Prescription Drug Data Collection (RxDC)

Frequently Asked Questions

September 23, 2022

May multiple reporting entities submit the same data file type for the same plan or issuer?

As noted in the Section 3.4 of the RxDC reporting instructions, plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS is complete. If one reporting entity is responsible for only some fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before the data file is submitted in HIOS.

Section 3.4 instructs reporting entities to contact the CMS help desk at CMS_FEPS@cms.hhs.gov if there are extenuating circumstances that prevent vendors from working together to submit a unique file for each data file type.

If there are extenuating circumstances that prevent vendors from working with each other, the vendors should follow the RxDC reporting instructions to prepare and submit independent RxDC reports. Below are examples of plan list files when multiple vendors submit the same data file type on behalf of the same plan, issuer, or carrier.

Example1:ChangeinVendorswithinaReferenceYear

Suppose Plan A is a self-funded plan administered by TPA A, the plan switches PBMs from PBM A to PBM B on April 15, 2020, and the PBMs are unable to share information. In this case, both PBMs may submit the same data file type for the plan. In this example, assume that TPA A is submitting D1 and D2 and is responsible for reporting the actual plan year beginning and end dates, states in which the coverage is offered, and the number of members as of 12/31 of the reference year.

To help CMS reconcile submissions, PBM A should enter 01/01/2020 and 04/14/2020 in the fields labeled Plan Year Beginning Date and Plan Year End Date, respectively. Similarly, PBM B should enter 04/15/2020 and 12/31/2020 in the fields labeled Plan Year Beginning Date and Plan Year End Date, respectively.

PBM A's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan A	…	01/01/2020	04/14/2020	…	TPA A	PBM A	…	0	0	1	…	1

PBM B's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan A	…	04/15/2020	12/31/2020	…	TPA A	PBM B		0	0	1	…	1

If Plan A's plan year is the calendar year, TPA A should fill out P2 as follows:

TPA A's P2 file for the 2020 reference year - plan year is a calendar year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan A	…	01/01/2020	12/31/2020	…	TPA A	PBM A; PBM B		1	1	0	…	0

If Plan A's plan year is not the calendar year, TPA A should follow the instructions in Section 4.1 of the RxDC reporting instructions for non-calendar plan years. For example, if Plan A's plan year begins on July 1, 2020, TPA A should fill out P2 as follows:

TPA A's P2 file for the 2020 reference year - plan year is NOT the calendar year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan A	…	07/01/2019	06/30/2020	…	TPA A	PBM A; PBM B		1	1	0	…	0
Plan A	…	07/01/2020	06/30/2021		TPA A	PBM B		1	1	0		0

Example 2: Multiple Vendors for Pharmacy Benefits

Suppose Plan B is insured by Issuer A and uses PBM C for specialty drugs and PBM D for non-specialty drugs. Suppose also that Plan B's plan year is the calendar year and that Issuer A is submitting D1 and D2 and is responsible for reporting the actual plan year beginning and end dates, states in which the plan is offered, and the number of members as of 12/31 of the reference year in P2. To assist CMS with reconciliation, Issuer A, PBM C, and PBM D should fill out P2 as follows:

PBM C's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan B	…	01/01/2020	12/31/2020	…	PBM C	…	0	0	1	…	1

PBM D's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	PBM Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	Included in D3? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan B	…	01/01/2020	12/31/2020	…	PBM D		0	0	1	…	1

Example 3: Multiple Vendors for Medical Benefits

Suppose Plan C uses TPA A for behavioral health services and TPA B for other medical benefits. Assume Plan C's plan year is a calendar year and both TPAs will submit D1 and D2.

