Prescription Drug Event (PDE) Common Issues and Best Practices Computer Based Training (CBT) Text-Only Version

1. Introduction Module

1.1 Introduction

Welcome to the Prescription Drug Event Common Issues and Best Practices Computer Based Training. The purpose of this course is to provide plans with best practices to common issues surrounding Prescription Drug Event, or PDE, reporting for Medicare-Medicaid Plans and PDE reporting for Medicare Secondary Payer situations.

1.2 Learning Objectives

By the end of this course, participants should be able to:

Summarize background and guidance related to PDE Reporting in the Medicare Part D Prescription Drug Event Program, Medicare-Medicaid Plans or (MMPs) and Medicare Secondary Payer (MSP) situations, identify guidance as best practices to avoid common issues, identify helpful tips and examples to properly implement guidance, and apply knowledge to complete assessment questions.

2. Medicare-Medicaid Plans (MMP) Module

2.1 Overview

The MMP section is broken into the following topics: Background, Guidance, Tips, an Example, and Assessment Questions.

2.2 Background

Let's review some of the requirements and payment mechanisms for MMPs. MMPs are required to submit Prescription Drug Event records to CMS for Medicare Part D covered drugs. We will discuss the four payment mechanisms CMS uses to pay plans for Part D basic benefits implemented by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which is also known as the MMA: direct subsidy, low-income subsidy, risk sharing, and reinsurance subsidy.

Direct Subsidy

The direct subsidy is designed, together with beneficiary premiums, to cover the plan's cost for the risk portion of the basic benefit. The plan's standardized bid is designed to cover a certain percentage of drug costs as well as administrative costs that include the plan's estimate of gain or loss. The direct subsidy is a capitated per member per month risk payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment score, minus the monthly beneficiary premium related to the standardized bid amount. As MMPs do not submit standardized bids, the direct subsidy will be based not on a bid

submitted by each plan, but on the standardized national average monthly bid amount (NAMBA). The NAMBA will be risk adjusted according to the same rules that apply to all other Part D plans.

Reinsurance Subsidy

Reinsurance reduces the risk of participating in Part D by guaranteeing plans a certain amount of payment for beneficiaries with high drug costs. The reinsurance subsidy is a federal subsidy for 80 percent of allowable drug costs above the out-of-pocket (OOP) threshold, net of any other remuneration (e.g., rebates, coupons, discounts collectively referred to as direct and indirect remuneration or DIR). The reinsurance subsidy is subject to cost-based reconciliation.

Low-Income Subsidy

The MMA provides two types of subsidies for qualifying low-income beneficiaries: premium assistance and cost-sharing assistance. Low-income premium subsidies are part of the risk payment that results from the standardized bid. The government also issues cost-sharing subsidies that are not included in the standardized bid amount and are separate government payments on behalf of certain beneficiaries based on their income and asset levels. When applicable, this low-income cost-sharing subsidy (LICS) applies to each prescription drug event and is subject to year-end cost-based reconciliation. MMPs may implement further reduction of the LIS cost-sharing amount to an amount less than the LIS statutory maximum.

Risk Sharing

The purpose of risk sharing is to limit a plan's exposure to unexpected expenses not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits or losses resulting from expenses for the basic benefit within defined symmetrical risk corridors around a target amount. Risk sharing payment is also referred to as risk corridor payment and can be positive, negative, or zero.

2.3 Background (continued)

Financial Alignment Demonstrations

In July 2011, CMS issued guidance to State Medicaid Directors on opportunities to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for individuals enrolled in both programs (also referred to as "Medicare-Medicaid enrollees" or "dual eligibles"). Financial Alignment Demonstrations took the form of either a capitated arrangement using Medicare-Medicaid Plans or a managed fee-for-service arrangement.

2.4 Guidance

For MMPs, CMS offers States a waiver of the requirement that cost-sharing for non-institutionalized individuals eligible for Low-Income Subsidy or LIS be greater than $0.00, allowing reduced Part D cost-sharing levels below the requirement.

MMPs that choose to reduce cost-sharing under the waiver may fund the difference between the statutory LIS cost-sharing amount and the reduced cost-sharing amount out of the Part D direct subsidy payment, and will not be required to forego the low-income cost-sharing subsidy (LICS) that reimburses plans for the difference between the defined standard benefit's cost-sharing amount and the LIS statutory copayment amounts.

2.5 Tips

A Medicare-Medicaid Plan may reduce cost-sharing for an LIS beneficiary beyond the LIS cost-sharing statutory maximum after the Covered Plan Paid (CPP) and Low Income Cost-Sharing Subsidy (LICS) are calculated and reported on the PDE record. The difference between the LIS Cost-Sharing amount and the reduced patient pay amount is reported on the PDE as Non-Covered Plan Paid Amount (NPP).

2.6 Scenario

Let's look at two examples of MMP plans: one that does not have a reduction in the beneficiary's cost-sharing, and one that does. First, we will walk through an example of a Level 1 beneficiary without a reduction in beneficiary cost-sharing, and then we will see what happens when the reduction is applied.

In 2016, an LIS level 1 beneficiary purchases a $100.00 brand covered drug while in the Deductible phase. The beneficiary is in a Medicare-Medicaid Enhanced Alternative plan. The LICS Level 1 copay is $2.95 for generics and $7.40 for brand drugs. The Total Gross Covered Drug Cost (TGCDC) Accumulator and Total Out-of-Pocket (TrOOP) Accumulator are both $200.00 when the claim is filled. The MMP charges LIS beneficiary cost-sharing to meet the defined standard and LICS parameters and there is no MME/MMP reduction applied.

2.7 Calculating and Reporting Steps

Before starting the calculations, examine the five steps required when MMPs offer a cost-sharing reduction beyond the Low-Income Subsidy or LIS statutory cost-sharing maximum.

In Step 1, calculate both amounts as though the beneficiary were not eligible for LIS and had no other source of coverage. Cost-sharing and plan payment amounts often vary per benefit phase. Plans must apply Year-to-Date (YTD) Gross Covered Drug Costs and incurred True Out-of-Pocket (TrOOP) costs to the plans' benefit structure to determine the beneficiary's benefit phase. In Step 2, determine the LIS beneficiary's statutory maximum cost-sharing amount that corresponds to the category of assistance for which the beneficiary is eligible.

In Step 3, compare the amount of non-LIS cost-sharing to the amount of LIS statutory maximum cost-sharing. The lesser of these two amounts is the beneficiary liability, reported in the Patient Pay Amount Field, and is a contributor to TrOOP.

In Step 4, apply the LICS Amount Formula. The amount calculated represents the amount of subsidy advanced by the plan at the point-of-sale (POS), is reported as the LICS Amount on the PDE record, and is a contributor to TrOOP.

In Step 5, after CPP and LICS are calculated on the PDE, the MMP can reduce the cost-sharing for an LIS beneficiary beyond the LIS cost-sharing statutory maximum. The Patient Pay Amount is thus reduced. The difference between the original Patient Pay Amount and the reduced Patient Pay Amount is reported in NPP on the PDE Record.

It is important to remember that the plans will not be reimbursed for the difference between the statutory LIS cost-sharing amounts and the reduced cost-sharing amounts.

2.8 Step 1: Calculate the Non-LI Beneficiary's Cost-Sharing

Since the beneficiary is in the deductible, the non-LIS cost-sharing is calculated as $100.00. The Covered Plan Paid Amount or CPP reported on the PDE is $0.00.

2.9 Step 2: Determine Maximum LIS Cost-Sharing

According to the 2016 parameters, the Maximum Level 1 LIS Cost-Sharing equals $7.40.

2.10 Step 3: Lesser Than Test

The Maximum Level 1 LIS Cost-Sharing of $7.40 is less than the Non-LIS Cost-Sharing of $100.00. Therefore, the Preliminary Beneficiary Cost-Sharing is $7.40.

2.11 Step 4: Calculate Low-Income Cost-Sharing

The difference between the Non-LI Cost-sharing and LIS Cost-sharing is $100.00 minus $7.40, which is $92.60. Therefore, $92.60 is reported as Low-Income Cost-Sharing or LICS on the PDE record.

2.12 Step 5: Calculate Non-Covered Plan Paid Amount

Step 5 does not apply since the plan did not reduce the cost-sharing beyond the statutory copay amount. The Non-Covered Plan Paid (NPP) Amount equals $0.00.

2.13 Applying the MMP Reduction

Now, using the same example, we are going to apply the Medicare-Medicaid MMP reduction. The MMP reduces the LIS beneficiary cost-sharing to $0.00 for brand drugs. The first four steps in the example calculation remain the same.

2.14 Step 5: Calculate Non-Covered Plan Paid Amount

As just noted, the MMP reduces the beneficiary cost-sharing to $0.00, which is an amount below the LIS cost-sharing maximum for this beneficiary, for this drug. The $0.00 is reported in the final PDE as the Patient Pay Amount.

The difference between the original beneficiary liability calculated in Step 3 and the reduced patient pay amount offered by the Medicare-Medicaid Plan, which totals $7.40, is reported on the PDE as NPP.

2.15 Assessment Overview

Welcome to the assessment portion of the CBT. In this assessment, you will be given a question and the opportunity to test your knowledge.

2.16 MMP Assessment Question

Plans are reimbursed for the difference between the statutory LIS cost-sharing amounts and the reduced cost-sharing amounts. Is this statement true or false?

This is false. Because the Capitated Financial Alignment Demonstration waiver does not increase Federal costs, plans will not be reimbursed for the difference between the statutory LIS cost-sharing amounts and the reduced cost-sharing amounts.

3. Medicare Secondary Payer (MSP) Module

3.1 Overview

The Medicare Secondary Payer section is broken into the following topics: Background, Guidance, Tips, an Example, and Assessment Questions.

