INSTRUCTIONS FOR THE PART D PAYMENT DEMONSTRATION

May 10, 2005

Part D Payment Demonstration Guidance

Part D Payment Demonstration Background

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Conference Report, the conferees noted that the reinsurance provisions of the Part D benefit, and specifically as they relate to the True Out-Of-Pocket (TrOOP) threshold established in section 1860D-2(b)(4)(B) of the Act, may create a disincentive for Part D plans to provide supplemental prescription drug benefits. In response to the Part D notice of proposed rulemaking, several commenters agreed with the conferees that the risk to plans and the cost to beneficiaries through the supplemental premium would be powerful disincentives to offering enhanced alternative coverage.

To address this concern, the conferees suggested use of the Secretary of Health and Human Services' Medicare demonstration authority to "allow private sector plans maximum flexibility to design alternative prescription drug coverage." The authority to conduct Medicare demonstrations is provided in section 402 of the Social Security Amendments of 1967 (42 U.S.C. § 1395b–1). Under section 402(b), the Secretary is authorized to waive requirements in Title XVIII that relate to reimbursement and payment. The conferees specifically stated that CMS should demonstrate the effect of filling in the gap in coverage by reimbursing participating plans a capitated payment that is actuarially equivalent to the amount that plans would otherwise receive from the government.

Summary of Part D Reinsurance Payment Demonstration Notice

On February 25, 2005, CMS announced in the Federal Register (Vol. 70, No. 37) the opportunity to participate in the Part D Reinsurance Payment Demonstration. The notice outlined the following two reinsurance demonstration options aimed at reducing the aforementioned disincentive to providing supplemental benefits in the coverage gap:

- Option 1 (the "capitated option")-enhanced alternative coverage with a supplemental benefit in the coverage gap with a capitated reinsurance payment; and

- Option 2 (the "MA rebate option")-enhanced alternative coverage with a supplemental benefit in the coverage gap paid for with Medicare Advantage (MA) Part A/B rebate dollars, which count towards the TrOOP threshold.

We have subsequently refined Option 1 into two versions: the Flexible Capitated and the Fixed Capitated Option. Both are explained in more detail in the Part D Payment Demonstration Options table below.

The Federal Register notice also established the budget neutrality requirement of this demonstration, which will be achieved through restrictions on the organizations that are eligible to participate in the demonstration and other means. All Prescription Drug Plans (PDPs) and Medicare Advantage organizations offering Prescription Drug Plans (MA–PD plans) are eligible to participate in certain options with the exception of the following: Program of All Inclusive Care for the Elderly (PACE), MA-PD employer only plans, and employer direct contract plans.

In addition to restricting organizational participation, CMS has determined that this demonstration can be budget neutral only if the capitated payments are reduced by at least $3.13 per member per year for the capitated option and at least $7.57 per member per year for the MA rebate option.

The remainder of this document provides additional guidance on the demonstration concept first articulated in the February 25, 2005 Federal Register notice. This document supercedes the description provided in the Federal Register notice.

The table on the following page presents additional guidance on the payment demonstration as a side-by-side comparison between the flexible capitated, fixed capitated and MA rebate options. Some of the demonstration elements reflect no difference between the options. Note that the payment methods in this guidance supercedes the methods promulgated in the 45-day Advance Notice released on February 18, 2005 and the final payment rates notice released on April 4, 2005.

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
Enhanced alternative-supplemental benefit in the coverage gap	Must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap.	Must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap.	Must provide a supplemental benefit filling in all or part of the defined standard benefit's coverage gap. The coverage gap exists between the initial coverage limit of $2,250 (amount for 2006; see 42 CFR §423.104(d)(3) for increases in subsequent coverage years) and the point at which the beneficiary has reached $3,600 in true out-of-pocket (TrOOP) spending, which is $5,100 in total drug spend for 2006.
Catastrophic coverage for the beneficiary	As defined in 42 CFR §423.104 (d)(5)(iii), begins when the out-of-pocket threshold ($3,600 in 2006) is met.	Is fixed at $5,100 in total drug spend (for 2006) regardless of the TrOOP calculation. That is, a beneficiary could reach the catastrophic protection level without having spent $3,600 out of pocket.	As defined in 42 CFR §423.104 (d)(5)(iii), begins when the out-of-pocket threshold ($3,600 in 2006) is met.
Out-of-pocket threshold	The out-of-pocket threshold is the same as non-demonstration Part D. The out-of-pocket threshold is defined in 42 CFR §423.104 (d)(5)(iii) as $3,600 for 2006 and is increased in subsequent coverage years by the annual percentage increase in average per capita aggregate expenditures for Part D drugs for Part D eligible individuals	In this option the attachment point for catastrophic coverage is locked in at $5,100 in total drug spend in 2006 regardless of the TrOOP calculation. This would correspond to the attachment point for catastrophic for a defined standard benefit plan in 2006 when a beneficiary reaches $3,600 in TrOOP. In this variation the TrOOP	Same as non-demonstration Part D. Defined in 42 CFR §423.104 (d)(5)(iii) as $3,600 for 2006 increased in subsequent coverage years by the annual percentage increase in average per capita aggregate expenditures for Part D drugs for Part D eligible individuals rounded to the nearest multiple of $50. This option modifies 42 CFR

