



Centers for Medicare & Medicaid Services

Module 01: Part D Payment Methodology

2025 Prescription Drug Event (PDE) Participant Guide

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1. Purpose

This module introduces and describes Part D payment mechanisms, statutorily established payment methodologies and the financial data needed to process Part D payment.

2. Objectives

The information contained within this module applies to benefit years 2025 and forward. For benefit years prior to 2025, refer to the [2011 Prescription Drug Event \(PDE\) Participant Guide](#) located on the Customer Service and Support Center (CSSC) website.

The information provided in this module will help participants to:

- Identify and define the legislative payment mechanisms.
- Describe payments subject to reconciliation and risk sharing.
- Establish other context for understanding PDE data reporting and reconciliation processes.
- Understand the provisions of the Inflation Reduction Act (IRA), including the Manufacturer Discount Program (MDP).

3. Overview

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement, and Modernization Act (MMA), amending the Social Security Act (the Act) by adding Part D under Title 18. The new benefit allows Medicare payment to plans that contract with Centers for Medicare & Medicaid Services (CMS) to provide qualified Part D prescription drug coverage. The law provides payment mechanisms and, as a condition of payment, requires that plans submit data and information necessary for CMS to carry out those payment provisions.

The Affordable Care Act, as enacted in section 3301, and amended by section 1101 of the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) (HCERA) phases in a reduction in beneficiary cost-sharing for non-low-income beneficiaries when they purchase applicable drugs in the Coverage Gap Phase of the Medicare Part D benefit through the Coverage Gap Discount Program (CGDP) and coverage for generic drugs in the Coverage Gap.

The Inflation Reduction Act of 2022, Public L. 117-169 (IRA) was enacted into law on August 16, 2022, and makes significant changes to the Part D benefit design.

- Effective January 1, 2023:
 - The IRA eliminates the deductible and imposes a statutory maximum beneficiary cost-sharing limit for Part D covered insulin products.
 - The IRA eliminates the deductible and imposes a statutory maximum beneficiary cost-sharing of \$0 for adult vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP).
- Effective January 1, 2024:
 - The IRA amends section 1860D-2(b)(4)(A)(i)(II) of the Social Security Act so that enrollee cost-sharing in the Catastrophic Phase is eliminated.
 - The plan liability in the Catastrophic Phase increases from 15% to 20% for all covered Part D drugs, with plans continuing to receive an 80% federal reinsurance subsidy.
- Effective January 1, 2025:

- The IRA eliminates the Coverage Gap Phase, introduces manufacturer discounts in the Initial and Catastrophic Coverage Phases, changes enrollee and plan liability in the Initial Coverage Phase (ICP), and changes plan and government reinsurance liability in the Catastrophic Phase.
- The IRA sunsets the CGDP and the new MDP replaces the CGDP. CGDP invoices for drugs dispensed prior to 2025 will continue to be produced for a total of 17 quarters until 2028. For additional details on the CGDP, please refer to the [2011 version of the PDE Participant Guide](#).
- Effective January 1, 2026:
 - The IRA establishes the Medicare Drug Price Negotiation Program (Negotiation Program) to negotiate maximum fair prices (MFPs) for certain high expenditure, single source drugs and biological products.
 - Section 11201 of the IRA added section 1860D-14D to the Act, creating a new selected drug subsidy program which begins in Calendar Year (CY) 2026. Under the selected drug subsidy program, the Secretary must, periodically and on a timely basis, provide Part D sponsors with a subsidy for selected drugs equal to 10% of the drug's negotiated price.

4. Part D Payment Methodologies

All Part D plans are required to provide a minimum set of prescription drug benefits, typically referred to as the “basic” benefit (see Module 04: Calculating and Reporting the Basic Benefit). The MMA mandated either a specific benefit design called the Defined Standard (DS) benefit or an alternative benefit design that is considered to be actuarially equivalent (AE). For an extra premium, plans can offer benefits that exceed the basic amount (see Module 07: Calculating and Reporting the Enhanced Alternative Benefit), but the government only pays for the basic benefit.

