Medicare part D Prescription Drug Events (PDE) Reconciliation

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Outline

- What are PDEs and what are their purpose?
- How are they processed?
- Importance of PDEs
- Perspectives on PDEs

Medicare Part D

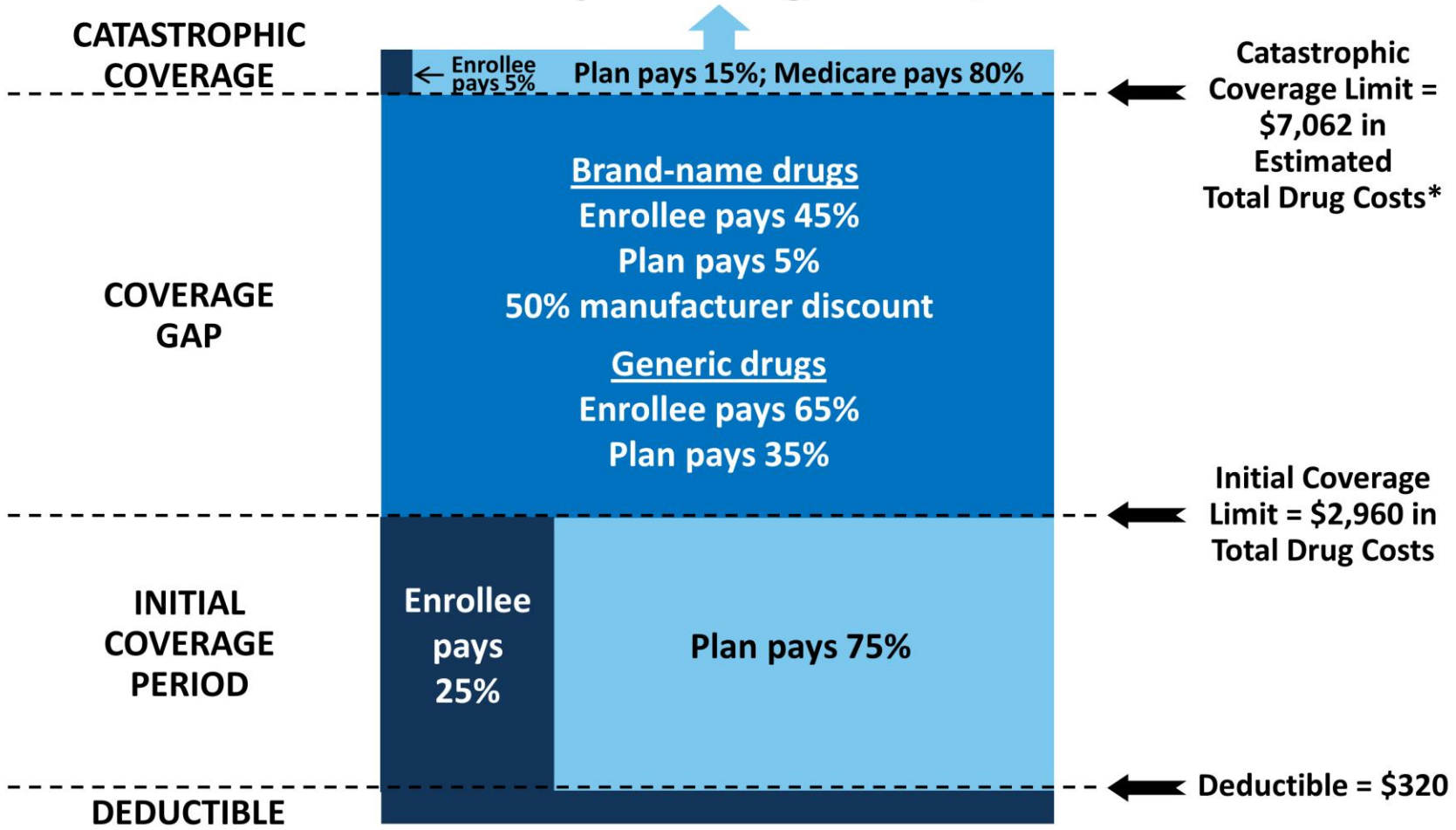
- Established in 2006
- Outpatient Prescription Drug Benefit
- Private insurance companies
  - Prescription Drug Plan (PDP)
  - Medicare Advantage Plan (MA-PD)
- Standard benefit for beneficiaries across all plans at the minimum