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
	rounded to the nearest multiple of $50.	requirement is waived. In subsequent years the fixed point would change to correspond to the total drug spend required in a defined standard benefit to get to the TrOOP amount for that coverage year.	§423.100 to count MA A/B rebate dollars as defined in 42 CFR §422.266 that are applied to a supplemental benefit in the coverage gap as beneficiary incurred costs for purposes of the out-of-pocket threshold. In other words, MA rebate dollars used for this purpose count towards TrOOP.
Reinsurance payment	A prospective capitated amount negotiated with the bid. The estimate is based on the basic benefit. Savings from the capitated reinsurance payment resulting from the increase in the point at which catastrophic coverage begins under the enhanced alternative benefit must be applied to the costs of the supplemental benefit. In contrast to the MA-rebate option and non-demonstration Part D plans, the prospective reinsurance payment will not be subject to the reconciliation process described in 42 CFR §423.343(c) and the Advance Notice of Methodological Changes for Calendar Year 2006. The additional capitation payment for reinsurance will be part of the	A prospective capitated amount negotiated with the bid. In contrast to the MA-rebate option and non-demonstration Part D plans, the prospective reinsurance payment will not be subject to the reconciliation process described in 42 CFR §423.343(c) and the Advance Notice of Methodological Changes for Calendar Year 2006. The additional capitation payment for reinsurance will be part of the risk corridor reconciliations by being included in the target amount. It will not be subtracted from allowable costs. More guidance on risk corridors is provided below.	Same as non-demonstration Part D plans. The reinsurance amount will be prospectively paid based on an estimate provided with the bid and then reconciled with submitted prescription drug event (PDE) data.

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
	risk corridor reconciliations by being included in the target amount. It will not be subtracted from allowable costs. More guidance on risk corridors is provided below.		
Supplemental premium	A supplemental premium will be necessary for supplemental benefits not covered by the capitated payment. MA plans may reduce any premium with the application of A/B rebate dollars.	A supplemental premium will be necessary for supplemental benefits not covered by the capitated payment. MA plans may reduce any premium with the application of A/B rebate dollars.	The full value of the supplemental benefit must be bought down by A/B rebate dollars. It is not permissible to have some supplemental benefits that count towards TrOOP while others do not.
Risk sharing (risk corridors)	The additional capitation payment for reinsurance will be included in the risk corridor targets and will not be subtracted from allowable costs. The allocation between basic and supplemental benefits will be the same as for all other enhanced alternative plans. Additional guidance on differences in comparison to previous guidance on payment methods and the prescription drug event (PDE) submission guidelines are provided below.	The additional capitation payment for reinsurance will be included in the risk corridor targets and will not be subtracted from allowable costs. The allocation between basic and supplemental benefits will be the same as for all other enhanced alternative plans. Additional guidance on differences in comparison to previous guidance on payment methods and the prescription drug event (PDE) submission guidelines are provided below.	Same as non-demonstration Part D plans with an enhanced alternative benefit. For detailed information see the Part D payment methods guidance the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/ and for data submission see Prescription Drug Event Data paper at www.cms.hhs.gov/pdps/ PDClaimProc.asp
Plans that are eligible to	All Prescription Drug Plans (PDPs) and Medicare Advantage	All Prescription Drug Plans (PDPs) and Medicare Advantage	Only MA organizations have MA rebate dollars, therefore only MA

Elements of payment demonstration	**Part D Payment Demonstration Options**		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
participate	organizations offering Prescription Drug Plans (MA–PD plans) are eligible to participate with the exception of the following: Program of All Inclusive Care for the Elderly (PACE), MA-PD employer only plans, and employer direct contract plans.	organizations offering Prescription Drug Plans (MA–PD plans) are eligible to participate with the exception of the following: Program of All Inclusive Care for the Elderly (PACE), MA-PD employer only plans, and employer direct contract plans.	organizations can participate in this option. As mentioned previously, Program of All Inclusive Care for the Elderly (PACE) plans, MA-PD employer only plans, and employer direct contract plans may not participate.
Capitated adjustment for budget neutrality	At least $3.13 per member per year.	At least $3.13 per member per year.	At least $7.57 per member per year.
Direct subsidy	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/
Risk adjustment	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/.	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/.	No changes from the guidance provided in the Part D payment methods section the Advance Notice of Methodological Changes for Calendar Year 2006 and the Part D section of the 2006 Medicare Advantage Payment Rates notice documents available online at www.cms.hhs.gov/healthplans/rates/