Part D provides mechanisms to pay plans for Part D basic benefits. The PDE record is structured to report data to determine these payments. The payment mechanisms are as follows:

- Direct Subsidy—The direct subsidy is designed, together with beneficiary premiums, to cover the plan's cost for the risk portion of the basic benefit. The direct subsidy is a capitated per member per month risk payment that is equal to the product of the plan's approved Part D standardized bid and the beneficiary's health status risk adjustment score, minus the monthly beneficiary premium related to the standardized bid amount.
- Low-Income Subsidy (LIS)—The MMA provides two types of subsidies for qualifying low-income beneficiaries: premium assistance and cost-sharing assistance. Low-income premium subsidies are part of the risk payment that results from the standardized bid. The government also issues cost-sharing subsidies that are not included in the standardized bid amount and are separate government payments on behalf of certain beneficiaries based on their income and asset levels. When applicable, this low-income cost-sharing subsidy amount (LICS) applies to each prescription drug event and is subject to year-end cost-based reconciliation.
- Reinsurance subsidy—Reinsurance reduces the risk of participating in Part D by guaranteeing plans a certain amount of payment for beneficiaries with high drug costs. The reinsurance subsidy is a federal subsidy equal to 20% of allowable drug costs above the out-of-pocket (OOP) threshold for applicable drugs and 40% of allowable drug costs above the OOP threshold for non-applicable drugs and selected drugs, net of any

other remuneration (e.g., rebates, coupons, or discounts collectively referred to as direct and indirect remuneration (DIR); see 6.2.2). The reinsurance subsidy is subject to cost-based reconciliation.

- **Risk Sharing (Risk Corridors)**—The purpose of risk sharing is to limit a plan’s exposure to unexpected expenses not already included in the reinsurance subsidy or taken into account through health status risk adjustment. The federal government and the plan share the profits or losses resulting from expenses for the basic benefit within defined symmetrical risk corridors around a target amount. Risk sharing payment is also referred to as risk corridor payment and can be positive, negative, or zero.
- **Selected Drug Subsidy**—The purpose of this is to provide Part D sponsors with a subsidy for selected drugs equal to 10% of the drug’s negotiated price. The selected drug subsidy applies to a covered Part D drug that would otherwise meet the definition of an applicable drug but for being a selected drug during a price applicability period. The subsidy is paid on behalf of an applicable beneficiary who is enrolled in a Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD), has not incurred costs that are equal to or exceed the annual OOP threshold, and is dispensed a selected drug. Under the selected drug subsidy program, once an enrollee incurs costs exceeding the annual deductible specified in section 1860D-2(b)(1) of the Act, that is, the deductible under the DS benefit, the selected drug subsidy is available in the ICP of the benefit. The selected drug subsidy lowers Part D sponsor liability on the negotiated price of the drug.

Note:

- The plan’s standardized bid is designed to cover a certain percentage of drug costs as well as administrative costs that include the plan’s estimate of gain or loss.
- The beneficiary premium related to the standardized bid amount includes premium amounts paid by enrollees or paid on their behalf, including A/B rebates applied to the basic benefit and low-income premium subsidies. Unless specifically noted, reference to the basic beneficiary premium in this module means the “premium related to the standardized bid amount” without specifying who pays the premium. Excluded are any premiums for supplemental benefits or A/B benefits.

Reminder: The MDP has its own payment process separate from the Part D payment methodologies (see Module 15: MDP Invoice & Payment).

4.1 Covered Drugs

The payment methodologies above only apply to covered drugs. The term covered drugs refers to Part D drugs that a plan covers under its basic benefit. Covered drugs are Part D drugs approved for coverage under a specific Plan Benefit Package (PBP) or under exceptions, transitions, grievances, appeals, or other coverage determination processes. A Part D drug is defined as:

- Any prescription drug described in §1927(k)(2)(A) of the Act, a vaccine licensed under section 351 of the Public Health Service Act (PHSA), a biological product described in §1927(k)(2)(B) of the Act, or insulin described in §1927(k)(2)(C) and medical supplies associated with the injection of insulin as allowed under §1860D-2(e)(1)(B). Except for smoking cessation drugs, Part D drugs must be prescribed for the purposes allowed under §1862(a) and §1927(d)(2) (e.g., reasonable and necessary guidelines, exclusion of drug classes used for weight loss or cosmetic surgery). Drugs cannot be billed as Part

D drugs if they are already covered under Medicare Parts A or B as prescribed, dispensed, or administered (§1860D-2(e)(2)(B)).

- For an applicable drug or a selected drug during a price applicability period to be covered under Part D, the FDA-assigned labeler code of such applicable drug or selected drug must be covered under an MDP agreement that is fully executed and in effect.

