



Request for Proposals

Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries

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Center for Health and Drug Plan Choices
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SECTION A -- STATEMENT OF WORK

A.1 PURPOSE AND BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) seeks a single contractor to cover Part D prescription drug claims for retroactive periods of coverage for Full-Benefit Dual Eligible and SSI-Eligible individuals, as well as point of sale coverage at a pharmacy for certain individuals with the Part D low-income subsidy (LIS) who are not yet enrolled in a Part D plan. This solicitation identifies the required tasks and bidding process.

The contract shall include a start-up period, an initial term of two years, with three option years. The final contract shall consist of this Request for Proposals (RFP), written clarifications to the RFP provided by CMS, the Contractor's response to it as amended, and the demonstration agreement.

A.2 DEFINITIONS

Throughout this Statement of Work (SOW), when the terms described in this section are capitalized throughout the rest of this document, they have the meaning described in this section. When not capitalized, they have the meaning generally ascribed in the Medicare Part D benefit.

Best Available Evidence (BAE) – CMS' policy requiring Part D Sponsors to provide a reduced Copayment Level when presented with certain evidence. (See Chapter 13 of the Medicare Prescription Drug Benefit Manual).

Confirmed Beneficiaries -- Beneficiaries who do not yet have Temporary Enrollment in the Contractor's Unique Contract/PBP, but whose eligibility for Temporary Enrollment has been validated. Confirmed Beneficiaries include individuals who can be validated as eligible at the point of claims submission (i.e. for whom LIS eligibility is already reflected in CMS' systems), as well as previously Unconfirmed Beneficiaries for whom the Contractor has validated LIS eligibility subsequent to claims payment.

Contractor – The National Prescription Drug Plan (PDP) Sponsor awarded a contract pursuant to this Request for Proposals.

Copayment Levels – The maximum copayments a Part D Sponsor may charge an LIS eligible. The level varies by type of LIS eligible (see Chapter 13 of the Medicare Prescription Drug Benefit Manual). The four levels are:

- Copayment Level 1 = High (\$2.40/\$6.00 in 2009)
- Copayment Level 2 = Low (\$1.10/\$3.20 in 2009)
- Copayment Level 3 = Zero (\$0)
- Copayment Level 4 = 15%

Coverage for Enrollees – Payment for Covered Claims submitted for dates of service that fall within a Temporary Enrollment period.

Covered Claims – All Part D drug claims (as required in 42 CFR 423.100, see specifically “Part D drug”) filed within the applicable Timely Filing Limit that the Contractor is obligated to reimburse, pursuant to Section A.6.29.

Current Coverage – Payment for Covered Claims submitted within 30 days of the Date of Service for certain POS FE Eligible Beneficiaries (limited to Confirmed Beneficiaries).

Date of Service – Date on which a prescription was filled.

Eligibility Review Process – The Contractor’s process in which individuals determined to be Ineligible Beneficiaries may request the Contractor to reassess a denial of claims payment.

Eligibility Verification System (EVS) – A Medicaid system used to verify the Medicaid eligibility status of an individual. These systems are state specific.

Enrollees/Enrollments – Individuals who have a period of Temporary Enrollment in the Contractor’s Unique Contract/PBP as confirmed by CMS’ MARx enrollment system. Individuals may become Enrollees by being enrolled by CMS into the Contractor’s Unique Contract/PBP, or by being Confirmed Beneficiaries whom the Contractor itself enrolls.

Full-Benefit Dual Eligibles (FBDE) – Individuals who are: 1) entitled to Part A or enrolled in Part B under Medicare; and 2) eligible for full Medicaid benefits.

Immediate Coverage – Payment for claims submitted within 7 days of the Date of Service for certain POS FE Eligible Beneficiaries (applies to Unconfirmed Beneficiaries).

Ineligible Beneficiary - Beneficiaries who do not qualify for Immediate, Current, or Retroactive Coverage. Ineligible Beneficiaries includes individuals who, as of the Date of Service of the prescription drug claim for which they seek reimbursement, are any of the following:

- Not Medicare Part D eligible;
- Enrolled in a Part D plan;
- Enrolled in an RDS plan;
- Enrolled in a Medicare Advantage plan where concomitant enrollment in a stand-alone Prescription Drug Plan is precluded;
- A resident of the U.S. Territories or foreign country;
- Confirmed not to be Full Benefit Dual Eligible, SSI-Only Eligible, Partial Dual Eligible, or approved LIS Applicant ; or
- Whose claims are not submitted within applicable Timely Filing Limits.

Low Income Subsidy (LIS) – Financial assistance provided under the Medicare Part D prescription drug benefit for beneficiaries who have limited income and resources. Those who are LIS eligible receive help in paying for their monthly premium, yearly deductible, prescription coinsurance and copayments, and are not subject to the coverage gap.

LIS Applicants – Individuals who apply and are determined eligible for the LIS by the Social Security Administration or their State Medicaid Agency.

National Prescription Drug Plan (PDP) – A sponsor offering at least one individual market (i.e., employer group or union-only plans do not qualify) PDP in PDP regions 1-34; or an organization that owns the controlling interest in at least two legal entities operating as PDP sponsors under multiple PDP contracts that, combined, offer PDPs in PDP regions 1-34.

Partial Dual Eligibles -- Individuals who are eligible for Medicare Savings Programs (MSP) but not full Medicaid benefits (i.e. QMB-only, SLMB-only, or QI).

Plan-to-Plan (P2P) – This financial reconciliation process is a settlement process by which the Part D Contract of Record pays any other Part D Contract that initially paid for Part D drugs in good faith when Part D plan enrollment data were not up-to-date.

Point of Sale Facilitated Enrollment (POS FE) – The process by which certain Full-Benefit Dual Eligibles, SSI-only Eligibles, Partial Dual Eligibles, and approved LIS Applicants can obtain prescription drug coverage when they are not enrolled in a Medicare Part D plan as of the Date of Service of the claim.

POS FE Eligible Beneficiaries (POS FE Eligibility) – Individuals who are not Enrollees but who qualify for payment of Covered Claims under this contract because:

- As of the Date of Service of the claim they meet all of the following conditions:
 - are Part D eligible,
 - are not enrolled in a Part D plan,
 - are not enrolled in a Medicare Advantage plan that precludes concomitant enrollment in a stand-alone Prescription Drug Plan (PDP),
 - reside in the 50 States or District of Columbia,
 - are not enrolled in a Retiree Drug Subsidy (RDS) plan,
 - are a Full Benefit Dual Eligible, SSI-only Eligible, Partial Dual Eligible, or approved LIS Applicant; and
- Their claims are submitted within the applicable Timely Filing Limits.

Retiree Drug Subsidy (RDS) – The subsidy payment option available under Medicare Part D designed to encourage employers and unions to continue offering prescription drug coverage to their Medicare-eligible retirees.

Retroactive Coverage – Payment for claims with dates of service older than 30 days from the date of claims submission to the Contractor, but no earlier than January 1, 2006. Retroactive Coverage is limited to Confirmed Beneficiaries who are Full Benefit Dual Eligibles and SSI-Only Eligibles. Note that the length of retroactivity is specific to the individual, i.e. there is no standard number of days.

SSI-Only Eligibles – Individuals who qualify for Supplemental Security Income (SSI) and Medicare, but not Medicaid.

Temporary Enrollment in Contractor's Unique Contract/PBP (Temporary Enrollment) – Actual enrollments successfully processed by CMS' MARx system into the unique contract/plan benefit package (PBP) established solely for enrollments under this contract. This includes those beneficiaries enrolled by CMS, as well as those Confirmed Beneficiaries whom the Contractor enrolls. Enrollment is time-limited, in that CMS will subsequently randomly enroll these

individuals into qualified PDPs for a prospective effective date, i.e. the first day of the second month after CMS' auto/facilitated enrollment run.

Timely Filing Limits – The deadline by which a request for claims payment under this contract shall be made to the Contractor to qualify for payment. The Timely Filing Limit varies by population (see Appendix 1).

Unconfirmed Beneficiaries – Beneficiaries who do not yet have Temporary Enrollment, and who meet all defined criteria for POS FE Eligibility, except that their LIS eligibility cannot be confirmed by CMS' systems at the time of claims submission.

Throughout this Request for Proposals, "day" shall mean calendar day unless otherwise noted.

A.3 BACKGROUND

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted, authorizing a new Medicare Part D benefit that provides prescription drug insurance coverage to individuals who are entitled to Part A or enrolled in Part B. The benefit is administered by private health and drug plans, and individuals must be enrolled in a plan to access prescription drug coverage. Under the MMA, drug coverage for all dual eligible individuals transitioned from Medicaid to Medicare Part D on January 1, 2006. Section 1935(c) of the Social Security Act precludes subsequent Medicaid coverage of Part D-covered prescription drugs for these individuals and thus essentially requires that all such coverage for full benefit dual eligible individuals be provided under Medicare Part D.

Thus, CMS works closely with States to identify all dual eligible individuals and other individuals deemed eligible for the Part D low income subsidy (LIS). We then automatically enroll these individuals into Medicare prescription drug plans (PDPs) on a monthly basis, consistent with section 1860D-1(b)(1)(C) of the Act, which directs that Full-Benefit Dual Eligibles who failed to enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MA-PD) plan be randomly auto-enrolled into PDPs that have a monthly beneficiary premium that does not exceed the low-income premium subsidy amount. (See 42 CFR 423.34 and the PDP Guidance on Eligibility, Enrollment, and Disenrollment for additional details on this process, as well as on the CMS facilitated enrollment process for others with the LIS.)

1) Retroactive Coverage

Medicaid prescription drug coverage for individuals who are newly Full-Benefit Dual Eligibles ceases as soon as the individual is *eligible* for Part D, regardless of whether the individual is *enrolled* in a Part D plan. This creates the risk of coverage gaps for new Full-Benefit Dual Eligibles. Thus, to prevent coverage gaps between the end of Medicaid and start of Medicare prescription drug coverage, the regulation specifies that auto-enrollment is effective the month in which the person becomes full-dual eligible. Because Medicaid eligibility is often retroactive, since the start of the Part D program, CMS has randomly auto-enrolled new Full-Benefit Dual Eligibles into Part D plans retroactive to the start of their full dual status.

In facilitated enrollment, the effective date is prospective, i.e. the first day of the second month after the individual is included in a facilitated enrollment process. The

only exception is for SSI-Only Eligibles; since almost all convert to full-benefit dual eligible status within a short timeframe after CMS is first notified of their SSI-only status, their effective date is retroactive to the start of SSI-only status.

Before June 2008, CMS performed auto- and facilitated enrollment on a monthly basis, but starting in June 2008, these processes are run nightly whenever a State MMA or Social Security Administration (SSA) file is submitted. Certain individuals are excluded from auto- and facilitated enrollment, including those who opt-out (i.e. of having CMS auto/facilitate their enrollment into a Part D plan), are incarcerated, have RDS, or are in MA organizations. CMS directs MA Organizations and cost plans that offer a Part D optional supplemental benefit to facilitate enrollment of their LIS eligibles into their Part D plans (see Chapter 2 of the Medicare Managed Care Manual).

In summary, through the combination of auto/facilitated enrollment, each month CMS randomly enrolls approximately 40,000 new FBDEs and SSI-Only Eligibles with retroactive effective dates. An average of 88% have effective dates within the last three months. Please see Appendix 2 for specific details.

2) Point of Sale Coverage

Since Part D coverage is contingent upon enrollment in a Part D plan, CMS offers the Point of Sale Facilitated Enrollment (POS FE) process in the event that an LIS-eligible individual is not yet enrolled in a Part D plan when he or she presents at the pharmacy. Since 2006, CMS has contracted with a national PDP sponsor to provide this point-of-sale coverage. The contractor pays for claims for any individual that pharmacies submitted to their system as alleged full-benefit dual or LIS eligibles without Part D enrollment or RDS. For beneficiaries without LIS status on CMS' systems, the POS FE contractor is currently required to use a separate CMS eligibility verification contractor, which confirms dual eligible status by querying State Medicaid Eligibility Verification Systems.

To access the existing POS FE process, beneficiaries, their caregivers, or providers must initiate a request for claims payment through a pharmacist. Pharmacists are instructed to first determine if there is no other Part D plan enrollment (e.g., by performing an eligibility query (known as the "E1" query) to CMS' systems via CMS' TrOOP facilitator contractor), and check for proof the person is Medicaid or LIS eligible. The pharmacist then submits an on-line claim using POS FE-specific "4Rx data," which are 4 data fields specified by NCPDP which pharmacists need to submit a claim on-line. If the claim passes front-end edits performed by the TrOOP facilitation contractor (i.e., Part D eligible, no Part C or D plan, no RDS), the claim is adjudicated with default copayment levels (generally Copayment Level 2 [\$1.10/\$3.20 in 2009], with Copayment Level 3 [\$0] for institutionalized beneficiaries). These default levels are applied regardless of the LIS status indicated in CMS' systems at the time of claims submission (if any status is available).

Those for whom LIS eligibility is present on CMS' systems are immediately enrolled into the Contractor's standard PDP product retroactive to the month of the covered claim's date of service. Beneficiaries for whom no LIS eligibility could be identified are sent to a separate CMS contractor, which queries State Eligibility Verification systems to confirm Medicaid status. If confirmed, they are immediately enrolled in the Contractor's PDP; if not, they become ineligible beneficiaries and the Contractor seeks to recoup the cost of the covered claims from the beneficiary.

In the current POS FE process, approximately 26,000 beneficiaries use POS FE each month (20,000 rejected, 8,000 accepted, and 2,500 enrolled). Approximately 67,000 claims are processed (24,000 accepted and 55,000 rejected). Approximately 1,600 beneficiaries are sent to the Eligibility Verification Contractor each month, of whom 1,000 are confirmed eligible. Approximately 454 beneficiaries are determined ineligible and subject to claim recovery, but this is expected to drop to under 100 based on a new edit implemented in December, 2008, to prevent those previously determined ineligible from submitting additional claims. Please see Appendix 2 for detailed data for the most recent six months.

A.4 DEMONSTRATION AUTHORITY

Beginning in 2010, CMS has demonstration authority to test a revised approach for providing retroactive and immediate need coverage. Under the demonstration, CMS will contract with a single PDP Sponsor to pay for all claims for retroactive auto-enrollment periods plus current and immediate need claims for all LIS eligibles. CMS would modify its auto/facilitated enrollment process so that all those with retroactive effective dates are assigned to the demonstration Contractor for those retroactive periods, but continue to be randomly auto/facilitated for prospective periods to standard LIS PDPs. The demonstration Contractor would also operate the POS FE process, and enroll Confirmed Beneficiaries for current periods, but CMS would randomly auto/facilitate their enrollment into standard LIS PDPs for prospective periods. The demonstration Contractor would have an open formulary, minimal edits, and no network restrictions, and would accept requests for claims coverage from both beneficiaries and pharmacists. CMS would pay on a modified capitation basis with narrowed risk corridors.

A.5 PURPOSE

The purpose of this Request for Proposals and related documents is to solicit proposal for a contractor to administer an improved process for retroactive and POS prescription drug coverage for certain low-income beneficiaries. In this process, the Contractor agrees to provide coverage for Enrollees with Temporary Enrollment, including those who are auto/facilitated enrolled by CMS. For POS FE Eligible Beneficiaries who are not enrolled, the Contractor shall provide Immediate Coverage to Unconfirmed Beneficiaries; Current Coverage for Confirmed Beneficiaries; and Retroactive Coverage for Confirmed Beneficiaries who are Full-Benefit Dual Eligibles or SSI-Only Eligibles.

The POS FE process is only available to certain LIS eligibles; it is not available to those who are not LIS-eligible or LIS eligibles who meet the criteria for Ineligible Beneficiaries. In addition, individuals must be residents of the 50 States and the District of Columbia; residents of the U.S. Territories do not qualify.

A.6 SERVICE-RELATED TASKS UNDER THE CONTRACT

Providing Coverage for Enrollees and Immediate, Current, and Retroactive Coverage for POS FE Eligible Beneficiaries can be accomplished by implementing the following tasks. Except as noted otherwise, the Contractor shall provide all necessary services, qualified personnel, materials, equipment, supplies, and facilities, not otherwise provided by the Government or CMS contractor, as needed to perform the tasks of the SOW as identified below.

Build Capacity

- 1) Contractor shall have the technical capability and the infrastructure for providing Coverage for Enrollees; Immediate, Current, and Retroactive Coverage for POS FE Eligible Beneficiaries; and related tasks of data exchanges, queries, reconciliation, and reporting. Unless otherwise noted, the subtasks below shall be completed by December 31, 2009.
 - a) Contractor shall secure necessary Data Use Agreement(s) (DUA) and obtain necessary CMS user ID and password(s).
 - b) The Contractor shall ensure that appropriate security measures are implemented to protect all data collected or received under this Contract from inappropriate access, release or use for any purpose other than for the tasks associated with this contract.
 - i) The Contractor shall have specific processes and procedures in place to prevent access to, or release or use of, data available through the enhanced Batch Eligibility Query (of Medicare Part D eligibility, enrollment, and LIS status) or State EVS query to its other lines of PDP business.
 - c) Contractor shall establish secure connectivity with MBD, MARx, DDPS, HPMS, and other CMS systems as necessary.
 - d) Contractor shall establish secure connectivity with CMS contractors required to perform the services under this SOW and identified by CMS.
 - e) Contractor shall establish policies and procedures and build systems requirements that comply with applicable privacy and data security laws.
 - f) Contractor shall support all established Part D PDP business and systems requirements for the unique contract/PBP number created solely this demonstration contract, unless otherwise directed by CMS.
 - g) Contractor shall establish all additional policies and procedures and build systems requirements that comply with the requirements for performing tasks under this SOW. Additional systems processes include but are not limited to requirements related to mandatory fields on pharmacy claims, building the interface with the TrOOP Facilitation Contractor to incorporate E1 data into front-end claims eligibility edits for claims submitted within 30 days of the Date of Service, establishing access to CMS systems to perform front-end edits on claims submitted more than 30 days from the Date of Service, submitting retroactive enrollment transactions, notifying beneficiaries, establishing access to CMS' special role for enhanced Batch Eligibility Queries, submitting LIS status corrections, submitting PDE, and conducting payment reconciliation.
 - h) Contractor shall establish the capability to send and receive specified data on applicable individuals with CMS.
 - i) Contractor shall begin testing with CMS and its applicable contractor(s) on information systems interfaces and connectivity starting August 1, 2009, and data exchanges starting October 1, 2009, or as mutually agreed to by all parties. These shall include submitting enrollment transactions, LIS status corrections, and enhanced BEQ submissions.

