DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

January 4, 2006

TO: Medicare Part D Plans

FROM: Cynthia G. Tudor, Ph.D., Acting Director Medicare Drug Benefit Group

SUBJECT: Information to Assist Pharmacists in Completing Pharmacy Transactions

Congratulations! We all made it through the initial weekend of the Medicare Part D benefit, with many beneficiaries receiving their prescriptions without delay. The TrOOP Facilitator, NDCHealth, is now fully operational and providing excellent response times to pharmacist E1 queries. Now we need Part D plans to make greater efforts to assist pharmacies in getting the information they need to fill prescriptions on ALL of your enrollees.

We know that you are working hard to address start-up issues that have been identified in operations, as well as data inaccuracies. As these efforts continue, we need you to develop workarounds or shore up systems already in place to ensure that all beneficiaries get their prescriptions filled at the point-of-sale. Based on information we are receiving from you and from pharmacies, we need plans to immediately make improvements in the following 7 areas:

1. Customer Service Representative (CSR) Line Availability: In some cases plans experienced substantial backups at their Customer Service Representative (CSR) lines. In a number of instances reported to CMS, pharmacists who were attempting to fill an enrollee's prescriptions either could not get through to a CSR to obtain an acknowledgement of the beneficiary's enrollment in the plan or alternatively, had to remain on the telephone line for a protracted amount of time in order to obtain the necessary information to fill the prescription. We need plans to increase capacity on plan help lines, in general, and we need plans to identify a technical assistance number (for instance, a help desk supported by the PBMs or CSRs with access to PBM systems) that will be able to support these calls without redirection. We are adding this new Pharmacy Technical Help Desk contact to the Contract Management Module in HPMS; see more on this in item #5 below.

2. CSR Line Technical Assistance: Pharmacies have reported that when they do get through to customer service lines, many CSRs are not providing the "4Rx" data need to bill the member's claim. It is not appropriate for plan CSRs to refer such questions to the TrOOP Facilitator and the E1 query. Pharmacies contact the plans because the plans and/or their processors are the issuers of the 4Rx data, the most important one of which is the CardholderID, a mandatory billing element in the NCPDP 5.1 pharmacy transaction. Plans are the back-up to the E1, and since the E1 is easier to use than calling the plan, pharmacists can be assumed to have exhausted

this option when they call the plan – consequently these calls must be supported by plan CSRs. Again, we would like plans to identify a technical assistance number (for instance, a help desk supported by the PBMs or CSRs with access to PBM systems) that will be able to support these calls without redirection.

In addition to providing the 4Rx data, CSRs supporting the technical calls should be able to provide information on dual eligible and LIS copays (see item #3 below), nursing home copays, and correct information on transitional coverage of non-formulary drugs. We continue to receive numerous reports that plan CSRs are not aware of their plan's transition policies and that plans are inappropriately denying some scripts.

3. Providing Information on LIS Cost Sharing: If plans are aware that a beneficiary is subsidy-eligible, but do not know the exact subsidy level, they should default the enrollee to a $2/$5 benefit package. If they have no information indicating that the beneficiary is subsidy-eligible, they may default the enrollee to the base non-subsidized benefit package, however—

Even with these defaults in place, plan CSRs who answer pharmacist calls should be trained and prepared to assist pharmacists with overriding default benefit packages in the event that an enrollee presents at the pharmacy with evidence of dual eligibility or an SSA subsidy determination.

Even if a plan has not yet received the weekly TRR, it can still obtain information on LIS status from the following sources:

- CMS Batch Status Summary Reports (these are generally sent out within 48 hours of receipt of the enrollment transactions)
- CMS Drug Plan Finder web tool - (available status limited to either "no more than $2/$5" or "15%")
- 1-800-MEDICARE - (available status limited to "no more than $2/$5" or "15%")
- Speaking with the beneficiary about an auto-enrollment or SSA letter.

4. Prompt Submission of 4Rx Files to CMS: Many pharmacies have automated their billing based on the E1 eligibility data. Therefore the sooner plans can submit their 4Rx files to CMS, the faster complete data can be available from the E1. To date, CMS has not established a deadline for submission of the 4Rx files. However, given the delays we are experiencing in receiving these files, we must now establish a requirement that plans submit the 4Rx files to CMS **within 48-72 hours** of receiving confirmation of enrollment on the TRR. Plans should begin to adhere to this schedule no later than Monday January 9, 2006.

5. Reporting of 3Rx Data to CMS: CMS is rethinking the 4Rx submission process and, as a preliminary step, we will now require that plans enter certain data, including the RxBIN, RxPCN and/or RxGRP for each plan ID, into an HPMS screen that will be available no later than noon EST on January 5, 2006. **Please complete this HPMS data entry by close of business on Friday, January 6, 2006**. This data must be maintained and prospectively updated in HPMS in the event of any change of processing arrangements. It is absolutely critical that this information is maintained, is up-to-date, and accurately reflects your various plans' processing arrangements

and whatever information you are publishing via your payer sheets. Please note that this does not replace the current requirement to send in 4Rx files, as described in item #4 above.

The data elements we need entered into HPMS include the following:

- For each contract number, we are requesting the RxBIN, RxPCN, and RxGroup for EACH of the plan benefit packages (PBPs) (or plans). (If the plan sponsor or its claims processor cannot break out the PBP at the PCN level and needs to report at the RxGROUP level, then the information must be submitted at the level of granularity for a "plan.")
- For each contract number, you must enter the Pharmacy Technical Help Desk contact information, including a telephone number, into the HPMS Contract Management Module.
- For each contract number, you must enter the Processor contact information, including a telephone number, into the HPMS Contract Management Module.

CMS will send an e-mail to all Part D plans with further technical instructions on how to complete these tasks in HPMS.

6. Improved Communication with Network Pharmacies and CSRs on Acknowledgement Letters: Since enrollments can be received until the last day of the month, it is very important that your network pharmacies and CSRs understand their responsibility to support the CMS requirements with respect to honoring acknowledgement letters. Plans must clearly communicate to their contracted provider networks that these letters must be accepted and used for billing claims in advance of the distribution of plan ID cards. CSRs answering pharmacist calls must be trained in assisting pharmacists with understanding their responsibility and with obtaining the 4Rx data needed for proper billing if this data is not contained in the acknowledgement letters. We expect plans to broadcast notices to their network pharmacies on proper use of the acknowledgement letter, and ensure that CSRs are adequately trained.

7. Earlier Submission of Enrollment Transactions: In order to avoid processing delays at month-end, plans should submit enrollment transactions on a flow basis. Plans must also improve their procedures and systems for downloading enrollments from the Online Enrollment Center. To the extent possible, please submit all available February enrollments to CMS by the February payment cut-off date of January 13, 2006. For best results, submit enrollments to CMS on a daily basis. Prompt submissions improve the quality of the data available to pharmacists at the point-of-sale.

If you have questions about these requirements, please contact the MMA Help Desk or your CMS plan account manager. Thank you.