MEDICARE PART D
REPORTING REQUIREMENTS
Contract Year 2007

Updated: 01/18/07

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Introduction

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing coverage of outpatient prescription drugs under the new Medicare Part D benefit. In accordance with Title I, Part 423, Subpart K (§ 423.514), the Act requires each Part D Contract to have an effective procedure to provide statistics indicating:

1) the cost of its operations
2) the patterns of utilization of its services
3) the availability, accessibility, and acceptability of its services
4) information demonstrating it has a fiscally sound operation
5) other matters as required by CMS

The purpose of this document is to assure a common understanding of reporting requirements and how these data will be used to monitor the prescription drug benefit provided to Medicare beneficiaries. CMS will use the following terminology to ensure consistency in these reporting requirements:

- Part D Sponsor –a parent organization which encompasses a group of Part D Contracts.
- Part D Contract – an organization contracted with CMS to provide Part D benefits to Medicare beneficiaries (e.g. H#)
- Part D Plan – a plan benefit package (PBP) offered within a Part D contract (e.g. Plan ID #)

This document represents current expectations of data elements to be reported by Part D Contracts at the Part D Sponsor (parent organization), Contract, or Plan (PBP) level, reporting timeframes, and monitoring of Part D contracts. These requirements will be in effect for Contract Year 2007 and are subject to change at the discretion of CMS. According to Subpart O, sanctions may be imposed on Part D Contracts who fail to comply with these reporting requirements.

The following criteria were used in selecting reporting requirements:

1) Minimal administrative burden on Part D Contracts
2) Legislative and regulatory authority
3) Validity, reliability, and utility of data elements requested
4) Wide acceptance and current utilization within the Industry

Reporting requirements are described in this document for the following areas: Reversals, Medication Therapy Management Programs, Generic Dispensing Rate, Grievances, Pharmacy & Therapeutics (P&T) Committees, Transition, Exceptions, Appeals, Call Center Measures – Beneficiary Service line and Pharmacy Support line, Overpayment, Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions, Long-Term Care (LTC) Rebates, Licensure and Solvency, Business Transactions and Financial Requirements, and Drug Benefit Analyses.

Each Part D Contract shall provide necessary data to CMS to support payment, program integrity, program management, and quality improvement activities. Additional reporting requirements are identified in separate guidance documents throughout the year. Guidance has previously been released for formulary, TrOOP, coordination of benefits, payment and 1/3 audit, and low income subsidy.

Part D Contracts may also be required to submit other information as defined by requirements in the application, guidances, or other documents (e.g. pharmacy access and formularies) during the annual contract bidding, application, or renewal process. Information is also required to be submitted throughout the contract year as allowable changes are made (e.g. formulary changes).

Part D Contract Reporting Requirements

In each of the sections that follow, the method of submission (e.g. entered into or uploaded via the Health Plan Management System (HPMS)) and the level of reporting are specified following the reporting timeline. Sections that refer to prescriptions should encompass all Part D drugs, including compounded drugs.

For PACE Organizations offering Part D coverage, reporting requirements will be limited to: Section III. Generic Dispensing Rate; Section V. Pharmacy & Therapeutics (P&T) Committees (for PACE Organizations utilizing formularies); Section VI. Transition (for PACE Organizations utilizing formularies); Section VII. Exceptions (for PACE Organizations utilizing formularies); Section X. Overpayment; Section XI. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions; and Section XII. Long-term Care (LTC) Rebates.

MA Organizations and Medicare Cost Plans that offer Part D benefits will be required to comply with all reporting requirements contained herein, with the exception of subsections 1, 2 and 3 of Section XIII. Licensure and Solvency, Business Transactions and Financial Requirements.

Data format

Each reporting section provides details regarding data format and calculations pertaining to specific elements. With the exception of data element J in the Medication Therapy Management Programs section, all data should be reported in whole numbers, rounding to the nearest whole number (ex. 1.78 should be rounded to 2). HPMS will require data for element J of Medication Therapy Management Programs section to be entered to two decimal places.

Section I. Reversals

Part D Contracts will be responsible for reporting data elements related to claim reversals. Information on claim reversals will serve as a component in the monitoring of Part D operational functions

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at either the Contract or Plan (PBP) level:

A. Provide the total number of out-of-cycle pharmacy transactions with reversal as the final disposition, which were adjudicated during the time period specified above. This should be a numeric field.

Note: Reversed claim records must be maintained (the number of elements retained per record should at a minimum be equivalent to those of the prescription drug event record), and upon request, submitted to CMS.

Section II. Medication Therapy Management Programs

The requirements stipulating that Part D Contracts provide Medication Therapy Management Programs (MTMP) are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D Contracts will be responsible for reporting several data elements related to their MTMP.

Data related to the identification and participation in the MTMP will be submitted according to the following timeline (note: Period 2 encompasses one full year):

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	January 1 - December 31
Data due to CMS/HPMS	August 31	February 29

Data elements to be entered into the HPMS at the Contract level.

A. The method used to enroll beneficiaries into the MTMP. Method of enrollment may be opt-in, opt-out, a combination of opt-in and opt-out, or other. This will be selection from a drop-down box. If "other" is selected, a description will be required as a text field.
B. The number of beneficiaries who met the eligibility criteria for the MTMP in the specified time period above. This should be a numeric field.
C. The total number of beneficiaries who participated in the MTMP at any point during the time period specified above. This should be a longitudinally cumulative total, and be a subset of the number of beneficiaries who met the criteria for the MTMP in the specified time period. This should be a numeric field.
D. The total number of beneficiaries who discontinued participation from the MTMP at any time during the specified time period above. This should be a subset of the total number of beneficiaries who participated in the MTMP in the specified time period. This should be a numeric field.
E. The number of beneficiaries who discontinued participation from the MTMP due to death at any time during the specified time period above. This should be a subset of the total number of beneficiaries who discontinued participation from the MTMP in the specified time period. This should be a numeric field.
F. The number of beneficiaries who discontinued participation from the MTMP due to disenrollment from the Plan at any time during the specified time period above. This should be a subset of the total number of beneficiaries who discontinued participation from the MTMP in the specified time period. This should be a numeric field.
G. The number of beneficiaries who discontinued participation from the MTMP at their request at any time during the specified time period above. This should be a subset of the total number of beneficiaries who discontinued participation from the MTMP in the specified time period. This should be a numeric field.
H. The number of beneficiaries who declined to participate in the MTMP during the specified time period above. This should be a subset of the number of beneficiaries who met the criteria for the MTMP in the specified time period. This should be a numeric field.
I. For beneficiaries participating in the MTMP as of the last day of the reporting period specified, provide the prescription cost of all covered Part D medications on a per MTMP beneficiary per month basis. This should be a currency field, rounded to the nearest dollar. The numerator represents the total prescription drug costs. The total prescription cost should be limited to covered Part D medications and be calculated using gross drug cost as follows: (Ingredient Cost Paid + Dispensing Fee + Sales Tax). This is based on the sum of all Part D covered prescriptions that were dispensed within the reporting period specified for each beneficiary participating in the MTMP as of the last day of the reporting period. This includes both MTMP beneficiary cost sharing and Part D costs paid. The denominator represents the total number of member months for the MTMP participating beneficiaries. These member months should include all months enrolled in the Part D Contract during the reporting period specified, not only the months that the beneficiary enrolled in the MTMP.