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
	Additional risk adjustment model information is available at http://www.cms.hhs.gov/pdps/ PmntNtcNRskAdjMdl.asp	Additional risk adjustment model information is available at http://www.cms.hhs.gov/pdps/ PmntNtcNRskAdjMdl.asp	Additional risk adjustment model information is available at http://www.cms.hhs.gov/pdps/ PmntNtcNRskAdjMdl.asp.
Interaction with a negative premium	In the event that a plan's bid is below the national average bid amount by more than the value of the base beneficiary premium, the plan would have a "negative premium". As directed by 42 CFR §423.286(d)(1) the absolute value of a negative premium amount must be applied to a supplemental benefit. This amount should be applied to the supplemental benefit before any capitated reinsurance dollars, supplemental premiums paid by the beneficiary and/or MA rebate dollars are applied.	In the event that a plan's bid is below the national average bid amount by more than the value of the base beneficiary premium, the plan would have a "negative premium". As directed by 42 CFR §423.286(d)(1) the absolute value of a negative premium amount must be applied to a supplemental benefit. This amount should be applied to the supplemental benefit before any capitated reinsurance dollars, supplemental premiums paid by the beneficiary and/or MA rebate dollars are applied.	In the event that a plan's bid is below the national average bid amount by more than the value of the base beneficiary premium, the plan would have a "negative premium". As directed by 42 CFR §423.286(d)(1) the absolute value of a negative premium amount must be applied to a supplemental benefit. This amount should be applied to the supplemental benefit before any capitated reinsurance dollars, supplemental premiums paid by the beneficiary and/or MA rebate dollars are applied.
Employer coverage issues	The Part D payment demonstration plan must have any prospective enrollee attest that the beneficiary is not receiving any employer benefits for Medicare prescription drug benefits. The plan has the discretion on how to develop a method for obtaining and recording this information during the enrollment process. The	The Part D payment demonstration plan must have any prospective enrollee attest that the beneficiary is not receiving any employer benefits for Medicare prescription drug benefits. The plan has the discretion on how to develop a method for obtaining and recording this information during the enrollment process. The	The Part D payment demonstration plan must have any prospective enrollee attest that the beneficiary is not receiving any employer benefits for Medicare prescription drug benefits. The plan has the discretion on how to develop a method for obtaining and recording this information during the enrollment process. The

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
	plan will not have to report anything to CMS, but is expected to maintain records for auditing purposes. Beneficiaries with a history of employer support will be flagged. Specifically, if the prospective enrollee has at any time had the retiree drug subsidy, an employer has paid their premiums, or has been enrolled in an "800" series plan or direct contract employer-sponsored plan, CMS shall alert the demonstration plan to halt the enrollment until the plan has had the enrollee attest that the employer is not currently funding their premiums. If the beneficiary attests that he/she is no longer receiving employer support the suspended enrollment can be overridden by a repeated enrollment transaction. Demonstration plans are required in their marketing materials to make prospective enrollees aware that they may not enroll in a demonstration plan if they are receiving employer support for prescription drug benefits.	plan will not have to report anything to CMS, but is expected to maintain records for auditing purposes. Beneficiaries with a history of employer support will be flagged. Specifically, if the prospective enrollee has at any time had the retiree drug subsidy, an employer has paid their premiums, or has been enrolled in an "800" series plan or direct contract employer-sponsored plan, CMS shall alert the demonstration plan to halt the enrollment until the plan has had the enrollee attest that the employer is not currently funding their premiums. If the beneficiary attests that he/she is no longer receiving employer support the suspended enrollment can be overridden by a repeated enrollment transaction. Demonstration plans are required in their marketing materials to make prospective enrollees aware that they may not enroll in a demonstration plan if they are receiving employer support for prescription drug benefits.	plan will not have to report anything to CMS, but is expected to maintain records for auditing purposes. Beneficiaries with a history of employer support will be flagged. Specifically, if the prospective enrollee has at any time had the retiree drug subsidy, an employer has paid their premiums, or has been enrolled in an "800" series plan or direct contract employer-sponsored plan, CMS shall alert the demonstration plan to halt the enrollment until the plan has had the enrollee attest that the employer is not currently funding their premiums. If the beneficiary attests that he/she is no longer receiving employer support the suspended enrollment can be overridden by a repeated enrollment transaction. Demonstration plans are required in their marketing materials to make prospective enrollees aware that they may not enroll in a demonstration plan if they are receiving employer support for prescription drug benefits.

