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Center for Medicare
Medicare Plan Payment Group

Date: July 9, 2010

To: All Part D Plan Sponsors

From: Cheri Rice, Acting Director, Medicare Plan Payment Group

Subject: Revised Guidance for Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap

This memorandum provides Part D sponsors with revised guidance regarding PDE record changes for 2011, taking into account the comments received in response to PDE and Program draft guidance, "Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap" and "Medicare Coverage Gap Discount Program Beginning in 2011", released via HPMS on April 30, 2010. Specifically, this guidance includes PDE record changes necessary to implement the Medicare Coverage Gap Discount Program, as required under Section §1860D-14A and §1860D-43 of the Social Security Act (the Act) as well as coverage for generic drugs in the coverage gap, as required under Section §1860D-14A(b)(1)(C) of the Act. The guidance also includes one additional PDE record change in anticipation of forthcoming revisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard for retail pharmacy transactions. Finally, the guidance includes PDE record changes that improve our ability to evaluate data quality, for the Gap Discount program and for overall payment accuracy. Please direct further questions regarding this guidance and implementation of the Gap Discount Program and cost sharing for generic drugs in the gap by email to PDEJan2011@cms.hhs.gov. In subsequent guidance CMS will publish additional information describing PDE editing and reporting.

In response to public comments, we offer the following responses:

Comment: One commenter suggested adding additional values to the Formulary Code field to identify prescriptions that are filled through a transition fill, exception or appeal.

Response: We have not added additional values because additional reporting would burden those sponsors who process exceptions and appeals outside their claims processing system. Furthermore, we believe the information in the Drug Coverage Status Code and the Formulary Code will identify these special situations. If Drug Coverage Status Code = C and Formulary Code = N, we will assume that the PDE documents a transition fill, exception or appeal.

Comment: Many commenters suggested adding all new fields to the end of the current PDE record layout and making the position where Prescription Service Reference No. is currently housed into filler.

Response: While we acknowledge this suggestion, we must consolidate as much contiguous filler space as possible to afford ourselves the maximum flexibility in the event that new PDE fields are required in the future. Leaving filler in place of the old Prescription Service Reference No. in the middle of the PDE record potentially limits our options to add additional data elements in the future.

Comment: Many commenters were concerned that CMS would institute hard rejects when the Reported Gap Discount submitted by the sponsor and the CMS Calculated Gap Discount values differed.

Response: A full description of how each of the new fields will be edited will be provided in future CMS guidance.

Comment: Commenters asked which field, Reported Gap Discount or CMS Calculated Gap Discount, would appear on the manufacturer invoices.

Response: CMS will submit Reported Gap Discount on manufacturer invoices.

Recertification

Because the 2011 PDE layout and editing changes will be significant, CMS will require that existing PDE submitters complete re-certification and that each Part D Sponsor be associated with a PDE submitter who has completed recertification. Part D Sponsors shall confirm that their submitters have completed recertification. On an on-going basis we urge all PDE submitters to make full use of the testing/certification database to ensure accurate PDE reporting as submitters apply system changes. Effective January 1, 2011, successful recertification is a requirement for file submission. At that time CMS will reject files from submitters who have not completed recertification, regardless of date of service. Existing certification procedures are posted on our customer service web-site at www.CSSCOperations.com. Early this fall, CMS will outreach to existing submitters with additional information about recertification procedures.

Operational Instruction Clarifications

In response to further policy guidance issued by CMS on the Gap Discount program (HPMS Memos dated April 16, May 21, May 25, and June 2) we have identified several areas in which we wish to further clarify our operational instructions.

CMS Program guidance states that the Gap Discount does not apply in two specific circumstances when 1.) Medicare pays Secondary (MSP) and when 2.) Part D Sponsors coordinate benefits with Non-Part D payers who incorrectly pay primary to Medicare.

Medicare as Secondary Payer (MSP): The Gap Discount does not apply when Medicare pays secondary. To clarify further, Part D Sponsors have a responsibility to pay secondary when they have identified MSP claims based on Coordination of Benefit files, beneficiary self report or communication with the primary payer. CMS instructs the Sponsor 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. When claim status changes, the Sponsor must revise the claim and report a corrected PDE. 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 Reported Gap Discount to zero. To identify MSP status, Sponsors report the value of "M" in the Pricing Exception Code on the PDE.

Benefit Coordination with Non-Part D payers who incorrectly pay primary to Medicare: CMS requires that Part D Sponsors coordinate benefits with payers outside Part D when a non-Part D payer pays in error, either by paying when there was no payment responsibility or by paying out of order as the primary rather than secondary. Although Part D Sponsors must continue to meet their responsibilities to coordinate benefits with other payers, additional Program Guidance published on June 2, 2010 titled "Additional Guidance Pertaining to the Medicare Coverage Gap Discount Program beginning in 2011" clarifies that the Gap Discount does not apply when Part D sponsors coordinate benefits directly with other payers. In these coordination of benefit scenarios, one can assume that the beneficiary did not encounter a coverage gap on the original claim. Sponsors shall identify these claims by reporting the value of "C" in the Non-Standard Format Code on the PDE. (Please note that this guidance does not apply to paper claims submitted to Part D Sponsors by beneficiaries and providers.)

Group Health and Waiver Plans (EGWPs): In program guidance published in HPMS on May 21, 2010 and June 2, 2010 CMS determined that EGWPs are included in the Gap Discount Program. An EGWP may provide supplemental benefits in the coverage gap or may restructure to provide commercial (non-Part D) wrap-around coverage that supplements a basic Part D benefit package. The supplemental payer examples in Attachment 4 apply equally to an EGWP that offers a supplemental benefit in the coverage gap. (See Examples 8, 9 and 10.) These examples clarify that the supplemental benefit applies before the gap discount. When an EGWP offers supplemental benefits in the Coverage Gap, CMS assumes that EGWP applies the defined standard ICL. We also provide "Other Health Insurance" examples for payers who are and are not TrOOP eligible. Both OHI examples illustrate that the Gap Discount applies in full before the OHI payer further reduces beneficiary cost-sharing. EGWPs that restructure the Part D benefit in the coverage gap with a commercial wrap-around should review the OHI example for the payer who is not TrOOP eligible. (See Example 3.)

Dispensing Fee Paid: A small number of pharmacies including some mail order pharmacies receive no dispensing fee. In all other cases, when the Sponsor pays the pharmacy a dispensing fee, the Sponsor must report the dispensing fee in the Dispensing Fee Paid field on the PDE and exclude that same reported value from the Gap Discount calculation. Currently some sponsors combine the dispensing fee with the ingredient cost (e.g. Usual & Customary) when they apply lesser of logic to determine negotiated price. Since the total amount was correct this practice previously had no adverse payment impact. In order to validate Gap Discount calculation in 2011 and beyond, CMS requires that sponsors explicitly identify and report dispensing fees.

Default and Sponsor-defined values in non-Standard Format PDEs: CMS will no longer accept sponsor-defined values submitted in Non-Standard format PDEs reporting Gap Discounts. Effective in 2011 CMS rescinds its guidance published in 2005 that allowed Service Provider ID Qualifier = '99', the default "PAPERCLAIM" value and other plan-defined values in Service Provider ID or Prescription Service Reference No when Gap Discount is greater than zero.

PDEs reporting Vaccine Administration Fee only: CMS analyzed current reporting practice and determined that Sponsors rarely report a vaccine administration fee on a PDE separate from the vaccine drug cost. In the majority of cases we receive a single PDE combining both the vaccine drug cost and the vaccine administration fee. We will further evaluate the necessity of reporting vaccine administration fees separately. In the limited instances in which a Sponsor currently submits a vaccine administration fee only, Sponsors should report the same Tier, Brand/Generic Code and Formulary Code submitted on the PDE reporting vaccine drug cost. We eliminated the proposed Formulary Code and Brand/Generic Code value of "V- Vaccine administration Fee only" because the volume of PDEs is insufficient to justify a unique value.

Quantity: CMS reminds sponsors to review edit and data quality procedures to identify incorrect quantity amounts. Accurate unit price calculations, which are part of manufacturer invoice reporting, are dependent on correct quantity amounts.

Data Timeliness: CMS needs timely PDE data to implement the Gap Discount Program successfully. We will review timely submission patterns and outreach to sponsors with trends indicating delayed data submission.

Changes to PDE Record Layout

Effective January 1, 2011, CMS will revise the PDE detail record layout. See Attachment 1 for the revised PDE File Layout. See Attachment 2 for the revised PDE Return File Layout. Sponsors and CMS will use the revised record layouts for all PDE files submitted on or after January 1, 2011, regardless of date of service. New data elements defined in this guidance apply only to dates of service on and after January 1, 2011, excluding the Date Original Claim Received field which we require for PDEs submitted by LI-Net contracts for all dates of service.(There is one exception to this for the LI NET contract. See Date Original Claim Received field description below.) For earlier dates of service sponsors shall report either blanks or zeros in financial or date fields (Date Original Claim Received, Claim Adjudication Began Timestamp, Total Gross Covered Drug Cost Accumulator, True out-of-Pocket Accumulator and Reported Gap Discount) and blanks in alphanumeric fields (Brand/Generic Code, Beginning Benefit Phase, Ending Benefit Phase, Tier and Formulary Code). Until CMS issues further guidance, sponsors shall report blank in the Gap Discount Plan Override Code for all dates of service. We discuss the revised Prescription Service Reference No field format in further detail below. Finally, CMS is reserving a two position filler field in the event that we collect Unit of Measure at some point in the future. A description of each new or changing field follows.