The following equation also describes this calculation

$$\left[\begin{array}{l}\text{Total prescription cost}\\ \text{per MTMP beneficiary}\\ \text{per month}\end{array}\right] = \frac{\sum_{i}^{n}\left(\sum_{\text{j}}^{\text{m}}(\text{Gross Drug Cost}\right)}{\sum_{i}^{n}(\text{Member Months in Part D Contract during Reporting Period})}$$

$\{\text{Gross Drug Cost} = (\text{Ingredient Cost Paid} + \text{Dispensing Fee} + \text{Sales Tax}).$

For beneficiaries i to n, and prescriptions j to m from the i^{th} beneficiary}

J. For beneficiaries participating in the MTMP as of the last day of the reporting period specified, provide the number of covered Part D 30-day equivalent prescriptions on a per MTMP beneficiary per month basis. This should be a numeric field.

This numerator should be calculated by first summing days supply of all covered Part D prescriptions dispensed for beneficiaries participating in MTMP as of the last day of the reporting period, and dividing by 30 to determine the number of 30 day equivalent prescriptions dispensed. The denominator represents the total number of member months for the MTMP participating beneficiaries. These member months should include all months enrolled in the Part D Contract during the reporting period specified, not only the months that the beneficiary enrolled in the MTMP.

The following equation also describes this calculation:

$$\left[\begin{array}{c}\text{Total number of 30 - day prescription equivalents}\\ \text{per MTMP beneficiary per month}\end{array}\right] = \frac{\sum_{i}^{n}\left(\sum_{\text{j}}^{\text{m}}(\text{Days Supply})\right)}{\sum_{i}^{n}\left(\begin{array}{c}\text{Member Months in Part D Contract}\\ \text{during Reporting Period}\end{array}\right)}$$

{For beneficiaries i to n, and prescriptions j to m from the i^{th} beneficiary}

Section III. Generic Dispensing Rate

Cost control requirements for Part D Contracts are presented in Title I, Part 423, Subpart D. Accordingly, Part D Contracts will be responsible for reporting data elements needed to monitor utilization of generic drugs (defined by Title I, Part 423, Sub-Part A, § 423.4).

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. Number of paid claims for Part D generic drugs (regardless of days supply) with dates of service during the specified reporting period identified above. First DataBank or Medispan generic drug classifications will be used to identify generic drugs. This should be a numeric field.
B. Total number of Part D paid claims (regardless of days supply) with dates of service during the specified reporting period identified above. This should be a numeric field.

Section IV. Grievances

Title I, Part 423, Subpart M of the regulation includes regulations that require Part D Contracts to maintain grievance information. All plans (PBPs) will be responsible for reporting data related to grievances received.

A grievance is defined as any complaint or dispute, other than one that involves a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D organization, regardless of whether remedial action is requested. Examples of subjects of a grievance provided in the solicitation for applications include, but are not limited to, timeliness, appropriateness, access to, and/or setting of services provided by the PDP, concerns about waiting times, demeanor of pharmacy or customer service staff, a dispute concerning the timeliness of filling a prescription or the accuracy of filling the prescription.

Part D Contracts are required by the regulations to track and maintain records on all grievances received orally and in writing. Grievance data, requested herein by CMS, should be reported based on the date the grievance was received by the Plan (PBP), not the date the event or incident that precipitated the grievance occurred. Multiple grievances by a single complainant should be tracked and followed as separate grievances. Plans may report grievances in the categories as determined by the Plans after initial investigation. Plans should not dismiss or exclude any grievances filed by beneficiaries from this reporting section.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. For the time period identified above, provide the number of fraud and abuse grievances received related to Part D. A fraud grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. An abuse grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, or beneficiary engaged in behavior that the individual should have known to be false, and the individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person. This should be a numeric field.
B. For the time period identified above, provide the number of enrollment/disenrollment grievances received related to Part D. Examples include, but are not limited to, discrimination in the enrollment process, enrollment information and/or identification cards not being received by beneficiaries in a timely manner, and disenrollment requests not being processed in a timely manner. This should be a numeric field.
C. For the time period identified above, provide the number of benefit package grievances received related to Part D. Examples include, but are not limited to, beneficiary cost sharing, pricing co-insurance issues and issues related to coverage during the coverage gap period. This should be a numeric field.
D. For the time period identified above, provide the number of pharmacy access/network grievances received related to Part D. Examples include, but are not limited to, network pharmacy refusing to accept a beneficiary's card and network/non-network pharmacy concerns. This should be a numeric field.

E. For the time period identified above, provide the number of marketing grievances received related to Part D. Examples include, but are not limited to, marketing materials or promotional messages by sales representatives that include misrepresentations or false/misleading information about plans and benefits, and discriminatory practices identified in marketing materials or through oral/written promotional messages. This should be a numeric field.
F. For the time period identified above, provide the number of customer service grievances received related to Part D. Examples include, but are not limited to, grievances regarding services provided by the pharmacist/pharmacy staff, plan or subcontractor representatives, or customer service representatives. This should be a numeric field.
G. For the time period identified above, provide the number of confidentiality/privacy grievances received related to Part D. Examples include, but are not limited to, potential violations of medical information privacy standards by the plan or pharmacy. This should be a numeric field.
H. For the time period identified above, provide the number of quality of care grievances received related to Part D. Examples include, but are not limited to, grievances received from beneficiaries or Quality Improvement Organizations (QIOs) regarding quality of care. This should be a numeric field.
I. For the time period identified above, provide the number of exception grievances received related to Part D. An example of an exception grievance is one which is filed because an enrollee's request to have their coverage determination expedited was denied. This should be a numeric field.
J. For the time period identified above, provide the number of appeal grievances received related to Part D. An example of an appeal grievance is one which is filed because an enrollee's request to have a redetermination expedited was denied. This should be a numeric field.
K. For the time period identified above, provide the number of other grievances received related to Part D not falling into one of the categories described above. This should be a numeric field.
L. For the time period identified above, provide the total number of grievances received related to Part D. This should be a numeric field.