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
Demonstration coverage years	As stated in the February 25, 2005 notice, this demonstration is scheduled to take place during the 2006-2010 coverage years.	As stated in the February 25, 2005 notice, this demonstration is scheduled to take place during the 2006-2010 coverage years.	As stated in the February 25, 2005 notice, this demonstration is scheduled to take place during the 2006-2010 coverage years.
Bid pricing	New bid tool required. The new tool reflects that the reinsurance capitation is based on the defined standard benefit. The determination of gap coverage and catastrophic coverage should be consistent with the requirements of beneficiary cost sharing. Specifically, amounts reported for the catastrophic period must reflect to point at which the beneficiary pays the greater of $2/$5 or 5% or an actuarially equivalent amount. Consistent with the development of other bids, the bids must reflect the experience for the population that the plan expects to enroll. Plans must reflect the selection impact of the benefit design being offered. The selection impact should reflect both the potential higher use for net positive supplemental benefit values and the potential lower use for supplemental benefits that have net negative values, that is where	New bid tool required. The new tool reflects that the reinsurance capitation is based on the defined standard benefit. The determination of gap coverage and catastrophic coverage should be consistent with the requirements of beneficiary cost sharing. Specifically, amounts reported for the catastrophic period must reflect to point at which the beneficiary pays the greater of $2/$5 or 5% or an actuarially equivalent amount. Consistent with the development of other bids, the bids must reflect the experience for the population that the plan expects to enroll. Plans must reflect the selection impact of the benefit design being offered. The selection impact should reflect the potential higher use for net positive supplemental benefit values. Separate additional guidance on the bid pricing tool will be provided.	The bidding structure fits into the existing bid pricing tool. Note that this option does not result in a shift from catastrophic coverage to gap coverage for offering supplemental benefits. Separate additional guidance on the bid pricing tool will be provided.

Elements of payment demonstration	Part D Payment Demonstration Options		
	Flexible capitated option	**Fixed capitated option**	**MA rebate option**
	premiums are greater than supplemental benefits. Separate additional guidance on the bid pricing tool will be provided.		
TrOOP rule for disenrollment	If a beneficiary disenrolls from a demonstration plan and then enrolls in a non-demonstration Part D plan or a demonstration plan using a different option, their TrOOP transfer amount would be based on normal Part D rules, not the demonstration waiver.	If a beneficiary disenrolls from a demonstration plan and then enrolls in a non-demonstration Part D plan or a demonstration plan using a different option, their TrOOP transfer amount would be based on normal Part D rules, not the demonstration waiver.	If a beneficiary disenrolls from a demonstration plan and then enrolls in a non-demonstration Part D plan or a demonstration plan using a different option, their TrOOP transfer amount would be based on normal Part D rules, not the demonstration waiver.
Payment appeals	Per 42 CFR §423.350, payment appeals may be made if CMS does not apply its stated payment methodology correctly. Please note that the payment methods detailed in this document, or any future guidance on this demonstration, preempt the Part D payment methods described in the 45-day "Advance Notice of Methodological Changes for Calendar Year 2006" and the final "Announcement of Calendar Year 2006 Medicare Advantage Payment Rates" notice.	Per 42 CFR §423.350, payment appeals may be made if CMS does not apply its stated payment methodology correctly. Please note that the payment methods detailed in this document, or any future guidance on this demonstration, preempt the Part D payment methods described in the 45-day "Advance Notice of Methodological Changes for Calendar Year 2006" and the final "Announcement of Calendar Year 2006 Medicare Advantage Payment Rates" notice.	Per 42 CFR §423.350, payment appeals may be made if CMS does not apply its stated payment methodology correctly. Please note that the payment methods detailed in this document, or any future guidance on this demonstration, preempt the Part D payment methods described in the 45-day "Advance Notice of Methodological Changes for Calendar Year 2006" and the final "Announcement of Calendar Year 2006 Medicare Advantage Payment Rates" notice.

INSTRUCTIONS FOR SUBMITTING PRESCRIPTION DRUG EVENT DATA: RULES FOR PART D PAYMENT DEMONSTRATIONS

Introduction

On April 12, 2005 CMS issued instructions to all Part D plans for submitting prescription drug event (PDE) data (see http://www.cms.hhs.gov/pdps/PDClaimProc.asp). However, because payment demonstrations will have non-standard benefit structures and some variations in payment methodology, they have several different rules for submitting PDE data for payment calculations. In this document, we describe requirements particular to plans that participate in the payment demonstrations. Note that unless otherwise specified, these plans must also follow all requirements in the April 12th instructions issued to all plans.

Special Rules

We define two rule sets. We define rules for plan payment allocation that apply to the Flexible Capitated Option and the Fixed Capitated Option. We define rules for TrOOP allocation that apply to the Flexible MA Rebate Option only.