- j) Contractor shall be prepared to pilot or test procedures for accepting and processing claims requests for Confirmed, Unconfirmed, and/or Ineligible Beneficiaries no later than November 1, 2009. Such pilot shall be conducted with a small number of pharmacies that shall be designated by CMS.
 - k) Contractor shall establish the capability to store and retrieve claims and enrollment data for both the POS FE Eligible Beneficiaries and Enrollees served by the Contractor and shall make such data available to CMS in required reporting and upon request.
 - l) The Contractor shall be able to receive electronic, real-time claims from any U.S. pharmacy capable of transmitting such claims, including pharmacies outside of the Contractor's pharmacy network.
- 2) No later than September 1, 2009, the Contractor shall submit its pre-implementation outreach plan to CMS pursuant to tasks A.6.23-24. The Contractor shall commence with that outreach plan no later than October 1, 2009.
- 3) No later than October 31, 2009, the Contractor shall have in place functionality via CMS' TrOOP Facilitation Contractor to obtain claims eligibility determinations and routing services based on the TrOOP Facilitation Contractor's access to certain CMS eligibility and enrollment data. These data are necessary to support the front-end edits for claims submitted within 30 days of the Date of Service for POS FE Eligible Beneficiaries (i.e., to confirm Medicare Part D eligibility, no other Part D or MA enrollment (that precluded concomitant PDP enrollment), no RDS; and LIS status). CMS permits the TrOOP Facilitation Contractor to utilize the same data that supports the "enhanced E1 query" for this purpose, and allows the TrOOP Facilitation Contractor to release a beneficiary's Health Insurance Claim Numbers (HICN), name, date of birth (DOB), and gender, as well as Claim Reference numbers, Dates of Service, and Pharmacy National Council of Prescription Drug Programs (NCPDP) or National Provider Identification (NPI) numbers, on paid claims for Unconfirmed Beneficiaries to the Contractor for the purpose of Medicaid eligibility verification (see task A.6.18).

In addition, by October 31, 2009, the Contractor shall have in place functionality to directly query CMS' systems to perform front end edits on claims submitted more than 30 days from the Date of Service.

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The data needed to support front end edits are:

- a) Part D eligibility effective and termination dates (Effective and termination dates of Part A entitlement or Part B enrollment)
- b) Part D plan enrollment, including contract ID/PBP number, effective and termination dates and 4Rx data
- c) LIS cost-sharing levels or other data establishing LIS eligibility status
- d) Data distinguishing Full-Benefit Dual Eligibles and SSI-Only Eligibles from others with LIS
- e) Retiree Drug Subsidy eligibility

- f) Enrollment in a Part C plan (that precludes concomitant enrollment in a stand-alone PDP)
 - g) Beneficiary opt-out
- 4) No later than October 31, 2009, the Contractor shall finalize and be prepared to distribute payer sheets for Enrollees and for POS FE Eligible Beneficiaries, pursuant to task A.6.26.
 - a) No later than October 31, 2009, the Contractor and CMS will develop a distribution schedule, and the Contractor shall be responsible for distributing the payer sheet to identified parties according to the schedule.
 - 5) No later than October 31, 2009, the Contractor shall establish the technical capability and develop the infrastructure necessary for verifying Medicaid dual eligibility status for Unconfirmed Beneficiaries pursuant to Task A.6.18. To do so, the Contractor or its subcontractor shall establish direct query capability to State EVS in all 50 States and the District of Columbia.
 - 6) By November 1, 2009, the Contractor shall submit to the CMS Project Officer all model beneficiary notices initially required under this contract.
 - 7) The Contractor shall ensure that its Pharmacy Benefits Manager (PBM) can adjudicate claims in accordance with this SOW no later than October 31, 2009.
 - 8) By November 30, 2009, the Contractor shall have in place written policies and procedures as specified in Task A.8.10.
 - 9) By December 1, 2009, the Contractor shall establish and/or maintain a toll-free Customer Service telephone line and fax line that can be accessed by United States-based pharmacy providers and beneficiaries, or others acting on their behalf, to inquire about services under the demonstration contract, including the status of eligibility or claims, or to submit Best Available Evidence. The Contractor shall ensure that the hours of service and performance metrics of this pharmacy service call center are in compliance with those of the Contractor's Part D contract with CMS. The Contractor or its subcontractor shall have dedicated customer service representatives (CSR) retained to facilitate requests and respond to questions from the pharmacy community and beneficiaries pursuant to this contract. Specifically, CSRs utilized to answer calls from pharmacies shall be fully trained on both the technical and procedural aspects of the demonstration processes and shall have access to appropriate call scripts approved by CMS. The fax line shall be secure and dedicated to the demonstration contract. Capacity shall be phased in starting December 1, 2009, and be at full capacity by December 31, 2009.
 - 10) The Contractor shall participate in transition planning with CMS, CMS contractors, and the 2009 POS FE contractor. The Contractor shall take all necessary steps to ensure a smooth transition to the new processes for retroactive auto/facilitated enrollments and Coverage for POS FE Eligible Beneficiaries. The 2009 POS FE contractor will go offline December 31, 2009 at 11:59pm, so the 2010 contractor must be fully operational and be prepared to go online on January 1, 2010 at 12:00 am.
 - a) The Contractor shall also participate in risk management efforts, and shall

have in place contingency plans that are sound and executable, and address both foreseen and unforeseen interruptions, such as routine system maintenance (foreseen) and natural disasters (unforeseen), and including a delay in the implementation date of the Demonstration.

Coverage for Enrollees

The Contractor is responsible for processing enrollment and disenrollment requests, and reimbursing all Covered Claims for Enrollees.

Accept Retroactive Auto/Facilitated Enrollments

As often as daily, CMS will autoenroll Full-Benefit Dual Eligibles and all SSI-Eligibles with retroactive effective dates into the Contractor's Unique Contract/PBP. As with the normal auto/facilitated enrollment process, PDP notification files will be sent the same night that auto/facilitated enrollment is run, and confirmation notification will appear on the next weekly TRR. Please note that in limited instances, CMS Regional or Central Office staff may manually create an auto/facilitated enrollment in response to casework or complaints. In these instances, the Contractor shall be notified via TRR with Transaction Reply Codes of either 701 (new UI enrollment) , or 011 (Enrollment Accepted as Submitted) and either 117 (FBD Auto Enrollment Accepted) or 118 (LIS Facilitated Enrollment Accepted). However, the individual will not be included in the PDP Notification file; instead, the Contractor shall obtain the individual's address through a query of the MARx system or the enhanced BEQ functionality provided pursuant to this contract.

- 11) The Contractor shall accept all Enrollments generated by CMS into its Unique Contract/PBP.
 - a) The Contractor shall submit 4Rx data for Enrollees via 72 transactions to CMS' MARx system within the required timeframe of 72 hours applicable to all auto/facilitated enrollees.
 - b) The Contractor shall have procedures in place to pay for Covered Claims for new Enrollees prior to notification via the TRR and Contractor submission of 4Rx data to CMS. For those automatically generated by CMS, this provision is triggered by receipt of the PDP notification file. For those manually created by CMS staff, this provision is triggered by verbal or written notice from the relevant CMS staff, or confirmation on the TRR, whichever is earlier.
 - c) The Contractor shall send a confirmation letter to new Enrollees within 10 days of notification on a weekly TRR. The Contractor shall use a model confirmation letter that is prior approved by CMS.

Adjudicating Claims for Enrollees

- 12) For all Enrollees, the Contractor shall:
 - a) Reimburse all Covered Claims that have a Date of Service within a period of Temporary Enrollment, and are filed within the applicable Timely Filing Limit

(see Appendix 1).

- i) Claims submitted more than 36 months after the Date of Service are subject to prior authorization. Such claims are only considered Covered Claims if a new Medicaid or Medicare eligibility determination was made in the last 90 days granting Full-Benefit Dual Eligible or SSI-Only Eligible status retroactive to the Date of Service.
 - (a) For on-line claims, initially reject the claim with direction to the pharmacist to obtain prior authorization, at which point above determination is made.
 - (b) For paper claims, make the above determination as part of determining if the individual qualifies as a POS FE Eligible Beneficiary, and prior to claims payment.
- b) Comply with CMS' Best Available Evidence policy for charging a reduced LIS Copayment Level, as specified in Chapter 13 of the Medicare Prescription Drug Benefit Manual and additional guidance provided in subsequent HPMS memos.
- c) Charge no deductible or monthly premium (even for LIS applicants with less than 100% premium subsidy), nor impose a coverage gap.
- d) Accept requests to cover eligible claims from pharmacy providers, Enrollees, as well as individuals acting on behalf of the Enrollee at the Enrollee's request, pursuant to tasks A.6.25 and 27-28.

Coverage Determinations and Appeals for Enrollees

13) The Contractor shall maintain the Part D grievances, coverage determinations, and appeals processes set out in Subpart M of Part 423 for all Enrollees.

Disenrollments

Most disenrollments will occur as a result of an automatic disenrollment pursuant to a CMS auto/facilitated enrollment into qualified PDPs. Requests may also be submitted by beneficiaries.

- 14) The Contractor shall comply with the following procedures for disenrollments.
- a) The Contractor may not involuntarily disenroll Enrollees for any reason other than fraud and abuse, as outlined in Section 40.3.3 of the PDP Eligibility and Enrollment Guidance.
 - b) The Contractor shall accept disenrollments generated by CMS' established prospective, random, auto/facilitated enrollment into qualified PDPs, or by an Enrollee's voluntary enrollment into another PDP.
 - c) The Contractor shall accept request from Enrollees to voluntarily disenroll from the Contractor's Unique Contract/PBP, or opt-out of the enrollment altogether, at any time.

- i) In general, the effective date of a voluntary disenrollment will be the first day of the month following the receipt of the disenrollment request.
- ii) The Contractor shall retroactively cancel an enrollment upon request of an individual. These will include beneficiaries who would otherwise lose employer or other coverage for prescription drug or other employee/retiree benefits, and for other reasons to be determined by CMS.
- d) The Contractor shall send a model disenrollment confirmation letter within established timeframes specified in CMS PDP Enrollment Guidance. The model letter is subject to CMS prior approval.

Coverage for POS FE Eligible Beneficiaries

The Contractor is responsible for reimbursing Covered Claims for POS FE Eligible Beneficiaries who do not yet have Temporary Enrollment in the Contractor's Unique Contract/PBP.

Verify Confirmed or Unconfirmed Beneficiaries

Individuals who do not have Temporary Enrollment may request coverage for claims payment under this contract. This includes individuals who have no Temporary Enrollment for the Date of Service, as well as those who have Temporary Enrollment for certain months, but are requesting claims payments for other months in which they do not have Temporary Enrollment. The Contractor shall accept requests for claims payment in writing (i.e. paper claims/receipts), and via electronic claims submission, and from both pharmacy providers and beneficiaries. As a first step, the Contractor is responsible for determining if the individual is a POS FE Eligible Beneficiary, based on data provided by CMS or the TrOOP Facilitation contractor, on the claim itself, or for paper claims, from the submitter.

- 15) The Contractor shall determine if an individual is a Confirmed or Unconfirmed Beneficiary for purposes of qualifying for payment of claims. The Contractor shall work with CMS to determine what data are sufficient to adjudicate claims. Most of the data are available via the TrOOP Facilitation Contractor, with whom the Contractor shall subcontract to perform front-end edits for claims submitted within 30 days of the Date of Service; for claims submitted more than 30 days from the Date of Service, the Contractor shall perform an on-line query directly into CMS' systems. Other data shall be collected on the pharmacy claim form or from the individual.

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- a) The Contractor shall complete this task in the following timeframes:
 - i) For claims submitted on-line and in real time, the Contractor shall make the verifications in this task in real time.
 - ii) For claims submitted on paper by pharmacy providers or beneficiaries, the Contractor shall complete tasks A.6.15.b and task A.6.15.c.i within 3

business days, and if necessary, task A.6.15.c.ii within 2 additional business days.

- b) The Contractor shall determine whether the individual meets all the following criteria as of the Date of Service to qualify as a Confirmed or Unconfirmed Beneficiary. Such determination shall be made prior to claims payment.
 - i) The HICN submitted on the claim is valid.
 - ii) The individual is eligible for Medicare Part D on the Date of Service.
 - iii) The individual is not already enrolled in a Part D plan on the Date of Service.
 - iv) The individual is not enrolled in a Part C plan for which concomitant enrollment in a PDP is precluded.
 - v) The individual does not have an employer who is receiving an RDS on his/her behalf, designated by the presence of an RDS flag or RDS effective dates in MBD.
 - vi) The individual does not have permanent residence outside of the fifty States or the District of Columbia.
 - vii) The individual has not opted-out.
- c) If CMS' systems indicate that the individual meets all the criteria in task A.6.15.b above as of the Date of Service, then the Contractor shall attempt to determine if the individual is LIS eligible as a Full-Benefit Dual Eligible, a Partial Dual Eligible, an SSI-Only Eligible, or LIS Applicant.
 - i) If the Contractor can confirm the LIS eligibility, the Contractor shall then determine if the applicable Timely Filing Limit has been met (see Appendix 1).
 - (1) If the claim was submitted between 31 days and 36 months from the Date of Service, and data indicate the individual was a Full-Benefit Dual Eligible or SSI-Eligible as of the Date of Service, the individual is a Confirmed Beneficiary who qualifies for Retroactive Coverage.
 - (2) If the Date of Service was more than 36 months ago, and the individual was a Full-Benefit Dual Eligible or SSI-Eligible as of the Date of Service, the individual is only considered a Confirmed Beneficiary if a new Medicaid or Medicare eligibility determination was made in the last ninety (90) days granting Full-Benefit Dual Eligible or SSI-Only Eligible status retroactive to the Date of Service.
 - (i) For on-line claims, initially reject the claim with direction to the pharmacist to obtain prior authorization, at which point above determination is made.
 - (ii) For paper claims, make the above determination as part of determining if the individual is a POS FE Eligible Beneficiary, and prior to claims payment.

- (3) If the claim was submitted 30 days or less from the Date of Service, the individual is a Confirmed Beneficiary who qualifies for Current Coverage.
- ii) If the individual meets all the criteria to qualify as a POS FE Eligible Beneficiary except presence of LIS eligibility on CMS' systems for the Date of Service, the Contractor shall determine if the Date of Service is within the past 7 days.
 - (1) If the Date of Service is within the past 7 days, the Contractor shall determine if the individual no longer qualifies for Immediate Coverage because a previous eligibility check indicated the individual was ineligible for the month included in that Date of Service (see task A.6.20.d).
 - (a) If so, the individual is considered an Ineligible Beneficiary.
 - (b) Otherwise, the individual is considered an Unconfirmed Beneficiary if the claim was submitted on-line and in real time. In that situation, the Contractor shall presume LIS eligibility to ensure an individual at the point of sale with an immediate need may have the prescription filled. If the subsequent eligibility verification pursuant to task A.6.18 determines the individual was not LIS eligible, the individual is liable for reimbursing the Contractor for the claims.
 - (c) For beneficiaries or pharmacy providers who submit paper claims for prescriptions that have already been filled, the Contractor shall require proof of LIS eligibility before reimbursing the claim.
 - (i) If the individual or pharmacy provider cannot provide such proof as part of the request for payment, the Contractor shall conduct eligibility verification pursuant to task A.6.18.
 - 1. If LIS eligibility is determined, the individual is considered a Confirmed Beneficiary.
 - 2. If LIS eligibility is not confirmed, the individual is considered an Ineligible Beneficiary.
 - (2) If the Date of Service is not within the past 7 days, the individual is considered an Ineligible Beneficiary.

Adjudicating Claims for POS FE Eligible Beneficiaries

- 16) The Contractor shall adjudicate claims for POS FE Eligible Beneficiary according to the following guidelines.
 - a) For those determined to be Ineligible Beneficiaries, the Contractor shall follow the procedures in task A.6.19.
 - b) The Contractor shall adjudicate claims for Confirmed Beneficiaries in compliance with the Copayment Level in CMS' system, unless Best Available Evidence is provided.

- c) The Contractor shall adjudicate claims for Unconfirmed Beneficiaries with a default to Copayment Level 2 (\$1.10/\$3.20 in 2009), unless Best Available Evidence is provided.
- d) The Contractor shall not charge any deductible nor coverage gap for any POS FE Eligible Beneficiaries, including LIS Applicants who qualify for partial premium subsidy (i.e. 25%, 50%, or 75%).
- e) The Contractor shall reimburse only claims that meet the requirements for Covered Claims in task A.6.29.

Enrolling Confirmed Beneficiaries

The Contractor will enroll Confirmed Beneficiaries, who shall remain enrolled until CMS subsequently enrolls the individual into a qualifying PDP for a prospective effective date (i.e., the first day of the second month after the person is included in CMS' auto/facilitated enrollment run), or the individual makes a voluntary plan election or request for disenrollment.

17) After payment of a claim for a Confirmed Beneficiary, the Contractor shall take actions to promptly submit a Temporary Enrollment for the individual.

- a) Contractor shall submit enrollment transactions to CMS in a timely and efficient manner, but no later than 7 days from the date of determination of Confirmed Beneficiary status. Deleted: 2
- i) The Contractor shall calculate the enrollment effective date as the first day of the month of the earliest Date of Service for a claim submitted on behalf of a Confirmed Beneficiary. For example, if claims were submitted for March 15, April 2, and April 16, the effective date of the enrollment will be March 1.
- ii) The Contractor shall populate certain fields as instructed by CMS to identify the enrollment as an enrollment for a Confirmed Beneficiary, and to trigger immediate processing by MARx (since all transactions will have a retroactive effective date).
- iii) The Contractor shall include 4Rx data for the month(s) of enrollment.
- b) The Contractor shall send a model enrollment confirmation letter to the individual within deadlines established in PDP Eligibility, Enrollment, and Disenrollment Guidance. The model enrollment confirmation letter is subject to prior approval by CMS.
- c) The Contractor shall continue to reimburse all subsequent Covered Claims for Confirmed Beneficiaries while awaiting confirmation the enrollment has been accepted by CMS' MARx system.