Section V. Pharmacy & Therapeutics (P&T) Committees

In addition to satisfying and maintaining P&T committee requirements described in §423.120, Part D Contracts will be responsible for providing information to CMS relating to changes made during a contract year to their P&T committees on a periodic basis. CMS recognizes the importance of maintaining confidentiality of these records. Additionally, CMS will provide methods other than HPMS data submission for those Part D Contracts with contractual limitations in providing these data.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Contract level:

A. Indicate if there have been changes in P&T committee membership. This will be a selection from a drop-down box.
B. If changes have occurred, indicate if these changes have been reflected within the Contract Management module. For those Contracts operating under confidentiality agreements, indicate if these changes have been sent to CMS per those agreements. This will be a selection from a drop-down box.

Section VI. Transition

As described in §423.120 and other guidance issued by CMS, Part D Contracts must maintain and implement an effective transition process to ensure that beneficiaries transitioning into a Plan are provided a smooth transition to drugs on the formulary. Plans (PBPs) will be responsible for reporting various data elements related to prescriptions dispensed during newly enrolled beneficiaries' transition periods for CMS oversight.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. Total number of beneficiaries who are in transition during the reporting time period. This should be a numeric field.
B. Number of prescriptions authorized during transition periods within the reporting time period. This should be a numeric field.
C. Number of enrollees receiving one or more prescriptions authorized during transition periods within the reporting time period. This should be a numeric field.
D. Number of days per transition period. This should be a numeric field.

Section VII. Exceptions

Title I, Part 423, Subpart D includes regulations regarding formulary and tier exceptions, and exceptions to established drug utilization management programs. Plans (PBPs) that utilize prior authorization or step therapy edits as utilization management tools (including for non-formulary exceptions) will be responsible for reporting several data elements related to these activities.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. Number of pharmacy transactions rejected due to failure to complete step therapy edit requirements in the time period specified above. This should be a numeric field.
B. Number of pharmacy transactions rejected due to need for prior authorization (not including first pass step therapy edits or early refills) in the time period specified above. This should be a numeric field.
C. Number of pharmacy transactions rejected due to quantity limits in the time period specified above. This should be a numeric field.
D. Number of prior authorizations requested for formulary medications in the time period specified above (not including first pass step therapy edits or early refills). This should be a numeric field.
E. Number of prior authorizations approved for formulary medications, of those submitted in the time period specified above (not including first pass step therapy edits or early refills). This should be a numeric field.
F. Number of exceptions requested for non-formulary medications in the time period specified above (not including early refills). This should be a numeric field.
G. Number of exceptions approved for non-formulary medications, of those submitted in the time period specified above (not including early refills). This should be a numeric field.
H. Number of tier exceptions requested in the time period specified above (not including first pass step therapy edits or early refills). This should be a numeric field.
I. Number of tier exceptions approved, of those submitted in the time period specified above (not including first pass step therapy edits or early refills). This should be a numeric field.
J. Number of quantity limit exceptions requested in the time period specified above (not including early refills). This should be a numeric field.
K. Number of quantity limit exceptions approved, of those submitted in the time period specified above (not including early refills). This should be a numeric field.

Section VIII. Appeals

Title I, Part 423, Subpart M includes regulations regarding coverage determinations and appeals under Part D. As defined in §423.560, an appeal is any of the procedures that deal with the review of adverse coverage determinations made by the Plan on the benefits the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage. These procedures include redeterminations by the Plan and reconsiderations by the independent review entity (IRE). Redeterminations or reconsiderations may result in reversal or partial reversal of the original decision.

- Example of a full reversal of an original decision: Non-formulary exception request approved upon redetermination for drug and quantity prescribed.
- Example of a partial reversal of an original decision: Non-formulary exception request approved upon redetermination for drug, but full quantity prescribed is not approved.

CMS will request appeal data as part of the monitoring of a Plan's availability, accessibility, and acceptability of its services.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 29

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. Number of appeals submitted for **standard** redetermination in the time period specified above. This should be a numeric field.
B. Number of appeals submitted for **expedited** redetermination in the time period specified above. This should be a numeric field.
C. Number of appeals submitted for **expedited** redetermination that were granted **expedited** status in the time period specified above. This should be a numeric field.
D. Number of appeals submitted for **standard** redetermination withdrawn by the enrollee in the time period specified above. This should be a numeric field.
E. Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee in the time period specified above. This should be a numeric field.
F. Number of redeterminations in the time period specified above resulting in full reversal of original decision. This should be a numeric field.
G. Number of redeterminations in the time period specified above resulting in partial reversal of original decision. This should be a numeric field.
H. Number of adverse redeterminations in the time period specified above due to insufficient evidence of medical necessity from enrollee's prescribing physician. Examples of insufficient evidence of medical necessity may include, but are not limited to, when the plan does not receive the information, or the information received does not support medical necessity. This should be a numeric field.
I. Number of appeals submitted for IRE reconsideration in the time period specified above due to inability to meet timeframe for **coverage determination**. This should be a numeric field.
J. Number of appeals submitted for IRE reconsideration in the time period specified above due to inability to meet timeframe for **redetermination**. This should be a numeric field.
K. Number of IRE decisions for **standard** reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination. This should be a numeric field.
L. Number of IRE decisions for **standard** reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination. This should be a numeric field.

M. Number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination. This should be a numeric field.
N. Number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination. This should be a numeric field.
O. Number of IRE decisions for **standard** reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination. This should be a numeric field.
P. Number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination. This should be a numeric field.

Section IX. Call Center Measures: Beneficiary Service line and Pharmacy Support line

CMS will suspend reporting by Part D Contracts for the Call center reporting section through 3rd quarter 2007 due to CMS' direct monitoring of Part D call centers. All Part D Contracts are required to continue collection of these data, in the event CMS reinstitutes call center data submission.

Part D Contracts will report several data elements related to customer service center calls related to Part D. This information will be utilized to monitor plan performance. These reporting requirements were designed to provide flexibility around each Part D call center structure. Part D Contracts may choose to submit data at the Part D Sponsor level, Contract level, or Other. Part D Contracts must record in HPMS the level of data provided. CMS understands call centers may be structured at other levels such as call center operational entities that do not fall into Sponsor or Contract relationships, and it therefore may be appropriate in some cases for these call center operation entities to prepare aggregate data for their clients' reporting to CMS. Contracts reporting aggregate data from call center operation entities outside of a Sponsor relationship should record the level of reporting as "Other". It should be noted that call center data will be used for performance monitoring and reporting as submitted to CMS. Part D Contracts, therefore, who submit aggregate data will be considered as providing the equivalent call center services across these contracts.