TPA A's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan C	…	01/01/2020	12/31/2020	…	TPA A; TPA B	…	1	1	…	0

TPA B's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan C	…	01/01/2020	12/31/2020	…	TPA A; TPA B		1	1	…	0

For TPA A and TPA B to include the information of both TPAs in the TPA fields in their respective P2 files, Plan C needs to provide each TPA with the name and EIN of the other TPA. If Plan C does not provide this information to the TPAs, then Plan C needs to submit a P2 file in HIOS to alert CMS that two different TPAs are submitting the same data file type on its behalf. (**Note**: A reporting entity can submit a plan list in HIOS without submitting a data file, but it is not possible to submit a data file in HIOS without submitting a plan list.)

Plan C's P2 file (if Plan C does not provide its TPAs with each other's name and EIN)

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	TPA Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan C	…	01/01/2020	12/31/2020	…	TPA A; TPA B		0	0	…	0

Example 4: Different Vendors for Different Provider Networks

Suppose Issuer A covers Plan D's in-network claims and Issuer B covers Plan D's out-of-network claims Suppose Issuer A and Issuer B are unaffiliated and that Plan D's plan year is the calendar year. Follow the same instructions given in the example for multiple vendors for medical benefits (Example 4.3).

Issuer A's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	Issuer Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan D	…	01/01/2020	12/31/2020	…	Issuer A; Issuer B	…	1	1	…	0

Issuer B's P2 file for the 2020 reference year

Group Health Plan Name	…	Plan Year Beginning Date	Plan Year End Date	…	Issuer Name	…	Included in D1? (1= Yes; 0 = No)	Included in D2? (1= Yes; 0 = No)	…	Included in D8? (1= Yes; 0 = No)
Plan D	…	01/01/2020	12/31/2020	…	Issuer A; Issuer B		1	1	…	0

As noted in the example for multiple vendors for medical benefits, Plan D will need to provide Issuers A and B with each other's name and EIN, or submit its own P2 file in HIOS showing the name and EIN of both issuers.

Example 5: Employer offers multiple benefit packages, each with their own vendor

Suppose Plan E offers Benefit Package X through Issuer A and Benefit Package Y through Issuer B. Assume that Issuer A will submit information on Benefit Package X and Issuer B will submit information on Benefit Package Y. To help CMS reconcile submissions, Issuer A and Issuer B should use different plan names and plan numbers for different benefit packages. For example, they may add a modifier to the plan number, as demonstrated below.

Issuer A's P2 file for the 2020 reference year

Group Health Plan Name	Group Health Plan Number	…	Plan Year Beginning Date	Plan Year End Date	…	Issuer Name	…	Included in D2? (1= Yes; 0 = No)	…
Plan E's Benefit Package X	987-01	…	01/01/2020	12/31/2020	…	Issuer A	…	1	…

Issuer B's P2 file for the 2020 reference year

Group Health Plan Name	Group Health Plan Number	…	Plan Year Beginning Date	Plan Year End Date	…	Issuer Name	…	Included in D2? (1= Yes; 0 = No)	…
Plan E's Benefit Package Y	987-02	…	01/01/2020	12/31/2020	…	Issuer B		1	…

If Issuer A and Issuer B do not use different group health plan names and numbers for the different benefit packages, then at least one reporting entity's P2 file should include information of both issuers in the Issuer Name and Issuer EIN fields, respectively. For example, Plan E could submit a P2 file as follows:

Plan E's P2 file for the 2020 reference year (Only necessary if Issuer A and Issuer B use the same group health plan name and group health plan number for different benefit packages.)

Group Health Plan Name	Group Health Plan Number	…	Plan Year Beginning Date	Plan Year End Date	…	Issuer Name	…	Included in D2? (1= Yes; 0 = No)	…
Plan E	987	…	01/01/2020	12/31/2020	…	Issuer A; Issuer B		0	…

In this example, if Plan E doesn't ensure that Issuers A and B use different group health plan names and numbers for the different benefit packages, and Plan E also doesn't ensure that CMS receives a P2 file demonstrating that Plan E has multiple issuers, CMS would need to follow-up with the reporting entities to determine whether duplicate data has been submitted.