Procedures for Unconfirmed Beneficiaries

The Contractor shall perform additional steps subsequent to claims payment to determine if an Unconfirmed Beneficiary is LIS eligible, and therefore qualifies as a Confirmed Beneficiary, or does not, and therefore qualifies as an Ineligible

Beneficiary. This includes researching Medicaid status through State EVS, verifying LIS eligibility through CMS' systems, and/or obtaining proof from the individual.

- 18) The Contractor shall make an initial determination within 2 business days of claims payment for an Unconfirmed Beneficiary.
 - a) For each Unconfirmed Beneficiary, the Contractor shall first attempt to verify Medicaid eligibility with the State of residence for anytime during the month of the Date of Service by querying State systems.
 - i) Those who cannot be found to be eligible upon first query of the State EVS are determined to be Ineligible Beneficiaries, and the Contractor shall follow the procedures for Ineligible Beneficiaries in task A.6.20.
 - (1) The Contractor shall conduct two additional EVS queries for beneficiaries initially found to be Ineligible Beneficiaries upon the first query. The second and third queries shall be performed 15 and 30 days subsequent to the initial query. These two additional queries are performed to account for routine lags in updating eligibility data.
 - (a) If either the second or third query result in confirming Medicaid eligibility for the Date of Service, the individual becomes a Confirmed Beneficiary, and the Contractor shall follow the procedures for enrolling Confirmed Beneficiaries pursuant to task A.6.17.
 - (b) If neither the second or third query confirms Medicaid eligibility, the individual remains an Ineligible Beneficiary.
 - ii) In the event that the data elements necessary to query State EVS are not provided, or appear to conflict with existing data (i.e., from the State), the Contractor shall verify such data elements in CMS' systems to identify any discrepancies. The Contractor shall then attempt to resolve the discrepancy and research Medicaid and/or LIS status with corrected data.
 - b) During the period required to make the first determination, the Contractor shall continue to provide Immediate Coverage for subsequent claims submitted by an Unconfirmed Beneficiary for the same month as on the Date of Service of the initial claim(s). For claims submitted with a different service month, the Contractor shall follow the procedures in task A.6.15.
 - c) Individuals for whom data confirms Medicaid or LIS eligibility on the Date of Service become Confirmed Beneficiaries, and the Contractor shall follow the procedures described in task A.6.17 for enrolling the individual.
 - d) If the Contractor has accurate identifying information for the individuals but cannot confirm his/her Medicaid or LIS eligibility, the individual becomes an Ineligible Beneficiary, and the Contractor shall follow the procedures for Ineligible Beneficiaries pursuant to task A.6.20.

Procedures for Ineligible Beneficiaries

The Contractor shall have procedures to reject claims for Ineligible Beneficiaries and attempt recovery of claims reimbursed for Unconfirmed Beneficiaries who are subsequently determined to be Ineligible Beneficiaries.

19) The Contractor will reject claims for those determined to be Ineligible Beneficiaries at the time of claims submission.

- a) If the claim is submitted on-line in real time by a pharmacy provider, the claim rejection response shall provide the reason for the rejection (see Appendix 3). Additional written notice will not be required; however, the Contractor shall provide information on payer sheets (see task A.6.26) and pharmacy outreach materials (see task A.6.24) on how to request an Eligibility Review.
- b) If the claim is submitted by an individual, the Contractor shall notify the individual in writing if claims payment is rejected, including the reason for rejection, and how to request an Eligibility Review. The notification shall be sent within 10 days of a decision. The model notice shall be approved by CMS prior to use.
- c) For each subsequent claim submitted on behalf of the individual, the Contractor shall follow the procedures for determining if the person qualifies as a POS FE Eligible Beneficiary.

20) For those Unconfirmed Beneficiaries for whom the Contractor reimbursed on-line real time claims requests, but for whom subsequent eligibility verification determined to be Ineligible Beneficiaries, the Contractor shall:

- a) Notify the individual in writing that s/he has been determined ineligible, clearly explain the costs of the claims for which the individual is responsible, and request that the individual provide proof of Medicaid or LIS eligibility.
- b) If the individual is able to provide proof of LIS eligibility that meets the criteria for Best Available Evidence, the individual becomes a Confirmed Beneficiary, and the Contractor shall follow procedures for enrolling a Confirmed Beneficiary described in task A.6.17.
- c) If the individual is not able to provide such proof, the Contractor shall attempt to recover the costs of the claims from the individual. The risk of unrecoverable costs will be the responsibility of the Contractor and should be accounted for in the bid amount.
 - i) If, at any point in the recovery process, the Contractor determines LIS eligibility for the service month(s), the recovery process shall cease and the Contractor shall follow the procedures for Confirmed Beneficiaries in task A.6.17, as well as comply with the requirements below:
 - (1) Reimburse the individual within 14 days for any payments recouped for claims that now qualify as Covered Claims, and
 - (2) Re-adjudicate any on-line claims rejected during the period of determination.
- d) The Contractor shall reject future claims for Unconfirmed Beneficiaries

subsequently determined to be Ineligible Beneficiaries, regardless of the Date of Service.

- i) The Contractor shall have a process that allows for such edits to be promptly removed within four days if an Eligibility Review determines the person is eligible, and provide Immediate, Current, or Retroactive Coverage as applicable.

Eligibility Review Process for Ineligible Beneficiaries

- 21) The Contractor shall provide an Eligibility Review Process for Ineligible Beneficiaries to provide additional evidence that the individual qualifies as a POS FE Eligible Beneficiary subsequent to having a claim initially rejected for payment.
 - a) The Contractor shall accept all Eligibility Review requests made within 60 days from the date of the notice of the Contractor's denial of claims payment, unless the individual shows good cause for not filing within this timeframe.
 - i) The Contractor shall accept written or oral eligibility review requests, but the Contractor shall require written evidence.
 - ii) The Contractor shall accept requests from the pharmacy provider, the individual, or someone acting on the individual's behalf.
 - iii) The Contractor will provide a secure, dedicated fax line for the transmission of such evidentiary documents.
 - b) The Contractor shall permit up to two requests for review per rejected claim.
 - i) The first review shall provide the opportunity for an individual to provide proof the individual qualifies as a POS FE Eligible Beneficiary. This includes individuals whose claims were initially rejected but who, due to updated data, may qualify as a POS FE Eligible Beneficiary. (For example, on the date of claims submission CMS' systems indicate the individual is enrolled in a Part D plan as of the Date of Service. However, a disenrollment transaction is subsequently processed by CMS' MARx system, and a later query reveals the person was not actually enrolled in a Part D plan as of the Date of Service.)
 - ii) The second review shall be available for an individual who has new and material evidence not available or known when the first Eligibility Review request was made that may result in a different conclusion or if the evidence that was considered in making the initial Eligibility Review decision to uphold the denial of claims payment clearly shows that an obvious error was made at the time of the initial decision. The individual shall have 60 days from the date of the notice of the first review to request a second review.
 - c) At each level of Eligibility Review, the Contractor shall make a determination and notify the requester within 7 days of the request being made.

- i) The Contractor shall provide written notice to such beneficiaries of the result of the Eligibility Review Process. The Contractor shall obtain CMS' prior approval for the model notice.
- d) The Contractor shall accept proof of Medicaid or LIS eligibility that is acceptable proof under CMS' Best Available Evidence (BAE) policy.
- e) The Contractor will be required to maintain documentation of all Eligibility Reviews conducted throughout the contract term.
- f) Those who provide acceptable proof of eligibility shall become Confirmed Beneficiaries, and the Contractor shall follow the procedures for enrolling Confirmed Beneficiaries pursuant to task A.6.17.
- g) Those who cannot provide acceptable proof of eligibility remain Ineligible Beneficiaries.

LIS Status Corrections

The Contractor shall transmit requests to CMS' MBD to update LIS deemed status. This includes data for Unconfirmed Beneficiaries who are subsequently determined to be Confirmed Beneficiaries, as well as Confirmed Beneficiaries and/or Enrollees for whom Best Available Evidence is provided. At such time as a process is available for updates to the status of LIS Applicants, the Contractor shall utilize that process as well.

- 22) The Contractor shall submit a file to CMS within 1 business day when it determines that an individual needs to be newly deemed for LIS (i.e. Unconfirmed Beneficiaries subsequently determined to be Confirmed Beneficiaries), or needs a change in existing LIS status, pursuant to receipt of Best Available Evidence. The file shall include information on such beneficiaries and shall be in a format specified by CMS.

Outreach

- 23) The Contractor shall develop and carry out an outreach plan in consultation with CMS that identifies a variety of initiatives targeting key stakeholders to inform them of the availability of Immediate, Current, and Retroactive Coverage for POS FE Eligible Beneficiaries and Coverage for Enrollees, as well as the Eligibility Review Process. The Contractor should customize its outreach initiatives for the various key stakeholders to address when and how they request coverage under the demonstration contract.
- 24) The plan shall include both pre-implementation and on-going outreach to key stakeholders.
 - a) The outreach plan shall identify a variety of initiatives targeting key stakeholders to inform them of the availability of Immediate, Current, and Retroactive Coverage for POS FE Eligible Beneficiaries and Coverage for

Enrollees, as well as the Eligibility Review Process, and when and how to use them.

- b) The outreach plan shall identify strategies for, and frequency of, outreach to key stakeholders, including pharmacies (non-network and network), State & national pharmacy associations, CMS Regional Office pharmacists and caseworkers, State programs, State Medicaid Directors, State Health Insurance Assistance Programs, beneficiaries, caregivers and advocates.
 - i) The Contractor shall include a link on its website to relevant pages on CMS' website.
 - ii) The formats for outreach most suitable for each key stakeholder group and report the means used to provide and maintain education and outreach.
- c) The Contractor shall submit outreach plans to CMS for approval.
 - i) The first outreach plan will cover the pre-implementation period of October-December 2009, and subsequent outreach will address each 6-month period starting January 1, 2010, through the rest of the contract term.
 - ii) The Contractor shall submit the proposed outreach plan to CMS 30 days prior to the period it addresses, and shall make changes as directed by CMS.
- d) The Contractor shall not conduct any outreach or marketing activities related to the subject matter of the demonstration contract beyond those activities outlined in the above-mentioned outreach plan and approved by CMS.

Reimbursing Covered Claims

The Contractor shall reimburse Covered Claims submitted by, or on behalf of, Enrollees and POS FE Eligible Beneficiaries. The request for coverage may be made by a pharmacy provider. It may also be made by an individual or a person acting on his/her behalf.

Reimbursing Beneficiaries

The Contractor shall accept requests for coverage directly from beneficiaries or individuals acting at the request of beneficiaries, including beneficiaries who are Enrollees and POS FE Eligible Beneficiaries. Since such claims will be submitted on paper, the Contractor shall confirm the individual meets all qualifications for POS FE Eligible Beneficiaries – including whether the person was a Full-Benefit Dual Eligible, Partial Dual Eligible, SSI-Only Eligible, or LIS Applicant – before reimbursing the claim.

- 25) The Contractor shall have in place a process to accept requests directly from Enrollees and POS FE Eligible Beneficiaries for reimbursement of Covered Claims

already paid out-of-pocket by them or someone on their behalf. The Contractor shall accept such requests on an individual by individual basis, and shall accept such requests from the individual him/herself, or the individual's advocate, representative, family member or other individual acting on behalf of the individual.

- a) The Contractor shall require the individual to provide proof of claims payment and other appropriate documentation. The Contractor shall develop a form for use in submitting such requests, and shall have it prior approved by CMS. This may include information (i.e. SSN or Medicaid ID Number) needed to query State EVS systems to confirm Medicaid eligibility.
- b) If the individual is not an Enrollee as of the Date of Service of the claim, the Contractor shall determine if the individual qualifies as a POS FE Eligible Beneficiary by completing tasks A.6.15.b and task A.6.15.c.i within 3 business days.
 - i) If the Contractor determines that an individual is a Confirmed Beneficiary, the Contractor shall reimburse the individual or his/her legally authorized representative directly.
 - ii) If the determination is that the individual is an Unconfirmed Beneficiary, the Contractor shall not reimburse the claims. Instead, the Contractor shall perform the eligibility verification pursuant to task A.6.15.c.ii, and shall complete that subtask within 2 additional business days. Only if the eligibility verification results in a determination that the individual is a Confirmed Beneficiary shall the Contractor reimburse the claim. This prevents the situation in which the Contractor pays the individual and then soon after has to recoup that payment.
- c) If the individual is an Enrollee, the request for payment is considered a request for coverage determination pursuant to 42 CFR 423.568(b), and the Contractor shall make a determination and notify the Enrollee within 72 hours.
- d) The Contractor shall reimburse Enrollees for the full amount s/he paid for the claim (less any applicable copayment), regardless of what the Contractor's normal reimbursement rate would be.
- e) If the claim was for a prescription drug filled at a non-network pharmacy, Contractor will reimburse the individual for the total out-of-pocket expense, less any applicable copayment.
- f) The Contractor shall transmit payment to the individual or her/his legally authorized representative within 14 business days of the date it determined the individual was a Confirmed Beneficiary.
- g) No deductible or coverage gap shall be applied to any Covered Claim, including those submitted on behalf of partial subsidy LIS applicants.

Reimbursing Pharmacy Providers

- 26) The Contractor shall develop and distribute a payer sheet for both Enrollees and POS FE Eligible Beneficiaries, including updates as needed.
- a) The payer sheet will be made available on the Contractor's website, as well as CMS' website. The Contractor shall widely distribute it to the pharmacy community through multiple channels, including network communications, non-network communications, direct electronic e-mailing, and upon request; to independent as well as chain pharmacies; and to network as well as non-network pharmacists.
 - b) For POS FE Eligible Beneficiaries who are not already Enrollees, the payer sheet shall include a unique set of 4Rx data (distinct from its standard PDP products) to which pharmacists should bill claims. The 4Rx data specifications shall be uniformly established for all 50 States and the District of Columbia.
 - i) The payer sheet for claims for POS FE Eligible Beneficiaries shall include instructions on which fields shall be populated to provide data necessary to determine if the individual qualifies as a POS FE Eligible Beneficiary, including:
 - (1) SSN (for purposes of querying State Eligibility Verification Systems to confirm Medicaid eligibility)
 - (2) Health Insurance Claim Number/Railroad Retirement Board Number (HICN/RRB)
 - (3) Name
 - (4) Date of Birth
 - (5) Gender Code
 - (6) Medicaid ID number (should be listed as an optional field, rather than a mandatory field, on the payer sheet since some LIS beneficiaries will not have Medicaid ID numbers)
 - (7) State of residence
 - (8) Mailing address
 - (9) State in which she/he has Medicaid
 - (10) Date of Service for the prescription drug claim
 - ii) The payer sheet for POS FE Eligible Beneficiaries shall describe the primary edits that shall be applied, including, at a minimum, quantity limits for Unconfirmed Beneficiaries per Task A.6.29.d, and edits per task A.6.29.b.
 - c) The payer sheet shall include instructions on billing for Enrollees.
 - d) The payer sheet shall include information on Timely Filing Limits (see Appendix 1).

- e) The payer sheet shall include information on how to request an Eligibility Review per task A.6.21.
- 27) The Contractor shall reimburse Covered Claims submitted by pharmacy providers as follows.
- a) Pharmacy providers that have a contractual relationship with the Contractor shall be paid the lesser of the billed charges or the Part D contract-negotiated rate that the Contractor has with the pharmacy provider for its other Part D contract.
 - i) If a sponsor uses a standard for reimbursement of pharmacies based on the cost of a drug, the sponsor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.
 - b) Pharmacy providers that do not have a contractual relationship with the Contractor shall be
 - i) paid their Usual and Customary (U&C) rate; and
 - ii) provided the means for submitting claims at no greater cost than contracted pharmacy providers would incur for the same transaction.
 - c) No deductible or coverage gap shall be applied to any Covered Claim, including those submitted on behalf of partial subsidy LIS eligibles.
 - d) The Contractor shall be able to accept claims electronically from any and all switch vendors, and on paper.
 - e) The Contractor may not seek to recover any claims reimbursement made under this contract from pharmacy providers, with the exception of duplicate claims and claims submitted with invalid HICNs.
 - i) If the Contractor determines subsequent to claims payment that the individual was enrolled in another Part D plan for the Date of Service, the Contractor shall use CMS' monthly P2P Reconciliation process to recoup claims costs from that Part D plan as specified in Task A.6.30.
- 28) Pursuant to Task A.6.25(d), the Contractor will recoup from a network pharmacy the difference between what the individual paid (i.e., U&C – which is what the Contract shall reimburse the individual) and the negotiated rate, less the applicable copayment. This ensures that network pharmacies are not paid in excess of the negotiated rate for Covered Claims.

Covered Claims

- 29) For all Confirmed Beneficiaries, Unconfirmed Beneficiaries, and Enrollees, the Contractor shall use the following criteria.
- a) The Contractor shall maintain an open formulary for all Part D–covered drugs.

- i) For claims with dates of service of January 1, 2013 or later, the Contractor shall cover previously-excluded drug classes that shall be covered pursuant to MIPPA. For claims with dates of service prior to January 1, 2013, these drugs shall not be covered.
- b) The Contractor shall utilize appropriate safety edits such as quantity edits (e.g. "maximum daily dose"); abuse edits (e.g. "refill too soon"); duplicate claims; Part B covered drugs; or excluded Part D drugs, in consultation with CMS.
- c) The Contractor shall not apply any other utilization management or prior authorization processes, except as specified in subtask A.6.12.a for Enrollees, and A.6.15.c.i(2) for POS FE Eligible Beneficiaries.
- d) The Contractor shall fill no more than a 34 day supply at a time for Covered Claims that qualify for Immediate Coverage for Unconfirmed Beneficiaries.
- e) The Contractor shall not limit reimbursement to prescriptions filled at network pharmacy providers, i.e. it shall reimburse Covered Claims submitted by non-network pharmacy providers. The Contractor should generally limit reimbursement for provider-submitted claims to pharmacy providers.

Claims Reconciliation with Other Part D Plans

- 30) Under some circumstances, the Contractor may pay claims for Enrollees or POS FE Eligible Beneficiaries who have other Part D plan enrollment that is unknown to CMS' systems at the time of claims submission to the Contractor. In these cases, the Contractor shall reconcile paid claims for eligible beneficiaries with the appropriate plan(s) in which the eligible individual has been enrolled for the service month.
- a) This process will occur on a monthly basis through CMS' P2P Reconciliation processes as soon as the Contractor creates and submits appropriate prescription drug event (PDE) data based on the Medicare Part D defined standard benefit. For such claims, "Perpetual Phase One" P2P will be made available, in which CMS executes the transfer rather than the Contractor. As with all PDEs, CMS shall accept P2P PDEs until the reconciliation deadline for a given benefit year.