Part D: Standard Benefit – 2015

- $320 deductible
- $2960 coverage limit
- $4700 coverage gap ($4700 Out of Pocket Threshold)
  - 55% discount on brand while in “donut hole”
  - 50% discount by manufacturer will still apply to True Out Of Pocket costs (TrOOP)
  - 35% subsidy for generic
- 5% or $2.65 generics ($6.60 brands) minimum cost-sharing in catastrophic coverage

Exhibit 3

Standard Medicare Prescription Drug Benefit, 2015



NOTE: *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($6,680 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,700 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.

SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2015 (standard benefit parameter update from Centers for Medicare & Medicaid Services, 2014). Amounts rounded to nearest dollar.

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Payment to Plans

- Each plan submits a bids annually → Prospective
  - Reflect: Expected benefit payments + admin costs
  - Based on *expected average health* of beneficiaries and *Medicare standard benefit*

- CMS adjusts monthly payments based on *actual health status* from PDE data

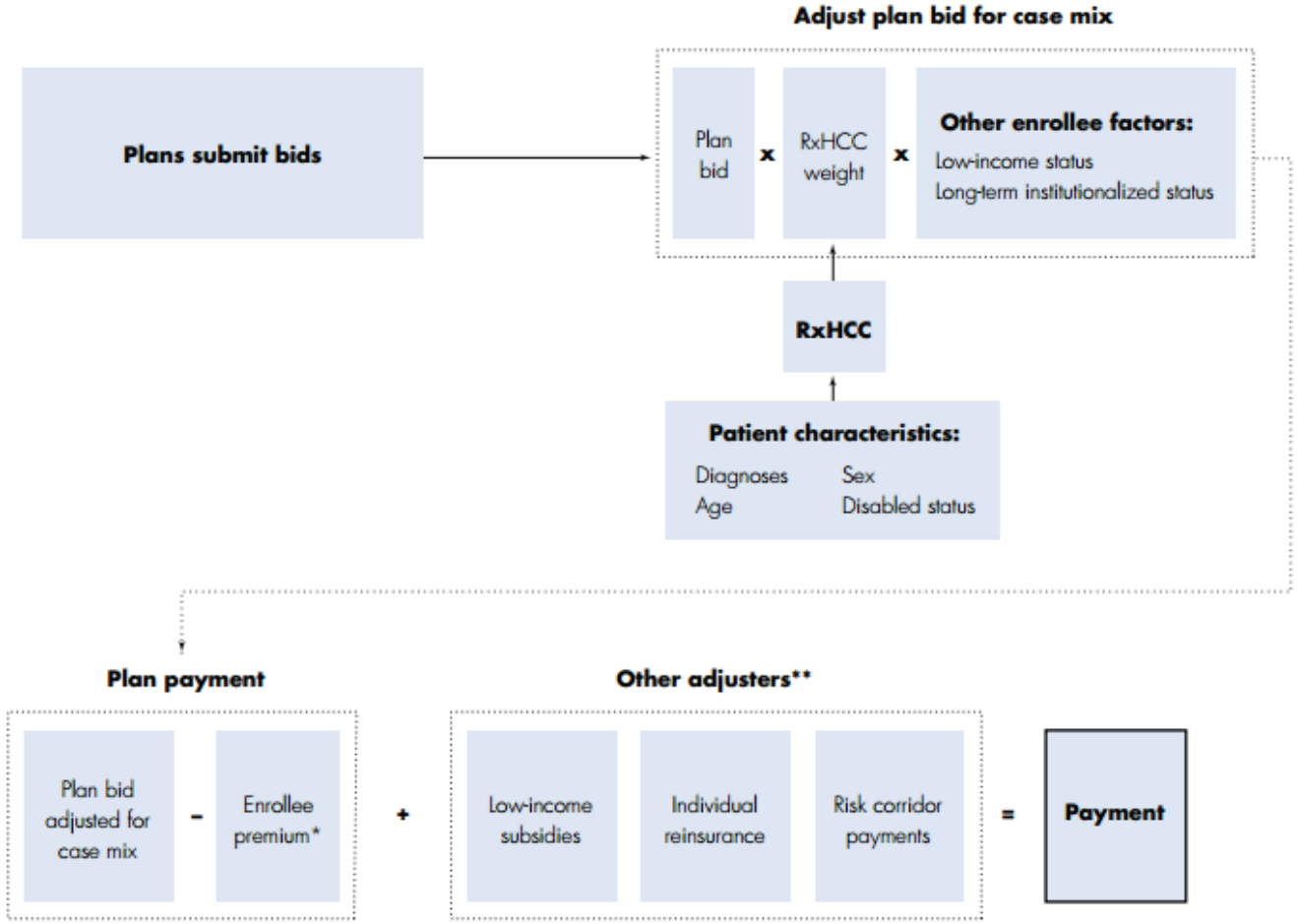
- For each enrollee:
  - Medicare provides plans ~74.5% of standard coverage for all types of beneficiaries