Resource: Health Plan Management System (HPMS) memorandum, Revised Medicare Part D Manufacturer Discount Program Final Guidance, December 20, 2024.

4.2 Gross Covered Drug Cost

This module and subsequent modules delineate specific rules plans must follow to report the prescription drug cost and payment amounts for covered drugs on the PDE record under all types of PBPs. This guide also describes how CMS then uses those amounts to determine allowable costs for reinsurance and risk corridor payment and to pay the LICs and the Selected Drug Subsidy.

For two reasons, the drug cost reported on a PDE record must be net of plan administrative costs and net of any point of sale (POS) price concessions/remuneration:

1. Part D payment is based on a subset of the reported cost that must be net of these amounts; and
2. Beneficiary cost-sharing is determined as a portion of the cost net of these two amounts.

Resource: 42 CFR 423.308, 42 CFR 423.104 and 42 CFR 423.100

Part D payment is made based on the gross covered drug cost for a dispensing event, as reported on the PDE.

Resource: §1860D-15(b) and 42 CFR 423.308

On the PDE record, the plan reports gross covered drug cost using several fields:

1. As the sum of the detail fields Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee; and
2. In the summary fields Gross Drug Cost Above OOP Threshold (GDCA) and/or Gross Drug Cost Below OOP Threshold (GDCB).

The statute and regulation define the sub-categories of gross covered drug costs that are subject to reinsurance and risk corridor payment, namely “allowable reinsurance costs” and “allowable risk corridor costs”. These allowable costs are subsets of gross covered drug costs that are “actually paid”. CMS determines allowable costs based on values reported on PDE records.

Resource: §1860D-15(b) and 42 CFR 423.308

Reminder: Reinsurance and risk corridor payments are net of administrative costs, POS price concessions/remuneration, and all other DIR.

Part D sponsors must base beneficiary cost-sharing and price reporting to CMS on the price ultimately received by the pharmacy or other dispensing provider. Therefore, plans that use a Pharmacy Benefit Manager (PBM) to negotiate prices and/or provide administrative services on its behalf must use the price paid to the pharmacy (also known as the pass-through amount) to calculate beneficiary cost-sharing and to report gross covered drug cost on PDE records. The

plan must use this pricing approach as a consistent basis for (i) calculating beneficiary cost-sharing; (ii) accumulating gross covered drug costs; (iii) calculating True Out-of-Pocket costs (TrOOP); (iv) reporting drug costs on the PDE; and (v) developing bids submitted to CMS. This ensures that the beneficiary cost-sharing and reinsurance payments received by the plan are consistent with its bidding assumptions.

5. The Payment Mechanisms Related to the Defined Standard Benefit

The payment mechanisms can be illustrated by showing how they apply in the DS benefit.

5.1 The Defined Standard Benefit

Figure 1 illustrates the phases of the 2025 DS benefit and Figure 2 illustrates the phases of the 2026 DS benefit.

The DS benefit has three benefit phases: the Deductible Phase, the ICP, and the Catastrophic Phase. Year-to-Date (YTD) TrOOP costs determine when the beneficiary is in the Deductible Phase, the ICP and the Catastrophic Phase.

In accordance with law, the parameters (dollar values) of the DS benefit are indexed annually to account for factors such as inflation and average annual Part D per capita drug expenditure. Table 1 provides benefit parameters associated with the DS benefit in 2025 and Table 2 provides benefit parameters associated with the DS benefit in 2026.