Field Name	Picture	Length	Values
Date Original Claim Received	9(8)	8	CCYYMMDD
Claim Adjudication Began Timestamp	X(26)	26	CCYY-MM-DD-HH.MM.SS.MMMMMM
Total Gross Covered Drug Cost Accumulator[P]	S9(7)V99	9	$9,999,999.00
True Out-of-Pocket Accumulator[P]	S9(6)V99	8	$999,999.00
Brand/Generic Code	X(1)	1	B, G
Beginning Benefit Phase[P]	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic
Ending Benefit Phase[P]	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic
Tier[P]	X(1)	1	1, 2, 3, 4, 5, 6
Formulary Code[P]	X(1)	1	F, N
Reported Gap Discount[P]	S9(6)V99	8	$999,999.00
CMS Calculated Gap Discount[P]	S9(6)V99	8	$999,999.00
Gap Discount Plan Override Code[P]	X(1)	1	blank, additional values to be defined
Prescription Service Reference No	9(12)	12	This field currently exists as 9 positions and will be expanded to 12 positions

Table Notes:
[P] Not Reported for Program of All Inclusive Care for the Elderly (PACE) Organizations

Date Original Claim Received: Date Original Claim Received is the date the sponsor received the original claim. This date applies to both standard and non-standard format claims. When a corrected PDE is submitted, Date Original Claim Received does not change. (Sponsors correct PDEs either by submitting an adjustment PDE or by submitting a delete PDE followed by a new original PDE that replaces the previous record.) LI NET plans *only* must populate the Date Original Claim Received on all PDEs *submitted* on or after January 1, 2011, regardless of date of service. All other sponsors shall report Date Original Claim Received on all PDEs with date of service on or after January 1, 2011.

CMS will use Date Original Claim Received to reconcile Limited Income Newly Eligible Transition (LI NET) plans because the LI NET reconciliation is based on claims received during a year instead of year of service. Additionally, CMS will compare Date of Service, Date Original Claim Received and the Date Adjudication Began Time Stamp (described below) to identify claims with processing lags.

Claim Adjudication Began Timestamp: The Claim Adjudication Began Timestamp reports the date and time adjudication of the claim began in timestamp format, using Greenwich Mean

Time. The Claim Adjudication Began Timestamp reported in a corrected PDE documents the time stamp when the claim was corrected. Stated another way, if a sponsor changes a PDE through an adjustment or a deletion/resubmission, the Claim Adjudication Began Timestamp will change.

To validate benefit phase for coverage gap claims, as well as other claims in other benefit phases, we must simulate claims processing by sorting PDEs in processing order (i.e. ascending order by the Claim Adjudication Began Timestamp.) While we realize that there are circumstances that would inhibit our ability to simulate processing order exactly, CMS believes this is a marked improvement over our current process of using date of service to replicate processing order. (That approach is inadequate when a beneficiary has multiple PDEs on a single date of service, when a claim is adjusted or when a claim is processed late, after claims with subsequent dates of service were processed.

Total Gross Covered Drug Cost 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. Total Gross Covered Drug Cost 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. We use The Total Gross Covered Drug Cost Accumulator in combination with the True Out-of-Pocket (TrOOP) Accumulator described below to validate benefit phase. The Total Gross Covered Drug Cost Accumulator field should be left blank on PDEs for OTC or Enhanced drugs.

True Out-of-Pocket (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) and Other TrOOP and will include the newly 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.

Brand/Generic Code: Brand/Generic Code is a plan reported value indicating that the plan *adjudicated the claim* as a brand drug or a generic drug. For example, if a brand NDC is adjudicated as a generic drug for the purpose of assessing generic cost sharing, the PDE should reflect Generic in the Brand/Generic code. Applies to Covered Drugs only.

Beginning Benefit Phase: The Beginning Benefit Phase is the plan-defined benefit phase that is in effect for the beneficiary at the time the sponsor begins adjudication of the individual claim being reported. For example, the Beginning Benefit Phase for a beneficiary's first claim in the benefit year is the Initial Coverage Period in a plan with no deductible. In a defined standard plan, the Beginning Benefit Phase for a beneficiary's first claim in the benefit year is the Deductible Phase. Applies to Covered Drugs only.

Ending Benefit Phase: The Ending Benefit Phase is the plan-defined benefit phase that is in effect at the time the sponsor completes adjudication of the individual claim being reported. The Ending Benefit Phase should always be a benefit phase equal to or later than the Beginning Benefit Phase. Applies to Covered Drugs only.

With the addition of Total Gross Covered Drug Cost Accumulator, True Out-of-Pocket (TrOOP) Accumulator, Beginning Benefit Phase, and Ending Benefit Phase, CMS can readily identify PDEs that straddle benefit phases which will assist in our review of the accuracy of the PDE data.

There are valid reasons why the reported accumulators, the phases and the cost-sharing can appear inconsistent on the same PDE or in comparison to other PDEs for the same beneficiary. When sponsors report "as administered" isolated inconsistencies can occur if a prior PDE is deleted after a beneficiary has entered the next benefit phase and future PDEs are used to pay back the cost-sharing associated with the deleted PDE. Please see the example in Attachment 3.

Tier: Tier is the formulary tier in which the sponsor adjudicated the claim. CMS will use tier to validate cost-sharing. In the case of an OTC PDE, the Tier field should be left blank. Plans that administer the Defined Standard Benefit shall report the value of "1" in Tier. Applies to Covered Drugs only.

Formulary Code: The Formulary Code indicates if the drug is on the plan's formulary. The Gap Discount applies to a drug that is on the plan's formulary or is provided through a transition fill, exception or appeal. Applies to Covered Drugs only.

Reported Gap Discount: Reported Gap Discount is the reported amount that the sponsor advanced at point-of-sale for the Gap Discount. Part D sponsors advance the Gap Discount at point-of-sale to applicable beneficiaries who purchase an applicable drug that falls, in part or in full, in the Coverage Gap. The Gap Discount is based on the plan-defined benefit phase. The Gap Discount applies to the negotiated price as defined in §1860D-14A(g)(6) which excludes dispensing fee. For purposes of calculating the Gap Discount, the negotiated price is the sum of the Ingredient Cost Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee.

CMS Calculated Gap Discount: CMS Calculated Gap Discount is the Gap Discount amount calculated by CMS during on-line PDE editing, based on the data reported in the PDE. CMS will populate the CMS Calculated Gap Discount in the PDE return file sent back to submitters after PDE records are edited. CMS will evaluate differences between the Reported Gap Discount submitted by the sponsor and the CMS Calculated Gap Discount.

Gap Discount Plan Override Code: The Gap Discount Plan Override Code is a field reserved for future use. It will potentially provide sponsors and CMS the flexibility to report additional information that resolves differences between CMS Calculated Gap Discount and Reported Gap Discount. For example, if CMS rejected a PDE because Reported Gap Discount submitted by the plan and the CMS Calculated Gap Discount differed, the sponsor could use the Gap Discount

Plan Override Code to explain a valid reason for the difference. CMS reserves this field for future use because we need experience with Reported Gap Discount to maximize the utility of this approach.

Data Reporting Changes for Existing PDE Fields

Prescription Service Reference No: Effective January 2012, the National Council for Prescription Drug Programs (NCPDP) will update the current HIPAA standard format for retail pharmacy transactions. The update expands the current Prescription Service Reference No to twelve positions. The Prescription Service Reference No is one of several PDE fields that originate in NCPDP billing transactions. Therefore CMS must make the same change. In addition to increasing field length, we must shift adjacent fields three positions to the right. This format change affects the PDE detail record only. We are consolidating the Prescription Service Reference No expansion with other format changes discussed in this guidance to minimize workload for CMS, sponsors and their processors.
Today, because the NCPDP format for Prescription Service Reference No is 9(7) and the PDE format is 9(9), we instruct sponsors to report leading zeros in the two leftmost positions of the PDE field. Effective with all PDEs submitted on or after January 1, 2011 (regardless of DOS), CMS instructs sponsors to report the Prescription Service Reference No as a twelve position field, using leading zeros as necessary to fully populate the new twelve position format.

If sponsors implement the full twelve position value ahead of schedule during 2011, CMS will be ready to receive the expanded value. However, we remind these sponsors to use the 2011 Prescription Service Reference No format displayed below when submitting adjustment, deletion and resubmitted PDEs that modify records submitted before January 1, 2011. Otherwise, CMS cannot link the adjustment, deletion and resubmitted PDEs to the appropriate parent records,

CMS instructs sponsors who continue to report the existing seven position value in 2011 to report leading zeros in the five leftmost positions. The example below shows how a seven position Prescription Service Reference No is currently reported in 2010 and how it will be reported in 2011.

Prescription Service Reference No – 2010

0	0	7	7	7	7	7	7	7

Prescription Service Reference No – 2011

0	0	0	0	0	7	7	7	7	7	7	7

Dispensing Status: CMS will no longer accept any values in the Dispensing Status field on the PDE record for dates of service on or after January 1, 2011. The legal values for this field are ‘P’ for partial claim or ‘C’ for complete claim. At program start-up, CMS collected Dispensing Status as a key field in order to align with industry practice. Based on our analysis of recent PDE data, the number of PDEs with Dispensing Status values of ‘P’ or ‘C’ is negligible. It is cost prohibitive to continue collecting and testing data that is seldom used. Effective for dates of service on or after January 1, 2011, CMS will reject PDEs reporting Dispensing Status values of ‘P’ or ‘C’. If sponsors accept partial and complete claims from pharmacies, CMS instructs sponsors to combine the partial and complete claims and report a single PDE summarizing both

billing transactions. If a sponsor reports a PDE prematurely based on a partial fill only, the Sponsor must adjust the PDE if the completion billing transaction is subsequently received. Sponsors shall continue reporting Dispensing Status values of 'P' or 'C' on PDEs for dates of service before January 1, 2011.

Catastrophic Coverage Code: The newly added Beginning Benefit Phase and Ending Benefit Phase fields will replicate data currently reported in the Catastrophic Coverage Code field. Therefore, Catastrophic Coverage Code is optional for dates of service on or after January 1, 2011. If reported for dates of service on or after January 1, 2011, CMS will continue to edit this field for valid values, however we will rely on the new benefit phase fields for other benefit phase specific editing. Sponsors shall continue reporting Catastrophic Coverage Code on PDEs for dates of service before January 1, 2011.

Coverage for Generic Drugs in the Coverage Gap for Non-Low Income Subsidy (LIS) Beneficiaries

Effective January 1, 2011, generic coinsurance is reduced for non-low income (LI) eligible beneficiaries with claims that fall, in part or in full, in the coverage gap. On January 1, 2011, generic co-insurance for non-LI eligible beneficiaries with drugs that fall in the Coverage Gap will be 93 percent. The sponsor will pay the remaining seven percent. By 2020 the coverage gap will effectively be closed for generics; beneficiary cost-sharing for generics in the gap will be 25% which is equivalent to initial coverage period cost-sharing. Sponsors will report the plan's cost-sharing in the PDE in the Covered D Plan Paid (CPP) amount which will be subject to risk-sharing.

