary data to screen for duplicate claims that may have already been paid by the PDP to the provider.

28. Are administrative edits (such as maximum cost limits) allowed? Some plans have such edits in place to catch quantity submission errors.

    No. These edits are not allowed.

29. How should coordination of benefits (COB) be handled in the State-to-Plan process – should any Medicare Secondary Payer (MSP) edits be ignored? Would there ever be a situation where other payor information is passed to the PBM from PCG - and if so, would we ignore or process as MSP claim?

    MSP edits should remain on for the submission of these claims. If the Plan's PBM has received data from CMS indicating a primary non-Part D payer, claims should be denied. States almost entirely reimbursed the pharmacies as the primary payer. As such, very little if any COB information is available on these claims. If the State populated field 308-C8 (Other Coverage Code) from the State claim then we will submit it along to the PDP and the PDP would know if any other payer had already touched the claim. Generally, the field is populated with the following: No Other Coverage Exists, Other Coverage Exists - Payment Collected, Other Coverage Exists - This Claim Was Not Covered, etc). But without the COB segment information, it is impossible to determine the actual amount already paid on the claim. The PDP will know the existence of MSP, but again, without the Other Coverage Code and COB information on the State claim would not know what the Primary has or has not already done with the claim. In the absence of specific information regarding the MSP and the amount paid on the claim, the PDP should process the claim as the primary payer.

30. The document infers that we should suspend formulary edits, does this mean all drugs are covered or just Part D drugs.

    For the State-to-Plan submission, all Part D drugs (formulary and non-formulary) are considered covered. PCG has already screened the drugs with an excluded drug filter that will filter out drugs (Medicare excluded and always Part B drugs) specifically excluded from Part D.

31. There are circumstances in which we will not be providing a dispensing fee on the NCPDP 5.1 claim response to Per-Se. Will there be any issues with that?

    Yes, this is a problem. Plans must process the claim exactly as you would if it came from the pharmacy including the calculation of dispensing fees.

Transactions
32. Will this process include paid transactions only, as opposed to including reversals and/or rejected transactions?

    PCG will only submit claims as paid transactions. There will be no reversals or denials.

33. Will there be any COB for these claims? Will we expect to see N1 transactions for these claims? Is there specific guidance for these?

    N1s will not be generated, as there is no secondary payment opportunity.

34. Is Per Se ensuring that no other claims/pharmacies/transactions are sent with the unique vendor certification number?
    Yes. Per Se will reject any claims submitted by any other pharmacy with the unique vendor certification ID designated for this process.

35. If optional fields currently not captured and stored are submitted on the transaction they will not be stored. Is this acceptable?

    Yes, that is acceptable.

36. Will a dedicated connection with PerSe be required for Testing? Will a dedicated connection with PerSe be required for the actual claims transactions?

    No. Claims will be sent through existing connectivity to plans. PCG will have special connection to PerSe to ensure pharmacies are not billed.

37. Can we assume that the claim requests will be submitted during off peak hours?   Will we be notified in advance when the claims will be submitted through PerSe?

    If desired, the claims can be submitted off peak hours. The PDPs and processors will be notified in advance by PCG as to the actual date and time of the production run.

38. If file transmission takes longer than "off hours", will the transmission be stopped and then started again the next evening, or will it continue until finished?

    No. It is not feasible to start and stop this process for all processors. Once the submission begins, it will run until all claims are submitted for the designated BIN.

39. We are concerned about Duplicate Transactions within our system. Some of these claims will have processed under a State Medicaid plan already on our system, and exist as Paid claims.

Processing a batch or online claim for the same pharmacy, Rx#, date of service, and fill number will cause a duplicate claim situation and not be able to process.

If the processor for the PDP is also a processor for the State Medicaid agency, the processor may not reject the claims as duplicates. If this is a concern, the processor may consider the NCPDP 1.1 batch format to ensure potential duplicates are handled accordingly. The unique software/vendor identification entry could also be used to identify claims as not duplicative.

Rejections
40. Can we reject for duplicate claim? What if we have previously processed these claims in our system?

    The claims can be rejected as duplicates if the claims were paid to a pharmacy by the Part D plan independent of any processing the processor does on behalf of a State Medicaid program.

41. May plans implement "claims too old" rejects?

    No. PDPs and their processors are asked to "turn off" timely filing edits and accept claims regardless of the original date of service.