Also, while call centers may track other metrics such as calls related to medical care, calls related in any matter to Part D should be tracked separately for inclusion in this reporting requirement.

Reporting timeline: Part D Contracts will provide monthly data on a quarterly basis to CMS.

	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**		
Reporting Period	1/1 – 1/31	2/1 – 2/28	3/1 – 3/31	4/1 – 4/30	5/1 – 5/31	6/1 – 6/30	7/1 – 7/31	8/1 – 8/31	9/1 – 9/30	10/1 – 10/31	11/1 – 11/30	12/1 – 12/31
Data due to CMS/HPMS	May 31			August 31			November 30			February 29		

Data elements to be entered into the HPMS at the Part D Sponsor level, Contract level, or Other:

- Level of Reporting:
  ___ Sponsor Level
  ___ Contract level
  ___ Other

- Reporting is based on:
  ___ Part D calls alone (via having a dedicated Part D line or some other way to separate out only calls related to Part D from other calls)
  ___ Combination of calls (incoming and abandoned Part-D related calls are not segregated from other calls)

A. For the time period specified above, provide the total number of inbound Part D connections abandoned to the Beneficiary Service line. This should be a numeric field. For call centers that cannot separate abandoned Part D calls from other calls, the total number of inbound connections abandoned will be reported and also the total number of inbound calls for the customer service center, during the reporting period specified. Calls that end within 5 seconds of being connected should not be included in abandoned call counts.
B. For the time period specified above, provide the total number of inbound Part D connections abandoned to the Pharmacy Support line. This should be a numeric field. For call centers that cannot separate abandoned Part D calls from other calls, the total number of inbound

connections abandoned will be reported and also the total number of inbound calls for the customer service center, during the reporting period specified. Calls that end within 5 seconds of being connected should not be included in abandoned call counts.

C. For the time period specified above, provide the total number of inbound Part D calls to the Beneficiary Service line. This should be a numeric field.
D. For the time period specified above, provide the total number of inbound Part D calls to the Pharmacy Support line. This should be a numeric field.
E. For the time period specified above, provide the average hold time for Part D calls to the Beneficiary Service line. This is defined as the average time spent on hold following the IVR system and before reaching a customer service representative. All calls, including abandoned calls, should be included in this calculation. This should be a numeric field (mm:ss).
F. For the time period specified above, provide the average hold time for Part D calls to the Pharmacy Support line. This is defined as the average time spent on hold following the IVR system and before reaching a customer service representative. All calls, including abandoned calls, should be included in this calculation. This should be a numeric field (mm:ss).
G. For the time period specified above, provide the number of Part D calls to the Beneficiary Service line answered in ≤30 seconds. This should be a numeric field.
H. For the time period specified above, provide the number of Part D calls to the Pharmacy Support line answered in ≤30 seconds. This should be a numeric field.
I. For the time period specified above, provide the average length of calls to the Beneficiary Support line. Length of call is defined as the period of time between call connection and disconnection. All increments of the call should be included, such as time spent navigating the IVR. This should be a numeric field (mm:ss).
J. For the time period specified above, provide the average length of calls to the Pharmacy Support line. Length of call is defined as the period of time between call connection and disconnection. All increments of the call should be included, such as time spent navigating the IVR. This should be a numeric field (mm:ss).

Section X. Overpayment

Part D Contracts will be responsible for reporting data related to overpayments associated with Part D benefits. An overpayment occurs when a Part D Contract erroneously makes a payment in excess of the amount due and payable under the Part D drug benefit. Examples would include overpayments a plan makes to pharmacies, sub-contractors, or PBMs for claims payment. This information is necessary to ensure that overpayments are being identified and recouped appropriately.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 – December 31
Data due to CMS/HPMS	August 31	February 29

Data elements to be entered into the HPMS at the Contract level:

A. For the time period identified above, provide the total overpayment dollars identified to be recouped by the Contract (i.e., any funds recovered from any entity it has overpaid, including, pharmacies, providers, Pharmaceutical Benefit Managers, etc.) This should be a currency field.
B. For the time period identified above, provide the total overpayment dollars recouped by the Contract. This should be a currency field.

Section XI. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions

Part D Contracts will be responsible for reporting multiple data elements related to rebates. These data will be monitored as components of a Part D Contract's operational costs. CMS recognizes the importance of maintaining confidentiality of these records.

Rebates, discounts, and other price concessions will be reported at either the CMS Part D Sponsor or Contract level. Reporting will not be combined by the subcontractor PBM to include multiple Part D Sponsors' data. For example: (1) national Part D sponsors with multiple regional plans contracting independently or through a PBM will report rebates from the level of the national Part D sponsor; (2) regional or local Part D sponsor whether utilizing subcontractor PBM or not report at the Part D sponsor specific level; (3) PBM providing Part D coverage outside of a subcontractor role will report rebates at the PBM level. Rebate information should be summarized for each drug, rolled up to include multiple strengths, package sizes, dosage formulations, or combinations. The quarterly reported totals are not cumulative YTD totals.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	September 30	December 31	March 31	June 30

Data files to be uploaded through the HPMS at the CMS Part D Sponsor or Contract level as specified above. HPMS will provide an option to report "No Data to Report" for Part D Sponsors or Contracts that have no rebate or discount/price concessions data; those contracts will not upload data files.

A. Part D Sponsors/Contracts will provide an Excel file (filename=REBATES_(SPONSORNAME)_(2007Q#).XLS, replacing '(SPONSORNAME)' following the below file layout.

Pharmaceutical Manufacturer Rebate File Record Layout			
Field Name	**Field Type**	**Field Length**	**Field Description**
Manufacturer Name	CHAR REQUIRED	100	For each rebate, provide the contracting manufacturer name. This should be a character field.
Drug Name	CHAR REQUIRED	100	For each rebate, provide the drug name. This should be a character field.
Rebates Received	NUM (CUR) REQUIRED	12	For each unique manufacturer/drug combination, provide the rebate amount received in the reporting period specified. - Limit to 999,999,999,999, no decimals, can be a negative number. - Zero should be entered in the currency fields if no rebate was received in the reporting period specified.
Pending Rebates	NUM (CUR) REQUIRED	12	For each unique manufacturer/brand name combination, provide the rebate amount requested for the reporting period specified but not yet received (if applicable). - Limit to 999,999,999,999, no decimals, can be a negative number - Zero should be entered in the currency fields if no rebate was requested but not received for the reporting period specified.