3.2 Background

Let's review some background information regarding the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, also known as the MMA, and the interaction with Medicare Secondary Payer, or MSP, laws. We will also identify when, according to statute, there are situations in which Medicare is the secondary payer.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), §1860D-2(a) (4), extended laws applicable to Medicare Advantage (MA) organizations to Part D sponsors. Under Medicare Secondary Payer (MSP) laws, Part D sponsors have the same responsibilities as MA plans. F

Chapter 14 is the Coordination of Benefits Chapter of the Prescription Drug Benefit Manual that includes guidance on the coordination of benefits in Section 50.12 about applying Medicare Secondary Payer Requirements for Part D and is available on the CMS website.

This module reviews situations in which Medicare is the secondary payer. Medicare is a secondary payer in the following situations:

- Non- Group Health Plans
    - Worker's Compensation (WC) - The beneficiary is covered under WC due to job-related illness or injury.
    - Black Lung (BL) - The beneficiary has black lung disease and is covered under the Federal Black Lung Program.
    - No-Fault/Liability - The beneficiary is covered by no-fault or liability insurance due to an accident.
- Employer Group Health Plans (EGHP) MSP
    - Working Aged Group Health Plans - A beneficiary is covered through active employment of self or family member (≥20 employees; or another employer in GHP > 20 employees). (42 U.S.C. §1395(y)(b))
    - Disability with Group Health Plans - A beneficiary is covered through active employment by self or family member in a large GHP (LGHP, ≥100 employees).
    - End Stage Renal Disease (ESRD) Group Health Plans - Any size ESRD GHP is primary for the first 30 months of Medicare Part A eligibility, and then Medicare becomes primary.

3.3 Guidance

MSP Claim Pricing and Adjudication Logic

In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan's negotiated price for the drug. Payments are applied to this

price in the following order: primary issuer's payment, beneficiary cost-sharing liability under the Part D Plan Benefit Package (PBP), and the Part D plan payment. If primary payment is greater than or equal to the Part D negotiated drug price, no other payments are made.

In the Coverage Gap Phase, beneficiaries with MSP will not receive the manufacturer discount on the negotiated drug price of applicable (i.e., brand) drugs. The beneficiary and plan liabilities for Ingredient Cost, Sales Tax, Dispensing Fee, and Vaccine Administration Fee are calculated using the annually published Part D parameters.

In an MSP situation, the payment by a primary payer never counts toward True Out-of-Pocket (TrOOP) costs, but must be reported on the Prescription Drug Event Record (PDE) as reductions to the beneficiary liability and/or Part D plan liability. This data ensures that TrOOP costs and plan paid amounts for risk sharing are accurate.

Pricing Exception Code

The Pricing Exception Code identifies PDEs that use pricing rules that differ from the negotiated price. Plans should apply the codes as follows when calculating and reporting MSP claims:

- M = MSP claim
- O = Out-of-network pharmacy claim
- M indicates that the claim was in accordance with MSP rules and overrides O if both M and O apply for a given PDE record because it has the greater effect in payment calculations.

Workers' Compensation (WC)

- Medicare is a secondary payer when there is WC.
- Medicare may not pay for any item or service when payment has been made, or can reasonably be expected to be made, for such item or service under a WC law or plan of the United States or any State. Part D sponsors are expected to make good faith efforts to identify claims associated with WC.

In an effort to protect Medicare's interests when parties enter into WC settlements, there is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medicals and future prescription drug expenses. CMS recommends Medicare beneficiaries (and individuals who expect to become entitled to Medicare within 30 months of receiving a WC settlement) who are parties to WC settlements, judgments, or awards to submit WCMSA proposals to CMS for review prior to settlement to ensure Medicare's interests are considered. Additional information on WCMSA is available in Chapter 14 – Coordination of Benefits of the Medicare Prescription Drug Manual.

3.4 Tips

Part D sponsors are required to properly apply MSP laws and regulations in all MSP situations, so next we'll review a helpful tip for MSPs.

Beneficiaries with Medicare Part D as a secondary payer will not receive the manufacturer discount on the negotiated drug price of applicable (i.e., brand) drugs.

3.5 Scenario

Let's work through an example of calculating and reporting a PDE record for an MSP situation. In 2016, ABC Health PDP, a Defined Standard plan, processed a claim for a beneficiary for the

primary payment for a brand drug of $10.00, and the beneficiary is in the Coverage Gap Phase. Before the claim is received, the year to date gross covered drug cost is $3,500.00, and the True Out-of-Pocket Costs (TrOOP) Accumulator is $3,000.00. The Negotiated Price of the Drug is $100.00. There is no dispensing fee.

3.6 Calculating and Reporting

Before starting the calculations, examine the eight steps required when calculating and reporting a PDE record for an MSP situation.

The first step is to price the claim according to the Part D plan's negotiated price for the drug. In Step 2, report the Primary Payment amount in the Patient Liability Reduction due to Other Payer Amount (PLRO) field. In the third step, determine the beneficiary and plan cost-sharing amounts. For amounts in the Coverage Gap Phase, the beneficiary cost-sharing percentage assumes that the beneficiary pays the percentage normally covered by the manufacturer. The fourth step is to calculate the beneficiary's and plan's cost-sharing amounts, subtract the Primary Payment from the negotiated price. In Step 5, determine the Patient Pay Amount. The beneficiary is responsible for whichever is less, the cost-sharing as calculated in Step 3, or the difference between the negotiated price and the amount paid by the primary payer from Step 4. We report the lesser amount in the Patient Pay Amount field. In Step 6, after calculating the Patient Pay Amount, calculate the Part D Plan Paid amount at the point of sale (POS). The Part D plan pays the pharmacy any amount remaining after the Primary Payment and the beneficiary's cost-sharing under the plan benefit package have been applied, up to the Part D plan's negotiated price. The seventh step is to calculate the Covered Plan Paid, or CPP, and Non-Covered Plan Paid, or NPP, amounts. Finally, the plan determines the value to input into the Pricing Exception Code. Plans will populate this field with M to indicate that the plan paid the claim in accordance with MSP rules and populate the PDE record accordingly.

3.7 Step 1: Determine Price of Claim

The first step is to price the claim according to the Part D plan's negotiated price for the drug, which is $100.00. This amount is reported in the Ingredient Cost Paid field.

3.8 Step 2: Determine Primary Payment Amount

Next, we report the Primary Payment amount in the Patient Liability Reduction due to Other Payer Amount or PLRO field. The Primary Payment is $10.00. Note that if the PLRO is greater than or equal to the gross drug cost (negotiated price), all other payment amounts on the PDE record are $0.00.

3.9 Step 3: Calculate the Cost-Sharing Amounts

In the third step, we calculate the beneficiary's and plan's cost-sharing amounts in the Coverage Gap if the Primary Payment was not applied. This value is calculated by multiplying the Beneficiary Cost-Sharing Percentage (95%), without the manufacturer's discount, by the negotiated price of the drug ($100.00), which equals $95.00. The Plan's Cost-Sharing is calculated by multiplying the Plan Cost-Sharing Percentage (5%) by the Negotiated Price of the Drug ($100.00), which equals $5.00.

3.10 Step 4: Calculate Difference

After calculating the beneficiary's and plan's cost-sharing amounts, we subtract the Primary Payment from the negotiated price.

The Negotiated Price of the Drug ($100.00) minus the Primary Payment ($10.00) equals the difference between the Negotiated Price and Payment ($90.00).

3.11 Step 5: Lesser Than Test

Next, we determine the Patient Pay Amount. The beneficiary is responsible for whichever is less, the cost-sharing as calculated in Step 3, or the difference between the Negotiated Price of the drug and the Primary Payment, which is $90.00. We report the lesser amount of $90.00 in the Patient Pay Amount field.

3.12 Step 6: Calculate Part D Plan Paid Amount

After calculating the Patient Pay Amount, we calculate the Part D Plan Paid amount at the point of sale or POS. The Part D plan pays the pharmacy any amount remaining after the Primary Payment ($10.00) and the beneficiary's cost-sharing under the plan benefit package ($90.00) have been applied, up to the Part D plan's negotiated price ($100.00). Therefore, the Part D Plan Paid Amount equals $0.00.

3.13 Step 7: Calculate CPP and NPP Amounts

The next step is to calculate the Covered Plan Paid, or CPP, and Non-Covered Plan Paid, or NPP, amounts. In this example, there are no CPP or NPP amounts to report.

3.14 Step 8: Determine Pricing Exception Code

Finally, the plan determines the value to input into the Pricing Exception Code. Plans will populate this field with M to indicate that the plan paid the claim in accordance with MSP rules and populate the PDE record accordingly. In this example, we populate this field with the value M.

3.15 Assessment Overview

The assessment portion for the MSP section includes one question.

3.16 MSP Assessment Question

Which of the following is not a situation where Medicare is the secondary payer?

a. Working Aged GHP
b. Black Lung (BL)
c. No Fault/Liability
d. Workers' Compensation
e. None of the Above

The answer is e. None of the Above. All of the situations listed are instances when Medicare may be the secondary payer.

