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

MEDICARE PLAN PAYMENT GROUP

TO: All Part D Plan Sponsors

FROM: Cheri Rice, Director
Medicare Plan Payment Group

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

DATE: April 23, 2013

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

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

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

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

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

Table 1: Steps to Calculate an MSP Claim

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

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

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

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

MSP in the Coverage Gap

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

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

See example 10 in Appendix 1 below.

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

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

See example 11 in Appendix 1 below.

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

Reinsurance under MSP

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

Adjusted GDCA = GDCA – PLRO

The reinsurance calculation will be:

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

Mistaken Payment Recovery

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

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

Appendix 1

PDE Examples

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

Examples 1 – 4 Defined Standard Benefit

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

Example 1

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

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

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

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

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

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

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

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

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

Example 2

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

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

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

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

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

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

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

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

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

Example 3

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

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

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

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

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

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

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

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

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

Appendix 1

Example 4

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

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

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

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

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

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

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

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

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

Example 5 Primary payment > negotiated price

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

Example 5

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

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

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

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

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

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

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

Step 7. CPP Amount = $0.

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

Examples 6 – 9 Enhanced Alternative Benefits

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

Example 6

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

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

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

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

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

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

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

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

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

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

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

Example 7

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

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

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

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

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

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

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

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

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

Appendix 1

Example 8

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

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

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

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

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

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

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

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

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

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

Example 9

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

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

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

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

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

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

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

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

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

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

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

Example 10 and 11 Coverage Gap Phase Examples

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

Example 10

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

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

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

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

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

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

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

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

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

Example 11

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

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

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

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

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

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

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

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

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