NDC Numbers
42. Are Plans to validate the incoming NDC number?

    Plans may validate the incoming NDC number, however the plans are asked to accept any Part D drug with a valid NDC. PCG will be using the most current and valid NDC data available for the demonstration period (January through March 2006).

Claim Adjudication
43. Are we to assume that any copayment amount identified in the adjudication and reported on the PDE will be addressed by CMS should not to be collected by the plan from the beneficiary?

    Yes. The objective of State-to-Plan is to appropriately reimburse the Medicare Trust Fund for amounts the plans should have paid. States will end up financing any amount of cost sharing that would have been charged under the Part D plan that was not collected at the point-of-sale. Plans should treat these amounts as patient pay on their PDEs.

44. What happens when the state paid $100 for a claim rather than $90 (since they didn't know to take a $10 copay) when the plan adjudicates the claim? Is the plan to assume that the state is responsible for the copay and treat it as though it were the member? Does the plan add the state paid member portion to TrOOP?

    Plans will not receive copay information. They will only receive ingredient cost and dispensing fee information. Plans should adjudicate as if no other payer has processed the claim.

45. Will there be any sales tax on the claims submitted for State-to-Plan and if so, how should we handle?

    No sales tax will be submitted to plans on State-to-Plan claims.

Refunds to Members

46. The PDP will adjudicate the transactions based on the plan design at the PDP, therefore if the beneficiary paid a different amount at the point of sale than the result of the reimbursement processing, there is an imbalance. If the member's copay is lower under the plan reimbursement calculation for the member's portion, is it expected that the plan issue a refund to the member?

    The PDP should adjudicate the claim as if the claim had never been paid before. The PDP should not issue a refund to the member unless the beneficiary submits receipts indicating the beneficiary has overpaid cost sharing.

Beneficiary's EOB

47. When will we have EOB requirements? Since these claims will be processed after the end of the benefit year, is there an EOB requirement at all?

    PDPs may choose to issue an EOB, however this is not required, nor is it advised by CMS as it may cause questions and concerns from the members. See 12/28/06 HPMS letter "Reporting 2006 Explanation of Benefits Data to Beneficiaries After January 2007."

Reports

48. Can we have a copy/review the summary report that CMS is creating with payable data by PDP?

    A sample report will be shared with each PDP once the first plan completes the entire process. The report will go directly to the PDP. As requested on the call, each PDP is asked to update the "COB Contact" information on HPMS. This person will receive all correspondence from PCG. The data will be broken down by PDP ("H" or "S") number but not by State/region.

Adjustment Code Reason

49. Will the amounts recouped by CMS be identified by a specific adjustment reason code? If so, what code will be used?

    The amounts recouped by CMS will be from future MARX payments via the Automated Plan Payment System (APPS) adjustments. Further guidance regarding how these amounts will be identified will be forthcoming.

Communicating with Part D Sponsor vs. PBM

50. Plans feel that the communication should be to the plan first, not the PBM. The plan is ultimately responsible and should be the focal point for communication, not the PBM.

    As requested on the call, each PDP is asked to update the COB contact information on HPMS. Communication will be directed to each COB contact regarding status of the claims adjudication process. Each COB contact will be asked to confirm a contact for their claims processor who will serve as the technical liaison throughout the testing and production of the claims processing cycles.

51. Is it appropriate for the PBM to sign an Attestation of System Readiness when they do not hold a contract with CMS?

    It is up to the individual plans to ensure that their PBMs/processors are coordinating with PCG and to determine who will sign the Attestation of System Readiness. However, PCG must maintain contact with PBMs to ensure that the PBM is system ready. The PBM needs to confirm that the system is prepared to handle the claims appropriately on behalf of the plans.
    Plan COB contacts will receive test schedules, test results, productions schedules and reports.

52. At the point that PCG is ready to send production files to PBMs, will they schedule a specific time for these files to be submitted?

    Yes, PCG will schedule a specific time for these files to be sent.

Claims Date of Service, TrOOP and Drug Spend Impact

53. These claims will be processed as being received on the date submitted to the PDP (not the state), without regard for the fill date. Therefore, the beneficiary's TrOOP and Drug Spend accumulation will be impacted by all 2006 claims processing prior to these claims. Is this assumption correct?

    This assumption is correct.