PDE Common Issues and Best Practices Resources

Table 1: General Links

Resource	Source
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov
Code of Federal Regulations (CFR): 42 CFR §423 – Voluntary Medicare Prescription Drug Benefit	http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=069e43ffce0d8f5ae52e30b22802a415&ty=HTML&h=L&r=PART&n=pt42.3.423
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)	http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf
Patient Protection and Affordable Care Act (ACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html

Table 2: The Defined Standard Benefit
Excluding Low Income Eligible Beneficiaries, 2016

Benefit Phase	Parameters to Define Benefit Phase Year-to-Date (YTD) Gross Covered Drug Costs	Parameters to Define Benefit Phase YTD TrOOP Costs	Beneficiary Cost-Sharing	Plan Liability
Deductible	Less than or equal to $360.00	N/A*	100% coinsurance	0%
Initial Coverage	Greater than $360.00 and less than or equal to $3,310.00	N/A*	25% coinsurance	75%
Coverage Gap	Greater than $3,310.00	Less than or equal to $4,850.00	58% coinsurance for generic drugs 45% for brand drugs** 45% of any Dispensing Fee or Vaccine Administration Fee for a brand drug	42% for generic drugs 5% for brand drugs 55% of Dispensing Fee and Vaccine Administration Fee for brand drugs
Catastrophic Phase	N/A***	Greater than $4,850.00 (OOP threshold)	Greater of 5% coinsurance or $2.95/$7.40 (generic/brand) co-payment	Lesser of 95% or (Gross Covered Drug Cost - $2.95/$7.40)****

*It is not necessary to achieve a minimum TrOOP balance for transitioning from the Deductible to the Initial Coverage Phase or from the Initial Coverage Phase to the Coverage Gap. These phases are dependent upon YTD gross covered drug costs, regardless of who pays for the drug. Any beneficiary paid amounts will count as TrOOP during these phases of the benefit.

** Assumes the claim falls squarely in the gap and there is no supplemental coverage.

*** It is not necessary to achieve a minimum YTD GCDC balance for transitioning from the Coverage Gap to the Catastrophic Phase. The transition from the Coverage Gap to the Catastrophic Coverage Phase is based upon accumulating TrOOP and exceeding the OOP threshold.

**** If the beneficiary liability is less than the statutory copay amount, the formula changes to Gross Covered Drug Cost minus beneficiary liability.

Table 3: Medicare-Medicaid Plans Module

Resource	Source
9/20/2012 HPMS Memo: *Waiver of Part D Low-Income Subsidy Cost-Sharing Amounts by Medicare-Medicaid Plans and Operational Implications for Prescription Drug Event Data and Plan Benefit Package Submissions*	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Part_D_Cost_Sharing_Guidance.pdf
MMP Webinar Training – January 22, 2015	http://csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Medicare%20Medicaid%20Plans~Training?open&expand=1&navmenu=Medicare^Medicaid^Plans||
2011 Prescription Drug Event Participant Guide	http://csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Prescription%20Drug%20Event~Training?open&expand=1&navmenu=Prescription^Drug^Event||
7/8/2011 Letter to State Medicaid Directors: *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*	http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

Table 4: Medicare Secondary Payer Module

Resource	Source
Social Security Act	http://www.ssa.gov/OP_Home/ssact/title18/1852.htm#act-1852-a-4
Medicare Prescription Drug Benefit Manual – Chapter 14: Coordination of Benefits	http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html
Section 17, PDE Instructions for Medicare as Secondary Payer (MSP)	Section 17, PDE Instructions for Medicare as Secondary Payer (MSP)
PDE Inbound File Layout	http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Prescription%20Drug%20Event~File%20Layouts?open&expand=1&navmenu=Prescription%5eDrug%5eEvent||
4/23/13 HPMS Memo: *Medicare Secondary Payer Prescription Drug Event Calculations and Reporting Standards*	4/23/13 HPMS Memo: Medicare Secondary Payer Prescription Drug Event Calculations and Reporting Standards
Medicare Secondary Payer Recovery Portal (MSPRP)	http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/MSPRP/Medicare-Secondary-Payer-Recovery-Portal.html
The Official U.S. Government Site for Medicare	https://mymedicare.gov/

Table 5: PDE Common Issues and Best Practices (CIBP) CBT Glossary

Term	Definition
Actual Cost	As defined in 42 CFR §423.100: Actual cost means the negotiated price for a covered Part D drug when the drug is purchased at a network pharmacy, and the usual and customary price when a beneficiary purchases the drug at an out-of-network pharmacy consistent with §423.124(a).
Alternative Prescription Drug Coverage	As defined in 42 CFR §423.100: Coverage of Part D drugs, other than standard prescription drug coverage that meets the requirements of §423.104(e). The term alternative prescription drug coverage must be either— (1) Basic Alternative Coverage (alternative coverage that is actuarially equivalent to defined standard coverage, as determined through processes and methods established under § 423.265(d)(2)); or (2) Enhanced Alternative Coverage (alternative coverage that meets the requirements of § 423.104(f)(1)).

Term	Definition
Applicable Beneficiary	As defined in 42 CFR §423.100: Applicable beneficiary means an individual who, on the date of dispensing a covered Part D drug— (1) Is enrolled in a prescription drug plan or an MA-PD plan; (2) Is not enrolled in a qualified retiree prescription drug plan; (3) Is not entitled to an income-related subsidy under §1860D-14(a) of the Act; (4) Has reached or exceeded the initial coverage limit under §1860D-2(b)(3) of the Act during the year; (5) Has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in §1860D-2(b)(4)(B) of the Act; and (6) Has a claim that— (i) Is within the coverage gap; (ii) Straddles the initial coverage period and the coverage gap; (iii) Straddles the coverage gap and the annual out-of-pocket threshold; or (iv)Spans the coverage gap from the initial coverage period and exceeds the annual out-of-pocket threshold.
Applicable Drug	As defined in 42 CFR §423.100: Applicable drug means a Part D drug that is— (1)(i) Approved under a new drug application under §505(b) of the Federal Food, Drug, and Cosmetic Act (FDCA); or (ii) In the case of a biological product, licensed under §351 of the Public Health Service Act (other than a product licensed under subsection (k) of such §351); and (2)(i) If the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; (ii) If the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; or (iii) Is provided to a particular applicable beneficiary through an exception or appeal for that particular applicable beneficiary.
Basic Alternative (BA) Coverage	As defined in 42 CFR §423.100: Alternative coverage that is actuarially equivalent to defined standard coverage, as determined through processes and methods established under §423.265(d)(2).
Coverage Gap	As defined in 42 CFR §423.100: Coverage Gap means the period in prescription drug coverage that occurs between the initial coverage limit and the out-of-pocket threshold. For purposes of applying the initial coverage limit, Part D sponsors must apply their plan specific initial coverage limit under basic alternative, enhanced alternative or actuarially equivalent Part D benefit designs.

Term	Definition
Covered D Plan Paid Amount (CPP)	This field contains the net amount the plan paid for a Covered Part D drug under the Defined Standard benefit. The Drug Data Processing System (DDPS) will use this field to facilitate reconciliation calculations, especially determining allowable risk corridor costs.
Covered Part D Drug	As defined in 42 CFR §423.100: Covered Part D drug means a Part D drug that is included in a Part D plan's formulary, or treated as being included in a Part D plan's formulary as a result of a coverage determination or appeal under §§423.566, 423.580, and 423.600, 423.610, 423,620, and 423.630, and obtained at a network pharmacy or an out-of-network pharmacy in accordance with §423.124.
Dispensing Fees	As defined in 42 CFR §423.100: Dispensing fees means costs that- (1) Are incurred at the point of sale and pay for costs in excess of the ingredient cost of a covered Part D drug each time a covered Part D drug is dispensed; (2) Include only pharmacy costs associated with ensuring that possession of the appropriate covered Part D drug is transferred to a Part D enrollee. Pharmacy costs include, but are not limited to, any reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing quality assurance activities consistent with §423.153(c)(2), measurement or mixing of the covered Part D drug, filling the container, physically providing the completed prescription to the Part D enrollee, delivery, special packaging, and salaries of pharmacists and other pharmacy workers as well as the costs associated with maintaining the pharmacy facility and acquiring and maintaining technology and equipment necessary to operate the pharmacy. Dispensing fees should take into consideration the number of dispensing events in a billing cycle, the incremental costs associated with the type of dispensing methodology, and with respect to Part D drugs dispensed in LTC facilities, the techniques to minimize the dispensing of unused drugs. Dispensing fees may also take into account costs associated with data collection on unused Part D drugs and restocking fees associated with return for credit and reuse in long-term care pharmacies, when return for credit and reuse is permitted under the State in law and is allowed under the contract between the Part D sponsor and the pharmacy. (3) Do not include administrative costs incurred by the Part D plan in the operation of the Part D benefit, including systems costs for interfacing with pharmacies.
Enhanced Alternative (EA) Coverage	As defined in 42 CFR §423.100: Alternative coverage that meets the requirements of §423.104(f)(1).
Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB)	This field represents the gross covered drug cost (Ingredient Cost Paid + Dispensing Fee Paid + Vaccine Administration Fee + Total Amount Attributed to Sales Tax) paid to the pharmacy below the OOP threshold for a given PDE for a covered drug. For claims at or below the OOP threshold, this field will list a positive dollar amount. For claims above the OOP threshold, this field will have a zero dollar value. For a claim that straddles the OOP threshold in a single PDE, there will be a positive dollar amount in this field and there is likely to be a positive dollar amount in the GDCA field.