Figure 1: 2025 Defined Standard Benefit

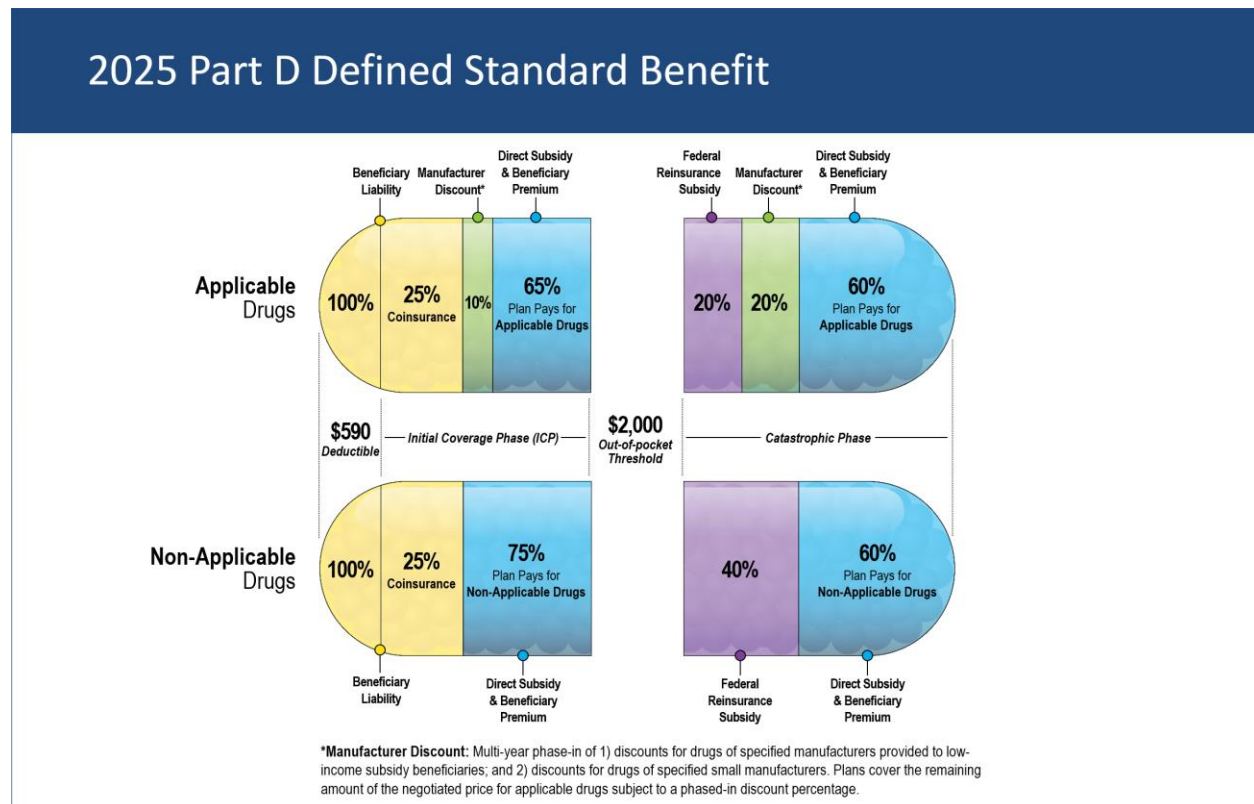


Figure 2: 2026 Defined Standard Benefit

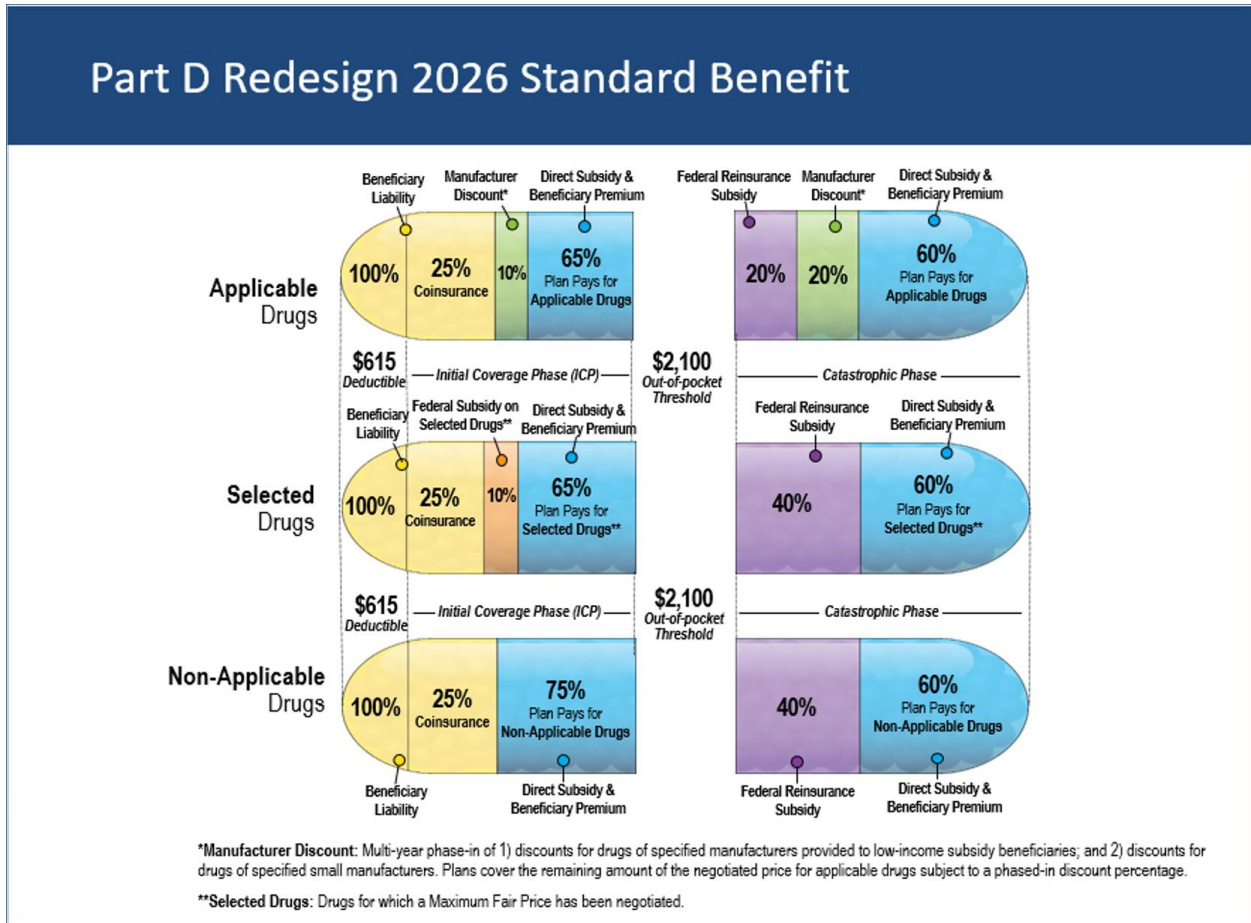


Table 1: The 2025 Defined Standard Benefit

Benefit Phase	Year-to-Date TrOOP Costs	Beneficiary Cost-Sharing	Plan Liability	Manufacturer Discount
Deductible Phase	< \$590	100% coinsurance	0%	0%
Initial Coverage Phase	≥ \$590 < \$2,000	25% coinsurance	Non-Applicable Drug – 75% Applicable Drug – 65% MDP Phase-in Eligible Applicable Drug – 74%	Non-Applicable Drug – 0% Applicable Drug – 10% MDP Phase-in Eligible Applicable Drug – 1%
Catastrophic Phase	= \$2,000 (OOP threshold)	0% coinsurance	Non-Applicable Drug – 100% Applicable Drug – 80% MDP Phase-in Eligible Applicable Drug – 99%	Non-Applicable Drug – 0% Applicable Drug – 20% MDP Phase-in Eligible Applicable Drug – 1%

Notes to Table 1:

1. This table excludes cost-sharing for covered insulin products and ACIP-recommended vaccines and excludes cost-sharing for LIS beneficiaries.
2. The plan liability column refers to the Covered D Plan Paid Amount (CPP) reported on the PDE and does not account for the Medicare Reinsurance amount, which in CY 2025 is 20% for applicable drugs and 40% for non-applicable drugs in the Catastrophic Phase.