Comply with all PDP Requirements

- 31) In general, in this demonstration contract the Contractor shall comply with all requirements in its standard PDP Sponsor contract with CMS. The only exceptions are:
- a) The Contractor shall limit enrollment to those eligible for Temporary Enrollment.
 - b) The Contractor shall not charge a premium or deductible to any Enrollee or POS FE Eligible Beneficiary, including LIS Applicants eligible for partial premium subsidy.
 - c) The Contractor shall conduct outreach as specified in this document. No other outreach shall be permitted.

- d) The Contractor may not market the demonstration product, nor may it market its other PDP products to Enrollees or POS FE Eligible Beneficiaries absent a specific request for information from the individual.
- e) Other requirements as determined by CMS.

Security Provisions

32) Security

The contractor shall ensure that the MA & Part D system complies with federal and Department of Health and Human Services (DHHS) security policy and best practices. The contractor shall follow the Security guidelines in accordance with the ESD SOW Sections J.9.1.6 and J.9.1.8, and current HHS and CMS security policies.

The contractor shall ensure that production data are kept secure as described in CMS Security guidelines. In addition, the contractor shall ensure production data is not used for any purpose other than required by CMS. This includes ensuring contractor staff does not perform any searches or updates of data that are for their own purpose and not required by work. Any copy (hard copy or electronic copy) containing beneficiary identifiable data shall be destroyed in accordance with CMS Security guidelines. Please see the following link for more information:
<http://www.cms.hhs.gov/InformationSecurity/>

33) CMS Policy for the Information Security Program (PISP)

To safeguard the confidentiality, integrity, and availability of its information and information systems effectively, CMS has established an enterprise-wide Information Security (IS) Program. As part of this program, security controls must be implemented to protect all information assets, including hardware, systems, software, and data. These controls must be designed to ensure compliance with all federal legislation, policies and standards (e.g., by managing risk; facilitating change control; reporting and responding to security incidents, intrusions, or violations; and formulating contracts).

The PISP policy addresses the reduction in risks to information resources through adoption of preventive measures and controls designed to detect any errors that occur. It also addresses the recovery of information resources in the event of a disaster. CMS has established three (3) classes of Information Security (IS) controls: Management, Operational, and Technical. This structure is consistent with the guidance established by the National Institute of Standards and Technology (NIST), Special Publication (SP) 800-53, Rev. 1, Recommended Security Controls for Federal Information Systems.

34) CMS Information Security Acceptable Risk Safeguards (ARS)

The ARS contains a broad set of required security standards based upon NIST SP 800-53 Rev. 1, Recommended Security Controls for Federal Information Systems, dated December 2006, and NIST 800-63 Version 1.0.2, Electronic Authentication Guideline, dated, April 2006 as well

as additional standards based on CMS Policies, Procedures, and Guidance, other Federal and non-Federal guidance resources and industry leading security practices. The ARS provides technical guidance to CMS and its contractors as to the minimum level of security controls that must be implemented to protect CMS' information and information systems.

A.7 PAYMENT TO CONTRACTOR

Capitation with Narrowed Risk Corridors

The Contractor shall receive prospective per enrollee per month capitated payments from CMS for providing Coverage to Enrollees, and for Retroactive, Current, and Immediate Coverage for POS FE Eligible Beneficiaries under this demonstration contract. The prospective capitated payments shall be determined using a single payment rate agreed to and negotiated by CMS. This per enrollee per month payment rate shall be based on administration cost estimates (Payment Rate A) and drug cost estimates (Payment Rate B) provided by the Contractor for the provision of services under this demonstration contract. This payment rate shall be the same across all PDP regions and shall not be adjusted for regional variations in drug costs. The capitated payments shall not be risk-adjusted for each enrollee's health status. CMS and the Contractor may negotiate and determine a new Payment Rate B for each year of this contract. At CMS' discretion, Payment Rate A may be re-negotiated by CMS and the Contractor after the first year of the contract if the Contractor's administration costs are found to be significantly different than the administration cost estimates originally submitted by the Contractor. CMS and the Contractor shall negotiate and determine new Payment Rates A and B each year that the contract is extended based on cost estimates submitted by the Contractor each year and the Contractor's costs in prior years under the contract. The Contractor shall not receive any direct subsidy, low-income subsidy, or reinsurance subsidy payments for the provision of retroactive and immediate coverage under this contract.

After the end of each contract year, the prospective capitated payments received by the Contractor for the Contractor's estimated drug costs under this contract (based on Payment Rate B) shall be subject to Part D risk sharing with modified risk corridors as described below. The Contractor shall report drug cost data to CMS on Prescription Drug Event (PDE) records based on the price paid to the pharmacy or other dispensing provider (the pass-through price). In addition, the Contractor shall submit direct and indirect remuneration (DIR) data on the DIR Report for Payment Reconciliation for purposes of determining final reconciled payments under this modified risk sharing arrangement. Final reconciled payments to the Contractor shall be conditioned upon the timely submission of:

- a) accurate and complete drug cost data on PDE records in accordance with CMS regulations and guidance regarding this demonstration,
- b) accurate and complete DIR data on the DIR Report for Payment Reconciliation in accordance with CMS regulations and guidance; and
- c) the Attestation of Data Relating to CMS Payment to a Medicare Part D Sponsor for the applicable contract year.

Final reconciled payments to the Contractor shall not be subject to appeal. However, CMS shall have the option to reopen and revise the final reconciled payments based on new or corrected data.

Monthly Capitated Payments:

Payment Rate A= Contractor's per enrollee per month administration cost estimate as agreed to and negotiated by CMS under this contract

Payment Rate B= Contractor's per enrollee per month drug cost estimate as agreed to and negotiated by CMS under this contract

Monthly Capitated Payment (per enrollee) = Payment Rate A + Payment Rate B

Modified Risk Sharing Provisions:

Demonstration Target Amount = Total Capitated Payments received under demonstration for applicable contract year x Drug Cost Ratio

Drug Cost Ratio = Payment Rate B/(Payment Rate A + Payment Rate B)

1st Threshold Upper Limit for Demonstration = 101%

1st Threshold Lower Limit for Demonstration = 99%

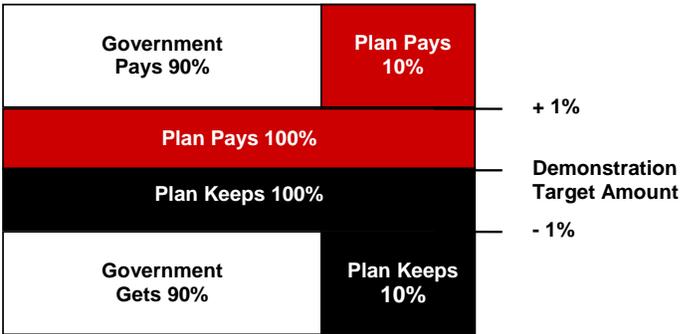
No 2nd Threshold Upper Limit or 2nd Threshold Lower Limit shall be applied.

Demonstration Allowable Risk Corridor Costs* (DARCC) = Covered Plan Paid Amounts from PDE records + LICS amounts from PDE records – Contractor's Direct and Indirect Remuneration (DIR)

*DARCC shall be based on the Contractor's drug costs incurred during the applicable contract year for providing coverage under this demonstration contract. In the event that adequate data is not provided for the accurate and timely calculation of the Contractor's DARCC, CMS shall assume that the Contractor's DARCC equal 50% of the Demonstration Target Amount.

CMS shall share 0% of the Contractor's profits or losses which are within 1% of the Demonstration Target Amount. CMS shall share 90% of the Contractor's profits or losses which exceed 1% of the Demonstration Target. Therefore, if the Contractor's DARCC are above 101% of the Demonstration Target Amount, the Contractor shall be paid an amount equal to 90% of the Contractor's DARCC above 101% of the Demonstration Target Amount. If the Contractor's DARCC are below 99% of the Demonstration Target Amount, the Contractor shall pay CMS an amount equal to 90% of the difference between the Contractor's DARCC and 99% of the Demonstration Target Amount.

Figure 1: Demonstration Risk Corridors



A.8 ADMINISTRATIVE TASKS

At a minimum, the Contractor shall conduct the following administrative tasks in support of the contract. Please see Appendix 4 for a summary of timelines for deliverables under this section.

Meetings with CMS

- 1) The Contractor shall participate in an initial meeting/kickoff conference that shall be held within 7 days after award of the Contract. The Contractor and the CMS Project Officer shall mutually determine the time and date of this conference. The conference may be held by telephone, video/satellite, or in person.
- 2) After the initial meeting, the Contractor and CMS shall meet regularly on a frequency to which the parties mutually agree. The frequency may be modified by mutual agreement of the parties.

Report Media and Transmission

- 3) All reports required under this project shall be delivered in an electronic version via e-mail to the CMS Project Officer. Any protected health information shall be encrypted. All electronic files shall be submitted in a format that is compatible with Microsoft Windows XP. This is subject to change, and the Contractor shall be prepared to submit deliverables in any new CMS standard, provided both parties agree on the new standard.

Project Implementation Plan

- 4) The Contractor shall submit to the CMS Project Officer a project plan including planning for each of the requirements and shall highlight each step of implementation of this contract.
 - a) The Contractor shall submit a draft project implementation plan to CMS for approval within 30 days after the award of the contract or as mutually agreed to by both parties.
 - b) The Contractor shall incorporate CMS comments and submit a final project

plan within 7 days of receiving comments from CMS.

- c) The Project Plan shall include, at a minimum, the following information (not necessarily in the order presented here):
 - i) Key milestones signifying successful completion readiness to perform each service related task in section A.6 and periodic internal assessment/progress reports planned.
 - ii) Activity interdependency and critical path for completion of all tasks.
 - iii) Key staff types devoted to each task or activity, if appropriate, and time allocation for each.
- d) Bi-weekly after the Project Implementation Plan is finalized, or as mutually agreed to by the Contractor and CMS, the Contractor shall submit progress reports on the status of executing the project implementation plan and the systems implementation plan. The first report shall be due 14 days after the project implementation plan is finalized, and subsequent reports are due at 14-day intervals thereafter. The bi-weekly progress reports shall discuss, at a minimum, the following:
 - i) milestones met
 - ii) actual risks identified to successful, timely, achievement of milestones
 - iii) mitigation strategies for identified risks

Data Systems Implementation Plan

- 5) The Contractor shall submit to the CMS Project Officer a systems plan that outlines how it shall receive, store, safeguard, manipulate, send, and analyze data necessary to perform these tasks.
 - a) The Contractor shall submit a draft systems plan to CMS for approval within 30 days after the award date of the contract or as mutually agreed to by both parties.
 - b) The Contractor shall incorporate CMS comments and submit a final systems plan within 7 days of receiving comments from CMS.
 - c) The systems plan shall, at a minimum, include the following (unless mutually agreed otherwise by both parties):
 - i) List and description of Contractor's internal systems that will be used to support the demonstration Contract.
 - ii) A discussion of new functionalities and changes necessary for internal systems to ensure that the service-related tasks in section A.6 can be met within CMS timelines.
 - iii) Explanation of back-up systems or systems support should front-line systems be compromised or fail.

- iv) Identify, from a systems perspective, how it shall perform the service-related tasks in section A.6., including build capacity, enrollment, eligibility verifications, claims adjudication, data transmittals with CMS and CMS contractors, and data exchanges with relevant subcontractors.
- v) A description of how the Contractor shall ensure compliance with The Health Insurance Portability and Privacy Act and CMS Contractor Security Requirements.
- vi) Other items as identified by the Contractor.

On-Going Reports On Service-Related Tasks

CMS requires the Contractor to provide on-going reports to assist CMS in monitoring the efficacy of this demonstration. The Contractor may suggest changes to the specifications below, and these shall be implemented if CMS approves those changes. The Contractor may also suggest additional reports it believe will assist CMS' monitoring efforts.

- 6) The Contractor shall submit standard reports on specified service-related tasks in Section A.6 on a scheduled basis, and ad hoc reports upon request. Please see Appendix 5 for a summary chart of required on-going reports for service-related tasks.
 - a) Reports are due 30 days from the end of the reporting period.
- 7) For **Enrollees**, the Contractor shall provide
 - a) Monthly reports identifying those for whom the Contractor does not receive a disenrollment confirmation on a weekly TRR within 2 months after the initial enrollment confirmation appears on a weekly TRR, for purposes of providing CMS with individuals it needs to manually auto/facilitate enroll on a prospective basis. Report shall include for each individual:
 - i) Individual name
 - ii) HICN
 - iii) State of residence, and
 - iv) Date the enrollment confirmation initially appeared on a weekly TRR.
 - b) Upon CMS request -- Number of disenrollment requests received from beneficiaries
 - i) For retroactive cancellations
 - ii) For prospective effective dates
- 8) For **POS FE Eligible Beneficiaries** requesting claims payment, the Contractor shall provide reports identifying
 - a) A monthly cumulative snapshot of "throughput" of beneficiaries at the key stages of verification an individual qualifies as a POS FE Eligible Beneficiary,

as specified below. The report shall provide data specified below for the most recent twelve months, broken down by month.

- i) Number of POS FE Eligible Beneficiaries who request coverage by submitting claim
- ii) Number rejected as Ineligible Beneficiaries upon claims submission
- iii) Number who are Confirmed Beneficiaries upon claims submission
- iv) Number who are Unconfirmed Beneficiaries upon claims submission
 - (1) Number subsequently determined Confirmed Beneficiaries
 - (2) Number subsequently determined Ineligible Beneficiaries
 - (3) Number of Ineligible Beneficiaries who request Eligibility Review and become Confirmed Beneficiaries
- b) Upon Request -- Confirmed Beneficiaries (i.e. who qualify upon claims submission)
 - i) Total number of Confirmed Beneficiaries
 - ii) Breakdown of number of Confirmed Beneficiaries by state
 - iii) Breakdown of number and percent of total Confirmed Beneficiaries who qualify for:
 - (1) Retroactive Coverage, with a further breakdown of number and percent of those who qualify for Retroactive Coverage of a claim with a Date of Service
 - (a) 31 days to one year from date of claim(s) submission
 - (b) One year to two years from date of claim(s) submission
 - (c) Two years to three years from date of claim(s) submission
 - (d) Over three years from date of claim(s) submission
 - (2) Current Coverage
 - iv) Breakdown of number and percent of total Confirmed Beneficiaries (upon claims submission) by type of LIS eligible
 - (1) Full Benefit Dual Eligible, with a further breakdown of number and percent of subtotal by Copayment Level
 - (2) Partial Dual Eligible
 - (3) SSI only Eligible
 - (4) LIS applicant

- c) Unconfirmed Beneficiaries
 - i) Monthly -- Total number of Unconfirmed Beneficiaries (upon claims submission)
 - ii) Upon CMS request -- Breakdown of number of Unconfirmed Beneficiaries by state
 - iii) Monthly -- Number and percent of total Unconfirmed Beneficiaries who became Confirmed Beneficiaries, including a further breakdown of the number and percent who became Confirmed because they were confirmed as :
 - (1) Full-Benefit Dual Eligible, with a further breakdown of number and percent of subtotal (i.e. of Unconfirmed who become Confirmed Full-Benefit Dual Eligibles) by Copayment Level
 - (2) SSI-Only Eligible
 - (3) Partial Dual Eligible
 - (4) LIS Applicant
 - iv) Monthly -- Number and percent of total Unconfirmed Beneficiaries who became Ineligible Beneficiaries, with further breakdowns of number and percent by
 - (1) State
 - (2) Number and percent of subtotal (i.e. of Unconfirmed Beneficiaries who initially become Ineligible Beneficiaries) who provide proof of Medicaid or LIS eligibility and are subsequently considered Confirmed Beneficiaries again
 - v) Data on efforts to recover claims costs from Unconfirmed Beneficiaries who become Ineligible Beneficiaries, as follows:
 - (a) Total number of claims paid by Contractor
 - (b) Total claims costs for which recovery is sought
 - (c) Total claims costs recovered
 - (d) Total number of beneficiaries from whom recovery is sought
 - (e) Total number of beneficiaries from whom claims costs were recovered
- d) Monthly -- Number of individuals determined to be Ineligible Beneficiaries (upon claims submission), with further breakdown by
 - (1) Number and percent rejected because person has No Part A or Part B eligibility

- (2) Number and percent rejected because of invalid HICN
 - (3) Number and percent rejected because person has other Part D plan enrollment on Date of Service
 - (4) Number and percent rejected because person has Part C plan enrollment that prohibits concomitant enrollment in a PDP
 - (5) Number and percent rejected because person enrolled in an RDS plan
 - (6) Number and percent rejected because residence is outside of 50 States/District of Columbia
 - (7) Number and percent rejected because individual had opted out
 - (8) Number and percent rejected because the Timely Filing Limit was not met
 - (9) Number and percent who were initially Unconfirmed Beneficiaries but subsequently determined Ineligible Beneficiaries (pursuant to task A.6.20.d)
- e) Quarterly -- Requests for Eligibility Review for Ineligible Beneficiaries
- i) Total number of requests for each month of the reporting quarter
 - ii) Number of requests each month by level of review
 - (1) First request
 - (2) Second request
 - iii) Results at each level of review
 - (1) The number and percent of Ineligible Beneficiaries who are subsequently determined to be Confirmed Beneficiaries, so have claims paid
 - (a) A further breakdown for those subsequently determined to be Confirmed Beneficiaries by reason for review result (e.g., proof of Medicaid eligibility, data available at time of claims rejection not accurate, etc.)
 - (2) Remain Ineligible Beneficiaries, so claims rejection is upheld
 - (3) Number and percent requested by pharmacists versus Ineligible Beneficiaries (or someone acting on their behalf)
 - (a) With further breakdown by state
- f) Monthly -- Claims activity for POS FE Eligible Beneficiaries requesting claims payment
- i) Total number of claims submitted, with additional breakdowns as follows:

- (1) Number and percent of total claims that were paid upon submission, i.e. passed front end edits (Confirmed Beneficiaries)
 - (2) Number and percent of subtotal of claims paid for Unconfirmed Beneficiaries
 - (3) Number and percent of subtotal of claims paid for Unconfirmed Beneficiaries who become Confirmed Beneficiaries
 - (4) Number and percent of subtotal of claims for Unconfirmed Beneficiaries who become Ineligible Beneficiaries
- ii) Total number of claims rejected by the front-end edits (Ineligible Beneficiary upon claims submission)
- (1) a summary by rejection type
 - (a) Required fields missing on claim
 - (b) Did not a criterion necessary to qualify as a POS FE Eligible Beneficiary, by following reasons
 - (i) Number and percent rejected because person has No Part A or Part B eligibility
 - (ii) Number and percent rejected because of invalid HICN
 - (iii) Number and percent rejected because person has other Part D plan enrollment on Date of Service
 - (iv) Number and percent rejected because person has Part C plan enrollment that prohibits concomitant enrollment in a PDP
 - (v) Number and percent rejected because person enrolled in an RDS plan
 - (vi) Number and percent rejected because residence is outside of 50 States/District of Columbia
 - (vii) Number and percent rejected because the Timely Filing Limit was not met
 - (viii) Number and percent who were previously Unconfirmed but subsequently determined Ineligible (pursuant to task A.6.20.d)
 - (c) Claims rejected when account "turned off" for Unconfirmed Beneficiary subsequently determined to be an Ineligible Beneficiary
- g) Upon CMS request, the reports on POS FE Eligible Beneficiaries shall be further broken down by whether the request for claims payment was made by a pharmacy provider, or by an individual (or someone acting at their direction)

9) **General** – The Contractor shall submit reports on the following

a) Customer Service toll-free line

i) Monthly:

1) Calls Received

2) Calls Answered

3) Calls Abandoned

4) Average speed of answer (time on hold)

5) Average Talk Time

ii) Upon request: Number of calls for given time period broken down by nature of call

b) Outreach efforts (quarterly)

i) Number of activities each quarter, including target population

Written Policies and Procedures

10) The Contractor shall have in place written standard operational protocols and internal controls for this contract.

a) These must be in place by November 30, 2009.

b) If the Contractor subcontracts with two separate entities for PBM services and for enrollment services for this Contract, the Contractor shall stipulate in its standard operational protocols how it will ensure same day communication between the two subcontractors on issues that affect both claims processing and enrollment under the demonstration contract.

c) These documents shall be updated as needed on an ongoing basis. The Contractor shall make such documentation available to CMS upon request.