The examples below illustrate application of these rule sets to each of the three payment demonstration options. Please assume the simplest case, that is, the beneficiary does not qualify for low income cost-sharing subsidy and the beneficiary has no other health insurance.[1]

Flexible and Fixed Capitated Options

The PDE reporting rules for Payment Demonstration plans implementing either the Flexible Capitated Option or the Fixed Capitated Option are very similar to the rules for reporting Enhanced Alternative Cost-Sharing (see Instructions, Section 7). We require these rules because risk sharing for the Flexible and Fixed Capitated Options differ from risk sharing for other plans; plans implementing Flexible or Fixed Capitated Options share risk based on all amounts they would have paid under the standard benefit, including the 80% reinsurance subsidy. These rules allocate all plan paid amounts, including those amounts that would otherwise be included in the reinsurance subsidy, as if the claim had been adjudicated according to the standard benefit. Plan paid dollars allocated to the standard benefit are included in risk corridor calculations. Plan paid dollars that exceed the standard benefit are considered supplemental benefits and are excluded from risk corridor calculations.

The Fixed Capitated Option differs from the Flexible Capitated Option in one important way. Fixed Capitated Option plans will always administer catastrophic coverage at $5,100 of total covered drug spending, so the attachment point claim is always reported at $5,100. From that point forward, the plan will administer and report the benefit according to the standard catastrophic coverage rules.

[1] Payment Demonstration Plans calculate the low-income cost-sharing (LICS) subsidy in the same way that all other plans do. See Instructions to all Part D plans for submitting prescription drug event (PDE) data (http://www.cms.hhs.gov/pdps/PDClaimProc.asp).

The rules impact reporting in the following three fields: Patient Pay Amount, Covered D Plan Paid Amount (CPP) and Non-covered Plan Paid Amount (NPP). Please note that there is no change in the business rules to populate three other related fields: Catastrophic Coverage Code, Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA) and Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB).

Patient Pay Amount, Covered Plan Paid Amount (CPP), Non-covered Plan Paid Amount (NPP)

When reporting PDE records for covered drugs, Payment Demonstration plans will apply the following rules to calculate amounts submitted in Patient Pay Amount, Covered D Plan Paid Amount and Non-Covered Plan Paid Amount. Note the following definitions:

Total Covered Drug Cost – the sum of Ingredient Cost, Dispensing Fee, and Sales Tax for a given PDE

Year-to-date (YTD) Total Covered Drug Cost – the sum of all Total Covered Drug Costs for a beneficiary to-date within a coverage year

Initial coverage period – the phase of the benefit above the deductible and at or below the initial coverage limit in the defined standard benefit

Payment Demonstration coverage period – the phase of the benefit above the initial coverage limit in the defined standard benefit up to the point at which the beneficiary has reached $3,600 in true out-of-pocket (TrOOP) spending. If the Payment Demonstration plan does not completely fill in the coverage gap as defined by the standard benefit, the Payment Demonstration coverage period extends from the defined standard initial coverage limit up to the initial coverage limit in the Payment Demonstration plan benefit package.

1. Pay pharmacy according to plan's cost-sharing formula and note the patient and plan paid amounts at POS.
2. Report patient cost-share at point of sale (POS) in Patient Pay Amount field
3. Calculate the amount to report in Covered D Plan Paid Amount (CPP). Covered D Plan Paid Amount is determined by the standard benefit, and will not necessarily be the same as the plan paid amount at POS (as calculated in step 1). To calculate Covered D Plan Paid Amount multiply Total Covered Drug Cost by the applicable percentage below:

    Rules for Flexible Capitated Option and Fixed Capitated Option

    The purpose of the rules is to allocate plan paid dollars between two plan payment fields: Covered Plan Paid Amount (CPP) and Non-covered Plan Paid Amount (NPP). The CPP field captures Allowable Risk Corridor Costs. Costs in the NPP field are excluded from Allowable Risk Corridor Costs.

    Allocation rules at or below $5,100 in total covered drug costs are the same for both options.

    Rules above $5,100 in total covered drug costs differ slightly to reflect that fact that total covered drug cost corresponding to the point at which the beneficiary

reaches the Out-Of-Pocket Threshold in the Flexible Capitated Option will always be higher than that in the Fixed Capitated Option. The extent to which total covered drug cost is higher depends on plan's benefit structure. To emphasize this difference, we split total covered drug cost above $5,100 into costs greater than $5,100 and less than or equal to the Out-Of-Pocket Threshold and costs greater than the OOP. The former rule never applies to the Fixed Capitated Option. The latter rule applies to both the Flexible and Fixed Capitated Option. Both rules have the same effect which is to allocate all plan paid covered drug costs above $5,100 to CPP.