Term	Definition
Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)	This field represents the gross covered drug cost (Ingredient Cost Paid + Dispensing Fee Paid + Vaccine Administration Fee + Total Amount Attributed to Sales Tax) paid to the pharmacy above the OOP threshold for a given PDE for a covered drug. For claims at or below the OOP threshold, this field will list a zero dollar amount. For claims above the OOP threshold, this field will have a positive dollar value. For a claim that straddles the OOP threshold in a single PDE, there will be a positive dollar amount in this field and there will be a positive dollar amount in the GDCB field.
Low Income Subsidy	There are two types of subsidies for qualifying low-income beneficiaries: premium assistance and cost-sharing assistance. Each month CMS pays plans prospectively a low income subsidy for assistance to certain low-income individuals to supplement the premium and cost-sharing associated with the Part D benefit.
Maximum Coverage Gap Discount Amount	The maximum discount value manufacturers are required to provide beneficiaries on the negotiated price of applicable drugs under the Medicare Coverage Gap Discount Program.
Maximum Gap Discount Amount Formula	The formula used to calculate the maximum coverage gap discount amount for a single claim. The maximum aggregate applicable discount amount that a beneficiary could receive from multiple coverage gap claims is the applicable year's TrOOP. Troop Dollar Amount / (Beneficiary Cost-Sharing Percentage + Manufacturer Cost-Sharing Percentage) = Gap Eligible Portion of Negotiated Price Gap Eligible Portion of Negotiated Price X 50% = Maximum Coverage Gap Discount for Single Claim
Medicare-Medicaid Plans (MMPs)	Medicare-Medicaid Plans serve people who are enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees, also known as dual eligibles.
Medicare Secondary Payer (MSP)	The term generally used when the Medicare program does not have any primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare.
Negotiated Price	As defined in 42 CFR §423.100: Negotiated prices means prices for covered Part D drugs that— (1) The Part D sponsor (or other intermediary contracting organization) and the network dispensing pharmacy or other network dispensing provider have negotiated as the amount such network entity will receive, in total, for a particular drug; (2) Are reduced by those discounts, direct or indirect subsidies, rebates, other price concessions, and direct or indirect remuneration that the Part D sponsor has elected to pass through to Part D enrollees at the point of sale; and (3) Includes any dispensing fees.
Non-Applicable Drug	Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug. Non-applicable drugs are subject to "generic" Coverage Gap cost-sharing.

Term	Definition
Non-Covered Plan Paid Amount (NPP)	This is a PDE file field that is used to report the dollar amount paid by plans for benefits beyond the Defined Standard benefit, called supplemental or enhanced benefits, or for OTC drugs. This dollar amount is excluded from risk corridor calculations.
Other Health Insurance (OHI)	OHI refers to a source of coverage other than the Part D plan. Some OHI payments count towards TrOOP, however, many OHI payments are excluded from TrOOP. For example, group health plans, employer-sponsored insurance, non-Part D government-funded programs, Workers' Compensation, and similar third party arrangements. Third party payments made by such entities typically do not count toward a beneficiary's TrOOP. Payments by OHI payers that are not TrOOP eligible are reported in the PLRO field.
Other Troop Amount	Other health insurance payments by TrOOP-eligible other payers. This field records all third party payments that contribute to a beneficiary's TrOOP except LICS, Patient Pay Amount, and Reported Gap Discount. This amount increments the True Out-of-Pocket Accumulator amount.

Term	Definition
Part D Drug	As defined in 42 CFR §423.100: Part D drug means— (1) Unless excluded under paragraph (2) of this definition, any of the following if used for a medically accepted indication (as defined in §1860D-2(e)(4) of the Act)— (i) A drug that may be dispensed only upon a prescription and that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act. (ii) A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act. (iii) Insulin described in §1927(k)(2)(C) of the Act. (iv) Medical supplies associated with the injection of insulin, including syringes, needles, alcohol swabs, and gauze. (v) A vaccine licensed under §351 of the Public Health Service Act and for vaccine administration on or after January 1, 2008, its administration. (vi) Supplies that are directly associated with delivering insulin into the body, such as an inhalation chamber used to deliver the insulin through inhalation. (vii) A combination product approved and regulated by the FDA as a drug, vaccine, or biologic described in paragraphs (1)(i), (ii), (iii), or (v) of this definition. (2) Does not include any of the following: (i) Drugs for which payment as so prescribed and dispensed or administered to an individual is available for that individual under Part A or Part B (even though a deductible may apply, or even though the individual is eligible for coverage under Part A or Part B but has declined to enroll in Part A or Part B). (ii) Drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under sections 1927(d)(2) or (d)(3) of the Act, except for smoking cessation agents. (iii) Medical foods, defined as a food that is formulated to be consumed or administered orally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation, and that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act.
Patient Pay Amount	This field lists the dollar amount the beneficiary paid directly (e.g., copayments, coinsurance, deductible, or other patient pay amounts). It excludes amounts paid by other parties on behalf of the beneficiary. This amount contributes to a beneficiary's TrOOP only when it is payment for a covered Part D drug. Plans are responsible for ensuring that beneficiaries are charged amounts that are consistent with their benefit packages as approved in the bidding process.
Plan Allowance	As defined in 42 CFR §423.100: Plan allowance means the amount Part D plans that offer coverage other than defined standard coverage may use to determine their payment and Part D enrollees' cost-sharing for covered Part D drugs purchased at an out-of-network pharmacy or in a physician's office in accordance with the requirements of §423.124(b).

Term	Definition
Preferred Drug	As defined in 42 CFR §423.100: Preferred drug means a covered Part D drug on a Part D plan's formulary for which beneficiary cost-sharing is lower than for a non-preferred drug in the plan's formulary.
Reported Gap Discount	This field is used by Part D sponsors to report the manufacturer discount made available to a beneficiary at the point of sale under the Coverage Gap Discount Program. The amounts reported are used for the cost-based reconciliation of the Coverage Gap Discount Program's prospective payments made to each Part D sponsor.
Straddle Claims	Straddle claims are PDEs that fall partially in two different benefit phases. For example, a PDE may fall in the Deductible phase at the start of the claim but end in the Initial Coverage Phase at the end of the claim. A straddle claim could straddle anywhere from 2 to 4 benefit phases.
Supplemental Benefits	Supplemental benefits consist of: • Reductions in cost-sharing in the coverage gap such that enrollees are liable for less than the coinsurance in the gap for defined standard coverage, and the actuarial value of the benefit provided is increased above the actuarial value of basic prescription drug coverage. • Reductions in cost-sharing that increase the actuarial value of the benefits provided above the actuarial value of basic prescription drug coverage – for example: (1) a reduction in the deductible; (2) a reduction in the coinsurance percentage or copayments applicable to covered Part D drugs obtained between the annual deductible and the initial coverage limit and/or above the annual out-of-pocket threshold; and/or (3) an increase in the initial coverage limit. • Supplemental drugs
Total Gross Covered Drug Cost (TGCDC) Accumulator	The Total Gross Covered Drug Cost (TGCDC) Accumulator is one of two values Part D sponsors maintain in real time in order to adjudicate a beneficiary's claim in the correct benefit phase. The TGCDC Accumulator is the sum of the beneficiary's covered drug costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. The Total Gross Covered Drug Cost Accumulator value moves the beneficiary through the deductible phase (if any), the initial coverage period, and into the Coverage Gap. The TGCDC Accumulator is used in combination with the True Out-of-Pocket (TrOOP) Accumulator described below to validate benefit phase. The TGCDC Accumulator field should be left blank on PDEs for OTC or Enhanced drugs.
True Out-Of-Pocket Cost (TrOOP) Accumulator	The TrOOP Accumulator is the second value Part D sponsors maintain in real time in order to adjudicate a beneficiary's claim in the correct benefit phase. The TrOOP Accumulator is the sum of the beneficiary's incurred costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. Incurred costs are reported in the existing PDE as Patient Pay, Low Income Cost-Sharing Subsidy (LICS), Other TrOOP, and Reported Gap Discount. By definition, TrOOP costs apply only to Part D Covered drugs. After the TrOOP Accumulator reaches the out-of-pocket threshold, the beneficiary enters the catastrophic phase of the benefit. The TrOOP Accumulator field should be left blank on PDEs for OTC or Enhanced drugs. The TrOOP Accumulator does not increase after the beneficiary reaches the out-of-pocket threshold.

Section 17. PDE Instructions for Medicare as Secondary Payer (MSP)

17.1 Background

This document is a follow-up to our Coordination of Benefits (COB) guidance issued July 1, 2005. In Sections E and J of the COB guidance, we provided an introduction to the role of Medicare as Secondary Payer (MSP) in coordinating benefits under the Medicare Modernization Act of 2003 (MMA). This document extends that early guidance by describing certain MSP scenarios in greater detail and delineating rules for calculating and reporting prescription drug event (PDE) data in MSP situations. It will be incorporated as Section 17 in CMS's PDE Instructions.

The Part D benefit is structured with Medicare as a primary payer and in most cases of other health insurance coverage, Medicare will be primary. However, there will be times when other insurers are primary. Clarification regarding a limited number of MSP situations is provided below; however, all MSP laws shall be properly applied whether or not they are mentioned in this document. Part D plans should reference other CMS guidance for detailed rules about establishing payer precedence and interacting with the Coordination of Benefits Contractor (COBC) to establish, verify or manage an MSP situation.

The MMA extended MSP laws applicable to MA organizations to Part D sponsors (§1860D-2(a)(4)). Accordingly, Part D sponsors will have the same responsibilities under MSP laws as do MA plans, including collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities; and the interaction of MSP rules with State laws. Part D plans must properly apply MSP laws and regulations to their payments (e.g., working aged, worker's compensation, other).

17.2 Verifying and establishing MSP

The COBC is the central repository for verifying and establishing an MSP situation. It has sole responsibility for establishing an MSP record for a beneficiary in the Medicare Beneficiary Database (MBD), although Part D plans and beneficiaries have various responsibilities to exchange COB information with each other, with other payers, and with the COBC.

The COBC uses a variety of investigational tools, such as MSP questionnaires, telephone contacts, and data exchanges to determine if there is an MSP situation. Once the COBC updates the Medicare Beneficiary Database (MBD) with an MSP record indicating that Medicare is the secondary payer for a beneficiary, Part D plans are responsible for adjudicating enrollees' claims and submitting prescription drug event (PDE) records in accordance with the following MSP rules. Also, the plans are then responsible for identifying and recovering any MSP-related mistaken payments and submitting associated adjustments to CMS.