Medicare Subsidies

- 4 legislated payment mechanisms
  - Direct Subsidies
    - *Capitated calculated as share of adjusted national average of plan bid*
  - Low-Income Subsidies
    - *For plans that enroll low-income beneficiaries (135% FPL)*
  - Federal Reinsurance Subsidies
    - *80% drug spending in catastrophic threshold if above $45,000 to max of $250,000*
    - *"Risk Adjustment"*
  - Risk Corridor
    - *Limits a plans losses or profits*
    - *Ex: If ↑3% projection, Medicare pays 50% of excess; 8% Medicare pays 80%*

PAYMENT CALCULATION

Figure 2 Part D payment system



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

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PDEs

- Data from prescription claims given to Center for Medicare & Medicaid Services (CMS)

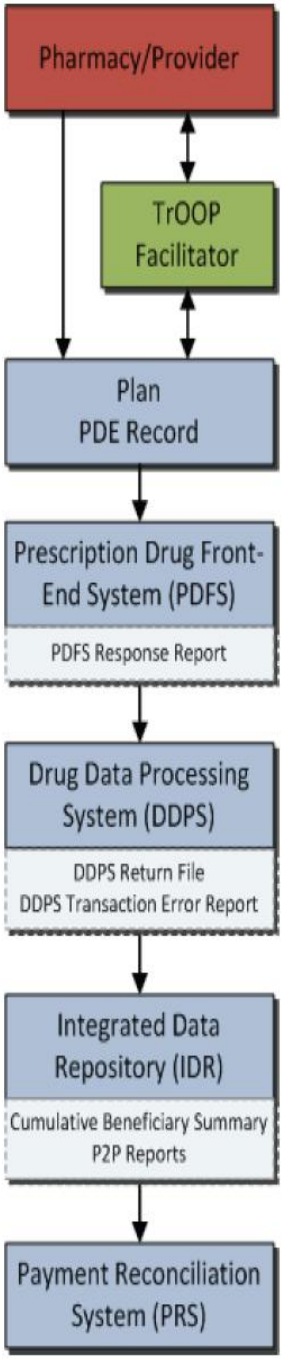
- Multi-Purpose
  - Proper CMS reconciliation
    - Under/Overpayment
    - Prospective, capitated system
  - Research
  - Drug Utilization
    - DURs
    - Provide statistics to Congress and public
    - Evaluation of programs

PDEs cont.

- NOT the same as individual drug claim transactions
  - **Summary extracts** of CMS-defined standards
    - *Does not reflect other drug coverage (eg. Employer or union)*
    - *Does not represent Medicare population*
      - *Plan D population only*
  - However, still on a 1:1 basis (PDE : Rx Claim)
  - Processed several weeks *after* *initial claim* adjudication at the pharmacy

PDE Elements

- **37 data elements in total**
- Identifiers
  - Beneficiary ID, Plan ID, Prescriber ID, Pharmacy ID
- Drug Utilization Information
  - Date of service, Drug information
- Cost
  - Total (ingredient + dispensing)
- Coverage Information
  - Date paid, Plan paid, Cost sharing, TrOOP, Low income subsidy
- Other Descriptive Data
  - Gender, Catastrophic coverage, electronic vs paper claim