Support Evaluation

11) The Contractor will comply with CMS requests to support CMS or other governmental agency monitoring of the contract, including submitting data and operational metrics, and hosting site visits.

SECTION B - CMS RESPONSIBILITIES

B.1 CMS RESPONSIBILITIES

CMS will perform certain tasks in support of the demonstration contract. Specifically, CMS will:

- 1) Modify its auto/facilitated enrollment process to
 - a. Create a Temporary Enrollment into the Contractor's Unique Contract/PBP for all Full Benefit Dual Eligibles and SSI-only eligible individuals who have effective dates prior to the prospective effective dates for random auto/facilitated enrollment. The effective dates that shall prompt a Temporary Enrollment include those in past months, the current month (i.e. in which CMS is creating the Enrollment), or the following month. For example, in August, 2010, CMS will create Temporary Enrollments for all individuals with effective dates through September 1, 2010.
 - i. Please note that the rules for calculating the effective date will be the same as those stipulated in section 30.1.4 and 30.1.5 of the PDP Eligibility, Enrollment, and Disenrollment Guidance.
 - b. Create prospective random auto/facilitated enrollments into standard PDPs with basic benefit and premium below the region's LIS benchmark for Enrollees, including those auto/facilitated by CMS into the Contractor's Unique Contract/PBP, as well as Confirmed Beneficiaries enrolled by the Contractor. The effective date shall be the first day of the second month after an individual is included in a CMS auto/facilitated run. For example, in August, 2010, CMS will create random, prospective auto/facilitated enrollments effective October 1, 2010.
- 2) Modify its data use agreements with the TrOOP Facilitation Contractor retained by the Contractor so that claims eligibility determination and routing can proceed as envisioned by this document. Other release or use of the CMS eligibility data is prohibited, unless directed by CMS.
- 3) Facilitate Contractor requests to the Medicaid Agencies in the 50 States and District of Columbia to obtain query access to their EVS for purposes of verifying Medicaid eligibility for Unconfirmed Beneficiaries.
- 4) Provide enhanced BEQ access, which provides additional data such as beneficiary address not usually provided in a BEQ response file to a Part D plan. The enhanced access is provided to assist the Contractor in researching Unconfirmed or Ineligible Beneficiaries.
- 5) Provide a list of Part C plans in which, during the next benefit year, concomitant enrollment in a PDP is precluded. Such list shall be provided each October prior to the following benefit year.
- 6) Provide guidance on and approval of all secondary messaging for all rejection

codes for claims submitted electronically. Please see Appendix 3 for a preliminary listing.

- 7) Approve materials submitted by the Contractor as follows.
 - a. For model beneficiary material and outreach plans requiring prior CMS approval, approve such material within 14 days, unless otherwise specified in this SOW. The 14 days commence when the CMS Project Officer acknowledges to the Contractor receipt of document for which Contractor requests approval. CMS reserves the right to an extension on this time frame to include directions for modifications, or requests for additional information or clarification, before the material is deemed approved. Please see Appendix 6 for a preliminary list of model materials requiring CMS prior approval.
 - b. All other written deliverables identified to be delivered to the CMS Project Officer will be deemed to have been approved 30 days after date of delivery, except as otherwise specified in this contract, if written approval or disapproval has not been given within such period. Please see Appendix 4.
 - i. The CMS Project Officer shall provide the Contractor with comments on draft reports within 14 days of receipt.
 - ii. If no response is received within 14 days, the Contractor shall assume that the draft report is approved for development of final reporting.
 - iii. The CMS Project Officer's approval or revision to the items submitted shall be within the general scope of work stated in this contract.
- 8) Provide, through its TrOOP Facilitation Contractor, TrOOP accumulator data for all Enrollees upon disenrollment from the demonstration Contract. Providing total covered drug costs and TrOOP for each month of Temporary Enrollment in the Contractor's Unique Contract/PBP will be a Contractor responsibility. CMS, through the TrOOP Facilitator, will handle the actual transfer of data to the Enrollee's next PDP.
- 9) Provide "Perpetual Phase One" P2P prior to the reconciliation deadline for a given benefit year, for instances where the Contractor initially reimbursed the claim but subsequent data reveals the individual was enrolled in another Part D plan on the Date of Service.
- 10) Conduct ongoing program monitoring throughout the start-up period and the contract term.
- 11) Designate a CMS Project Officer.
 - a. The responsibilities and duties of the CMS Project Officer include:
 - i) monitoring the Contractor's technical progress, including the surveillance and assessment of performance and compliance with all substantive project objectives;

- ii) interpreting the statement of work and any other technical performance requirements;
- iii) performing technical evaluation as required;
- iv) performing technical inspections and acceptances required by this contract; and
- v) assisting in the resolution of technical problems encountered during performance.

b) The CMS may unilaterally change its Project Officer designation.

12) Provide on-line query capability for the Contractor to perform front-end edits on claims submitted more than 30 days from the Date of Service (see section A.6.3 for list of the front end edits). Please note the following qualifications:

- a) The Contractor shall submit the HICN, date of birth, and Date of Service in its request
- b) CMS shall match the individual in its system, and then validate that the front end edits were met.
 - i) Please note that for claims submitted more than 30 days after the Date of Service, only Full-Benefit Dual Eligible Beneficiaries and SSI-Only Beneficiaries qualify for such Retroactive Coverage
- c) CMS will generate a response identifying whether the individual passed the front end edits, or if not, why. In addition, data on copayment level and type of LIS eligibility (e.g. Full-Benefit Dual Eligible beneficiary) will be returned.
- d) The query is generally available on-line and in real time, but there are scheduled times when it will not be available, as follows:
 - i) Each night, there is an outage of approximately two hours.
 - ii) An outage of up to one day per month during a weekend, when the system being queried will be shutdown for maintenance.

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SECTION C – PROPOSAL PROCESS

The Centers for Medicare & Medicaid Services (CMS) is seeking proposals from qualified entities interested in entering into a Demonstration Agreement. Proposals are to be submitted according to the process described under "Instructions to Proposers" in Section C.2. Various qualifications and criteria will be assessed, and at a minimum, only current National Prescription Drug Plan sponsors, as defined in Section A.2, may be considered. CMS will award a single contract pursuant to this process.

C.1 PROPOSAL PROCESS

Important Dates

- 1) The following chart depicts the key dates and steps in the proposal process for this RFP.

Proposal & Review Process	
Date	Milestone
February 17, 2009	CMS issues RFP
February 27, 2009, No later than 12 noon EST	Register for pre-proposal conference if you plan to attend. Questions due to CMS for Pre-Proposal Conference by 12 noon.
February 27, 2009, 5:00 p.m. EST	Potential proposer's Notification of Intent to Submit Proposal due to CMS.
March 2, 2009	Pre-proposal Conference (limited to potential proposers).
March 6, 2009, 5:00 p.m. EST	Written questions due from potential proposers
March 20, 2009	CMS' written responses to summary questions from potential proposers available
May 8, 2009, 5:00 p.m. EDT	Proposals due
April 29 May, 2009 – June 30, 2009	Review of proposals, negotiations, finalize & sign demonstration contract.

Deleted: April 28,

We expect the Contractor to start up and operate in accordance with the timelines in task A.6.1-10 and Appendix 4 of the SOW.

Notice of Intent to Submit Proposal

- 2) CMS requests potential proposers submit a Notice of Intent to Submit a Proposal. The purpose of such notification is to assist CMS in planning for the review of proposals, and to assure that potential proposers are notified of any additional CMS updates and clarifications.

Potential proposers should notify CMS in writing by 5:00 p.m. EST February 27, 2009 of their intention to submit a proposal. To do so, submit an email to PARTDDEMONSTRATION2010@cms.hhs.gov with subject line "Notice of Intent to

Submit Proposal," and in the body of the email identify the name, title, phone number, and e-mail address of the contact person to whom subsequent CMS updates should be addressed.

Submission of a Notice of Intent to Submit a Proposal does not obligate the potential proposer to submit a proposal.

Potential proposers who do not submit a Notice of Intent to Submit a Proposal are not precluded from submitting a proposal; however, they may not receive updates issued subsequent to the issuance of the Request for Proposals.

Pre-proposal Conference

- 3) CMS will hold a pre-proposal conference March 2, 2009. Participation shall be limited to National Prescription Drug Plan sponsors as defined in Section A.2. The purpose of this conference is to give potential proposers the opportunity to ask questions about this solicitation. Potential proposers may participate via conference call or in person. CMS will directly notify National Prescription Drug Plan sponsors (as defined in section A.2) of details on how to participate.

Questions e-mailed to CMS at PARTDDEMONSTRATION2010@cms.hhs.gov by 12 Noon EST on February 27, 2009 will have priority for oral response by CMS during the conference. Questions submitted after this date and from the floor will be addressed orally as time permits. Oral responses provided by CMS are not binding.

Questions From Potential Proposers

- 4) Potential proposers may request clarifications of the RFP, including the proposal process, using the following procedures:
 - a) Submit questions in writing, as a Word attachment to an e-mail. Include in the e-mail a point of contact's name, e-mail, phone number, and name of National PDP sponsor.
 - b) For each question, reference the section number being referenced.
 - c) Questions should be e-mailed to PARTDDEMONSTRATION2010@cms.hhs.gov.
 - d) The deadline for submitting questions is 5:00 p.m. EST on March 6, 2009.
- 5) CMS will provide written responses, as follows:
 - a) The written responses will be available by March 20, 2009. They will be posted on CMS' website at <http://www.cms.gov> as well as e-mailed to those who submitted a Notice of Intent to Submit Proposal.
 - b) Only responses provided by CMS in writing are binding.

CMS Point of Contact for RFP

- 6) Prior to contract award, the CMS point of contact for all inquiries and submission of required documents from potential proposers shall be:

Sharon Donovan
E-mail: PARTDDEMONSTRATION2010@cms.hhs.gov
Phone: 410-786-2561

CMS Qualifications to Proposal Process

- 7) This solicitation does not commit CMS to pay any cost for the preparation and submission of an proposal.
- 8) CMS reserves the right to amend or cancel this solicitation.

C.2 INSTRUCTIONS TO PROPOSERS

Proposers shall use the following process to submit proposals in response to this RFP. Proposers are advised that the information in their proposals, and any subsequent written clarifications provided in response to CMS' request(s), will be referenced in the contract with CMS.

Preparing the Proposal

- 1) A proposer must submit comprehensive information to support the proposal. Proposals shall have four sections:

Signed Certification

Technical Approach

Sponsor Organization, Structure, and Experience

Sealed Business Proposal – Cost Estimates

Certification

- 2) In preparing your signed certification, please print out the certification provided in Appendix 7 of this RFP and submit a signed original document.

Technical Approach

- 3) Using the prompts in Section C.4, the proposer shall provide a description of the proposed program, demonstrating how it meets the qualifications described in Section A, the Statement of Work (SOW). In preparing the Technical Proposal section of your proposal, respond to the prompts in Section C.4 of this solicitation. Please repeat each question as stated, followed by your response. Provide complete answers, and detail the opportunities and value your organization offers to Medicare beneficiaries and the Medicare program, in a clear, concise manner. If you have additional information you would like to provide, please include it as an appendix to your proposal, and cross-reference its relation to the information requested. If you have proposals for alternate processes to accomplish the goals of the RFP, you may include them, but shall clearly identify why the acceptance of the proposal would be advantageous to CMS. Any deviations from the terms and conditions of the RFP, as well as the comparative advantage to the Government, shall be clearly identified and explicitly defined.

Sponsor Organization, Structure, and Experience

- 4) In preparing the section of your proposal on Business Proposal – Experience, respond to the prompts in Section C.4 of this solicitation. Please repeat each question as stated, followed by your response. Provide complete answers, and detail the opportunities and value your organization offers to Medicare beneficiaries and the Medicare program, in a clear, concise manner. If you have additional information you would like to provide, please include it as an appendix to your proposal, and cross-reference its relation to the information requested.

Sealed Business Proposal – Cost Estimate

- 5) In preparing the section of your proposal on Business Proposal – Cost Estimate, submit the information in the required formats specified in Section C.5 of this solicitation. Provide complete answers. If you have additional information you would like to provide, please include it in the sealed envelope as an appendix to your original proposal, and cross-reference its relation to the information requested.

Proposal Format

- 6) Proposers shall submit both written and electronic versions of their proposal to CMS.

All copies and the original proposal should be in 3-ring binders. Tab indexing should be used to identify all major sections of the proposal. Page size should be 8 1/2 by 11 inches, with one inch margins, and the pages should be numbered. Type size should not be less than 12 point with a space and a half between lines. Proposals shall not exceed forty (40) pages in their entirety, excluding the sealed Business Proposal – Cost Estimate, and resumes for key personnel, which shall be provided as an attachment. (While CMS recommends that one original and four copies of the written proposal be delivered to CMS, CMS is only requiring that one original and two copies be delivered.)

In addition to submitting written versions of the proposal, proposers must e-mail to CMS a zip file of the certification and proposal (in a format compatible with MS Office 2003), excluding the Business Proposal – Cost Estimate.

Both written and electronic versions of the proposals shall have, on the first page, the following:

Name of this RFP, i.e. "Medicare Part D Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries"

The proposer's legal entity name, contact's name, address, e-mail, and telephone and facsimile numbers, and

Names, titles, e-mails, and telephone and facsimile numbers of persons authorized to negotiate on the proposer's behalf with the Government in connection with this solicitation.

The rest of the required sections shall be in the following order:

Signed Certification

Technical Approach

Sponsor Organization, Structure, and Experience

Sealed Business Proposal – Cost Estimate

A single copy of the Business Proposal – Cost Estimate shall be submitted in writing and electronically in a sealed envelope, clearly marked on the outside:

Name of this RFP, i.e. "Medicare Part D Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries"
Legal Entity Name - BUSINESS PROPOSAL – COST ESTIMATE

The electronic version shall be in Excel for the required tables. The electronic version shall be on CD, and shall be encrypted and password protected. The password for the electronic version shall be emailed to PARTDDEMONSTRATION2010@cms.hhs.gov by the deadline for proposal submissions.

Submitting the Proposal

- 7) To assure that each CMS review panelist receives the proposal in the manner intended by the proposer (e.g., collated, tabulated, colorized), proposers should deliver one (1) original (original includes the Business Proposal – Cost Estimate in a sealed envelope) and four (4) copies (copies exclude the Business Proposal – Cost Estimate) of the written proposal to the address below:

Attn: Sharon Donovan

Centers for Medicare & Medicaid Services (CMS)
Center for Health and Drug Plan Choices (CPC)
7500 Security Boulevard
Mail Stop C2-12-13
Baltimore, Maryland 21244-1850

The electronic version of the proposal shall be emailed to CMS at PARTDDEMONSTRATION2010@cms.hhs.gov.

Do not submit proposals in response to this RFP to HPMS.

Deadline for Submission

- 8) Proposers are responsible for submitting proposals, and any modifications or revisions, so as to reach the CMS office designated in the solicitation by 5:00 EDT, April 28, 2009.
- a) Please note that the Centers for Medicare & Medicaid Services is located in a secure building. Therefore, when hand-delivering proposals in response to CMS solicitations, ensure that ample time is allowed to obtain parking and building passes from the Security Guards.

- b) You are advised that the CMS mailroom only accepts mail from the U.S. Postal Service. When utilizing overnight mail carriers you are cautioned that you must allow ample time for the proposal to be delivered to the Contract Specialist at his/her cubical location by the overnight carrier by the times specified in the RFP, since they are not accepted in the CMS mailroom.
- 9) Any proposal, modification, or revision received at the Government office designated in the solicitation after the exact time specified for receipt of proposals is "late" and will not be considered unless one of the following conditions is met:
- a) There is acceptable evidence to establish that it was received at the Government installation designated for receipt of proposals and was under the Government's control prior to the time set for receipt of proposals. Acceptable evidence to establish the time of receipt at the Government installation includes the time/date stamp of that installation on the proposal wrapper, other documentary evidence of receipt maintained by the installation, or oral testimony or statements of Government personnel.
 - b) If an emergency or unanticipated event interrupts normal Government processes so that proposals cannot be received at the office designated for receipt of proposals by the exact time specified in the solicitation, and urgent Government requirements preclude amendment of the solicitation, the time specified for receipt of proposals will be deemed to be extended to the same time of day specified in the solicitation on the first work day on which normal Government processes resume.