Below we provide beneficiary and plan generic cost-sharing in the coverage gap by year from 2011 through 2020.

Year	Beneficiary Cost-Sharing	Plan Cost-Sharing
2011	93%	7%
2012	86%	14%
2013	79%	21%
2014	72%	28%
2015	65%	35%
2016	58%	42%
2017	51%	49%
2018	44%	56%
2019	37%	63%
2020	25%	75%

CMS requires no additional PDE data to implement reduced beneficiary cost-sharing for generic drugs in the Coverage Gap. In accordance with current guidance, sponsors report beneficiary cost-sharing in the existing Patient Pay Amount field (and Other TrOOP Amount or Patient Liability Reduction Due to Other Payer Amount (PLRO), if applicable) and plan cost-sharing in the existing CPP field. Unlike Gap Discount calculations that apply to the sum of the Ingredient Cost Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee, generic cost-sharing in the gap applies to the sum of the aforementioned fields plus the Dispensing Fee Paid.

CPP Mapping Rules: Reduced beneficiary cost-sharing for generic drugs in the Coverage Gap does alter PDE reporting rules for Enhanced Alternative (EA) plans. CMS uses CPP to calculate risk-sharing. In order to apply risk-sharing uniformly across all plan types, we instruct EA plans to map CPP consistent with the defined standard benefit. EA plans apply mapping rules based on total gross covered drug cost, without regard to plan-defined benefit phases, to calculate the covered portion and the non-covered portion of plan payments. For additional information see Module 8: Calculating and Reporting Enhanced Alternative Benefit in the Participant Training Guide available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.

The mapping rules must change to account for the impact of generic utilization in the Coverage Gap. We require two different mapping methodologies.

Beneficiaries eligible for LIS: We extend the current methodology for beneficiaries eligible for LIS because cost-sharing for generic drugs in the Coverage Gap does not apply.

Beneficiaries who are not eligible for LIS: Because cost-sharing reduces beneficiary payments that count towards TrOOP, the beneficiary has additional drug spending before reaching the OOP threshold. Mapping rules 3 and 4 use the total gross covered drug cost at the OOP threshold for the defined standard beneficiary (with no other health insurance) to determine the percentage to calculate the defined standard benefit. In 2011, that amount is $6,447.50. To account for additional generic drug spending to reach the OOP threshold, we increase that amount from $6,447.50 to $6,483.72**.** Please see mapping charts below**.**

MAPPING TO THE DEFINED STANDARD BENEFIT
TO CALCULATE CPP AMOUNT 2011
LIS ELIGIBLE BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	<= $310	0%
2	>$310 and <= $2,840	75%
3	>$2,840 and <= $6,447.50	0%
4	>$6,447.50 and <= OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost -$2/$5)

MAPPING TO THE DEFINED STANDARD BENEFIT
TO CALCULATE CPP AMOUNT 2011
BENEFICIARIES INELIGIBLE FOR LIS

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	<= $310	0%
2	>$310 and <= $2,840	75%
3	>$2,840 and <= $6,483.72	0%
4	>$6,483.72 and <= OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost -$2/$5)

Examples of calculating cost sharing on generic PDEs in the coverage gap are provided as Attachment 5.

Prescription Drug Event Record Layout

HDR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"HDR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Unique ID assigned by CMS.
3	FILE ID		10 - 19	X(10)	10	PDFS	Unique ID provided by Submitter. Same ID cannot be used within 12 months.
4	TRANS DATE		20 - 27	9(8)	8	PDFS	Date of file transmission to PDFS.
5	PROD TEST CERT IND		28 - 31	X(4)	4	PDFS	PROD, TEST, CERT
6	FILLER		32 - 512	X(481)	481		SPACES

BHD RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BHD"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Assigned by CMS
4	PBP ID		16 - 18	X(3)	3	CMS	Assigned by CMS
5	FILLER		19 - 512	X(494)	494		SPACES

DET RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CLAIM CONTROL NUMBER		11 - 50	X(40)	40	CMS	Optional Field
4	HEALTH INSURANCE CLAIM NUMBER (HICN)		51 - 70	X(20)	20	CMS	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER ID	302-C2	71 - 90	X(20)	20	NCPDP	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	304-C4	91 - 98	9(8)	8	NCPDP	CCYYMMDD Optional Field
7	PATIENT GENDER CODE	305-C5	99 - 99	9(1)	1	NCPDP	1 = M 2 = F Unspecified or unknown values are not accepted
8	DATE OF SERVICE (DOS)	401-D1	100 - 107	9(8)	8	NCPDP	CCYYMMDD
9	PAID DATE		108 - 115	9(8)	8	CMS	CCYYMMDD, The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans , Optional for all other plans
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 - 127	9(12)	12	NCPDP	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 which applies to all PDEs submitted January 1, 2011 and after. Field will be right justified and filled with 5 leading zeroes.
11	FILLER		128 - 129	X(2)	2		SPACES
12	PRODUCT SERVICE ID	407-D7 or 489-TE	130 - 148	X(19)	19	NCPDP	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is MMMMMDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996.
13	SERVICE PROVIDER ID	202-B2	149 - 150	X(2)	2	NCPDP	Mandatory for Standard Format

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
	QUALIFIER						The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Number 08 = State License 11 – Federal Tax Number 99 – Other For Non-Standard formats any of the above values are acceptable. For Standard Data Format, valid values are 01 – NPI or 07 – NCPDP Provider ID
14	SERVICE PROVIDER ID	201-B1	151 - 165	X(15)	15	NCPDP	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Number 08 = State License 11 = Federal Tax Number 99 = Other (and Reported Gap Discount = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
15	FILL NUMBER	403-D3	166 - 167	9(2)	2	NCPDP	Values = 0 - 99.
16	DISPENSING STATUS	343-HD	168 - 168	X(1)	1	NCPDP	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
17	COMPOUND CODE	406-D6	169 - 169	9(1)	1	NCPDP	0=Not specified 1=Not a Compound 2=Compound
18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	408-D8	170 - 170	X(1)	1	NCPDP	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
							4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	442-E7	171 - 180	9(7)V999	10	NCPDP	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER		181 - 182	X(2)	2		SPACES
21	DAYS SUPPLY	405-D5	183 - 185	9(3)	3	NCPDP	0 – 999
22	PRESCRIBER ID QUALIFIER	466-EZ	186 - 187	X(2)	2	NCPDP	The type of prescriber identifier used in field 22. 01 = National Provider Identifier (NPI when implemented) 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for Standard Format. Optional when non-standard data format = 'B', 'C', 'P', or 'X'
23	PRESCRIBER ID	411-DB	188 - 202	X(15)	15	NCPDP	Mandatory for Standard Format. Mandatory for non-standard data format when Prescriber ID Qualifier is present and valid. Optional when non-standard data format = 'B', 'C', 'P', or 'X' when Prescriber ID Qualifier is not present
24	DRUG COVERAGE STATUS CODE		203 - 203	X(1)	1	CMS	Coverage status of the drug under part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE		204 - 204	X(1)	1	CMS	A = Adjustment D = Deletion Blank = Original PDE
26	NON- STANDARD FORMAT CODE		205 - 205	X(1)	1	CMS	Format of claims originating in a non-standard format. B = Beneficiary submitted claim

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
							C = COB claim P = Paper claim from provider X = X12 837 Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE		206 - 206	X(1)	1	CMS	M= Medicare as Secondary Payer (Medicare is Primary) O = Out-of-network pharmacy service (Medicare is Primary) Blank = In-network pharmacy
28	CATASTROPHIC COVERAGE CODE		207 - 207	X(1)	1	CMS	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are A = Attachment Point C = Above Attachment Point met on this event Blank = Attachment Point not met
29	INGREDIENT COST PAID	506-F6	208 - 215	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	507-F7	216 - 223	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee reported in Field 41.
31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX		224 - 231	S9(6)V99	8	CMS	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.
32	GROSS DRUG COST BELOW OUT- OF-POCKET THRESHOLD (GDCB)		232 - 239	S9(6)V99	8	CMS	Reports covered drug costs at or below the out of pocket threshold. Equals the sum of Ingredient Cost + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. Any remaining portion is reported in GDCA. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
							Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling at or below the OOP threshold. The remaining portion is reported in GDCA. These amounts increment the Gross Covered Drug Cost Accumulator amount.
33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)		240 - 247	S9(6)V99	8	CMS	Reports covered drug costs above the out of pocket threshold. Equals the sum of Ingredient Cost + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. Any remaining portion is reported in GDCA. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling above the OOP threshold. The remaining portion is reported in GDCB. These amounts increment the Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	505-F5	248 - 255	S9(6)V99	8	NCPDP	Payments made by the beneficiary or by family or friends at point of sale. These amounts increment the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT		256 - 263	S9(6)V99	8	CMS	Other health insurance payments by TrOOP-eligible other payers (i.e. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP, except LICS, Patient Pay Amount, and Reported Gap Discount. These amounts increment the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)		264 - 271	S9(6)V99	8	CMS	Amount the plan advanced at point-of-sale due to a beneficiary's LI status. These amounts increment the True Out-of-Pocket Accumulator amount.
37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)		272 - 279	S9(6)V99	8	CMS	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g. VA, TRICARE), Workers' Compensation,

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
							Auto/No-Fault/Liability Insurances.
38	COVERED D PLAN PAID AMOUNT (CPP)		280 - 287	S9(6)V99	8	CMS	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing and over-the-Counter drugs are excluded from this field.
39	NON COVERED PLAN PAID AMOUNT (NPP)		288 - 295	S9(6)V99	8	CMS	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.
40	ESTIMATED REBATE AT POS		296 - 303	S9(6)V99	8	CMS	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE		304 - 311	S9(6)V99	8	CMS	The fee reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee
42	PRESCRIPTION ORIGIN CODE	419-DJ	312 - 312	X(1)	1	NCPDP	'0'=Not Specified '1'=Written '2'=Telephone '3'=Electronic '4'=Facsimile <Blank>
43	DATE ORIGINAL CLAIM RECEIVED		313 - 320	9(8)	8	CMS	Date sponsor received original claim from provider/beneficiary. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to 1/1/2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP		321 - 346	X(26)	26	CMS	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR		347 - 355	S9(7)V99	9	CMS	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011,

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
							must be blank or zeros.
46	TRUE OUT-OF-POCKET ACCUMULATOR		356 - 363	S9(6)V99	8	CMS	Sum of benficiary's incurred costs (Patient Pay, LICS, Other TrOOP, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank or zeros.
47	BRAND/GENERIC CODE		364 - 364	X(1)	1	CMS	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B - Brand G - Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
48	BEGINNING BENEFIT PHASE		365 - 365	X(1)	1	CMS	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank. Applies to covered drugs only.
49	ENDING BENEFIT PHASE		366 - 366	X(1)	1	CMS	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank. Applies to covered drugs only.
50	REPORTED GAP DISCOUNT		367 - 374	S9(6)V99	8	CMS	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011 must be blank or zeros. These amounts increment the True Out-of-Pocket Accumulator amount.