Rule #	YTD Total Covered Drug Cost	Percentage to calculate standard benefit	
		Flexible Capitated Option	Fixed Capitated Option
1	Between $0.00 and $250.00*	0%	
2	Between $250.01 and $2,250.00	75%	
3	Between $2,250.01 and $5,100.00	0%	
4	Greater than $5,100.00 and less than or equal to Out-of-Pocket Threshold	Lesser of 95% or (Total Covered Drug Cost - $2/$5)	N/A**
5	Greater than Out-of-Pocket Threshold	Lesser of 95% or (Total Covered Drug Cost - $2/$5)	Lesser of 95% or (Total Covered Drug Cost - $2/$5)

***Not applicable to plans that retain the full $250.00 deductible*
****By definition, the Out-of-Pocket Threshold will always coincide with $5,100 in total covered drug costs in the Fixed Capitated Option.*

4. Determine the amount to report in Non-covered Plan Paid Amount (NPP). Subtract Patient Pay Amount (Step 2) and Covered D Plan Paid Amount (Step 3) from Total Covered Drug Cost.[2]

Examples to illustrate Flexible Capitation Option

Plan A – Plan A illustrates the Flexible Capitated Option. Plan A retains the $250 deductible After the deductible is satisfied, it offers 25% cost-sharing throughout the benefit until the beneficiary reaches catastrophic coverage. Because Plan A eliminates the coverage gap, a beneficiary does not reach the out-of-pocket threshold until total covered drug costs equal $13,650.

[2] If a beneficiary has other health insurance (reported in PLRO or Other TrOOP Amount) and/or Low-Income Cost-Sharing Subsidy (reported in LICS), we also subtract those amounts from total covered drug cost to determine NPP.

Example 1 – The beneficiary's total covered drug costs = $2,000.00. The beneficiary purchases a covered drug for $100.00. Apply Rule #2.

YTD Total Covered Drug Cost = $2000.00 – Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .75	NPP (a) - (b + d)
$100.00	$25.00	$75.00	$75.00	$0.00

Explanation: According to the standard benefit the beneficiary is in the Initial Coverage Period where the beneficiary pays 25% cost-sharing and the plan pays 75%. Plan A's benefit structure is the same. There is no difference between the Plan's benefit structure and the standard benefit plan structure.

Example 2 – The beneficiary's total covered drug costs = $3,000.00. The beneficiary purchases a covered Part D drug for $100.00. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000.00 – Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .00	NPP (a) - (b + d)
$100.00	$25.00	$75.00	$0.00	$75.00

Explanation: According to the standard benefit the beneficiary is in the coverage gap where the beneficiary pays 100% cost-sharing and the plan pays 0%. In Plan A's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan A the beneficiary pays 25% cost share and the plan pays 75%. The difference between the plan liability in the Plan's benefit structure (75%) and the standard benefit plan structure (0%) is a supplemental benefit. This amount is reported in the NPP field.

Example 3 – The beneficiary's total covered drug costs = $6,000.00. The beneficiary purchases a covered Part D drug for $100.00. Apply Rule #4.

YTD Total Covered Drug Cost = $6,000.00 – Rule #4				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .25	Plan Paid at POS (a) * .75	Covered D Plan Paid Amount (CPP) (a) * .95	NPP (a) - (b + d)
$100.00	$25.00	$75.00	$95.00	-$20.00

Explanation: According to the standard benefit the beneficiary is in the catastrophic phase of the benefit where the beneficiary cost-sharing is the greater of $2/$5 or 5%. In Plan A's benefit structure, the beneficiary is in the payment demonstration coverage period where the beneficiary pays 25% cost share and the plan pays 75%. As with prior examples, the amount reported in the CPP field is the amount the plan would pay under the standard benefit, $95. This constraint results in a negative NPP amount to account for the difference between what the plan actually paid at POS and what the plan would have paid under the standard benefit. Note also that Plan A would be reporting a blank in the Catastrophic Coverage Code for this event, indicating that the beneficiary has not reached catastrophic coverage under Plan A's benefit structure. All drug costs would be reported as below the out of pocket threshold in the GDCB field.

Example 4 – The beneficiary's total covered drug costs = $13,651. The beneficiary purchases a covered drug for $100.00. Apply Rule #5.

YTD Total Covered Drug Cost = $13,651 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount (a) * .05	Plan Paid at POS (a) * .95	Covered D Plan Paid Amount (CPP) (a) * .95	NPP (a) - (b + d)
$100.00	$5.00	$95.00	$95.00	$0.00

Explanation: The beneficiary has reached $3,600 in true out-of-pocket costs, thus is in the catastrophic phase of the benefit where cost-sharing is the greater of $2/$5 or 5%. Plan A must provide catastrophic coverage under the standard benefit provisions from here forward, so there is no difference between the Plan's benefit structure and the standard benefit plan structure. Note also that Plan A would be reporting a Catastrophic Coverage Code "C" for this event, indicating that this is catastrophic coverage under Plan A's benefit structure, and all drug costs would be reported as above the out of pocket threshold in the GDCA field.