Withdrawal of a Proposal

- 10) A proposer may withdraw a proposal at any time before the contract is signed and becomes effective. Proposal withdrawals shall be submitted in writing to the CMS contact noted above, and are effective upon receipt.

Amendments to a Proposal

- 11) Proposers may submit modifications to their proposals at any time before the proposal submission closing date and time.
- 12) After the proposal submission closing date and time, CMS will not accept any amendments, revisions, or alterations to proposals unless requested by CMS.

Protection of Confidential Commercial Information

- 13) If any information within a submitted proposal (or attachments thereto) constitutes and is clearly labeled by the proposer as a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), then such information will be protected from release by CMS under 5 U.S.C. § 552(b)(4).

Certification Instructions

14) After submitting proposal, proposers must notify CMS in writing if they become aware of changes to the certification provided (see Appendix 7), including:

- any information in the proposal is not true, correct, or complete
- there are any changes that may jeopardize the proposer's ability to meet the qualifications prior to such change or within 30 days of the effective date of such change
- circumstances that preclude full compliance with the requirements of the RFP by January 1, 2010.

Changes to the information furnished in this proposal must be reported promptly to:

Attention: Sharon Donovan
Centers for Medicare & Medicaid Services (CMS)
Center for Health and Drug Plan Choices
7500 Security Boulevard, Mail Stop C2-12-13
Baltimore, Maryland 21244-1850
PARTDEMONSTRATION2010@cms.hhs.gov

C.3 SUMMARY OF QUALIFICATIONS

Proposer responses to the prompts in Section C.4 of the RFP, in combination with the Business Proposal – Cost Estimate prepared in response to the instructions in section C.5 of the RFP, will provide the information necessary for CMS to select a single contractor to provide the Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries. Only those proposals that demonstrate the proposer will effectively and timely meet all stated qualifications described in the SOW, Sections A.6 and A.8, will be considered for award of this contract.

The proposals will be evaluated on the following factors, which are listed in descending order of importance. All evaluation factors, other than cost or price when combined, are significantly more important than cost or price.

- Technical Approach
- Sponsor, Structure, and Experience
- Past Performance

The following table provides a summary of the qualifications on which the proposer's proposal will be scored. Section C.4 provides the information the proposer must submit in the proposal to demonstrate that each qualification in this table, and the requirements within the SOW, are met.

Additionally, there are requests for information in Sections C.4 and C.5 that do not cross-reference to a specific qualification, but the information is nonetheless important because the selected proposer will certify as part of the contract that the program described in the proposal is the same program the proposer will operate. In order for CMS to monitor whether beneficiaries are receiving the benefits offered in the proposal and whether a proposer's proposed solution accurately reflect the requirements of the SOW, proposers need to provide a full description as requested

in Sections C.4 and C.5.

Summary of Qualifications	
Technical Approach	
Requirement	Method of Demonstrating Ability to Meet Requirement
Approach to the Technical Proposal	<p>Proposer fully demonstrates its unique ability to:</p> <ul style="list-style-type: none"> • Meet the operational requirements in the SOW that differ from the proposer’s PDP operations; • Achieve each operational requirement , including quality controls, and manual versus automated processes; and • Maintain fully functional PDP operations while concurrently operating the contract.
POS FE Eligibility	<ul style="list-style-type: none"> • Demonstrate that the Proposer has the systems capacities required to provide services to Medicare beneficiaries who qualify as POS FE Eligible Beneficiaries; • Describe where existing systems will be utilized and their capabilities expanded, and where new systems, if any, will be implemented; and • Provide an implementation plan for eligibility systems updates or acquisitions.
Eligibility Confirmation	<ul style="list-style-type: none"> • Demonstrate that the Proposer has the capacity to differentiate between beneficiaries who are Confirmed Beneficiaries, Unconfirmed Beneficiaries, and Ineligible Beneficiaries; • Describe the process for tracking and updating the status of beneficiaries to ensure claims are paid according to the requirements of the demonstration; and • Describe the Eligibility Review Process beneficiaries may request when determined to be Ineligible Beneficiaries by the Contractor.
Temporary Enrollment	<ul style="list-style-type: none"> • Demonstrate the Proposer’s capacity to enroll Confirmed Beneficiaries in the Contractor’s Unique Contract/PBP for a specified period of Temporary Enrollment; and • Describe how the Contractor’s enrollment and claims processing systems will be updated when beneficiaries are confirmed by CMS’ MARx enrollment system (including auto/facilitated Enrollees), as well as Confirmed Beneficiaries for whom the Contractor submits enrollment transactions.
Retroactive Effective Date of Auto/Facilitated Enrollment	<ul style="list-style-type: none"> • Demonstrate that the Proposer has the capacity to process retroactive auto/facilitated Enrollments.
Contract Benefit Design	<ul style="list-style-type: none"> • Demonstrate that individuals with Temporary Enrollment and POS FE Eligibles Beneficiaries will have all Covered Claims reimbursed, including guarantees to

	an open formulary, with no deductible, monthly premium, nor coverage gap, and with copayments corresponding to the individuals' LIS level.
Claims Adjudication Requirements	<p>Demonstrate that the Proposer has the capacity for:</p> <ul style="list-style-type: none"> • Immediate Coverage for Unconfirmed Beneficiaries and Current Coverage for Confirmed Beneficiaries; • Retroactive Coverage of Confirmed Beneficiaries (Full Benefit Dual Eligibles and SSI-Only Eligibles) • Receiving electronic, real-time claims from any U.S. pharmacy capable of transmitting such claims, including pharmacies outside the Contractor's network (describe any systems changes necessary to achieve this requirement); and • Claims Processing of paper claims submitted by pharmacists or beneficiaries or their designees in timely manner.
Call Centers	<p>The Proposer demonstrates the call center capacity to:</p> <ul style="list-style-type: none"> • Proactively address increased call volumes, including staffing levels; • Monitor call center performance; and • Meet CMS standards of PDP Call Center Performance (80% of incoming calls answered within 30 seconds, abandonment rate not exceeding 5%).
Connectivity to CMS and State EVS Systems	<ul style="list-style-type: none"> • Proposer demonstrates the capacity for connectivity to CMS and State systems per Section A.6.
Contingency Planning	<ul style="list-style-type: none"> • Proposer develops sound and executable contingency plans for both foreseen and unforeseen interruptions, such as routine system maintenance (foreseen) and natural disasters (unforeseen), and including a delay in the implementation date of the Demonstration.
Comply with all PDP Requirements with only CMS-Approved Exception	<ul style="list-style-type: none"> • For Enrollees and POS FE Eligible Beneficiaries, the Proposer demonstrates that it complies with all requirements in its other PDP Sponsor contract(s) with CMS, with the only exceptions as listed in the SOW.
Sponsor Organization, Structure, and Experience	

Requirement	Method of Demonstrating Ability to Meet Requirement
Years of Experience contracting with CMS as a national PDP sponsor	<p>Proposers meeting the following criteria will have their proposals reviewed by CMS:</p> <ul style="list-style-type: none"> • A minimum of two consecutive years contracting with CMS as a National Prescription Drug Plan sponsor as defined in section A.2, including CY 2008. Selection for the contract will be contingent upon renewal of proposer's CY 2010 contract; and • Organized and licensed under State law as a risk bearing entity eligible to offer health insurance or health benefits coverage in each State in which they offer a Part D plan.
Management and Operations	<ul style="list-style-type: none"> • Demonstrate that the Proposer has administrative and management arrangements that feature personnel and systems sufficient to meet all requirements necessary to perform the tasks of the SOW; • Provide the organization chart, depicting the placement of the management and operations of the Contract within the Proposer's organization; and • Proposer complies with Federal and State laws.
Key Personnel and Staffing Plan	<ul style="list-style-type: none"> • Identify personnel designated to work under the contract, including the full-time and part-time equivalents dedicated to this contract for each person; • Provide resumes of key personnel; and • Provide staffing plan for key areas impacted by the additional volume of beneficiaries to be served under the contract (e.g., call center staffing triggers).
First Tier, Downstream, and Related Entities	<ul style="list-style-type: none"> • Provide the names of the first tier, downstream, and related entities providing key Part D functions for the contract. Indicate where the entities are currently providing a Part D function for the Proposer's PDP(s), and/or the entities are new (as applicable) to providing one of the key Part D functions on behalf of the proposer; and • Provide copies of executed contracts and fully executed letters of agreement (PDF format) demonstrating: <ul style="list-style-type: none"> ▪ The functions to be performed by the entities; ▪ A clear agreement of the entity to participate in the Proposer's Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries contract; and ▪ All other contractual requirements for PDP first tier, downstream and related entities contracts.
Letters of Support from Key Stakeholders (Optional)	<ul style="list-style-type: none"> • Proposers may to submit up to five letters of support from key stakeholders (e.g., beneficiaries, advocacy groups, and state-run low income programs such as State Medicaid programs or State Pharmacy Assistance Programs (SPAPs))
Past Performance	
Past Medicare Part D, PDP Performance	<ul style="list-style-type: none"> • The CMS Division of Benefit Purchasing and Monitoring will provide the Proposal Review Team Lead with the Past Performance Score for each proposer. Past Performance will be determined using data from Part D

	Plan Ratings, including but not limited to, history of receiving compliance notices and actions from CMS.
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Selection of Finalist

Award will be made to the proposer whose proposal contains the combination of those criteria offering the best overall value to the Government. This will be determined by comparing differences in the value of technical and management features with differences in cost to the Government. In making this comparison the Government is more concerned with obtaining superior technical or management features than with making an award at the lowest overall cost to the Government. However, the Government will not make an award at a significantly higher overall cost to the Government to achieve slightly superior technical or management features. We reserve the right to award without discussions.

A competitive range will not be established and disclosed to proposers prior to contract award. CMS may conduct discussions/negotiations with the proposers(s) that have the greatest potential for award of the contract. CMS shall award a contract to the proposer who has demonstrated the overall best value to the Government through its proposal submission, negotiations, and any subsequent proposal revisions.

C.4 PROPOSAL CONTENT

Please respond to the following questions regarding your qualifications and your ability to uniquely meet the requirements of this demonstration. You may submit additional information that demonstrates your ability to meet and/or exceed the summary of qualifications found in Section C.3.

Please respond to the following items regarding your qualifications and your ability to uniquely meet the requirements of this demonstration. You may submit additional information that demonstrates your ability to meet and/or exceed the summary of qualifications found in Section C.3.

Technical Proposal

Responses to the specific elements in this section should incorporate the Proposer’s technical solution and technical understanding of the tasks in sections A.6 and A.8 of the SOW, and describe the proposer’s unique qualifications to successfully execute those tasks under the demonstration contract. As applicable:

- Identify the SOW operational requirements that will differ from the Proposer’s PDP operational requirements;
- Describe how each operational requirement will be achieved, including quality controls, and manual versus automated processes; and
- Describe how the Proposer will maintain its PDP operations in a fully functioning state while concurrently implementing, then operating, the demonstration contract.

1) Attest that the Proposer will perform all the tasks in sections A.6 and A.8 and

related appendices of the SOW, within stipulated timeframes.

- a) Attest to the Proposer's ability to comply with all PDP requirements with only CMS approved exceptions, per the SOW.
- 2) Describe in detail how the Proposer will address the systems infrastructure and capacities, including how the Proposer's unique approach qualifies it for the contract.
- a) Where applicable, describe where existing systems will be utilized and where new systems, if any, will be implemented, including the implementation plan for system updates and/or acquisitions as applicable.
 - b) Build Capacity – Demonstrate that the Proposer has the technical capability and infrastructure to achieve the service related tasks related to Building Capacity by December 31, 2009:
 - Appropriate security measures in place to protect data,
 - Support all established Part D systems and business requirements for demonstration contract with only CMS-approved exceptions,
 - Establish all additional policies and procedures necessary to carry out the required tasks under the demonstration contract,
 - Build all additional systems functionality necessary to carry out the tasks in this SOW,
 - Establish and test secure connectivity and data exchanges with CMS' and CMS' contractors systems as necessary,
 - Incorporate the special role and or procedures for, Enhanced Batch Eligibility Queries
 - Submitting LIS status correction files to CMS
 - PDE submission for claims under this contract
 - Payment reconciliation
 - Establish and test secure connectivity and query capability with State EVS,
 - Test procedures for accepting and processing claims for POS FE Eligible Beneficiaries, and
 - Incorporating necessary data from the TrOOP Facilitation Contractor [and direct query to CMS' systems](#) to support front-end edits for claims submitted for POS FE Eligible Beneficiaries.
- 3) Describe the Proposer's approach for providing Coverage for Enrollees, including:
- Accepting Temporary Enrollments created by CMS,
 - How the Proposer would pay for Covered Claims for new Enrollees prior to notification via the TRR,
 - The Contractor's submission of 4Rx data to CMS, and
 - Disenrollment procedures.
- 4) Describe the Proposer's approach for establishing the capability and development of the infrastructure necessary for verifying whether a POS FE Eligible Beneficiary is a Confirmed, Unconfirmed, and Ineligible Beneficiary, including:
- Implementing processes for Confirmed Beneficiaries,
 - Implementing processes for Unconfirmed Beneficiaries,
 - Verifying Medicaid dual eligibility status for Unconfirmed Beneficiaries by query capability with State EVS, and
 - Implementing processes for Ineligible Beneficiaries, including

- Rejecting claims for Ineligible Beneficiaries and attempting recovery of claims reimbursed for Unconfirmed Beneficiaries subsequently determined to be Ineligible Beneficiaries.
- 5) Describe the Proposer's approach for claims adjudication for Temporary Enrollees, Confirmed Beneficiaries, and Unconfirmed Beneficiaries
- Reimbursing all Covered Claims,
 - How different Timely Filing Limits will be applied,
 - Charging the correct LIS copayment level, including default copayment level for Unconfirmed Beneficiaries, and how CMS' Best Available Evidence policy for charging a reduced LIS Copayment Level will be applied, and
 - Charge no deductible or monthly premium, nor impose a coverage gap.
- 6) Describe the Proposer's approach for an Eligibility Review Process for Ineligible beneficiaries in which the beneficiary may provide additional evidence s/he is a POS FE Eligible Beneficiary prior to having a claim initially rejected for payment.
- 7) Describe the Proposer's approach for Reimbursing Covered Claims from:
- Beneficiaries, including the timeframes and processes detailed in the SOW; and
 - Pharmacy providers, including processes:
 - Paper and on-line claims, and
 - Network and non-network pharmacists.
- 8) Demonstrate the Proposer's understanding of the demonstration contract benefit design, specifically that individuals with Temporary Enrollment and those Confirmed and Unconfirmed individuals will receive at the point of sale:
- All Medicare Part D prescription drugs via an open formulary, with no deductible, monthly premium, nor coverage gap, and with copayments corresponding to the individuals LIS level;
 - Unconfirmed Beneficiaries will have a 34-day supply limit per prescription; and
 - The demonstration contract and corresponding PBP will be fully functional and able to operate concurrently with the Proposer's existing, separate PDPs and associated PBPs, including separate formularies when the PDP has a restricted formulary and/drug utilization edits not allowable under the demonstration contract.
- 9) Describe the Proposer's existing Beneficiary and Pharmacy Technical Help Call Centers' capabilities and future enhancements required to meet the increased volume generated by the additional beneficiaries and claims under the demonstration contract.
- a) Specifically address, for both the Proposer's Beneficiary Call Center, and the Pharmacy Technical Help Call Center/Call Support:
- Staffing levels and staff triggers,
 - Hours of operation meet PDP requirements, and
 - Performance and operating standards for:
 - Incoming call answering, and
 - Incoming call abandonment rate.

- 10) Describe the Proposer's contingency plans for both foreseen and unforeseen interruptions to service, such as routine system maintenance (foreseen), unplanned system outages (unforeseen), and natural disasters (unforeseen), and a delay in the implementation date of the Demonstration contract.

Sponsor Organization, Structure and Experience

11) Sponsor Organization

- a) Identify the legal entity (same as Proposer) that would enter into agreement with CMS for the demonstration contract. The legal entity seeking a contract with CMS to offer the Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries program may submit one proposal for CMS consideration.
- b) Provide a brief summary of the Proposer's organizational history, structure and ownership. Identify all entities with which the proposer is under contract or other legal arrangement to meet the qualifications (first tier, downstream, and related entities).
- c) Identify the responsibilities of these entities in meeting the qualifications.
- d) Provide copies of the executed contracts or other fully executed legal arrangements demonstrating:
- e) The functions to be performed by the entities;
- f) A clear agreement of the entity to participate in the Proposer's demonstration contract; and
- g) All other contractual requirements for PDP first tier, downstream, and related entity contracts.

12) Management and Operations

- a) If two or more contracts are combined to meet the national PDP requirement (e.g., two or more subsidiaries of the same parent organization), then provide the applicable contract numbers.
- b) Demonstrate that the Proposer has administrative and management arrangements that feature personnel and systems sufficient to meet all requirements necessary to perform the tasks of the SOW. Provide the organizational chart, depicting the placement of the management and operations of the Demonstration contract within the Proposer's organization.
- c) Demonstrate that the Proposer is a non-government legal entity. Demonstrate the Proposer complies with Federal and State laws.

13) Key Personnel and Staffing Plan

- a) Identify key personnel designated to work under the contract, including the full-time equivalents of those designated personnel.

- b) Indicate key personnel fully dedicated to the demonstration contract. Provide a summary of the qualifications and resumes of key personnel.
 - i) Resumes should include work history, education, background, and industry accomplishments.
- c) Provide the staffing plan for key operational areas impacted by the additional volume of beneficiaries to be served, and drug claims to be processed, under the Demonstration contract (e.g., call center staffing and triggers).

14) Years of Experience as a PDP Sponsor

- a) Describe the Proposer's experience as a national PDP sponsor including:
 - i) Total number of years contracting with CMS as a Part D sponsor and specify which contract years as a national PDP sponsor,
 - ii) Total beneficiary enrollment in the PDP(s) used as a qualifier for the proposal (i.e. point-in-time snapshot as of June 30, 2008),
 - iii) Total LIS beneficiary enrollment in the PDP(s) used as a qualifier for the proposal (i.e. point-in-time snapshot as of June 30, 2008),
 - iv) Volume of processed and adjudicated claims at point of service for calendar year 2008, and
 - v) Optional Letters of Support from Key Stakeholders
 - (1) The proposer may submit up to five letters of support from key stakeholders.