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
51	TIER		375 - 375	X(1)	1	CMS	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
42	FILLER		376-512	X(137)	137	CMS	SPACES

Notes:

For any field that references NCPDP values, please refer to the appropriate NCPDP specification to ensure compliance.

All dollar fields are mandatory. If the field is not applicable, report a default value of zeroes. Since the field is a signed field, plans must utilize the appropriate overpunch signs as specified in the *NCPDP Telecommunications Standard, Version 5.1*.

BTR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BTR"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Must match BHD
4	PBP ID		16 - 18	X(3)	3	CMS	Must match BHD
5	DET RECORD TOTAL		19 - 25	9(7)	7	CMS	Total count of DET records
6	FILLER		26 -512	X(487)	487	CMS	SPACES

TLR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"TLR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Must match HDR
3	FILE ID		10 - 19	X(10)	10	PDFS	Must match HDR
4	TLR BHD RECORD TOTAL		20 - 28	9(9)	9	CMS	Total count of BHD records
5	TLR DET RECORD TOTAL		29 - 37	9(9)	9	CMS	Total count of DET records
6	FILLER		38 -512	X(475)	475	CMS	SPACES

Note:
Maximum number of detail records per file is 3 million records. If one file contains multiple batches, maximum record count applies to the cumulative total across all batches.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0982. The time required to complete this information collection is estimated to average two (2) hours per one million (1,000,000) transactions or 0.0074 seconds per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment 2: PDE Return File Layout

HDR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD ID	1-3	X(3)	3	"HDR"
2	SUBMITTER ID	4-9	X(6)	6	Unique ID assigned by CMS.
3	FILE ID	10-19	X(10)	10	Unique ID provided by Submitter.
4	TRANS DATE	20-27	9(8)	8	Date of file transmission to PDFS.
5	PROD TEST CERT IND	28-31	X(4)	4	PROD, TEST, or CERT
6	DDPS SYSTEM DATE	32-39	9(8)	8	CCYYMMDD = DDPS file creation date
7	DDPS SYSTEM TIME	40-45	9(6)	6	HHMMSS = DDPS file creation time
8	DDPS REPORT ID	46-50	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
9	FILLER	51-512	X(462)	462	SPACES

BHD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD ID	1-3	X(3)	3	"BHD"
2	SEQUENCE NO	4-10	9(7)	7	Must start with 0000001
3	CONTRACT NO	11-15	X(5)	5	Contract Number from submitted batch
4	PBP ID	16-18	X(3)	3	Plan Benefit Package (PBP) ID from submitted batch
5	DDPS SYSTEM DATE	19-26	9(8)	8	CCYYMMDD = DDPS file creation date
6	DDPS SYSTEM TIME	27-32	9(6)	6	HHMMSS = DDPS file creation time
7	DDPS REPORT ID	33-37	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
8	FILLER	38-512	X(475)	475	SPACES

DET

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1 - 3	X(3)	3	"ACC", "REJ", or "INF"
2	SEQUENCE NO	4 - 10	9(7)	7	Must start with 0000001
3	CLAIM CONTROL NUMBER	11 - 50	X(40)	40	Optional field
4	HEALTH INSURANCE CLAIM NUMBER (HICN)	51 - 70	X(20)	20	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER ID	71 - 90	X(20)	20	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	91 - 98	9(8)	8	CCYYMMDD Optional field
7	PATIENT GENDER CODE	99 - 99	9(1)	1	1 = M 2=F
8	DATE OF SERVICE (DOS)	100 - 107	9(8)	8	CCYYMMDD
9	PAID DATE	108 - 115	9(8)	8	CCYYMMDD. The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans.
10	PRESCRIPTION SERVICE REFERENCE NO	116 - 127	9(12)	12	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 which applies to all PDEs submitted January 1, 2011 and after. Field will be right justified and filled with 5 leading zeroes.
11	FILLER	128 - 129	X(2)	2	SPACES
12	PRODUCT SERVICE ID	130 - 148	X(19)	19	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is MMMMMDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996.

13	SERVICE PROVIDER ID QUALIFIER	149 - 150	X(2)	2	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Number 08 = State License 11 = Federal Tax Number 99 = Other (and Reported Gap Discount = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
14	SERVICE PROVIDER ID	151 - 165	X(15)	15	When Plans report Service Provider ID Qualifier = '99' - Other, populate Service Provider ID with the default value "PAPERCLAIM" defined for TrOOP Facilitation Contract.When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report embedded dashes)
15	FILL NUMBER	166 - 167	9(2)	2	Values = 0 - 99.
16	DISPENSING STATUS	168 - 168	X(1)	1	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
17	COMPOUND CODE	169 - 169	9(1)	1	0=Not specified 1=Not a Compound 2=Compound

18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	170 - 170	X(1)	1	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed 4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	171 - 180	9(7)V999	10	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER	181 - 182	X(2)	2	SPACES
21	DAYS SUPPLY	183 - 185	9(3)	3	0 - 999
22	PRESCRIBER ID QUALIFIER	186 - 187	X(2)	2	The type of prescriber identifier used in field 23. 01 = National Provider Identifier 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for Standard Format. Optional when Non-Standard Data Format = "B", "C", "P", or "X".
23	PRESCRIBER ID	188 - 202	X(15)	15	Mandatory for Standard Format Mandatory for non-standard data format when Prescriber ID Qualifier is present and valid. Optional when non-standard data format = 'B', 'C', 'P' or 'X' when Prescriber ID Qualifier is not present.

24	DRUG COVERAGE STATUS CODE	203 - 203	X(1)	1	Coverage status of the drug under Part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE	204 - 204	X(1)	1	A = Adjustment D = Deletion Blank = Original PDE
26	NON- STANDARD FORMAT CODE	205 - 205	X(1)	1	Format of claims originating in a non-standard format. X = X12 837 B = Beneficiary submitted claim C= COB claim P = Paper claim from provider Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE	206 - 206	X(1)	1	M= Medicare as Secondary Payer (Medicare is Primary) O = Out-of-network pharmacy service (Mediare is Primary) Blank = In-network pharmacy
28	CATASTROPHIC COVERAGE CODE	207 - 207	X(1)	1	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are A = Attachment Point C = Above Attachment Point met on this event Blank = Attachment Point not met
29	INGREDIENT COST PAID	208 - 215	S9(6)V99	8	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	216 - 223	S9(6)V99	8	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee reported in Field 41.

31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX	224 - 231	S9(6)V99	8	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.
32	GROSS DRUG COST BELOW OUT-OF-POCKET THRESHOLD (GDCB)	232 - 239	S9(6)V99	8	Reports covered drug costs at or below the out of pocket threshold. Equals the sum of Ingredient Cost + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. Any remaining portion is reported in GDCA. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling at or below the OOP threshold. The remaining portion is reported in GDCA. These amounts increment the Gross Covered Drug Cost Accumulator amount.

33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)	240 - 247	S9(6)V99	8	Reports covered drug costs above the out of pocket threshold. Equals the sum of Ingredient Cost + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. Any remaining portion is reported in GDCA. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling above the OOP threshold. The remaining portion is reported in GDCB. These amounts increment the Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	248 - 255	S9(6)V99	8	Payments made by the beneficiary or by family or friends at point of sale. These amounts increment the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT	256 - 263	S9(6)V99	8	Other health insurance payments by TrOOP-eligible other payers (i.e. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP, except LICS, Patient Pay Amount, and Reported Gap Discount. These amounts increment the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)	264 - 271	S9(6)V99	8	Amount the plan advanced at point-of-sale due to a beneficiary's LI status. These amounts increment the True Out-of-Pocket Accumulator amount.

37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)	272 - 279	S9(6)V99	8	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g., VA, TRICARE), Workers' Compensation, Auto/No-Fault/Liability Insurances.
38	COVERED D PLAN PAID AMOUNT (CPP)	280 - 287	S9(6)V99	8	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and over-the-Counter drugs are excluded from this field.
39	NON COVERED PLAN PAID AMOUNT (NPP)	288 - 295	S9(6)V99	8	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.
40	ESTIMATED REBATE AT POS	296 - 303	S9(6)V99	8	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE	304 - 311	S9(6)V99	8	The amount reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
42	PRESCRIPTION ORIGIN CODE	312 - 312	X(1)	1	0 = Not Specified 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile Blank is also allowed.

43	DATE ORIGINAL CLAIM RECEIVED	313 - 320	9(8)	8	Date sponsor received original claim from provider/beneficiary. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to 1/1/2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP	321 - 346	X(26)	26	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR	347 - 355	S9(7)V99	9	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
46	TRUE OUT-OF-POCKET ACCUMULATOR	356 - 363	S9(6)V99	8	Sum of benficiary's incurred costs (Patient Pay, LICS, Other TrOOP, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank or zeros.
47	BRAND/GENERIC CODE	364 - 364	X(1)	1	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B - Brand G - Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

48	BEGINNING BENEFIT PHASE	365 - 365	X(1)	1	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank. Applies to covered drugs only.
49	ENDING BENEFIT PHASE	366 - 366	X(1)	1	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank. Applies to covered drugs only.
50	REPORTED GAP DISCOUNT	367 - 374	S9(6)V99	8	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011 must be blank or zeros. These amounts increment the True Out-of-Pocket Accumulator amount.
51	TIER	375 - 375	X(1)	1	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
52	GAP DISCOUNT PLAN OVERRIDE CODE	376 - 376	X(1)	1	for future use - values TBD. On PDEs with DOS prior to 1/1/2011, must be blank.

