Non-Medicare Prescription Drug Enrollment File Exchanges With PBMs

Office of Financial Management

CMS

PBM-CMS Data Exchange

CMS is entering into data exchanges with non-Medicare payers of prescription drug benefits primary or secondary to Part D. This information will be provided to the TrOOP Facilitation Contractor and the Part D Plans for TrOOP facilitation, tracking, and calculation, as well as payer primacy determinations.

CMS currently has data exchanges with insurers and employers and will also seek prescription drug coverage from these sources. CMS sees PBMs as valuable sources for this information, as well.

CMS would like to enter into data exchanges with PBMs to satisfy the requirements of exchanges with PBMs' insurer and employer clients, as well as any other prescription drug coverage that CMS would otherwise not receive through one of its exchanges. CMS will provide Medicare Part D entitlement data to the PBMs in exchange for their non-Medicare coverage.

Medicare Secondary Payer (MSP) and PBMs

- In certain situations, Group Health Plans (GHPs) are statutorily required to pay primary to Medicare, i.e. for Active (working) Employees and dependents, as found at 42 U.S.C. § 1395y(b).

- Under provisions found in § 1860D-2(a) (4) of the MMA, the MSP rules have been incorporated in the MMA and are applicable to GHPs prescription drug coverage.

- PBMs are required to make payer order determinations for prescription drug coverage based on the MSP laws in the same way insurers and employers do for hospital and medical coverage.

- PBMs will need their insurer and employer clients to inform them of the Active or Inactive status of covered individuals.

A description of the information contained in this presentation

CMS recognizes that PBMs will have both Part D Plan and non-Medicare insurance clients. The data exchanges described here are between CMS and non-Medicare prescription drug coverage of PBMs.

It is likely that PBMs will provide non-Medicare (i.e. GHP) prescription drug coverage to individuals that are Part D beneficiaries, but enrolled in a Part D Plan not affiliated with that PBM.

This presentation contains two diagrams. Diagram 1 is of the Part D Plan data exchanges with CMS and is for reference only. This is to distinguish that process from the exchange in diagram 2 and in the scenarios contained in it, which is the exchange of non-Medicare coverage.