Pharmaceutical Manufacturer Rebate File Record Layout			
Field Name	**Field Type**	**Field Length**	**Field Description**
Prior Rebates	NUM (CUR) REQUIRED	12	For each unique manufacturer/brand name combination, provide the rebate amount received that is associated with a prior reporting period (if applicable). - Limit to 999,999,999,999, no decimals, can be a negative number - Zero should be entered in the currency fields if no rebate was received that is associated with a prior reporting period.

B. It is expected that the file specified above will summarize most rebate information. However, for all non-rebate discounts, price concessions, or other value adds such as gift-in-kind or other programs (e.g., coupons or disease management programs specific to a Part D Sponsor), Part D Sponsors will provide an additional Excel file (filename=DISCOUNTS_(SPONSORNAME)_(2007Q#).XLS, replacing '(SPONSORNAME)' with the Part D Sponsor's name and '(2007Q#)' with the year and quarter number) following the below file layout.

Discounts and Other Price Concessions File Record Layout			
Field Name	**Field Type**	**Field Length**	**Field Description**
Manufacturer/ Company Name	CHAR REQUIRED	100	List the name of each manufacturer for whom there is an associated discount, price concession, or other value add.
Description	CHAR REQUIRED	250	Describe the discount, price concession, or other value adds.
Value	NUM (CUR) REQUIRED	12	Provide the value of the discount, price concession, or other value adds. •0 is not an allowable value
Justification	CHAR OPTIONAL	4000	For each discount, price concession, or value add, provide a justification for receipt.

Section XII. Long-Term Care (LTC) Rebates

As described in the CMS 2007 Call Letters, Part D Contracts must require disclosure of access/performance rebates or other price concessions received by their long-term care (LTC) network pharmacies designed to or likely to influence or impact utilization of Part D drugs. The term "access/performance rebates" refers to rebates manufacturers provide to pharmacies that are designed to prefer, protect, or maintain that manufacturer's product selection by the pharmacy or to increase the volume of that manufacturer's products that are dispensed by the pharmacy under its formulary (referred to as "moving market share"). As evidence that they are managing and monitoring drug utilization, Part D Contracts must report these data to CMS for oversight. CMS recognizes the importance of maintaining confidentiality of these records.

Access/performance rebates received and reported by pharmacies will be reported at either the CMS Part D Sponsor or Contract level. Data should include rebates received for all Part D drugs, not limited to formulary/covered drugs. Rebate information should be summarized for each drug, rolled up to include multiple strengths, package sizes, dosage formulations, or combinations. The quarterly reported totals are not cumulative YTD totals. CMS reserves the right to request Long-term Care (LTC) rebate information at the NDC level. The NDC level rebate information may be necessary to understand the dosage/route supplied to beneficiaries at the LTC facilities. CMS also expects Part D Contracts to work with LTC pharmacies in cases where additional detailed data are needed to ensure appropriate utilization by Medicare beneficiaries living in LTC facilities.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	September 30	December 31	March 31	June 30

Data files to be uploaded through the HPMS at the Part D Sponsor or Contract level as specified above. HPMS will provide an option to select "No Data to Report" for Part D Sponsors or Contracts that have no long-term care rebates; those contracts will not upload data files.

Part D Sponsors/Contracts will provide an Excel file (filename=REBATES_LTC PHARMACIES_(CONTRACTNAME)_(2007Q#).XLS, replacing '(CONTRACTNAME)' with the Part D Sponsor's name and '(2007Q#)' with the year and quarter number) containing the following fields.

1. LTC Pharmacy Name: Provide the name of the LTC pharmacy for which the listed rebates apply.
2. LTC Pharmacy NCPDP Number: Indicate the contracted LTC pharmacy NCPDP number for which the listed rebates apply. This should be a numeric field.
3. NPI Number: Indicate the contracted LTC pharmacy NPI (National Provider Identifier) number for which the listed rebates apply. This should be a numeric field.
4. Manufacturer name: Provide the contracting manufacturer name. This should be a character field.
5. Drug name: Provide the drug name. This should be a character field.
6. Rebate $ per unit received: Provide the contractual per unit rebates received during the reporting period (cash basis) associated with the listed rebate.
7. Technical notes: Provide any technical notes regarding the LTC pharmacy rebate calculations.

LTC Pharmacy Name	**LTC Pharmacy NCPDP Number**	**NPI Number**	**Manufacturer name**	**Drug name**	**Rebate $ per unit received**	**Technical notes**
Text	Numeric	Numeric	Text	Text	Currency	Text

Section XIII. Licensure and Solvency, Business Transactions and Financial Requirements

Title I, Part 423, Subpart I includes regulations regarding Licensure and Solvency. Part D Contracts and will be responsible for reporting multiple data elements and documentation related to their licensure and solvency and other financial requirements. Direct Contract Employer Group Waiver Plans (Direct EGWPs) will be responsible for reporting multiple data elements and documentation related to their solvency and other financial requirements. Some data will be entered into the HPMS and other information will be mailed directly to CMS. Documentation requirements are listed separately for Part D PDP Contracts and Direct EGWPs. These data will be used to ensure Part D PDP Contracts and Direct EGWPs continue to be fiscally solvent entities.

Additionally, all Part D Contracts will enter PBM information into the HPMS on a quarterly basis.

- Subsection 1. Financial and Solvency Requirements Documentation - Part D PDPs
- Subsection 2. Financial and Solvency Requirements Documentation – Direct EGWPs
- Subsection 3. Financial and Solvency Requirements HPMS data– Part D PDPs and Direct EGWPs
- Subsection 4. Performance of Part D Activities HPMS data – MA-PDs, PDPs, and Direct EGWPs

Reporting timeline:

	Quarter 1 YTD	Quarter 2 YTD	Quarter 3 YTD	Annual
Reporting Period	January 1 - March 31	January 1 - June 30	January 1 - September 30	January 1 - December 31
Data due to CMS/HPMS	May 15	August 15	November 15	120 days after the end of the calendar year or within 10 days of the receipt of the Annual Audited F/S whichever is earlier.

I. Financial and Solvency Requirements Documentation for Part D PDP Contracts:

A. According to the quarterly time periods specified above, Part D PDP Contracts that are licensed will mail the following completed Health Blank form pages directly to CMS:
   - Jurat
   - Assets
   - Liabilities, Capital and Surplus
   - Statement of Revenue and Expenses
   - Capital and Surplus Account
   - Cash Flow

   Note: CMS will accept a copy of the Health Blank form submitted to the state in its entirety.

B. According to the quarterly time periods specified above, non-licensed Part D PDP Contracts will mail un-audited financial statements, which convey the same information contained in the Health Blank form, directly to CMS. An alternative for non-licensed Part D PDP Contracts would be to complete the Health Blank pages as prescribed in A. above.