53	FORMULARY CODE	377 - 377	X(1)	1	Indicates if the drug is on the plan's formulary. F - Formulary N - Non-Formulary Required on PDEs with service dates January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be blank. Applies to covered drugs only.
54	FILLER	378 - 407	X(30)	30	SPACES
55	CMS CALCULATED GAP DISCOUNT	408 - 415	S9(6)V99	8	Amount calculated by CMS during on-line PDE editing based on data reported in the PDE.
56	PBP OF RECORD	416 - 418	X(3)	3	PBP of Record assigned by CMS during P2P Update Process. Returned only when the PBP of Record changes from the time the PDE was processed and accepted by CMS.
57	ALTERNATE SERVICE PROVIDER ID QUALIFIER	419 - 420	X(2)	2	The Alternate Service Provider ID Qualifier cross-referenced by CMS to the Service Provider ID submitted on the PDE. '01' - NPI (if Service Provider ID Qualifer submitted on PDE is '07' - NCPDP Number) '07' - NCPDP Number (if the Service Provider ID Qualifier submitted on PDE is '01' - NPI)
58	ALTERNATE SERVICE PROVIDER ID	421 - 435	X(15)	15	The Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE. Corresponds to the Alternate Service Provider ID Qualifier.
59	ORIGINAL SUBMITTING CONTRACT	436 - 440	X(5)	5	Contract that submitted the previously accepted PDE (in conjunction with edit 784)
60	P2P CONTRACT OF RECORD	441 - 445	X(5)	5	Contract of Record for accepted P2P PDES
61	CORRECTED HICN	446 - 465	X(20)	20	The beneficiary HICN has changed according to CMS records.
62	ERROR COUNT	466 - 467	9(2)	2	Count of errors encountered during processing
63	ERROR 1	468 - 470	X(3)	3	First error encountered during processing
64	ERROR 2	471 - 473	X(3)	3	Second error encountered during processing

65	ERROR 3	474 - 476	X(3)	3	Third error encountered during processing
66	ERROR 4	477 - 479	X(3)	3	Fourth error encountered during processing
67	ERROR 5	480 - 482	X(3)	3	Fifth error encountered during processing
68	ERROR 6	483 - 485	X(3)	3	Sixth error encountered during processing
69	ERROR 7	486 - 488	X(3)	3	Seventh error encountered during processing
70	ERROR 8	489 - 491	X(3)	3	Eighth error encountered during processing
71	ERROR 9	492 - 494	X(3)	3	Ninth error encountered during processing
72	ERROR 10	495 - 497	X(3)	3	Tenth error encountered during processing
73	EXCLUSION REASON CODE	498 - 500	X(3)	3	Subcategory reject code for an NDC Error Code of 738 identified in Errors 1-10.
74	FILLER	501 - 512	X(12)	12	SPACES

BTR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1-3	X(3)	3	"BTR"
2	SEQUENCE NO	4-10	9(7)	7	Must match BHD
3	CONTRACT NO	11-15	X(5)	5	Must match BHD
4	PBP ID	16-18	X(3)	3	Must match BHD
5	DET RECORD TOTAL	19-25	9(7)	7	Total count of DET records
6	DET ACCEPTED RECORD TOTAL	26-32	9(7)	7	Total count of ACC records as determined by DDPS processing
7	DET INFORMATIONAL RECORD TOTAL	33-39	9(7)	7	Total count of INF records as determined by DDPS processing
8	DET REJECTED RECORD TOTAL	40-46	9(7)	7	Total count of REJ records as determined by DDPS processing
9	FILLER	47-512	X(466)	466	SPACES

TLR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1-3	X(3)	3	"TLR"
2	SUBMITTER ID	4-9	X(6)	6	Must match HDR
3	FILE ID	10-19	X(10)	10	Must match HDR
4	TLR BHD RECORD TOTAL	20-28	9(9)	9	Total count of BHD records
5	TLR DET RECORD TOTAL	29-37	9(9)	9	Total count of DET records
6	TLR DET ACCEPTED RECORD TOTAL	38-46	9(9)	9	Total count of ACC records as determined by DDPS processing
7	TLR DET INFORMATIONAL RECORD TOTAL	47-55	9(9)	9	Total count of INF records as determined by DDPS processing
8	TLR DET REJECTED RECORD TOTAL	56-64	9(9)	9	Total count of REJ records as determined by DDPS processing
9	FILLER	65-512	X(448)	448	SPACES

Attachment 3: Example of Non-Sequential Beginning Benefit Phase

In Part D the beneficiary moves through the benefit by paying cost-sharing that is specific to each benefit phase. Part D Sponsors use the Total Gross Covered Drug Cost (TGCDC) Accumulator and the TrOOp Accumulator to determine the benefit phase and the beneficiary cost-sharing on each individual claim. When PDEs are sorted in ascending processing order (using the Claim Adjudication Began Timestamp) the TGCDC and TrOOP accumulator values increase from one claim to the next in a logical pattern. Typically CMS expects a logical relationship between the accumulator values, the plan-reported benefit phase values and the beneficiary cost-sharing amounts reported in PDEs. (Beneficiary cost-sharing is reported in Patient Pay, Low Income Cost-Sharing Subsidy (LICS), Other TrOOP and Patient Liability Reduction due to Other Payer).

That logical order can be disrupted when a claim change reduces beneficiary and plan spending after other subsequent claims processed, especially when the subsequent claims processed in a later benefit phase. We illustrate this concept with a deleted claim; however other circumstances like changing status to MSP or correcting an over-priced claim can have a similar result. In effect, the deleted claim creates a hole in the benefit which must be repaid. The sponsor must correct subsequent claims either by adjusting all claims processed after the deleted claim or by applying the beneficiary and plan cost-sharing terms of the deleted claim to the next claim or claims. We describe this first method as reporting as adjusted (also described as re-stacking); we describe the second method as "reporting as administered". Sponsors who adjust (or restack) the subsequent claims update Claim Adjudication Began Timestamp reported on the adjusted PDE. When the adjusted final action PDEs are re-sorted, CMS will see a logical relationship between the accumulator values, the plan-reported benefit phase values and the beneficiary cost-sharing amounts reported in PDE.

However, if the sponsor reports as adjudicated, the relationship between the TGCDC Accumulator, the benefit phases and the cost-sharing terms will appear to be out of order. In the following example we show the claims history for a beneficiary with six claims. On January 22 when the fourth claim is processed the beneficiary is in the initial coverage period. Two days later on January 24, the sponsor deletes the beneficiary's first claim with a January 10 date of service. The first claim was a deductible claim. The sponsor subtracts $100 from both the TGCDC and TrOOP accumulators. Because the sponsor "reports as administered" the sponsor will "fill the hole in the benefit" and apply deductible cost-sharing to the next claim which is received on January 25. The PDE reports the facts of the claim adjudication. In this PDE the value in the TGCDC Accumulator corresponds to the initial coverage period; however, the reported benefit phases and the beneficiary cost-sharing correspond to the deductible. When the sponsor completes adjudication of the January 25th claim, the beneficiary has "paid back" the deductible cost-sharing from the deleted claim. When the sponsor adjudicates the next claim on February 5, the TGCDC Accumulator, the benefit phases and the cost-sharing values reported in that PDE are internally consistent and document a claim adjudicated in the initial coverage period.

CMS gives sponsors the option to “report as administered”. Therefore, during on-line editing we will accept PDEs with apparently illogical accumulator values, benefit phase values and cost-sharing. As we gain experience with the new Accumulator and Benefit Phase data, we will analyze saved PDEs and review trends it identify disproportionately high percentages of “out-of-order” PDEs.

					Pre-adjudication Accumulators		Current PDE			Post-adjudication Accumulators	
Date of Service	Date Original Claim Received	Claim Adjudication Began Timestamp	Beginning Benefit Phase	Ending Benefit Phase	TGCDC Accumulator	TrOOP Accumulator	Total Claim Cost	Patient Pay Amount	CPP Amount	TGCDC Accumulator	TrOOP Accumulator
	Balance effective January 1				$0.00	$0.00					
10-Jan-11	10-Jan-11	10-Jan-11	D	D	$0.00	$0.00	$100.00	$100.00	$0.00	$100.00	$100.00
15-Jan-11	15-Jan-11	15-Jan-11	D	D	$100.00	$100.00	$210.00	$210.00	$0.00	$310.00	$310.00
20-Jan-11	20-Jan-11	20-Jan-11	N	N	$310.00	$310.00	$100.00	$25.00	$75.00	$410.00	$35.00
22-Jan-11	22-Jan-11	22-Jan-11	N	N	$410.00	$335.00	$100.00	$25.00	$75.00	$510.00	$360.00
	Reversal of January 10 claim:										
10-Jan-11	10-Jan-11	24-Jan-11					<$100>	<$100>		$410.00	$260.00
25-Jan-11	25-Jan-11	25-Jan-11	D	D	$410.00	$260.00	$100.00	$100.00	$0.00	$510.00	$360.00
05-Feb-11	05-Feb-11	05-Feb-11	N	N	$510.00	$360.00	$200.00	$50.00	$150.00	$710.00	$410.00

Attachment 4 – 2011 PDE examples: Calculating and Reporting Gap Discount

The following examples describe Gap Discount Calculations and Prescription Drug Event (PDE) reporting. For additional information about PDE fields not defined in this guidance, see the PDE Participant Guide available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.

The gap discount applies when all of the following situations occur: the beneficiary is non-LI, the drug is a covered drug, the NDC is an applicable drug, and the ingredient cost, sales tax and vaccine administration fee fall either fully or partially in the coverage gap. Please note that the Gap Discount is included in TrOOP.

To simplify discussion, we introduce the term "Discount Eligible Cost". Discount Eligible Cost is the sum of ingredient cost, sales tax and vaccine administration fee (as reported in PDE fields Ingredient Cost Paid, Amount Attributable to Sales Tax, and Vaccine Administration Fee) that falls in the Coverage Gap. Discount Eligible Cost excludes supplemental benefits and dispensing fee. The Gap Discount is calculated as 50% of the Discount Eligible Cost.