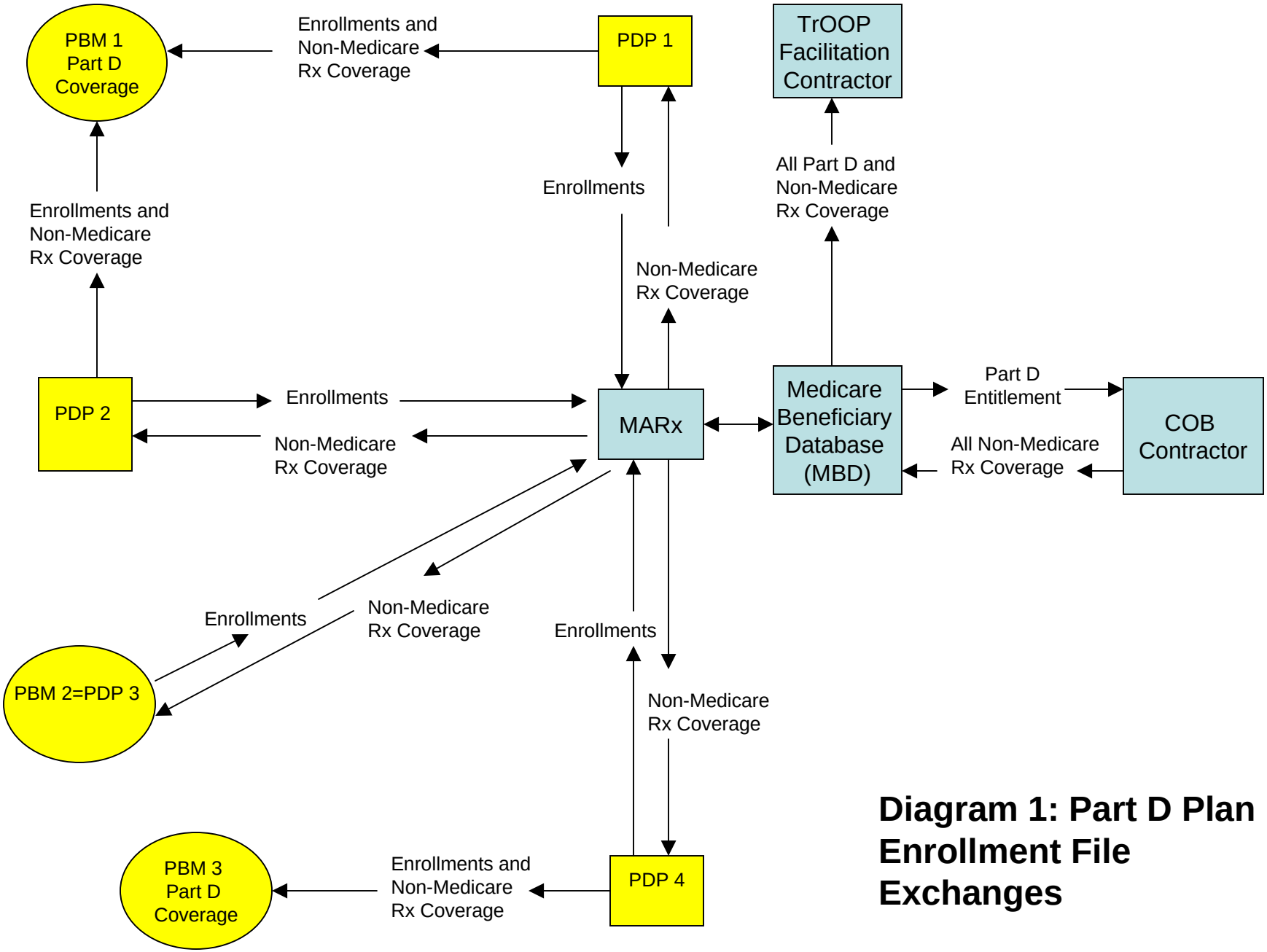
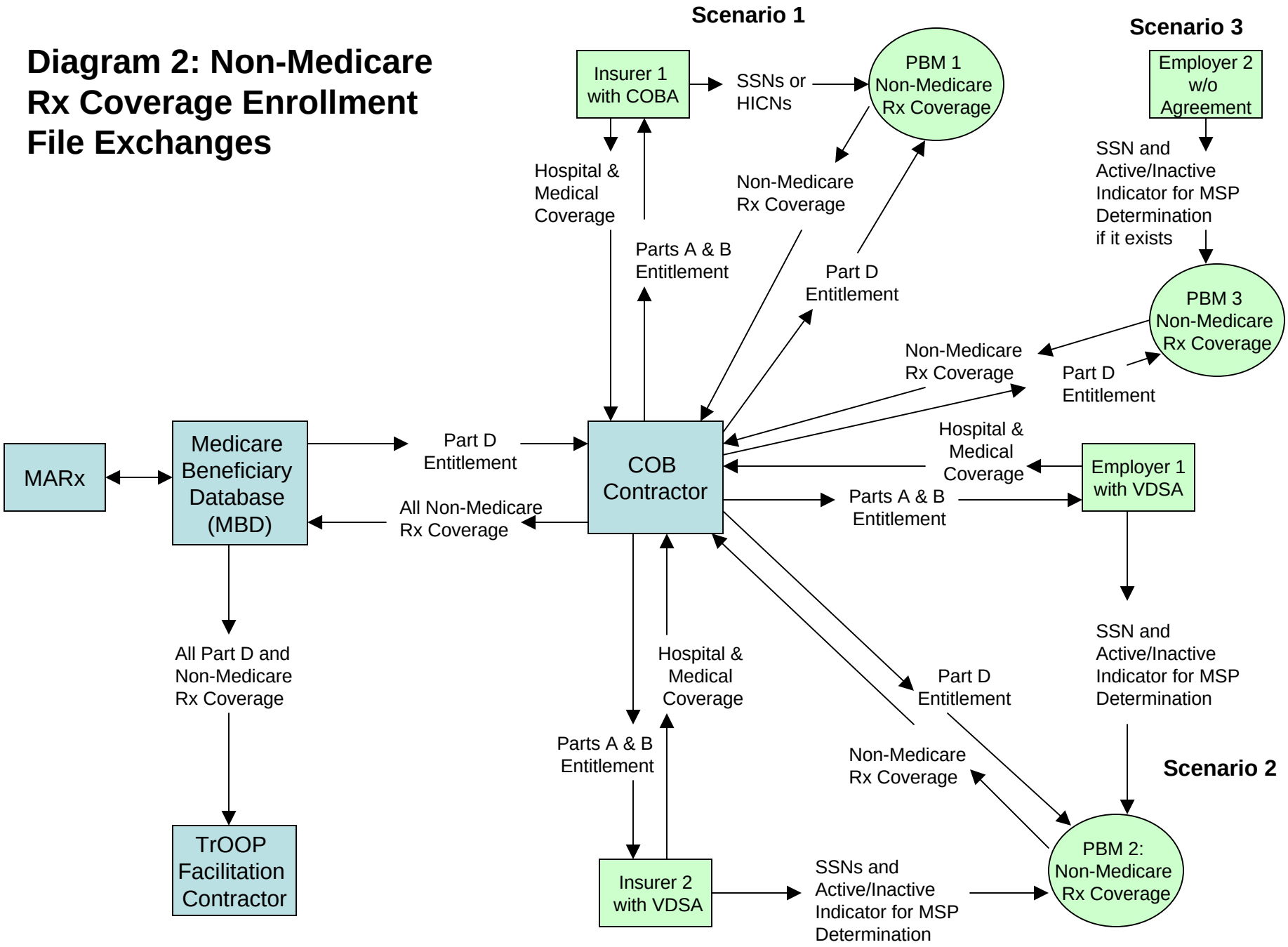


Diagram 1: Part D Plan Enrollment File Exchanges

Diagram 2: Non-Medicare Rx Coverage Enrollment File Exchanges



Scenario 1 of Diagram 2: PBM and Supplemental Insurer with a Coordination of Benefits Agreement (COBA)

- Insurer 1 has a COBA with CMS to have Parts A and B claims crossed over for supplemental payment by Insurer 1.

