DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

TO: All Part D Plan Sponsors

FROM: Cheri Rice, Director
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SUBJECT: November 2013 Updates to the Drug Data Processing System

DATE: November 1, 2013

The Centers for Medicare & Medicaid Services (CMS) is announcing upcoming changes to the Drug Data Processing System (DDPS) that will take place in the month of November. An updated edit spreadsheet will be posted to the Customer Service and Support Center (CSSC) Operations website. Please submit questions regarding these changes to PDEJan2011@cms.hhs.gov.

Edit Changes for Employer Group Waiver Plans (EGWPs) Considered Defined Standard Plans in 2014:

In the February 15, 2013 memo titled, "Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter", CMS stated: EGWPs currently provide additional coverage as either 1) Medicare Part D supplemental benefits, reported on Prescription Drug Events (PDEs) as Non Covered Plan Paid Amount (NPP) or 2) Non-Medicare Other Health Insurance (OHI), reported on PDEs as patient liability reduction due to other payer (PLRO) amount. Beginning on January 1, 2014, all additional coverage provided by EGWPs will be considered OHI and reported as PLRO.

DDPS will regard all EGWP plans as Defined Standard plans with the statutorily specified benefit design and will apply all edits to EGWPs in the same manner that they are applied to Defined Standard plans. This change applies to Calendar Year (CY) and non-Calendar Year (non-CY) EGWP PDEs with Dates of Service (DOS) on and after January 1, 2014, regardless of the specific employer plan benefit year start date.

The following edits will now apply to EGWPs:

- Reject edit code762: If the drug coverage status code is "E", the contract type must be Enhanced Alternative.
- Reject edit code 779: Submitting Plan cannot report NPP for Covered Part D drugs.
- Informational edit code 787: Beginning and Ending Benefit Phase combination does not match the True Out-of-Pocket (TrOOP) Accumulator and/or Total Gross Covered Drug Cost (TGCDC) Accumulator.
- Reject edit code 869: No portion of this claim is in the coverage gap, therefor the coverage gap discount does not apply.
- Reject edit code 870: Reported Gap Discount <> CMS Calculated Gap Discount +/- 0.05.

- Informational edit code 872: Reported Gap Discount is less than or equal to amount estimated by CMS. This PDE may be subject to additional scrutiny. Estimation necessary because the accumulator amounts did not agree with the benefit phase values.
- Informational edit code 878: Reported Gap Discount is zero. No Gap discount applies when a PDE straddles two adjoining co-pay benefit phases and the second benefit phase is the coverage gap. This PDE may be subject to additional scrutiny.
- Reject edit code879: Reported coverage gap discount is zero and generic cost sharing is reported for gap discount eligible PDE.

Also effective with PDEs with DOS on and after January 1, 2014, DDPS will bypass the Low Income Cost-sharing Subsidy (LICS) edits 716-721 for EGWP PDEs where either the reported LICS or PLRO is not zero.

Editing Reported Gap Discount Amount on Enhanced Alternative (EA) plan PDEs:

CMS is implementing the policy finalized in the Advance Notice of Methodological Changes for CY 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter that specified the dispensing/vaccine administration fee liability on applicable drug coverage gap claims under EA plans with Part D supplemental coverage in the gap would be commensurate with the coinsurance percentage. Similarly, if the EA plan has a fixed copay, then the beneficiary liability for the dispensing/vaccine administration fee will be commensurate with the percentage of the total Part D claim cost attributed to the before discount copay. This policy change necessitates an update to the calculation used to edit the reported gap discount amount on EA PDEs that are squarely in the gap, where the EA plan offers a supplemental benefit in the gap. Specifically, the beneficiary's portion of the dispensing/vaccine administration fee must be deducted from the discount eligible cost prior to calculating the gap discount amount. The new calculation supporting Edit 870 will be applied to EA PDEs with DOS on and after January 1, 2014.

Eliminate Rule 4 Mapping for EA Plans:

CMS is eliminating EA Mapping Rule 4 beginning with PDEs with DOS of January 1, 2014. Consequently, EA plans will always use EA Mapping Rule 3 to map to the basic Part D benefit when a beneficiary has drug spend above the initial coverage limit but TrOOP amount is less than or equal to the Out-of-Pocket (OOP) threshold. Calculations supporting Reported Gap Discount editing for EA plans have been modified to remove reference to the Rule 4 adjustment amount for PDEs with DOS on and after January 1, 2014. Previously, the Rule 4 adjustment amount was determined prior to calculating the CMS Calculated Gap Discount amount and processing the PDE through the logic for the gap discount edits.