Gap Discount = Discount Eligible Cost * .5

If the Gap Discount calculation must be rounded, round up to the nearest penny. For example, if the Discount Eligible Cost is $10.75, the Gap Discount is $5.375, or $5.38 under this rounding rule.

The steps to populate the PDE fields on a claim that falls completely or in part in the gap are:

1. **Determine costs that fall in the Coverage Gap**: (using existing adjudication logic) Claims that begin and end in the coverage gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases. In the case of straddle claims apply dispensing fee, to the greatest extent possible, outside the coverage gap.

2. **Determine Discount Eligible Cost:** Discount Eligible Cost is cost falling in the coverage gap, excluding supplemental benefits and dispensing fee. The supplemental benefit is calculated first. The dispensing fee is included in the supplemental benefit to the extent that the supplemental benefit equals or exceeds the dispensing fee.

3. **Calculate Gap Discount:** The gap discount is 50% of Discount Eligible Cost**.**

4. **Determine beneficiary cost-sharing:** For claims falling squarely in the coverage gap with no other secondary health insurance, beneficiary cost-sharing is Total Drug Cost less Gap Discount. If the beneficiary has other secondary health insurance, the other secondary health insurance reduces beneficiary cost-sharing remaining after the Gap Discount is applied. In Straddle claims Beneficiary Cost-Sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

5. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

6. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

To simplify the examples, the Ingredient Cost, Dispensing Fee Amount, Sales Tax, and Vaccine Administration Fee remain the same in all examples (see chart below). The drug is a covered drug that is applicable for the Gap Discount.

Field	Amount
Ingredient Cost	$195.00
Sales Tax Amount	$5.00
Vaccine Administration Fee	$0.00
Negotiated Price w/o Dispensing Fee (Discount Eligible Cost)	**$200.00**
Dispensing Fee Amount	$2.00
Total Gross Covered Drug Cost	**$202.00**

Be reminded that the sum of PDE fields Ingredient Cost, Sales Tax, and Vaccine Administration Fee equals negotiated price as defined for the Gap Discount. We treat that sum as one entity and do not prorate individual amounts like sales tax in straddle claims.

Example #1: The Claim Falls Squarely inside the Coverage Gap (Defined Standard Plan)

Step 1 Determine costs that fall in the Coverage Gap*:* The claim falls squarely in the coverage gap. The beneficiary's Total Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Cost (TrOOP) remain below the TrOOP threshold throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $1,102.50. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap. The Beginning and Ending Benefit phase values and the TGCDC ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$1,102.50**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. Discount Eligible Cost excludes the Dispensing Fee. Discount Eligible Cost is $200.00.

PDE Fields	Claim Total
Ingredient Cost Paid	$195.00
Total Amount Attributed to Sales Tax	$5.00
Vaccine Administration Fee	$0.00
Discount Eligible Cost	**$200.00**

Step 3 Calculate Gap Discount: The Gap Discount $100.00; $200 * .5 = $100.00.

Step 4 Determine beneficiary cost-sharing: The beneficiary pays any cost in the gap (including the dispensing fee) that remains after the discount is applied. Beneficiary cost-sharing is $102.00, which is calculated as $202.00 minus $100.00.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: In 2011 and 2012 when a claim with a gap discount falls squarely in the coverage gap , this plan has no liability to report as Covered D Plan Paid Amount.
PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	Value
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$102.00**

Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $202.00 from $1102.50 to $1,304.50.

Example #2: The claim has an Other Health Insurance (OHI) Payer (OHI pays secondary to Part D); The OHI Payer is TrOOP eligible. (Defined Standard Plan)

The purpose of this example is to show that the gap discount applies first before any secondary payer receives the claim. The OHI payer is a State Pharmaceutical Assistance Plan (SPAP) that reduces the beneficiary's cost-sharing by $25.00. The SPAP is a TrOOP eligible payer. Sponsors report TrOOP eligible payments in the Other TrOOP field. These payments increment the beneficiary's TrOOP Accumulator and advance the beneficiary toward the catastrophic benefit phase. The OHI payment reduces beneficiary cost-sharing from $102.00 to $77.

Step 1 Determine costs that fall in the Coverage Gap*:*The claim falls squarely in the coverage gap. The beneficiary's Total Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $1,100. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap. The Beginning and Ending Benefit phase values and the TGCDC ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$1,102.50**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. Discount Eligible Cost excludes the Dispensing Fee. Discount Eligible Cost is $200.00.

PDE Fields	Claim Total
Ingredient Cost Paid	$195.00
Total Amount Attributed to Sales Tax	$5.00
Vaccine Administration Fee	$0.00
Discount Eligible Cost	**$200.00**

Step 3 Calculate Gap Discount: The Gap Discount $100.00; $200 * .5 = $100.00.

Step 4 Determine beneficiary cost-sharing: Because this beneficiary has an OHI payer, there are multiple steps to determine beneficiary cost-sharing. At Point-of-Sale the pharmacy sends the first billing transaction to the Part D plan. The Part D plan replies that it will pay $100 (the Reported Gap Discount) and the beneficiary will pay $102.00. Immediately after the pharmacy receives the Part D Sponsor's reply, the pharmacy sends a second billing transaction to the SPAP. The SPAP payer replies that it will pay the pharmacy $25. At that point the pharmacy knows that it will charge the beneficiary

$77.00, the balance that remains after the Part D Sponsor and the SPAP pay the pharmacy. Finally the Part D sponsor receives an information (or N) transaction from the TrOOP Facilitator. The N transaction identifies the SPAP and the amount the beneficiary paid to the pharmacy ($77.00). The Part D Sponsor computes the SPAP payment by subtracting the N transaction amount ($77.00) from the original patient pay amount ($102.00). Since the Part D Sponsor knows that the OHI payer is an SPAP, the $25.00 will be included in TrOOP and is reported in the Other TrOOP field on the PDE.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: In 2011 and 2012 when a claim with a gap discount falls squarely in the coverage gap , this plan has no liability to report as Covered D Plan Paid Amount.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$77.00**
Other TrOOP Amount	**$25.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $202.00 from $1100.00 to $1302.00.

Example #3: The EGWP claim has a Commercial Wraparound Payer (the commercial wrap pays secondary to Part D) (EGWP is a Defined Standard Plan.)

The purpose of this example is to show that the gap discount applies first before any secondary payer receives the claim. This Plan is an EGWP. Rather than offer supplemental benefits this EGWP re-structured it's benefit to provide a commercial (non-Part D) wrap-around that reduces the beneficiary's cost-sharing to $25.00. Using this re-structured benefit the EGWP's enrollee pays, at maximum, a $25.00 co-pay throughout the benefit. The commercial wrap-around payment is not included in TrOOP. Sponsors report TrOOP excluded payments by OHI payers in the PLRO field on the PDE. These payments never increment the beneficiary's TrOOP Accumulator. Sponsors must correctly identify and report payments by TrOOP excluded payers; otherwise the beneficiary may receive catastrophic benefits in error.

Step 1 Determine costs that fall in the Coverage Gap*:* The claim falls squarely in the coverage gap. The beneficiary's Total Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $1,102.50. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap. The Beginning and Ending Benefit phase values and the TGCDC ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$1,102.50**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. Discount Eligible Cost excludes the Dispensing Fee. Discount Eligible Cost is $200.00.

PDE Fields	**Claim Total**
Ingredient Cost Paid	$195.00
Total Amount Attributed to Sales Tax	$5.00
Vaccine Administration Fee	$0.00
Discount Eligible Cost	**$200.00**

Step 3 Calculate Gap Discount: The Gap Discount $100.00; $200 * .5 = $100.00.

Step 4 Determine beneficiary cost-sharing: Because this beneficiary has an OHI payer, there are multiple steps to determine beneficiary cost-sharing. At Point-of-Sale the pharmacy sends the first

billing transaction to the Part D plan. The Part D plan replies that it will pay $100 (the Reported Gap Discount) and the beneficiary will pay $102.00. Immediately after the pharmacy receives the Part D Sponsor's reply, the pharmacy sends a second billing transaction to the commercial wrap-around. The commercial wrap-around replies that it will pay the pharmacy $77.00. At that point the pharmacy knows that it will charge the beneficiary $25.00, the balance that remains after the Part D Sponsor and the commercial wrap-around pay the pharmacy. Finally the Part D sponsor receives an information (or N) transaction from the TrOOP Facilitator. The N transaction identifies the commercial wrap-around payer and the amount the beneficiary paid to the pharmacy ($25.00). The Part D Sponsor computes the OHI payment by subtracting the N transaction amount ($25.00) from the original patient pay amount ($102.00). Since the Part D Sponsor knows that the commercial wrap-around is a TrOOP excluded payer, the $77.00, which is excluded from TrOOP, is reported in the PLRO field on the PDE.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: In 2011 and 2012 when a claim with a gap discount falls squarely in the coverage gap , the plan has no liability to report as Covered D Plan Paid Amount.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$25.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$77.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $125.00 from $1102.50 to $1227.50.

Example #4: Straddle Claim (ICP to Gap) (Defined Standard Plan)

In this example the claim straddles the Initial Coverage Period and the Coverage Gap. In a defined standard plan the beneficiary enters the coverage gap when Total Gross Covered Drug Cost Accumulator exceeds the initial coverage limit or $2,840.00 in 2011.

Step #1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,788.00 and the TrOOP Accumulator is $929.50; the beginning benefit phase is the initial coverage period. The first $52.00 of the claim falls in the initial coverage period. The amount is calculated as ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,788.00. The remaining $150.00 of the claim falls in the coverage gap. Because the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim, the Ending Benefit phase is the Coverage Gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$2,788.00**
True Out of Pocket Accumulator	**$929.50**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$195.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period Cost	Coverage Gap Cost
$52.00	**$150.00**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. The $2.00 Dispensing Fee Paid was applied outside the coverage gap. Therefore **Discount Eligible Cost** is $150.00, the coverage gap amount.

Step 3 Calculate Gap Discount: The gap discount is $75.00; $150.00 * .5 = $75.00.

Step 4 Determine beneficiary cost-sharing: The beneficiary is responsible for cost-sharing in each benefit phase the claim straddles. Initial Coverage Period cost-sharing is 25%; coverage gap cost-sharing is 100% of the coverage gap costs, less Gap Discount.