C. According to the quarterly time periods specified above, non-licensed Part D PDP Contracts will mail documentation showing that an insolvency deposit of $100,000 is being held in accordance with CMS requirements by a qualified financial institution.

D. According to the quarterly time periods specified above, Part D PDP Contracts not licensed in any state must submit documentation that demonstrates they possess the allowable sources of funding to cover projected losses for the greater of 7.5% of the aggregated projected target amount for a given year or resources to cover 100% of any projected losses in a given year. This documentation should include a worksheet indicating how they arrived at the aggregated

projected target amount and a pro-forma income statement that includes enrollment projections through the remainder of the period. Guarantees, letters of credit and other documents essential to demonstrating that the funding for projected losses requirement has been met must also be included.

E. All Part D PDP Contracts will mail a copy of their independently audited financial statements (which are statutory based or GAAP based) with a management letter within one hundred twenty days following their fiscal year end or within 10 days of receipt of those statements, whichever is earlier directly to CMS.
F. All Part D PDP Contracts will mail a copy of an Actuarial Opinion by a qualified actuary within one hundred twenty days following their fiscal year end directly to CMS. The opinion should address the assumptions and methods used in determining loss revenues, actuarial liabilities, and related items.
G. Part D PDP Contracts with any state licensure waivers, must submit an update on the status of obtaining licensure for each waived state.
H. Each Part D sponsor must report to CMS annually, within 120 days of the end of the fiscal year, significant business transactions, as defined in § 423.501, between the Part D sponsor and a party in interest, as defined in § 423.501.
    1) Documentation submitted should include the following:
    2) A description of the transaction or transactions taking place with the party in interest.
    3) Identification of the party in interest and an explanation of how that party meets the definition of a party in interest.
    4) The costs incurred during the fiscal year relating to the transactions between the party in interest and the Part D sponsor and what those costs would have been if incurred at fair market value. If the costs incurred exceed fair market value, provide an explanation justifying that the costs are consistent with prudent management and fiscal soundness requirements.
    5) Combined financial statements for the Part D plan sponsor and a party in interest if 35% or more of the costs of operation of the Part D sponsor go to a party in interest, or 35% or more of the revenue of a party in interest is from the Part D sponsor.

Part D PDP Contracts' Documentation should be mailed to the following address:
Centers for Medicare & Medicaid Services
Attn: Part D Licensure & Solvency
Mail Stop C1-25-04
7500 Security Boulevard
Windsor Mill, Maryland 21244

II. Financial and Solvency Requirements Documentation for Direct EGWPs:

A. According to the quarterly time periods specified above, Direct EGWPs will mail un-audited financial statements directly to CMS.
B. According to the quarterly time periods specified above, Direct EGWPs will mail documentation showing that an insolvency deposit of $100,000 is being held in accordance with CMS requirements by a qualified financial institution (unless CMS waived this requirement in writing with respect to the sponsor).
C. Direct EGWPs will mail a copy of their independently audited financial with a management letter within one hundred twenty days following their fiscal year end or within 10 days of receipt of those statements, whichever is earlier directly to CMS.
D. All Direct EGWPs will mail a copy of their credit rating (or, if they have no credit rating, a Dun & Bradstreet report) on a quarterly basis directly to CMS as follows:

For Quarter 1:	May 15th
For Quarter 2:	Aug. 15th
For Quarter 3:	Nov. 15th
For Quarter 4:	Feb. 15th

E. All Direct EGWPs will mail an ERISA Sec. 411(a) attestation directly to CMS by February 15th. See *2007 Solicitation for Application for Employer/Union Direct Contract PDPs, Appendix VI, Sec. E.4* for explanation of this attestation.

Direct EGWPs' Documentation should be mailed to the following address:
Centers for Medicare & Medicaid Services
Attn: Financial Solvency Reporting
Mail Stop C1-22-06
7500 Security Boulevard
Windsor Mill, Maryland 21244

III. Financial and Solvency Requirements data elements to be entered into HPMS – For Part D PDP Contracts / Direct EGWP Sponsors:

Data to be entered at the Part D Contract level per NAIC #. Each Contract-NAIC# entity will be listed under each contract.

A. Total assets as of the end of the quarterly reporting period identified above. This should be a currency field.
B. Total liabilities as of the end of the quarterly reporting period identified above. This should be a currency field.
C. Total cash as of the end of the quarterly reporting period identified above. This should be a currency field.
D. Total cash equivalents as of the end of the reporting period identified above. This should be a currency field.
E. Total current assets as of the end of the quarterly reporting period identified above. This should be a currency field.
F. Total current liabilities as of the end of the quarterly reporting period identified above. This should be a currency field.
G. Total revenue as of the end of the quarterly reporting period identified above. This should be a currency field.
H. Total expenses as of the end of the quarterly reporting period identified above. This should be a currency field.
I. Total administrative expense as of the end of the quarterly reporting period identified above. This should be a currency field. *NOTE: Direct EGWPs are waived from this element*
J. Total net income as of the end of the quarterly reporting period identified above. This should be a currency field.
K. Drug benefit expenses (excluding administrative expenses) as of the end of the quarterly reporting time period. Drug benefit expenses are paid claims costs which would be comprised of negotiated costs and dispensing fees less member share. This should be a currency field.
L. Drug benefit revenues as of the end of the quarterly reporting period. Drug benefit revenues would include premiums, CMS subsidies, rebates and other reinsurance. This should be a currency field.

IV. Performance of Part D Activities data elements to be entered into HPMS – For All Part D Contracts (including MA-PDs, PDPs, and Direct EGWPs)

Data to be entered at the Part D Contract level:

A. Indicate if there have been changes to this information. This will be a selection from a drop-down box.
B. If changes have occurred, indicate if these changes have been reflected within the Contract Management module.

Section XIV. Drug benefit analyses

Part D Contracts must provide enrollees with coverage of benefits as described within §423.104. For the purposes of CMS review, Plans (PBPs) will be required to report multiple data elements related to their provision of Part D benefits. HPMS will display each Plan's benefit design for integration with the data reported by Part D Contracts. If a Plan does not have a coverage gap, the Plan should list the number of people who are pre-catastrophic in the data element B field, and then indicate zero in the data element C field.

Reporting timeline: Part D Contracts will provide monthly data on a quarterly basis to CMS.