3. Applicable, non-applicable, and MDP phase-in eligible applicable drugs are described in additional detail in Module 15: MDP Invoice & Payment.
4. See Attachment V of the Announcement of CY 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies and Section 20 of the Final CY 2025 Part D Redesign Program Instructions for a detailed discussion of the benefit phase changes in place in 2025.

Table 2: The 2026 Defined Standard Benefit

Benefit Phase	Year-to-Date TrOOP Costs	Beneficiary Cost-Sharing	Plan Liability	Manufacturer Discount	Selected Drug Subsidy
Deductible Phase	< \$615	100% coinsurance	0%	0%	0%
Initial Coverage Phase	≥ \$615 < \$2,100	25% coinsurance	Non-Applicable Drug – 75% Applicable Drug or Selected Drug – 65% MDP Phase-in Eligible Applicable Drug – 73%	Non-Applicable Drug – 0% Applicable Drug – 10%* MDP Phase-in Eligible Applicable Drug – 2%	Selected Drug – 10%*
Catastrophic Phase	= \$2,100 (OOP threshold)	0% coinsurance	Non-Applicable Drug or Selected Drug – 100% Applicable Drug – 80% MDP Phase-in Eligible Applicable Drug – 98%	Non-Applicable Drug – 0% Applicable Drug – 20% MDP Phase-in Eligible Applicable Drug – 2%	0%

*Within the Initial Coverage Phase (ICP), either a manufacturer discount or a selected drug subsidy applies, but not both. Manufacturers provide a 10% discount on applicable drugs, while for selected drugs, CMS pays a 10% subsidy.