Initial Coverage Period cost-sharing is $13.00 ($52 .00 * .25)Coverage gap cost-sharing is $75.00 ($150.00 - $75.00)
The beneficiary's total cost-sharing is $88.00**.**

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: The plan pays 75% of the cost falling in the ICP and, in 2011 and 2012, none of the cost in the gap. ($52.00 *.75 = $39.00). This amount is included as CPP.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$75.00**
Patient Pay Amount	**$88.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$39.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,788.00 to $2,990.00; the TrOOP Accumulator increases by $163.00 from $929.50 to $1092.50.

Example #5: Straddle Claim with Only Part of Dispensing Fee Falling Outside the Gap (Defined Standard Plan)

In this example the claim straddles the Initial Coverage Period and the Coverage Gap. In a defined standard plan the beneficiary enters the coverage gap when Total Gross Covered Drug Cost Accumulator exceeds the initial coverage limit or $2,840.00 in 2011.

Step 1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,839.00 and the TrOOP Accumulator is $942.50; the beginning benefit phase is the initial coverage period. The first $1.00 of the claim falls in the initial coverage period. (The amount is calculated as ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,839.00.) Note that amount in the initial coverage period is insufficient to fully cover the $2 dispensing fee so a portion of the dispensing fee will fall in the gap. However, the dispensing fee is not eligible for the Gap Discount. Because the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim, the remaining $201.00 of the claim falls in the coverage gap. The Ending Benefit phase is the Coverage Gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$2,839.00**
True Out of Pocket Accumulator	**$942.50**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$195.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period Cost	Coverage Gap Cost
$1.00	**$201.00**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. The first dollar of the Dispensing Fee Paid is applied to the $1.00 amount outside the coverage gap. Calculate Discount Eligible Cost by subtracting the second dollar remaining in the Dispensing Fee Paid from the $201.00 falling in the coverage gap. Therefore **Discount Eligible Cost** is $200.00.

Step 3 Calculate Gap Discount: The gap discount is $100.00; $200.00 * .5 = $100.00.
Step 4 Determine beneficiary cost-sharing: The beneficiary is responsible for cost-sharing in each benefit phase the claim straddles. Initial Coverage Period cost-sharing is 25%; coverage gap cost-sharing is 100% of the coverage gap costs, less Gap Discount.

Initial Coverage Period cost-sharing is $0.25 ($1 .00 * .25). (The plan pays the remaining $0.75)
Coverage cap cost-sharing is the sum of the claim cost falling in the coverage gap minus the Calculated Gap Discount ($201.00-$100.00= $101.00)

The beneficiary's total cost-sharing is the sum of the cost sharing in the ICP plus the cost sharing in the Gap ($0.25+$101.00= $101.25)

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: The plan pays 75% of the cost falling in the ICP and, in 2011 and 2012, none of the cost in the gap. ($1.00 *.75 = $0.75). This amount is included as CPP.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$101.25**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.75**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,839.00 to $3041.00; the TrOOP Accumulator increases by $201.25 from $942.25 to $1143.50.

Example #6: Co-pay / Coinsurance Straddle claim with Lesser Of Logic (Basic Alternative Plan)

This example illustrates the Gap Discount calculation when the co-pay and coinsurance in a single claim exceed the negotiated price. Whenever a claim straddles a co-pay benefit phase and a coinsurance benefit phase, the plan must apply a lesser of test to ensure that beneficiary cost-sharing never exceeds the negotiated price. If the claim fails the lesser of test (i.e. the sum of the copay and the coinsurance exceeds negotiated price) the beneficiary pays the negotiated price instead. When the beneficiary pays the negotiated price, the claim dollars are allocated to each benefit phase as shown below and the gap discount is calculated based on the dollars falling in the coverage gap. In this example we show a basic alternative plan with a $30 copay for Brand drugs in the ICP. However, the scenario applies to any claim with coinsurance in the Coverage Gap and a co-pay in the adjacent benefit phase (either the Initial Coverage Period or the Catastrophic benefit phase) regardless of plan type.

Step 1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,839.00 and the TrOOP Accumulator is $935.50; the beginning benefit phase is the initial coverage period. Because the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim, the Ending Benefit phase is the Coverage Gap.

In order to apply the lesser of test, first calculate beneficiary cost-sharing without the gap discount. The first $1.00 of the claim falls in the initial coverage period; therefore the beneficiary would normally pay the $30 ICP copay. The remaining $201.00 falls in the Coverage Gap; therefore the beneficiary would normally pay $201.00 in coverage gap coinsurance. The sum of the $30 ICP copay and the $201.00 coinsurance is $231.00 which is greater than the negotiated price of $202.00. Therefore the beneficiary will pay $202.00.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	**$2,839.00**
True Out of Pocket Accumulator	**$935.50**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$195.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period	Coverage Gap
$1.00	**$195.00**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. The first dollar of the Dispensing Fee Paid is applied to the $1.00 amount outside the coverage gap. Calculate Discount Eligible Cost by subtracting the second dollar remaining in the Dispensing Fee Paid from the $201.00 falling in the coverage gap. Therefore **Discount Eligible Cost** is $200.00.

Step 3 Calculate Gap Discount: The gap discount is $100.00; $200.00 * .5 = $100.00.

Step 4 Determine beneficiary cost-sharing: Because lesser of logic applies, beneficiary cost-sharing is calculated simply by subtracting Reported Gap Discount which is $100.00 from the total claim cost of $202.00 .The beneficiary is responsible for $102.00.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: There is no CPP on this PDE because the lesser of logic employed in determining beneficiary cost sharing plus the calculated gap discount cover the entire cost of the drug.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	Value
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$102.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,839 to $3041.00; the TrOOP Accumulator increases by $202.00 from $935.50 to $1137.50.

Example #7: Straddle Claim in plan with Copays in ICP (Basic Alternative Plan)

In this example the claim straddles the Initial Coverage Period and the Coverage Gap in a Basic Alternative plan with a $5/$15/$30 copay structure in the ICP. In this BA plan the beneficiary enters the coverage gap when Total Gross Covered Drug Cost Accumulator exceeds the initial coverage limit or $2,840.00 in 2011. The applicable drug in this example falls in the $30 copay tier.

Step 1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,800.00 and the TrOOP Accumulator is $925.00; the beginning benefit phase is the initial coverage period. The first $40.00 of the claim falls in the initial coverage period. (The amount is calculated as ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,800.00.) Because the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim, the remaining $162.00 of the claim falls in the coverage gap. The Ending Benefit phase is the Coverage Gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$2,800.00**
True Out of Pocket Accumulator	**$925.00**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$195.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period Cost	Coverage Gap Cost
$40.00	**$162.00**

Step 2 Determine Discount Eligible Cost: There are no supplemental benefits. The $2.00 Dispensing Fee Paid was applied outside the coverage gap. Therefore Discount Eligible Cost is $162.00, the coverage gap amount.

Step 3 Calculate Gap Discount: The gap discount is $81.00; $162.00 * .5 = $81.00.

Step 4 Determine beneficiary cost-sharing: The beneficiary is responsible for cost-sharing in each benefit phase the claim straddles. Initial Coverage Period cost-sharing in this BA plan is $30; coverage gap cost-sharing is 100% of the coverage gap costs, less Gap Discount.

Initial Coverage Period cost-sharing is $30. (The plan pays the remaining $10.00 of the total claim amount falling in the ICP)
Coverage cap is cost-sharing is $81.00 ($162.00 - $81.00)
The beneficiary's total cost-sharing is $111.00. ($30 copay in ICP + $81 bene liability in gap)

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: The plan pays the remainder of cost falling in the ICP beyond the beneficiary copay in the ICP ($40.00 - $30.00 = $10.00) and none of the cost in the gap. This amount is included as CPP.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$81.00**
Patient Pay Amount	**$111.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$10.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,800.00 to $3,002.00; the TrOOP Accumulator increases by $192.00 from $925.00 to $1,117.00.

Example #8: Gap Claim with Supplemental Coinsurance Benefit in the Gap (Enhanced Alternative Plan or EGWP offering additional benefits)

In this example the plan offers supplemental benefits in the Gap either by being an Enhanced Alternative plan or through an EGWP offering additional benefits. The claim falls squarely in the coverage gap. Supplemental benefits are additional plan payments that reduce beneficiary cost sharing below the amount of coinsurance defined in the standard benefit. The value of the supplemental benefit must be calculated on a claim by claim basis. Since supplemental benefits apply before the gap discount, we modify Step #2 by first calculating the value of the supplemental benefit on this claim.

Step 1 Determine costs that fall in the Coverage Gap*:*
The claim falls squarely in the coverage gap. The beneficiary's Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold (Accumulated TrOOP < TrOOP threshold) throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $900.00. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$900.00**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine Discount Eligible Cost: First we must determine the value of the supplemental benefit on this claim by comparing it to the plan cost sharing in the defined standard benefit. In this example the sponsor's supplemental benefit is 40% coinsurance in the Gap. The value of the supplemental benefit is $80.80 which is calculated below.

Defined Standard	
Beneficiary	Plan
100%	0%
$202.00	$0.00

EA or EGWP Plan	
Beneficiary	Plan
60%	40%
$121.20	$80.80

Value of Supplemental Benefit
$Plan_{EA}$ - $Plan_{DS}$
$80.80-$0.00
$80.80

Secondly, compare the dispensing fee to the supplemental benefit. Since the supplemental benefit is greater than or equal to the dispensing fee, we assume the dispensing fee is included in the supplemental benefit and we will reduce the discount eligible cost no further.

Finally, calculate the discount eligible cost as follows:

Total Drug Cost in Gap	$202.00

Supplemental Benefit	<$80.80>
Dispensing Fee	Covered by the supp benefit
Discount Eligible Cost	**$121.20**

Step 3 Calculate Gap Discount: The gap discount is $60.60; $121.20 * .5 = $60.60.
Step 4 Determine beneficiary cost-sharing: The beneficiary is responsible for 60% of cost falling in the gap minus the amount covered by the gap discount, which equals $60.60.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: As a part of step 2 we determined the value of the supplemental benefit in the gap to be $80.80. This amount is included as NPP.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$60.60**
Patient Pay Amount	**$60.60**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$80.80**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $121.20 from $900.00 to $1,081.60.

