



**Center for Medicare  
Medicare Plan Payment Group**

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Date: November 2, 2010

To: All Part D Plan Sponsors

From: Cheri Rice, Acting Director  
Medicare Plan Payment Group

Subject: Clarification of Prescription Drug Event (PDE) Rules for Reporting  
Covered Plan Paid (CPP) Amounts

This memo amends the July 9, 2010 HPMS memo entitled “Revised Guidance for Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap.” In order to apply risk-sharing uniformly across all plan types, CMS directs Enhanced Alternative (EA) Plans and Employer Group Health and Waiver Plans (EGWPs) to map the Covered Plan Paid (CPP) Amount reported on the PDE to the Defined Standard Benefit. In this memorandum, we expand rule #3 below by adding an instruction for non-applicable drugs. In 2011, CPP is 7% of the Total Gross Covered Drug Cost when a non-Low Income Subsidy (LIS) beneficiary who is in the coverage gap fills a prescription for a non-applicable Part D drug under the Coverage Gap Discount Program (CGDP).

**2011 MAPPING TO THE DEFINED STANDARD BENEFIT  
TO CALCULATE CPP AMOUNT FOR  
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	Applicable drugs 0% Non-applicable drugs 7%
4	>\$6,483.72 and <= OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost -\$2/\$5)

In the September 10, 2010 HPMS memo entitled “Additional Guidance concerning the Coverage Gap in 2011,” CMS clarified the definition of a non-applicable drug and stated

that “generic” coverage gap cost-sharing applies to all categories of Part D drugs that are not applicable drugs (e.g. medical supplies associated with the delivery of insulin and Part D Compounds). Previously “generic” coverage gap cost-sharing applied only to drugs approved by the FDA under an abbreviated new drug application (ANDA).

Recall that in 2011, the “generic” coverage gap cost-sharing for non-LI beneficiaries is 93%. “Generic” coverage gap cost-sharing reduces the non-LI beneficiary’s cost-sharing incrementally each year until the Gap is effectively closed in 2020. (The schedule of cost-sharing for 2011 through 2020 is presented in the July 9<sup>th</sup> memo.)

Please direct questions regarding this guidance to [PDEJan2011@cms.hhs.gov](mailto:PDEJan2011@cms.hhs.gov). Thank you.

**Example: Claim for a non-applicable drug with a Supplemental Copay Benefit (Enhanced Alternative Plan or EGWP)**

The following example shows plan cost-sharing calculations and Prescription Drug Event (PDE) reporting for a non-applicable drug purchased in the Coverage Gap by a non-LI beneficiary. The beneficiary is enrolled in an Enhanced Alternative Plan that charges a \$25 co-pay for compounds purchased in the Coverage Gap. The beneficiary purchases a \$50 compound drug.

PDE Field	Amount
Ingredient Cost Paid	\$46.00
Total Amount Attributed to Sales Tax	\$2.00
Vaccine Administration Fee	\$0.00
Dispensing Fee Paid	\$2.00
Gross Drug Costs Below Out-of-Pocket Threshold	\$50.00

The claim falls squarely in the coverage gap. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is \$3,000 and the TrOOP Accumulator is \$1,102.25. 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 TGCDL ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap.

The value of 2 in the Compound Code field indicates that the prescription is for a compounded drug; therefore this is a non-applicable drug and the Coverage Gap Discount does not apply.

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
Compound Code	2

Per the plan's benefit design, the beneficiary pays a \$25 co-pay.

Using rule #3 in the 2011 mapping table, the Covered Plan Paid Amount (CPP) is calculated as \$3.50. ( $\$50.00 * .07$ ).

The Non-Covered Plan Paid Amount is \$21.50 which is calculated as Total Gross Covered Drug Cost reduced by beneficiary cost-sharing (as specified in the plan's benefit design) and CPP. ( $\$50.00 - (\$3.50 + \$25.00)$ ) For additional information, see the module entitled "Calculating and Reporting the Enhanced Alternative Benefit" in the PDE Participant Guide available at <http://www.csscooperations.com/new/pdic/pdd-training.html>.

PDE Reporting: Populate the PDE as indicated below.

PDE Fields	Value
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)	\$0.00
Covered D Plan Paid Amount (CPP)	\$3.50
Non Covered Plan Paid Amount (NPP)	\$21.50
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$50.00
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$0.00

Finally, update the Total Gross Covered Drug Cost Accumulator and the TrOOP Accumulator. After the claim is processed, the TGCDCA Accumulator increases by \$50.00 from \$3,000.00 to \$3,050.00; the TrOOP Accumulator increases by \$25.00 from \$1102.25 to \$1127.25. These updated amounts would be reported on the PDE record for the next claim that is processed.