According to law, Medicare is the secondary payer in the following situations:

1. Employer group health plans (EGHP) MSP
    a. Working Aged GHP – A beneficiary is covered through active employment of self or family member (≥20 employees; or another employer in GHP≥ 20 employees.) (42 U.S.C. §1395(y)(b))
    b. Disability with GHP – If beneficiary is covered through active employment by self or family member in a large GHP (LGHP, ≥100 employees)
    c. ESRD GHP – GHP (any size) is primary for the first 30 months of Medicare Part A eligibility, then Medicare becomes primary
2. Non-GHP MSP
    a. Worker's Compensation (WC) – Beneficiary covered under WC due to job-related illness or injury
    b. Black Lung (BL) – The beneficiary has black lung disease and is covered under the Federal Black Lung Program
    c. No-Fault/Liability – The beneficiary is covered by no-fault or liability insurance due to an accident

However, Part D plans should not immediately pay only as secondary. The action required of the Part D plan is dependent on the type of other primary payer as follows:

1. For the types of Employer Group Health Plans (EGHP) listed above, the Part D plan will always deny primary claims that fall within the EGHP's applicable coverage dates and default to MSP. The types as listed above include: working aged GHP, disability GHP, and ESRD GHP for first 30 months of Medicare Part A eligibility.

2. For Worker's Compensation (WC), Black Lung (BL), and No-Fault or Liability coverage the plan will always make conditional primary payment unless the plan is aware that the enrollee has WC/BL/No-Fault/Liability coverage and has previously established that a certain drug is being used exclusively to treat a related injury. For example, when a beneficiary refills a prescription previously paid for by WC, the Part D plan may deny primary payment and default to MSP.

    In all other instances, the Part D plan is required to make conditional primary payment then recover any mistaken payments where it should have only paid secondary to WC/BL/No-Fault/Liability coverage. For example, if a plan does not know whether a given drug for which it is billed is related to the covered injury, the plan must pay for the drug (if it is covered) and later retrieve any amounts that the other insurance was supposed to cover.

17.3 Mistaken payment recovery

Once a Part D plan has determined that a non-EGHP settlement has occurred for a beneficiary for whom the plan has reported PDE records, the plan must determine and

recover any payments that should have been covered by the other party. Once the other party has adjudicated related claims, the Part D plan must submit adjustment and/or deletion PDEs for those claims to CMS. The plan must also re-determine beneficiary liability for those claims.

CMS instructs plans to submit adjustments only after the primary payer has reimbursed the plan for mistaken payments. However, plans should report these data as soon as possible and exert every effort so that adjusted PDEs may be included in the next reconciliation.

CMS will issue additional guidance to plans on rules for mistaken payment recovery, for example reporting settlements that are received after a given coverage year has been closed out for reconciliation.

17.4 Populating the PDE record as MSP

Once an MSP situation has been established, Part D plans will use the following rules to calculate and report MSP payments on PDE records.

17.4.1 Pricing Exception Code

CMS renamed the field Out-of-Network Code to Pricing Exception Code. It now has two values:
O = Out-of-network claim
M = Medicare as Secondary Payer (MSP) claim

Plans will populate this field with 'M' to indicate that the PDE has been paid in accordance with MSP rules. If both codes 'O' and 'M' apply for a given PDE, report 'M' as the overriding code because it has the greater effect in payment calculations.

17.4.2 Pricing and calculation rules

To price an MSP claim and populate a PDE record, plans shall use the following process that can be summarized in eight steps:

1. Price or re-price the claim according to the Part D plan's negotiated price for the drug. Report the negotiated price in the GDCB or GDCA field.

2. Report the primary payment amount in the PLRO field. Note that if PLRO > gross drug cost (negotiated price), all other dollar amounts on the PDE record are $0.

3. Determine the beneficiary and Part D plan liabilities under the PBP.

4. Subtract the primary payment from the negotiated price.

5. Determine Patient Pay Amount. The beneficiary will actually be responsible for either the amount from Step 2 or the remainder in Step 3, whichever is less. Report the lesser amount in Patient Pay Amount; if the lesser amount is negative, report $0 in Patient Pay Amount.

6. Calculate Plan-Paid amount at POS. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price.

7. Report this payment in CPP, NPP and/or LICS as follows:

a) If the PBP only provides basic coverage or if the drug is a supplemental drug, the Plan-Paid amount at POS is reported in CPP (for covered drugs) or NPP (for non-covered drugs).

b) The calculations to determine LICS Amount do not change under MSP (see Section 10).

c) If the PBP provides enhanced alternative cost-sharing, use the mapping rules in Section 7 to calculate CPP which we refer to as CPP_c. CPP_r is the reported CPP Amount on the PDE record.

- If PLRO > CPP_c, then NPP Amount = Plan-Paid at POS
  CPP_r Amount = $0

- If PLRO < CPP_c, then CPP_r Amount = (CPP_c – PLRO)
  NPP Amount = (Patient Pay Amount – CPP_r Amount)

LICS Amounts reduce NPP Amounts when there is enhanced alternative cost sharing. Specifically:

- If PLRO > CPP_c, then NPP Amount = (Plan-Paid at POS – LICS Amount).
  CPP_r Amount = $0.

- If PLRO < CPP_c, then CPP_r Amount = (CPP_c – PLRO).
  NPP Amount = (Patient Pay Amount + LICS Amount – CPP_r Amount).

8. Report a value = M in the Pricing Exception Code field.

17.4.3 Non-standard data format

If a Part D plan receives notice of a primary payment via a beneficiary-submitted claim, Explanation of Benefits, pharmacy receipt or other non-standard method, the plan will follow the instructions in Section 4 to submit a non-standard format PDE record.

17.4.4 PDE Examples

The following examples illustrate how a plan will use these steps to price a claim and populate a PDE record when a primary payment has already been made. In each example, a Part D plan receives a COB segment or non-standard format claim indicating payment by a primary payer.

Examples 1 – 5 Defined standard benefit

In examples 1-5, the beneficiary is enrolled in a defined standard PBP and the drug is a covered Part D drug. In examples 1-3, the beneficiary is in the initial coverage period; in example 4, the beneficiary is in the coverage gap and is eligible for LICS at Level 2 (see Section 10); and in example 5, the beneficiary has no cost sharing for a particular drug under their PBP. The examples are summarized in the following table and are then described in detail in the text below it.

Pricing and Populating a PDE: Defined Standard Benefit and LICS					
	Ex #1	**Ex #2**	**Ex #3**	**Ex #4**	**Ex #5**
Primary Payer Payment	$75	$65	$90	$40	$15
Part D Plan Negotiated Price (based on NDC on COB segment).	$100	$100	$100	$100	$10
Part D Plan Liability under the PBP	$75	$75	$75	$0	$10
Beneficiary Liability under the PBP	$25	$25	$25	~~$100~~ $5	$0
Part D Plan pays pharmacy	$0	$10	$0	$55	$0
PDE field: CPP Amount	$0	$10	$0	$0	$0
PDE field: Patient Pay Amount	$25	$25	$10	$5	$0
PDE field: PLRO	$75	$65	$90	$40	$15
PDE field: GDCB	$100	$100	$100	$100	$10
PDE field: LICS Amount	$0	$0	$0	$55	$0

Example 1

The primary payment was $75 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $75 in PLRO. (Steps 2 and 5 describe how this payment reduces the plan liability by $75).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $75 = $25.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3). In this example, the amounts are the same, $25. The plan reports $25 in the Patient Pay Amount field.

6. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. Since the primary paid $75 and the beneficiary liability is $25, the full negotiated price has been covered and Plan-Paid at POS is zero.
7. This is a basic plan and a covered drug, so CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Example 2

The primary payment was $65 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $65 in PLRO. (Steps 2 and 5 describe how this payment reduces the plan liability by $65).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $65 = $35.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $35). The plan reports $25 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($65) and beneficiary liability ($25) = $90. The plan pays the pharmacy the remaining $10 of the negotiated price ($100 - $90 = $10).
7. This is a covered drug under a basic plan, so the Plan-Paid amount at POS is reported as CPP Amount = $10 on the PDE.
8. The plan reports Pricing Exception field = 'M'.

Example 3

The primary payment was $90 and the beneficiary is in the initial coverage period.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $90 in PLRO. (Steps 2, 4 and 5 describe how this payment reduces the plan liability by $75 and the beneficiary liability by $15, for a total liability reduction of $90).
3. It determines the beneficiary's liability of $25 and plan liability of $75 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $90 = $10.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $25) or the difference between the negotiated price and the amount paid by

the primary payer (from Step 3, $10). The plan reports $10 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($90) and beneficiary liability ($25) = $115, exceeding the negotiated price. Since the full negotiated price has been covered; there is no remaining amount to be paid by the plan.
7. The plan reports CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Example 4

The primary payment was $40 on a brand name covered drug. The beneficiary is in the coverage gap and is eligible for LICS at Level 2.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $40 in PLRO. (Steps 3, 4 and 5 describe how the plan's liability including LICS is reduced by $40, from $100 to $55).
3. It determines the beneficiary's liability of $5 (see Section 10) and plan liability of $0 under the PBP.
4. The difference between the negotiated price and the primary payment is $100 - $40 = $60.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $5) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $60). The plan reports $5 in the Patient Pay Amount field.
6. At POS, the Part D plan pays any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($5) = $45. Even though the beneficiary is in the coverage gap, he/she is eligible for LICS so the plan pays the pharmacy the remaining $55 of the negotiated price ($100 - $45 = $55).
7. It reports this payment in LICS Amount.
8. The plan reports Pricing Exception field = 'M'.

Example 5

The primary payment was $15 for a generic covered drug. The Part D plan benefit package has no cost sharing for generic drugs.

1. The plan prices the claim at its negotiated price of $10, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $15 in PLRO. Note that all other payment fields will equal $0 since PLRO > gross drug cost (negotiated price).
3. It determines that there is no beneficiary liability for a generic drug under the PBP, so plan liability is $10.