Examples to illustrate Fixed Capitated Option

Plan B - Plan B illustrates the Fixed Capitated Option; it eliminates both the $250 deductible and cost sharing in the coverage gap. This plan offers tiered cost sharing in the following structure: $5/$20/$40 (These amounts are for illustration only and are not necessarily representative of an actuarially equivalent benefit structure. Also note that a Flexible Capitated plan can offer a tiered cost-sharing arrangement). The beneficiary in Fixed Capitated Option reaches catastrophic coverage at $5,100 of total drug spending rather than $3,600 of TrOOP.

Example 1 – The beneficiary's total covered drug costs = $50.00. The beneficiary purchases a covered Part D drug for $40.00. The co-pay for this drug is $5.00. Apply Rule #1.

YTD Total Covered Drug Cost = $50.00 - Rule #1				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d)
$40.00	$5.00	$35.00	$0.00	$35.00

Explanation: According to the standard benefit, the beneficiary is in the deductible phase where the beneficiary pays 100% cost-sharing and the plan pays 0%. In Plan B's benefit structure, the beneficiary cost-sharing is reduced to a flat $5.00 co-pay. The difference between the plan liability in the Plan's actual benefit structure ($35.00) and the plan's payment under standard benefit plan structure ($0.00) is a supplemental benefit. This amount is reported in the NPP field.

Example 2 – The beneficiary's total covered drug costs = $1,400.00. The beneficiary purchases a covered Part D drug for $100.00. The co-pay for this drug is $20. Apply Rule #2.

YTD Total Covered Drug Cost = $1,400.00 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d)
$100.00	$20.00	$80.00	$75.00	$5.00

Explanation: According to the standard benefit the beneficiary is in the initial coverage period where the beneficiary pays 25% cost share and the plan pays 75%. In Plan B's benefit structure, the beneficiary has a flat $20.00 co-pay, which is 20% of the total drug cost. The plan liability is $80.00 under Plan B's benefit structure as compared with $75.00 under the standard defined benefit. The difference between the plan liability in the Plan's benefit structure and the standard benefit plan structure is a supplemental benefit. This amount is reported in the NPP field.

Example 3 – The beneficiary's total covered drug costs = $1,500.00. The beneficiary purchases a covered Part D drug for $100.00. The co-pay for this drug is $40. Apply Rule #2.

YTD Total Covered Drug Cost = $1,500.00 - Rule #2				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d)
$100.00	$40.00	$60.00	$75.00	-$15.00

Explanation: According to the standard benefit the beneficiary is in the initial coverage period where the beneficiary pays 25% cost share and the plan pays 75%. In Plan B's benefit structure, the beneficiary has a flat $40.00 co-pay, which is 40% of the total drug cost. The plan liability is $60.00 under Plan B's benefit structure as compared with $75.00 under the standard defined benefit. The difference between the plan liability in the Plan's benefit structure and the standard benefit plan structure is a supplemental benefit. In this case, the amount is negative because the plan paid less than under the defined standard. This amount is reported in the NPP field.

Example 4 – The beneficiary's total covered drug costs = $3,000.00. The beneficiary purchases a covered Part D drug for $100.00. The co-pay for this drug is $40. Apply Rule #3.

YTD Total Covered Drug Cost = $3,000.00 - Rule #3				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d)
$100.00	$40.00	$60.00	$0.00	$60.00

Explanation: According to the standard benefit the beneficiary is in the coverage gap where the beneficiary pays 100% cost-sharing and the plan pays 0%. In Plan B's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan B the beneficiary has a flat $40.00 co-pay, which is 40% of the total drug cost. The plan liability is $60.00 under Plan B's benefit structure as compared with $0.00 under the standard defined benefit. The difference between the plan liability in the Plan's benefit structure and the standard benefit plan structure is a supplemental benefit. This amount is reported in the NPP field.

Example 5 – The beneficiary's total covered drug costs = $6,000.00. The beneficiary purchases a covered Part D drug for $100.00. Apply Rule #5.

YTD Total Covered Drug Cost = $6,000.00 - Rule #5				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	NPP (a) - (b + d)
$100.00	$5.00	$95.00	$95.00	$0.00

Explanation: According to the standard benefit the beneficiary is in the catastrophic phase of the benefit where the beneficiary cost-sharing is the greater of $2/$5 or 5%. Since Plan B is a Fixed Capitated Option plan, when total covered drug cost reaches $5,100 the OOP Threshold is reached and catastrophic coverage commences regardless of accumulated TrOOP. Plan B would be reporting a Catastrophic Coverage Code of "C" for this event, indicating that the beneficiary has reached catastrophic coverage under Plan B's benefit structure. All drug costs would be reported as above the out of pocket threshold in the GDCA field.