Timeline

54. We have concerns about the time required to finalize these specifications. There is a limited amount of time left this year to code, test, and deploy before testing with PCG.

    CMS believes this is sufficient time to finalize system changes necessary to process these claims and is an appropriate compromise between CMS and plans to getting the project completed and the costs identified in advance of reconciliation.

55. Is this envisioned as a one-time process, or will a similar process exist for future benefit years?

    This is a 2006 benefit year process only. CMS expects 2 rounds of claims submitted by PCG to the PDPs. The first production run will not occur until all claims are adjudicated with the State Medicaid agencies including the 5% withhold and the 2 rounds of the SPAP claims. The second round will include only those claims inappropriately rejected during the 1st production run.

56. The State-to-Plan guidance issued reflects only dates of service for the period of 01/01/2006 thru 03/31/2006. Will there be any 'Phase II' guidance for dates of service after 03/31/2006?

No. CMS is only adjudicating these claims with dates of service through 3/31/2006. If plans need assistance reimbursing/coordinating benefits for State claims after this time period, the plans may consider contacting a firm in the industry capable of submitting these claims in a similar manner to the ones submitted by PCG for the State-to-Plan project.

57. During the last plan call it was stated that this reconciliation process would be a one-time project, however we were informed from one of our clients that we should be prepared to receive future state-to-plan data in addition to the "old" data. Is this true?

This depends on what is meant by "one-time project." State-to-Plan reconciliation will not be expanded to address claims outside the 2006 demonstration period. However, it is not yet clear how many submissions from PCG to the plans will be required. Data is still being analyzed to determine whether separate submissions will be needed to address differences in processing of: 1)Medicaid claims, 2)SPAP claims, 3)COB claims rejected as duplicates in #1, and 4)other unanticipated rejections in #1 or #2. Plans must also independently coordinate with States for any other claims, when appropriate.

Recouping Claims

58. Our plan operates both Medicaid Managed Care plans and MA-PD plans in several states. In the beginning of this year, our Medicaid business paid for lots of pharmacy claims for duals at the state's direction. Does CMS have any guidance for these situations?

Medicaid MCOs should work with the Part D plans to reconcile any claims they paid on behalf of their beneficiaries that should have been covered by the Part D plan. Part D plans must coordinate benefits with other providers of prescription drug coverage, including Medicaid MCOs in accordance with 1860D-23 and 1860D-24 of the Social Security Act (the Act) and Subpart J of the Federal regulations implementing Part D. Consistent with the coordination of benefit (COB) requirements implemented under the regulation at 42 CFR 423.464(b), plans are required to reimburse Medicaid MCOs and SPAPs (up to the amount the plan would have paid as the primary payer) when they, instead of the plan, paid the claims.

Special Needs Plans – Other Considerations

59. What is the process for working with the contact on dispute resolution? Could claims be submitted multiple times until the dispute is resolved?

The claims my be submitted multiple times if the claim is rejected inappropriately by the PDP and/or its processor. However, this will be rare considering CMS will rescreen for eligibility and enrollment in mid January and share this eligibility filter with PCG.

DDPS Readiness/PDE Guidance

60. When will the final PDE guidance be released? Will there be a testing process for the PDE? Will there be a 'separate' State to Payer PDE or will the PDE records be fully integrated into the standard PDE processing.

The guidance for PDE processing was provided in response to question number 16 in the October 6, 2006 HPMS memorandum. All State-to-Plan claims should be reported as non-standard claims by populating an "S" in the Non-Data format code field. While the posted PDE guidance will be

revised to incorporate the guidance provided in our October 6, 2006 memo, no new instructions regarding this process are envisioned.

61. Once Plan-to- plan settlements have occurred, is there any chance that a State-to-Plan PDE will error with a code of 708?

    Yes. When Plan-to-Plan Phase Two is implemented, P2P logic will apply on an ongoing basis to all incoming PDEs, including State-to-Plan PDEs. Edit 708 is an informational edit explaining that the PDE was saved and will be subject to Plan-to-Plan reconciliation. (Plan-to-Plan Phase Two implementation is scheduled for early 2007.)

Year End Reconciliation

62. How will the State-to-Plan additional drug costs flow through year-end reconciliations, including federal reinsurance and risk corridors as needed?