4. The difference between the negotiated price and the primary payment is $10 - $15 = -$5.
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $0) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, -$5). However, the beneficiary cannot have a negative cost-share so the plan reports $0 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($15) and beneficiary liability ($0) = $15, exceeding the negotiated price. Since the full negotiated price has been covered; there is no remaining amount to be paid by the plan.
7. Therefore, CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Examples 6 – 8 Enhanced alternative benefit, tiered

In examples 6-8, the beneficiary is in an enhanced alternative (EA) plan (see Section 7). We illustrate the MSP rules and rules for reporting EA benefits to populate a PDE record. Note that third party payments are applied to covered benefits before non-covered benefits; specifically, they reduce CPP amounts before NPP amounts. Also, NPP can be negative as described in Section 7, but CPP cannot be reduced below zero.

The PBP has no coverage gap and the enhanced initial coverage period has a tiered cost sharing structure of $5/$20/$40/25%. The beneficiary purchases a Tier 2 drug.
The examples are summarized in the following table and are then described in detail in the text below it.

Pricing and Populating a PDE: Enhanced Alternative Benefit, Tiered				
	Ex #6	**Ex #7**	**Ex #8**	**Ex #9**
Primary Payer Payment	60	$40	50	50
Part D Plan Negotiated Price (based on NDC on COB segment)	$100	$100	$100	$100
Part D Plan Liability under the PBP	80	80	80	80
Beneficiary Liability under the PBP	20	20	20	~~20~~ 2
Part D Plan-Paid at POS	20	40	30	30
PDE field: Patient Pay Amount	20	20	20	2
PDE field: CPP Amount	15	0	0	0
PDE field: NPP Amount	5	40	30	30
PDE field: PLRO	60	40	50	50
PDE field: GDCB	100	100	100	100
PDE field: LICS Amount	0	0	0	18

Example 6
Year-to-date (YTD) total covered drug costs = $300 and the drug is a covered Part D drug.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $60 in PLRO. (Steps 3, 6 and 7 describe how CPP is reduced by this amount).
3. Under the PBP, the beneficiary is in the initial coverage period and is liable for a co-pay of $20. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $40 (100 - $60).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $60). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($60) and beneficiary liability ($20) = $80. So at POS, the plan-paid amount is $20.
7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $75 by mapping to the defined standard benefit (Section 7, Rule #2).
   - PLRO < CPP_c, so CPP_r Amount = (CPP_c -PLRO) = ($75-$60) = $15.
   - NPP Amount = (Patient Pay Amount + LICS Amount – CPP_r) = ($20-$15) = $5.
8. The plan reports Pricing Exception field = 'M'.

Example 7
YTD total covered drug costs = $4,600 and the drug is a supplemental drug.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $40 in the PLRO field. (Steps 3, 6 and 7 describe how the payment reduces NPP by this amount).
3. Under the PBP, the beneficiary is still in the initial coverage period so is liable for a $20 co-pay. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $60 (100 - $40).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $60). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($20) = $60. So at POS, the plan-paid amount is $40.
7. Since this is a supplemental drug, this $40 payment is reported in NPP Amount.

8. The plan reports Pricing Exception field = 'M'.

Example 8
YTD total covered drug costs = $6,000 and the drug is a covered drug.

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $50 in the PLRO field. (Steps 3, 6 and 7 describe how CPP and NPP were reduced by this amount).
3. Under the PBP, the beneficiary is still in the initial coverage period so is liable for a $20 co-pay. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $50 (100 - $50).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $50). The plan reports $20 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($50) and beneficiary liability ($20) = $70, so Plan-Paid at POS = $30.
7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $15 by mapping to the defined standard benefit (Section 7, Rule #4).
   - PLRO > CPP_c, so NPP Amount = Plan-Paid at POS = $30.
   - CPP Amount = $0.
8. The plan reports Pricing Exception field = 'M'.

Example 9
The conditions are the same as in Example 8 except the beneficiary is eligible for LICS at Level 2 (see Section 10).

1. The plan prices the claim at its negotiated price of $100, and reports this amount in the GDCB field.
2. The plan reports the primary payment of $50 in the PLRO field. (Steps 3, 6, and 7 show how CPP and NPP were reduced by this amount).
3. Under the PBP, the beneficiary is liable for a $20 co-pay, reduced to $2 because of LICS. The plan liability is $80.
4. The difference between the negotiated price and the primary payment is $50 (100 - $50).
5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $2) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $50). The plan reports $2 in the Patient Pay Amount field.
6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the

Part D plan's negotiated price. The sum of the primary payment ($50) and beneficiary liability ($2) = $52, so Plan-Paid at POS = $48.
7a) LICS calculations do not change under MSP, so LICS Amount is the difference between the non-LI cost sharing and the LI cost sharing under the PBP (see Section 10). LICS Amount = ($20 - $2) = $18.
7b) Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c = $15 by mapping to the defined standard benefit (Section 7, Rule #4).

- PLRO > CPP_c, so NPP Amount = (Plan-Paid at POS – LICS) = ($48 - $18) = $30. CPP Amount = $0.

8. The plan reports Pricing Exception field = 'M'.

17.5 MSP and progression through the Part D benefit

In an MSP situation, payments by both the primary party and Medicare contribute in certain ways to a beneficiary's progression through their Part D benefit. If the drug is a Part D covered drug, the price that the Part D plan allows for the drug (the negotiated price) will count towards total covered drug costs for purposes of moving a beneficiary through their Part D benefit. If the drug is covered under a Part D supplemental benefit, the price that the Part D plan allows will count towards supplemental (non-covered) drug costs.

Patient Pay Amounts and other applicable payments for Part D covered drugs (e.g., LICS) will count towards TrOOP costs. Payments by a primary payer never count towards TrOOP. However, they must be reported on the PDE record as reductions to beneficiary and/or Part D plan liability, in the PLRO field. These data assure that TrOOP costs and plan-paid amounts for risk sharing are accurate.

When a beneficiary has Part D coverage, CMS recommends that primary insurers always file a secondary claim with the Part D plan. Much of the time, beneficiaries will have benefits under their Part D plan that can only be claimed by filing a PDE record with CMS. However, even if a beneficiary does not have coverage for a given drug under their Part D plan, it is beneficial for other insurers to report all utilization to the Part D plan to ensure coordination under any Part D medication therapy monitoring program or utilization management program. The Part D plan may deny the claim, but the plan will have more comprehensive utilization information about their enrollee for use in such programs.

17.6 Reinsurance under MSP

We anticipate having few beneficiaries in the catastrophic coverage phase with Medicare as a secondary insurance. However, in those instances CMS will not calculate reinsurance on amounts paid by a primary insurer. Instead, CMS will use adjusted GDCA which will be calculated as:

Adjusted GDCA = GDCA – PLRO

The reinsurance calculation will be:

0.80 * (Adjusted GDCA – reinsurance DIR)

Note: If Adjusted GDCA includes both a Part D plan-paid amount (CPP) and a Patient Pay Amount, reinsurance will cover 80 percent of the sum of these amounts, net of direct and indirect remuneration (DIR). If the Part D plan has no liability and there is only a Patient Pay Amount, the Patient Pay Amount is the only component of Adjusted GDCA and reinsurance will cover 80 percent of the Patient Pay Amount net of DIR.

17.7 Sample Q&As

1. If a beneficiary has Workers' Compensation (WC) coverage, is WC the primary payer or is Part D?

If the Part D Plan knows that the drug used to treat the condition is related to the WC injury and claim, WC would be primary. However, Part D plans should not deny all incoming primary claims simply because a beneficiary has WC coverage. Part D plans will make primary payment in all situations where they do not know whether or not the drug on the claim is related to the WC injury, and should only deny a primary claim when the Part D plan has confidence that the drug is related to the WC injury. If WC was primary, the plan must recover any mistaken payment and submit an adjustment or deletion record to CMS reflecting the change in claim adjudication.

2. If WC or another payer is primary, would the amounts paid by the primary count towards a beneficiary's Part D TrOOP costs and/or total drug costs?

Payments by a primary payer never count towards TrOOP. However, they must be reported on the PDE record as reductions to beneficiary and/or Part D plan liability, in the PLRO field.

If the drug is a Part D covered drug, the price that the Part D plan allows for the drug (the negotiated price) will count towards total covered drug costs for purposes of moving a beneficiary through their Part D benefit. If the drug is covered under a Part D supplemental benefit, the price that the Part D plan allows will count towards supplemental (non-covered) drug costs.

3. Does CMS want PDE records submitted for prescriptions covered under WC or another liability case such as automobile insurance?

In general, yes. Technically, if the drug is not covered at all under the beneficiary's Part D plan, the plan will deny any claim and a PDE does not need to be submitted. Similarly, where a Part D plan denies a claim because it knows that the drug on the claim is related to the WC injury, it would not submit a PDE record to CMS. However, much of the time beneficiaries will have benefits under their Part D plan that need to be claimed by filing an PDE record with CMS. If a beneficiary files a claim with Part D after WC or other

liable party pays, or if a claim is automatically filed under the COB system, the drug costs may count towards TrOOP or other progression by a beneficiary through their Part D benefit (see #2) and should therefore be reported.

In addition, even if a beneficiary does not have coverage for a given drug under their Part D plan, it is beneficial to report all utilization to the Part D plan to ensure coordination under any Part D medication therapy monitoring program or utilization management program. The Part D plan would deny the claim and would not submit a PDE record, but it would have more comprehensive utilization information about their enrollee for use in such programs.

4. If a beneficiary has coverage under AIDS Drug Assistance Program (ADAP), would the ADAP be primary or secondary to Part D?

ADAPs do not fall into any of the categories of primary payers under the MSP laws (GHP, no-fault, liability, or worker's compensation), so they will always be secondary to Part D; there is no MSP with regard to ADAPs. In general, when a plan discovers information about any other health insurance possessed by a beneficiary, it should first report that information to the COBC according to the rules found in the forthcoming ECRS Welcome Packet. The COBC will then follow federal, state, NAIC, and other guidelines to determine payer of precedence. If a payer is primary to Part D, the COBC will post an MSP record in MBD as notice to the Part D plan.