Notes to Table 2:

1. This table excludes cost-sharing for covered insulin products and ACIP-recommended vaccines and excludes cost-sharing for LIS beneficiaries.
2. The plan liability column refers to the CPP reported on the PDE and does not account for the Medicare Reinsurance amount, which in CY 2026 is 20% for applicable drugs and 40% for non-applicable drugs in the Catastrophic Phase.
3. Applicable, non-applicable, and MDP phase-in eligible applicable drugs are described in additional detail in Module 15: MDP Invoice & Payment.

4. See Attachment V of the Announcement of CY 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies and Section 20 of the Final CY 2026 Part D Redesign Program Instructions for a detailed discussion of the benefit phase changes in place in 2026.

5.2 Payment Methodologies in Relation to the Defined Standard Benefit

The payment mechanisms apply to the DS benefit as follows:

- In 2025, the direct subsidy applies in the ICP and in the Catastrophic Phase of the benefit. The direct subsidy is one of the two risk components of payment. The other is the basic beneficiary premium. The direct subsidy and basic beneficiary premium are designed to cover 75% of covered drug cost in the ICP and 60% of covered drug costs in the Catastrophic Coverage Phase, as well as administrative costs approved in the bid.
- LICS applies in the Deductible and Initial Coverage Phases of the benefit for low-income eligible beneficiaries.
- Reinsurance Subsidy applies in the Catastrophic Phase of the benefit. The reinsurance subsidy is calculated as 20% of total allowed costs for applicable drugs in the Catastrophic Phase and 40% of total allowed costs for non-applicable and selected drugs in the Catastrophic Phase.
- Risk sharing applies to allowable plan-paid amounts in the ICP and in the Catastrophic Phase of the benefit. Risk sharing is calculated at the plan level for the basic benefit and compares risk payments (the direct subsidy and basic beneficiary premium) with aggregate allowed plan-paid drug costs.
- In 2026, the selected drug subsidy applies in the ICP of the benefit. In the ICP, CMS will pay a 10% subsidy for selected drugs during a price applicability period.

6. General Summary of Part D Payment Reconciliation

Throughout the benefit year, the government makes prospective payments to plans that cover subsidies: the direct subsidy, LICS, the reinsurance subsidy, and the selected drug subsidy. The payment amounts are based on information in the approved basic bid and on data provided by CMS that update payments throughout the year. These data include enrollment dates, low-income subsidy eligibility, long-term institutional status, and risk adjustment scores. Enrollment dates and low-income subsidy status may change throughout the year, and retroactive changes may occur after the payment year. Those updates will result in monthly adjustments to prior prospective payments. There is a final update of long-term institutional status and risk adjustment scores before reconciliation begins. During reconciliation, CMS compares the finalized prospective payments, and the corresponding actual costs reported on PDEs and makes payment adjustment according to the rules for each payment methodology. Payment adjustment can be positive or negative. For more information on Part D payment reconciliation, see Module 16: Reconciliation.

Reminder: The MDP has its own payment process separate from the Part D payment methodologies (see Module 15: MDP Invoice & Payment).

6.1 Payment Timetable and Part D Payment Reconciliation Status

Table 3 displays the payment types and shows if the payment is prospective and subject to reconciliation.

Table 3: Payment Mechanisms

Payment Mechanism	Payment Schedule	Reconciliation
Direct Subsidy	Monthly Prospective Payments	Yes-recalculate Risk Adjustment Scores
LICS*	Monthly Prospective Payments	Yes
Reinsurance Subsidy	Monthly Prospective Payments	Yes
Risk sharing	Reconciliation Payment	Yes
Selected Drug Subsidy	Monthly Prospective Payments	Yes

*Low-income subsidy beneficiaries also receive premium assistance, which is paid and reported separately.