Examples to illustrate Flexible MA Rebate Option

Payment Demonstration plans that implement the Flexible MA Rebate Option are considered to be the same as the standard benefit with one qualifier. These plans reduce or eliminate the coverage gap, with all plan spending in that phase of the benefit funded by A/B rebates which count towards TrOOP. These plans may offer tiered cost sharing in the initial coverage period provided the cost sharing is actuarially equivalent to the defined standard. On average, the cumulative TrOOP will reach $3,600 at the same time that total covered drug spend reaches $5,100. Above $3,600 TrOOP, these plans must offer the standard catastrophic coverage.

Reporting in the initial coverage period and in the catastrophic phase of the benefit will be the same as for any plan that offers basic Part D coverage, that is, all plan spending for covered drugs is considered covered plan paid amounts. In the coverage gap all plan spending shall be attributed to Other TrOOP amount and therefore counted toward cumulative TrOOP.

Plan C –Plan C retains the deductible and it eliminates the coverage gap, funding the additional coverage with A/B rebate dollars. The plan offers tiered cost sharing that is actuarially equivalent to the defined standard, but carries this cost sharing throughout the benefit up until catastrophic coverage. The plan offers the following cost-sharing structure: $5/$20/$40 (These amounts are for illustration only and are not necessarily representative of an actuarially equivalent benefit structure).

Example 1 – The beneficiary's total covered drug costs = $1650.00. The beneficiary purchases a covered Part D drug for $100.00. The co-pay for this drug is $40.00.

YTD Total Covered Drug Cost = $1650.00				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d)
$100.00	$40.00	$60.00	$60.00	$0.00

Explanation: According to the standard benefit the beneficiary is in the initial coverage period, which for a Flexible MA Rebate Option plan must be actuarially equivalent to the standard defined benefit. In this phase of the benefit, all plan spending is reported as covered plan paid amount.

Example 2 – The beneficiary's total covered drug costs = $3000.00. The beneficiary purchases a covered Part D drug for $100.00. The co-pay for this drug is $5.00.

YTD Total Covered Drug Cost = $3000.00				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d)
$100.00	$5.00	$95.00	$0.00	$95.00

Explanation: According to the standard benefit the beneficiary is in the coverage gap where the beneficiary pays 100% cost-sharing and the plan pays 0%. In Plan C's benefit structure, the beneficiary is in the payment demonstration coverage period. In Plan C the beneficiary has a flat $5.00 co-pay for this drug, which is 5% of the total drug cost. The plan liability is $95.00 under Plan C's benefit structure as compared with $0.00 under the standard defined benefit. The plan liability of $95.00 is reported in the Other TrOOP field.

Example 3 – The beneficiary's total covered drug costs = $5200.00. The beneficiary purchases a covered Part D drug for $150.00. The co-pay for this drug is $40.00 normally, but is the greater of 5% or $2/$5 in the catastrophic phase (in this case, 5% is greater).

YTD Total Covered Drug Cost = $5200.00				
(a)	(b)	(c)	(d)	(e)
Total Covered Drug Cost	Patient Pay Amount	Plan Paid at POS	Covered D Plan Paid Amount (CPP)	Other TrOOP (a) - (b + d)
$150.00	$7.50	$142.50	$142.50	$0.00

Explanation: The beneficiary is in the catastrophic phase of the benefit, and Plan C must administer and report the benefit in a manner consistent with the rules governing catastrophic coverage.

Payment Reconciliation for Flexible Capitation Option and Fixed Capitated Option

Payment reconciliation for the Flexible Capitated Option and Fixed Capitated Option differ from other plan types in two ways. There is no reinsurance reconciliation and the target amount is computed differently.

Target Amount – The Capitated Reinsurance Payment is added to the Target Amount since risk sharing is applied to reinsurance. The Target Amount calculation outlined in Section 13 changes

From: Direct Subsidy
+ Beneficiary Premiums
+ A/B Rebate
= Target Amount before Administrative Cost Adjustment
* (1 - Administrative Cost Ratio)
= Target Amount

To:
Direct Subsidy
+ Beneficiary Premiums
+ A/B Rebate
+ Capitated Reinsurance Payment
= Target Amount before Administrative Cost Adjustment
* (1 - Administrative Cost Ratio)
= Target Amount

Allowable Risk Corridor Costs – Reinsurance calculations outlined in Instructions, Section 12 do not apply. Therefore, the Reinsurance Subsidy Amount subtracted in the calculation for Adjusted Allowable Risk Corridor Costs is always zero. (See Instructions, Section 13).

Please submit any questions by e-mail to Mark Newsom at Mark.Newsom@cms.hhs.gov