- Insurer 1 sends monthly enrollment files of covered individuals that the COB Contractor uses to identify beneficiaries with Parts A and B claims to cross over.

- As part of its COBA, Insurer 1 is required to send its prescription drug coverage to the COB Contractor to be used in TrOOP facilitation and calculation.

- Insurer 1 contracts with PBM 1 to administer prescription drug coverage and has PBM 1 send its prescription drug coverage enrollment to the COB Contractor.

Scenario 1 Process

- Insurer 1 provides SSNs and HICNs of individuals with coverage seconndary to Part D to PBM 1.
- PBM 1 sends monthly prescription drug coverage enrollment files to the COB Contractor, indicating which insurer it is submitting for using the insurer's COBA ID.
- The COB Contractor searches for Part D entitlement based on HICN or SSN and applies records that match.
- The COB Contractor sends response file indicating records that did not match, any errors, and for records that did match, Medicare Part D entitlement reason and dates and which Part D plan the beneficiary is enrolled in.
- PBM 1 must correct any errors identified by the COB Contractor before sending its next file.

Scenario 2 of Diagram 2: PBM and Insurer or Employer with a Voluntary Data Sharing Agreement (VDSA)

- Employer 1 and Insurer 2 have VDSAs with CMS to report MSP situations where the GHP should be primary to Medicare. They also report prescription drug coverage secondary to Part D. Employer 1 also intends to claim the subsidy for one of its Groups and wishes to use the VDSA to send retiree enrollment files.

- Employer 1 and Insurer 2 send quarterly enrollment files of Active covered individuals age 55 and up to the COB Contractor to report MSP. They are required to report hospital, medical and drug coverage.

- As part of VDSA, Employer 1 and Insurer 2 are required to send prescription drug coverage of Inactive covered individuals to the COB Contractor to be used in TrOOP facilitation, tracking, and calculation, as well as processing for the Retiree Subsidy.

- Employer 1 and Insurer 2 contract with PBM 2 to administer prescription drug coverage and have PBM 2 send their prescription drug coverage enrollment. PBM 2 is also obligated to follow MSP rules for payment.

Scenario 2 Process

- Employer 1 and Insurer 2 provide SSNs and HICNs to PBM 2. They also indicate which covered individuals are Active and Inactive.

- PBM 2 sends monthly prescription drug coverage enrollment files for Employer 1 and Insurer 2. It sends an MSP File of Actives and a Non-MSP File of Inactives,for each of its clients to the COB Contractor. PBM 2 also submits file of retirees Employer 1 is claiming the Subsidy for. PBM 2 indicates which insurer and employer it is submitting for using Employer 1 and Insurer 2's VDSA IDs.

- The COB Contractor searches for Part D entitlement based on HICN or SSN and applies MSP and Non-MSP records that match. Subsidy file is passed on to RDS Contractor for processing.

- The COB Contractor sends response file indicating records that did not match, any errors, and for records that did match, Medicare Part D entitlement reason and dates and which Part D plan the beneficiary is enrolled in. The COB Contractor also sends the RDS Contractor's response for the Subsidy file.

- PBM 2 must correct any errors identified by the COB Contractor before sending its next file.

Scenario 3 of Diagram 2: PBM and Employer without a VDSA

- Employer 2 has no VDSA, but is still required to comply with MSP laws and have its GHP make payments primary to Medicare for Active covered individuals.

- Employer 2 contracts with PBM 3 to administer prescription drug coverage. PBM 3 is obligated to follow MSP rules for payment, as well.

Scenario 3 Process

- PBM 3 asks Employer 2 to provide SSNs and indicate which covered individuals are Active and Inactive.
- PBM 3 sends two monthly prescription drug coverage enrollment files, an MSP File of Actives and a Non-MSP File of Inactives,to the COB Contractor.
- The COB Contractor searches for Part D entitlement based on HICN or SSN and applies MSP and Non-MSP records that match.
- The COB Contractor sends response file indicating records that did not match, any errors, and for records that did match, Medicare Part D entitlement reason and dates and which Part D plan the beneficiary is enrolled in.
- PBM 3 must correct any errors identified by the COB Contractor before sending its next file.

For more information on data sharing with CMS, contact:

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