    Plans will have until the end of May to submit PDE data that will reflect these additional claims and will be treated as any other PDE for LICS, reinsurance and risk sharing.

LICS Calculation

63. Is the LICS calculation still the same?

    There is no change to the LICS calculation under this process. You should process in accordance with the plan's benefit design and compare to the standard benefit.

64. Are PBMs/Plans expected to price the claim as though the beneficiary is at the pharmacy based upon the DOS on the claim? If so, do we re-adjudicate any subsequent PDEs that the Plan processed for that beneficiary where it may impact the LICS, member pay, or gross drug cost above buckets? (i.e. coverage gap claims)

    No. The PDP should price the claim at its national average plan allowable or its regional average plan allowable. Plans should retain supporting documentation of the calculation of its plan allowable for audit purposes. The claim should be processed at the point the claim was submitted to the plan.

Reimbursement to Plans and/or PBMs

65. States are being reimbursed for administrative burdens associated with this modification. WillCMS also reimburse plans and/or PBMs for this service?

    No demonstration funds are available for this purpose. CMS will not reimburse the PDPs any additional administrative costs for programming and/or processing of these claims.

Rebates

66. It is assumed that plans will have to bill for rebates on State-to-Plan claims. Please confirm. At what point will rebates have to be collected in order to incorporate on final PDE DIR reporting

    CMS believes all rebates related to Part D claims be paid to the Part D plans. Rebates will need to be collected by the plan prior to submitting its final PDE data and DIR report, which is due by May 31st.

Future Rate Factor Adjustments

67. How will these records impact future rate factor adjustments?

These claims will result in PDEs that may impact future rate factor adjustments.

Network Average

68. For those claims containing the default NCPDP number of 5300378, CMS is requesting that the Plan's Network Average be utilized to adjudicate the claim.   Will CMS be providing additional instruction around what "Network Average" means? For example, can the average across all contracts be used, or does the average need to be by contract?

The PDPs may define its network average (allowable) in the most efficient manner for this process as long as the methodology is justifiable upon audit.

Managed Medicaid

69. Is Medicaid managed care organizations part of the State -to-Plan recon process? If not, is CMS considering including them?

CMS is only adjudicating claims on behalf of State Medicaid agencies and SPAPs for low-income subsidy entitled individuals. If Medicaid managed care plans need assistance adjudicating claims, the plans should consider contacting a firm in the industry capable of submitting these claims in a similar manner to the ones submitted by PCG for the State-to-Plan project.

Repayments to CMS

70. Regarding the payment reconciliation with CMS, is the Automated Plan Payment System (APPS) the same as MMR?

The Automated Plan Payment System, or APPS, is not the same as the MMR. The APPS is the system responsible for calculating CMS' monthly payments, considering inputs from Marx (MMR), as well as other payment adjustments (for example – user fees).

71. How and when will CMS be deducting the payment for these claims?

As stated in the October 6 memorandum regarding State-to-Plan Reconciliation, CMS will recoup payments from PDPs via the Automated Plan Payment System. Further instructions as to how that process will impact plans payments is forthcoming.

"PBM Contact" field in HPMS

72. For the PBM contact information being requested to be updated in HPMS, is the Part D Sponsor updating specific PBM contact data or is the Plan Sponsor updating their contact information? If PBM contact information is requested, what information is required?

The Plan Sponsor should ensure that the PBM contact in HPMS is up-to-date by providing its current PBM, contact name, phone number and e-mail address. This contact should be an employee of the PBM that can confirm the plans processing requirements.

States and Plans affected by the State-to-Plan Reconciliation process

73. Is there a current list of states and plans that are affected by the State-to-Plan Reconciliation process?

    The 30 states participating are: Alaska, Arizona, Arkansas, California, Connecticut, DC, Hawaii, Idaho, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin. CMS has posted a list with gross state total claims received to date.

July 7 Memo vs. October 6 Memo

74. Is the July 7, 2006 CMS memo regarding State-to-Plan Reconciliation Project still applicable?

    No it is not. The October 6, 2006 memo supersedes the July 7, 2006 memo.

PACE

75. PACE organizations generally do not utilize PBMs or third party claims processors to administer Part D -- they administer these functions themselves. As a consequence of this, what are your expectations in regard to State-to-Plan reconciliation for PACE organizations?

    CMS does not envision a role for PACE organizations in the State-to-Plan process.