6.2 Data Collection for Part D

6.2.1 Prescription Drug Event (PDE)

For CMS to carry out the payment mechanisms, Part D plans must submit PDE data as a condition of payment. CMS uses the PDE data to reconcile LICS, reinsurance payments, the selected drug subsidy, and to implement risk sharing.

Criteria to determine data requirements – CMS uses the following criteria to determine which data elements are necessary to collect on the PDE:

- Ability to administer the Part D program and make timely, accurate payments including:
 - Using the legislated payment mechanisms (direct subsidy, LICS, reinsurance subsidy, risk sharing, and selected drug subsidy), and
 - The MDP invoices, Medicare Drug Price Negotiation Program, and the Medicare Prescription Payment Plan.
- Minimal administrative burden on CMS, plans, and other entities including PBMs, pharmacies, and others.
- Legislative authority.
- Data validity and reliability.

Data elements collected on the PDE include information about the beneficiary, entity and event identification, drug and quantity identification, cost, payment breakout, prescriber, service provider, and the plan benefit design. More details about the specific fields on the PDE can be found in Module 03: Data Format.

Reminder: The PDE record may summarize multiple transactions and documents the final adjudication of a dispensing event. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted and replicate the summarization.

6.2.2 Direct and Indirect Remuneration (DIR)

DIR includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source, including manufacturers, pharmacies, enrollees, or any other person that would serve to decrease the costs incurred by the Part D plan for the drug.

Resource: 42 CFR 423.308

DIR also includes any payments or repayments that plans make as part of risk arrangements with providers in accordance with CMS guidance. By law, all DIR must be excluded from reinsurance and risk corridor payment. Allowable costs for reinsurance and risk corridor payment are a portion of gross covered prescription drug costs, net of all DIR and net of administrative costs.

Beginning January 1, 2024, 42 CFR § 423.100 makes clear that the negotiated price is the lowest possible reimbursement that a network dispensing pharmacy or other network dispensing provider will receive, in total, for a particular drug. The negotiated price, therefore, includes all network pharmacy and other network provider price concessions, and is reduced by all price concessions and other DIR that the Part D sponsor passes through at the POS. Accordingly, the applicable discount is always calculated based on a negotiated price that, at a minimum, represents the lowest possible reimbursement to a network dispensing pharmacy or other network dispensing provider. All DIR, regardless of whether or not it is reflected in the cost of the drug on the PDE record, must be reported separately to CMS for exclusion from allowable costs for payment. Within six months of year-end, plans must submit all applicable DIR to CMS.

Reminder: The Final Medicare Part D DIR Reporting Guidance is released annually through HPMS and provides detailed instructions to plans for reporting DIR data to CMS.

7. Overview of the Manufacturer Discount Program

The Inflation Reduction Act (IRA) establishes the MDP by adding sections 1860D-43 and 1860D-14C to the Act. Effective January 1, 2025, the MDP makes manufacturer discounts available to applicable Medicare beneficiaries receiving applicable drugs while in the Initial Coverage Phase and Catastrophic Phase. In general, the discount on each applicable drug is 10% of an amount equal to the negotiated price for costs falling in the Initial Coverage Phase and 20% of an amount equal to the negotiated price for costs falling in the Catastrophic Phase for drugs not subject to a phase-in. The discount is 1% of an amount equal to the negotiated price for costs falling in the Initial Coverage Phase and Catastrophic Phase for drugs eligible for a Discount Program phase-in in 2025. The phase-in percentage will increase in subsequent benefit years until it reaches 10% of costs falling in the Initial Coverage Phase starting in 2029, and 20% of costs in the Catastrophic Phase starting in 2031. Table 4 shows changes to the phase-in over time.

Table 4: Discount Phase-in Percentage by Benefit Year

Benefit Year	Pre-Catastrophic Phase-In	Catastrophic Phase-In
2025	1%	1%
2026	2%	2%
2027	5%	5%
2028	8%	8%
2029	10%	10%
2030	10%	15%
2031 and thereafter	10%	20%

7.1 Applicable and Non-Applicable Drugs

Applicable drugs are defined at section 1860D-14C(g)(2) of the statute and are generally brand covered Part D drugs that are either approved under a new drug application (NDA) under

section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (PHSA). All applicable drugs must be covered under a manufacturer discount agreement with CMS for coverage to be available under Part D. Non-applicable drug means any Part D drug that is not an applicable drug including a selected drug during a price applicability period.