Proposer's Past Performance of Medicare Part D Requirements

The Division of Benefit Purchasing and Monitoring within the Medicare Drug Benefit and C & D Data Group in CMS will provide the Proposal Review Team Lead with the Past Performance Score for each proposer. Past Performance will be determined using data from Part D Plan Ratings, including but not limited to, history of receiving compliance notices and actions from CMS.

C.5 PAYMENT PROPOSAL

Submission of Cost Estimates

Proposers for this demonstration must submit their estimated costs associated with providing coverage under this contract. These estimates shall be the basis for negotiating and determining the payment rates that will be used to calculate the capitated payments made under this contract. Proposers must submit their cost estimates and the assumptions used to develop these estimates using Tables 1, 2, and 3 provided below. In addition, proposers must submit their administration costs associated with offering PDPs in a prior year using Table 1. Thus, proposers must submit two versions of Table 1- one with their experience from a prior year (2008 or 2007 as applicable) and a second with their projected administration costs under this contract. The first version will be used by CMS to better understand and evaluate the proposers' projected administration costs. The second version will be used to negotiate and determine payment rate A. Proposers must provide a detailed explanation for any significant difference between the values in the two versions of

Table 1.

The estimates submitted by proposers in Tables 1, 2, and 3 shall be subject to review and negotiation by CMS for the purposes of determining payment rates A and B. These two payment rates shall be used to determine the capitated payments made under this contract. As part of the negotiation, CMS may request supporting documentation for the information submitted in these Tables. Proposers should be prepared, upon request, to provide CMS with documentation to support the development of the estimates and data in Tables 1, 2, and 3. The data submitted shall be subject to audit by CMS or by any person or organization that CMS designates.

Administration Cost and Gain/Loss Estimates (Table 1):

Proposers must submit their actual and projected administration costs and gain/loss in the following categories on Table 1:

1. Direct Administration

Administration costs associated with functions that are directly related to the administration of the benefit, such as customer service, enrollment, claims administration, and True Out-of-Pocket (TrOOP) administration. This would include any fees or expenses associated with establishing and maintaining connectivity to required systems.

2. Indirect Administration

Administration costs associated with functions that may be considered "corporate services," such as accounting operations, actuarial services, legal services, and human resources.

3. Private Reinsurance (Net Cost)

Private reinsurance premiums paid by proposer less private reinsurance recoveries.

4. Gain/Loss

Proposer's profit or loss in providing the benefit.

Version 1. Prior Year's Prescription Drug Plan Experience

Proposers must provide credible prior year experience for a PDP contract previously offered nationally or across multiple regions. Specifically, proposers must report the combined 2008 experience of all basic PDPs (with the exception of PACE and Employer/Union-only Group Waiver plans) under a PDP contract that was offered by the proposer either nationally or across multiple regions in 2008. This experience must be reported without adjustment. Adjustments may be made in version 2 of Table 1 to accommodate differences in population or other differences with regards to providing retroactive and immediate coverage under this contract. These adjustments or differences should be explained in detail. All administration costs from a prior year's experience must be reported using the appropriate generally accepted accounting principles (GAAP) methodology.

At the top of Table 1, proposers must indicate the version of the table, Version 1- Prior Year's PDP Experience. In addition, proposers must indicate the PBP contract and contract year used for Version 1 of Table 1. Proposers must also list any plans in the indicated PBP contract that were excluded from the data used to complete Table 1. At the top of Table 1, proposers must also provide the average risk score of the beneficiaries enrolled in the PDPs that were used to develop Version 1 of the table.

Proposers must provide a detailed description of the costs included in the line items "Other Direct Administration Costs", "Overhead", and "Other Indirect Administration Costs". For any line items that are not applicable, proposers should enter "N/A". In the "Total" Line (second to last row in Table 1), proposers must enter the sum of the amounts in line items "Total Direct administration Cost", "Total Indirect Administration Costs", "Private Reinsurance (Net Cost)", and "Gain/Loss". In the last row of Table 1, "Total/Avg Risk Score", proposers must divide the amounts in the "Total" row by the average risk score of their enrollee population (reported at the top of Table 1).

Version 2. Projected Administration Costs and Gain/Loss under Contract

Proposers must provide detailed estimates for the administration costs that they expect to incur under this contract. These estimates shall be negotiated with CMS to establish payment rate A and the capitated payments which shall be made to the Contractor under this contract.

At the top of Table 1, proposers must indicate the version of the table, Version 2- Projected Administration Costs and Gain/Loss under Contract, and the projected average risk score for their expected enrollee population.

Proposers must provide a detailed description of the projected costs included in the line items "Other Direct Administration Costs", "Overhead", and "Other Indirect Administration Costs". For any line items which are not applicable, proposers should enter "N/A". In the "Total" Line (second to last row in Table 1), proposers must enter the sum of the amounts in the line items "Total Direct administration Cost", "Total Indirect Administration Costs", "Private Reinsurance (Net Cost)", and "Gain/Loss". The total per member per month value in the "Total" row of Table 1 Version 2, shall be used for negotiations with CMS to establish payment rate A. In the last row of Table 1, "Total/Avg Risk Score", proposers must divide the amounts in the "Total" row by the projected average risk score of their expected enrollee population (reported at the top of Table 1).

Drug Cost Estimates (Table 2):

Proposers must provide estimates for the drug costs that they expect to incur under this contract. These estimates must be based on the prices expected to be paid to the pharmacies or other dispensing providers (the expected pass-through prices) as well as expected discounts, rebates, and other price concessions. These estimates shall be negotiated with CMS to establish payment rate B and the capitated payments which shall be made to the Contractor under this contract.

The drug estimates in the "Total Drug Cost" column must be net of beneficiary cost sharing. In the column "Total DIR", proposers must include an estimate of the direct and indirect remuneration (DIR) they expect to receive in association with the drug costs incurred under this contract. Per 42 C.F.R. Section 423.308, DIR is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug.

The net drug cost per enrolled member per month value in the last row of Table 3, "Total", shall be used for negotiations with CMS to establish payment rate B.

Assumption Used In Estimates (Table 3):

Proposers must provide their assumptions regarding:

- 1) the number of Ineligible Beneficiaries for whom claims are expected to be initially paid,
- 2) the number of claims for these Ineligible Beneficiaries, and
- 3) the number of Plan-to-Plan claims expected to be received under this contract.

For the first line item, "Number of Ineligibles", proposers should indicate the number of Ineligible Beneficiaries expected in one month in the last column, "Per Member Per Month".

Demonstration Contract Cost Estimates Tables

Tables 1, 2, and 3 must be completed in accordance with the instructions provided in section C.5 of the Medicare Part D Retroactive and Point of Sale Coverage for Certain Low Income Beneficiaries RFP.

Table 1. Administration Cost and Gain/Loss Estimates for Payment Rate A

Proposals must include two versions of Table 1- version 1 reflecting prior PDP experience and version 2 reflecting estimated administration costs under demonstration contract.

Required Item	(to be filled in)
Name of Proposer	
Version of Table 1	
If Version 1, Contract Number and Contract Year	
If Version 1, Excluded PBPs	
Average Risk Score of Enrollee Population****	

Administration Costs	Total	PMPM*
1. Direct Administration Costs		
Member Materials		
Customer Service/Call Center		
Quality Assurance		
Bad Debt: Ineligibles' Claims		
Bad Debt: Uncollected Cost Sharing		
Bad Debt: Other		
PBM Administration (Benefit Admin, Price and Rebate Negotiations)		
COB User Fees		
Pharmacy Processing Fees		
Claims Processing (Paper Claims)		
IT: Claims Processing*		
IT: Eligibility and 4Rx Transactions*		
IT: TrOOP Admin and Tracking*		
IT: Other IT costs*		
Other Direct Administration Costs**		
Total Direct Administration Costs		
2. Indirect Administration Costs		
Overhead**		
Other Indirect Administration Costs**		
Total Indirect Administration Costs		

3. Private Reinsurance (Net Cost)		
4. Gain/Loss		
Total (for Payment Rate A) * * *		
Total/Average Risk Score		

* PMPM= Per Enrolled Member Per Month; IT = Information Technology

** Provide a detailed description of costs included in this category of administration costs

*** Total = Direct Administration Costs + Indirect Administration Costs + Private Reinsurance + Gain/Loss

**** For demonstration contract estimates, indicate projected average risk score for expected enrollee population.

Table 2. Drug Cost Estimates for Payment Rate B

Type of Claim	Number of Claims	Number of Enrollees	Number of Member Months	Total Drug Cost*	Total DIR	Net Drug Cost Per Member Per Month
Retroactive enrollments generated by CMS						
POS FE Eligible Beneficiaries						
Total (for Payment Rate B)						

* Drug Costs must be net of beneficiary cost sharing.

Table 3. Assumptions Used In Estimates

Assumption	Total	Per Member Per Month*
Number of Ineligibles Beneficiaries		
Number of Claims for Ineligibles Beneficiaries		
Number of Plan-to-Plan claims		

* For Ineligible Beneficiaries, indicate the number of beneficiaries expected in one month.

APPENDICES

APPENDIX 1 – TIMELY FILING LIMITS

As noted in Section A.2, Timely Filing Limits are the deadlines by which a request for claims payment under this contract shall be made to the Contractor to qualify for payment. The Timely Filing Limit varies by population, as follows:

- POS FE Eligible Beneficiaries
 - Confirmed Beneficiaries who qualify for Retroactive Coverage (i.e., Full-Benefit Dual Eligibles and SSI-Only Eligibles)
 - Request for payment must be made within **36 months** from the Date of Service
 - Prior authorization is required for those filed more than 36 months after Date of Service
 - Confirmed Beneficiaries who qualify for Current Coverage
 - Request for payment must be made within **30 days** from the Date of Service, i.e., the time limit for Current Coverage.
 - Unconfirmed Beneficiaries
 - Request for payment must be made within **7 days** from the Date of Service, i.e. the time limit for Immediate Coverage
- Enrollees
 - Prior to disenrollment from the Contractor
 - Request for payment must be made within **36 months** of the Date of Service
 - Prior authorization is required for claims submitted more than 36 months after the Date of Service.
 - Dates of Service must fall within periods of Temporary Enrollment with the Contractor.
 - After disenrollment from the Contractor
 - Beneficiaries and pharmacy providers must submit a request to the Contractor for payment of claims within **180 days** of the effective date of disenrollment from Temporary Enrollment in the Contractor's Unique Contract/PBP.
 - Prior authorization is required for those that have Dates of Service more than 36 months prior to the date the request for payment is made to the Contractor
 - Dates of Service must fall within the period of Temporary Enrollment

How Timely Filing Limits Will Be Applied

POS FE Eligible Beneficiaries

For POS FE Eligible Beneficiaries, the Timely Filing Limit varies by whether the individual is a Full-Benefit Dual Eligible, SSI-Only Eligible, Partial Dual Eligible, or LIS Applicant. Below is an illustration of how the Timely Filing Limits work.

Step 1 – Determine if claim meets front end edits

- a) Verify that as of Date of Service, person meets all of the following:
- is Part D eligible,
 - is not already enrolled in a Part D plan,
 - is not already enrolled in Part C plan in which concomitant PDP enrollment is precluded;
 - is not enrolled in an RDS plan,
 - has not opted out; and
 - is a permanent resident of the 50 states or District of Columbia
- i) If person does not meet all six criteria, person is Ineligible Beneficiary; Contractor denies claim
- ii) If person meets all five criteria, continue to Step 2

Step 2 - Determine if CMS's systems indicate that as of Date of Service, person is LIS eligible, and calculate appropriate Timely Filing Limit:

- a) If there is LIS eligibility, determine type of LIS Eligible
- i) If Full-Benefit Dual Eligible or SSI-only as of the Date of Service
- A) Determine if claim was submitted 30 days or less after the Date of Service
- 1) If so, person is Confirmed Beneficiary for Current Coverage; Contractor pays claim and enrolls individual
- 2) If not, determine if claim was submitted from 31 days through 36 months after the Date of Service.
- (a) If so, person is Confirmed Beneficiary for Retroactive Coverage; Contractor pays claim and enrolls individual
1. If the claim was submitted more than 36 months after the Date of Service, prior authorization is required to determine whether a new Medicaid or Medicare eligibility determination was made in the last ninety (90) days granting Full-Benefit Dual Eligible or SSI-Only Eligible status retroactive to the Date of Service.
- a. If so, person is Confirmed Beneficiary for Retroactive Coverage; Contractor pays claim and enrolls individual
- b. If not, person is Ineligible Beneficiary; Contractor denies claim

- ii) If Partial Dual Eligible or LIS Applicant
 - A) Determine if claim was submitted 30 days or less from Date of Service
 - 1) If so, person qualifies as Confirmed Beneficiary for Current Coverage; Contractor pays claim and enrolls individual
 - 2) If not, person is Ineligible Beneficiary; Contractor denies claim
- b) If no LIS eligibility on CMS systems
 - i) Determine if claim was submitted within 7 days of Date of Service
 - A) If claims was submitted within 7 days of Date of Service, determine if claim how claim was submitted
 - 1) If submitted by pharmacy provider on-line and in real time, person is Unconfirmed Beneficiary for Immediate Coverage; Contractor pays claim (Contractor performs eligibility verification subsequent to claims payment; recoups payment if eligibility not verified)
 - 2) If claim is paper claim, Contractor first performs eligibility verification.
 - (a) If State EVS or other data show person is LIS eligible, person is Confirmed Beneficiary for Current Coverage; Contractor pays claim and enrolls individual
 - B) If not submitted with 7 days of Date of Service, person is Ineligible Beneficiary; Contractor denies claim.

Enrollees

For Enrollees, the Date of Service must fall in a period of Temporary Enrollment. The expectation is that most will be filled while the individual is an actual enrollee. Those with Dates of Service over 36 months in the past require prior authorization.

Pharmacy providers and beneficiaries have 180 days from the disenrollment effective date from the Contractor's Unique Contract/PBP to submit a claim that has a Date of Service within a period of Temporary Enrollment.

Examples of Timely Filing Limits

POS FE Eligible Beneficiaries

Below are examples of how the Timely Filing Limit works for POS FE Eligible Beneficiaries.

Example 1: A POS FE Eligible Beneficiary presents at the pharmacy on August 10, 2010, and the pharmacy submits a claim to the Contractor that same day. The claim passes all front-end edits, except that no LIS status is indicated on CMS' systems.

The individual meets the criteria for Unconfirmed Beneficiary, and since the claim was submitted within 7 days from Date of Service, meets the Timely Filing Limit for Immediate Coverage. The claim is paid.

Example 2: The pharmacist fills a prescription for a POS FE Eligible Beneficiary on August 10, 2010, and 10 days later (on August 20, 2010), requests payment from the Contractor. The claim passes all front-end edits, except that no LIS status is indicated on CMS' systems. As a result, while the individual meets most of the criteria for Unconfirmed Beneficiary, since the claim was not submitted within 7 days from the Date of Service, it did not meet the Timely Filing Limit for Immediate Coverage. The claim is denied.

Example 3: The pharmacist fills a prescription for a POS FE Eligible Beneficiary on August 10, 2010, and 36 days later (on September 15, 2010), requests payment from the Contractor. The claim passes all front-end edits, and CMS' systems indicates the person is a Full-Benefit Dual Eligible or SSI-Only Eligible. As a result, the individual meets the criteria for a Confirmed Beneficiary, and meets the Timely Filing Limit for Retroactive Coverage. The claim is paid.

Example 4: The pharmacist filled a prescription for a POS FE Eligible Beneficiary on August 10, 2010, and 36 days later (on September 15, 2010), requested payment from the Contractor. The claim passes all front-end edits, and CMS' systems indicates the person is a Partial Dual Eligible or approved LIS Applicant. As a result, while the individual meets the criteria for a Confirmed Beneficiary, it is only for Current Coverage (since only Full-Benefit Dual Eligibles and SSI-Only Beneficiaries qualify for Retroactive Coverage). Since the claim was not submitted within 30 days from the Date of Service, it did not meet the Timely Filing Limit for Current Coverage. The claim is denied.

Enrollees

Below are examples of how the Timely Filing Limit works for Enrollees. It assumes that the claim passed all the front end edits, and meets the requirements for a Covered Claim.

Example 5: On September 15, 2010, CMS creates a Temporary Enrollment for an individual for the period of March 1, 2010 through October 31, 2010. A pharmacy provider submits a claim on September 30, 2010, for a claim with a Date of Service of June 1, 2010 (i.e. 214 days ago). The claim was submitted while the individual was still an Enrollee, and the Date of Service was less than 36 months ago, so the Timely Filing Limit was met. The claim is paid.

Example 6: On September 15, 2010, CMS creates a Temporary Enrollment for an individual for the period of March 1, 2010 through October 31, 2010. A pharmacy provider submits a claim on November 30, 2010, for a claim with a Date of Service of June 1, 2010 (i.e. 265 days ago). The claim was submitted within 180 days after the effective date of disenrollment from the Contractor, and less than 36 months from the Date of Service, so the Timely Filing Limit was met. The claim is paid.

Example 7: On September 15, 2010, CMS creates a Temporary Enrollment for an individual for the period of March 1, 2010 through October 31, 2010. A pharmacy provider submits a claim on April 30, 2011, for a claim with a Date of Service of June

1, 2010. The claim was submitted 181 days after the effective date of disenrollment from the Contractor, so the Timely Filing Limit was not met. The claim is denied.

APPENDIX 2 – SPECIFIC EXPERIENCE

This Appendix provides data on specific experience with retroactive auto/facilitated enrollments and POS FE in the current environment.

Experience with Retroactive Auto/Facilitated Enrollments

Background Information on Drug Costs for Retroactive Auto/Facilitated Enrollments

In December 2006, approximately 28,400 full-benefit dual eligible beneficiaries were auto-assigned with a retroactive effective dates. The average period of retroactive enrollment for these beneficiaries was 2.5 months. These beneficiaries incurred approximately \$8.0 million in total drug costs during their period of retroactive coverage. Of this \$8.0 million, approximately \$130,000 were paid by the beneficiaries in cost sharing and \$7.9 million were paid by their Part D plans (approximately \$278 per member). Please note that the term “retroactive” in this paragraph means effective dates of January-November, 2006. This analysis does not include retroactive SSI-only beneficiaries.