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

MEDICARE PLAN PAYMENT GROUP

TO: All Part D Plan Sponsors

FROM: Cheri Rice, Director
Medicare Plan Payment Group

SUBJECT: Medicare Secondary Payer Prescription Drug Event Calculations and Reporting Standards

DATE: April 23, 2013

The Centers for Medicare & Medicaid Services (CMS) has received questions regarding Prescription Drug Event (PDE) reporting in Medicare Secondary Payer (MSP) situations. Many of these questions are specific to beneficiaries in the coverage gap. The purpose of this memorandum is to provide guidance in those situations.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 extended Medicare secondary payer (MSP) laws applicable to Medicare Advantage (MA) organizations to Part D sponsors. *See* §1860D-2(a)(4). Accordingly, Part D sponsors have the same responsibilities under MSP laws as do MA plans. Part D plans should refer to CMS guidance for detailed rules about establishing payer precedence and interacting with the Coordination of Benefits (COB) contractor to establish, verify and manage an MSP situation. *See* Chapter 14 of the Prescription Drug Benefit Manual.

In the logic for pricing and adjudicating an MSP claim under Part D, the provider/pharmacy receives at least the Part D plan's negotiated price for the drug. Payments are applied to this price in the following order: primary insurer's payment, beneficiary cost sharing liability under the Part D Plan Benefit Package (PBP), and finally the Part D plan payment. If the primary payment is greater than or equal to the Part D negotiated drug price, no other payments are made.

If the drug is a covered Part D drug, the Part D plan's negotiated drug price counts towards gross covered drug costs. Patient Pay Amounts and other applicable payments for covered Part D drugs (*e.g.*, LICS) count towards TrOOP costs. In an MSP situation, the payment by a primary payer never counts towards TrOOP. However, those costs must be reported on the PDE record as reductions to the beneficiary liability and/or Part D plan liability. This data ensures that TrOOP costs and plan-paid amounts for risk sharing are accurate.

Table 1 describes the steps for calculating an MSP claim and populating the PDE record. *See also* Appendix 1 for PDE calculation examples.

Table 1: Steps to Calculate an MSP Claim

STEP	DESCRIPTION
Step 1	Price or re-price the claim according to the Part D plan's negotiated price for the drug. In the Gross Drug Cost Below the OOP Threshold (GDCB) and/or Gross Drug Cost Above the OOP Threshold (GDCA) field, report the negotiated price if the drug is covered under the Part D plan or $0 if the drug is non-covered.
Step 2	Report the primary payment amount in the Patient Liability Reduction due to Other Payer Amount (PLRO) field. Note that if PLRO ≥ gross drug cost (negotiated price), all other payment amounts on the PDE record are $0.
Step 3	Determine the beneficiary and Part D plan liabilities under the PBP.
Step 4	Subtract the primary payment from the negotiated price.
Step 5	Determine Patient Pay Amount. The beneficiary is responsible for either the amount from Step 3 or the remainder in Step 4, whichever is less. Report the lesser amount in Patient Pay Amount; if the lesser amount is negative, report $0 in Patient Pay Amount.
Step 6	Calculate Part D Plan-Paid amount at point of sale (POS). The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price.
Step 7	Report the Part D Plan-Paid, in Covered Plan-Paid Amounts (CPP), Non-covered Plan-Paid Amount (NPP), and/or LICS as follows: a) If the PBP only provides basic coverage, or if the drug is a supplemental drug, the Plan-Paid amount at POS is reported in CPP (for covered drugs) or NPP (for non-covered drugs). b) The calculations to determine LICS Amount do not change under MSP. c) If the PBP provides enhanced alternative cost-sharing, use the following rules to calculate and report CPP Amount and NPP Amount: i. Use the mapping rules[1] to calculate what CPP would be under non-MSP rules; we refer to this value as CPP_c. ii. Subtract the primary payment from CPP_c to determine CPP_r, the value to report in CPP Amount on the PDE record. Note that if primary payment ≥ CPP_c, CPP_r = $0 because CPP_r cannot be a negative amount. iii. NPP_r = Gross Drug Cost – (Patient Pay + PLRO + CPP_r + LICS + Reported Gap Discount* + Other TrOOP). This value is reported in

[1] For mapping rules, see The 2011 PDE Participant Guide, available at http://www.csscoperations.com/internet/Cssc.nsf/files/PDEParticipantGuide%20cameraready%20081811.pdf/$File/PDEParticipantGuide%20cameraready%20081811.pdf.

STEP	DESCRIPTION
	NPP Amount on the PDE record. *Reported Gap Discount will be zero on all MSP PDEs.
Step 8	Report a value = M in the Pricing Exception Code field. Plans will populate this field with 'M' to indicate that the PDE has been paid in accordance with MSP rules. If both codes 'O' (*i.e.*, out-of-network) and 'M' apply for a given PDE, report 'M' as the overriding code because it has the greater effect in payment calculations.

We urge sponsors to carefully follow the steps above to ensure that the PDE fields are populated correctly. Note that on every PDE, the dollars in the detail cost fields (Ingredient Cost Paid, Dispensing Fee Paid, and Total Amount Attributed to Sales Tax) and the dollars in the payment fields (Patient Pay Amount, LICS, Other TrOOP Amount, PLRO, CPP, NPP, and Reported Gap Discount) are compared. If the total costs and the total payments differ by more than the $.05, allowed for rounding error, the PDE will be rejected with error codes 690 (when the costs exceed the payments) or 692 (when the payments exceed the costs).

MSP in the Coverage Gap

Beneficiaries with Medicare Part D as a secondary payer will not receive the manufacturer discount on the negotiated drug price of applicable (*i.e.*, brand) drugs. Therefore, in Step 3 above for brand drugs in 2013:

- the beneficiary liability is 97.5% of the ingredient cost, sales tax, dispensing fee and vaccine administration fee, and
- the plan liability is 2.5% of the ingredient cost and sales tax, dispensing fee and vaccine administration fee.

See example 10 in Appendix 1 below.

For non-applicable (*i.e.*, generic) drugs in 2013:

- the beneficiary liability is 79% of the negotiated price of the drug, and
- the plan liability is 21% of the negotiated price of the drug.

See example 11 in Appendix 1 below.

These liabilities will change each year until the coverage gap is closed in 2020, at which point the beneficiary liability will be 75% for brand drugs and 25% for generic drugs.

Reinsurance under MSP

CMS anticipates having only a few beneficiaries in the catastrophic coverage phase with Medicare as a secondary insurance. In those instances, CMS will not calculate reinsurance on amounts paid by a primary insurer. Instead, CMS will use an adjusted GDCA, which will be calculated as:

Adjusted GDCA = GDCA – PLRO

The reinsurance calculation will be:

0.80 x (Adjusted GDCA[2] – reinsurance DIR)

Mistaken Payment Recovery

CMS instructs the sponsors to process the claim based on the facts known at the time of adjudication and update the claim later if status changes from Medicare primary to Medicare secondary or vice versa. The plan must determine and recover any payments that should have been covered by the other party. Once the other party has adjudicated related claims, the Part D plan must submit adjustment and/or deletion PDEs for those claims. The plan must also re-determine beneficiary liability for those claims. If the sponsor advanced a gap discount on the original claim when Medicare paid primary, the corrected PDE showing that Medicare paid secondary will change the Reported Gap Discount to zero.

[2] If the Adjusted GDCA includes both a Part D plan paid amount (CPP) and a Patient Pay Amount, reinsurance will cover 80% of the sum of these amounts, net of direct and indirect remuneration (DIR). If the Part D plan has no liability and there is only a Patient Pay Amount, the Patient Pay Amount is the only component of the Adjusted GDCA, and reinsurance will cover 80% of the Patient Pay Amount net of DIR.

Appendix 1

PDE Examples

The following examples illustrate how a plan will use these steps to price a claim and populate a PDE record when a primary payment has already been made. In each example, a Part D plan receives a COB segment or non-standard format claim indicating payment by a primary payer. The examples use benefit year 2013 parameters.

Examples 1 – 4 Defined Standard Benefit

In examples 1-4, the beneficiary is enrolled in a defined standard PBP and the drug is a covered Part D drug. In examples 1-3, the beneficiary is in the initial coverage period; in example 4, the beneficiary is in the coverage gap and is eligible for LICS at Co-pay Category Code 1.

Example 1

The primary payment was $75, the negotiated price is $100, and the beneficiary is in the initial coverage period.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $75 in PLRO.

Step 3. Under the PBP, the beneficiary's liability is $25 and plan liability is $75.

Step 4. The difference between the negotiated price and the primary payment is $25, ($100 - $75 = $25).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $25). In this example, the amounts are the same, $25. The plan reports $25 in the Patient Pay Amount field.

Step 6. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. Since the primary paid $75 and the beneficiary liability is $25, the full negotiated price has been covered and Plan-Paid at POS is zero.

Step 7. This is a basic plan and a covered drug, so CPP Amount = $0.

Step 8. The plan reports Pricing Exception field = 'M'.

Example 2

The primary payment was $65, the negotiated price is $100, and the beneficiary is in the initial coverage period.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $65 in PLRO.

Step 3. Under the PBP, the beneficiary's liability is $25 and plan liability is $75.

Step 4. The difference between the negotiated price and the primary payment is $35, ($100 - $65 = $35).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $35). The plan reports $25 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($65) and beneficiary liability ($25) is $90. The plan pays the pharmacy the remaining $10 of the negotiated price, ($100 - $90 = $10).

Step 7. This is a covered drug under a basic plan, so the Plan-Paid amount at POS is reported as CPP Amount = $10 on the PDE.

Step 8. The plan reports Pricing Exception field = 'M'.

Example 3

The primary payment was $90, the negotiated price is $100, and the beneficiary is in the initial coverage period.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $90 in PLRO.