7.2 Plan Liability in the Manufacturer Discount Program

Beginning in 2025, the IRA eliminates the Coverage Gap Phase, introduces manufacturer discounts in the ICP and Catastrophic Phases, changes plan liability in the ICP, lowers the annual OOP threshold, and changes plan and government reinsurance liability in the Catastrophic Phase.

Under the MDP, participating manufacturers are required to provide discounts on their applicable drugs both in the Initial and Catastrophic Phases of the Part D benefit. There is no manufacturer discount provided during the Deductible Phase.

7.3 Applicable Beneficiary

An applicable beneficiary is defined as an individual who, on the date of dispensing a covered Part D drug:

- Is enrolled in a prescription drug plan or an MA-PD plan;
- Is not enrolled in a qualified retiree prescription drug plan; and
- Has incurred costs, as determined in accordance with section 1860D-2(b)(4)(C) of the Act, for Part D drugs in the year that exceed the annual deductible specified in section 1860D-2(b)(1) of the Act.

Participants in Program of the All-Inclusive Care for the Elderly (PACE), Limited Income Newly Eligible Transition (LINET), and Employer Group Waiver Plans (EGWPs) are eligible for participation in MDP if they otherwise satisfy the definition of an applicable beneficiary.

7.4 Manufacturer Discount Program Prospective Payment

CMS provides a monthly prospective Manufacturer Discount payment to Part D sponsors for the discounts made available to their enrollees under the MDP.

7.4.1 Timing of Payment

Part D sponsors will receive the prospective MDP payments on the first of each month with their other Part D prospective payments. The MDP payments will be reflected as a separate line item on each Part D sponsor's Monthly Membership Detail Reports and included in the Part D payments displayed on the Monthly Membership Summary Reports.

For any benefit year, the prospective payments begin with the January monthly payment for the benefit year and end with the December monthly payment. Adjustments to a benefit year's prospective payments continue to January of the following year. For benefit year 2025, the first prospective payment will be in the January 2025 monthly payment and the last payment containing adjustments to previously paid 2025 prospective payments will be in the January 2026 monthly payment.

7.4.2 Calculation of the Manufacturer Discount Program Prospective Payment

The prospective MDP payments will be calculated based on the projections in each Part D plan's bid and their current enrollment. CMS will estimate the per member per month cost of the manufacturer discounts for each plan based on the drug costs projected in their approved Part D bids. This plan specific estimate will be made available to Part D sponsors on HPMS on the Part C & D Bid and premium information page.

Each month, CMS will determine the prospective MDP payment by multiplying the plan specific MDP discount estimate by the number of beneficiaries enrolled in the plan.

Note: EGWPs do not submit Part D bids; therefore, CMS will not have the information necessary to estimate the cost of applicable discounts for these plans, and will not provide prospective MDP payments to EGWPs.

Resource: ["Announcement of Calendar Year \(CY\) 2025 Medicare Advantage \(MA\) Capitation Rates and Part C and Part D Payment Policies"](#).

Appendix A: Acronyms

Table 5: Acronyms

Acronym	Literal Translation
ACIP	Advisory Committee on Immunization Practices
AE	Actuarially Equivalent
CGDP	Coverage Gap Discount Program
CMS	Centers for Medicare & Medicaid Services
CPP	Covered D Plan Paid Amount
CSSC	Customer Service and Support Center
CY	Calendar Year
DIR	Direct and Indirect Remuneration
DS	Defined Standard
EGWP	Employer Group Waiver Plan
GDCA	Gross Drug Cost Above OOP Threshold
GDCB	Gross Drug Cost Below OOP Threshold
HCERA	Health Care and Education Reconciliation Act of 2010
HPMS	Health Plan Management System
ICP	Initial Coverage Phase
IRA	Inflation Reduction Act
LINET	Limited Income Newly Eligible Transition
LICS	Low-Income Cost-Sharing Subsidy Amount
LIS	Low-Income Subsidy
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MDP	Manufacturer Discount Program
MFP	Maximum Fair Price
MMA	Medicare Prescription Drug Benefit, Improvement, and Modernization Act
NDA	New Drug Application
OOP	Out-of-Pocket
PACE	Program of the All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PHSA	Public Health Service Act
POS	Point of Sale
TrOOP	True Out-of-Pocket
YTD	Year-to-Date