Reported Gap Discount Amount Editing for Out-of-Network PDEs:

The Network Differential costs applied to PDEs where the beneficiary visited an out-of-network pharmacy cannot be part of the eligible costs for the gap discount. DDPS has modified the coverage gap discount calculation logic for out-of-network PDEs. This change applies to PDEs with DOS on and after January 1, 2011. CMS will identify out-of-network PDEs by the Pricing Exception Code of "O" for out-of-network pharmacy. Sponsors may resubmit any 870 rejected PDEs that meet this criteria beginning on November 10, 2013. As a result of the change in the gap discount editing logic for out-of-network PDEs, the following edit codes may apply:

- Reject edit code 871: Reported Gap Discount exceeds amount estimated by CMS +/- 0.05.
- Informational edit code 876: Reported Gap Discount (minus rounding error) is less than the discount amount estimated by CMS, provided that NPP includes supplemental benefits in the Coverage Gap. This PDE may be subject to additional scrutiny.
- Informational edit code 877: Reported Gap Discount +/- rounding error equals the discount amount estimated by CMS, provided that NPP reports supplemental benefits in other benefit phases excluding the coverage gap. This PDE may be subject to additional scrutiny.
- Informational edit code 878: Reported Gap Discount is zero. No Gap discount applies when a PDE straddles two adjoining co-pay benefit phases and the second benefit phase is the coverage gap. This PDE may be subject to additional scrutiny.

Correction to Edit 870:

In our editing of gap discount PDEs, CMS evaluates the benefit phase indicators and the TGCDC Accumulator and the TrOOP accumulator and in instances where the indicators and accumulators do not match, CMS calculates the maximum gap discount amount. It was discovered that in some instances where benefit phases did not match accumulators, and the PDE was submitted by an EA plan that provided supplemental gap benefits, the DDPS issued some incorrect 870 edits. With this correction, the maximum gap discount amount will be calculated on all PDEs in which the benefit phase indicators do not match the accumulators. This correction applies to all DOS. Sponsors may resubmit any 870 rejected PDEs that meet this criteria beginning on November 10, 2013.

Bypass Edits 670 and 671 for Non-CY EGWP Plans:

CMS has determined that there are instances where edits 670 and 671 are being issued on PDEs from Non-CY EGWP plans when they should not be. This issue has occurred when a Non-CY EGWPs benefit year falls across calendar years. The editing logic for edits 670 and 671 uses the OOP threshold amount for the calendar year. When the non-CY EGWP enters a new calendar year but continues with the TrOOP threshold from their plan benefit year, PDEs were receiving edits 670 and 671 in error. For example, if the DOS on the PDE was in 2013, CMS used the 2013 OOP threshold amount when editing PDEs. If the non-CY EGWP began in 2012, the plan was using the 2012 OOP threshold to determine how to populate the PDE. Beginning in January 2013, this plan could have received edits 670 and 671 in error because CMS was editing the PDEs using the 2013 not 2012 OOP threshold. Therefore, DDPS shall bypass catastrophic phase edits, 670 and 671, for non-CY EGWP for DOS on and after January 1, 2011. Sponsors may resubmit any 670/671 rejected PDEs that meet this criteria beginning on November 10, 2013.

Change in Part D Barbiturate Coverage:

Medicare Part D began covering barbiturates (used for epilepsy, cancer, or chronic mental health disorder) as of January 1, 2013. Effective January 1, 2014, the restriction on barbiturate coverage under Part D is removed. Beginning January 1, 2014, barbiturates that otherwise meet the definition of a Part D drug may be covered under Part D for any medically accepted indication. Based upon this policy change, the following information describes how PDEs with Barbiturates will be processed depending on the DOS.

- Barbiturates submitted with DOS prior to 1/1/2013 will continue to receive edit 738, subcategory code 201.

- For 2013, barbiturates that are Part D drugs with DOS in 2013 are covered when used to treat epilepsy, cancer, or chronic mental health disorder. All other barbiturates on PDEs with DOS in 2013 will continue to receive edit 738, subcategory code 201.
- Starting in 2014, any PDEs for barbiturates that are Part D drugs with dates of service on and after 1/1/2014, will no longer receive edit 738. Barbiturates will no longer be limited to use in the treatment of epilepsy, cancer, or chronic mental health disorder.