PDE Flow

- PDE submission required at least once a month
- **PDFS** Checks: Acceptance or Rejection
- **DDPS**: Detail editing and error codes
- **IDR**: Calculates other costs
  - Risk corridor, reinsurance, low income cost sharing
- **PRS**: Calculates reconciliation payment for beneficiary and plan level

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SAMPLE FORMAT

DET RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES	M, S, O (See Notes)
1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"	M
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001	M
3	CLAIM CONTROL NUMBER		11 - 50	X(40)	40	CMS		O
4	HEALTH INSURANCE CLAIM NUMBER (HICN)		51 - 70	X(20)	20	CMS	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.	M
5	CARDHOLDER ID	302-C2	71 - 90	X(20)	20	NCPDP	Plan identification of the enrollee. Assigned by plan.	M
6	PATIENT DATE OF BIRTH (DOB)	304-C4	91 - 98	9(8)	8	NCPDP	CCYYMMDD	O
7	PATIENT GENDER CODE	305-C5	99 - 99	9(1)	1	NCPDP	1 = M 2 = F Unspecified or unknown values are not accepted	M
8	DATE OF SERVICE (DOS)	401-D1	100 - 107	9(8)	8	NCPDP	CCYYMMDD	M
9	PAID DATE		108 - 115	9(8)	8	CMS	CCYYMMDD, The date the plan paid the pharmacy for the prescription drug.	Fallback plan = M, All other plans = O
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 - 124	9(9)	9	NCPDP	The field length is 9 to accommodate proposed future NCPDP standard. Under 5.1 right justify and fill with 2 leading zeros. When plans compile PDEs from non-standard formats, the plans must assign a unique reference number if necessary. A reference number must be unique for any DOS and Service Provider ID combination.	M
11	FILLER		125 - 126	X(2)	2		SPACES	M

Example Error Codes

Code	Description	Suggestion
131	The File ID is missing. The File ID is blank.	Enter a unique File ID on the HDR record.
604	The Cardholder ID is missing.	No Suggestion Listed
605	The DOB is an invalid date. Dates must be in CCYYMMDD format.	DOB is optional. If Plans choose to report DOB, the format must be correct. Matching is done on Month and Year only, Day is disregarded. If no DOB is to be provided, zeros or spaces should be used to populate this field.
606	The Gender is missing or invalid. The Gender must be either '1' or '2'.	No Suggestion Listed

Importance of Flow

- Ensures plans report all eligible beneficiaries and relevant data
  - *Proper reconciliation*
  - Errors in submission: Found in DDPS
    - If errors are not fixed – will NOT be included in PRS calculation
  - Intense scrutiny

Plans Perspective

- Part D Reconciliation
  - Capitation (not fee-for-service)
    - Utilization and duplicates impact on overall revenue
- May lead to severe losses if criteria for PDE is not met
  - In 2007: Initial PDE Reconciliation
    - Plans paid CMS more than $4 billion dollars
    - 80% of all parent organizations owed money to CMS
    - Key issue in this year was not having *valid membership data*
      - Payment subsidized on a PMPM basis

CMS Perspective

- Imperative to analyze PDE data closely
  - *Basis of accurate Part D Payment Reconciliation*
- Provides important data on drug utilization
  - Fraud, waste, and abuse
  - Prescriber tendencies

Potential Issues

- Limitations
  - *Not individual drug claim*
    - PDE may not reflect what was *actually paid* at point of sale
  - Does not reflect all drug claims submitted by beneficiary (*if paid by other coverage)*
  - Not all Medicare beneficiaries are enrolled in Part D
    - *Data not representative of Medicare population*
- Data analysis
  - Drug on PDE *not necessarily on formulary*
  - Cannot study drug history of patient
    - *Not all drugs paid by Part D*
  - Only measures acquisition (persistence) – not consumption/adherence

Conclusions

- PDE data is an essential aspect in the part D payment system
- Also serves as a source for multiple avenues of research and decision plans
- Certain limitations should be realized when using PDE for research purposes

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