	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**		
Reporting Period	1/1 – 1/31	2/1 – 2/28	3/1 – 3/31	4/1 – 4/30	5/1 – 5/31	6/1 – 6/30	7/1 – 7/31	8/1 – 8/31	9/1 – 9/30	10/1 – 10/31	11/1 – 11/30	12/1 – 12/31
Data due to CMS/HPMS	May 31			August 31			November 30			February 29		

Data elements to be entered into the HPMS at the Plan (PBP) level:

A. HPMS will display each Plan's benefit design (e.g. defined standard, enhanced alternative)
B. Provide the total number of non-LIS enrollees in the pre-initial coverage limit phase as of the last day of the month. (If a Plan does not have a coverage gap, the Plan should list the number of people who are pre-catastrophic in this field, and then indicate zero in the data element C.) This should be a numeric field.
C. Provide the total number of non-LIS enrollees in the coverage gap as of the last day of the month. (If a Plan does not have a coverage gap, the Plan should list the number of people who are pre-catastrophic in data element B, and then indicate zero in this field.) This should be a numeric field.
D. Provide the total number of non-LIS enrollees in the catastrophic coverage level as of the last day of the month. This should be a numeric field.

Table 1. Summary of Reporting Elements

Note: this summary table is for quick reference use only. Please refer to the respective detailed sections for full definitions, timelines, reporting level, and submission procedures.

Section	Element	Format	Frequency	HPMS
Reversals	Total number of out-of-cycle pharmacy transactions with reversal as the final disposition	Numeric	Quarterly	Yes
Medication Therapy Management Programs (MTMP)	The method used to enroll beneficiaries into the MTMP	Text	Semi-annually	Yes
	Number of beneficiaries who met the eligibility criteria for the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who participated in the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who discontinued participation from the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who discontinued participation from the MTMP due to death	Numeric	Semi-annually	Yes
	Number of beneficiaries who discontinued participation from the MTMP due to disenrollment from the Contract	Numeric	Semi-annually	Yes
	Number of beneficiaries who discontinued participation from the MTMP at their request	Numeric	Semi-annually	Yes
	Number of beneficiaries who declined to participate in the MTMP	Numeric	Semi-annually	Yes
	Prescription cost of all medications for all beneficiaries participating in the MTMP (as of the last day of the reporting period specified) on a per MTMP beneficiary per month basis	Currency	Semi-annually	Yes
	Number of covered Part D 30-day equivalent prescriptions on a per MTMP beneficiary per month basis	Numeric	Semi-annually	Yes
Generic Dispensing Rate	Number of paid claims for generic drugs	Numeric	Quarterly	Yes
	Total number of paid claims	Numeric	Quarterly	Yes
Grievances	Number of fraud and abuse grievances received	Numeric	Quarterly	Yes
	Number of enrollment/disenrollment grievances received	Numeric	Quarterly	Yes
	Number of benefit package grievances received	Numeric	Quarterly	Yes
	Number of pharmacy access/network grievances received	Numeric	Quarterly	Yes
	Number of marketing grievances received	Numeric	Quarterly	Yes
	Number of customer service grievances received	Numeric	Quarterly	Yes
	Number of confidentiality/privacy grievances received	Numeric	Quarterly	Yes
	Number of quality of care grievances received	Numeric	Quarterly	Yes
	Number of exception grievances received	Numeric	Quarterly	Yes
	Number of appeal grievances received	Numeric	Quarterly	Yes
	Number of other grievances received	Numeric	Quarterly	Yes
	Total number of grievances	Numeric	Quarterly	Yes

Pharmacy & Therapeutics Committees	Indicate if changes in P&T Committee membership.	Text	Quarterly	Yes
	If changes, indicate if these are reflected within Contract Management module.	Text	Quarterly	Yes
Transition	Number of newly enrolled beneficiaries	Numeric	Quarterly	Yes
	Number of prescriptions authorized during transition periods	Numeric	Quarterly	Yes
	Number of enrollees receiving one or more prescriptions authorized during transition periods	Numeric	Quarterly	Yes
	Number of days per transition period. This should be a numeric field.	Numeric	Quarterly	Yes
Exceptions	Number of pharmacy transactions rejected due to failure to complete step edit requirements	Numeric	Quarterly	Yes
	Number of pharmacy transactions rejected due to need for prior authorization (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of pharmacy transactions rejected due to quantity limits in the time period specified above.	Numeric	Quarterly	Yes
	Number of prior authorizations requested for formulary medications (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for formulary medications (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of exceptions requested for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of exceptions approved for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of exceptions requested for tier exceptions (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of exceptions approved for tier exceptions (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of exceptions requested for quantity limits (not including early refills)	Numeric	Quarterly	Yes
	Number of exceptions approved for quantity limits (not including early refills)	Numeric	Quarterly	Yes
Appeals	Number of appeals submitted for **standard** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination that were granted **expedited** status	Numeric	Quarterly	Yes
	Number of appeals submitted for **standard** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of redeterminations resulting in full reversal of original decision	Numeric	Quarterly	Yes
	Number of redeterminations resulting in partial reversal of original decision	Numeric	Quarterly	Yes
	Number of adverse redeterminations due to insufficient evidence of medical necessity from enrollee's prescribing physician	Numeric	Quarterly	Yes

	Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **coverage determination**	Numeric	Quarterly	Yes
	Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **redetermination**	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in full reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in partial reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in full reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in partial reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes
Call Center Measures: Beneficiary Service line and Pharmacy Support line	Level of reporting	Text	Quarterly	Yes
	Type of line for reporting basis	Text	Quarterly	Yes
	Total number of inbound Part D connections abandoned to the Beneficiary Service line	Numeric	Quarterly	Yes
	Total number of inbound Part D connections abandoned to the Pharmacy Support line	Numeric	Quarterly	Yes
	Total number of inbound Part D calls to the Beneficiary Service line	Numeric	Quarterly	Yes
	Total number of inbound Part D calls to the Pharmacy Support line	Numeric	Quarterly	Yes
	Average hold time for Part D calls to the Beneficiary Service line	Numeric	Quarterly	Yes
	Average hold time for Part D calls to the Pharmacy Support line	Numeric	Quarterly	Yes
	Number of Part D calls to the Beneficiary Service line answered in ≤30 seconds	Numeric	Quarterly	Yes
	Number of Part D calls to the Pharmacy Support line answered in ≤30 seconds	Numeric	Quarterly	Yes
	Average length of calls to the Beneficiary Service line	Numeric	Quarterly	Yes
	Average length of calls to the Pharmacy Support line	Numeric	Quarterly	Yes
Overpayment	Total overpayment dollars identified to be recouped	Currency	Semi-Annually	Yes
	Total overpayment dollars recouped	Currency	Semi-Annually	Yes
Pharmaceutical Rebates, Discounts, and Other Price Concessions	REBATES_(SPONSORNAME)_(2007Q#).XLS	MS Excel	Quarterly	Yes
	DISCOUNTS_(SPONSORNAME)_(2007Q#).XLS	MS Excel	Quarterly	Yes