Table 1 -- Retroactive Auto/Facilitated Enrollments

Table 1 shows the number of beneficiaries that were auto/facilitated enrolled by CMS for each of the most recent six months of auto/facilitated enrollment for which data are available. For each “run” month, it includes the number of member months by effective date. The effective dates included are those for which an individual would have been assigned by CMS to the Contractor had this contract been in place in 2008.

Experience with POS FE

Table 2 -- POS FE Beneficiaries and Claims

Table 2 identifies the current POS FE experience in the most recent six months for which data are available, including number of beneficiaries and claims processed.

Please note the following:

- “Processed Claims” will not equal the sum of “Accepted Claims” and “Rejected Claims” because the latter two include some claims that are counted in each, i.e. start as accepted but are later rejected, and vice versa (see below for details).
 - The columns “Accepted Claims” and “Rejected Claims” are updated as additional data become available, so each month’s numbers change slightly over time.
 - “Accepted Claims” include those submitted in the current month and immediately processed as accepted, as well as those initially rejected, but later processed (i.e., due to results of the exceptions process [a process similar to Eligibility Review as described in this Statement of Work]).
 - “Rejected Claims” include those immediately rejected upon submission, as well as those previously accepted but are now rejected

(i.e., for Unconfirmed Beneficiaries who are subsequently determined to be Ineligible Beneficiaries; as well as Unconfirmed Beneficiaries for whom, during the time taken for eligibility verification of LIS, MARx processes a new Part D plan enrollment that covers the Date of Service).

- "Processed Beneficiaries" will not equal the sum of "Accepted Beneficiaries" and "Rejected Beneficiaries" for the same reasons as noted above for "Processed Claims" (i.e., some individuals are counted in both categories when they are accepted initially but later rejected, and vice versa).
 - "Accepted Beneficiaries" do not equal "Enrolled into POS FE 2009 Contractor" because for approximately 20% of "Accepted Beneficiaries," MARx subsequently processes a new Part D plan enrollment that covers the Date of Service. In addition, some individuals are counted more than once because they use POS FE more than once during the reporting month.
- "Unconfirmed Beneficiaries Sent to Elig Verification Contractor" does not equal the sum of "Confirmed by Elig Verification Contractor" and "Ineligible Benes Subject to Recovery of Claims."
 - The "Unconfirmed Beneficiaries Sent to Elig Verification Contractor" number can include multiple records for a single individual when the individual has Dates of Service in multiple months.
 - "Confirmed by Elig Verification Contractor" represents the subset of Unconfirmed Beneficiaries for whom the Eligibility Verification Contractor confirmed LIS status, and so are subsequently enrolled.
 - "Ineligible Benes Subject to Recovery of Claims" represents the subset of Unconfirmed Beneficiaries whom the Eligibility Verification Contractor found no proof of LIS eligibility (thus leading to a determination of POS FE ineligibility), and from whom the 2009 POS FE contractor seeks recovery of claims costs. It does not include those who were initially unconfirmed, but for whom MARx subsequently processed a new Part D plan enrollment that covers the Date of Service.

Table 3 – POS FE Ineligible Beneficiaries

Table 3 shows the monthly number of Ineligible Beneficiaries and results of recovery attempts by the current POS FE contractor.

Please note the following:

- The "Total Letters posted, 1st attempt" number represents number of letters sent that month. It may include individuals who used POS FE in the previous month, so will not match exactly the "Ineligible Benes Subject to Recovery of Claims" number for the corresponding month in Table 2.
- The "Total Dollars Billed 1st letter" number represents the total dollar amounts for claims for which recovery is being attempted.
- The "Total Dollars Received from Benes" number represents the dollar amounts amount collected from Ineligible Beneficiaries in the respective months.

Table 1 – Retroactive Auto/Facilitated Enrollments

Effective Date	Month of Auto/Facilitated Run					
	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
1/1/2006	144	130	92	101	80	82
2/1/2006	29	8	9	5	11	3
3/1/2006	27	10	9	10	13	10
4/1/2006	16	8	7	4	7	7
5/1/2006	10	3	10	6	8	5
6/1/2006	14	6	10	6	6	9
7/1/2006	7	8	12	12	7	16
8/1/2006	31	11	12	8	12	17
9/1/2006	22	30	8	3	8	7
10/1/2006	41	12	42	5	14	12
11/1/2006	10	7	16	36	14	17
12/1/2006	43	13	14	19	14	28
1/1/2007	83	30	30	48	49	59
2/1/2007	44	23	23	12	27	44
3/1/2007	63	18	35	24	18	56
4/1/2007	122	41	54	33	24	38
5/1/2007	69	55	54	42	45	46
6/1/2007	94	33	40	38	30	33
7/1/2007	134	52	45	56	28	33
8/1/2007	144	52	42	47	33	21
9/1/2007	91	62	70	71	30	23
10/1/2007	207	68	100	81	60	56
11/1/2007	143	92	91	98	70	45
12/1/2007	229	108	105	85	65	41
1/1/2008	469	192	173	207	133	560
2/1/2008	565	250	216	169	88	77
3/1/2008	902	513	294	201	137	94
4/1/2008	1,545	801	622	300	193	120
5/1/2008	2,807	1,690	975	614	402	254
6/1/2008	11,926	3,156	1,619	764	511	291
7/1/2008	24,192	5,113	2,672	1,533	851	444
8/1/2008	3,443	22,649	7,131	2,454	1,552	690
9/1/2008		1,313	26,062	4,663	2,293	1,410
10/1/2008			1,389	24,263	5,297	2,307
11/1/2008				1,219	23,132	4,917
12/1/2008					1,381	23,880
1/1/2009						1,477
Total	47,666	36,557	42,083	37,237	36,643	37,229

Table 2 - POS FE Beneficiaries and Claims

(as of 1/15/09)

	Processed Claims	Accepted Claims	Rejected Claims	Processed Beneficiaries	Accepted Benes	Rejected Benes	Enrolled into 2009 POS FE Contractor	Unconfirmed Beneficiaries Sent to Elig Verification Contractor	Confirmed by Elig Verification Contractor*	Ineligible Benes Subject to Recovery of Claims**
Jul-08	80,666	24,870	71,513	27,509	8,081	22,981	3,763	1,673	965	580
Aug-08	68,040	26,277	54,377	25,247	8,395	19,468	1,949	1,572	1,070	666
Sep-08	60,668	23,474	49,870	23,848	7,592	18,935	2,707	1,608	936	654
Oct-08	60,955	22,500	50,387	24,237	6,850	19,503	1,687	1,580	961	620
Nov-08	54,006	19,703	43,062	21,385	6,031	16,718	2,078	1,323	682	572
Dec-08	57,106	19,119	46,299	23,131	6,491	18,663	2,660	1,204	636	83
Average	63,574	22,657	52,585	24,226	7,240	19,378	2,474	1,493	875	529

* Subset of Unconfirmed Beneficiaries whom the Eligibility Verification Contractor determined were Confirmed Beneficiaries.

** Subset of Unconfirmed Beneficiaries whom the Eligibility Verification Contractor determined were Ineligible Beneficiaries. Please note that the significant decrease in December 2008 was due to implementation of an edit to reject claims from beneficiaries previously determined to be Ineligible Beneficiaries

Table 3 -- POS FE Ineligible Beneficiaries

Month - - Year	Total Letters posted, 1st attempt	Total Dollars Billed 1st letter	Total Dollars Received from Benes
Jul-08	527	\$194,756	\$9,448
Aug-08	330	\$134,965	\$11,291
Sep-08	424	\$203,751	\$15,255
Oct-08	662	\$281,299	\$15,077
Nov-08	579	\$238,551	\$7,329
Dec-08	742	\$306,296	\$18,664
Total	3,264	\$1,359,619	\$77,064
Average	544	\$226,603	\$12,844

APPENDIX 3 – CLAIMS REJECT CODES AND MESSAGES

The Contractor shall use the following rejection codes and secondary messages for claims rejected for Ineligible Beneficiaries.

Description	NCPDP Reject Code	NPCP Primary Message	Secondary Message (Customizable)
Not Found on Part AB	65	Patient is not covered	Unable to validate patient's eligibility for Medicare, please call CMS at 866-835-7595.
Found on Part AB but not effective	65	Patient is not covered	Unable to validate patient's eligibility for Medicare, please call CMS at 866-835-7595.
Found on Part AB but patient expired	65	Patient is not covered	Unable to validate patient's eligibility for Medicare, please call CMS at 866-835-7595.
Found current Part D plan	41	Submit Bill To Other Processor or Primary Payer	<Custom Message With Patient and Plan Information>
Patient has employer subsidy	65	Patient is not covered	Patient has subsidized employer group retiree drug benefits, not eligible for POS FE.
Patient lives outside the 50 States and DC	65	Patient is not covered	Beneficiary lives outside of fifty States or District of Columbia, not eligible for POS FE
Contract Num Not Eligible	65	Patient is not covered	Patient not eligible for POS FE
Various Missing Required Fields	Various	Various	Required Field(s) Missing
Claim Older than Timely Filing Limit	81	Claim Too Old	For exception info call <insert Contractor toll-free number> or go to <insert Contractor URL that has more information>
Prior Authorization Required	75	Prior Authorization Required	Prior authorization required for claims older than 36 months

Note:

- For NPI reject code 41, in the secondary message, the Contractor shall provide the 4Rx data and the five-character contract number for the Part D plan in which the individual is already enrolled for the Date of Service
- "Contract Num Not Eligible" shall be used when the claim is rejected because the individual is enrolled in a Part C plan for which concomitant enrollment in a PDP is precluded.

APPENDIX 4 – TIMELINE FOR DELIVERABLES

Deliverable #	ITEM (Task #)	DUE DATE
1	Initial Meeting (task A.8.1)	5 days after date of award
2	Draft Project Implementation Plan (task A.8.4.a)	30 days after date award
3	Final Project Plan (task A.8.4.b)	7 days after CMS comments received
4	Draft Data Systems Implementation Plan (task A.8.5)	30 days after effective date of the contract
5	Final Data Systems Implementation Plan (task A.8.5)	7 days after CMS comments received
6	Start testing connectivity with applicable CMS' systems (task A.6.1.i)	August 1, 2009
7	Submit pre-implementation outreach plan (task A.6.2)	September 1, 2009
8	Pre-implementation outreach plan finalized; outreach commences (task A.6.2)	October 1, 2009
9	Start testing data exchanges with applicable CMS systems (task A.6.1.i)	October 1, 2009
10	Front-end edit functionality in place with TrOOP facilitation contractor and CMS' systems (task A.6.3)	October 31, 2009
11	Pharmacy Benefits Manager changes in place to adjudicate claims for Enrollees and POS FE Eligible Beneficiaries (task A.6.7)	October 31, 2009
12	Payer sheet and distribution schedule finalized (task A.6.4)	October 31, 2009
13	Capacity in place to query State EVS (task A.6.5)	October 31, 2009
14	Model notices submitted to CMS for approval (task A.6.6)	November 1, 2009
15	Pilot processing POS FE Eligible Beneficiary claims (task A.6.1.j)	November 1, 2009

Deliverable #	ITEM (Task #)	DUE DATE
16	Written Standard Operating Procedures finalized (task A.6.8)	November 30, 2009
17	Toll-free Customer Service Line phased-in availability in place (task A.6.9)	December 1, 2009
18	Build Capacity (task A.6.1)	December 31, 2009
19	Regular status calls with CMS (task A.8.2)	TBD
20	Bi-weekly progress reports on Project Implementation Plans and Data Systems Implementation plan submitted to CMS (task A.8.4.d)	First due 14 days after Project Implementation Plan Finalized, through first report in month of December 2009
21	Updated outreach plans (A.6.24.b)	December 1, 2009, and every six months thereafter
22	On-going reports on service-related tasks (A.8.6-9)	Due 30 days after end of reporting period

APPENDIX 5 – REQUIRED ON-GOING REPORTS FOR SERVICE-RELATED TASKS

Report in Task #	Frequency			General Area	Report Description	Cross-walk to Service-Related Task #s
	Monthly	Upon Request	Quarterly			
A.8.7.a	x			Enrollees	Beneficiaries not disenrolled within 2 months of enrollment confirmation on TRR	A.6.14.c
A.8.7.b		x		Enrollees	Beneficiary disenrollment requests (retroactive cancellation vs. prospective effective date)	A.6.14.c
A.8.8.a	x			POS FE Eligibles	Cumulative "throughput" of # of beneficiaries at key POS FE eligibility stages	A.6.15-21
A.8.8.b		x		POS FE Eligibles	Confirmed Beneficiaries <ul style="list-style-type: none"> • Total • By state • By Retroactive vs. Current Coverage • By type of LIS eligibility 	A.6.15
A.8.8.c.i		x		POS FE Eligibles	Unconfirmed Beneficiaries by State	A.6.15.c
A.8.8.c.ii - iv	x			POS FE Eligibles	Unconfirmed Beneficiaries <ul style="list-style-type: none"> • Total • Become Confirmed Beneficiaries • Become Ineligible Beneficiaries • Recover claims costs from those who become Ineligible 	A.6.15.c & 18
A.8.8.d	x			POS FE Eligibles	Ineligible Beneficiaries - Total	A.6.15 & 19

Report in Task #	Frequency			General Area	Report Description	Cross-walk to Service-Related Task #s
	Monthly	Upon Request	Quarterly			
A.8.8.e			x	POS FE Eligibles	Eligibility Review for Ineligible Beneficiaries <ul style="list-style-type: none"> • Total • By level of review • By review results • By who requested review (pharmacy vs. beneficiary) 	A.6.21
A.8.8.f	x			POS FE Eligibles	Claims activity <ul style="list-style-type: none"> • Total • By Confirmed Beneficiaries • By Unconfirmed Beneficiaries • By Ineligible Beneficiaries <ul style="list-style-type: none"> • upon claims submission • by rejection reason • initially Unconfirmed Beneficiary 	A.6.15, 18, & 19
A.8.8.g		x		POS FE Eligibles	All POS FE Eligible Beneficiary reports broken down by type of requestor (pharmacy or beneficiary)	A.6.15-19
A.8.9.a.i	x			General	Call center – volume	A.6.9
A.8.9.a.ii			x	General	Call center – breakdown by nature of call	A.6.9
A.8.9.b			x	General	Outreach activities	A.6.23

APPENDIX 6 - MODEL MATERIALS REQUIRING CMS PRIOR APPROVAL

At a minimum, the following model materials specific to this Contract require CMS prior approval:

Task #	Model Material
A.6.11.c	Confirmation notice to beneficiary of auto/facilitated enrollment
A.6.14.d	Disenrollment confirmation notice to beneficiary
A.6.17.b	Confirmation notice of enrollment for Confirmed Beneficiaries
A.6.19.b	Notice to beneficiary who submitted claim of denial of payment
A.6.21.g	Notice to beneficiary that Eligibility Review finds person remains an Ineligible Beneficiary
A.6.25.a	Form for beneficiary to request claims payment

APPENDIX 7 - PROPOSAL CERTIFICATION

I, _____, attest to the following:
Name & Title

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware that any information in this proposal is not true, correct, or complete, I agree to notify the Centers for Medicare & Medicaid Services (CMS) immediately and in writing.

I authorize CMS to verify the information contained herein. I agree to notify CMS in writing of any changes that may jeopardize my ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change. I understand that such a change may result in my organization's disqualification from or termination of the contract.

I agree that if CMS selects my organization as the contractor and my organization enters into the demonstration contract with CMS, the organization will abide by the requirements contained in Section 3.0 of this Proposal and provide the services outlined in its proposal.

I agree that CMS may inspect any and all information necessary, including inspecting the premises of the Proposer's organization or plan to ensure compliance with stated Federal requirements. Such requirements include those elements related to my organization's qualification for and operation of the contract. I further agree to immediately notify CMS if, despite these attestations, I become aware of circumstances which preclude full compliance by January 1, 2009 with the requirements stated here in this proposal as well as in Part 423 of Title 42 of the Code of Federal Regulations.

I understand that in accordance with 18 U.S.C. § 1001, any omission, misrepresentation or falsification of any information contained in this proposal or contained in any communication supplying information to CMS to complete or clarify this proposal may be punishable by criminal, civil, or other administrative actions including revocation of approval, fines, and/or imprisonment under Federal law.

I further certify that I am an authorized representative, officer, chief executive officer, or general partner of the business organization that is applying for qualification to enter into the contract with CMS.

I acknowledge that I am aware that there is operational policy guidance, including the forthcoming 2010 Call Letter, relevant to this proposal that is posted on the CMS website and that it is continually updated. I further acknowledge that in submitting this proposal, my organization agrees to comply with such guidance as it relates to the demonstration program should it be awarded the contract.

_____ Authorized Representative Name (printed)	_____ Title
_____ Authorized Representative Name Signature	_____ Date (MM/DD/YYYY)

APPENDIX 8 – ACRONYMS LIST

BAE	Best Available Evidence
CMS	The Centers for Medicare & Medicaid Services
CPC	Center for Drug and Health Plan Choices
CSR	Customer Service Representatives
DARCC	Demonstration Allowable Risk Corridor Costs
DIR	Direct and Indirect Remuneration
DOB	Date of Birth
DUA	Data Use Agreement
EVS	Eligibility Verification System
FBDE	Full Benefit Dual Eligible
GAAP	Generally Accepted Accounting Principles
HICN	Health Insurance Claim Numbers
HIPAA	Health Insurance Portability and Accountability Act
HPMS	Health Plan Management System
LICS	Low Income Costsharing Subsidy
LIS	Low-Income Subsidy
MA-PD	Medicare Advantage Prescription Drug
MARX	Medicare Advantage Prescription Drug enrollment and payment system
MBD	Medicare Beneficiary Database
MEAG	Medicare Enrollment and Appeals Group
MIPPA	Medicare Improvements for Patients and Providers Act
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP	Medicare Savings Programs
NCPDP	National Council of Prescription Drug Programs
NPI	National Provider Identification
P2P	Plan-to-Plan
PBP	Plan Benefit Package
PBM	Pharmacy Benefits Manager
PDE	Prescription Drug Event
PFFS	Private Fee-For-Service
PDP	Prescription Drug Plan
PO	Project Officer
POS FE	Point of Sale Facilitated Enrollment
RDS	Retiree Drug Subsidy
RFP	Request for Proposals
RRB	Railroad Retirement Board
SOW	Statement of Work
SPAP	State Pharmacy Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
TrOOP	True Out Of Pocket
TRR	Transaction Reply Report
U&C	Usual and Customary