Example #9: Gap Claim with Supplemental Copay Benefit in the Gap (Enhanced Alternative Plan or EGWP offering additional benefits)

In this example the plan offers supplemental benefits either by being an Enhanced Alternative plan or through an EGWP offering additional benefits. The claim falls squarely in the coverage gap. Supplemental benefits are additional plan payments that reduce beneficiary cost sharing below the amount of coinsurance defined in the standard benefit. The value of the supplemental benefit must be calculated on a claim by claim basis. Since supplemental benefits apply before the gap discount, we modify Step #2 by first calculating the value of the supplemental benefit on this claim.

Step 1 Determine costs that fall in the Coverage Gap*:*
The claim falls squarely in the coverage gap. The beneficiary's Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $900.00. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$900.00**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine Discount Eligible Cost: First we must determine the value of the supplemental benefit on this claim by comparing it to the plan cost sharing in the defined standard benefit. In this example the sponsor's supplemental benefit is a $30 copay for brand drugs in the Gap. The value of the supplemental benefit is $172.00 which is calculated below.

Defined Standard	
Beneficiary	Plan
100%	0%
$202.00	$0.00

EA or EGWP Plan	
Beneficiary	Plan
$30 copay	remainder
$30.00	$172.00

Value of Supplemental Benefit
$Plan_{EA}$ - $Plan_{DS}$
$172.00-$0.00
$172.00

Secondly, compare the dispensing fee to the supplemental benefit. Since the supplemental benefit is greater than or equal to the dispensing fee, we assume the dispensing fee is included in the supplemental benefit and we will reduce the discount eligible cost no further.

Finally, calculate the discount eligible cost as follows:

Total Drug Cost in Gap	$202.00
Supplemental Benefit	<$172.00>
Dispensing Fee	Covered by the supp benefit
Discount Eligible Cost	**$30.00**

Step 3 Calculate Gap Discount: The gap discount is $15.00; $30.00 * .5 = $15.00.
Step 4 Determine beneficiary cost-sharing: The beneficiary is responsible for a copay of $30 minus the amount covered by the gap discount, which equals $15.00.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: As a part of step 2 we determined the value of the supplemental benefit in the gap to be $172.00. This amount is included as NPP.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$15.00**
Patient Pay Amount	**$15.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$172.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $30.00 from $900.00 to $930.00.

Example 10: Claim straddles two co-pay benefit phases: Initial Coverage Period and Coverage Gap (Enhanced Alternative Plan or EGWP offering additional benefits)

CMS guidance stipulates that when a single claim straddles two adjacent co-pay benefit phases, only the first co-pay applies. This guidance affects gap discount calculations for the two plan types that can offer supplemental benefits in the coverage gap: Enhanced Alternative plans and EGWPs, provided the plan applies co-pays. This scenario occurs frequently in plans with a flat co-pay throughout the pre-catastrophic benefit phases. When a claim straddles the initial coverage period and the coverage gap and a co-pay applies in both benefit phases, there is no discount because the plan effectively closes the coverage gap on and individual claim basis, as demonstrated in this example. However, the discount does apply when a claim straddles the coverage gap and the catastrophic benefit phase and a co-pay applies in both benefit phases.

Step 1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,680.00 and the TrOOP Accumulator is $800.00; the beginning benefit phase is the initial coverage period. The first $160.00 of the claim falls in the initial coverage period. (The amount is calculated equals ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,680.00.) Because, the beneficiary has not met the TrOOP threshold the remaining $42.00 of the claim falls in the coverage gap. The Ending Benefit phase is the Coverage Gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$2,680.00**
True Out of Pocket Accumulator	**$800.00**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$195.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period	Coverage Gap
$160.00	**$42.00**

Step 2 Determine Discount Eligible Cost: Determine the value of the supplemental benefit in the gap by comparing it to the plan cost sharing in the defined standard benefit. The beneficiary co-pay of $30.00 does not apply; instead the plan pays the full cost falling in the coverage gap ($162).

Defined Standard	
Beneficiary Coinsurance	Plan
100%	0%
$42.00	$0.00

EA or EGWP Plan	
Beneficiary Co-pay	Plan
$0	$42.00

Value of Supplemental Benefit
$Plan_{EA}$ - $Plan_{DS}$
$42.00-$0.00
$42.00

Finally, calculate the discount eligible cost as follows:

Total Drug Cost in Gap	$42.00
Supplemental Benefit	<42.00>
Dispensing Fee	Covered by the supp benefit
Discount Eligible Cost	**$0**

Step 3 Calculate Gap Discount: The gap discount is 0; $0.00 * .5 = $0.00 (50% of the $0).

Step 4 Determine beneficiary cost-sharing: Beneficiary payment is limited to the first $30.00 co-pay in the initial coverage period.

Step 5 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: The plan pays the remaining $130.00 in the Initial Coverage Period; $120 is reported as Covered D Plan Paid Amount (CPP) and $10 is reported as Non Covered Plan Paid Amount (NPP). The $10 NPP amount is the amount by which the supplemental benefit in the ICP reduced the beneficiary payment from the $40.00 ($160.00 * .25) coinsurance that applies in the Defined Standard Benefit. The $42.00 of supplemental benefit in the Coverage Gap is also reported as NPP. (For additional information about NPP calculations see the PDE Participant Guide.)

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$0.00**
Patient Pay Amount	**$30.00**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$120.00**
Non Covered Plan Paid Amount (NPP)	**$52.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 6 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,680.00 to $2882.00; the TrOOP Accumulator increases by $30.00 from $800.00 to $830.00.

Attachment 5 – 2011 Generic PDE examples

The following examples demonstrate calculations and Prescription Drug Event (PDE) reporting for generic drugs obtained during the gap. The reduced gap cost sharing applies such that in 2011 the non-LI beneficiary pays 93% of the Total Gross Covered Drug Cost falling in the gap and the plan pays the remaining 7%. The Total Gross Covered Drug Cost includes Ingredient Cost, Sales Tax Amount, Vaccine Admin Fee, *and Dispensing Fee Amount*.

The steps to populate the PDE fields on a generic claim that falls completely or partially in the gap are:

1. **Determine costs that fall in the Coverage Gap**: (using existing adjudication logic) Claims that begin and end in the coverage gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases.

2. **Determine beneficiary cost-sharing:** For claims falling squarely in the coverage gap with no other secondary health insurance, the non-LI beneficiary cost-sharing is 93% of the Total Drug Cost. In straddle claims, beneficiary Cost-Sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

3. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

4. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

To simplify the examples, the Ingredient Cost, Dispensing Fee Amount, Sales Tax, and Vaccine Administration Fee remain the same in all examples (see chart below). The drug is a generic drug.

Field	Amount
Ingredient Cost	$46.00
Sales Tax Amount	$2.00
Vaccine Administration Fee	$0.00
Dispensing Fee Amount	$2.00
Total Gross Covered Drug Cost	**$50.00**

Example #1: The Generic Claim for a Non-LI Beneficiary Falls Squarely inside the Coverage Gap (Defined Standard Plan)

Step 1 Determine costs that fall in the Coverage Gap*:* The beneficiary's Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True out of Pocket Costs (TrOOP) remain below the TrOOP threshold (Accumulated TrOOP < TrOOP threshold) throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $1102.25. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap. The Beginning and Ending Benefit phase values and the TGCDC ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$1102.25**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine beneficiary cost-sharing: The beneficiary pays 93% of the Total Gross Covered Drug Cost falling in the gap. Beneficiary cost-sharing is $46.50, which is calculated as $50.00 * .93.

Step 3 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: In 2011 when a generic claim falls squarely in the coverage gap , this plan pays 7% which is reported as Covered D Plan Paid Amount. In this example the CPP amount is $3.50, or $50.00 * .07.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	Value
Patient Pay Amount	**$46.50**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$3.50**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$50.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 4 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $50.00 from $3,000.00 to $3,050.00; the TrOOP Accumulator increases by $46.50 from $1102.25 to $1148.75.

Example #2: The Generic Claim for a non-LI Beneficiary Straddles the ICP and the Coverage Gap (Defined Standard Plan)

Step 1 Determine costs that fall in the Coverage Gap*:* When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,820.00 and the TrOOP Accumulator is $937.50; the beginning benefit phase is the initial coverage period. The first $20.00 of the claim falls in the initial coverage period. (The amount is calculated as ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,820.00.) Because, the beneficiary has not met the TrOOP threshold the remaining $30.00 of the claim falls in the coverage gap. The Ending Benefit phase is the Coverage Gap.

PDE Fields	Claim Total
Total Gross Covered Drug Cost Accumulator	**$2,820.00**
True Out of Pocket Accumulator	**$937.50**
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**
Pricing Exception Code	**<blank>**
Non-Standard Format Code	**<blank>**
Drug Coverage Status Code	**C**

Step 2 Determine beneficiary cost-sharing: The first $20.00 of the claim falls in the initial coverage period. (The amount is calculated equals ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,820.00.) In the ICP, the beneficiary pays 25% or $5, calculated $20 * .25. The remaining $30 of the claim falls in the gap. In 2011, the beneficiary pays 93% or $27.90, calculated $30 * .93. The total beneficiary cost sharing is $32.90 ($5.00 from ICP + $27.90 from Gap).

PDE Field	Reported on the PDE Record
Ingredient Cost Paid	**$46.00**
Dispensing Fee Paid	**$2.00**
Total Amount Attributed to Sales Tax	**$2.00**
Vaccine Administration Fee	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$50.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Initial Coverage Period Cost	Gap Cost
$20.00	**$30.00**

Step 3 Calculate Covered and non-Covered Portion of Plan Paid cost-sharing: The plan pays 75% of the amount of the claim falling in the ICP, or $15 ($20* .75). The plan pays 7% of the amount of the claim falling in the gap, or $2.10 ($30 * .07). The total plan paid amount on this PDE is $17.10 ($15.00 from ICP + $2.10 from Gap).

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Patient Pay Amount	**$32.90**
Other TrOOP Amount	**$0.00**
Low-Income Cost-Sharing Subsidy Amount (LICS)	**$0.00**
Patient Liability Reduction due to Other Payer Amount (PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$17.10**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$50.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

Step 4 Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator: After the claim is processed, the TGCDC Accumulator increases by $50.00 from $2,820.00 to $2,870.00; the TrOOP Accumulator increases by $32.90 from $937.50 to $970.40.