Long-term Care (LTC) Rebates	REBATES_LTCPHARMACIES_(SPONSORNAME)_(2007Q#).XLS	MS Excel	Quarterly	Yes
Licensure and Solvency, Business Transactions and Financial Requirements	Licensed Part D PDP Contracts will submit Completed Health Blank form pages: Jurat, Assets, Liabilities, Capital and Surplus, Statement of Revenue and Expenses, Capital and Surplus Account, and Cash Flow OR Non-licensed Part D PDP Contracts will submit un-audited financial statements	Mailed to CMS	Quarterly	No
	Documentation showing that an insolvency deposit of $100,000 is being held (for non-licensed Part D PDP Contracts and Direct EGWPs)	Mailed to CMS	Quarterly	No
	Funding for projected losses worksheet (for non-licensed Part D PDP Contracts only)	Mailed to CMS	Quarterly	No
	Independently audited financial statement with a management letter for Part D PDPs and Direct EGWPs	Mailed to CMS	Yearly (fiscal)	No
	Copy of an Actuarial Opinion by a qualified actuary for the Part D PDP	Mailed to CMS	Yearly (fiscal)	No
	Documentation on the status of obtaining licensure for each waived state (for Part D PDP Contracts with any state licensure waivers only)	Mailed to CMS	Quarterly	No
	Documentation of significant business transactions	Mailed to CMS	Yearly (fiscal)	No
	Un-audited financial statements for Direct EGWPs	Mailed to CMS	Quarterly	No
	Copy of credit rating for Direct EGWPs	Mailed to CMS	Quarterly	No
	ERISA Sec. 411(a) attestation for Direct EGWPs	Mailed to CMS	Yearly	No
	Total assets	Currency	Quarterly	Yes
	Total liabilities	Currency	Quarterly	Yes
	Total cash	Currency	Quarterly	Yes
	Total cash equivalents	Currency	Quarterly	Yes
	Total current assets	Currency	Quarterly	Yes
	Total current liabilities	Currency	Quarterly	Yes
	Total revenue	Currency	Quarterly	Yes
	Total expenses	Currency	Quarterly	Yes
	Total administrative expense	Currency	Quarterly	Yes
	Total net income	Currency	Quarterly	Yes
	Drug benefit expenses (excluding administrative expenses)	Currency	Quarterly	Yes
	Drug benefit revenues	Currency	Quarterly	Yes
	Indicate if changes have occurred in entities performing Part D activities.	Text	Quarterly	Yes
	If changes, indicate if these are reflected within Contract Management module.	Text	Quarterly	Yes
Part D Benefit Analyses	Number of enrollees in the pre-initial coverage limit phase	Numeric	Quarterly	Yes
	Number of enrollees in the coverage gap	Numeric	Quarterly	Yes
	Number of enrollees in the catastrophic coverage level	Numeric	Quarterly	Yes

Table 2: Changes made from CY 2006 Reporting Requirements

Reporting Requirements Section	Changes
Enrollment/Disenrollment	This section has been deleted.
Reversals	This section can now be reported at the Part D Contract or Plan (PBP) level
Medication Therapy Management Programs	Data element revised: • The prescription cost of all covered Part D medications on a per MTMP beneficiary per month basis. Data elements added: • The method used to enroll beneficiaries into the MTMP. • The number of beneficiaries who discontinued participation from the MTMP due to death at any time during the specified time period above. • The number of beneficiaries who discontinued participation from the MTMP due to disenrollment from the Plan at any time during the specified time period above. • The number of beneficiaries who discontinued participation from the MTMP at their request at any time during the specified time period above. • The number of covered Part D 30-day equivalent prescriptions per MTMP beneficiary per month.
Generic Dispensing Rate	No changes made to this reporting section
Grievances	Data elements added: • Number of quality of care grievances received related to Part D. • Number of exception grievances received related to Part D. • Number of appeal grievances received related to Part D. • Total number of grievances received related to Part D.
Pharmacy & Therapeutics (P&T) Committees	New reporting section added for 2007
Transition	New reporting section for 2007
Exceptions	This reporting section was renamed Exceptions, previously titled as Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions Data elements added: • Number of pharmacy transactions rejected due to quantity limits • Number of quantity limit exceptions requested • Number of quantity limit exceptions approved
Appeals	Data elements added: • Number of redeterminations resulting in partial reversal of original decision. • Number of adverse redeterminations due to insufficient evidence of medical necessity from enrollee's prescribing physician. • Number of IRE decisions for standard reconsideration resulting in partial reversal of original coverage determination or redetermination. • Number of IRE decisions for expedited reconsideration resulting in partial reversal of original coverage determination or redetermination.
Call Center Measures: Beneficiary Service line and Pharmacy Support line	• Announcement of suspension of the Call Center reporting requirement through 3rd quarter 2007. • Data elements added for monitoring of Pharmacy Support line

Reporting Requirements Section	Changes
	• Provision of monthly data on a quarterly basis • This section can now be reported at the Part D Sponsor level, Contract level, or Other <u>Data element removed</u> • Average speed of answer for Part D calls <u>Data elements added:</u> • Average length of calls to the Beneficiary Support line. • Average length of calls to the Pharmacy Support line.
Overpayment	This section can now be reported at the Contract level.
Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions	This section can now be reported at the Contract level as well as the Part D Sponsor
Long-term Care (LTC) Rebates	New Reporting Section for 2007
Licensure and Solvency, Business Transactions and Financial Requirements Subsection 1: Financial and Solvency Requirements Documentation for Part D PDP Contracts; Subsection 2: Financial and Solvency Requirements Documentation for Direct EGWPs; Subsection 3: Financial and Solvency Requirements HPMS Data elements for Part D PDPs and Direct EGWPs; Subsection 4: Performance of Part D Activities HPMS Data elements for all Part D Contracts (including MA-PDs, PDPs, and Direct EGWPs)	• Subsection 1 lists documentation required for Part D PDP contracts. • Three documentation requirements added to subsection 1: o Pro-forma income statement that includes enrollment projections through the remainder of the period. o For PDP contracts with any state licensure waivers, submission of updates on the status of obtaining licensure for each waived state. o Documentation of significant business transactions. • Subsection 2 lists documentation required for direct EGWPs. • Subsection 3 lists HPMS data elements required for Part D PDPs and direct EGWPs. Data will be reported at the Part D Contract level per NAIC #. • Subsection 4 – New Reporting Section for 2007.
Drug benefit analyses	New Reporting Section for 2007