DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

DATE: February 6, 2012

TO: All Part D Plan Sponsors

FROM: Cheri Rice, Director

SUBJECT: Drug Data Processing System (DDPS) Updates for February 2012

The Centers for Medicare & Medicaid Services (CMS) is announcing new updates to DDPS. The majority of the updates will take effect on February 24, 2012. This memorandum describes the changes that will occur. The updated edit spreadsheet will be posted to the CSSC Operations website.

Changes to the editing logic for informational edit code 787

Informational edit code 787 is currently issued when the benefit phase does not match the accumulators on a Prescription Drug Event (PDE), the date of service is on or after 1/1/2011, the plan is not a Program of All-Inclusive Care for the Elderly (PACE) plan, and the drug has a coverage status code of "C" for a covered drug. Prior to the implementation of this system enhancement, the edit generates even when there is a tier exception to the plan's deductible amount. For example, the plan defines in its bid that the standard or plan-specified alternative deductible does not apply to Tier 1 drugs. Plans have been instructed to submit benefit phases according to their plan design, so a Tier 1 drug adjudicated at any point prior to reaching the initial coverage limit (ICL) will have a beginning benefit phase (BBP) of "N" (initial coverage period). However, DDPS currently does not consider exceptions to the deductible in the logic that triggers informational edit code 787.

Effective for PDEs submitted on or after February 24, 2012 for dates of service of January 1, 2011 and forward, CMS will no longer return informational edit code 787 on PDEs submitted by plans with tier exceptions to the deductible (either the standard deductible or an alternative deductible) when the PDE is submitted with a BBP indicating "N" for the Initial Coverage Phase and a Tier reported on the PDE that matches the tier excepted from the deductible according to the plan's bid. The edit message reported for edit code 787 will not change.

PDE edit changes impacting Employer Group Waiver Plans (EGWPs)

CMS received feedback from EGWPs that received edit 869 for PDEs that are in the coverage gap phase of the benefit when the EGWP has a lower ICL than the Defined Standard benefit and therefore the Coverage Gap Phase begins at a lower Gross Covered Drug cost than expected. Effective on February 24, 2012 for dates of service on or after January 1, 2011, CMS will adjust the edit logic for reject edit code 869 to bypass PDEs submitted by EGWPs. The edit message reported for edit code 869 will not change.

CMS will also adjust the calculation for the Maximum Gap Discount Calculation when PDEs that are eligible for the Coverage Gap Discount Program are submitted by EGWPs. Effective on February 24, 2012, the new calculation is:

Maximum Gap Discount = (GDCB reported on the PDE * 0.5)

If the Reported Gap Discount Amount on the PDE exceeds the amount as calculated by this new formula, then the PDE will receive reject edit code 871.

Changes to the Gap Discount Calculation for Enhanced Alternative (EA) plans

For EA plans that have gross covered drug costs that exceed the amount that typically aligns with the out-of-pocket threshold (OOP) for defined standard benefit plans yet the True Out-of-Pocket (TrOOP) costs is less than the OOP threshold (i.e., EA plans that fall within Rule #4 when mapping CPP to the Defined Standard Benefit), CMS is adjusting the calculations when determining the Gap Discount eligible cost. The new calculation will apply to PDEs submitted by EA plans that fall either partially or completely in the Coverage Gap Phase and meet the Rule #4 criteria.

The following steps will be taken to determine the Gap Discount eligible cost:

Step 1: Calculate the portion of the coverage gap discount dollar amount that falls within Rule 4, as the lower of:

- Gross Drug Cost Below the Threshold (GDCB), or
- Total Gross Covered Drug Cost (TGCDC) Accumulator + GDCB – Rule 4 dollar amount

  Note: The Rule 4 Dollar amount is defined as the Gross Covered Drug Cost that is aligned with the OOP threshold for Defined Standard Benefit plans. For 2011, the Rule 4 dollar amount is $6,483.72. For 2012, the Rule 4 dollar amount is $6,730.39

If the lower amount selected in step 1 is negative, then the amount from step 1 will be zero.

Step 2: Determine the Rule 4 adjustment amount by multiplying the amount from Step 1 by 0.15 to determine the Covered D Plan Paid Amount (CPP) that is not subject to the gap discount.

Step 3: Modify the calculation of the gap discount by subtracting the amount calculated in Step 2 from the discount eligible amount, then multiply this amount by 0.5

> Calculated Gap Discount = (Discount Eligible Cost – Rule 4 adjustment amount) * 0.5

As a result of this change in the calculation logic, PDEs submitted by EA plans that fall within Rule 4 that received edit 870 under the previous logic may be accepted when resubmitted.

Changes to edit 788

In the December 22, 2010 Health Plan Management System (HPMS) memorandum titled, "Part D Payment Reconciliation reopening for 2006 and 2007 and Closing the Drug Data Processing System (DDPS) Database Three Years following the end of the each contract year", CMS announced the closure of the DDPS database thirty-seven months following the end of each benefit year. Effective on January 31, 2012, reject edit code 788 began to reject PDEs with dates of service prior to January 1, 2009 in order to close the DDPS database to PDEs for benefit year 2008. The edit message for edit 788 now states, "DDPS no longer accepts PDEs with dates of service before 1/1/2009".

Changes to edit 671

CMS is revising its logic for edit 671. For PDEs with dates of service after January 1, 2011, edit 671 uses the TrOOP Accumulator and the TrOOP eligible fields on the PDE record to validate Gross Drug Cost Above the out-of-pocket threshold (GDCA). The message for edit 671 states that "If (True Out-of-Pocket Accumulator + Patient Pay + Other TrOOP + Reported Gap Discount + LICS) <= OOP Threshold, GDCA must be zero."

However, through research, we have found that the logic for edit 671 does not take into account situations in which the plan benefit design or a secondary payer reduces or eliminates beneficiary liability in the catastrophic coverage phase. Therefore, edit 671 will allow GDCA > 0 on PDEs in which the TrOOP Accumulator + Patient Pay + Other TrOOP + Reported Gap Discount + LICS = OOP Maximum and NPP > 0 and/or PLRO > 0. The edit message for edit 671 will remain the same.

Upcoming changes to the Coverage Gap Discount Program Invoice reports

CMS will be enhancing the Coverage Gap Discount Program invoice reports (i.e. the Contract Summary Report and the Contract Data Report) prior to the release of the Q1 2012 invoice that will allow for the aggregation of invoiced amounts across multiple benefit years. The purpose of this change is to reduce the number of potential EFT transactions between

manufacturers and Part D sponsors and to simplify the payment confirmation process. An HPMS memo scheduled to be released at the end of February will detail all changes to the affected reports.

Please submit questions regarding the February 2012 updates to PDEJan2011@cms.hhs.gov.