Step 3. It determines the beneficiary's liability is $25 and plan liability is $75 under the PBP.

Step 4. The difference between the negotiated price and the primary payment is $10, ($100 - $90=$10).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $25) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $10). The plan reports $10 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. Since the full negotiated price has been covered, there is no remaining amount to be paid by the plan.

Step 7. The plan reports CPP Amount = $0.

Step 8. The plan reports Pricing Exception field = 'M'.

Appendix 1

Example 4

The primary payment was $40 on a brand name covered drug. There is no dispensing fee for this drug. The beneficiary is in the coverage gap in CY 2013 and is eligible for LICS at co-pay Category Code 1.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $40 in PLRO.

Step 3. Under the PBP, the beneficiary's liability would have been 97.5% or $97.50 but is reduced to $6.60 because the LIS beneficiary is not eligible for cost sharing in the gap.

Step 4. The difference between the negotiated price and the primary payment is $60, ($100 - $40=$60).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 2, $6.60) or the difference between the negotiated price and the amount paid by the primary payer (from Step 3, $60). The plan reports $6.60 in the Patient Pay Amount field.

Step 6. At POS, the Part D plan pays any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($6.60) = $46.60. The plan pays the pharmacy the remaining $53.40 of the negotiated price, ($100 - $46.60 = $53.40).

Step 7. LICS Amount is the difference between the non-LI cost sharing ($97.50) and the LI cost sharing ($6.60) under the PBP, $92.50. Since all that remains after the primary payer and beneficiary liability is $53.40, all $53.40 is attributable to LICS.

Step 8. The plan reports Pricing Exception field = 'M'.

Example 5 Primary payment > negotiated price

In example 5, we illustrate calculating and reporting rules in an MSP situation where the primary payment exceeds the negotiated price of the drug. The plan is an alternative plan (either basic or enhanced). We also use this example to show calculations in a case where a beneficiary has no cost sharing for a particular drug under their PBP.

Example 5

A beneficiary is in the pre-catastrophic phase of his/her benefit and fills a prescription for a generic covered drug with zero beneficiary cost sharing. The primary payment was $15, which is greater than the $10 negotiated price of the drug.

Step 1. The plan prices the claim at its negotiated price of $10 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $15 in PLRO. Note that all other payment fields will equal $0 since PLRO > gross drug cost (negotiated price).

Step 3. It determines that there is no beneficiary liability for a generic drug under the PBP, and the plan liability is $10.

Step 4. The difference between the negotiated price and the primary payment is -$5, ($10 - $15= -$5).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $0) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, -$5). The beneficiary cannot have a negative cost-share, so the plan reports $0 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. Since the full negotiated price has been covered, there is no remaining amount to be paid by the plan.

Step 7. CPP Amount = $0.

Step 8. The plan reports Pricing Exception field = 'M'.

Examples 6 – 9 Enhanced Alternative Benefits

In examples 6-9, the beneficiary is in an enhanced alternative (EA) plan. We illustrate the MSP rules and rules for reporting EA benefits to populate a PDE record for covered and non-covered drugs. Note that third party payments are applied to covered benefits before non-covered benefits; specifically, they reduce CPP amounts before NPP amounts. Also, NPP can be negative, but CPP cannot be reduced below zero. The enhanced PBP has no coverage in the gap and the enhanced initial coverage period has a tiered cost sharing structure of $5/$20/$40/25%. The beneficiary purchases a Tier 2 drug.

Example 6

Year-to-date (YTD) total covered drug costs is $360. The drug is a covered Part D drug with a negotiated price of $100. Primary Payment is $60.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $60 in PLRO.

Step 3. Under the PBP, the beneficiary is in the initial coverage period and is liable for a co-pay of $20. The plan liability is $80.

Step 4. The difference between the negotiated price and the primary payment is $40, (100 - $60 = $40).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid

by the primary payer (from Step 4, $40). The plan reports $20 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($60) and beneficiary liability ($20) = $80. So at POS, the plan-paid amount is $20, ($100 - $80 = $20).

Step 7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c of $75 by mapping to the defined standard benefit (Mapping Rule 2). CPP_r = $75 - $60 = $15

NPP_r = $100 – ($20 + $60 + $15 + $0 + $0 + $0) = $5

Step 8. The plan reports Pricing Exception field = 'M'.

Example 7

YTD total covered drug costs is $4,600. The drug is a supplemental drug with a negotiated price of $100. The primary payment is $40.

Step 1. The plan prices the claim at its negotiated price of $100. Because the drug is non-covered, the plan reports $0 in the GDCB field.

Step 2. The plan reports the primary payment of $40 in the PLRO field.

Step 3. Under the PBP, the beneficiary is still in the initial coverage period so is liable for a $20 copay. The plan liability is $80.

Step 4. The difference between the negotiated price and the primary payment is $60, ($100 - $40 =$60).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $60). The plan reports $20 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($40) and beneficiary liability ($20) is $60. So at POS, the plan-paid amount is $40, ($100 - $60 = $40).

Step 7. Since this is a supplemental drug, the $40 payment is reported in NPP Amount.

Step 8. The plan reports Pricing Exception field = 'M'.

Appendix 1

Example 8

YTD total covered drug costs is $6,960. The beneficiary is in the enhanced initial coverage period. The drug is a covered Part D drug with a negotiated price of $100. The primary payment is $50.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $50 in the PLRO field.

Step 3. Under the PBP, the beneficiary is still in the initial coverage period and is liable for a $20 copay. The plan liability is $80.

Step 4. The difference between the negotiated price and the primary payment is $50, ($100 - $50 = $50).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $20) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $50). The plan reports $20 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($50) and beneficiary liability ($20) is $70, so Part D Plan-Paid at POS = $30.

Step 7. Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c of $15 by mapping to the defined standard benefit (Mapping Rule 4). CPP_r = $15 - $50 = $-35, therefore CPP_r = $0

NPP_r = $100 – ($20 + $50 + $0 + $0 + $0 + $0) = $30

Step 8. The plan reports Pricing Exception field = 'M'.

Example 9

The conditions are the same as in Example 8 except the beneficiary is eligible for LICS at co-pay Category Code 1 and the primary payment is $10.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $10 in the PLRO field.

Step 3. Under the PBP, the beneficiary is liable for a $20 co-pay, reduced to $2.65 because of LICS. The plan liability is $80 (not taking LICS into account).

Step 4. The difference between the negotiated price and the primary payment is $90, (100 - $10 = $90).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $2.65) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $90). The plan reports $2.65 in the Patient Pay Amount field.

Step 6. The Part D plan is only responsible for any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The sum of the primary payment ($10) and beneficiary liability ($2.65) is $12.65, so Part D Plan-Paid at POS = $87.35, ($100 - $12.65 = $87.35).

Step 7. a) The LICS Amount is the difference between the non-LI cost sharing ($20) and the LI cost sharing under the PBP ($2.65). LICS Amount = $20 - $2.65 = $17.35.

b) Since this is an enhanced alternative plan and a covered drug, the plan calculates CPP_c of $15 by mapping to the defined standard benefit (Mapping Rule 4). CPP_r = $15 - $10 = $5

NPP_r = $100 – ($2.65 + $10 + $5 + $17.35 + $0 + $0) = $65

Step 8. The plan reports Pricing Exception field = 'M'.

Example 10 and 11 Coverage Gap Phase Examples

The following examples illustrate the MSP rules in the Coverage Gap for Defined Standard Benefit plans. Example 10 illustrates that the PDE is exempt from the Coverage Gap Discount, however the plan cost-sharing of 2.5% in 2013 applies. Example 11 illustrates that the generic cost-sharing applies to MSP PDEs.

Example 10

The primary payment for a brand name drug was $10, and the beneficiary is in the coverage gap in CY 2013. There is no dispensing fee for this drug.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $10 in PLRO.

Step 3. Under the PBP, the beneficiary's liability is 97.5% of the negotiated price, $97.50. The plan liability is 2.5%, $2.50.

Step 4. The difference between the negotiated price and the primary payment is $90, ($100 - $10 = $90).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $97.50) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $90). In this example, the beneficiary pays $90. The plan reports $90 in the Patient Pay Amount field.

Step 6. The Part D plan pays the pharmacy any amount remaining after the primary payment ($10) and the beneficiary's cost sharing ($90) under the PBP have been applied, up to the Part D plan's negotiated price. The Part D Plan-Paid Amount is $0 because the primary payment and the beneficiary liability cover the negotiated cost of the drug.

Step 7. CPP Amount = $0, and the NPP Amount = $0.

Step 8. The plan reports Pricing Exception field = 'M'.

Example 11

The primary payment for a generic drug was $10 and the beneficiary is in the coverage gap in CY 2013.

Step 1. The plan prices the claim at its negotiated price of $100 and reports this amount in the GDCB field.

Step 2. The plan reports the primary payment of $10 in PLRO.

Step 3. Under the PBP, the beneficiary's liability is 79% of the negotiated price of the drug, $79. The plan liability is 21% of the negotiated price of the drug, $21.

Step 4. The difference between the negotiated price and the primary payment is $90, ($100 - $10 = $90).

Step 5. The beneficiary is responsible for whichever is less, the cost sharing under the PBP (from Step 3, $79) or the difference between the negotiated price and the amount paid by the primary payer (from Step 4, $90). In this example, the beneficiary pays $79. The plan reports $79 in the Patient Pay Amount field.

Step 6. The Part D plan pays the pharmacy any amount remaining after the primary payment and the beneficiary's cost sharing under the PBP have been applied, up to the Part D plan's negotiated price. The Part D Plan-Paid Amount = Negotiated drug price – (Primary Payment + Patient Pay Amount). $100 – ($10 + $79) = $11

Step 7. This is a covered Part D drug, therefore, CPP Amount = $11, and the NPP Amount = $0.

Step 8. The plan reports Pricing Exception field = 'M'.